MEETING

HEALTH & WELL-BEING BOARD

DATE AND TIME

THURSDAY 27TH JUNE, 2013

AT 9.00 AM

VENUE

HENDON TOWN HALL, THE BURROUGHS, NW4 4BG

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

Chairman: Councillor Helena Hart (Chairman),
Vice Chairman:

Andrew Howe	Dr Sue Sumners	Selina Rodrigues
Cllr Sachin Rajput	Kate Kennally	Dawn Wakeling
Dr Charlotte Benjamin	John Morton	
Dr Clare Stephens	Cllr Reuben Thompstone	

Substitute Members

Mathew Kendall	David Riddle	Jay Mercer

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

Andrew Nathan – Head of Governance

Governance Services contact: Lawnetta Greaves 020 8359 7113

Media Relations contact: Sue Cocker 020 8359 7039

ASSURANCE GROUP

ORDER OF BUSINESS

Item No	Title of Report	Pages
1.	Minutes of the Previous Meeting	
2.	Absence of Members	
3.	Winterbourne View - Update report	1 - 16
4.	Report of the Barnet Health and Well-Being Board/ Partnership Boards Summit	17 - 52
5.	Social Care Funding	53 - 76
6.	Barnet CCG Recovery Plan	77 - 174
7.	Barnet CCG Integrated Care Plan for 13/14	175 - 194
8a	Contract Management of Healthwatch Barnet	195 - 202
8b	Healthwatch Barnet Update	203 - 210
9a	Presentation from NHS England on it's role and responsibilities/the NHS Assurance framework	
9b	The NHS England Assurance Framework: national report for consultation	211 - 216
10.	Performance Management Framework for the Health and Well-Being Strategy	217 - 230
11.	Public Health Intelligence Briefings	231 - 258
12.	Pharmaceutical Needs Assessment	259 - 264
13.	Clinical Commissioning Programmes	265 - 274
14.	Forward Work Programme	275 - 284

FACILITIES FOR PEOPLE WITH DISABILITIES

Hendon Town Hall has access for wheelchair users including lifts and toilets. If you wish to let us know in advance that you will be attending the meeting, please telephone Andrew Nathan 020 8359 7029 andrew.nathan@barnet.gov.uk. People with hearing difficulties who have a text phone, may telephone our minicom number on 020 8203 8942. All of our Committee Rooms also have induction loops.

FIRE/EMERGENCY EVACUATION PROCEDURE

If the fire alarm sounds continuously, or if you are instructed to do so, you must leave the building by the nearest available exit. You will be directed to the nearest exit by Committee staff or by uniformed custodians. It is vital you follow their instructions.

You should proceed calmly; do not run and do not use the lifts.

Do not stop to collect personal belongings

Once you are outside, please do not wait immediately next to the building, but move some distance away and await further instructions.

Do not re-enter the building until told to do so.

This page is intentionally left blank

Meeting	Health and Well-Being Board	AGENDA ITEM 3
Date	27 June 2013	
Subject	**Winterbourne View- Update report**	
Report of	Cabinet Member for Public Health	
Summary of item and decision being sought	Barnet Council has been asked to coordinate a local "stocktake" on progress being made to deliver the Winterbourne View Concordat. Norman Lamb MP, Minister of State for Care Services, has also recently written to Local Authority Chairmen of Health and Well-Being Boards outlining their leadership role in ensuring that the Winterbourne View Concordat commitments are achieved. The Health and Well-Being Board is asked to note the actions that have been taken place locally to progress delivery of the Concordat, and to note the actions requested of the Board by Norman Lamb MP (detailed in this Report).	

Officer Contributors	Claire Mundle, Commissioning and Policy Advisor - Public Health / Health & Well-Being
Reason for Report	The purpose of the Report is twofold. Firstly, the Health and Well-Being Board is asked to note the progress at both the national and local level in response to the publication of the Winterbourne View Review by the Department of Health, and the subsequent signing of the Concordat. Secondly, the Health and Well-being Board is asked to note the actions requested of the Board by Norman Lamb (detailed in this Report).
Partnership flexibility being exercised	None
Wards Affected	All
Contact for further information	Claire Mundle, Commissioning and Policy Advisor – Public Health / Health & Well-Being, 020 8359 3478, Claire.mundle@barnet.gov.uk

1. RECOMMENDATION

1.1 That the Health and Well-Being Board (HWBB) notes the actions taking place locally to support delivery against the Winterbourne View Concordat outlined in this Report.

1.2 That the Health and Well-Being Board notes the specific requests made by Norman Lamb MP that Health and Well-Being Board's embody a leadership role with respect to delivery against the Winterbourne View Concordat in their local area.

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 Health and Well-Being Board- Winterbourne View One Year On- Thursday 29th November 2012.

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

3.1 This Report focuses on the safeguards and safety of people with learning disabilities. Safeguarding is one of the key responsibilities of the Health and Well-Being Board. The safeguarding agenda links directly with the four main themes of the Health and Well-Being Strategy 2012-15; '*Preparing for a healthy life'*, '*Wellbeing in the community', 'How we live', and 'Care when needed'.*

4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 Barnet's Joint Strategic Needs Assessment shows that people with learning disabilities are one of the most excluded groups in the Community. They are much more likely to be socially excluded and to have significant health risks and major health problems including obesity, diabetes, mental health problems, heart and respiratory diseases.

5. RISK MANAGEMENT

5.1 A failure to keep adults at risk of abuse safe from avoidable harm represents not only a significant risk to residents but also to the reputation of the Council and Barnet Clinical Commissioning Group (CCG). Although safeguarding must be the concern of all agencies working with vulnerable adults, and is also of particular relevance to the Special Safeguarding Overview and Scrutiny Committee, the Local Authority is lead agency through the multi-agency Safeguarding Adults Board, chaired by the Adults and Communities Director.

5.2 Barnet's Health and Well-Being Board has a key leadership role to play in ensuring that the commitments made in the Winterbourne View Concordat are achieved.

6. LEGAL POWERS AND IMPLICATIONS

6.1 None relating specifically to this report.

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

7.1 None relating specifically to this report.

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 The Barnet Learning Disability Partnership Board (LDPB), a multi-agency partnership arrangement bringing together people with learning disabilities and autism, family carers and professionals from the Council, NHS, voluntary sector and other mainstream services has played an important role to date in fostering a partnership approach to keeping people safe.

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 Barnet Safeguarding Adults Board (SAB) provides an inter-agency framework for coordinating actions in respect of safeguarding with representation from the Council, CCG, NHS Trusts, the voluntary sector, the police and service users.

9.2 The Adult and Communities Director, in her role of Director of Adult Social Services, will involve Health and Well-Being Board partner organisations in completing aspects of the review of local progress on meeting the Concordat where this is relevant/ necessary.

10. DETAILS

10.1 In December 2012 the Department of Health published its final report into the events at Winterbourne View Hospital and set out a programme of action to transform services so that vulnerable people no longer live inappropriately in hospitals and are cared for in line with best practice.

10.2 Barnet responded quickly to both the events at Winterbourne and the government's report, putting an action plan in place to ensure that there would not be any similar failings here. The Safeguarding Adults Board (SAB) has played a proactive role in coordinating our approach locally to safeguarding vulnerable adults. In March 2013, the SAB planned a conference to make sure everyone locally could learn lessons from what went wrong at Winterbourne View. The event was attended by 84 staff who commission and monitor services, as well as health and social care professionals, and provider services.

10.3 Following the Department of Health report, all relevant statutory and non-statutory (50 in total) agencies / organisations signed up to a national 'Concordat' which outlines key actions and their commitments in response to Winterbourne View.

10.4 The Concordat contains a number of specific commitments that will lead to all individuals receiving personalised care and support in community settings no later than 1st June 2014.

10.5 On the 31st May 2013, Local Authority Chief Executives received a request to complete a "stocktake" of progress against the commitments made in the Concordat. The purpose of the stocktake is to enable local areas to assess their progress against commitments in the Concordat and to allow for good practice and progress from local areas to be shared nationally.

10.6 Locally, there are the following plans in place to complete the stocktake:

- The stocktake response will be prepared jointly by London Borough of Barnet (LBB) Adults and Communities and the Clinical Commissioning Group (CCG), and signed-off by Dawn Wakeling as the LBB Director of Adult Social Services (DASS) and the relevant CCG lead.
- The paper will then be referred to Councillor Hart and the Chief Executive of the Local Authority for final sign-off.
- The DASS will then circulate the document to the HWBB.
- The DASS will involve HWBB partner organisations in completing aspects of the stocktake where this is relevant/ necessary.

10.7 The stocktake will be bought to the September 2013 meeting of the Health and Well-Being Board for the Board to discuss in detail. In the interim, the Board is asked to note the efforts being made locally to support delivery against the Concordat.

10.8 In terms of the key requirements from the national programme, the Board is asked to note the following:

- The Barnet Safeguarding Adults Board has played a key role in monitoring these type of placements
- The Learning Disabilities service has a register of all out-of-borough placements and a review programme is in place.

10.9 The main action now required by the Department of Health in respect of Winterbourne View type service users is to identify all users placed in Learning Disability hospitals, review them by June 2013 and move them onto local care settings by June 2014.

10.10 In Barnet, there are:

- 17 service users placed in NHS hospital settings
- 16 of them had a multi-disciplinary team (MDT) review in line with the national timescale by the end of May 2013.
- The 17th person was placed just a few weeks before the June deadline so a review was not appropriate.

- There are already agreed plans to move 12 of these service users on to local environments, with plans for the rest to be developed over the coming weeks.

10.11 The other actions required from the Department of Health relate to local commissioning plans, and locally in Barnet there is already a Winterbourne action plan in place (See Appendix 1).

10.12 Norman Lamb MP, Minister of State for Care Services, has also written to Chairman's of Health and Well-Being Boards outlining their leadership role in ensuring that the Winterbourne View Concordat commitments are achieved.

10.13 The letter from Norman Lamb MP clearly sets out aspirations for Health and Well-Being Boards to be key vehicles locally to ensure the commitments in the Concordat are met. The Board is at this stage asked to note the specific requests made in the letter, set out below:

1- That Health and Well-Being Boards should both challenge and ultimately agree the CCG and Local Authority joint strategic plan for commissioning local services to meet the needs of children, young people, and adults with challenging behaviour

2- That the Health and Well-Being Board should ensure there is the right clinical and managerial leadership and infrastructure in place to deliver the coordinated plan

3- That the Health and Well-Being Board should take an active interest in how far the other commitments in the Concordat, particularly those relating to care reviews (completed by June 2013) have been achieved

4- That the Health and Well-Being Board can be satisfied that commissioners are working across the health and care social care system to provide care and support which does not require people to live in inappropriate institutional settings

5- That Health and Well-Being Boards should agree when a pooled budget will be established and how it will promote the delivery of integrated care

11 BACKGROUND PAPERS

11.1 Letter from the LGA & NHS England to Local Authority Chief Executives, 'Winterbourne View Joint Improvement Programme- Local Stocktake'

11.2 Letter from Norman Lamb MP, Minister of State for Care and Support, to Chairs to Health & Wellbeing Boards, Council Leaders and Chief Executives, and Chairs and Chief Operating Officers of CCGs, 'Delivery of the Winterbourne View Concordat and review commitments'

Legal – CE
CFO – AD

Appendix 1: Barnet's Winterbourne Action Plan
Updated 070613

Recommendations of DH Review & the Serious Case Review	Actions Agreed	By whom	By when	RAG	Comment /Risk/Issue
1. Redesign services to invest in flexible good quality local services and away from sending people away from home. The use of in-patient services for assessment and treatment varies hugely across the country in terms of numbers of people and length of stay.	**1.1-** Ensure PWLD and their carers are involved in decisions about placements, move on and discharge planning by monitoring access to independent advocacy and involvement of family carers in review meetings.	Alan Brackpool	April 2013	Completed	Successfully completed. PWLD and carers involved in planning and reviews. Use of independent advocacy.
	1.2- Monitor workforce training on safeguarding, use of restraint, MCA and DOLS as part of NHS contract monitoring process and via the Barnet SAB.	Vivienne Stimpson- CCG David Jones/ Sue Smith- LBB	Ongoing	In progress	Regular monitoring of MCA/DOLs through the Barnet SAB. Annual report currently in development. CCG developing a framework for Board assurance on quality and safety

Appendix 1: Barnet's Winterbourne Action Plan
Updated 070613

	1.3 Implementation of a notification system to relevant agencies (local CLDS/GP/Commissioners) for people returning back or being place out of Borough.	Helen Duncan-Turnbull	April 2013	Completed	A notification system now in place
	1.4 Need to consider pooling of health and social care resources and opportunities to collaborate across CCGs to develop alternative community with complex needs	Alan Brackpool/Temmy Fasegha	June 2014	In progress	Work to be developed as a product of the MDT review following Winterbourne review
2. Voice of people with learning disabilities and their families	**2.1** Review and update information provided to PWLD and family carers at point of placements and monitor involvement of PWLD and carers via placement and contract reviews	Julian Easton-LBB Alan Brackpool-CCG	Sept 2013	In progress	Being developed for LA funded placements as part of the integration project

Appendix 1: Barnet's Winterbourne Action Plan
Updated 070613

	2.2 Liaise with Barnet Healthwatch to involve PWLD and carers on 'Enter & View' programme.	Temmy Fasegha	Oct 2013	In progress	Healthwatch was set up in April 2013. Meeting has taken place with Healthwatch and Barnet Mencap to develop a programme for training people to be involve in the 'Enter & View' programme.
3. Implementation of Personalisation. The Department expects the NHS and local authorities to demonstrate that they have taken action to assure themselves and the public that they provide personalised care and support with choice and control in all settings – including hospital.	**3.1-** Involving PWLD and carers in 'Complex Care Pathways development through LDPB, LD Parliament and other existing forums.	Temmy Fasegha	Sept 2013	In progress	Workshop at Partnership board re complex needs, all stakeholders to be involved in future strategy. Working group set up as part of the work of the Health Development Subgroup and the CLDT to engage with PMLD
	CCG to explore learning from personal health budgets pilots with view of implementation in Barnet for continuing health care.	Alan Brackpool	March 2014	In progress	
4. Providers and Ensuring Quality of Service:	**4.** Set up system for NHS Barnet CCG to share placement information with LBB to ensure better information sharing	Sue Smith	Feb 2012	Completed	Good information sharing already established. Formal liaison established

Appendix 1: Barnet's Winterbourne Action Plan
Updated 070613

5. Commissioning and Contracting:	**5.1** Map social care and health resources invested in the care of people with complex needs and who challenge services as part of the 'Complex Care are work stream of the Integrated Commissioning Plan with a view of achieve better outcomes and value for money.	Vivienne Stimpson Howard Ford	Sept 2014	In progress	Various workstreams on complex care that need to be coordinated to provide framework for developing commissioning response.
	5.2 Update contracts and Individual Placement Agreement to include additional reporting requirements.	Alan Brackpool-CCG David Jones	June 2014	In progress	
6. Workforce **The Academy of Royal Colleges and the professional bodies that make up the Learning Disability Professional Senate will work to develop core principles on a statement of ethics which will reflect wider responsibilities in the new health and care architecture.**	**6.** Use 'Skills for Care 'guidance to review workforce requirements and ensure monitoring through contract reviews.	Quality in Care Homes Team Commissioning Support Unit	October 2013	In progress	

Appendix 1: Barnet's Winterbourne Action Plan
Updated 070613

7. Safeguarding	**7.1** Monitor provider progress in implementing improvement actions identified in their Safeguarding Adults Assessment Framework (SAAF) submissions.	Sue Smith- LBB Vivienne Stimpson- BCCG	Ongoing	In progress	A comprehensive report and dashboard for quality and safety being developed for the CCG Board and to be reported on monthly. Barnet SAB currently in the process of completing annual report which will include an update from providers on actions to improve safeguarding
	7.2 Barnet CCG QIPP Board to discuss report on CCG recurrent transfer of resources to enable Council to develop capacity to fulfil new statutory responsibilities in respect of DOLS in hospitals.	Temmy Fasegha	April 2013	Completed	BCCG has agreed funding of £17k towards the development of the DOLS office by LBB

Gateway Reference Number: 00130

31 May 2013

Dear Chief Executive,

Winterbourne View Joint Improvement Programme – Local Stocktake

I am writing to you to ask for your assistance in completing a stocktake of progress against the commitments made in the Winterbourne View Concordat which was signed by a broad range of agencies and organisations.

The Concordat was the joint response of agencies including the LGA and the NHS to the Department of Health Transforming Care report arising from the significant failings at Winterbourne View. The Concordat sets out the commitment to transform health and care services and improve the quality of the care offered to children, young people and adults with learning disabilities or autism who have mental health conditions or behaviour that challenges.

You will recall that the Concordat contains a number of specific commitments that will lead to all individuals receiving personalised care and support in community settings no later than 1st June 2014.

The purpose of the stocktake therefore is to enable local areas to assess their progress against commitments in the Concordat and to allow for good practice and progress from local areas to be shared nationally.

Given his personal interest in the programme, Norman Lamb, Minister of State for Care Services, has recently written to Chairs of Health and Wellbeing Boards (HWBs) explaining the significant leadership role that HWBs should play in ensuring that the Concordat commitments are achieved. We are therefore sending this stocktake to local authorities given your leadership role in Health and Wellbeing Boards.

However, this stocktake is not simply about data collection but is to assist in your discussions locally with Clinical Commissioning Groups (CCGs) and other key partners including people who use services, family carers and advocacy organisations, as well as providers. The stocktake can only successfully be delivered through local partnerships. We would specifically ask that the responses are developed with local partners and shared with your Health and Wellbeing Board. We would also ask that CCG's sign off the completed stocktake.

The stocktake is also intended to enable local areas to identify what support and assistance they require from the Joint Improvement Programme. The core purpose of the programme is to work alongside local commissioners to enable you to deliver your local plans. Further information on the Winterbourne View Joint Improvement Programme is available on the Local Government Association Website

The deadline for the completed stocktake is Friday 5th July 2013. The stocktake should be returned to Sarah.Brown@local.gov.uk if you require any further information or have any questions please send these to Sarah Brown in the first instance.

I am fully aware that there will be other requests for information over the next few months relating to progress with Learning Disabilities and Autism. The Winterbourne View Programme will work to ensure that we do not ask for information that is duplicated elsewhere, as the purpose of this stocktake is to ensure support is provided to local areas and that we work together to deliver commitments in the Concordat.

Yours sincerely

Chris Bull

Chair of the Winterbourne View Joint Improvement Board

Cc
Chairs of Health and Wellbeing Boards
CCG Accountable Officers
CCG Clinical Leaders
Directors of Adult Social Service
Directors of Children's Services
NHS England Regional and Area Directors

From Norman Lamb MP
Minister of State for Care and Support

Department of Health

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 4850

To: Chairs, Health and Wellbeing Boards
Cc: Council Leaders and Chief Executives
Chairs and Chief Operating Officers, GGCs

Dear Colleague,

Delivery of the Winterbourne View Concordat and review commitments

I am writing to you at the start of your taking on your statutory functions to stress the pivotal local leadership role that Health and Wellbeing Boards can play in delivering the commitments made in the Winterbourne View Concordat[1] which represents a commitment by over 50 organisations across the sector – including the Local Government Association, NHS England, the NHS Confederation, Royal Colleges and third sector organisations – to reform how care is provided to people with learning disabilities or autism who also have mental health conditions or behaviours viewed as challenging. There is widespread agreement across the sector that the care of this group of vulnerable people requires fundamental change.

The abuse of people at Winterbourne View hospital was horrifying. For too long and in too many cases this group of people received poor quality and inappropriate care. We know there are examples of good practice. But we also know that too many people are ending up in hospital unnecessarily and they are staying there for too long.

NHS England, NHS Clinical Commissioners, the Local Government Association, the Association of Directors of Adult Social Services and the Association of Directors of Children's Services each committed to working collaboratively with CCGs and Local Authorities to achieve a number of objectives by 1 June 2014, including that from April 2013, health and care commissioners will set out:

> *"a joint strategic plan to commission the range of local health, housing and care support services to meet the needs of children, young people and adults with challenging behaviour in their area.*

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127312/Concordat.pdf.pdf

This could be undertaken through the health and wellbeing board and could be considered as part of the local Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy (JHWS) process;

- *The strong presumption will be in favour of supporting this with pooled budget arrangements with local commissioners offering justification where this is not done.*
- *We will promote and facilitate joint and collaborative commissioning by local authorities and CCGs to support these objectives.*

Health and wellbeing boards have an opportunity through their role in agreeing the CCG and Local Authority Joint Plans to challenge the level of ambition in the plan and ensure that the right clinical and managerial leadership and infrastructure is in place to deliver the co-produced plan.

Health and wellbeing boards will, no doubt, also want to take an active interest in how far the other commitments in the Concordat, particularly those relating to care reviews having been completed by June 2013, have been achieved, as well as satisfying themselves that commissioners are working across the health and social care system to provide care and support which does not require people to live in inappropriate institutional settings.

It will only be through creative local joint commissioning and pooled budgets working with people who use services, their families, advocacy organisations and carers and other stakeholders (including providers) that we will deliver more joined-up services from the NHS and local councils in the future and see real change for this very vulnerable group.

Health and wellbeing boards are well placed to agree when a pooled budget will be established (if not already) and how it will promote the delivery of integrated care – care that is coordinated and personalised around the needs of individuals; which is closer to home and which will lead to a dramatic reduction in the number of inpatient placements and the closure of some large in-patient settings.

The Department of Health has supported the establishment of an NHS England and Local Government Association-led Winterbourne View Joint Improvement Board. This Board will be working closely with a range of partners to develop and implement a sector-led improvement programme working with local health and social care communities to deliver real and lasting change in the support and

care for people with learning disabilities or autism who also have mental health conditions or behaviours viewed as challenging. It will shortly be in touch with you separately to take stock of progress in your area so that any appropriate level of support can be arranged.

Due to the very public nature of these failures in care, I am sure that you will want to ensure that your health and wellbeing board is able to provide transparent public information and assurance on progress locally.

Further information about the work of the improvement programme, including a recently issued framework for conducting reviews of care locally, is available on the LGA website. If you have any innovative practice to share, or views on how the programme can be designed and developed to ensure rapid progress and real and lasting change, please contact the programme chair via Chris.Bull@local.gov.uk

Yours sincerely,

NORMAN LAMB

We hope to publish progress around the country in reaching the commitments made in the Concordat in the Summer.

Thanks so much for your work on this incredibly important issue!

This page is intentionally left blank

Meeting	Health and Well-Being Board
Date	27 June 2013
Subject	**Report of the Barnet Health and Well-Being Board / Partnership Boards Summit**
Report of	Adults and Communities Director
Summary of item and decision being sought	**Report of the Barnet Health and Well-Being Board / Partnership Boards Summit held on 29 May 2013**

Officer Contributors	Karina Vidler, Partnership Boards Officer, Adults and Communities Emily Bowler, Customer Care Services Manager, Adults and Communities
Reason for Report	To present a full report on the of the Barnet Health and Well-Being Board / Partnership Boards Summit held on 29 May 2013
Partnership flexibility being exercised	N/A
Wards Affected	All
Contact for further information	Emily Bowler, Customer Care Service Manager, 020 8359 4463, Emily.bowler@barnet.gov.uk

1. RECOMMENDATION

1.1 That the Health and Well-Being Board reviews the Report (attached in Appendix 1), noting the contents and discussions at the Event.

1.2 That the Health and Well-Being Board notes that the information generated from discussions and workshops at the Summit with a view to inform their future work. The key points are included in the report.

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 Health and Well-Being Board- Review of Partnership Boards- 4 October 2012

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

3.1 The strategic review of Partnership Boards completed in 2012 recommended the establishment of a Summit to bring together the members of the Health and Well-Being Board and all five Partnership Boards. The first Summit was held on 29 May 2013 in the White Diamond Suite, North London Business Park.

3.2 The aims of the Summit were to enable the Partnership Boards and the Health and Well-Being Board to:

- Celebrate Partnership Boards' achievements in supporting the Health and Well-Being Strategy
- Share any lessons learned
- Work together in developing a coherent view of future priorities
- Explore themes that are relevant across all Partnership Boards
- Develop a set of key messages to deliver to the community.

3.3 Item 11 of the Health and Well-Being Board Terms of Reference formalises the Health and Well-Being Board's commitment to engage in the Summits, stating that the Board should "receive reports and recommendations from the Summit meetings between the HWBB and all the Partnership Boards that report to it".

4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 The Equality Act 2010 sets out to strengthen and simplify the existing legislation around equality. The Act impacts on how services are delivered. For example, the Public Sector has a duty of due regard to advancing equality of opportunity in relation to age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

4.2 The need for a Summit Event was established following the review of the Partnership Boards in 2012.

4.3 The Summit was designed and run as a fully accessible and inclusive Event so that all participants could be involved. Communication was supported through 'traffic light' communication cards, easy read format information, British Sign Language interpretation, and assistive technology including a hearing loop.

5. RISK MANAGEMENT

5.1 The Partnership Boards Summit provides a forum for meaningful engagement with providers and partners, which significantly reduces the risk that providers and wider stakeholders will not be engaged with the Health and Well-Being Board's work.

6. LEGAL POWERS AND IMPLICATIONS

6.1 None directly relating to this Event.

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

7.1 The Summit Event breakdown cost:

- £3,368, venue hire and refreshments
- £740.58 for Reward and Recognition

Total cost = £4,108

7.2 This spend is taken from the budget allocated to Engagement team work within Adults and Communities directorate and has been factored into the year's forecast.

7.3 Preparation and planning for the day was carried out by existing staff and therefore no additional resources were utilised. The cost of existing staff is not reflected in the breakdown above.

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 The review of the Partnership Boards was undertaken on the principle of co-production. Following discussions with members and co-chairs of each of the existing Boards, a number of changes and improvements were proposed. These will enable a better alignment between the partnership structures and supporting collaborative arrangements, whilst getting greatest impact from partnership activity. The proposed changes will also ensure a focus on co-production and more direct accountability to customers, carers and the local community.

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 To plan the Summit Event, the Engagement Team set up a number of planning meeting with Co-chairs of the Partnership Board, Commissioning Managers, members of the Health and Well-being Board and other key stakeholders.

9.2 The Event was created on the principle of co-production.

9.3 The Summit Event was designed and run as a fully accessible and inclusive event so that all participants could be involved. Communication was supported through 'traffic light' communication cards, easy read format information, British Sign Language interpretation, and assistive technology including a hearing loop.

10. DETAILS

10.1 The strategic review of Partnership Boards completed in 2012 recommended the establishment of a Summit to bring together the members of the Health and Well-Being Board and all five Partnership Boards. The first Summit was held on 29 May 2013 in the White Diamond Suite, North London Business Park.

The aims of the Summit were to enable the Partnership Boards and the Health and Well-Being Board to:

- Celebrate Partnership Boards' achievements in supporting the Health and Wellbeing strategy
- Share any lessons learned
- Work together in developing a coherent view of future priorities
- Explore themes that are relevant across all Partnership Boards
- Develop a set of key messages to deliver to the community.

In total 90 people participated in the Summit. These included:

- Chairman of the Health and Well-Being Board who is also Cabinet Member for Public Health
- Members of the Health and Well-Being Board including the Chief Officer, representative of Barnet Clinical Commissioning Group, Director for People for Barnet Council and the LINK
- Cabinet Member for Safety and Resident Engagement who is also Chairman of the Barnet Safer Communities Partnership
- Cabinet Member for Education, Children and Families
- Chairman and Vice-Chairman of the Health Overview and Scrutiny Committee
- Further representatives of the Barnet Clinical Commissioning Group, Barnet Council Adults and Communities, Barnet Enfield and Haringey Mental Health Trust and other stakeholder organisations
- Members of the Adults and Communities Commissioning and Engagement Teams
- Members of five Partnership Boards:
    - Carers Strategy Partnership Board

- Learning Disability Partnership Board
- Mental Health Partnership Board
- Older Adults Partnership Board
- Physical and Sensory Impairment Partnership Board

10.2 The full Report in Appendix 1 outlines details of Summit Event which includes contents and discussion of the Event.

10.3 The Partnership Boards and the Health and Well-Being Board will use the information generated through discussion and workshops at the Summit to inform their future work. An action plan will be developed and implemented.

11 BACKGROUND PAPERS

11.1 N/A

Legal- CE
CFO- JH

This page is intentionally left blank

Report on

Barnet Health and Well-Being Board / Partnership Boards Summit

Held on 29 May 2013

Contents

1. Introduction and aims of the Summit

The strategic review of Partnership Boards completed in 2012 recommended the establishment of a Summit to bring together the Health and Well-Being Board and all five Partnership Boards. The first Summit was held on 29 May 2013 in the White Diamond Suite, North London Business Park.

The aims of the Summit were to enable the Partnership Boards and the Health and Well-Being Board to:

- celebrate Partnership Boards' achievements in supporting the Health and Wellbeing strategy
- share any lessons learned
- work together in developing a coherent view of future priorities
- explore themes that are relevant across all Partnership Boards
- develop a set of key messages to deliver to the community.

In total 90 people participated in the Summit. This included:

- Chairman of the Health and Well-Being Board who is also Cabinet Member for Public Health
- Members of the Health and Well-Being Board including the Chief Officer of Barnet Clinical Commissioning Group
- Cabinet Member for Safety and Resident Engagement who is also Chairman of the Barnet Safer Communities Partnership
- Chairman and Vice-Chairman of the Health Overview and Scrutiny Committee
- Further representatives of the Barnet Clinical Commissioning Group, Barnet Council Adults and Communities, Barnet Enfield and Haringey Mental Health Trust and other stakeholder organisations
- Members of the Adults and Communities Commissioning and Engagement Teams
- Members of five Partnership Boards:
    - Carers Strategy Partnership Board
    - Learning Disability Partnership Board
    - Mental Health Partnership Board
    - Older Adults Partnership Board
    - Physical and Sensory Impairment Partnership Board

The Summit was designed and run as a fully accessible and inclusive event so that all participants could be involved. Communication was supported through 'traffic light' communication cards, easy read format information, British Sign Language interpretation, and assistive technology including a hearing loop.

2. Next Steps - moving forward from the Summit

The Partnership Boards and the Health and Well-Being Board will use the information generated through discussion and workshops at the Summit to inform their future work.

An action plan will be developed and implemented. This will reflect, in particular, the following key points:

- Strengthening links between Partnership Boards and developing work between boards on cross-cutting issues.
- Where appropriate, taking Partnership Board priority and cross-cutting issues to the Health and Well-Being Board.
- Involving all Partnership Boards in the consultation on the Joint Strategic Needs Assessment (JSNA) refresh.
- Developing links between Partnership Boards and Public Health.
- Reviewing Partnership Board membership to reflect the diversity of the Barnet population.
- Reviewing Partnership Board work plans to reflect workshop discussion on priorities for the next year.
- Reviewing Partnership Board work plans to reflect workshop discussion on how to overcome challenges.
- Ensuring that Partnership Boards assist Healthwatch Barnet in developing its priorities.
- Looking at methods of communication across Partnership Boards and with the public.
- Publicising Partnership Board activities and achievements, and involving the Press in this.

3. Summit Programme

29 May 2013, 9.30am-3pm
White Diamond Suite, North London Business Park

9.30am		**Registration** – tea, coffee, juice	
10am		**Introduction to the day** (and housekeeping)	Kate Kennally
10.05am		**Welcome from Councillor Hart**	Councillor Helena Hart
10.15am		**Quiz about the Health and Well-Being Board**	Kate Kennally
10.50am		**Partnership Board Presentation 1:** Celebrating our achievements	Co-chairs
11.05am		**Break** – tea, coffee, juice	
11.20am		**Partnership Board Presentation 2:** Our priorities	Co-chairs
11.30am 11.40am		**Workshop 1 – Are our priorities right?** Feedback on main points	

11.50am		**Partnership Board Presentation 3:** Our challenges	Co-chairs
12noon 12.10pm		**Workshop 2 – How can we overcome these challenges?** Feedback of main points	
12.30pm		**Lunch and networking**	
1.20pm		**Healthwatch Presentation**	Healthwatch Barnet
1.35pm 2pm		**Workshop 3 – Working with Healthwatch Barnet** Feedback of main points	
2.10pm		**Partnership Board discussions:** Agree 3 questions for the Health and Well-being Board	Co-chairs
2.15pm		**Questions to Health and Well-Being Board Panel**	Health and Well-being Board
2.45pm		**Round-up of the day**	Kate Kennally
3pm		**Summit ends** (refreshments available)	

4. Welcome and Quiz about the Health and Well-Being Board

Kate Kennally, Director for People (Barnet Council), introduced the day and thanked everyone for attending. Richard Harris, Chair of the Learning Disability Partnership Board Speaking Up Subgroup, showed participants how to use the 'Traffic Light' Communication cards. Kate invited Councillor Helena Hart, Chairman of the Health and Well-Being Board and Barnet Council Cabinet Member for Public Health, to open the Summit.

Councillor Hart warmly welcomed participants, emphasising that this first Summit would be a valuable opportunity to strengthen links between the Health and Well-Being Board and its Partnership Boards, and ensure coherent working in order to enhance the health and wellbeing of Barnet residents. Councillor Hart recognised the importance of the Partnership Boards in implementing the Barnet Health and Wellbeing strategy. She also emphasised the valued role of Partnership Boards in ensuring that the voice of stakeholders, including service users and carers, informs the development and delivery of services as the integration of health and social care progresses.

Participants worked in groups to complete a quiz about health and wellbeing in Barnet, demonstrating their knowledge of these key facts:

- 17.9% of adults in Barnet are classified as 'obese'.
- We expect 2,100 more people aged between 65-69 years to live in Barnet over the next ten years.
- Barnet's Clinical Commissioning Group is made up of 67 GP practices
- As part of its regeneration scheme, Barnet will be developing a new town centre in Cricklewood.
- Councillor Helena Hart is the Chair of the Barnet Health and Well-Being Board.
- Barnet's Health and Well-Being Board has a statutory obligation to use these documents to drive its work programme:
  - The Joint Strategic Needs Assessment
  - The Health and Wellbeing Strategy
- The themes of Barnet's Health and Wellbeing Strategy are:
  - Preparation for a healthy life (maternity care and early years development)
  - Well-being in the community (creating circumstances which enable people to be healthier and have greater life opportunities)
  - How we live (enabling and encouraging healthier lifestyles)
  - Care when needed (providing appropriate care and support)
- Barnet's Public Health team will help to deliver the Health and Wellbeing Strategy. The Public Health service in Barnet is now shared with Harrow.
- Members of the public can attend Barnet's Health and Well-Being Board meetings to observe, and can access papers online. Papers can be found on Barnet Council's website, here: http://barnet.moderngov.co.uk/ieListMeetings.aspx?CId=177&Year=0

5. Partnership Board Presentation 1: Celebrating our Achievements

Helen Duncan-Turnbull and Mahmuda Minhaz, Co-Chairs of the Learning Disability Partnership Board gave a presentation on how our five Partnership Boards help us to **achieve the aims** of the Barnet Health and Wellbeing Strategy:

- Keeping well
- Keeping independent

The co-chairs reported that the Partnership Board **achievements** under the Health and Wellbeing **strategy's themes** during the last year include:

Theme two: Wellbeing in the community

- 'Your Life' newsletter for Partnership Boards has been re-launched, to provide residents with information about new services and events, and tips for staying well.
- The Barnet Family Carers Forum has been re-launched and is led by a steering group of carers. There have been 3 forums since September 2012.
- Another successful year for Barnet Older People's Assembly, with well attended events and the Assembly's Committee made stronger.
- A new service called Eclipse has been set up to promote mental health and wellbeing and provide peer support to people with mental health problems.
- The Physical and Sensory Impairment Partnership Board acted as 'critical friend' supporting the development of the council's Information, Advice, Advocacy and Brokerage contract, and the review of British Sign Language (BSL) Interpretation Service.
- The Mental Health Partnership Board ran successful awareness raising events for World Mental Health Day in October 2012.
- The Learning Disability Partnership Board held a 'Have your say' day so that people with learning disabilities could influence the Board's work plan and share what was most important to them in areas such as employment, day opportunities, health and housing.
- Ruth Carter has developed a very useful leaflet on Good and Bad Friends. Ruth explained how she had developed the leaflet and showed it to participants, and received a round of applause.

Theme three: How we live

- Day opportunities for older people have been re-shaped, and the Older Adults Partnership Board is overseeing the change to the new Neighbourhood model for services.
- Work is taking place to improve access to GP surgeries for people with sensory impairments.

- The Older Adults Partnership Board is shaping the Ageing Well programme. Board members are actively involved in developing the 'Altogether Better' projects in different areas of the borough.
- There was an increase in the number of people with learning disabilities who had a health check in 2012.
- The Learning Disability Partnership Board held a 'Big Health Check' event in July 2012 to ask people about their health and the services that they get.

Theme four: Care when needed

- A new Carers Emergency Planning Scheme is being launched.
- The Physical and Sensory Impairment Partnership Board has supported the work starting on a Barnet Sensory Impairment Strategy and action plan.
- A pilot of a hearing impairment surgery has taken place.
- A Primary Care Learning Disability Nurse has been appointed. The nurse will work with GPs and other services to improve access.
- The Physical and Sensory Impairment Partnership Board have advised on the review of the Barnet stroke pathway.
- Carers health projects have been developed, including health break prescriptions
- A Carers hospital discharge coordinator
- Carers Charter and Carers badge scheme is being used by Barnet and Chase Farm hospitals.

6. Partnership Board Presentation 2: Our Priorities

Maria O'Dwyer and Elsie Lyons, Co-Chairs of the Mental Health Partnership Board gave a presentation on the five Partnership Boards' priorities to achieve the aims of the Barnet Health and Wellbeing Strategy.

The co-chairs reported that the Partnership Board priorities under the Health and Wellbeing **strategy's themes** during the next year include:

Theme two: Wellbeing in the community

- Increasing membership of some boards to reflect the diversity of Barnet's population.
- Supporting the Learning Disability Parliament.
- Working with Healthwatch Barnet to ensure that services are safe, and ensuring safeguarding representation on Boards.
- Feeding into the commissioning of new services (such as the wellbeing service for mental health), and acting as a 'critical friend'.
- Continuing to shape the Barnet Ageing Well Programme.
- Further development of Barnet Older People's Assembly.

Theme three: How we live

- Improving access to health services (such as GPs, hospitals and dentists) for people with a learning disability, and providing better information for people about staying healthy. The Learning Disability Partnership Board is also setting up health promotion groups.
- Evaluation of carers' health projects.

Theme four: Care when needed

- Ensuring that more carers have an emergency plan.
- Improving access to psychological therapies and crisis services for mental health.
- Re-modelling primary care mental health services and developing better information for patients about services available.
- Integrating carers support pathways with patient pathways (for Stroke and Falls).
- Implementing the new Carers Needs Assessment process.
- Shaping the Frail Elderly Pathway work as the Falls, Stroke and Dementia initiatives are implemented.
- Looking at national reports on failings of care services, to consider any implications for Barnet.
- Finalising the Barnet Sensory Impairment Action Plan.

- Creating a business case for investment following the recent Barnet Vision Strategy event.
- Contributing to the development of the mental health commissioning strategy.
- Publishing a report on the hearing impairment surgery pilot, and considering whether to pilot a visual impairment surgery.

Workshop 1 – Are our priorities right?

Participants worked in 10 mixed groups to discuss these questions:

- Are our priorities are right?
- If they need to be changed, what should those changes be?
- Is there anything missing?

The following key points made were:

Do you think our priorities are right and if they need to be changed, what should those changes be?

- There was broad support for the priorities. Some groups felt that there were too many priorities across the five Partnership Boards.
- It was agreed that priorities should focus on:
    - outcomes, not processes
    - need, not age or disability.
- There was strong agreement on the need to focus on prevention, integration and communication.
- There was strong support for the priority of improving access to GP practices and health services, with agreement that this should be broadened to relate to people with all types of disabilities.
- There was strong agreement to ensuring that the Partnership Boards' membership reflects the diversity of Barnet's population.

Is there anything missing?

A number of areas were identified, including:

- Addressing social isolation - being lonely, and being lonely in the community.
- Reviewing planned consultations to make sure that they are fair, clear and accessible.
- Raising the awareness of all professional staff of all disabilities, for example receptionists in GP surgeries.

- Promoting public health messages.
- Addressing issues relating to general (rather than health and social care) services, such as housing, the environment and transport.
- Looking at transition of young people to adult health and social care services, to ensure quality of services.
- Ensuring good practice for carers' support and extending carers' emergency plans to all vulnerable people.
- Communication - between Partnership Boards, and with the public.
- Addressing Hate Crime and reducing stigma and discrimination.
- Recognising the overlap between Partnership Boards and working in a way that deals with this efficiently.

The information from the workshop will inform Partnership Board future working.

7. Partnership Board Presentation 3: Our Challenges

Mathew Kendall and Peter Cragg, Co-chairs of the Older Adults Partnership Board gave a presentation on the five Partnership Boards' challenges in achieving the aims of the Barnet Health and Wellbeing Strategy.

Some challenges are **faced by all Boards.** These include:

- Involving people with complex needs in Board meetings.
- Ensuring that Boards get to hear the views of people who are not Board members.
- Increasing engagement from key partners in Board activities.
- Making sure that responses to issues and stories are made, and actions are followed through.
- How do the Partnership Boards, the Health and Well-Being Board, the Clinical Commissioning Group and the voluntary sector all work together?
- Making sure that all Partnership Board members contribute to the work of the Board.
- Effective engagement from Healthwatch Barnet in the future.
- Ensuring effective evaluation to measure the success of projects.
- Ensuring Board members have the right training, and information on changes in health and social care.
- Prioritising activities undertaken by Boards, and how links can be made across Boards for some projects / groups.

Partnership Board challenges under the Health and Wellbeing strategy's themes include:

Theme two: Wellbeing in the community

- The effect that welfare reforms could have on people who use health and social care services.
- Getting GP Carers Champions represented on the Barnet Clinical Commissioning Group.

Theme three: How we live

- Stopping Mental Health difficulties in a family passing from one generation to the next.
- Making sure people have information about where to get the support they need.

Theme four: Care when needed

- Ensuring that carers get mental health support when they need it.
- The integration of health and social care services will be complex. There is a challenge for the Boards about how to engage with this.

Workshop 2 – How can we overcome these challenges?

Participants worked in 10 mixed groups to discuss these questions:

1. What actions should we take to overcome our challenges?
2. How can the Health and Well-Being Board help us with this?
3. How can the Boards help each other to achieve their goals?

Key points made were:

1. What actions should we take to overcome our challenges?

- Robust forward planning reflecting Partnership Board priorities.
- Evaluation of Partnership Boards' work.
- Strong leadership on Partnership Boards and strong links with relevant organisations, for example the Mental Health Trust.
- Link into Overview and Scrutiny Committees.
- Link with Healthwatch Barnet to ensure that health and social care issues and priorities are identified and addressed.
- Clearly outline roles and responsibilities of Board members, supplemented by appropriate training.
- Look at methods of communication across Boards and with the public, for example through newsletters and with Black Minority Ethnic and Refugee communities.
- Use technology to enable people to be involved in the work of Partnership Boards, whilst recognising that not everybody uses the internet and social media.
- Identify and widely publicise best practice and success stories.

2. How can the Health and Well-Being Board help us with this?

- Take priority and cross-cutting issues identified by partnership Boards into its work plan.
- Ensure that Partnership Boards are involved in consultation on the Joint Strategic Needs Assessment (JSNA) refresh.
- Ensure that the JSNA is accurate and comprehensive, reflects complex needs and addresses identified gaps.
- Review representation and consider whether the public can be represented by one Healthwatch member.

3. How can the Boards help each other to achieve their goals?

- Identify cross-cutting issues that can be best addressed by Partnership Boards working together.
- Allocate one Partnership Board responsibility for leading on identified cross-cutting issues.

- Have regular meetings between Partnership Board Co-Chairs to review and plan joint working and to identify and monitor progress on cross-cutting issues.

The information from the workshop will inform the ways in which Partnership Boards work to overcome challenges.

8. Barnet Healthwatch Presentation

Selina Rodrigues, Head of Healthwatch Barnet, gave a presentation on local Healthwatch, making the following key points:

1. **Healthwatch Barnet is a consortium of 10 Barnet organisations:**
    - Community Barnet (leading and co-ordinating)
    - Barnet Citizens Advice Bureau
    - Barnet Centre for Independent Living
    - Barnet Home Start
    - Age UK Barnet
    - Jewish Care
    - Barnet Carers Centre
    - Barnet Mencap
    - Mind in Barnet
    - Advocacy in Barnet
2. Healthwatch Barnet will be **different from Barnet LINk** in a number of ways:
    - The **independent voice** for children and adults
    - Healthwatch England
    - Focus on under-represented communities
    - Information, Advice and Signposting
    - Health and Wellbeing partner organisations
    - Links with statutory partners (like the council and health authority).
3. Healthwatch Barnet will:
    - be a **strong, local voice for residents, patients and service users**
    - make sure **diverse and seldom listened-to voices** from across the borough are heard
    - **be a respected and credible** organisation
    - work in **partnership** across all sectors of health and social care
    - provide **evidence** to decision makers
    - **question and challenge** service providers and commissioners.

4. Healthwatch Barnet's **emerging priorities** are:

- **Young people**
- **Lesbian**, **Gay**, **Bisexual and Transgender people**
  Consult with and develop focus groups
- **Mental Health**
  Question how the Clinical Commissioning Group (CCG) and the Council will consult.
- **GP Appointments**
  Promote good practice
  Support for people with mental health conditions and learning disabilities and carers
  Make surgeries accessible.
- **Unscheduled / Out of Hours Care**
  Question the CCG on how it has acted upon its consultation.

Workshop 3 – Working with Barnet Healthwatch

Participants worked in eight Board-based groups to discuss these questions:

1. Are the emerging priorities the right priorities?
2. Are there other health and social care priorities which it is important for Healthwatch Barnet to be involved in?
3. How should Partnership Boards, Healthwatch Barnet and the Health and Well-Being Board work together?

Key points made in group discussion were:

1. Are the emerging priorities the right priorities?

- Healthwatch Barnet's emerging priorities are a good start.
- The priorities need to be developed through consultation. It would be helpful to know how these emerging priorities have been arrived at.
- The Partnership Boards are a good place for Healthwatch to pick up additional priorities.
- The identified items appear to be emerging areas of work rather than priorities. The priorities will need to tell us what Healthwatch will deliver and what will be better. They will need to link to outcomes.
- It will be important to ensure that Healthwatch does not have too many priorities.
- What is being done for adults needs to also happen for children. There is a lack of representation of disabled children / young people who cannot speak for themselves.

2. Are there other health and social care priorities which it is important for Healthwatch Barnet to be involved in?

- Responding to the Mid Staffordshire NHS Public Inquiry report.
- The challenges faced by social care and how Healthwatch engages with these.
- Integration of health and social care services.
- Holding the Health and Well-Being Board and partners to account.
- Healthwatch Barnet needs to have a clear link to the Patient Advice and Liaison Service (PALS), and also to link with Barnet Council regarding complaints in social care.
- The priorities need to be more broadly based, for example to address much more representation of learning disability and autism, older people, carers.
- Priorities need to include access issues, to GP surgeries and to health services. Healthwatch needs to challenge providers and commissioners about making reasonable adjustment for people with disabilities.
- Mental health issues for Black, Minority Ethnic and Refugee communities and for young people.
- Communication of the Healthwatch role, who they are and what they will do.

3. How should Partnership Boards, Healthwatch Barnet and the Health and Well-Being Board work together?

- Heathwatch should provide challenge on Health and Well-Being Board agreed priorities.
- Healthwatch should capture evidence regarding health and social care issues through involvement with Partnership Boards.
- There needs to be two-way communication between Healthwatch and Partnership Boards, and Healthwatch should work with Partnership Boards to develop its priorities.
- Healthwatch should have a place on all Partnership Boards, reporting on progress at meetings.
- Healthwatch should look at health intelligence working with Public Health.
- Healthwatch should fully involve the voluntary sector, and reflect the voluntary sector appropriately in its activity as a member of the Health and Well-Being Board.
- Health and Well-Being Board papers should be issued early, so that Partnership Boards and Healthwatch can forward comments on the papers before the meeting.

Full information has been recorded and will be passed to Healthwatch Barnet. The information will inform the ways in which Partnership Boards, Healthwatch Barnet and the Health and Well-Being Board work together.

9. Questions to the Health and Well-Being Board Panel

Participants worked in Partnership Board groups to agree three questions each for the Health and Well-Being Board Panel.

Panel Members were:

Health and Well-Being Board Members:

Cllr Helena Hart	Cabinet Member for Public Health
Gillian Jordan	Barnet Healthwatch representative
Kate Kennally	Director for People
Dr Jeff Lake	Deputy for Dr Andrew Howe, Director of Public Health, Barnet and Harrow
John Morton	Barnet Clinical Commissioning Group – Chief Officer
Selina Rodrigues	Head of Healthwatch Barnet
Dr Claire Stephens and Cllr David Longstaff	Barnet Clinical Commissioning Group- Board member Cabinet Member for Safety and Resident Engagement and Chairman of the Barnet Safer Communities Partnership Board

Question 1. Physical and Sensory Impairment Partnership Board

From all you have heard today, what action will be taken regarding access to GP surgeries and related issues?

John Morton

Whilst Barnet Clinical Commissioning Group (CCG) does not manage GPs directly in the new NHS structure, it knows that good primary care is essential to all integration work. Barnet CCG has a primary care strategy and this includes investment in primary care.

Barnet CCG's support to GP practices in the borough includes support for the use of technology for GP practices. Measures that will improve access include:

- Barnet CCG has funded all GPs to use texting
- Email appointments are being made in some surgeries
- consultations are being arranged with nurses rather than GPs.

On 6 June 2013, the CCG is meeting with GPs regarding additional support to primary care.

Selina Rodrigues

With guidance from Barnet CCG, a group of volunteers has been doing excellent work talking to patients about access to GP surgeries. The group has also looked at Mental Health, Learning Disability and Physical and Sensory Impairment Partnership Board issues regarding access to GP surgeries and support for patients.

Healthwatch Barnet will promote and publicise good practice with GP practice managers and Patient Participation Groups. Healthwatch Barnet plans to publish a one-page guide

on good practice points regarding access. Healthwatch volunteers will take this to Patient Participation Groups to spread good practice.

Partnership Board members with experiences regarding access to GP surgeries are invited to contact Healthwatch Barnet.

Question 2 Mental Health Partnership Board

What will be the outcome of the positive suggestions made today?

Kate Kennally

Depending on what they are, actions will be taken forward by:

- Partnership Boards
- Healthwatch Barnet
- The Health and Well-Being Board

Partnership Boards will be supported to be influential and effective, supporting Healthwatch to engage and champion the consumer voice.

Partnership Board co-chairs and Healthwatch Barnet will meet regularly to formulate actions to take forward.

Notes of the Summit will be written up so that actions can be identified.

Question 3 Carers Strategy Partnership Board

What can the Health and Well-Being Board do to support carers and ensure they promote carers' needs so that they can continue to care?

Jeff Lake

Public Health recognises the importance of carers looking after themselves whilst doing the important job of caring. Public Health is looking at developing health promotion resources. This will lead to a range of resources targeted at different groups. For example, June is 'Health in the Workplace Month' at North London Business Park. Further schemes are being developed focussed on older people. Best evidence models will be identified, and it will be important to make sure that they are being done well.

Cllr Helena Hart

The Health and Well-Being Board thinks that carers are essential. Early intervention and prevention are key points of the Health and Wellbeing Strategy, and this is reflected in the Board's work plan.

For example, Health in the Workplace Schemes are being set up across the borough. The Health and Well-Being Board is making sure that there is enough money for schemes to help people stay well, support themselves in healthier lifestyles, and identify health problems early on.

Kate Kennally

A key part of the new Care Bill reforming how adult social care is to be provided in England, gives carers new statutory rights. Currently carers have the right to an assessment but not to their needs being met. The proposed legislation challenges this. It is important to do work now on how to meet the new requirement. This will involve working with the Carers Strategy Partnership Board to support carers well, so that people who are cared for can stay in their homes longer and are happier and healthier.

Question 4 Learning Disability Partnership Board

What are your plans for inclusion of people with learning disabilities in the community?

Kate Kennally

A key priority in the Health and Well-Being Strategy for people with learning disabilities is around employment. Some progress has been made. There are also priorities regarding housing and making communities safer places. The Health and Well-Being Board will work with the safer Communities Board, chaired by Cllr Longstaff, on this.

It is not easy for people with learning disabilities to take on a job. It is useful to show that you could do a job by doing placements. Some people are worried that they could lose their benefits. The Council is working with JobCentre Plus and Disability Employment Advisers work alongside social workers and give information regarding benefits. Taking on a job is a big change for people with learning disabilities and it needs to be properly supported.

Supplementary question:

Does Barnet Council employ people with learning disabilities?

Kate Kennally

Yes, it does.

Question 5 Older Adults Partnership Board

How can the Health and Well-Being Board support Partnership Boards to link with other partners to achieve their objectives, for example, to link with Highways on falls prevention.

Cllr Helena Hart

The Summit has been an ideal opportunity to link with Partnership Boards. We have seen how different issues run across Partnership Boards, and Partnership Boards will be addressing cross-cutting issues together.

With regard to falls prevention, a number of stakeholders have been involved in the development of the new Falls Unit at Finchley Memorial Hospital. Finchley Memorial Hospital is a good example of how new services are being commissioned closer to people's homes. In addition to many other services, it is planned to have GPs in Finchley Memorial Hospital.

Kate Kennally

Councils now have a statutory duty to promote health and wellbeing. Therefore, if there is a particular issue affecting health and wellbeing, Council officers must consider this. Health and wellbeing is considered in the development of services. For example, health impact assessments are completed for new town design.

If Partnership Boards are experiencing difficulty in generating joined up responses to issues, they should let the Health and Well-Being Board know.

Question 6: Mental Health Partnership Board

How do we as members of Partnership Boards access the Health and Well-Being Board? For example, can Partnership Boards come and present issues to the Health and Well-Being Board?

Cllr Helena Hart

Partnership Board members are urged to attend Health and Well-Being Board meetings. As the last item of the public session of each meeting, the Board covers a topic or theme in depth. This is an ideal opportunity for a burning issue to be considered, especially if it is cross-cutting. Partnership Boards should put such issues to the Health and Well-Being Board, and these will be put into the Board's work programme.

The Board will also press for early publication of its meeting papers on Barnet Council's website http://barnet.moderngov.co.uk/ieListMeetings.aspx?CId=177&Year=0

Question 7: Older Adults Partnership Board

Many Partnership Board members are volunteers. We often need to research questions with the Council. How do I, as a Partnership Board member, ask a question such as whether a kerb which has been knocked over on a particular street can be repaired?

Kate Kennally

With regard to pavement issues, people can:

- contact the Council's Customer Services (020 8359 2000)
- use the 'Fix My Street' facility on the Council's website http://barnet.fixmystreet.com/

With regard to Partnership Board volunteer members' questions to the Council and the NHS, John Morton and colleagues are looking at how to strengthen the joint commissioning team so that we take issues into Health and Social Care and communicate responses back out to you.

John Morton

Barnet Clinical Commissioning Group will work much more closely with Barnet Council with regard to commissioning.

The NHS in Barnet is under new management. It was part of NHS North Central London. NHS management has moved to being more local and closer to patients. Barnet Clinical Commissioning Board has meetings for just Barnet. The Board has nine GPs within its 15 members. Therefore the Board has very real knowledge about what's happening locally.

Barnet Clinical Commissioning Group is a very new organisation. Challenge us on what we have done in 12 months or 24 months.

Question 8: Learning Disability Partnership Board

What will the timeframe be to see progress and how will we know that it is working?

John Morton

Barnet CCG will develop a work programme. This will be confirmed through the Integration Board and the Health and Well-Being Board. We'll clearly set out the jobs we'll do this year and next year.

The Health Overview and Scrutiny Committee, the Health and Well-Being Board and Healthwatch Barnet have a responsibility to see that we deliver our work plan.

Barnet Clinical Commissioning Group will work with the Health Overview and Scrutiny Committee, the Health and Well-Being Board and Healthwatch Barnet on how we deliver joint priorities.

Cllr Helena Hart

The Health and Wellbeing Strategy, within its four themes, sets out what needs to be done, what programmes need to achieve and measures to be taken to address issues.

Dr Jeff Lake

The Joint Strategic Needs Assessment provides high level health indicators for Barnet. This directs the development of the Health and Well-Being Board's strategy. The implementation of the strategy is measured against indicators, for example levels of physical activity in Barnet.

Selina Rodrigues

It is important to make sure that all information about our strategies, work plans and measures of success (key performance indicators) are accessible and meaningful.

Further questions agreed by Partnership Boards which were not answered at the Summit due to lack of time

Question 9 Carers Strategy Partnership Board

How can the Health and Well-Being Board ensure that carers are respected as partners in care as they are the experts in their cared-for's health needs?

The Health and Well-Being Board recognise that involving carers in the discussion about health and social care needs of the person cared for is essential, and that carers issues are a priority and seen as an integral part of health and well-being in Barnet. This is reflected in a number of schemes that aim to provide training on carers awareness within hospital wards for example. Further work is also planned to support GPs to identify carers and have clear updated protocols on carers.

Question 10: Mental Health Partnership Board

Why is voluntary sector representation on the Health and Well-Being Board so limited?

Barnet's Health and Well-Being Board consulted the guidance for statutory membership that was set out in the Health and Social Care Act (2012), and used this template to recruit its members.

This guidance requires that Healthwatch is a statutory member, to ensure patient, public and a wider community voice are represented in the Board's discussions and decision making. Healthwatch Barnet has contracts with a number of voluntary sector organisations to engage with more people and be the consumer voice for health and social care.

Whilst wider voluntary sector partners have not been asked to be statutory members of the Board, it recognises the immense value the sector can bring to its work, and has consulted the sector on the key documents that the Board developed - the Joint Strategic Needs Assessment and the Health and Wellbeing Strategy.

Each Health and Wellbeing Strategy lead will also need to work with the voluntary sector to achieve its objectives.

The Partnership Boards Summit will be a key forum through which the Health and Well-being Board can meet with voluntary sector partners to test its priorities and work programme.

Question 11: Mental Health Partnership Board

Who prioritises the priorities – how is that done – against what criteria and how can that be challenged?

The priorities of the Health and Well-Being Board have been set by:

1. National legislation (Health and Social Care Act (2012)) and policy guidance to Health and Well-Being Boards published by the Department of Health

2. Public Health research on the wider determinants of health by Michael Marmot
3. The results of the Joint Strategic Needs Assessment for Barnet (2011)

These documents have been reviewed and translated into the priorities and targets in the Health and Wellbeing Strategy.

The Health and Wellbeing Strategy includes clear objective which organisations need to deliver against. There are named leads against each target in the Health and Wellbeing Strategy. These leads are responsible for achieving the objectives of the Strategy, and are accountable to the Health and Well-Being Board for achieving against these targets.

Residents can make comments through Healthwatch about these priorities, which can raise emerging issues/ investigate concerns further through the Health and Well-Being Board

The Partnership Boards will be a key forum through which issues about the priorities can be raised by Partnership Boards and considered by the Health and Well-Being Board.

Question 12: Learning Disability Partnership Board

How will the Health and Well-Being Board make its work accessible to people with learning disabilities, especially people with complex needs, and how will it understand the barriers and lives of people with complex needs?

Whoever delivers services on behalf of the Council is required to make sure that they have regard to the needs of all of Barnet's residents in line with our equalities responsibilities. Personalisation is an important way for all people with difficulties to have a real say over their lives in line with Valuing People and the integrated learning disability service is committed to giving everyone meaningful choice and control.

The Board is committed to making information accessible to those with complex needs. For example, it has made a summary of the Health and Wellbeing Strategy which is presented in easy read format on the Council's website.

The Partnership Boards Summit will always have easy read materials available for people with complex needs.

Minutes from the Health and Well-Being Board are made available online. If there are areas of particular interest to the Learning Disability Partnership Board, they are welcome to raise this with the Health and Well-Being Board and agree for a presentation to be delivered on the area. Additionally there is a separate working group 'commissioned' by the Learning Disability Partnership Board exploring how best to engage with people with complex needs and ensure their needs/views are represented by the Learning Disability Partnership Board; the board is also inviting a stakeholder member whose priority is supporting people with complex needs to ensure these are considered as part of the board.

Question 13: Learning Disability Partnership Board

How will concerns of the Learning Disability Partnership Board be included in the Health and Well-Being Board's strategy and needs assessment?

The Public Health team are committed to refreshing the needs assessment in 2013. The team will be consulting with Partnership Boards before finalising the revised assessment. The revised needs assessment will be used to revise the Health and Wellbeing Strategy, if/where this is appropriate.

Question 14: Learning Disability Partnership Board

How will supported housing affect learning disability?

Having a home of your own with support is something which many people with a learning disability want. We remain committed to making this a reality for more people over the coming years.

10. Round-Up of the Day

Kate Kennally thanked participants for spending their time at the Summit, and all those involved in organising and running the event, and service users and carer members of Partnership Boards for volunteering. Kate emphasised that Partnership Boards and the Health and Well-Being Board would develop and undertake actions in response to learning from the Summit. In closing the event, Kate expressed how she was looking forward to seeing people again at the next Summit, which will be in autumn 2013.

11. Participant Evaluation of the Summit

29 participants completed feedback forms, giving their views on the event. Feedback will be taken into account in planning future Summits.

Summary of Main Points

Overall, there was very positive feedback. Key points are:

- 27 participants thought that the day was very good or fairly good.
- 24 participants rated being able to say what they wanted at the Summit as very good or fairly good.
- 26 participants thought that the venue was very good or fairly good.
- 26 participants rated the clarity of presentations as very good or fairly good.
- The most useful parts of the day were networking, updates, presentations and the workshops.
- Some people did not find different parts of the day useful.
- Suggestions on how to make the Summit better include having more time for questions and networking, co-producing the Summit and having more interactive activities.

Detailed Responses

1. Rating of different aspects of the event.

	Very Good ☺☺	Fairly Good ☺	Average 😐	Fairly Poor ☹	Very Poor ☹☹
How well were you able to say what you wanted at the day?	13	11	3	2	
Was the information clear in the packs?	21	7	2		
Were the presentations clear?	17	9	1	2	
How good was the venue?	19	7	1		2
How good was the day?	14	13	1	1	

2. Which part of the day was most useful to you?

- Networking (8)
- Update and presentations (7)
- Mahmuda and Helen's presentation on Partnership Board achievements
- Workshops (very focussed and energising) (4)
- Discussion on mixed boards table (3)
- Quiz was good – learnt new information (3)
- Healthwatch (3)
- Group discussion (although 15 minutes would be better than ten) (2)
- Finding out at first hand views of partnership board members and key strategic members (2)
- Being involved (2)
- Panel questions
- Feel more informed about the structure of the HWBB/Partnership Boards – more connected
- Group tasks
- Information packs

3. Which part of the day was least useful to you?

- Questions at the end – not really practical to do this and most of the panel did not speak (3)
- Workshops – attempt to address too broad a brief in too short a time (2)
- A shame that networking was truncated as lunch was 'abbreviated'
- Role of the Health and Well-Being Board
- Unable to ask questions
- None – all good

4. How could we make the Summit better?

- More time for workshops
- More time for questions (2)
- Make it two days
- More time for networking
- More time to speak to other board members and get ideas
- Mix the seating of the 5 partnership boards so there is more interactions and networking
- Hold a couple of times a year (2)
- Showcase/agree joint work programmes across Boards
- Outcome of feedback/impact/what has changed as a result
- Continue the good work – make sure we get feedback
- Avoid red/green pens on table
- Avoid school half term
- Label food at lunch better
- List of delegates in the pack (2)
- Documents not accessible enough – lots of text with a picture is not accessible enough
- More interactive activities and more co-production with users
- Map of organisations (Healthwatch/HWBB/CCG/PBs) and how they link with
- each other
- List of names in the above organisations
- Better access
- Use of other rooms – sometimes noisy and busy

- More representation from partnership boards
- Introductions of the groups and what they do
- Fewer workshops
- Have separate smaller Q&A sessions throughout the day
- Co-production
- Too serious, stuffy, and at times cheesy, need different approach in presenting information

5. Is there anything else you would like to say?

- Thank you – the day was very well organised (3)
- Very good atmosphere to launch first Summit – well chaired by Kate Kennally
- Lunch not great for people with special diet
- Including Children's Board and strategic partners in these joint discussions would be helpful
- Concerned that we do not have the funding to take effective action, training
- needed to do meaningful evaluation to justify and make future business cases for specific actions
- In this time of changes we keep hearing the same news from different people – heard nothing new
- Found everyone very supportive/caring/accessible and focussed on my needs
- More funding for Barnet council and more funding for people with learning disabilities
- I hope this continues and the public are made aware not just groups
- An excellent move towards integration of health and social services
- Highlight: participation and opportunity for those with impairments and difficulties
- Wasn't sure we were being taken seriously – isn't this exercise just lip service?
- More access to mental health services as there is nowhere near enough
- provision for people trying to access them at the moment
- Elderly people and wheelchair users can't climb the mountain to the Diamond Suite

AGENDA ITEM 5

Meeting	Health and Well-Being Board
Date	27 June 2013
Subject	**Social Care Funding**
Report of	Adults and Communities Director
Summary of item and decision being sought	This report summarises the implications of the Care Bill 2013-14 for the Health and Well-Being Board. The Bill is currently undergoing scrutiny in the House of Lords. A report to Cabinet 18 April 2013 noted the impact of the reform to the law relating to care and support for adults and the policy statement on Care and Support Funding Reform, presented to Parliament on 11 February 2013, setting out the implications (refer to Appendix) for Barnet based on empirical data and modelling where appropriate.

Officer Contributors	Dawn Wakeling, Adults and Communities, Director Rodney D'Costa, Head of Social Care Commissioning – Adults and Communities
Reason for Report	To update the Health and Well-Being Board on reforms to social care and related funding
Partnership flexibility being exercised	n/a
Wards Affected	All
Contact for information	Dawn Wakeling 020 8359 4290, dawn.wakeling@barnet.gov.uk Rodney D'Costa, 020 359 430 Rodney.d'costa@barnet.co.uk

1. RECOMMENDATIONS

1.1 That the Health and Well-Being Board notes the forthcoming changes to the statutory framework within which Adult Social Care is delivered.

1.2 That the Health and Well-Being Board notes the new responsibilities and modelled implications of the social care reforms on the Council, as set out in this report.

1.3 That the Health and Well-Being Board notes the potential financial impact of the reforms (refer to Appendix) along with the contribution of wider Council services and partner organisations in mitigating the impact.

1.4 That the Health and Well-Being Board notes the benefits of closer integrated working with the local NHS in addressing future demands on social care and, in line with the recommendation from Cabinet 18 April 2013, is asked to consider how its work programme supports the social care reforms.

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 Special Safeguarding Overview and Scrutiny Committee on 24 September 2012 received a report on the three key adult social care policy documents published in July 2012: Caring for Our Future (White Paper); the draft Care and Support Bill; and the Government's interim statement on funding reform for Adult Social Care. Committee endorsed Officers undertaking further work to assess the potential impact of these policy changes on Barnet.

2.2 Cabinet 18 June 2013 received a report on the impact of the White Paper, Caring for our Future, and the draft Care and Support Bill, both published in July 2012; and of the policy statement on Care and Support Funding Reform, presented to Parliament on 11 February 2013. The report set out the implications for Barnet based on empirical data and modelling where appropriate

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

3.1 The reforms align with the objectives in Barnet Council's 2013/14 Corporate Plan - "supporting families and individuals that need it - promoting independence, learning and wellbeing"; and "promote a healthy, active, independent and informed over 55 population in the Borough so that Barnet is a place that encourages and supports residents to age well".

3.2 The Health and Well-Being Strategy also echoes many themes of the new policy framework with its emphasis on promoting independence and wellbeing whilst ensuring care is provided when needed.

4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 The White Paper set out that age discrimination in health and social care became unlawful from October 2012. This is in line with the duties incumbent on all public bodies through the Equalities Act 2010. Adult Social Care works within the Council's policy framework for equalities and offers services to users within this framework. Relevant positive action is undertaken to ensure social care is accessible to groups with different equalities characteristics; for example, producing easy-read information for people with learning disabilities and offering interpreters for service users.

4.2 Age discrimination should be considered broadly: younger people may perceive that older people receive more favourable treatment from services as well as older people perceiving that they are less favourably treated. The prohibition does not mean that all age groups should therefore be offered identical supports or services. However, it does require the Council to have a transparent and fair rationale for different approaches or supports offered to different age groups, just as it already does for current positive action in place, such as providing interpreters.

4.3 However, there is a general risk from this prohibition applicable to all councils, which may face an increased level of potential legal challenge from individual users or groups, using this prohibition as its basis. Nationally, there have been legal challenges based on equalities legislation: for example, the 2011 challenge to Birmingham City Council on its proposed change to adult social care eligibility criteria.

4.4 In order to ensure Barnet Council remains compliant with this requirement, new policies and strategies will need to give consideration to existing social care supports specific to different age groups, along with wider universal services, to ensure there is a transparent and fair approach to the offer to social care users based on age.

5. RISK MANAGEMENT

5.1 Whilst the overall direction set out in the White Paper is positive for users and carers, with an emphasis on choice, control, prevention and planning ahead, this report identifies some potential risks for the Council in implementing its requirements. These include the resource and financial implications of providing enhanced services to carers; also to people who fund their own care; the potential start-up costs associated with the deferred payments scheme; and the demand implications of social care funding changes both in terms of direct care costs and social care staffing and infrastructure costs.

5.2 A number of new statutory requirements and duties are set out in the new policy and legislative framework and there would be risk for the council in failing to meet these new statutory requirements.

5.3 These changes need to be considered in the context of key financial and

demand risk factors already known concerning social care. These are demographic growth, particularly among older people and younger adults with complex disabilities; and increasing complexity of need among adult social care service users. Additional new risks include the new duties to provide services to carers and to people who fund their own care.

5.4 The Council is already addressing identified risk demand factors though the development of strategies, some of which are likely to be statutory responsibilities in the future. These include close working with public health to deliver a strong focus on prevention and early intervention, such as improved information and advice, increased use of telecare and enablement; joint working between Barnet Homes and Adult Social Care to develop housing which supports independent living; and the development of integrated services between the NHS and social care.

5.5 However, even with an increased focus on demand management, the combined impact of demographic change and the new policy and statutory requirements present a significant challenge that will require a sustained and robust council wide response with continued engagement with key partners. This will need to involve developing suitable accommodation that ensures people remain independent; supporting carers to continue caring; encouraging people to plan in advance for their care needs; and promoting well-being and independence and community inclusion. Only such a strategic approach can mitigate the demand and financial pressures that will continue to be faced by adult social care.

6. LEGAL POWERS AND IMPLICATIONS

6.1 The current social care legislation has evolved over a number of decades and in a piecemeal manner. The current legislation is complex and sometimes confusing and the Courts have commented on these difficulties in several cases. As with the Equality Act 2010, the draft Care and Support Bill sets out to consolidate several pieces of legislation and will replace over a dozen different pieces of legislation with one Act. The new legislation is designed to be less complex and easier to apply for practitioners within the council, their legal advisers and, in the case of legal challenges, the Courts.

6.2 The Equality Act 2010 introduces the term protected characteristics in respect of groups of people who are offered protection under the Act, and age is a protected characteristic s149 of The Equality Act 2010 introduced the public sector equality duty requiring public organisations to have due regard to

1. Eliminate unlawful discrimination, harassment and victimisation
2. Advance equality of opportunity between people who share a protected characteristic and those who don't and
3. Foster good relations between people who share a protected characteristic and those who do not.

Discrimination in respect of service provision for groups of a particular age is then already unlawful.

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

7.1 The White Paper and Care Bill set out a number of additional requirements for councils and has provided a high level impact assessment as to the resource required to meet them. The Policy Statement on Funding Reform estimates that the implementation of the cap on care costs and the changes to the means test threshold will cost an additional one billion pounds nationally per year. However, it is currently unclear how these additional requirements and costs will be funded at a national level and how funding will be given to councils. It is anticipated that more information will be issued by the Department of Health (DH) in the future.

7.2 This section of the report, section 9 and the appendix of the Cabinet Report 18 April 2013 set out the various proposals alongside an assessment of the impact based on local empirical data and modelling work. It is clear that the reforms will have a significant impact on social care locally.

However, it should be noted that it is not possible at this stage to predict with precision the demand changes that these reforms will bring. However, where it is known that it is likely to be an impact, this has been indicated, along with scenarios illustrating potential costs and volumes. The potential impacts described in this report should be considered in this context and will be refined as more information becomes available. Further work is required to understand the full impact of these proposals and prepare for implementation through a dedicated programme of work.

7.3 Based on those elements of the proposed changes that were able to be modelled (carers' assessments and services; service users' care and support plans and deferred payments) and based on scenarios set out in this report and the appendices, the headline potential additional costs could be £11.6m annually. This excludes any potential funding from Government to Councils for implementing the changes and is an estimate based on information currently available. Actual implementation costs could vary depending on any changes to the published reform proposals, actual take up of the schemes by residents and the pace of take up.

7.4 The White Paper states there will be an additional £300m funding for social care to local authorities via the national NHS commissioning board for integrated care in 2013/14 and 2014/15. From previous funding allocations, for Barnet, this can be assumed at a level of £1.8m over two years. However it is unclear as to whether this will be recurrent funding. This is welcome given the financial implications of the White Paper. However, Barnet adult social care continues to experience high levels of demand pressures arising from demographic change. Given this context, the Adults and Communities Delivery Unit is working to manage demand and cost and it will be important that it continues to do so. Nationally the King's Fund has calculated that a funding gap of £1.2bn could open up between 2011-15

due to the government's 28% real term cuts to council budgets reflecting Barnet Council's own analysis of the financial implications of growing needs for children's and adults social care. The additional responsibilities that the White Paper and Funding Reforms will confer and the funding levels required have been based on current budgets and not reduced future budgets. It will be important that this level of financial risk for the Council is quantified through the Finance and Business Planning process at the appropriate time.

7.5 The government estimates that the costs of its social care funding reforms, i.e. the cap on care costs and changes to capital limits, will cost £1 billion per annum. Based on this, it is assumed that funding is likely to be made available to local authorities to meet the additional costs of implementing the reforms. However, no announcements have been made about this and further details will be shared when known. Assuming that Barnet share of the total funding from government specific grants remains at 0.6% this equates to £6m.

7.6 The potential additional financial pressure on the authority as a result of these changes to social care is significant. The additional annual cost of implementing the proposals could be in excess of £10m per annum, and if government funding to support this falls short by, say, 25% this will result in a significant shortfall for the authority. Any shortfall in national funding would require the authority to re-prioritise resources from other areas, earmark additional business rate or Council Tax income or identify other measures to balance the budget.

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 There will be a legal duty to commission and provide preventative services and information and advice. Barnet Adult Social Care currently provides a range of information and advice services: Social Care Connect (an on-line directory); a wide range of information leaflets; internet information; specially commissioned advocacy services; 'My Care My Home", a dedicated service for people funding their own care including access to independent financial advice; "Care place", a web based tool giving information on care provision across Barnet and other boroughs in the West London Alliance. Healthwatch will have a key role to play in supporting and signposting local residents who may wish to access local health and social care services.

8.2 Whilst there has been a duty to offer direct payments to certain classes of service users since 2003 there will be a duty in law for the first time to inform users about rights to direct payments (DPs) and what needs could be met by DPs. Barnet Adult Social Care already advises service users and carers about DPs and actively promotes their use.

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 Local authorities will be required to take on the leadership role in situations of social care provider failure. More details of this will be published and council duties will be set out in legislation.

9.2 The following duties will be set out for local authorities that will require them to work with providers:

- Ensuring that adult social care and housing work together effectively in the area of adaptations and home repairs;
- Promoting diversity and quality in care and support provision: through our Market Position statement we are engaging with the provider market to ensure that we plan services for our diverse populations;
- Promoting the integration of services: the Council already has integrated care with the NHS for mental health and learning disabilities, community equipment and voluntary sector commissioning. The Council, with partners, has established a formal health and social care integration programme, reporting to the Health and Well-Being Board.

10. DETAILS

10.1 The following paragraphs set out the background to the government's policy agenda. The report to Cabinet 18 April 2013 (Appendix) contains an assessment of the impact of the proposals, based on local empirical data and modelling work undertaken by a small working group.

In July 2012, the government published the following key documents:

- *Caring for Our Future: Reforming Care and Support (White Paper).*
- *The draft Care and Support Bill.*
- *Caring for Our Future: progress report on funding reform.*

This was followed by the publication in February 2013, of the government's *Policy Statement on Care and Support funding Reform and Legislative Requirements*.

10.2 The White Paper, *Caring for our Future*, describes a vision of a new role for local authority adult social care. In the new system, the local authority becomes a system leader, as opposed to a provider of care management and service provision, reflecting the direction of the Council as a Commissioning Council. In the new policy, local authorities are expected to concentrate on needs assessment, supporting social capital, promoting Direct Payments, ensuring good information and advice and developing the care market. The Care and Support Bill is in pre-legislative scrutiny and will be introduced to Parliament sometime in 2013.

10.3 The strategic and business plans of the Council for adult social care are in line with many of the White Paper themes. The Council's policies for adult social care and older people have for some time focused on prevention through schemes such as the Ageing Well programme and the

neighbourhood model of older people's day support; new on-line information resources; promoting and increasing direct payments; enhancing support to carers; and building social capital through schemes like the Supporting Independence Fund and the development of the Barnet Centre for Independent Living (BCIL).

10.4 The focus on commissioning and system leadership for local authorities in national policy has strong synergy with the vision of the Commissioning Council and the creation of enhanced strategic capacity to develop cross-cutting approaches to issues that affect people with social care needs and population change.

10.5 **The key themes of the White Paper: Promotion of social capital and prevention**

This includes central and local government promotion of a range of initiatives to help reduce the need for formal care. It is proposed that there is the setting up of a national health and social care volunteering fund, national pilots of social impact bonds and promotion of time banks, enabling people to find ways of giving their time whilst they are able in exchange for care when needed. The White Paper established a £200m housing fund to be used to develop extra care schemes for older people and an aim to increase the use of telecare in social care.

10.6 **Better information and advice**

The Department of Health has established a national website containing information on social care providers, which will be added to over time. It also plans to establish national comparison and feedback sites for social care services. The White Paper requires local authorities to provide on line information about local services and how to access them. To assist councils to develop on line information, start-up funding of £32.5m will be made available.

10.7 **Dignity, standards and workforce**

There will be a new code of conduct and minimum training standards for care workers. The government will appoint a national chief social worker for adults (alongside a chief social worker for children's services) and recommends principal social workers in local adult social care. The Council has identified a designated post in the Adults and Communities Delivery Unit to act as principal adult's social worker. Work will start to develop a national social care evidence base, led by the National Institute for Clinical Excellence and a new system of national care audits will be implemented. There will be measures to improve the quality of personal assistants (carers directly employed by service users) and registered managers of care homes; and to increase entrants to social care as a career.

10.8 **New entitlements for service users and carers**

The Care Bill draws together existing social care law into a single statute and replaces out-dated legal aspects. Both the Care Bill and White Paper set out a range of new entitlements.

10.8.1 The right to a personal budget and direct payments will be enshrined in law for the first time. It should be noted that Barnet residents already have this legal right through the 'Right to Control', where Barnet is one of 7 local authorities piloting this approach to offering direct payments of specific social care, employment and housing funding to service users.

10.8.2 Access to statutory social care will be through nationally determined social care eligibility thresholds from April 2015, removing local authority discretion to set their own Fair Access to Care thresholds. At the moment, the vast majority of councils set their threshold at Substantial and Critical (from the four levels of Low, Moderate, Substantial and Critical). It is likely that the effect of this will be to prevent councils from moving thresholds to Critical only.

10.8.3 Service users will have a right to continuity of care after a move to a new area and care cannot be stopped pending a new assessment by the new host authority. Councils can still conduct their own assessment but will need to put in writing the reasons for a different outcome to the user. This will mean that councils may pay for care longer after a user has moved; or that the receiving council has to take up the cost of care earlier than is the case in the current system. The aim of this change is to prevent disruption of care for users and should reduce debate between councils about residence requirements and care entitlements.

10.8.4 The documents set out significant changes to Carers' entitlements. They are to receive extended assessment rights and for the first time, a legal entitlement to support services and review. The entitlement in law to support is new and could have significant financial implications in terms of meeting these needs. However, it is possible that it could in some cases lead to reduced care costs for some service users, as carers should in theory be more supported to carry on their caring role. The impact of this new entitlement is significant. In 2011/12, the council carried out 2,424 carers' assessments but did not provide services to all of them. In addition, the new entitlements are likely to encourage more carers to come forward for support.

10.8.5 Carers' needs are to be considered as equal to the needs of the service user. For the first time, a national eligibility threshold for carers will be set. The threshold for this is not yet known.

10.8.6 The White Paper states that people who fund their own care will be entitled to assessment, support planning and care management from the local authority. Under current legislation, anyone can request a community care assessment but not care planning and management and in practice many people with financial resources make their own care arrangements. The combination of this new entitlement with the cap on care costs, which incentivises people to come forward for an assessment to start their record of care costs, is likely to create significantly increased demands for assessment and care planning. This is traditionally done by social workers

within local authorities, although more recently independent and voluntary agencies now offer support planning services.

10.9 **New requirements on local authorities**
In addition to the care entitlements described above, there will be the following new requirements on local authorities:

10.9.1 There will be a legal duty to commission and provide preventative services and information and advice, although the level and nature of these services is not prescribed. Barnet adult social care currently provides a range of information and advice services: Social Care Connect (an on-line directory); a wide range of information leaflets; internet information; specially commissioned advocacy services; '*My Care My home'*, a dedicated service for people funding their own care including access to independent financial advice; '*CarePlace'*, a web based tool giving information on care provision across Barnet and other boroughs in the West London Alliance. The Council has recently commissioned Healthwatch which will have a key role to play in supporting and signposting local residents who may wish to access local health and social care services.

10.9.2 There will be a duty in law for the first time to inform users about rights to direct payments (DPs) and what needs could be met by DPs. This, like the new right to a personal budget, is in effect an update of the legal framework to reflect current best practice. Barnet adult social care already advises service users and carers about direct payments and actively promotes their use.

10.9.3 There will be a duty to open up council community buildings for local use, as part of the DH drive to promote social capital and prevention. This has synergy with work already being carried out by the Council to map community assets.

10.9.4 Local authorities will be required to take on the leadership role in situations of social care provider failure, such as the national situation with a care provider with significant financial problems, Southern Cross. More details of this will be published and council duties will be set out in legislation.

10.9.5 The White Paper states that "crude" commissioning of home care "by the minute" is to be banned. Barnet Council has three current home care contracts on a geographical basis with three home care providers, each worth around £3m per year, plus a specialist home care enablement service. Each home care service user has a plan of activities to be carried out with outcomes to be achieved, as part of their support plan. Contracts are monitored for quality on a regular basis. However, support is generally procured in time slots of 15 minutes. Barnet's approach combines a focus on outcomes and quality with a time based approach. It is not clear from the White Paper if all contracting on a time basis is to be banned or if it applies to more rudimentary approaches that focus on time alone. However, adult social care will adjust its approach if needed to ensure adherence to the requirements whilst maintaining a value for money.

10.9.6 There will be a duty to ensure that adult social care and housing work together effectively in the area of adaptations and home repairs. Barnet already has a strong approach in this area. Capital funding is allocated to the Disabled Facilities Grant (DFG) and there is close working between Barnet Homes, Environmental Health (EH) and Barnet adult social care on a single streamlined process for DFGs, with a dedicated Occupational Therapist working alongside EH staff.

10.9.7 The council has also identified priorities within the Housing Revenue Account Business Plan that will help adult social care to meet the support needs of residents; this is expected to deliver additional wheelchair adapted housing, dementia mixed extra care sheltered housing and homes suitable for older residents.

10.9.8 There will be a duty to promote diversity and quality in care and support provision. Currently this is already discharged in a variety of ways, for example: monitoring equalities data to ensure that are services meet the needs of our diverse population; the personalisation agenda where all support plans are individualised to ensure peoples race, disability, and gender are taken in account. Equality Impact Analysis is also used to assess the impact of all proposed changes to policies, procedures and practices and monitor their implementation. Through our Market Position Statement we are engaging with the provider market to ensure that we plan services for our diverse populations.

10.9.9 There will be a duty to promote the integration of services. The Council already has integrated care with the NHS for mental health and learning disability services, community equipment and voluntary sector commissioning. The Council, with partners, has established a formal health and social care integration programme, reporting to the Health and Wellbeing Board. This includes NHS Barnet CCG and the main NHS and social care providers working in Barnet. The programme will implement new integrated services, delivering improved outcomes for residents and financial benefits. The programme board has recently approved two projects. The first will deliver a community approach to frail elderly care; bringing together acute and community health, GPs and social care into multi-disciplinary care teams. These teams will work across 20 GP practices to support the frailest older people in the community, helping to prevent deterioration and promote wellbeing. This model has been trialled successfully in other London boroughs and evidence suggests it can prevent admissions to acute hospital or residential care, delivering cost savings. Preventing residential admissions will help manage the impact of the social care reforms as home based care is less costly than residential care. The intention is to extend the model across the borough, refining the model based on learning from the pilot phase. The second project will work with residential care homes in the borough to improve quality. This will assist with the mitigation of the social care reforms as it will assist all homes in meeting desired quality standards and support the Council's

maximum usual price, as opposed to higher price rates, ensuring better value for money in care costs.

10.10 **Safeguarding**

The Care and Support Bill sets out a continued leadership role for councils in adult safeguarding. Adult Safeguarding Boards will become statutory bodies, in the same way as Children's boards, with a defined core membership of the Council, NHS and Police. Councils will be required to publish an annual strategic plan and an annual report, which Barnet Council already does. Councils will have a legal duty to make safeguarding enquiries or ask others to do so. Previously, the council role in adult safeguarding was set out in statutory guidance as opposed to primary legislation. This change strengthens the role of councils in adult safeguarding and gives councils a clearer footing on which to work.

10.10.1 The government has also consulted on a new power of entry for social workers to make safeguarding enquiries. This would only apply in a very limited number of situations where there is evidence that access to the adult at risk in order to make those enquiries is being prevented by a suspected abuser.

10.11 **Care and Support Funding reform**

The government has accepted the two principles of the Commission on the Funding of Care and Support (Dilnot Commission). The Policy Statement published on 11th February 2013 states the government's intention to introduce a cap on lifetime care costs for eligible social care needs, which has been set at £72,000. The costs of meeting all a user's eligible needs will count towards the cap, not just their financial contribution to their total support plan costs (under the current system). Users would be expected to pay additional costs if they chose more expensive services or services for other than eligible needs. Users would still be required to pay living costs in residential care of £12,000 per year ('board and lodging'). The second accepted principle will lead to a rise in the capital means test threshold to an £118,000 upper capital limit for residential and nursing care from 2017, changed from £23,250 currently, and a £17,500 lower capital limit, changed from £14,250 currently. The DH has indicated that, subject to legislation, implementation is planned for 2016. There are also plans to introduce a care account system, which will give those purchasing social care regular statements of their spend against the cap threshold, enabling them to know when they have reached the cap level. The cap will be index linked and regulations will be introduced to allow the secretary of state to alter the levels of the cap and the capital limits.

10.12 **Deferred Payments**

The government has announced that it plans to legislate to introduce a national system for deferred payments for residential care from April 2015. Deferred payments mean that users or their spouses/partners do not need to sell their home in their lifetime to pay for care. The local authority will be required to fund the costs of the care and will later be refunded from the estate of the service user (after the death of the spouse if there is one).

Details of how the scheme will work have not been published. The DH plans to work with the care sector in 2013/14 to finalise the scheme. Barnet has a large number of owner occupiers among its older population and this scheme will potentially be attractive to significant numbers of residents

11. BACKGROUND PAPERS

11.1 Cabinet Report 18 April 2013 – Social Care Funding Reform and the draft Care & Support Bill: Implications for the London Borough of Barnet

11.1 Caring for our future: reforming care and support (White Paper)
http://www.dh.gov.uk/health/2012/07/careandsupportwhitepaper/

11.2 Draft Care and Reform Bill
http://www.dh.gov.uk/health/2012/07/care-and-support-bill-comment-online/

11.3 Caring for our future: progress report on funding reform
http://www.dh.gov.uk/health/2012/07/scfunding/

11.4 Department of Health: Policy Statement on Care and Support Funding and legislative requirements, 11 February 2013

Legal – SC
CFO – JH

Appendix 1: Summary Assessment of the impact of the Care Bill for London Borough of Barnet

Background

1. In July 2012, the Department of Health (DH) published the White Paper 'Caring for our future: reforming care and support'; and accompanying Draft Care and Support Bill which sets out the vision for a reformed care and support system.

2. London Borough of Barnet (LBB) has recognised that the proposed reforms will have broad reaching financial and cultural impacts on the way we commission services and our relationship with customers. There are circa 65 commitments, policy ideas and provisions in the White Paper, Draft Care and Support Bill and Impact Assessment published by DH. Of those circa 30 are likely to have a direct impact on the work of local authorities.

3. Paragraph 5 (Table) sets out an assessment of the impact of 32 of these measures on the basis that they include:

   - New / revised duties for local authorities (there are 19 in all).
   - Other commitments, not drafted into legislation, where there is a requirement on local authorities to deliver.

4. There are a number (circa 35) of other commitments made in the White Paper which are to be delivered by others (for example the Department of Health) but may have an impact on the way we operate services locally – for example activities to strengthen and support the social care workforce and the introduction of quality standards. This Appendix does not consider the impact of these commitments.

Summary of impacts

5. The Table below set out the impact (financial and otherwise) of the Care Bill for LBB. The main theme is that Councils will not be required to do anything radically differently; however, it presents an opportunity to look afresh at how services are commissioned.

TABLE

Provision in the White Paper / Care Bill	Current situation	Implications
1. Establishment of a **national minimum threshold for eligibility** for care and support (Clause 13)	a) LBB eligibility threshold is currently set at substantial & critical.	i) In the absence of information to the contrary, it is assumed that national levels are unlikely to be set below substantial. That being the case it is **unlikely that this element alone will have an impact**.
2. New duty to carry out needs **assessment for carers** (Clause 10)	a) Currently there is a legal duty to inform carers about their right to an assessment. A carer can have an assessment irrespective of whether the cared-for person is in receipt of a service; however, the carer's right to a service is dependent on the cared-for person being FACS-eligible. An Authority has a duty to consider whether they will provide services to the carer and has power to provide services under the Carers and Disabled Children's Act 2000. In 2011/12, 2,432 carers were assessed at an estimated cost of £20 per assessment (calculation based on empirical sampling in ASCH Directorate). A number of individuals did approach the council for an assessment but this was refused on the grounds that they were not providing substantial / regular care (the cared for person needs to be at the FACS threshold, Substantial and Critical).	i) The main difference from the current rules is that carers do not have to be providing a substantial amount of care regularly to be entitled to an assessment. Based on the 2011 census, there are 32,000 carers in Barnet. It is estimated that 2,000 carers in Barnet are 75 years or older and 5,000 provide 50 hours or more of care per week *(source: Carers Strategy LBB 2012)*. ii) It is unlikely that every carer in Barnet will request an assessment; however it is likely that the numbers requesting them will increase. As a proxy estimate, Barnet Carers Centre (BCC) hold a register of 5,209 carers (Dec 2012), so this may be an indication of the numbers of carers in Barnet currently likely to seek an assessment if the rights were extended this year. If 5,000 carers a year were to request an assessment this **could potentially cost us in the region of £100,000** based on the £20 calculated cost. iii) Population changes in Barnet over the next decade are likely to have an impact on the total number of carers in Barnet, and therefore the numbers seeking assessment are also likely to increase for this reason. iv) Importantly, the Care Bill gives local authorities new powers to delegate some of their care and support functions to other organisations, for instance, the assessment process or care planning. It may be possible to outsource the assessment of carers to an external provider at a lower cost.

Provision in the White Paper / Care Bill	Current situation	Implications
3. New duty to **meet a carer's eligible needs** for support (clause 19)	a) The carers' budget for 2012/13 is circa £1m. This includes support to carers delivered through a contract with Barnet Carers Centre as well as funding for services signposted and paid for by care workers. In 2011/12, 606 carers received a service (mainly respite care and carers direct payments). This cohort comprises carers who provide substantial and regular care. Currently right to support is dependent on the level of care needs of the person they are caring and not the level of need of the carer. It is not anticipated that this will change.	i) The provisional 2013/14 budget for Barnet based carers is £1.2m. Subject to any changes in the national eligibility threshold for carers i.e. if this is set below the levels at which LBB currently provides support, **this poses a potential financial risk**. ii) An increase in the numbers of carers and / or complexity of need coming to us for an assessment will add to this risk. Based on current activity and budget the unit cost for carers' services is £1,650 (£1m/606 carer services). Projecting on the assumption of an additional 5,000 carers who all require services (see aforementioned figure in Table 2a(ii) results in a projected spend of £8.2m.
4. Enablement of everyone to request assistance from their local authority with the **development of a care and support** plan for their eligible needs	a) In 2011/12, there were 11,227 assessment and review events. Each event results in the creation or review of an existing care and support plans with an estimated staff cost of between £40 and £100 per plan. b) The Joint Strategic Needs Analysis (JSNA) estimates that in 2012, there were approximately 67,500 adults living in Barnet with health and /or care needs. As stated above current estimates place the number of carers at around 30,000. This means the total pool of potential customers requiring an assessment could be as high as 97,500.	i) The Care Bill includes a new single duty to assess users (clause 9) and provide a care and support plan for both users and carers – including a personal budget (clause 23 and 24). It also includes principles which frame how local authorities must carry out their care and support functions to include the "well-being" principle and power for the Secretary of State to make regulations as to how an assessment is carried out. Subject to legislation, the Government has proposed a £72k cap on care costs. This is likely to mean that more people will be incentivised to request a care and support plan in order to track their expenditure against the cap. ii) By way of illustration, using the baseline of £1m (11,000 assessment and review events at a cost of £100 each) the potential resource implications are: 22,000 events – additional £1m 50,000 events – additional £4m 97,500 events – additional £9m

Provision in the White Paper / Care Bill	Current situation	Implications
		iii) It is also possible that changes to the process of how an assessment is undertaken and how a care and support plan is developed may need to be made. For example the White Paper includes an ambition that individual's skills, talents and goals are properly taken into account as part of the assessment. Cost implications of this are not yet clear. As previously noted the additional costs may be mitigated through working with an external partner.
5. Offer **deferred payment arrangements** on a universal basis, and charge interest on these arrangements	a) Barnet does currently have a deferred payment scheme, although usage is not significant. There are 78,350 owner occupied houses in Barnet which is 57.6% of all households. For all Outer London boroughs the percentage is 58.9% and national is 63.5%. b) Based on all service users who have been financially assessed (3,378 in 2011/12), 10% (354) have been identified as self-funders (split 54 for residential and 300 for community-based services). Simple projections suggest that population will increase by 10% over the next 5 years with a pro rata increase in self-funders. The number of self-funders will also be affected by the "offer" from LBB and the wider local social care market place. c) Depleted funders – In 2011/12, 26 users in residential or nursing care presented to Panel with depleted funds, compared to 27 in	i) Local authorities are still awaiting more details regarding the universal deferred payments scheme, implemented from April 2015 subject to legislation. LBB has assessed the likely impact of deferred payments based on residential placements; however it is possible that the scheme may apply to meeting the costs of care in the community as well. ii) If we use the number of current residential self-funders (54) as a proxy for the number of customers who may approach LBB for a deferred payment **the scheme is estimated to cost up to £14m in total and assuming both care and "hotel" cost elements with the Council not breaking-even until year 6 (based on no increase in take up year on year)**. Notes: • This is based on local data available regarding average stay in residential placements, average client contribution and residential placements based on LBB's maximum usual price (MUP) • This is a prudent estimate and the impact can be compounded by increased take up, having to pay more than the MUP or not being able to fully recover costs from the estate. Central government has stated that there will be funding available to assist in the up-front cash flow required; however, in the long run the expectation is that the scheme is self-funded

Provision in the White Paper / Care Bill	Current situation	Implications
	2010/11. This is half the number within our system who currently self-funding their residential or nursing care placement. However, these depleted funders will include those users who have previously been recorded on our system as a self-funder, as well as those who have previously been funding their own support privately without any social care involvement whatsoever. No data exists on the numbers of community-based social care users whose funds deplete each year.	
6. Funding of care and support	a) Currently only those service users with declared assets of less than £23,250 and low income receive help from the state with their care costs. There is no cap on care costs.	i) Subject to legislation and consultation on the fine details, the Government proposes the following key changes with implementation in 2017: • A cap on care costs of £61k at 2010/11 prices (equivalent to £72k at the point of implementation). This is intended to provide everyone with reassurance that they will have a level of protection if they have high-cost needs • Extended means test – those with property value and savings of £100k or less at 2010/11 prices (equivalent to £118k at the point of implementation) will receive financial support with the Government paying a proportion of their residential care costs on a sliding scale. Note “hotel” costs are excluded • People of working age who develop care needs before retirement age will benefit from a cap that is lower than £72k. People who have care needs before they turn 18 will effectively have their cap set at zero.

Provision in the White Paper / Care Bill	Current situation	Implications
7. Place a duty on local authorities to provide an equivalent package of care and support for **users and their carers who move into their areas** until they undertake a new assessment (clause 31)	a) "Sending" authority will provide funding for 6 weeks to allow LBB to carry out assessment, after which LBB will take over funding for community-based service users. b) For residential placements, where a person already funded by the "sending" authority moves to a residential home in Barnet to be near family, they do not become an "ordinary resident" in Barnet and therefore not entitled to be funded by Barnet.	i) The new Bill puts an obligation on "sending" councils, for the first time, to notify the "receiving" council if a person expresses intent to move; the receiving authority must then assess the individual. At present LBB assesses all known customers who move in to the borough, therefore the **impact is cost neutral**.
8. A range of new duties to support transitions from children's to adults services including power to assess a child's and a child's carers needs as well as the needs of a young carer	a) The power to assess a child's needs is already in place. ASCH assess from 16 years onward (Learning / Physical Disabilities and behavioural problems). b) LBB only deals with Adult customers who meet substantial and critical FACS threshold. For initial or core assessment of the child / young person, the carers needs and capacity to care are addressed.	i) By September 2014, as part of the Children and Families Bill, a single birth to 25 years assessment process will replace the current two-tier system of special educational needs assessment (currently there are SEN statements for children under 16/18 and a separate learning difficulty assessment for young adults, who meet the threshold requirements, aged up to 25). The new single assessment process, will cover education, health and care, ensuring that all of the different local agencies are working together to meet needs of the family. Education, Health and Care Plans will provide the same statutory protection to parents as the statement of SEN to up to 25-years-old in further education – instead of there being a 'cliff edge' when it is cut off at 16/18.
9. Improve access to **independent Information Advice and Guidance (IAG)** to help people who are eligible for support and plan to choose how their needs could be met.	a) LBB currently provides information, advice and advocacy services and Social Care Connect (Adult Social Care and Health online directory) which is available to all. The costs of these are currently met through ASCH base budget. b) As of 1 November 2012, two new projects	i) Plans are being drawn up to invest approximately one-off £500k s256 monies into improving and increasing this capacity. In addition, ASCH will be implementing an Information, Advice, Advocacy and Brokerage (IAAB) Strategy comprising: IAAB £350k, Peer Support Brokerage £123k, Healthwatch £198k; and Independent Health Complaints Advocacy £85k. ii) Based on informal legal advice circulated nationally, the above is **considered sufficient to meet the requirements set out in the Care Bill**.

Provision in the White Paper / Care Bill	Current situation	Implications
Make clearer the duty for local authorities to share information with individuals, carers and families	were launched aimed at supporting self-funders and improving information for customers: • Advice for self-funders – ASCH is working with "My Care My Home" to offer independent advice to self-funders. This advice service explains the options available to help people stay independently in their own home, but if they decide that a move to a care home is most suitable, they will support people with advice about how to choose a residential home and explaining the role of a local authority. *My Care My Home* can introduce people to pre-vetted independent financial advisors so they are aware of all of their options for financing their care, and know how to maximise their assets • CarePlace website (www.careplace.org.uk) – ASCH is part of the West London Alliance and participates in the website. The site contains information on our local residential care homes, including bed vacancies and costs, which are updated by our providers. This is a useful tool for commissioning and supply management staff not only for locating vacancies, but also for monitoring placements and reporting on their cost. We	

Provision in the White Paper / Care Bill	Current situation	Implications
	are working on integrating this information into our social care connect website so that it is available to self-funders via the Barnet website	
10. Duty on local authorities to **join up care and support with health and housing** - where this delivers better care and promotes well being	a) ASCH and its NHS and voluntary sector partners continue to work collaboratively, focusing on early intervention and enablement*, and reducing duplication of processes. (* Note: Enablement is about providing the means for people to do as much as they can for themselves and / or to be independent within their own homes for as long as possible.) b) Examples of joined up work involving ASCH Health and Housing includes the following: • Frail Elderly work stream (for example Dementia and Stroke Pathway) • Move on Team including x2 social workers and x1 community nurse working on Out of Borough placements mainly relating to Norwood-Ravenswood in Berkshire • Disabled Facilities Grants (mandatory and discretionary) • Since April 2011, the Housing Revenue Account has been self-financing. This has generated the capacity for additional headroom borrowing of £39m. As a result, revenue savings of £3.5m have been assumed in Adult Social Care Budgets based on additional HRA Headroom expenditure of up to £21m to deliver supported housing, subject to the development of a full business case. Potential projects include: a retirement village concept comprising 100 units; a 50 unit dementia mixed model of housing; and wheelchair accessible independent accommodation • Right to Control – a partnership involving ASCH, JobCentre Plus and Housing; with a Housing officer currently embedded in ASCH to help move on people from Barbara Langstone House	
11. Expectation on LAs to **maximise potential for spaces and buildings** in a community to act as meeting places or centres of activity	a) Commercial Services is currently looking at the council's property portfolio to assess how the community assets can be better utilised. This presents an opportunity for joint working to provide services from existing buildings, but further work is required to fully understand how best to make use of these buildings.	

Provision in the White Paper / Care Bill	Current situation	Implications
12. Help for LAs to write a **Market Position Statement** (MPS)	a) ASCH is currently on track to produce an MPS within 2012/13. Designed to be "outward facing" and hosted on a micro-site as part of the Council's website, the MPS is essentially a local authority "statement" that sets out our market messages regarding future care and support i.e. initiatives to shape the local social care and support market . It makes available the evidential background and is expected to stimulate a vibrant and innovative variety of care and support options for the people of Barnet to make use of as and when the need arises.	
13. Rule out **"contracting by the minute"**	a) LBB currently contracts with three home and support providers at a cost of around £3m per provider per year. Current contractual arrangements are such that homecare for adults in need of care and support is generally procured in 15 minute slots. This is known as "contracting by the minute". Concerns have been raised that this means providers focus on the time they are with a client, rather than a holistic view of the clients' needs. Analysis shows that on average, providers spend 88% of the commissioned time with clients. Reasons for this include: • Issues in the commissioning process e.g. calculation of need done with minimal information / time or risk aversion • Time and task driven support rather than delivering an outcome focused service, e.g. strict adherence to tasks as outlined within the support plan rather than taking a more holistic and enabling view • Rotas – Workers feeling under pressure, whether perceived or actual, to log out	i) Moving from "commissioning by the minute" to commissioning for outcomes will mean a change in way we procure services and a culture change in service delivery. **The financial impact is very hard to quantify**.

Provision in the White Paper / Care Bill	Current situation	Implications
	quickly and get to the next visit • Time lost due to activities performed prior to logging in. Providers report staff can often spend several minutes at each visit engaged with the service user before they can log in/out, in an effort to provide a more person centred and caring service	
14. Duty on local authorities to **incorporate preventative practice** and early intervention **into care commissioning** and planning (clause 7)	a) ASCH's Prevention Framework (2009) sets out the approach to preventative services. This includes the Royal Free Hospital NHS Trust's initiative, Post Acute Care Enablement (PACE). The partnership involving RFH and Barnet, Camden and Enfield councils aims to reduce hospital stays provide for a safe return home and ensures that patients get the medical support and assessment they need during recovery. b) LBB's current overall prevention budget for 2012/13 is £3.2m. This includes funding for enablement as well as equipment, adaptations, telecare and other services aimed at promoting independence of adults in need of care and support by keeping them at home, and/or delaying admissions into hospitals as well as expediting exit from hospital.	i) LBB's prevention budget has already been increased to £4.2m for 2013/14 but the new duty is not really about how much we spend on prevention, it is about how we spend it. Both the White Paper and the changes LBB is going through in order to become a "commissioning council" presents an opportunity for to reassess our approach to commissioning care services, to consider what we need to do differently in order to be better at commissioning for outcomes and further incorporate prevention practice and early intervention strategies into our commissioning approach.

Provision in the White Paper / Care Bill	Current situation	Implications
15. Ban on **age discrimination in health** and social care services from October 2012	a) LBB undertakes equalities impact in its budget and forward planning cycles to ensure proposed policies take into account the potential impact on clients or residents. Estimated personal budgets (via a managed service or direct payment) are underpinned by the FACE overview assessment. There is nothing that considers the customer's age in determining either the points allocation or the price per point applied when estimating personal budgets. The only price differential is due to market conditions that place a premium on the average prices of services for customers with a learning disability.	i) **Cost neutral impact**.

Meeting	Health and Well-Being Board
Date	27 June 2013
Subject	**Barnet Clinical Commissioning Group Recovery Plan**
Report of	Chief Officer, Barnet CCG
Summary of item and decision being sought	The Health and Well-Being Board is asked to consider and approve the Barnet CCG Recovery Plan.

Officer Contributors	John Morton, Chief Officer, Barnet CCG
Reason for Report	The Health and Well-Being Board is asked to consider and approve the Barnet CCG Recovery Plan outlined in this Report
Partnership flexibility being exercised	N/A
Wards Affected	All
Contact for further information	John Morton, Chief Officer, Barnet CCG, john.morton@barnetccg.nhs.uk

1. RECOMMENDATION

1.1 That the Health and Well-Being Board consider and approve the Barnet CCG Recovery Plan (attached in Appendix 1).

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 The Barnet CCG Recovery Plan has been approved by the CCG Finance Performance and QIPP committee and the CCG governing body.

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

3.1 The Plan sets out the Barnet Clinical Commissioning Group vision, strategic objectives and clinical commissioning programmes and explains how these reflect the key themes from the Barnet Joint Strategic Needs Assessment. It confirms how these will support the implementation of the Health and Well-Being Strategy and the achievement of the NHS Mandate and NHS Constitution standards.

4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 The Plan identifies the main themes from the Barnet Joint Strategic Needs Assessment and how these will be managed in each Clinical Commissioning Programme. There has been no equality impact assessment of the Plan as a whole but each of the Quality Improvement Prevention and Productivity projects will have been equality impact assessed as part of the project development process.

5. RISK MANAGEMENT

5.1 Risks identified within the Plan will be managed through the Barnet Clinical Commissioning Group Board Assurance Framework and Risk Register.

6. LEGAL POWERS AND IMPLICATIONS

6.1 Section 12 of the Health and Social Care Act 2012 introduces section 2B to the NHS Act 2006. This imposes a new target duty on the local authority to take such steps as it considers appropriate for improving the health of people in its area.

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

7.1 The financial position of Barnet Clinical Commissioning Group is a significant component of the Plan.

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 The Plan on a page summary and clinical commissioning programmes have been shared and discussed with user representatives and stakeholders at Partnership Boards, CCG Locality Boards, meetings with voluntary sector providers and public engagement events.

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 N/A

10. DETAIL

10.1 Introduction

NHS Barnet CCG is committed to improving the quality and outcomes of the services we commission for the people of Barnet. We believe as a Board that by tackling duplication and waste in the system we can improve patient experience and safety and reduce costs. We are embarking on some very significant and once in a generation changes in the local health system. These will have absolute synergy with what we are doing and result in an aligned primary, secondary and community service; in other words providing the right care in the right place at the right time. We believe as a Board that this is what will deliver a vibrant caring and effective health care system for the people of Barnet.

10.2 Major Changes

10.3 Barnet, Enfield and Haringey clinical strategy

The first major change is the Barnet, Enfield and Haringey clinical strategy. This will see a reduction in the range of services provided at Chase Farm Hospital in Enfield, resulting in a shift, particularly in Accident and Emergency, Paediatric and Maternity Services to Barnet Hospital, and North Middlesex Hospital in Enfield. The strategy is working with partners towards a planned move in November 2013.

This aligns Barnet & Chase Farm Hospitals Trust with the CCG's strategy of supporting people in the community and avoiding unnecessary hospital admissions and reducing overall secondary care activity. There is a planned reduction in acute beds and this is being supported by services in the community and urgent clinics providing alternatives to admission.

An update on progress with this strategy is included in Appendix 2.

10.4 Potential Acquisition of Barnet and Chase Farm Hospitals NHS Trust by the Royal Free London NHS Foundation Trust

The second major change is the potential acquisition of Barnet and Chase Farm Hospitals NHS Trust by the Royal Free London NHS Foundation Trust. Barnet and Chase Farm Hospitals NHS Trust approach to managing a challenging health economy has been to increase income by increasing

activity both directly and indirectly. Work in 2012/13 has confirmed that the Trust`s income for both maternity and A and E admissions was greater than indicated by the activity. The CCG is working closely with the new interim CEO and leadership team at Barnet and Chase Farm and we are already seeing a change in approach. The Royal Free health economy has over recent time been working collaboratively with commissioners to provide integrated care, for example, they have both an Executive and GP Director working to reduce hospital activity. We are now working with both trusts towards a more balanced system.

Barnet and Chase Farm is not viable on an ongoing basis; once it's income reduces to an affordable level which is appropriate for the catchment population, the infrastructure which has been built up will not be sustainable, hence the current option of acquisition. Acquisition would be both a transaction and a transformation.

The transaction is likely to take place early in 2014, the transformation over the next three to five years. A tangible example of the potential of this transformation are the seven pathway workshops held on 30th April and 1st May 2013 where secondary and primary care clinicians from the Royal Free, Barnet and Chase Farm, and Barnet, Camden, Enfield, and Hertfordshire CCGs came together to consider Cardiology, Respiratory, Orthopaedics, MSK, Pain, Rheumatology, Hepatology, Gastroenterology and Gynaecology pathways. These workshops completed the initial design of new systems which will be much more effective at getting the right decisions made much earlier in patient journeys by senior clinicians. This will be supported by systems, including technology, to ensure that the treatment is in the right care setting. Incentives will be attached to shared achievement of outcomes and value for the speciality or disease group, rather than individual provider activity.

An update on progress with this potential acquisition is included in Appendix 3

10.5 Challenged Health Economy

We recognise that NHS Barnet CCG is one of the most challenged health economies in the new system. This is partly due to the new system design and we have an expectation that this will be recognised by NHS England and that over time there will be some re-balance. However it is largely due to the historic position which we now assume responsibility for, the mantle has passed from the PCT to the CCG. We are very clear on the reasons for this historic position and these are set out in the Recovery Plan.

10.6 Principal Areas of Spend for Barnet CCG

We have the following principal areas of spend:

1. On mental health and community we set out the evidence that our spend is below or at average. These are critical areas to deliver our strategic

aims, we will drive efficiency and effectiveness but we will not reduce spending in real terms.

2. In acute hospital services we spend about £43M more than other London Boroughs for the same population. This is partly for the reasons set out above and partly because GPs refer more people to hospital in Barnet than elsewhere and there are more consultant to consultant referrals than elsewhere. This is the core of the Barnet problem and it must be addressed, this recovery plan is built on achieving this over the next three to five years.

3. We have a large primary care estate primarily based at Edgware Community and Finchley Memorial Hospitals. Barnet has two large acute hospitals, one just across the boundary, two very large community hospitals and a specialist orthopaedic hospital on the western boundary. As a new organisation we will need to spend some time considering how this estate can best be utilised to support our strategy, recognising our residents appreciate local access above most other measures. We will need to reduce estate costs; however this is likely to be over a longer period.

10.7 Recommendation

That the Health and Well-Being Board considers and approves the Barnet CCG Recovery Plan.

This page is intentionally left blank

Barnet Clinical Commissioning Group
Recovery Plan

Local clinicians working with local people for a healthier future

May 2013

Contents

I. Foreword, Dr Sue Sumners and John Morton

NHS Barnet CCG is committed to improving the quality and outcomes of the services we commission for the people of Barnet. We believe as a board that by tackling duplication and waste in the system we can improve patient experience and safety and reduce costs. We are embarking on some very significant and once in a generation changes in the local health system. These will have absolute synergy with what we are doing and result in an aligned primary, secondary and community service; in other words providing the right care in the right place at the right time. We believe as a board that this is what will deliver a vibrant caring and effective health care system for the people of Barnet.

The first major change is the Barnet, Enfield and Haringey clinical strategy. This will see a reduction in the range of services provided at Chase Farm Hospital in Enfield, resulting in a shift, particularly in Accident and Emergency, Paediatric and Maternity Services to Barnet Hospital, and North Middlesex Hospital in Enfield. The strategy is working with partners towards a planned move in November 2013.

This aligns Barnet & Chase Farm Hospitals trust with the CCG's strategy of supporting people in the community and avoiding unnecessary hospital admissions and reducing overall secondary care activity. There is a planned reduction in acute beds and this is being supported by services in the community and urgent clinics providing alternatives to admission.

The second major change is the potential acquisition of Barnet and Chase Farm Hospitals NHS Trust by the Royal Free London NHS Foundation Trust. Barnet and Chase Farm Hospitals NHS Trust approach to managing a challenging health economy has been to increase income by increasing activity both directly and indirectly. Work in 2012/13 has confirmed that the Trust`s income for both maternity and A and E admissions was greater than indicated by the activity. The CCG is working closely with the new interim CEO and leadership team at Barnet and Chase Farm and we are already seeing a change in approach. The Royal Free health economy has over recent time been working collaboratively with commissioners to provide integrated care, for example they have both an Executive and GP Director working to reduce hospital activity. We are now working with both trusts towards a more balanced system.

Barnet and Chase Farm is not viable on an ongoing basis; once its income reduces to an affordable level which is appropriate for the catchment population, the infrastructure which has been built up will not be sustainable, hence the current option of acquisition. Acquisition would be both a transaction and a transformation. The transaction is likely to take place early in 2014, the transformation over the next three to five years. A tangible example of the potential of this transformation are the seven pathway workshops held on 30th April and 1st May 2013 where secondary and primary care clinicians from the Royal Free, Barnet and Chase Farm, and Barnet, Camden, Enfield, and Hertfordshire CCGs came together to consider Cardiology, Respiratory, Orthopaedics, MSK, Pain, Rheumatology, Hepatology, Gastroenterology and Gynaecology pathways. These workshops completed the initial design of new systems which will be much more effective at getting the right decisions made much earlier in patient journeys by senior clinicians. This will be supported by systems, including technology, to ensure that the treatment is in the right care setting. Incentives will be attached to shared achievement of outcomes and value for the speciality or disease group, rather than individual provider activity.

I. Foreword, Dr Sue Sumners and John Morton

We recognise that NHS Barnet CCG is the most challenged health economy in the new system. This is partly due to the new system design and we have an expectation that this will be recognised by NHS England and that over time there will be some re-balance. However it is largely due to the historic position which we now assume responsibility for, the mantle has passed from the PCT to the CCG. We are very clear on the reasons for this historic position and these are set out in the recovery plan.

We have the following principal areas of spend:

1. On mental health and community we set out the evidence that our spend is below or at average. These are critical areas to deliver our strategic aims, we will drive efficiency and effectiveness but we will not reduce spending in real terms.
2. In acute hospital services we spend about £43M more than other London Boroughs for the same population. This is partly for the reasons set out above and partly because GPs refer more people to hospital in Barnet than elsewhere, and there are more consultant to consultant referrals than elsewhere. This is the core of the Barnet problem and it must be addressed, this recovery plan is built on achieving this over the next three to five years.
3. We have a large primary care estate primarily based at Edgware Community and Finchley Memorial Hospitals. Barnet has two large acute hospitals, two very large community hospitals and a specialist orthopaedic hospital on the western boundary. As a new organisation we will need to spend some time considering how this estate can best be utilised to support our strategy, recognising our residents appreciate local access above most other measures. We will need to reduce estate costs, however this is likely to be over a longer period.

The CCG would prefer not to be writing a recovery plan as our first document post-authorisation; importantly the Board has confirmed its commitment to tackling financial recovery a year at a time, while developing vibrant, caring, and sustainable services for Barnet residents.

Dr Sue Sumners
Chair

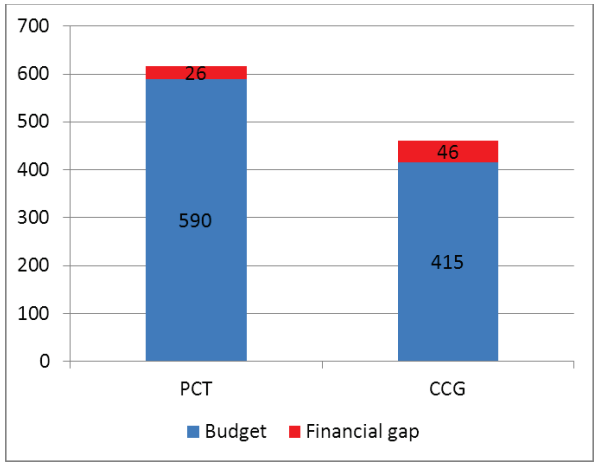
John Morton
Chief Officer

II. Executive Summary - Headlines

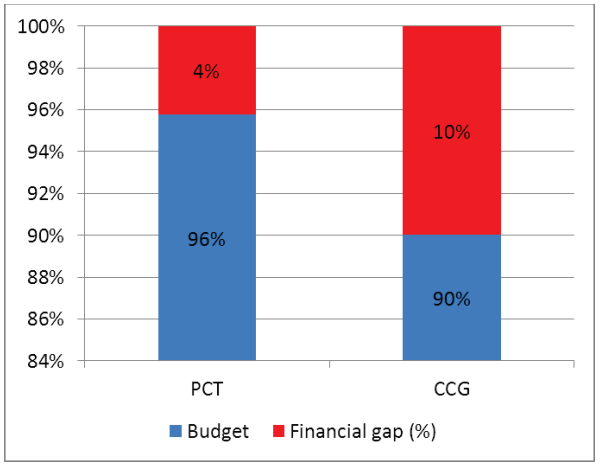
This recovery plan articulates the Barnet CCG approach to achieving financial balance. It should be read in conjunction with our Integrated Strategic Plan, available on www.barnetccg.nhs.uk.

We know and understand the size of the challenge

- The CCG forecasts a deficit in the 13/14 financial year of £46m before QIPP and any benefit from the 2% head room
- The CCG financial position is more challenging than the former PCT exit rate deficit position of £26m, primarily due to the loss of revenue allocation & increased costs totalling c£13m incurred in the transition from PCT to CCG. £9m is due to allocation differences which the CCG believes NHS England should resolve, and £3.8m is due to additional estates costs.



Budget and financial gap (£): PCT compared to CCG

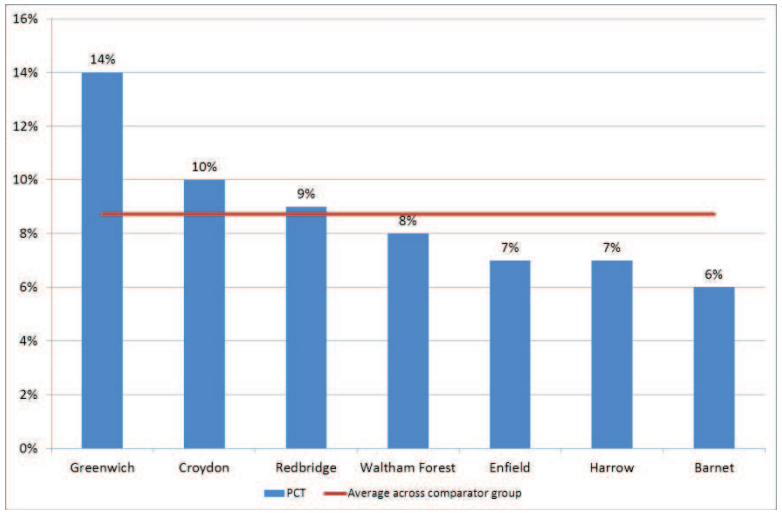


Budget and financial gap (%): PCT compared to CCG

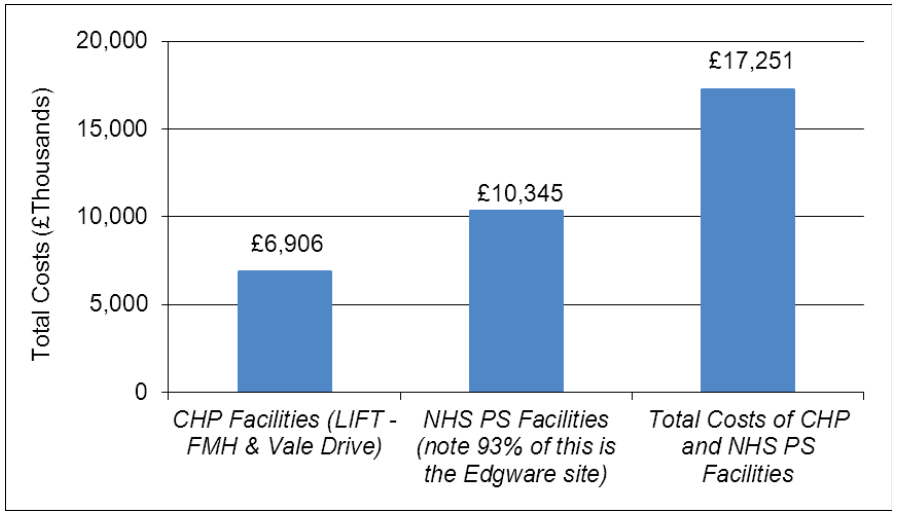
We know and understand the size of the challenge:

- We have compared spend on community and mental health services with our ONS comparator CCGs (PCT data from 2011/12). We have compared spend on estate with other North Central London CCGs (due to available data). We have compared our acute spend with other London CCGs. At a high level this shows:
  - We invest 3% less than average in mental health services;
  - We invest about the average in community services, however when embedded estates costs are taken into account this falls to significantly less than average;
  - We invest up to 10% more of our budget in acute services than the best performers; and
  - We invest 2% more than average on estate.
- Action is needed to significantly re-profile spend across these four areas, by reducing acute and estates costs.

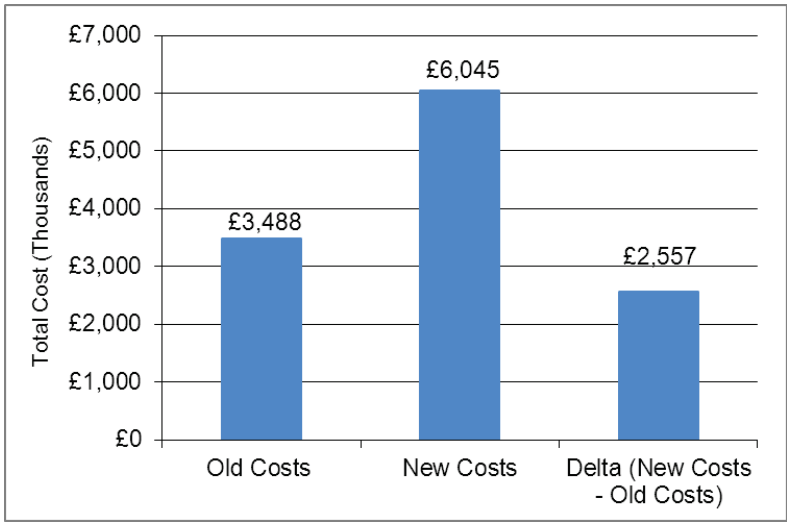
II. Executive Summary - Headlines



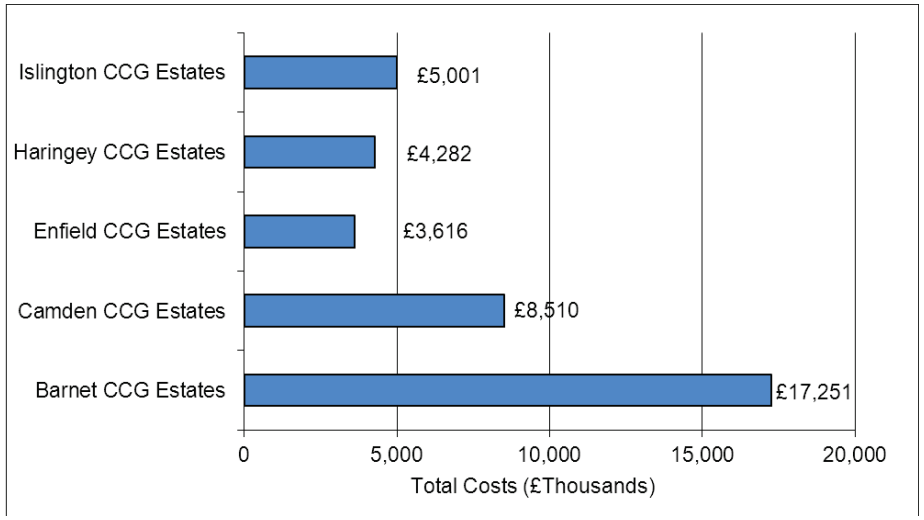
% of Barnet's expenditure on mental health against ONS comparator PCTs in 2011/12



Barnet total estates costs (2013/14)



Finchley Memorial Hospital old versus new total costs



North Central London CCGs total estates costs (2013/14)

*Not all comparator PCTs had comparable data available

II. Executive Summary - Headlines

We have considered a range of trajectories to achieve financial balance:

- An independent review of our financial position commissioned in March 2013 identified no one rapid solution, but rather that sustained effort is required across a range of system changes.
- To achieve in year breakeven in 3 years time will require the delivery of £42m of QIPP.
- Our model indicates in year breakeven in 3 years, in year business rules in 4 years and legacy deficit cleared in 5 years, although this assumes that the 2% headroom is utilised to repay the deficit.
- Without the 2% headroom benefit, these figures deteriorate to breakeven in 4 years, in year business rules in 5 years and legacy deficit cleared in 7 years

We have taken steps to achieve this trajectory:

- We have taken proactive steps over the last months to establish a robust, CCG owned QIPP plan for 13/14.
- As a result of these steps, QIPP opportunities have been identified of £18.9m for delivery in 13/14, risk assessed to deliver £17.05m
- We are developing further opportunities for 14/15. These will be worked up over the next 6 months.
- We are putting in place the right capability and capacity to drive the change programme underpinned by a best practice PMO.

We will know the financial impact of changes and the associated risks

- As programmes develop for FY15 and beyond, quality and risk will continue to be central to the approval process.
- The changes will require closer partnerships with providers sharing incentives to deliver change.
- In order to achieve its Recovery Plan, the CCG will need support from NHSE to increase capacity and capability. Change of the quantum required to deal with the deficit inherited by the CCG is outside of the scope envisaged within the resources available utilising the running costs allowance.
- If additional resources are not available to the CCG, the pace of delivery of change will be at risk, resulting in a prolonged and increased deficit position.

We will know the likely impact of the proposed changes on providers in the borough

- We are putting in place a robust quality KPI monitoring process. Therefore, we do not anticipate that provider operational standards or patient experience will suffer.
- Every QIPP scheme is subject to a Quality Impact Assessment and Equality Impact Assessment;
- Provider clinicians and GPs are being engaged through our plan development process and will continue to be engaged going forward, on implementation.
- Scheme level KPIs are being developed to help us track the impact of the QIPP on activity and finances.
- We will monitor the impact of our programme through the PMO to ensure we keep a real time view on performance both from an activity level and also in terms of savings made.

II. Executive Summary - Headlines

Clinical Commissioning Programmes

The PCT`s work was largely driven by the productivity elements of QIPP and we are determined to ensure we deliver quality and innovation which will in turn drive productivity. We are moving to a Clinical Commissioning Programme (CCP) delivery model which covers comprehensively the range of services we commission. These are clinically and managerially led with each CCP supported by a GP Board member as clinical strategic lead, a senior manager and project management team. The two directors of commissioning (Integration and Clinical) will support the six CCPs.

Each CCP will, working with partners, providers, the local authority, patients and the public, review the needs assessments, current service delivery and outcomes in order to decide which services within each portfolio need to be reviewed and in what priority. These will form the projects to be delivered in year by the project teams. This will encompass the delivery of QIPP and be supported by the project management office (PMO).

Our proposal to develop clinical commissioning programmes sets out a way to ensure our commissioning adequately covers the services that we are responsible for. CCPs need to be grouped in ways which people recognise and, collectively, these need to cover the whole health system which we have responsibility for. However, the health system is complex and each approach taken to dividing up into manageable parts has both advantages and disadvantages.

Our integrated plan and ‘plan on a page’ set out the strategic priorities for the CCG. In this context we have a very strong focus on:

- Transformational change of the health system through provision of integrated care for patients with complex needs. Through proactive identification, care planning and integrated management of care for patients with complex needs we will seek to avert crises, thus reducing the unplanned use of acute care;
- Reduction in elective acute care through robust management of referrals, and redesign of care pathways to provide upstream early intervention, a greater range of care in a primary care setting, and community based alternatives to acute care.
- This will require new ways of working; to provide robust foundation for a rebalanced system, we are restructuring the work of the CCG, and our team, into Clinical Commissioning Programmes (CCPs), which reflect the objectives set out in our plan on a page, which follows.

NHS BARNET CCG	Local clinicians working with local people for a healthier future	NHS BARNET CCG

We will work in partnership with local people to strive to: Improve the health and wellbeing of the population of Barnet , find solutions to challenges and commission new and improved collaborative pathways of care which address the health needs for the Barnet population.

Context

Health Inequalities in Cancer, CVD, Stroke and Respiratory conditions There were 294 early deaths from cancer, 158 from CVD and Stroke and 153 deaths related to winter in Barnet. in 2011/12	Barnet has the second largest cohort of Children in London with a 6.8% increase in the next 5 years.	Elderly population set to rise by 21% over next 10 years. Over 90 population to increase by 55% (1600)	Economic pressures and historic debt in the local health economy (7 years of over investment in Acute NHS Services)	The London Borough with the largest number of nursing home beds (999.)	Projected 26% increase in people with Dementia by 2020 (4743)	Challenged Local NHS Providers

Objectives	Clinical Commissioning Programmes	Initiatives	Outcomes To meet National Outcome Indicator Targets, and NHS Constitution standards, local, Health and Wellbeing and QIPP Outcome Measures – For example
Improve Inequalities in Health	Health and Well Being	Prevention CQUIN. Commissioning for every health contact to be a public health contact. Supporting Public Health colleagues to develop and implement ' preparing for a healthy life programme Lead with the London Borough of Barnet on the "Care when needed" programme.	Improve Potential Years of Life Lost (PYLL) from causes considered amenable to health care for adults and children and young people by 3.2% (59 deaths) Reduce the Under 75 mortality rate for Cardiovascular disease
Prepare Children and Young People for a Healthy Life	Children, Young People and Maternity	Maternity Care Pathways and Tariff Acute Paediatric Care Pathways Strategic Commissioning of CAMHS Barnet Children and Young Person's Plan Joint Procurement of Speech and Language Therapy	90% of pregnant women in Barnet to access NICE compliant maternity care by 12 weeks Gestation by March 2014. Reduce the smoking in pregnancy rate from 10% to below the London average of 7.5% by 2015. Maintain Immunisation rates at above national and regional target rates with preschool immunisations covering at least 90% of all children of Barnet
Provide the Right Care at the Right Time, in the Right Place	Elective Care	Care Closer to Home – ENT, Ophthalmology, Orthopaedics, MSK, Pain Management, Gastroenterology Glaucoma screening. Urology, Cancer, Acute Medicines Management, Vascular, Neurology, and Diabetes.	90% of Admitted patients will have started treatment within 18 weeks from referral Increased percentage of patients using community health services All patients who have cancelled operations on or after the day of admission for non clinical reasons will be offered another date within 28 days, or provided at the time and hospital of the patients choice.
	Emergency and Urgent Care	NHS 111; Urgent Care Centre; Ambulatory Care; GP Out of Hours Cardiology, Respiratory, General acute medicine Trauma	Reduce unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) Reduce emergency admissions for acute conditions that should not usually require hospital admission. The OOH Service meets all the national OOHs Quality Standards
Develop an Integrated Care System across health and social care	Mental Health and Learning Disabilities	Improving Access to Psychological Therapies RAID, Primary Care Mental Health Team Development Alcohol Standards, Complex and Secure Care pathways London Model of Care – Long Term Conditions	Year on year increase based on the 2009/10 baseline of people with a learning disability and those with a mental illness who have received an annual health check. Increase the number of patients receiving psychological therapies to 10% of those assessed as having depression or anxiety disorders.
	Frail Older People	Primary Care Risk Stratification, Care Navigators, Multidisciplinary Team and Case Management. Rapid Response and Enablement Plus, Palliative Care Services, Telehealth and Telecare, Admission Avoidance, Fracture Liaison Services, Enhanced Falls Service, Stroke Care Pathway, Dementia Care pathway.	Increase the percentage of people aged 65+ who are still at home 91 days after discharge into rehabilitation services to 87% in 2013 with a stretch target to reach 90% by 2015. Increase in the number of people who are receiving end of life care that are supported to die outside of hospital.

Enablers

Quality, Safety and Patient Experience	Primary Care Strategy	Medicines Management	Barnet, Enfield and Haringey Clinical Strategy	Demand Management , and Productivity	Health Promotion and Well Being

II. Executive Summary - Headlines

Management Structures

The CCG will draw, on broad terms, from three resources:

- The governing body provide oversight, challenge, and support. Specifically GP board members provide clinical leadership of programmes and, within localities, of their member practices. The Finance, Quality and QIPP committee provide specific oversight of the recovery plan. This is about 20% of the management allowance.
- The CCG commissioning team provide the intelligence and project management arrangements for finance, quality and commissioning, supported by corporate functions such as communications and engagement. This can be described as the service redesign elements of the commissioning cycle. This is about 20% of the management allowance
- The North and East London Commissioning Support Unit provide the procurement, contracting and review elements of the commissioning cycle, PMO review and advice, and a range of back office functions. The CSU have a Barnet presence at Director and senior level and this team contributes to planning and project management. The CSU is about 60% of the management allowance and is key to this recovery plan. The CCG and CSU have regular performance reviews. There is good support for contracting and the borough office has recently been strengthened. The remainder of the CSU remains developmental.

The CCG has appointed to the full governing body. The CCG has appointed permanently to the Chief Officer, Director of Integrated Commissioning and the Director of Quality. All deputy director level posts are filled with permanent and experienced staff who transfer their skill sets, from predominantly primary care commissioning to acute and community on an integrated basis. The CCG has been in extended and detailed discussion with the Local Authority and has formally agreed a joint commissioning structure and system which will provide the infrastructure to deliver the Integrated Commissioning Agenda. This in now out to one months formal consultation within the local authority, and will then be implemented.

The CCG has not recruited a permanent Chief Financial Officer (CFO) and is currently headhunting. The Interim CFO has the confidence of the board and the London Office and will continue until a permanent appointment is made. An experienced deputy interim CFO who has been both CFO and Director of Commissioning in previous roles, is supporting the shift in acute costs. The CSU, with CCG support, appointed Owen Richards, an experienced secondary care commissioner to the Borough Director role and Owen has agreed to support the vacant Director of Clinical Commissioning role. The CCG has appointed an experienced director as Transformation Director who will manage the PMO and a number of the most significant acute QIPP projects.

The revised support structures are attached at Appendix V and demonstrate considerably increased delivery capacity. We recognise Barnet is not as accessible as other London bases and this appears, alongside the level of financial challenge, to restrict recruitment.

The CCG will look for additional support particularly in people able to deliver projects on the ground and to accelerate progress with reducing acute costs and estate costs. We are clear on the challenges, benchmarking and analysis has been done and the focus is now on delivery.

II. Executive Summary - Headlines

The actions required to deliver the CCG's recovery plan are set out in the table below:

Action	Detailed action to be taken by the Governing Body	Delivery RAG	By when	Measure	Priority RAG
Agree and sign contract with main providers	- Sign off contracts for FY14 that support immediate action to align proportionate spend on acute services with other CCGs. - Finalise financial value for QIPP plan		May 2013	Signed contract in place	
Launch Clinical Commissioning Programmes	- Agree clinical leadership and supporting team; - Agree and communicate CCP work programme.		May / June 2013	Full team working to CCP	
Phase 1 PMO	-Strengthen PMO resource -Short term resource to set up PMO -Appoint Director of Transformation -Secure visibility on & reinforce existing QIPP schemes -Engage CSU support in QIPP scheme development -Appoint resource to develop formal PMO regime		May 2013	Evidenced to FPQ board on 16 May	
Phase 2 PMO	-Strategic PMO development complete to include: -Project life cycle & gateway review process -PMO controls -Reporting, governance & support structure -Training & go live -Embed new day to day working PMO practices within the CCG		May - July 2013	New PMO embedded	
New FY14 Opportunities	-For identified areas, ensure that each has a designated clinical lead and managerial support - Review outline QIPP plans; develop into robust, deliverable plans		Immediate	New plans have QIPP workbooks	
New FY15 Opportunities	- Building on work carried out to date. Carry out appropriate detailed analytics and develop business cases for approval.		August/ September 2013	New plans scoped for review	
Confirm CCG allowed a deficit budget and use of headroom and repayment of deficit with NHSE	-Agree and confirm with documentary evidence to backup position with NHSE.		May 2013		

III. Context – Strategic vision

The CCG's strategic vision

Local clinicians working with local people for a healthier future

We will work in partnership with local people to strive to improve the health and well-being of the population of Barnet, find solutions to challenges, and commission new and improved collaborative pathways of care which address the health needs for the Barnet population.

What will success look like?

3 Years:

- In collaboration with our partner CCGs we will have delivered the Barnet, Enfield and Haringey Clinical strategy and the development of the Royal Free/ Barnet and Chase Farm acquisition and clinical systems
- Quality and innovation will be recognised as the key priorities in our organisation
- We will be leading the development of integrated care systems across our providers

5 Years:

- People living in Barnet will understand and experience a health and social care system which will:
  - Encourage healthier lives and independent lives
  - Support people taking responsibility for their own lives and health
  - Provide seamless care when needed

III. Context – Clinical Commissioning Programmes

Health and wellbeing

There are four themes for health and social care commissioning identified in Keeping Well, Keeping Independent, (the Barnet Health & Well-being Strategy 2012 – 2015), Barnet Joint Strategic Needs Assessment and the 2012-13 Barnet Public Health Report.

- Preparation for a healthy life - Enabling the delivery of effective pre-natal advice and maternity care and early-years development;
- Wellbeing in the community - Creating circumstances that better enable people to be healthier and have greater life opportunities;
- How we live - Enabling and encouraging healthier lifestyles;
- Care when needed - Providing appropriate care and support to facilitate good outcomes and improve the patient experience.

These four health and wellbeing themes and the health programmes are an integral part of our Strategic and Operational Plans. Critical within this, is targeting people at highest risk both systematically (through specific health improvement programmes) and opportunistically ('making every contact count').

Our Health programmes are focussed upon:

- Reducing smoking prevalence through tobacco control and increasing smoking cessation
- Promoting healthier eating and increasing physical activity in people's everyday lives to reduce overweight and obesity and to reduce the risk of other conditions, including cardiovascular disease, dementia, poor mobility
- Encouraging and enabling people to be more independent, including those with physical, mental and learning disabilities, through various social development schemes and in the way that health and social care is provided
- Ensuring the recognition and proper management of concomitant mental health problems in people who have physical health problems
- Encouraging and enabling people to use alcohol in a sensible and healthy way if their lifestyle / religion permits its use
- Encouraging and enabling better sexual health
- Encouraging and enabling the earlier detection and thus early management of disease through screening and earlier presentation of suspicious symptoms.

These themes and health programmes form the basis of our strategic direction and the priorities in our plan, particularly improving health outcomes for children, frail older people and people with mental health needs.

III. Context – Clinical Commissioning Programmes

Children, Young People and Maternity

All children and young people in Barnet should achieve the best possible outcomes, to enable them to become successful adults, especially our most vulnerable children. They should be supported by high quality; integrated and inclusive services that identify additional support needs early; are accessible, responsive and affordable for the individual child and their family.

Strategic Needs / Issues to address

- Barnet has the second largest cohort of Children in London (87,641 0-19s in 2011) with a 6.8% increase in the next 5 years.
- About 17.6 % of children in year 6 (611 pupils) are classified as obese.
- A lower percentage than average pupils spend less than 3 hours per week on school sport.
- 10% of expectant mothers smoke during pregnancy.
- Ensuring that acute hospital activity for children and young people is in line with best practice.

Target Outcomes

- All women in Barnet to access NICE compliant maternity care by 12 weeks.
- Reduce the smoking in pregnancy rate from 10% to below the London average of 7.5% (Public Health Lead) .
- Maintain Immunisation rates at above national and regional target rates with preschool immunisations covering at least 90% of all children of Barnet. (National Commissioning Board and Public health Lead).
- Reduce the rate of obesity in reception year school children from 11% to be better than the London average. Reduce the rate of obesity in year 6 children from 17.5% baseline towards the England best of 10.7% (Public Health Lead).
- Reduce the number of children and young people misusing alcohol and drugs by 91% by 2014/15.(Public Health Lead).
- Work with the local authority to improve the management of children with complex needs including the development of transition pathways (London Borough of Barnet Lead).
- Reduce acute activity by 50% in outpatients, and 30% in A&E.

Clinical Commissioning Programme Objectives

Working with the London Borough of Barnet and NHS England the programmes priorities are:

1. Effective Implementation of the Maternity Pathways Tariffs by April 2013
2. The implementation of the Barnet, Enfield and Haringey Clinical Strategy that will transfer the provision of maternity services at Chase Farm and support increasing numbers of women to use expanded services at Barnet and North Middlesex University Hospital, likely to be from November 2013.
3. Ensure appropriate use of paediatric tertiary services at Great Ormond Street Hospital and ensure that children and families are supported within secondary and primary care when appropriate.
4. Achieve more effective and efficient provision of paediatric speech and language therapy services through a joint procurement with the London Borough of Barnet.
5. Continue to roll out the Family Nurse Partnership and enrol 100 families to the programme
6. Develop a section 75 agreement with the local authority for the joint commissioning of Child and Adolescent Mental Health Services .

III. Context – Clinical Commissioning Programmes

Elective Care

Ensure that good quality care is provided in the right place at the right time by the right person first time round.

Strategic Needs / Issues to address

Acute activity has traditionally been high in Barnet across a range of secondary care specialities. It is vital that this is addressed in order to ensure that funding is focused on those that need it most.

The latest national and peer group benchmarking has identified key areas where we can focus to reduce the higher than average elective admissions rates, for dermatology, urinary tract and male productive systems, vascular disease and children. Similarly there are high levels of outpatient attendances, particularly, in cardiology (including consultant to consultant referrals), nephrology, ophthalmology, rheumatology and urology.

Approach

We have used a Referral Management Service for the last two years, which has introduced support for GPs in directing referrals to the right setting. This is currently being strengthened with clinical support and development of clear referral protocols. Our approach will be to work in collaboration with acute clinicians, redesign services to make them more efficient, reducing the steps in the patient pathway and thereby reducing costs for both he provider and commissioner.

Recent workshops involving a range of clinicians identified across primary and secondary care identified the following key features to delivery of this:

- Integrated protocolised work ups
- Single point of access
- Consultant/Senior clinician at front end, essential to ensuring that patients are directed to the most appropriate service, first time
- Services to be one stop primarily with follow up only for the most complex

Clinical Commissioning Programme Objectives

GP Development - Managing and controlling demand

1. Ensure that GPs are fully aware of all local services, that primary care local protocols are followed prior to referral. Skills and learning needs of GPs are identified and addressed to enable GPs to do this. These will be identified and supported through the LPR programme.
2. Rationalise existing services making it easier and more straight forward for GPs to understand where they need to refer to.
3. Ensure that GP practices utilise the referral management system ensuring that referrals are complete, clear in their purpose, with all relevant information , including diagnostics attached and that these are directed to the right place first time.
4. Redesign services to ensure optimise use of resources and reduce steps in patient pathway where appropriate.
5. Work with acute trust to ensure that once patients have been referred appropriately, that they are not kept in the “system” for longer than is necessary and that discharge protocols are followed and that GPs/acute consultants agree and understand these. This will also ensure that capacity is created in the acute system to deal with red flags and more complex patients in a more timely way.

Self Care

1. Move care closer to home where possible, providing services in settings and locations closer to people’s homes for easier access.
2. Use LPR to identify self care/prevention initiatives to support self care.

III. Context – Clinical Commissioning Programmes

Emergency and Urgent Care

Ensure that good quality care is provided in the right place at the right time by the right person first time round.

Strategic Needs / Issues to address

- Develop a whole system urgent care model for an integrated urgent care system 24/7 across Barnet and neighbouring boroughs
- Improve patient flow through A&E and emergency pathways to reduce the number of unplanned hospital admissions
- Link with the integrated care programme to provide alternatives to admission.
- Effective discharge planning through integrated pathways that support step down arrangements and rapid care in the community where required
- Increase the number of ambulatory care sensitive pathways that will reduce the need for emergency admission and the discharge of patients from A&E for management within planned services
- Reduce duplication of services across the whole urgent and emergency care pathway
- LAS to convey suitable patients to UCCs, and improve handover arrangements with A&E departments
- Enable GPs to access clinical support from secondary care specialists to support a reduction in A&E attendances
- Reduce 0 length of stay through improved ambulatory pathways and step down arrangements

Clinical Commissioning Programme Objectives

1. Implement the Barnet, Enfield and Haringey (BEH) Clinical strategy, which includes implementation of the Barnet UCC.
2. Use of 111 as a single point of entry to ensure the first point of contact is to the most appropriate service.
3. Reduction in adult and childhood admissions for ambulatory care conditions..
4. Review of walk in services to understand impact on health, and to identify if there is duplication across existing unplanned services
5. The promotion of self-care options with people looking after themselves at home, accessing resources such as the minor ailments scheme
6. Implementation of the London LAS UCC Exclusion criteria with local A&E departments
7. Monitoring of urgent care services through the BEH urgent Care Network and development of an urgent care dashboard

- **Target Outcomes**
- Barnet UCC implemented, GP fronted, 12 hours per day, 365 days a year – new service specification and KPIs
- 40% of all A&E attendances are seen within the UCC and managed at Band 5 PBR tariff
- 98% of all patients that are seen within the A&E are treated within the 4 hour target
- Monitor OOH and 111 Service to ensure they are meeting all the national OOHs Quality Standards and local key performance indicators
- Reduce 0 length of stay for inpatient non-elective admissions to a performance improvement within the 20th percentile in line with the best performing CCGs
- LAS to meet Cat A&B calls within agreed contractual times

III. Context – Clinical Commissioning Programmes

Mental Health and Learning Disabilities

To develop and commission high quality and safe services that are person-centred and promote people's recovery and independence, enabling them to live rewarding and fulfilling lives. To ensure that all mental health and learning disabilities commissioned services take into account the physical health conditions as part of the holistic assessment and treatment process.

Strategic Needs / Issues to address

- Approximately 40,000 people in Barnet experience common mental health problems.
- Life expectancy amongst people with learning disabilities and people who experience mental ill health is lower that the general population and is also associated with higher levels of obesity and respiratory disease including COPD.
- An estimated 25% of people with long term health conditions such as diabetes, COPD etc. also experience Common Mental Illness which affects their recovery.
- There is a higher level of social exclusion and unemployment amongst this population group. Over 40% of incapacity claims in Barnet are related to mental ill health.

Clinical Commissioning Programme Objectives

1. To develop a mental health commissioning plan by end May 2013;
2. Increase the availability of NICE compliant evidence based talking therapies and re-commission the Barnet IAPT & Wellbeing Service;
3. Support the developments of 'RAID' style liaison arrangements between acute and mental health providers to achieve a redesigned effective pathway for patients with mental health conditions in acute hospitals settings;
4. Review and develop care pathways for co-morbid conditions including autism, ADHD, substance misuse and personality disorder;
5. Collaborate with Enfield and Haringey CCGs to develop and implement rehabilitation and recovery care pathways and systems to reduce need for Out of Area Treatments and other high cost placement;
6. To improve access to health care including annual health checks and health screening programmes for people with learning disabilities.
7. Building on the DH Concordat, to work with the Council to secure further opportunities for community based options that reduces the need for inpatient and out of area treatment options for people with learning disabilities.
8. Council to lead on the recommissioning of prevention services for people with learning disabilities, autism and mental health conditions.

Target Outcomes

- Year on year increase of people with a learning disability and mental illnesses to have received an annual health check.
- 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.
- Increase the number of patients (of those assessed as having depression or anxiety disorders) receiving psychological therapies to 10%.

III. Context – Clinical Commissioning Programmes

Integrated Care

To continue to develop proactive, planned care approaches including effective multidisciplinary working between providers in an integrated way. Through locality based integrated health and social care teams, commissioning will support the redesign of care pathways that promote improved management of patients with complex care needs , those who experience episodes of crisis and those with long term conditions to enable them to remain in their home . This approach will reduce the need for non-elective, unscheduled hospital and residential care admissions .

Strategic Needs / Issues to address

- Elderly population set to rise by 21% over next 10 years.
- 38% of older adults living alone.
- Older people are three times more likely to be admitted to hospital following attendance at an A&E department. Once there, they're more likely to stay and suffer life-threatening infections, falls and confusion.
- Older people are more likely to suffer from chronic and long-term conditions, mental health issues, falls and fractures.
- Hip fractures prompt entry to a care home in up to 10% of cases.
- The number of dementia sufferers is expected to increase. With early diagnosis, treatment and support they can continue to live good lives.
- There is an increased risk of social disconnectedness and isolation in an estimated 18,300 older adults in living alone, making up 38% of the elderly population in the borough. Over two thirds of these single pensioner households will be aged 75 or over.

Clinical Commissioning Programme Objectives

1. Increased use of health and social care preventative programmes supporting people to stay living at home for as long as possible and enabling them to take more responsibility for their own health leading to a reduction in unplanned and emergency admissions to hospital and delay admission to residential care .
2. Redesign services to ensure that they accessible and responsive to those who need them including out of hours support and rapid access.
3. Introduce locality based integrated health and social care teams to support patients remaining at home through appropriate interventions avoiding hospital admission where possible .
4. Proactive risk assessment to identify those with emerging complex health issues and those long term condition and ensure care is actively managed.
5. Supporting people to remain connected to their family ,carers and community and influencing well-being.

Target Outcomes

- The balance of spend on older people in both the NHS and Social Care has been realigned to provide a greater focus on prevention.
- Percentage of frail elderly people who are admitted to hospital three or more times in a 12 month period to be reduced from the 2010 baseline.
- Number of emergency admissions related to hip fracture in the over 65s to reduced by 10% from the 2009/10 baseline of 457.3 by 2015.
- The percentage of people aged over 65 who are still at home 91 days after discharge into rehabilitation services, to be increased to 87% in 2013 with a stretch target to reach 90% by 2015.
- All people who have continuing healthcare needs to have a personal health budget by 1st April 2014.
- An increase of 20% from 2012 to 2015 in the number of carers who self report that they are supported to sustain their caring role.
- Increase in the number of people (receiving end of life care) that are supported to die outside of hospital.

III. Context – Financial position (1)

- Barnet CCG has inherited an underlying deficit of c.£ 34m based on its operation as a PCT adjusted for non recurrent items and services where the responsibility for commissioning has been transferred to NHS England.
- This underlying CCG deficit is increased for FY13, pre QIPP, to c.£46m as a result of the required FY14 planning assumptions. Based on its inherited deficit the CCG has forecast a deficit of £20.9m for FY14. This assumes it will be able to deliver £17.0m of QIPP and that it will be able to use its 2% 'headroom allocation' (c.£8m).
- The CCG deficit is a result of a number of factors. In particular:
  - The loss of non-recurrent cluster support – c.£17m in 2013:
  - The loss of revenue allocation in the transition from PCT to CCG. c£9m of specialist revenue allocation has been lost, incorrectly, in the transition from PCT to CCG as allocations were made in late 2012 based on incorrect assumptions, see slide 20
  - Additional estates costs over and above existing community hospital costs for the new Finchley Memorial Hospital, of £2.2m
  - In 13/14 an additional impact of £1.9m following transfer of PCT estate
  - The CCG has a reasonable track record on delivery of QIPP targets, achieving between £20m-£30m per year over the past four years although delivery in 2012/13 was £14.5m against a target of £23m
  - Barnet is seeing population growth that is higher in percentage and real terms than other boroughs in North Central London. See page 22.
  - Potential under funding:
    - £10m to £20m if Barnet CCG received per capita 13/14 funding increases in line with the national, ONS Group or London average, see page 21
- A bridge from the PCT Forecast Out Turn (FOT) of £3.7m to the £20.9m forecast FY14 deficit is shown on page 23

III. Context – Financial position (2)

Loss of revenue allocation & increased costs

- £9m of specialist revenue allocation has been lost, incorrectly, in the transition from PCT to CCG, this relates to services that have moved to NHS England and public health from 1/4/13. The NHS England public health revenue deductions were the result of a complex process undertaken during 2012 utilising a combination of 12/13 plans, September year to date actuals and a number of supplementary templates submitted to NHS England by NHS North Central London. It has proved difficult to achieve a cost neutral position.

- Consequently, although £161.7m of revenue has passed across to NHS England, at this stage only £158m of the associated costs have been identified. The balance or shortfall of £3.7m currently rests with the CCG which in simple terms means that the CCG has £3.7m less to deliver the services that it is actually responsible for in 13/14.

- A similar situation exists with the public health deduction where although revenue has been reduced by a total of £12.5m, only £11.2m of costs have been identified. The shortfall of £1.3m has also been left with the CCG.

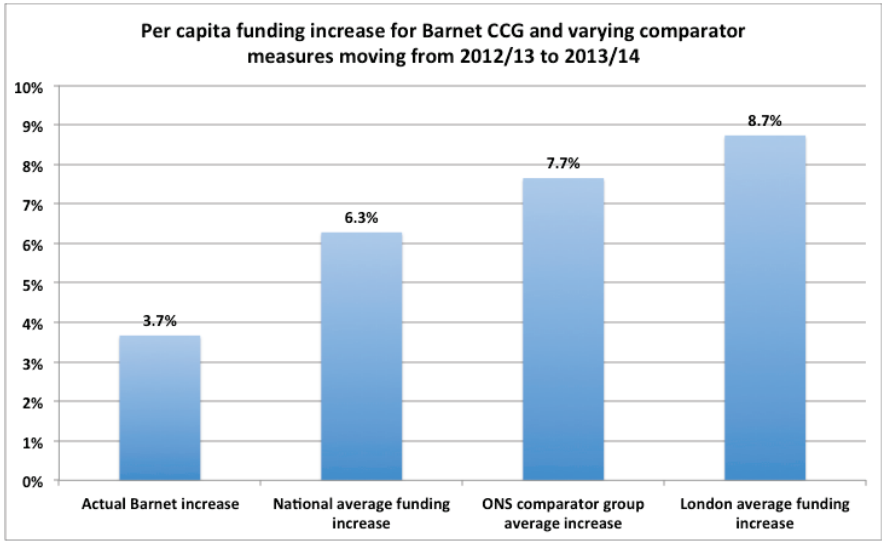
- In respect of the running cost allowance, during the submission phase last year there appears to have been a degree of confusion over the definition of the running costs that were deducted from the CCG baseline. The figure deducted was based upon the wider PCT/SHA definition of running costs rather than the narrower CCG definition, so for example the revenue to cover the costs of medicines management has not been passed to the CCG. This has translated into a shortfall in funding for the CCG of £3.5m.

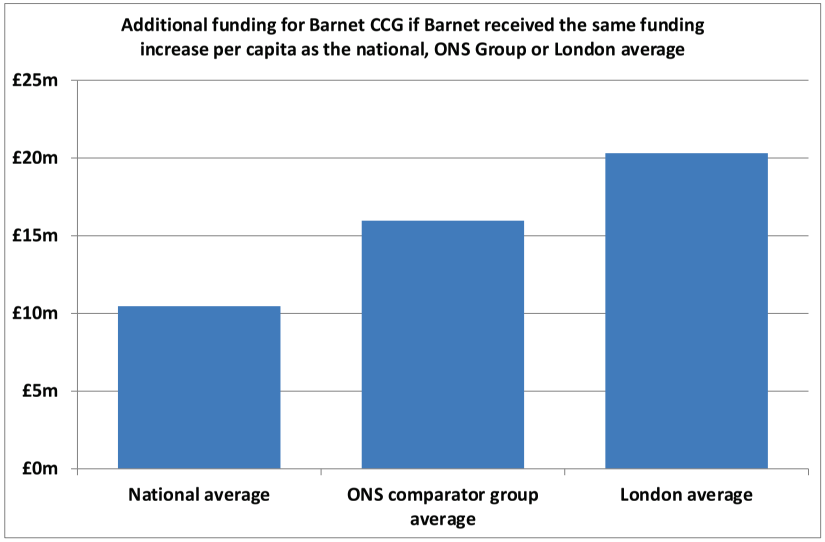
- In addition to the above & the CCG will now incur costs for un-tenanted space and the non-booked sessions in sessional space to the tune of £3.8m, of which £2.2m relates to FMH alone.

	£m pa
NHS E - Specialised services	3.71
NHS E - Public Health	0.00
Public Health - Local Authority	1.82
Public Health - England	-0.52
Running costs allowance - error	3.52
FMH - void/sessional cost pressure	2.20
Other - void/sessional cost pressure	1.60
Total	12.33

III. Context – Reduction in capitation funding

- The graphs below show the unfavourable Barnet position in terms of per capita increase in allocation when compared with National, ONS comparator group, and London average funding increase.





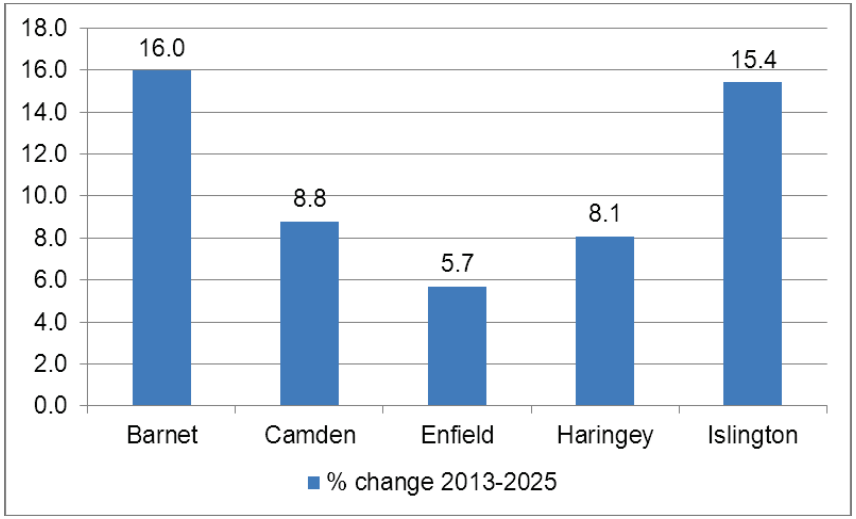
III. Context – Population growth

ONS projections are based on patterns of births and deaths, and migration into and out of an area. They take no account of changes in the number of dwellings in an area. The Greater London Authority does, however, produce projections which take account of planned changes in the quantity of housing stock within an area. For London Borough of Barnet, this has been calculated as 375,197 in 2013, a difference of 4509. By 2020, the GLA projection is 414,000, compared to the ONS projection of 411,000. By 2025, the ONS and GLA projections are very close at 435,500 and 435,100 respectively.

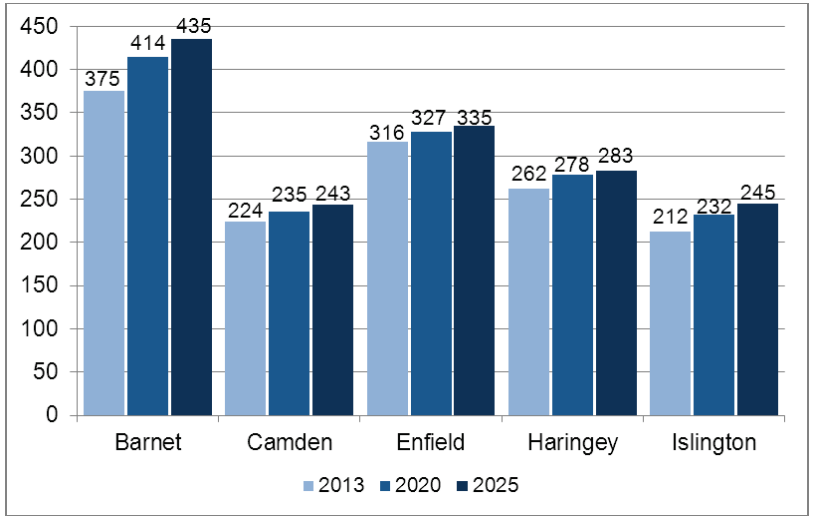
Within the Council's Local Development Framework, the Housing Strategy contains a projection of 28000 new homes being constructed by 2026 to meet housing need, alongside another 3000 units being brought back into use. Key areas for development by 2018 include:

- Colindale (including Grahame Park) - 5887
- West Hendon - 630
- Stonegrove/Spur Road – 155
- Mill Hill East – 1264
- Dollis Valley 250
- Brent Cross Cricklewood – 1138
- North London Business Park – 250

Further work is required to try and assess the impact of the development of these sites.

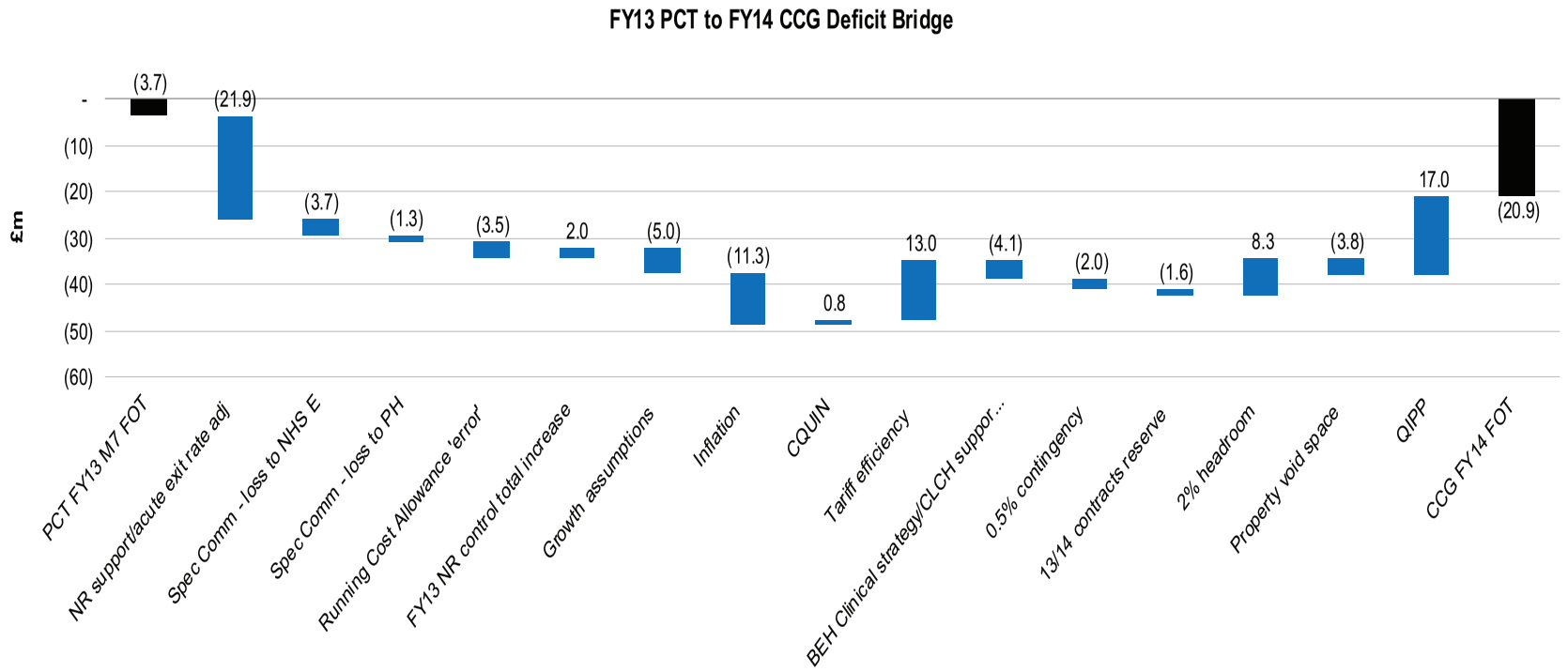


% increase, 2013-2025. GLA population projections



Population increase (000s), 2013-2025. GLA population projections

III. Context – PCT to CCG deficit bridge



FY14 Budget

The bridge from 12/13 to FY14 details the move from the PCT FY13 out turn to the CCG FY14 budgeted deficit of £20.9m.

This position deteriorates to a deficit of £29.2m if the benefit of the 2% non-recurrent is excluded.

The next slide illustrates the future years position with a reducing QIPP target but continued use of the 2% non-recurring headroom benefit.

III. Context – Financial position (5)

FY14 & beyond

The table opposite shows the FY14 budgeted deficit of £20.9m (after QIPP savings of £17m) and the forecast budget for FY15 and future years.

The FY15 & future years forecast has been prepared on the basis of the FY14 run rate and therefore assumes:

- delivery of the previous years budget including QIPP;
- the 2% headroom is available to offset against deficits;
- the CCG QIPP target is reduced by 10% p.a. to reflect lower level opportunities available over time
- benefit of £2m NR increase in FY13 control total excluded from FY15 calculations onwards
- the following annual increases in RRL & cost pressures

	Demo growth	Non demo growth	Inflation	Tariff Efficiency
Revenue Resource Limit				
Baseline Allocation	2.30%			
Spend				
Acute and Integrated Care	2.35%	1.65%	2.70%	-4.00%
Acute Other	2.35%	1.65%	2.70%	-4.00%
Mental Health	2.35%		2.70%	-4.00%
Continuing Care	2.35%		2.70%	
Community	2.35%		2.70%	-4.00%
Specialist Commissioning	2.35%	1.65%	2.70%	-4.00%
Prescribing	2.35%		2.70%	
Primary Care	2.35%			
Other Commissioning	2.35%		2.70%	-4.00%
Public Health	2.35%		2.70%	
Corporate	0.00%		0.00%	0.00%

FY14 - FY18 Forecast

	FY14	FY15	FY16	FY17	FY18
	£m	£m	£m	£m	£m
RRL Income	416.0	423.6	433.4	443.4	453.6
Expenditure					
Acute	258.2	249.1	241.1	234.0	227.8
Non Acute	149.5	153.4	157.3	161.3	165.5
Primary Care/other	9.6	9.9	10.1	10.4	10.7
Operating costs	16.9	16.9	16.9	16.9	16.9
Reserves/contingency	2.7	2.8	2.8	2.9	2.9
Total expenditure	436.9	432.1	428.3	425.6	423.8
Net surplus/(deficit)	-20.9	-8.6	4.9	17.6	29.6
QIPP savings	17.1	15.7	14.5	13.3	12.3
QIPP as a % of total costs	3.9%	3.6%	3.4%	3.1%	2.9%

III. Context – Financial position (6)

Worst case scenario

The CCG's projections have assumed that the 2% headroom allocation requirement will be relaxed to allow the CCG to reduce its in year deficit and therefore return to an in year operating surplus in 2015/16.

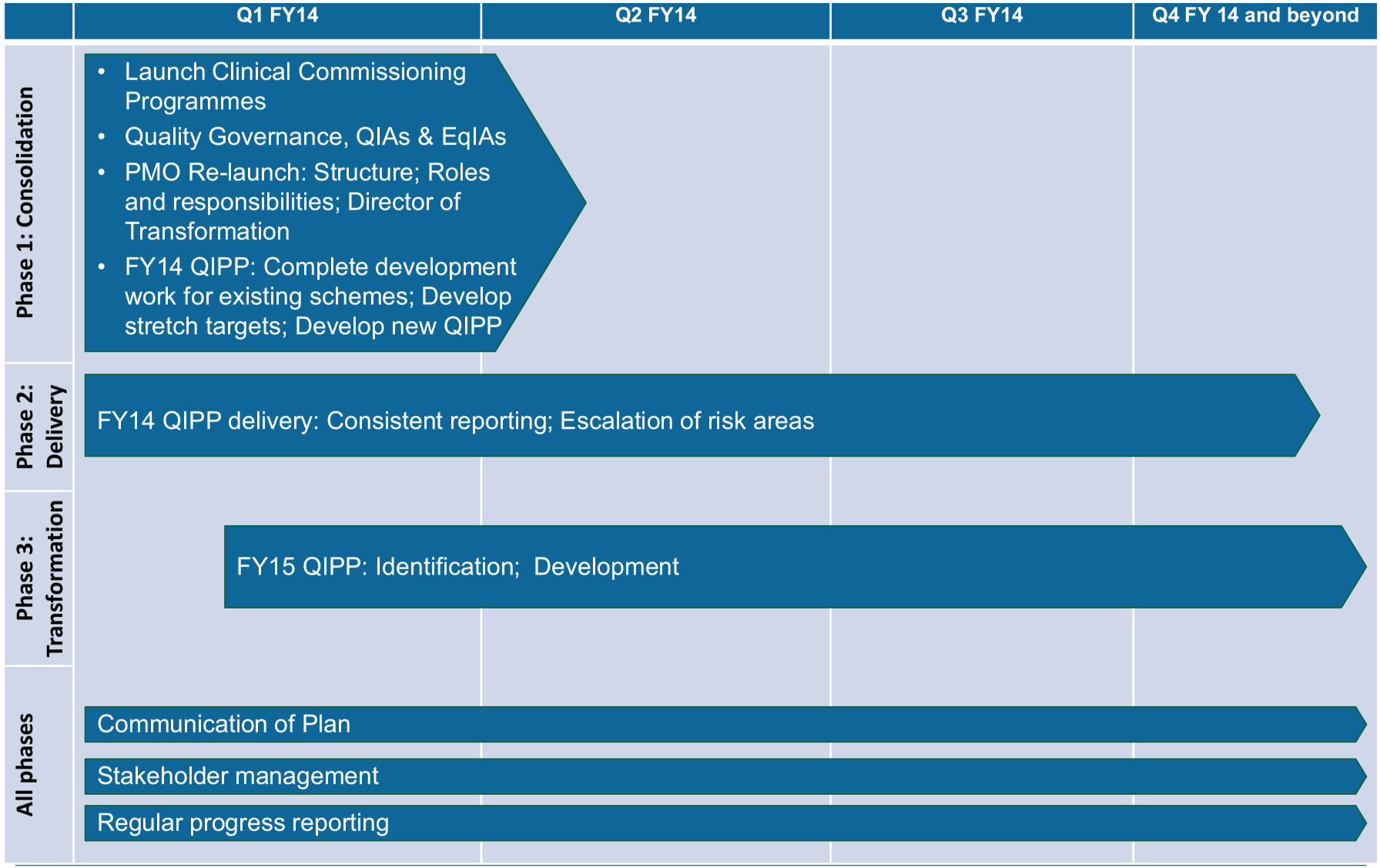
Should the 2% not be made available and the CCG be required to deliver 'normal business rules' the impact would be catastrophic and require an undeliverable QIPP target as modelled below. This would effectively render the CCG unviable:

		FY13/14 £'m	FY14/15 £'m	FY15/16 £'m	FY16/17 £'m	FY17/18 £'m
	In year (deficit)/surplus (including 2% headroom)	(29.3)	(17.0)	(3.7)	8.8	20.5
	Repayment of deficit	0.0	(29.3)	(46.3)	(50.0)	(41.3)
	(Deficit)	(29.3)	(46.3)	(50.0)	(41.3)	(20.8)
	Planned QIPP to deliver forecast	17.0	15.6	14.4	13.2	12.2
1% in FY13/14, 2% in FY14/15	Additional QIPP required to deliver surplus of 1% / 2%	33.3	54.3	58.0	49.3	28.8
	Total QIPP requirement for 'Business Rules'	50.3	69.9	72.4	62.5	41.0
	Memo: Total QIPP to deliver breakeven	46.3	61.9	64.4	54.5	33.0

The CCG does not believe it would be practical or possible to deliver cost reductions of this magnitude without the immediate cessation of services without replacement. Such actions would have a detrimental effect on the health provision and outcomes for the local population.

IV. Approach

Overview timeline



IV. Approach

Development of the Recovery plan

The following slides set out the approach taken by the CCG in the development of its recovery plan.

The Recovery Plan builds upon the work already being carried out by the CCG as commissioners including :

•QIPP development;

•Pathway redesign;

•Provider discussions and contract negotiations; and

•External advice (e.g. PwC, CSU)

The Recovery plan has also drawn upon the recent baseline and QIPP review carried out by PwC.

Timetable for recovery

The CCG has prepared a model based on its FY13 exit rate, (see page 14) to determine when it may reasonably expect to deliver an operating surplus but also clear legacy deficits.

Typically a Recovery Plan would outline a 3 year timeframe to deliver a turnaround however given the size of the deficit this is not possible.

A 5 year plan has therefore been outlined to achieve in year surplus & clearance of legacy deficits to achieve business rules based on the use of 2% 'planned headroom' to repay deficits

Phased approach to the Recovery plan.

The recovery plan that has been developed has 3 distinct phases, which will overlap:

Phase 1 – Consolidation

- Clinical Commissioning Programmes are being launched
- Quality Governance processes are being embedded
- The CCG is actively strengthening its programme management resource and supporting processes, including Quality and Governance to enhance its delivery of the Recovery Plan.
- A Director of Transformation and a resource to set up the PMO are being recruited.

Phase 2 – FY 14 delivery

- The delivery of FY14 QIPP will be progressed with pace, whilst developing opportunities to stretch and enhance the existing programmes . The CCG will continue to progress the development of plans for FY15 and future years.

Phase 3 - Transformation – FY15 and beyond

- The detailed planning of QIPP opportunities for FY15 and beyond, following business case approval, and the development of FY15 contracting strategies.
- The nature of plans for FY15 and beyond will involve detailed analytics to allow business case preparation and detailed planning is likely to require partnership working with providers, joint commissioners and neighbouring CCGs. The Recovery Plan therefore details areas for additional investigation for FY15 where further detailed evaluation and planning is ongoing.

IV. Approach – Phase 1: CCPs

Leadership for Clinical Commissioning Programmes (CCPs)

- Each CCP will be led by the relevant GP board member(s) alongside the Director of Integrated Care, or the Director of Clinical Commissioning (for elective and non elective services), supported by the relevant Senior Manager, with the Deputy Chief Financial Officer providing financial support.
- The Directorate of Quality and Governance will provide a supporting role in relation to quality across all CCPs.
- Senior Managers will take responsibility for 1) elective care, 2) urgent, unscheduled and emergency care, 3) integrated care – frail elderly and long term conditions (X2) 5) mental health and learning disabilities, and 6) children's services. The development of primary care will sit within the integrated care Clinical Commissioning Programme. Each senior manager will have at least two project managers. There will be an individual administrator giving admin support to each team.
- The GP lead, Director and Senior Manager will agree the work programme for each CCP and together will be responsible for delivery. For joint commissioning the programme will also be agreed with London Borough of Barnet.
- The principal role of the GP is both Clinical Leadership and Corporate (Board) ownership.

Organisation of CCPs

- Each CCP leadership team will decide on the approach to implementation. This will include any overarching group leading the CCP, which partners should be included, any task and finish groups, and the priorities for the CCP.
- Provider input will be essential and will be sought at Clinical Director/Specialist Lead level.
- A pathway / specialty will be allocated to a CCP based on where/how the majority of care takes place i.e. in the community, in hospital through elective care, or in hospital through emergency care. Specialities which should mainly be in the community will be in integrated care; those which are highly acute are more likely to be in elective or non elective.
- Pathways / specialities will be covered within one CCP to prevent duplication. GP leads will agree the allocation with the Chair providing guidance.
- In general the first months of the commissioning cycle will focus on considering overall service provision and identifying priorities improvement/redesign. The remaining cycle will detail the required changes and embed these in to contracts. In 13/14 the priority will be to embed existing projects to ensure 13/14 delivery.
- Each CCP will informed by outcomes, quality measures (hard and soft), activity finance and other benchmarks, and alignment with current and emerging best practice, innovation and guidance. There is an expectation of complete transformation and different approaches to population healthcare. The CCP leadership teams will need to listen to practices, patients, the public, providers, partners and agree priorities across these groups. Each CCP is likely to have about 12 projects at any one time.

IV. Approach - Phase 1: Quality

Quality Governance

Barnet CCG holds quality at the heart of commissioning and we strive to improve the quality of the services we commission through effective clinical leadership, and listening to our patients, public, partners and stakeholders. We work together for mutual benefit, ensuring that patients are central to our decision making process.

It is our aim to achieve continuous quality improvement, to assure ourselves that the services we commission are of good quality and reflect national priorities, and to assure the achievement of safe standards.

The CCG will promote and assure quality improvement through its local mechanisms which include:

- Quality Impact Assessments of all developments;
- Ongoing dialogue with stakeholders
- Local peer review
- Complaints information, equality data, national survey and patient experience data
- Patient Survey
- Balanced scorecard
- Performance monitoring framework

A focus on quality through structure

In developing and delivering its Recovery Plan, the CCG recognises there is a clear risk to the quality and safety of service provision. The CCG is clearly sighted on these risks and will take assurance from its Quality Governance Framework and the arrangements that it will continue to develop to monitor risk.

Clinically led quality assessment

With the scale of the challenge the CCG is facing, robust clinical risk assessment of all QIPP schemes is an essential component of the CCG's assurance processes. Enhanced PMO arrangements will facilitate the monitoring of identified and agreed KPIs to provide sensitive early warning systems, which in turn will lead to responsive and timely action if required. Quality Impact Assessments of all schemes will be complete by the end of May. The PMO will be responsible for reporting the performance to support the management of this.

IV. Approach – Phase 1: Quality

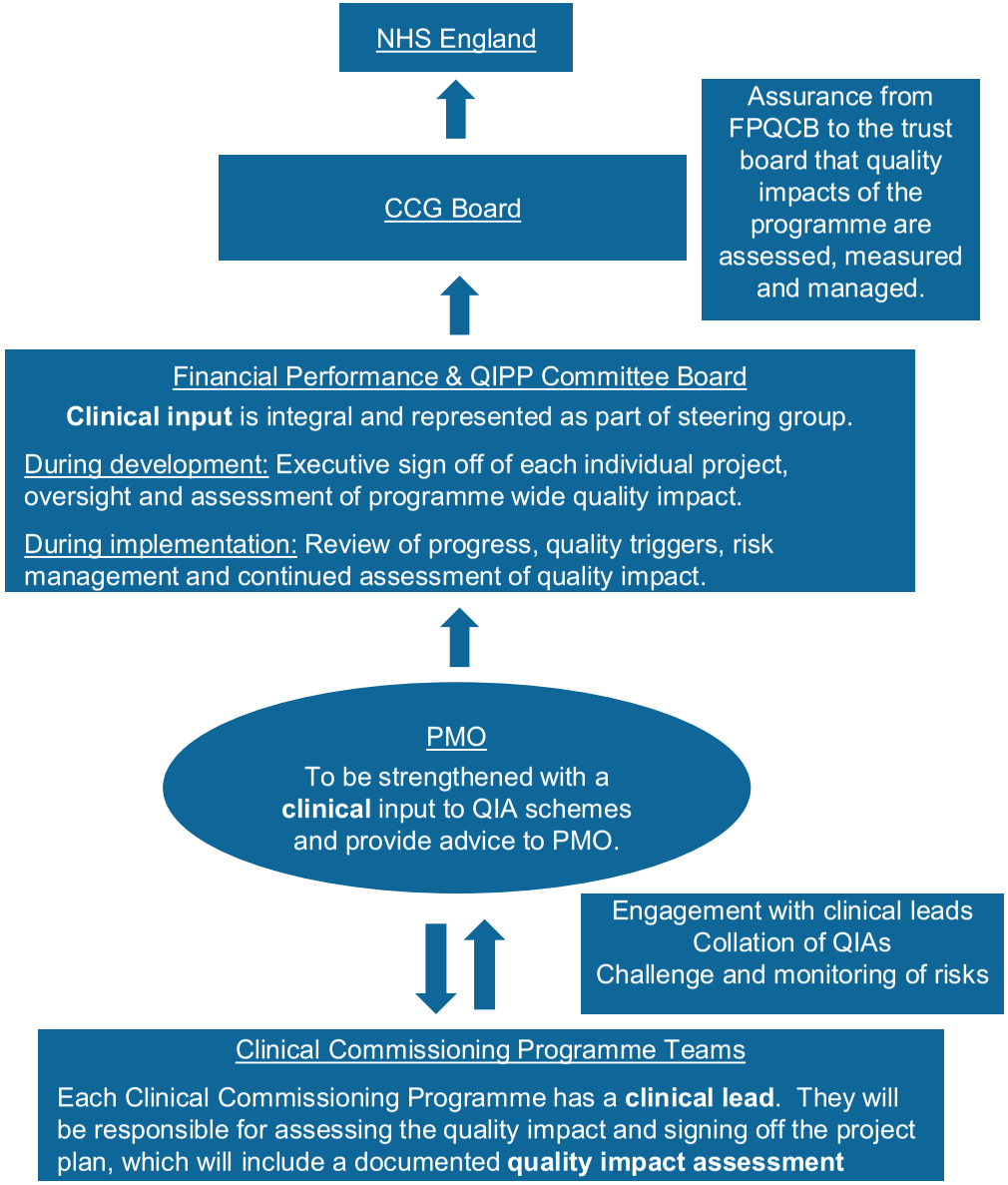
Quality Governance of the QIPP programme

The CCG is developing a more structured and integrated approach to its governance arrangements to ensure the CCG is best placed to deliver its challenging QIPP programme.

The structure and process outlined opposite will promote the sharing of information and the importance of risk identification and management.

In this model the escalation of blockers and the communication of project status will be much more straightforward. This will result in a more efficient and effective delivery of the overall savings programme.

Clinical engagement will be a significant part of this process and the CCG recognises the requirement for strong clinical ownership to drive the successful delivery of the identified QIPP schemes.



IV. Approach – Phase 1: Quality

Quality Governance of commissioning arrangements

- The Director of Quality and Governance chairs the quality contract monitoring meetings in place with our main local acute and community providers, Royal Free Hospital Trust, Royal National Orthopaedic Trust and Central London Community Healthcare Trust and is responsible for clinical review and sign off of all serious incidents.
- The Director of Quality and Governance and the clinical lead for Quality on the Governing Body are the strategic leads for quality within the CCG and champion Quality with all GP members.
- In addition the clinical lead for quality on the Governing Body has agreed to use the role to champion quality in primary care as well as commissioned services, at regional and national levels;
- The CCG will look to further refine the role not only of the clinical lead but also the role of all GP members in relation to monitoring.
- The CCG has had quality standards for patient safety, patient experience and clinical effectiveness in contracts for the past two years. Standards for contracts will be revised to build on current best practice and to further develop these standards into new areas such as safe staffing, integrated care, care and compassion, and collaborative working.

In light of the recommendations from recent events such as Mid Staffs and Winterbourne, the CCG has developed robust action plans which ensure that each of the recommendations is addressed in full. Safeguarding adults and children is of high priority to the CCG and we have ensured that we have the appropriate internal resources in place to manage, monitor, and maintain quality in these areas.

In particular:

- The CCG has put a structure in place to actively engage with GPs and their patients on a continuous basis. This builds on structures that the CCG has had in place previously.
- Each GP has an opportunity to gather feedback within each consultation; a patient feedback system is under development to allow the information gathered by GP's in consultation to be fed-back in a systematic way into the quality and risk system of the CCG. The CCG has a schedule of planned communication and engagement events as well as a patient participation system which allows patients and GPs to come together on a regular basis and discuss experience and concerns with care.
- The CCG's Clinical Quality and Risk Committee is chaired by a GP Board Member supported by the Clinical Director for Quality and Governance. Together they have overall responsibility for and oversight of clinical quality issues; the Quality committee as a sub committee of the board, also has a role to report areas of serious risk or concern to the Audit Committee, and both bodies report directly to the CCG Board.

IV. Approach – Phase 1: PMO

Re-establishing the PMO

The PwC draft report, dated 3 April 2013, makes 56 recommendations around the QIPP programme and the PMO within Barnet CCG, which can be summarised into seven clear areas of action:

1. Gain **visibility** over the entire programme of work, including the **gaps in resources**, and address them to ensure that projects are sufficiently resourced to achieve success
2. Complete the **project documentation** for existing projects to allow implementation to begin
3. Articulate and embed **a project lifecycle and gateway process** which supports projects from ideas generation, through start-up, initiation, delivery and close
4. Design and embed a **suite of PMO controls**, including a streamlined and **standardised reporting process**
5. Design and embed an **efficient governance structure**, including clear terms of reference for all roles, groups and meetings that sets out the responsibilities and accountabilities for each individual
6. Identify and address **communication and training** requirements to truly embed the new processes, tools and ways of working
7. Put patient **quality and safety is at the heart of programme delivery**.

A high level action plan to achieve the above focussing on the delivery of 11 key milestones within 40 working days has been developed & resource to implement is being identified. This will support the initial stages of the CCPs. The CSU are unable to resource the action plan however they will be fully integrated into the PMO framework once formally in place.

The key recommendations and steps taken by the CCG are detailed on the following pages.

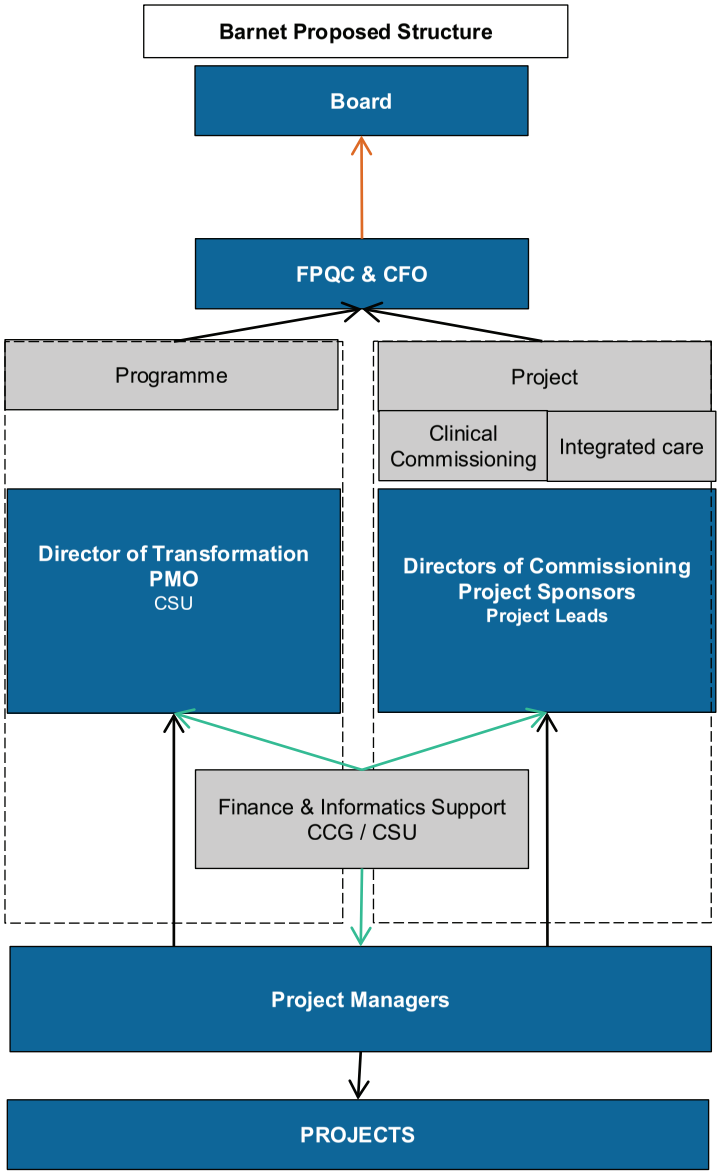
IV. Approach – Phase 1: PMO

PMO structure and delivery

In order to ensure a sustainable future, the CCG has had to improve the way it goes about both developing and delivering savings. We have recognised the need to develop the right capability and capacity required to drive the change programme, underpinned by a new best practice Programme Management Office (PMO) approach to project delivery. Key roles of the PMO:

- The approach in developing QIPP plans and monitoring and driving implementation is much more proactive and wide ranging than previous years and aims to maximise efficiencies and ensure deliverability.
- The PMO is responsible for managing the change programme and driving forward the delivery of the identified plans with rigour and pace.
- At the plan development stage of each project, the PMO will provide the robust check, challenge and reporting processes required to ensure the ambitions of the CCG in successfully delivering its savings and efficiency targets are achieved.
- The PMO is in the process of agreeing how it is supported by the CSU, both at an analytical and plan development stage and to support monitoring of plan implementation.
- Plan development is lead by the CCG's two Directors of Commissioning at a strategic level with GP clinical leads at plan level.

The diagram opposite outlines the tailored structure adopted within the CCG and shows the channels of reporting and approval. The roles and responsibilities at each level of this structure are described overleaf.



IV. Approach – Phase 1: PMO

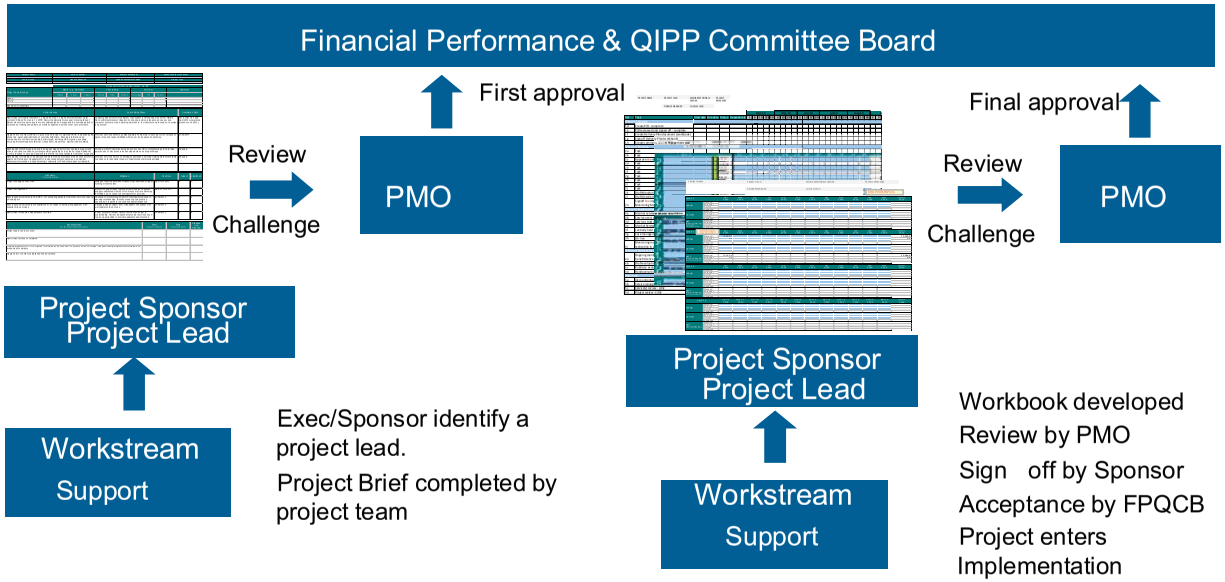
QIPP plan development

The development of QIPP plans is underpinned by an agreed systematic process. This process assures the CCG Board that plans are transparent and have a framework for identifying and monitoring key deliverables / benefits through accountable leads. In addition plans contain clarity on what is agreed in terms of managing quality issues, change management, impact and risks to patient services.

Each scheme has an identified project team, which includes an accountable sponsor, clinical lead and project lead.

The first stage of the QIPP development plan is to complete a Project Initiation Document (PID) which brings together the information needed to define the project, why the work is needed, likely outcomes and any resources required.

The PID is submitted to the PMO and approval sought for the development of business case to the Finance Performance and QIPP Committee (FPQC).



The second stage is the submission of a fully worked up business case outlining why the project is going ahead. It will include what it is expected to deliver, benefits / savings / costs of delivery and any impact and risks to services . This business case is again submitted to the PMO for a sense check and agreement sought if appropriate by the FRQC.

Stage three includes the development of the project workbook which sets out how the project with be implemented to completion, identifies the key milestones, monitors the project, flagging any issues and risks raised/monitored and how they will be mitigated against.

The project teams meet frequently with the PMO to discuss progress and delivery of plans against targets. This process helps to raise issues, find solutions, support, challenge and hold the team accountable for delivery of the project , escalating issues as necessary. Following these meetings, the PMO is best placed to track and report progress of each project and flag issues to the FPQC.

IV. Approach – Phase 1: PMO

Risk management

For all QIPP schemes approved by the Finance, Performance and QIPP Committee, a workbook is completed to monitor the project through implementation and delivery of benefits. This includes a project specific risk register, which is centralised onto the PMO risk register. Risks common to more than one project are highlighted to enable a linked approach by project managers when mitigating. Current themes are listed below.

Risk	Mitigation
Lack of project management resource	Increase project management capacity. Consider interim options
Availability of clinicians may impact on project timescales	Involve clinicians from outset and ensure they understand commitment required
Lack of GP engagement – unaware of new service and do not refer patients, slow to adopt new systems.	Work with communications team to promote services. Work through CCG GP members to develop relationships with GP community and share good practice.
New service increases demand	Ensure robust primary care pathways and thresholds for referring into service. Use contract monitoring process to review and manage.
Lack of skills in primary care to enable shift of services from acute setting	Development of primary care through primary care strategy Use of learning through peer review GP education sessions.
Plans developed in isolation from other neighbouring CCGs and local boroughs	Liaise with all service commissioners and providers in early stages
Patient confidentiality may mean that interactions between non NHS services will limit multi-disciplinary approach	Patients to be given option to consent information sharing
New pathway may destabilise providers	Ensure early engagement with providers and include in contract planning sessions and negotiations.
Inability to track progress due to poor quality of data available and ability to accurately interrogate systems	Work with informatics team to design KPIs using most reliable data to monitor monthly. Test data quarterly.

IV. Approach – Phase 2: Delivery

Roles and responsibilities

The table opposite outlines the roles, purpose and responsibilities in delivery of this recovery plan

As a CCG we have highlighted the importance of clear role designation in order to ensure clear working practices and defined governance channels.

The identified positions and accountability will make sure each QIPP scheme is well worked up and delivered according to the agreed timeline and quantum identified in each plan.

	Role	Purpose	Responsibility and accountability
Monitoring	**Finance, Performance & QIPP Committee and Chief Financial Officer**	• Executive decisions and approvals to manage programme.	• Responsible for ensuring all CCG staff are fully aware of the scale and challenge of the turnaround programme • Management of communication with internal and external stakeholders • Regular review of resources required to deliver programme
Programme Management	**Director of Transformation**	• Leadership and coordination of the overall turnaround process	• Coordination, challenge and assurance of turnaround work streams and overall financials • Turnaround and project management advice, training & support to project sponsors • Ensuring turnaround focus incorporated into day to day operations across the CCG
	PMO	• Management and coordination of the turnaround programme	• Upkeep of central project management schedules • Maintenance of project records • Resolution or escalation of issues as appropriate to the QIPP Director & Steering group • Turnaround and project management advice, training & support to project leaders and resources • Preparation of weekly and monthly progress reports
Delivery	**Project Sponsor (Dir. of Clinical Commissioning / Dir. of Integration**	• Provides executive leadership of project groups and associated benefits	• Responsible for and accountable to the executive team for delivery of turnaround work stream benefits
	Clinical Leads	• Clinical quality assessment	• Ensure clinical quality is maintained throughout the delivery of each of the savings projects. • Accountable to the Project Sponsor
	Project Lead	• Delivery of turnaround work streams and associated benefits	• Project management of turnaround work stream • Coordination of turnaround work streams with business as usual operations • Accountable to the Project Sponsor for delivery of turnaround work stream benefits

IV. Approach – Phase 2: Delivery

FY14 QIPP delivery

- The PMO will need to provide support to the QIPP programme and monitor and report on the financial and overall progress of the cost improvement schemes.
- Regular reporting will take place following a detailed review led by finance in conjunction with the programme managers. The PMO will risk adjusts the forecast level of savings and report this to the FPQCB.
- The CCG is in the process of implementing an effective set of tools, including templates for the planning and monitoring of QIPPs.
- The organisation's understanding of the PMO's role, and developing the right team for the role going forwards are critical. The CCG has recognised the need to change its PMO in line with the recent PwC report.
- The CCG are now ensuring there are sufficient core PMO staff , and that the PMO's core role, to monitor, challenge and measure progress, is understood within the organisation.
- The CCG have recognised the need to improve its monitoring of the QIPP impact on quality.

IV. Approach – Phase 2: Delivery

Approach to finding additional QIPP

- In collaboration with CSU and external organisation, developing systems to ensure robust programme management and clear visibility of project progress in place at all levels.
- Developing cycle of benchmarking and peer review, with CSU to identify new areas of opportunity looking at various websites including Audit Commission PBR National Benchmarking, NHS Comparators, NHS Better Care better Value Indicators.
- Developing series of ideas gathering workshops with GP community using locality meeting forum.
- Setting up sessions with patient and public groups to gather user input on proposed service improvement areas.
- Working with Local Authority and Public Health to develop an integrated care programme informed by the JSNA and HWBB Strategy.
- Working with provider Trusts to look at areas for shared delivery of services with cost efficiencies to both sides.
- Periodic sharing of good practice within CCG POD and with comparable CCGs and pan-London
- New opportunities identified will be scoped following same robust programme management system as previous slide.

IV. Approach – Phase 3: Transformation

FY15 QIPP approach

- Scoping and first stage proposal documents for areas identified by PwC benchmarking (appendix II) from Q2. This will determine size of opportunity and enable prioritisation and resource allocation.
- Programme presentation to CCG Board for approval early Q3.
- Final scoping and development of business cases and quality impact assessments for approved schemes, presented to Finance, Performance and QIPP Committee for sign off December/January.
- Implementation Q4 to enable full impact from FY15 Q1. In parallel agree methodology with CSU informatics and finance to monitor projects and ensure benefits tracking.
- In collaboration with CSU and external organisation, developing systems to ensure robust programme management and clear visibility of project progress in place at all levels.
- Developing cycle of benchmarking and peer review, with CSU to identify new areas of opportunity looking at various websites including Audit Commission PBR National Benchmarking, NHS Comparators, NHS Better Care better Value Indicators. Also sharing good practice within CCG POD and with comparable CCGs and pan-London.
- Working with Local Authority to develop an integrated care programme and with provider Trusts to look at areas for shared delivery of services (see previous slide outlining engagement with other stakeholders)

IV. Approach – Stakeholder Management

In the table below, the CCG has recognised the wide range of stakeholders who may be impacted by the implementation of the recovery plan. The table outlines the potential agenda of each stakeholder group, and the intended approach to communication. The PMO will be responsible for keeping the stakeholder matrix up to date and for making sure the communication requirements for each group are delivered.

Stakeholder	Key Priorities	Approach
Patients	• Engagement in commissioning	Continue implementing the communication and engagement strategy. Hold regular public meetings
GP's	• Engage GPs in commissioning and decision-making • Capitalise on clinical interests of GP's, encouraging participation as clinical leaders in the commissioning process	Locality meetings GP intranet / bulletin Use of Practice Development GPs and practice visits to keep practices appraised of CCG developments.
Local Authority	• Develop integrated working structure to facilitate integrated care	Work closely with the LA and Health and well being board
Acute Providers	Keep them informed of our commissioning issues. Ensure the delivery of Safe , quality services Develop a win- win working partnership	Hold regular provider events to engage them in the work of the CCG and to establish a partnership approach to local service delivery. Hold regular Clinical Quality and Risk meetings with provider Trusts.
NHS England	• To ensure we deliver the best possible health outcomes for Barnet patients by prioritising them in the decisions we make • commissioning quality services • Deliver a balanced health economy within budget	Hold regular meetings and submit the appropriate reports demonstrating our achievements.
CCG Staff	• Develop staff to ensure they are competent leaders within the commissioning process	Hold regular staff training / development events, directors will hold weekly staff meetings to ensure that staff are fully sited on the commissioning work being conducted throughout the CCG. Develop a staff news letter

V. Recovery plan

In addition to the actions identified within phases I and II, the CCG has developed a recovery plan which will focus on 'big ticket' QIPP opportunities that are required to deal with the deficit.

The table opposite summarises the anticipated impact of the CCG position; 3 years to in-year break even, 4 years to in-year business rules, and 5 years to clear legacy deficits.

As noted earlier in this report the CCG has forecast based on its existing 'run rate' and has made assumptions around demographic growth & associated cost pressures. The forecast also assumes that the 2% headroom requirement will be available to the CCG to reduce its in year deficit.

QIPP schemes with a target delivery of £17m (risk assessed from £18.9m) have been identified for FY 14. Individual QIPP schemes and targets have not yet been identified for FY15 and subsequent years.

The following pages summarise the existing QIPP plans for FY14 and the opportunity areas which will need to be explored to identify large additional savings for FY15 and beyond which will be key to the CCG's recovery.

These opportunity areas are based on initial benchmarking and experience of other CCG operations and will be investigated further to develop business cases for Board approval. The FY15 opportunities will be developed for implementation at the earliest opportunity. However, given the commissioning cycle, the majority of opportunities are unlikely to deliver savings in FY14.

In year & legacy deficit calculation

	13/14 £m	14/15 £m	15/16 £m	16/17 £m	17/18 £m
opening balance b/f		**-20.9**	**-29.5**	**-24.6**	**-6.9**
In year year surplus/(deficit)	-20.9	-8.6	4.9	17.6	29.6
Trading surplus/(deficit) c/f	**-20.9**	**-29.5**	**-24.6**	**-6.9**	**22.6**
2% headroom requirement	-8.3	-8.5	-8.7	-8.9	-9.1
1%/2% surplus requirement	-4.2	-8.5	-8.7	-8.9	-9.1
Surplus/(deficit) post Business rules	**-33.4**	**-46.5**	**-41.9**	**-24.7**	**4.5**

The transformational nature of many of the FY15 plans will involve changes in stakeholder behaviour – including acute and community providers, GP's, neighbouring CCG's and partner Local Authority organisations. The Barnet, Enfield and Haringey Clinical Strategy and the acquisition of Barnet and Chase Farm will be significant drivers for change.

These changes in stakeholder behaviour will require support and facilitation and the CCG recognises that, in many instances, this may prove challenging. The CCG will require additional resource capacity and capability in order to properly develop and implement its FY15 plans.

A number of these plans may also require initial investment in order to effect the changes required e.g. by dual running of pathways and pump priming (costs of set up) . Given the CCG's financial position it is therefore apparent that , in the absence of external support, the CCG may either be unable to progress with its transformation at pace or may result in an increased deficit position in the short term.

V. Recovery plan – CCG QIPP plans 13/14

The CCG's latest QIPP dashboard (23/04/13) shows plans of £18.9m are monitored within the PMO. A copy of the dashboard is included at Appendix 2. The net QIPP scheme savings (net after investment of £4.1m) identified for FY14 as at 23/04/13 are summarised below and described on the following pages:

	Clinical Lead	Existing Schemes	Comments		Pages
		Budget FY14 (£'000)		**Contracting**	
Children and Maternity	Dr Clare Stephens & Howard Ford	2.3m	Many of these schemes aim t achieve savings through procurement processes, tariff reductions and through a shift of activity out of the acute setting.		
Elective Care	Dr Lyndon Wagman, Dr Ahmer Farooqi and Teresa Callum	6.6m	Most of these schemes aim to achieve savings through moving services from a secondary setting into the community at lower tariffs.		
Emergency and Urgent Care	Dr Barry Subel and Beverley Wilding	1.5m	These schemes aim to achieve savings through a reduction in on sale costs and tariffs charged by the acute providers.		
Mental Health	Dr Charlotte Benjamin and Dr Ahmer Farooqi and Temmy Fasegha	0.6m	Most of this saving relates to a reduction in contract.		
Integrated Care	Dr Jonathan Lubin, Dr Deborah Frost and Karen Spooner	0.9m	These schemes aim to achieve savings through redesign of care pathways and initiatives to reduce acute admissions, and reduction of the Continuing Healthcare budget		
Other (Support Programmes)		6.9m	A majority of these savings are to come by way of contract negotiations and estates management.		
TOTAL		**18.9m**			

V. Recovery plan - Existing projects FY14

Children, Young People and Maternity (Total: £2,842k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
CAMHS Tier 3 Accepted referrals to the Generic Tier 3 service have been falling as a result of a new referral management process. Commissioners have used the CAPA model to understand demand, capacity and productivity. This indicates capacity for a significant reduction in the baseline budget.	To re-negotiate the contract for 2013/14 with a £500k reduction in the baseline contract value. Leads to reduced cost of children's mental health provision.	Demand and capacity modelling agreed with BEH MHT Trust. Contractual terms for a £500k reduction in contract value agreed and included in Heads of Terms. Contract due to be signed by 30 April 2013.	£500k	£500k
Maternity – national tariff In respect of maternity, contractual terms are being negotiated with the two largest providers, Royal Free and Barnet and Chase Farm. There is a need to agree the estimated activity and case split with the providers. There is also a recognition that PbR and loss of income should be shared between commissioner and provider.	Savings are to be achieved through a mandatory tariff change imposed by the department of health and through contract specification. 50% of the savings will be achieved in the first year. <u>Outcome of Scheme:</u> Implementation of the Maternity Pathways Tariffs by April 2013.	The nationally mandated tariff is embedded within the national contract for acute services. Contracts with the main providers of maternity services have been agreed for 2013/14.	£1.5m	£3.2m

V. Recovery plan - Existing projects FY14

Children, Young People and Maternity (Total: £2,842k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Children's SALT Procurement SaLT currently commissioned via 4 LA contracts and 1 CCG contract with same provider, and spot purchasing from smaller providers. There are significant gaps in the current provision, particularly for 12-18 year olds. There are unclear pathways for families and an inconsistent service offer to schools.	Savings are to be achieved through a procurement process to streamline the current SALT services. Outcome of scheme: A new SaLT service to be in place, managed under a single specification and contract by the CCG.	• Current service de-commissioned. • Needs assessment and service model agreed. • Joint service specification agreed. • Procurement commenced. Milestones: • 21/05/13 – Tender period closes. • 12/06/13 – Bidders present • 04/07/13 – Contract award • 01/09/13 – Service commences.	£184k	£364k
Children's elective & non elective Issue: Gaps in community service provision need to be reviewed.	• Implement triage referral management (TRM) service for paediatric referrals. • Develop validated management protocols and care pathways for GPs. • Support paediatric activity reduction and monitor demand at BCFH. Savings are to be achieved through: • Tariff reduction for community clinics. • Activity shift, acute into community clinic. • Reduction of follow up referrals to secondary care. Outcome: Improve management of children with complex needs including development of transition pathways. GP's with specialism would pick up a greater share of this work.	• GP training programme arranged. • Ongoing audit to inform service development and education. • Draft care pathways developed. • Service specification emailed to provider for feedback. Milestones: • Service specification and contract variation signed by provider. • Pathways to be signed off by all stake holder organisations. • Mainstream PIC project at Barnet. • Move triage to RMS. • Extend project to Royal Free Hospital.	£158k	£158k

V. Recovery plan - Existing projects FY14

Elective Care (Total: £6,612k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Referral management (£2m) and PoICE (£197k) Barnet is a high referrer of patients into the acute setting. A referral management system (RMS) and learning through peer review (LPR) scheme already exist in Barnet. These need to be built upon and strengthened. Some referrals are of low clinical value and outside the Procedures of Limited Clinical Effectiveness policy.	Savings are to be achieved through lower acute referrals and activity being diverted to the primary care settings, through: • Ensuring gaps in knowledge or skills of the GP population are identified and addressed through LPR Programme. • Enhancement of the RMS service with greater clinical involvement. GPs are to be trained to provide triage services to ensure referrals are sent to the right service. • Practice development visits to raise awareness of local pathways. <u>Outcomes from the schemes:</u> • Referrals are controlled, managed and are appropriate. • GP practices utilise the referral management system as part of the demand management programme. • Patients are referred in line with care pathways. • Patients are seen more in the community setting. • A decrease in the number of incorrect or inappropriate referrals.	<u>Progress to date:</u> Learning through Peer Review, an educational programme for GPs moves into its second year. First meetings have already taken place. Practice Development GPs have been recruited and trained and the schedule of visits begin in May. Each practice will be visited 2,3 or 4 times, depending on how much support is needed. GPs are now triaging all referrals in eight agreed specialities, with all specialities being covered by August 2013. <u>Key Milestones:</u> • Introduction of GP triage at RMS (Jan 13) • Commence Practice Development Visits (Apr 13) • Increase the percentage of prospective referral review through LPR (Jul 13)	£2.356m and £197k	£2.356m and £197k

V. Recovery plan - Existing projects FY14

Elective Care (Total: £6,612k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Urology Urological problems create a significant burden of work for primary care. The number of referrals to secondary care has been rising every year. With advances in diagnostics, urology becomes increasingly medicalised, offering an opportunity to reduce costs and allow treatment closer to home. An ongoing increase in the volume of referrals to local urological departments has resulted in a funding pressure. Patients can currently be seen by highly skilled urologist consultants for relatively minor conditions.	To expand the existing community service beyond continence, and relocate hormone therapy into primary care. The current specification sets out a proposed community urology service as a contract variation with CLCH. Savings are to be achieved through a shift of activity from secondary to the community. <u>Outcome:</u> • Appropriate referral process. • Improved clinical outcomes and patient experience by providing evidence-based care and ensuring patients access the most appropriate care, first time in a community setting. • Reduction in waiting times for patients. • Transfer of activity from acute to community at reduced costs.	• Ongoing engagement with CLCH • Contract funding discussion finalised with CLCH and BCF for roll out 2013/14 • Draft specification being finalised • CLCH undertaking preparatory work for roll out • GP supporting RMS for urology. <u>Milestones:</u> • Agree specification (Apr 13) • Pre-clinic assessment protocols and pathways agreed (Apr 13) • Contracts signed (Apr 13) • Staff recruited (Apr 13) • Infrastructure and equipment changes implemented (Apr 13) • Service starts (May 13) • Increase to full provision	£300k	£300k

V. Recovery plan - Existing projects FY14

Elective Care (Total: £6,612k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Expand Community MSK Service Pathway A community service in place but there are further opportunities to shift additional out patient/day case activity into the service	Expansion of the current MSK community based service to include a podiatric surgery pathway. Outcome: Current podiatric surgery (agreed HRGs) undertaken as a day case procedure at 70% of PBR tariff within ECH	CLCH already provide the service to inner boroughs and will expand into Barnet. Appropriate HRG activity has been identified. Activity and savings identified as part of the QIPP plan 13/14 for both BCF/RFH. New pathway would be delivered via the MSK service. Scheme being scoped. Milestones: Pathway confirmed with CLCH/service spec BCF/RFH to confirm QIPP Plan TUPE issues resolved Contract Variation in place Advise general practice re new pathway RMS to divert all activity to MSK service	£58k	£115k
Micro-suction The current micro-suction model is not fit for purpose and doesn't offer value for money. There is a also a disparity in service provision as patients in the borough don't all have equal access. It currently costs £180 under the PBR tariff.	To streamline the patient pathway, provide care closer to home and reduce the cost of the service. Savings achieved by moving the provision of micro suction from acute to community through either local practices or alternative providers. Outcome: • Reduced baseline cost of service • Reducted number of patients having micro suction within ENT clinics . • 95% of patients seen in community clinic without secondary referral.	• Advice on procurement obtained from CSU and currently awaiting CCG decision. • PID has been approved. Milestones: • Agree service model • Develop service specification • Complete procurement • Provider to implement new service model • Release QIPP savings The timing of milestones is yet to be confirmed.	£58k	£381k

V. Recovery plan - Existing projects FY14

Elective care (Total: £6,612k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Primary Care Medicines Management Prescription costs in the borough are slightly lower than the national average with a high levels of prescriptions of branded lipid lowering drugs , newer diabetes drugs; sip feeds and milk substitutes.	Medicines optimisation as an ongoing initiative. Additional schemes include appointing community dieticians to undertake targeted care homes work. Savings achieved through encouraging GPs to prescribe more cost-effective medicine alternatives, a move away from 'specials' and a reduction in wastage of medicines. <u>Outcome:</u> •Lower spend and wastage. •Cost of specials to be £200k less in 2013/14 compared to 2012/13. •Patent loss drugs to generate £1.1m of savings in 13/14 compared to 12/13 •Spend on corticosteroid inhalers to be £75k less in 13/14 compared to 12/13. •30-35% of decrease on in year drug spend on Omacor, Rosuvastatin and Ezetimibe comparing Q1 12/13 with Aug-Oct 2013	This is an ongoing initiative <u>Key Milestones:</u> •Review of branded to generic forecast savings and monthly monitoring (Apr 13 onwards) •Meet all 67 practices and agree savings areas (Apr -Sep 13). •Set practice drug budgets, monthly monitoring and feedback mechanisms (Jun - Oct 13). •Recruit paediatric dietician (Jul 13) •Development of primary care services such as FMH older people review service and LBB homes pilot homes project.	£2.2m	£2.2m

V. Recovery plan - Existing projects FY14

Elective Care (Total: £6,612k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Acute Medicines Management Issue: Prescription costs in the borough are higher than the national average in the acute setting. There is a high on cost of drugs from acute providers especially the Royal Free Hospital. Additional Pharmacist support at the CSU is required to undertake this work-proposal being debated in the 5CCGs.	This is an ongoing cost management initiative to reduce prescription costs in the acute setting, through; •pursuing bio-similar switches; • NICE audits; • Encouraging use of home care companies. •Challenging accuracy of high cost SLAM data Outcome: Lower prescription spend in acute setting	The plans are being worked up and for savings above 250k. Key Milestones: CSU bid for additional pharmacy support approved or declined 31st May 2013 Accurate information from the main acute providers (UCLH, Free and B/C) by 30th June 2013 Challenge data from the Royal Free audit re ant-tnfs and lucentus results in savings for Barnet CCG by 31st July 2013 BCF Business Case approved for improved home care service by 31st May 2013 CCU Med man team able to check high cost slam data re accuracy by 31st July 2013.	£250k	£250k

V. Recovery plan - Existing projects FY14

Elective Care (Total: £6,612k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Gastro and GI Surgery Potential savings have been identified as part of a benchmarking exercise. The project is currently at scoping stage.	Using good clinical practice and guidance to redesign gastroenterology diagnostics, acute management and chronic conditions management. Quality and patient experience are maintained and improved through establishing standards and effective service models. Productivity may be improved by working with colleagues in primary and secondary care to: • Reduce morbidity, hospital admissions and unnecessary secondary care appointments for patients with long term conditions. • Provide a one stop clinic model for patients with acute conditions.	Reviewed literature and guidance from NICE and the British Society of Gastroenterology; Reviewed out patient and procedure activity data for previous 2 years; Identified key stakeholders and made contact with lead Consultants at Royal Free and Barnet and Chase Farm. Milestones: Confirm the primary care view of current gastro services and care pathway; Review the activity information for both out patient and procedures; Meet with Secondary Care Consultant leads and other stakeholders; Develop a Project Initiation document and present to Barnet CCG PMO group and then Barnet CCG Finance and QIPP meeting.	£110k	£110k

V. Recovery plan - Existing projects FY14

Elective Care (Total: £6,612k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Ophthalmology Issues: A Community Ophthalmology service was commissioned in July 2011 for a pilot period of one year to test out the feasibility of providing such a service in a community setting. It became apparent that given the mobilisation period and time required to run a formal procurement, a year would not be long enough to properly test a new service. Therefore an extension of 18 months to the original pilot period of one year is being applied for. This extension will then be signed off on the understanding that we would go out to full procurement with a view to appointing a new provider at the end of the pilot extension in December 2013.	The scheme involves the provision of non-complex ophthalmology treatment in the community, including stable glaucoma. Objectives of the project are to: • Provide services closer to home • Bridge the gap between primary and secondary • Improve access and reduce waiting times. • Ensure referrals are appropriate • Develop common pathways of care Savings are to be achieved through lower acute activity and a shift to primary care. Outcomes of the scheme are: • Care closer to home – reduction of patients referred to secondary care • Cost benefits – services provided more economically • Better use of resources both in secondary and primary care • More responsive service to patients	Progress to date: Ophthalmology is in the middle of the procurement cycle. It is anticipated that a new provider will be appointed in August/September 13, with a start date of December 13/January 14. Milestones: • PQQ scoring by 9 May 2013 • ITT scoring by 26 June 2013 • Panel Presentation 5 July 2013	£120k	£314k

V. Recovery plan - Existing projects FY14

Elective Care (Total: £6,612k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Pain Management Barnet does not have a community Pain Service. Benchmarking reviews indicate that establishing a community pain service would provide better outcomes for patients and savings through reduced acute activity.	The scheme involves the introduction of a community pain management service. This is to be done via a joint approach with Enfield CCG. Savings are to be achieved through a local tariff at 70% of PBR. <u>Outcome:</u> • Provide effective triage of pain management presentations. • Provide a multidisciplinary service that is appropriate to patients needs. • A single pain pathway for both Barnet and Enfield boroughs. • Greater self management through the Pain Management Programme.	Approval in principle from BCF to the local variation, meeting with RFH consultants being arranged Savings have been mapped into the QIPP plans for 13/14 contract negotiations Request to fund the primary care CBT programme to support the pathway – would require reinvestment . <u>Milestones:</u> BCF identify locations within primary care to provide the service Sign-off service specification with BCF Meet with RFH consultants to discuss pathway changes/opportuntiies	£60k	£60k

V. Recovery plan - Existing projects FY14

Elective Care (Total: £6,612k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Diabetes Issues: In 2011 the Joint Strategic Needs Assessment (JSNA) identified that Barnet will continue to have a higher prevalence than both London and England. Barnet PCT has a higher than average follow-up ratio of Diabetes medicine outpatient appointments	To shift the care of stable patients with diabetes from secondary care into primary care in line with Healthcare for London Diabetes model Savings are anticipated through a reduction in follow-up appointments and investment within the community DSN team, and greater management of stable patients by their own GP	Progress to date: All practices with follow-up patients have been written to , feedback that at least 40% of the follow-ups could be managed in primary care. 40% of follow-up activity mapped and built into QIPP contract negotiatiions Milestones: Trust agreement to QIPP activity/cost to form part of 13/14 contracts Reinvestment additional DSN within community team Letter to GP practices to advise discharge plans Discharge of patients back to community/primary care from beg 3rd Qtr 13/14	£29k	£29k

V. Recovery plan - Existing projects FY14

Elective Care (Total: £6,612k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
ENT Issues: Ear Nose and Throat has been identified by the West practice based commissioning cluster as an area that would benefit from service redesign and also one that could provide a more efficient use of resources if were provided in a community setting. Data from a pilot indicated that a community service would be able to see approximately 50% of ENT referrals. It was agreed that initially a pilot service would be set up to test some of the assumptions. The pilot period ended on the 31st March 2012 but it was agreed to extend this by 9 months to gather additional information and further develop the specification.	The ENT service will improve quality of care for patients by providing a high quality community based integrated service for ENT that is based on best practice and is clinically effective. Savings are to be achieved by shifting activity from secondary care into the community and through tariff savings on commissioning the community ENT service. A one stop shop approach should also reduce consultant to consultant referrals with only one charge for the CCG. Outcomes from the scheme include: • Reduction in secondary care referrals • More appropriate referrals • Reduced waiting times • Reduction in the number of follow up appointments • Better informed GP community in the management of simple ENT conditions	Progress to date: A joint procurement process with Enfield CCG was undertaken that resulted in the appointment of UCLH as the provider of community ENT services in Barnet and Enfield The new service started on 1st Feb and after a short ramp up phase, now covers the whole of Barnet ENT referrals. Primary care pathways have been developed between acute and primary care clinicians which will support the RMS triage process. Clinics are based at Edgware Hospital and will be available at Finchley Memorial Hospital from May 13. A potential third site may be identified later in the year near the north of the borough. Milestones: • Service Starts 1st Feb 2013 • Expanded to cover all of Barnet 1st April 2013.	£137k	£157

V. Recovery plan - Existing projects FY14

Elective Care (Total: £6,612k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Dermatology •There is a high referral rate for OP appointments (79% above national benchmark) •For 2011/12, the CCG is 2nd in country for total dermatology elective activity (197% above national benchmark). •There is under utilisation of community provider. Instead the activity is taking place in the acute setting. •There is high level of activity at acute providers for relatively minor procedures. •There are high referrals from the community provider into the acute providers. Bench marking was excluded from this Service redesign project because it was inaccurate. The reason for this was that we are a head in this area in comparison to other areas because of the way our services are configured locally. (given that we already have a community dermatology service in place) hence this is not available.	The aim of this project is to move activity away from acute providers and into community or to keep it in primary care wherever possible, ensure that our community dermatology service is equipped to see more complex patients that would otherwise be seen as day cases keeping them out of acute hospital. The pathway is to be adjusted so that the acute providers are only used for specialist treatments. Savings are to be achieved through activity shift at lower community tariffs. <u>Outcome:</u> •Patients to be treated in appropriate setting. •Reduced GP referrals •Reduce referrals to acute by 50% in year. •Enforce switch from DC to OPPROC of 80% at all acute providers. •Increase patient choice by delivering care from a greater number of locations in the borough. •100% of non-cancer referrals to go through specialist dermatologist triage.	•Full PID in place supported by a comprehensive workbook ready for implementation. • GP triage resources under review within the RMS • Dermatology pathways approved and ready for implementation as part of RMS. •Clinical audit of provider activity underway. <u>Milestones:</u> •Design service specification and confirm pathway with all key stakeholders (Apr 13). •Confirm new pathway, roll out to all necessary parties. •Make any contractual changes required to facilitate new services. •Implement regular monitoring processes to confirm adherence to referral pathway and outcomes	£328k	£328k

V. Recovery plan - Existing projects FY14

Elective Care (Total: £6,612k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Cardiology Issue: Benchmarking has identified that the CCG has higher than average cardiology GPs and consultant to consultant referrals. The Royal Free Hospital (RFH) provide a community cardiology service for patients in the South with the north being provided via Primary Heart Care (now decommissioned). This decommissioning has left a gap in service delivery and creates inequalities in the delivery of Cardiology services in Barnet.	The target is for RFH to provide all services via a contract variation. Savings are to be achieved through a contract variation with RFH and a shift of activity from acute to community services, as well as reduced referrals. Outcome of scheme: • Expansion of the existing community cardiology services provided by the RFH to patients in the west and the north localities to fill the gap left by the Primary Heart Care Service. • A reduction of referrals to acute providers and a decrease in inappropriate referrals. • Care closer to home with improved patient experience. • To reduce Royal Free cardiology follow-up ratios and bring it back in line with national benchmarking average .	Progress to date: The implementation of the scheme has already began. The community service has been rolled out across all of Barnet in the week commencing 15 April 2013. A new community clinic is due to open in Finchley Memorial Hospital in the week commencing 22 April 2013. Milestones: • Local Tariff Negotiated and agreed • Business case approved • Revised Service Specification Drafted • Contract with Royal Free signed All of the above by end of Feb 13 • Project Phase 1 - Activity Ramp Up Start (Qtr 1) (April 13). • Project Evaluation (31 Jan 14)	£63k	£73k

V. Recovery plan - Existing projects FY14

Elective Care (Total: £6,612k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Evidence based pathology Issue: Current practice is resulting in the ordering of duplicate, redundant, and otherwise unnecessary diagnostic tests from providers.	Outcome: To develop evidence based standard templates for commonly requested screens. These will include thresholds for retesting as well as the cost of each test listed. This will ensure all test requests are clinically appropriate. It will also provide GPs with information around the cost of all tests, which will influence the volume and sequencing of requests. Additionally, the full use of an electronic system means that processing of specimens at the lab will be increase the speed at which requests and results are processed, avoid "lost" specimen, and, more critically, mean that information is passed directly between clinical systems, improving clinical governance processes.	Progress to date: • A series of templates have been developed in partnership with the B&C clinical lead for pathology, Enfield CCG and Hertfordshire CCG GPs. These have now been loaded onto the TQuest system. •Roll-Out of TQUEST to North and West Barnet localities undertaken by BCF, 95% coverage in these localities; •Early implementers for South locality ID'd; •Lessons Captured from N + W Roll-Out •Logistics for S Roll-Out Captured Milestones: •Confirmation of Resourcing of South locality roll-out to be provided •PID due for submission to PMO 13/05/2013 •Roll-Out to Early Implementers; •Roll-Out to rest of South Locality; •End User Training & Awareness Events to take place.	£180k	£180k

V. Recovery plan - Existing projects FY14

Elective Care (Total: £6,612k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Patient Navigator Issue: • Lack of robustness around the level of reduction we could expect to see in follow up appointments in each speciality. (which is likely to differ from specialty to specialty) • Difficulty in quantifying savings and potential costs. (see above) • Reluctance in acute trusts to take this forward without clarity in the above.	Outcome: In partnership with Enfield CCG we have agreed to tackle this specialty by specialty with a consultant and lead GP working through two virtual clinics to agree when it is appropriate to discharge back to primary care without additional follow up. We believe this will • Enable GPs to challenge the consultants in terms of the level of support general practice can provide. • Providing real examples for discussion with GPs, to get their buy in as to what can be discharged back to them. • Provide robust evidence around new to follow up rates that can be built into contracts for next year when the scheme is embedded. • Improve relationships between GPs and acute colleagues, working together.	Progress to date: Four initial specialities identified with a lead consultant and GP for each. Milestones: To have assessed the viability of this scheme in the initial four specialties by end of May.	£165k	£530k

V. Recovery plan - Existing projects FY14

Emergency and urgent care (Total: £1,500k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Urgent Care Centre Implementation of a UCC at Barnet Hospital is a requirement of the BEH clinical strategy. Patients with primary care/minor injuries will be seen within the UCC at a Band 5 tariff that will include near patient testing diagnostics	The UCC model is already operating as a pilot at Barnet Hospital – GP led, 9-9 7 days a week. Savings are to be achieved through a redirection of activity through the urgent care centre for primary care/minor injury cases. These patients would be paid for at a Band 5 Tariff <u>Outcome:</u> The target is for c40% of lower band patients to be seen in the urgent care centre.	The contract with Barnet and Chase Farm is currently under negotiation with a target to finalise by the end of April 2013. • BH UCC Service specification is complete, with BCF to finalise • Participate in interviews for long term GP provider of UCC • Contract monitoring arrangements agreed	£300k	£300k
High cost drugs and pathology Excluded drugs should be charged at the acquisition cost. Where price reductions are achieved in year through local and London wide negotiations these reduced costs should be passed onto the commissioner. As part of recent discussions with NICE a national price reduction has been agreed for LUCENTIS. There are other drugs used at RFH where the charge is significantly above acquisition cost.	The scheme relates to contracting negotiations in place to reduce the on-cost for drugs to the CCG. <u>Outcome:</u> A renegotiation of costs with providers as part of the 2013/14 contract round, releasing resources to address the CCGs financial position	Included as part of Contract offer to RFH sent April 18th Final figure to be agreed by RFH but agreement in principle has been obtained <u>Milestones:</u> Head of Terms signed May 2013 Contract signed June 2013	£1.2m	£1.2m

V. Recovery plan - Existing projects FY14

Mental Health and Learning Disabilities (Total: £625k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Mental health contract - growth reduction The CCG is developing a mental health commissioning strategy to inform mental health commissioning going forward and improve efficiency and Value for Money. The 2013/14Contract with BEH mental health trust (BEH MHT) is being renegotiated.	Savings have been achieved by not passing on growth funding (£660k) to BEH MHT in the current contract negotiation. This will drive improvements in the Value for Money and efficiency of the contract.	Contract negotiations are currently under way.	£625k	£625k
Alcohol related illness Barnet has the highest prevalence estimates of binge and dependant drinkers in NCL (ONS, 2011). It saw an increase of **9%** in alcohol-specific and alcohol-related admissions to hospital in 11/12. Alcohol related disorder accounts for three of ten local community issues of concern Safer Neighbourhood Team (SNT) ward data.	Develop provision of evidenced-based brief interventions in Acute and Primary Care settings, and develop the existing hospital liaison service for alcohol users. Savings are predominantly to be achieved through reducing alcohol related acute admissions. Outcome of the schemes are to: • Reduce alcohol related admissions and re-admissions to hospital. • Reduce of alcohol-related bed days. • Reduce ambulance repeat call-outs. • Reduce alcohol related offending/re-offending.	• New Alcohol Treatment care pathway agreed. Single Point of Contact (phone number) costed. Recruitment awaiting funding assurance Training in development Key Milestones: • Recruitment for alcohol liaison workers • Training for GP surgeries formulated and scheduled for delivery . • Hospital training scheduled for delivery • Single Point of Contact established and advertised • Initial cohort of most frequent hospital attendees identified and in placed in supported assertive services.	£1k	TBA

V. Recovery plan - Existing projects FY14

Integrated Care (Total: £944k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Dementia Issues: •Barnet has a fast aging population. •At present no specific memory service. •GP's refer patients to Old Age Psychiatry where they are assessed and a diagnosis is made. Referral data shows an increase in referrals. •Treatment is given and monitored by a nurse led memory treatment clinic. There are long waits for treatment and the memory assessment service is close to capacity. The project will support the development of a dementia hub in Barnet. The hub will integrate a network of key services and support provision for people with dementia and their carers. It will include the memory assessment service, a new dementia adviser service, and dementia café; along with the existing service provided by Barnet Alzheimers society. This is a joint project with the local authority.	The aim of the memory service is to deliver early diagnosis and intervention for people with mild to moderate dementia, which is estimated to be approximately 87.5% of people with dementia The scheme is to establish a multi-disciplinary memory assessment clinic. Patients ate to be referred to the memory clinic and placed on a dementia pathway. Savings are to achieved through: a reduction in activity and a shift of activity away from acute setting. Outcome: •Capacity to provide high quality early diagnosis and intervention for suspected Dementia sufferers. •Increase in early diagnosis from 57% to 69% over 5 years. •Early diagnosis to reduce institutionalisation, care home placements and acute emergency admissions.	Progress to date: •Wide Stakeholder consultation •Regular meetings BEHMHT •BEHMHT have submitted the business case and costings •Specification drafted •GP consultation commenced •Dementia café procurement completed (LBB) •S256 bid submitted for dementia advisor support •Project manager recruited Key Milestones: •Develop final specification (April 2013) •Agree delivery and location options (May 2013) •Determine contracting route (May 2013) •Review options for follow up in primary care (May 2013) •Procurement or agree contract with MH trust (May 2013) •Roll out and initial monitoring of KPIs (Jul-Dec 13)	£186k	**£379k**

V. Recovery plan - Existing projects FY14

Integrated Care (Total: £944k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Comprehensive Falls System Issues: •Barnet has a substantial population of elderly people with a growing trend in falls related admissions; with an FY 11/12 spend of £3.3m, an increase in of 10.5% since FY 09/10. •Falls services is fragmented, with no clear pathway. •Falls usually result in the need for long term care, and impact the whole system (making it one of the key priorities for any health and social care economy).	The objective of the scheme is to reduce the number of falls, and falls related admissions by bringing together a multi-disciplinary, multi-agency team. A redesign of the falls pathway is to include multi-disciplinary input. The scheme will also address gaps in service and ensure compliance with best practice. The scheme will also build a system for early identification of patients and strengthen the prevention and self care pathway, and being more innovative in the use of community services. Savings achieved through a reduction in falls thus reducing acute activity, and falls related admissions to care homes. This is a joint project with the local authority. Outcome: Reduce number of falls and falls related admissions.	Progress to date • Wide stakeholder engagement • Steering group established • A series of workshops with stakeholders • Design and impact assessment of new falls system completed • S256 bid submitted for a falls co-ordinator • Additional resource (short-term) to support next steps identified Key Milestones: • Design service specification and confirm pathway with all key stakeholders (April 13). • Make any contractual changes required to facilitate new services (May 13). • Hold training sessions for falls champions (May 13). • Implement contractual obligations and CQINS to ensure this becomes a key deliverable and to ensure compliance from organisations (June 13). • Roll out by phase (June onwards)	£82k	**£109k**

V. Recovery plan - Existing projects FY14

Integrated Care (Total: £944k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Stroke prevention and Intermediary care Issues: • Atrial fibrillation (AF) accounts for 14% of all strokes. Optimum management could reduce risk by 10% in population . • Traditional stroke care pathway includes acute and rehabilitation care in the hospital setting. • There is limited capacity of stroke-specific community rehabilitation services in Barnet. • There is not a comprehensive auditable system for stroke reviews in Barnet.	The stroke related schemes aim to increase provision of intermediate care and target a reduction of risk through early intervention and regular reviews, to maximise functionality and prevent a secondary stroke. Savings are to be achieved through reduced stroke activity and shift of activity away from acute setting. Outcome: An increase in the provision of specialist intermediate care/rehab for stroke patients including early supported discharge reducing acute activity. A formal review process resulting in better outcomes for patients. An increase in the recorded prevalence of AF and the proportion of patients with AF on anticoagulation across the sector. To be achieved through: •Integrating the GRASP AF- tool into each GP practice. •Opportunistic screening initiatives at GP practices. •Provide all practices with knowledge of, and access to, appropriate local anticoagulation pathways.	• Wide stakeholder engagement • Bid for S256 funding to LBB to part fund stroke reviews • Agreed mix of staff required for new ESD/Intermediate care team • Review of best practice in delivering stroke reviews • Project manager recruited Key Milestones: Stroke Intermediate care: • Advertise & train new staff (May/June 13) • Roll out of new service & KPIs (July 13) Stroke Prevention: • Training of GPs to use GRASP tool and agree contract with GPs (May/June 13). • Roll out and initial monitoring of KPIs (Jul-Nov 13). Stroke reviews • Agree delivery options and procurement route June/July 2013 • Develop specification and job roles June/July 2013 • negotiation Contract variation August 2013 • Service initiation 1 October 2013	£56k	**£74k**

V. Recovery plan - Existing projects FY14

Integrated Care (Total: £944k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Older peoples Integrated Care (Admissions Avoidance – Phase 2) The frail elderly group within Barnet represent significant financial cost to both health and social care budgets. •Barnet's elderly population is expected to increase by 20% over the next decade, placing increasingly severe pressure on both health and social care services. 60% of unplanned admissions costs in FY1 1/12 were for those aged 65 and over, costing £39.7m. •The current care pathway delivered to people with long term conditions within Barnet is not sustainable in the face of the projected future level of need	This project forms part of the Health and Social Care Integration Programme and aims to implement proposals to improve elements of the existing Frail and Elderly service in Barnet. These interventions are aimed at improving the outcomes of service users within this care group. They are designed to create access to better; more integrated care within the community and lead to a reduction of elderly admissions to hospital and residential care (reduce the need for care packages) Outcome: •Prevent unnecessary A&E attendances and unplanned hospital admissions •Optimise individual patient's health status •Optimise individual patient's social care support •Prevent or delay elderly admissions to residential care •Empower patients to self-care and manage their condition •Improve the patient's experience	• Wide stakeholder engagement including establishment of a provider network • Integration board set up and memorandum of understanding signed • Review of best practice in delivering integrated care • Successful procurement of risk stratification tool • Framework for working model agreed including MDT structure • Project manager recruited Key Milestones: Risk stratification: • Training for GPs on risk stratification tool (May 13) • Roll out new service and KPIs (June 13) Care navigators: • Recruitments underway for care navigators and case managers (May/June 13). • Roll out and initial monitoring of KPIs (July 13). Multi-disciplinary MDT • Weekly MDT in place for complex patients (July 2013) • Establish frailty clinic at FMH (Q3 2013-14)	£120k	£528k

V. Recovery plan - Existing projects FY14

Integrated Care (Total: £944k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
Continuing Care Issue: There Is a need to manage the ongoing costs of continuing care (CC). The CCG have determined a £500k savings target against budget for the CC department. This will need to be delivered through focused operational management.	The QIPP target relates to an ongoing operational savings target for the continuing care department. The team intend to deliver the savings target against budget through tight operational management of costs, particularly focusing on high cost packages of care to ensure that the quality of care is maintained at more efficient prices. The budget will be compared to financial outturn on a monthly basis to identify areas of cost pressure. Specific action plans will then be formulated to address these cost pressures. To manage CC costs there are regular reviews into the eligibility and support needs of patients. Part of this function is to be carried out by community matrons and review nurses.	Progress to date: This is an ongoing process and therefore spend is measured against budget on a monthly basis.	£500k	£500k

V. Recovery plan - Existing projects FY14

Supporting Programmes: Estates Management (Total: £1,102k)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY14 Savings	FYE
The CCG has a potential liability of c.£3.8m in association with the estate that transfers from Barnet PCT to NHS Property Services Ltd (NHS PS), Community Health Partnerships Ltd (CHP) or Central London Community Healthcare NHS Trust (CLCH). Financial liabilities essentially take two similar, but distinct, forms. •responsibility for the payment of rents on areas within CHP and NHS PS properties which are untenanted (vacant/void); and •responsibility for the payment of rent on areas within CHP and NHS PS properties which can be booked on a sessional basis.	The CCG has identified 9 work streams to mitigate the potential liability: •Manage the Sessional/Bookable Space •Relocate Services in Buildings Transferring to CLCH •Understand & Challenge Accommodation Charges •Project Manage NHS Property Services •Work with NHS Property Services on Disposals •Challenge the CCG's Accommodation Charges •Actively Manage the Whole Estate •Make Representation over Rental Income •Fitness for Purpose of Estate	<u>Progress to date:</u> The CCG has undertaken a detailed review of the Barnet estate with details of who occupies what space and full breakdowns of costs for all areas. From this the CCG has prepared a mitigation plan outlining work plans and business cases for each of the identified work streams and will be seeking formal FPQ committee approval for this strategy on 16 May <u>Major Milestones:</u> •31st May – Sessional Booking & Invoicing procedures in place to secure incomes (interim) •30th August – Strategic Estates Plan in place with longer-term restructuring planning to be undertaken with NHS PS	£1,102k	£2,100k

V. Recovery plan – FY15 and onwards

Further areas identified for investigation to deliver QIPP savings for FY15 and beyond are shown below and described on the following pages:

	New Opportunities FY15 and onwards	Benchmarked Potential Opportunity
		£'000
Health and Wellbeing		
Children and Maternity	• Maternity national tariff (Full year 3impact from FY14) • Paediatric assessment units	£1,800k
Elective Care	• Cardiology • Outpatients • Excess bed days	2014/15 £12,545k 2015/16 £5,979k Total £18,524k
Emergency and Urgent Care	• Ambulatory emergency care • Excess bed days • Care homes • Ambulance service • Decommissioning of specific services • Integrated assessment services • Clinical navigator	2014/15 £5,814k 2015/16 £4,375k Total £10,819k
Mental Health	• The RAID model	Only excess bed days identified as an opportunity within the original business case. Further work required to confirm savings
Integrated care	• Integrated Care programme for the frail elderly and people with long term conditions to reduce costs associated with secondary care admissions and residential care	This is required to deliver the savings above
Other	• Estates rationalisation (Full year impact from FY14)	2014/15 £2,100k
TOTAL		**2014/15 £20,159k** **2015/16 £12,454k** **Total £32,613k** **Three year total £49,663k**

V. Recovery plan - Projects for FY15

Children, Young People and Maternity

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY15 Potential Savings
Maternity – national tariff Issue: In respect of maternity, contractual terms are being negotiated with the two largest providers, Royal Free and Barnet and Chase Farm. There is a need to agree the estimated activity and case split with the providers. There is also a recognition that PbR and loss of income should be shared between commissioner and provider.	Second year of savings are to be achieved through a mandatory tariff change imposed by the Department of Health and through contract specification. Outcome of Scheme: Implementation of the Maternity Pathways Tariffs by April 2013.	The nationally mandated tariff is embedded within the national contract for acute services. Contracts with the main providers of maternity services have been agreed for 2013/14	£3.2m

V. Recovery plan - Projects for FY15

Children, Young People and Maternity

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY15 Potential Savings
Children's services- Non Elective The volume of outpatient appointments has been addressed through a triaging service. Inpatient non elective admissions are above the national average and will be addresses through the development of a paediatric assessment model and a range of community based services.	A review as taken place as part of the BEH clinical strategy, on the paediatric pathway. It has recommended the implementation of Paediatric Assessment Units (PAU) at both Chase Farm and Barnet hospitals. The primary benefits of this service are the quality of care received on a defined and appropriate pathway in the right setting. It is expected that assessment tariffs will be applied to the PAU pathway. There a number of community paediatrics projects which have commenced which include: • Triage of GP referrals by paediatric consultant • Community Ambulatory Care Service • Telephone advice for primary care, schools and local authorities • Rapid access	The current work includes determination of the staffing requirements and the clinical pathways for the PAU. The implementation date for the BEH strategy is November 2013. A paper which sets out the direction of travel for Barnet paediatric pathways is being drafted and stakeholders engaged in the proposed models. The triage service has commenced and forms part of the FY14 QIPP plans. The ambulatory care service is being introduced and should as it scales up, receive patients from urgent care, primary care and the community. Upon agreement of the direction of travel and formal project plan, activity benefits realisation will be developed.	Reduction in tariff for PAU Reduction in tariff (70%) Community Ambulatory Care Service.

V. Recovery plan - Projects for FY15

Elective Care QIPP 2014/15 and 2015/16

The table outlines where there is scope to reduce costs, identified through a national and peer group benchmarking exercise. These have been risk adjusted by 20%.

We intend to deliver these through a collaborative approach with our two main acute provider trusts and have already begun this work with them and agreed a shared approach.

The drivers behind this are the needs to reduce the commissioning spend of Barnet CCG, as well as the requirement to significantly reduce acute activity as part of the BEH clinical strategy.

The proposed merger of Barnet and Chase Farm and the Royal Free Hospitals will also support collaborative working and shared protocols as well as reduced activity.

In Patient Elective Admissions	Potential Savings	Risk Adjustment at 20%	Total Risk Adjusted Savings	Risk adjusted savings 14/15	Risk adjusted savings 15/16
Childhood and neonates	£668.00	£133.60	£534.40		£534.40
Female Reproductive System and assisted reproduction	£688.00	£137.60	£550.40	£550.40	
Mouth Head Neck and Ears	£1,219.00	£243.80	£975.20		£975.20
Vascular System	£1,188.00	£237.60	£950.40	£950.40	
Skin Breast and Burns	£1,646.00	£329.20	£1,316.80	£1,316.80	
Total Elective	**£5,409.00**	**£1,081.80**	**£4,327.20**	**£2,817.60**	**£1,509.60**
Outpatient Attendances					
Cardiology	£4,432.00	£886.40	£3,545.60	£3,545.60	
Clinical Haematology	£437.00	£87.40	£349.60		£349.60
Clinical Ocology	£912.00	£182.40	£729.60		£729.60
Dermatology	£860.00	£172.00	£688.00	£688.00	
ENT	£753.00	£150.60	£602.40	£1,201.40	
Gastroenterology	£1,502.00	£300.40	£1,201.60	£1,201.60	
Medical Oncology	£742.00	£148.40	£593.60		£593.60
Midwife Episode and obstetrics*	£1,600.00	£160.00	£1,440.00	£1,440.00	
Nephrology	£1,324.00	£264.80	£1,059.20		£1,059.20
Ophthalmology	£1,389.00	£277.80	£1,111.20		£1,111.20
Paediatrics	£690.00	£138.00	£552.00	£552.00	
Respiratory Medicine	£783.00	£156.60	£626.40		£626.40
Rheumatology	£1,374.00	£274.80	£1,099.20	£1,099.20	
Total Out patient attendances	**£16,798.00**	**£3,199.60**	**£13,598.40**	**£9,727.80**	**£4,469.60**
Total Potential QIPP Elective and Outpatient Attendances			**£17,925.60**	**£12,545.40**	**£5,979.20**

* Savings quoted for maternity and obstetrics reflect impact of new national tariff and are risk adjusted at 10% as opposed to 20%

The work with Barnet and Chase Farm and the Royal Free has already begun through a series of workshops looking at service redesign and identifying key features of success. Agreement following this was that these would be

- Robust primary protocols in place, rigorously enforced
- Single point of access
- Most senior clinician at the front end, ensuring that triage was effective
- One stop shop services where possible.

V. Recovery plan - Projects for FY15

Elective Care

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY15 Potential Savings
Cardiology Issue: Benchmarking has identified that the CCG has higher than average cardiology GPs and consultant to consultant referrals. Although there is to be a shift of activity from the acute providers to a community service in FY13, approximately 50% of patients still require referral into the acute trust. BCFHT currently charge, in addition to the outpatient tariff, a Consultant to Consultant referral charge for each diagnostic test, with over one hour's time lapse.	The following options could be used to address the issue of charging for individual diagnostics at Consultant to Consultant rates: 1. Negotiate an integrated assessment process from the Trust which includes all investigations at a lower cost than the existing arrangements [cost from Paul] 2. Use an alternative provider to provide the cardiology service, to include diagnostics at a lower cost. The community hospitals could be used as the setting to deliver the service. 3. The Referral Management System could be used to approve the additional diagnostic tests, however this would not be a streamlined solution.	Milestones: • Obtain comparative rates for diagnostic tests and determine the potential savings. • Research and propose a list of viable options for re-providing or renegotiating the service. • Complete an options appraisal process and present paper to the Board. • Complete Business Case for service change and dependant upon the outcome: - Draft revised Service Specification - Agree with the acute the tariff for an integrated service and serve notice and implement or - Tender and award new service contract to an alternative provider.	

V. Recovery plan - Projects for FY15

Elective Care

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY15 Potential Savings

Outpatients
Issues:
There is a high volume/cost of for OP appointments in a number of specialties, the key areas are:
• Cardiology
• Nephrology
• Rheumatology
• Ophthalmology
• Respiratory medicine
• Gastroenterology
 	
The gross opportunity to make savings is:
£6,250k to national average
£9,353k to Upper 20th centile
	• In order to understand the issues and the activity which have impacted on the benchmark data is to be reviewed:
	  • First Outpatient appointment
	  • Follow up
	  • Consultant to consultant referral
	• Clinical conversations will then take place to agree the appropriate settings and treatments:
	  • Is the follow up required at all?
	  • Can it be provided in a primary or community care setting rather than the acute?
	• Determine what will be required to be commissioned in an alternative setting and how it could be delivered.
	• Where community services such as MSK are in place, in receipt of the drilled down benchmarking data, a review of the current service will take place, if required.
		Milestones:
		• Design service specification and confirm pathway with all key stakeholders for each area.
		• Confirm new pathway, roll out to all necessary parties.
		• Make any contractual changes required to facilitate new services.
		• Implement regular monitoring processes to confirm adherence to referral pathway and outcomes
			OP new
			OP follow up
			C2C referrals

V. Recovery plan - Projects for FY15

Elective Care

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY15 Potential Savings
Excess bed days The excess bed day costs for elective inpatient stays in Barnet CCG is £892,000 which ranks Barnet CCG 70th nationally.	In order to understand the specialties and HRGs which have impacted upon the excess bed day costs, the CCG Trust data requires detailed analysis to determine the reasons for the excess bed days Discussions will then be held with the acute trusts, specialty leads and community services, if required to agree an action plan put in place processes to reduce length of stay e.g. • Reduce pre-operative bed day admissions • Effectively utilise EDD to manage patients through the elective pathway • Co-ordination of discharge processes	<u>Milestones:</u> • Review data set • Highlight areas for further review and investigation • Agree action plan on a specialty basis • Monitor implementation of plan and maintain exception reporting process	In patient elective admissions

V. Recovery plan - Projects for FY15

Emergency and Urgent Care QIPP 2014/15 and 2015/16

The table outlines where there is scope to reduce non-elective costs, identified through a national and peer group benchmarking exercise. These costs have been risk adjusted.

We intend to deliver these through a collaborative approach with our two main acute provider trusts and have already begun initial work with them by agreeing a shared approach to service redesign:

- Single point of access
- Most senior clinician at the front of service, ensuring effective triage
- One Stop shop where appropriate
- Robust primary protocols in place, rigorously enforced

The drivers behind this are the need to reduce the commissioning spend of Barnet CCG, as well as the requirement to significantly reduce acute activity as part of the BEH clinical strategy.

In Patient non-elective Admissions	Potential Savings	Risk Adjustment at 20%	Risk Adjustment at 10%	Total Risk Adjusted Savings	Risk adjusted savings 14/15	Risk adjusted savings 15/16
Female Reproductive System and assisted reproduction	430	86		344	172	172
Obstetrics *	1600		160	1440	1440	
Respiratory	2660	532		2128	1064	1064
Total non-Elective	4690	938	160	3912	2676	1236
Length of Stay						
length of stay - proportion of all inpatient non-elective 0 days	3,308	661.6		2646.4	1323.2	1323.2
Total admissions 0 day in-patient admissions from A&E	2,787	557.4		2229.6	1114.8	1114.8
	6095	1219		4876	2438	2438
Total Potential QIPP Non-Elective inpatient admissions				8788	5114	3674

*New National Tariff - Maternity**

V. Recovery plan - Projects for FY15

Emergency and urgent care

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY15 Potential Savings
Ambulatory Emergency Care (AEC) The benchmarking data shows Barnet CCG as an outlier for the proportion of inpatients who have a zero length of stay. The gross opportunity to make savings is: £3.3m to national average £7.8m to Upper 20th centile In addition, the CCG spends £29m on 0-2 day length of stay for patients > 65 years old.	Further develop to an 'industrial scale', the emergency ambulatory approaches for the 49 AEC clinical conditions. The scheme will increase the number of appropriate discharges from emergency departments; and secondly, where this is not possible, to increase the number of emergency admissions that have a zero day length-of-stay. Utilisation of the Best Practice tariff for a range of conditions is to be considered and appropriate tariffs commissioned. However, an opportunity exists to consider how these can be further improved to: a) provide alternative non-bed based pathways to deflect such activity; and b) extend / expand the number of areas / HRGs currently being considered.	Develop a business case to address the progress to date and the potential opportunities to develop further AEC pathways. An example of the key milestones is shown in the appendix.	Non elective inpatient admissions 0-2 days > 65 years
Excess bed days The non- elective excess bed day costs for Barnet CCG are £2,802,000	A review is required to understand the reasons for incurring excess bed day costs. Part of the investigation into costs will examine how patients move into the community setting from acute, the delays in transfers of care, including gaps in services, social care delays and equipment requirements.	Carry out audits of the reasons for delay in the discharge of those patients that are medically fit for discharge. Review data, ascertain the gaps in service or other capacity issues in community, primary or local authority.	Non- elective inpatient admission costs

V. Recovery plan - Projects for FY15

Emergency and urgent care

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY15 Potential Savings
Other Urgent Care initiatives to be considered: **Development of Integrated Assessment Services**	The establishment of a combined primary and acute led service at the front of A&E to provide a rapid assessment of all walking patients prior to them presenting at A&E. The service has the potential to result in reduced A&E attendances and short stay admissions by diverting any inappropriate attendances to alternative services. Utilising GPs to support junior doctors as part of the A&E team could increase the level of early discharges from A&E.		Non elective attendances and admissions
Excess bed days	Due to the nature of PbR reporting, proactive discharge management is required . Working with the acute trusts, an audit can be carried out determine the reasons for being an inpatient and gaps in services in primary and community care can be identified and addressed. Daily reports from the acute trusts detailing all patients with over 20 days length of stay and discharge status can be utilised by the discharge teams to proactively manage these patients home. This cohort of patients normally accounts for 75%-80%+ of the excess bed day costs. In year savings may be possible from addressing this issue	• .Agree the areas which need improvement and agree a plan of action. • Commence daily reporting for the agreed cohort of patients and align the discharge teams to focus on these patients. • Monitor weekly and report monthly on progress.	

V. Recovery plan - Projects for FY15

Emergency and urgent care

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY15 Potential Savings
Ambulance Service The cost of the ambulance service contract is c £10m. Currently there is no visibility of contract, but it appears to be based on last year's activity and there is a lack of influence over the commissioning criteria.	In order to reduce the number of ambulance conveyances to the acute trust, there are a variety of services which could be discussed and can be commissioned from LAS. Some options are: • Hear and treat • See, treat and refer • See, treat and convey	• Understand the current contract with LAS • Review the conveyancing rates and develop a case for locally agreed service specifications • Detail the commissioning contract including performance metrics	Non elective attendances Non elective admissions
Decommission services Given the CCG's budgetary constraints, services are to be reviewed to determine the viability of the service. Community provision and other supply side services will be reviewed.	Approximately £4m is spent on Walk In Centres. These centres will be reviewed to determine the level of duplication or substitution of services, particularly with Primary Care. If the outcome of the review is case to decommission a walk in centre, formal consultation will.be required.	• Carry out a review of the activity in the walk in centres to determine the nature and primary care practice of the patients • Work with primary care to agree the reasons for attendance at the walk in centres rather than general practice • Model the changes to patient behaviour a walk in centre is closed • Carry out Equality Impact assessment and write business case for change • Commence consultation process	Community costs

V. Recovery plan - Projects for FY15

Mental Health and Learning Disabilities

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY15 Potential Savings
The RAID Model BCFH have busy Accident & Emergency Departments with more than 110,000 presentations per year and 40,000 admissions. Roughly 1,400 (1.3%) of these present with explicit mental health problems such as depression or self-harm. There is a trend across the country for more patients to present to A & E with mental health problems as open access mental health centres close due to financial pressures and changes in commissioning. Mental health patients can present significant problems for A & E staff because: · Staff lacking appropriate experience, skills and training · Health system processes are focussed on physical health patients	RAID is a Rapid Assessment Interface and Discharge psychiatry liaison service. An effective liaison psychiatry service offers the prospect of saving money as well as improving health. RAID is a service which offers comprehensive mental health support, available 24/7, to all people aged over 16 within the hospital. The analysis of cost savings of RAID focuses on the ability of the service to promote quicker discharge from hospital and fewer re-admissions, resulting in reduced numbers of in-patient bed-days. Most of these savings come from reduced bed use among elderly patients. The service also offers some potential savings in addition to reductions in bed use, such as fewer discharges of elderly patients to institutional care rather than their own homes. The study also stated that there are possible benefits in admissions avoidance with over 40% of all referrals to the RAID service during the study period came from A&E and it is possible that interventions by the service at this point may have prevented some in-patient admissions.	• Provider to Provider discussions between BEHMHT and BCFH have been taking place and BEHMHT has developed an initial business case for mental health liaison in Barnet General and Chase Farm hospitals. • Set up stakeholder meeting with all partners impacted by the proposed service (May/June) • Determine the impact, both costs and savings by partner and propose a way forward • Obtain agreement to fund and pilot the RAID model	Reduction in length of stay Admissions avoidance - reduction in non elective admissions **(cont)**

V. Recovery plan - Projects for FY15

Mental Health and Learning Disabilities

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY15 Potential Savings
The RAID Model	There may also have been a 'RAID-influence' effect, associated with the training of A&E staff by the RAID team. However, no information has been collected on such diversion at this point of entry into the hospital. Based on LSE savings identified for City hospital Birmingham, the RAID model could potentially deliver savings to the health economy in the range of £3.4 - £9.5m for BCF hospital patients. Most of these savings would come from reduced bed days from the elderly. The report also suggests a costs benefit ratio of more than 4:1.		

V. Recovery plan - Projects for FY15

Integrated Care (plans cross FY14 and FY15)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones 13-14 or 14-15	FY15 Potential Savings
Integrated Care •Elderly population is set to increase significantly over the next 10 years •Older people are more likely to be admitted to hospital following an A&E attendance •Older people are more likely to suffer from chronic and long-term conditions, mental health issues, fractures and falls •There is a high frail and elderly population utilising urgent care within Barnet. The CCG spent £29m on non elective admissions of patients over 65 years old, £22.6m of which was for patients over 75 years old.	The aim is to integrate Health and Social Care in a Care Outside of Hospital model to deliver the frail and elderly pathway and better manage long term conditions. The model will focus on: •Admissions avoidance •Proactive care of 'at risk' populations •Crisis intervention. The health and social care model is currently being rolled out within Barnet with some services operational and others planned for 13-14. The services will require ramping up, converting to 24/7 where necessary and to become fully integrated health and social care teams with a single point of access. <u>Outcome:</u> •Rapid response to prevent admission •Case management of most 'at risk' •Optimal LTC case management •Reduction in A&E attendance, admissions and nursing/residential home spend	Programme includes: •Rapid response service in place (to be extended) (Q1 13-14) •Risk stratification tool implemented in practices (Q1 13-14) •Care navigators and case managers in place to identify and manage patients 'at risk' (Q2 13-14) •Weekly MDT in place for complex patients (Q2 13-14) •Establish a multi-disciplinary frailty clinic at FMH (Q3 13-14) •Development of Integrated locality team incorporating health and social care (13-14) •Comprehensive falls service (Q2 13-14) •Stroke prevention and intermediate care (Q2-3 13-14) •Dementia hub planned (Q2-3 13-14) •Establish robust older peoples assessment at Barnet A&E (13-14) •Review current community palliative care pathway including link to enablement (13-14)	Non elective in-patient attendances Non elective inpatient admissions

V. Recovery plan - Projects for FY15

Integrated Care (plans cross FY14 and FY15)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY15 Potential Savings
Integrated Care (continued)	•Improved quality of life and independence •Provision for care closer to home	•Establish Advance Care Planning across all care agencies, including primary care (13-14) •Care Homes pilot scheme underway building on 'My Home Life' (started May 2013) •Develop single point of access to integrated locality teams (14-15) •Review discharge arrangements from secondary care into community and link to integrated pathways (14-15) •Strengthen self-management programmes and primary care management of LTC and ambulatory care pathways (14-15)	

V. Recovery plan - Projects for FY15

Integrated Care (plans cross FY14 and FY15)

Area/Issues to address	Nature of Plan	Progress to date and Key Milestones	FY15 Potential Savings
Community Hospitals	A review of the form and function of community hospitals to ensure that value for money and efficiencies are being achieved in relation to integrated care model. To include: •A review , with the acute trusts, of utilisation of the community hospital as a step down facility for those patients that are medically stable but have a long length of stay •A review of how any additional capacity can be used to enhance the care outside of hospital strategy. •A review of the functions and opportunities related to the on-site GP surgery/OOH/pharmacy and diagnostics in relation to the integrated care model	To be scoped and options appraisal carried out.	Non elective excess bed days A&E attendances Non elective admissions

V. Recovery plan - Projects for FY15

Supporting Work Programmes

Contract Negotiation and Management

CCG Lead: Steve Hobbs (Chief Financial Officer) **Clinical Lead: Dr Subel, Dr Frost and Dr Wagman**

The CCG contract negotiations for FY13/14 with its main providers, supported by the CSU, commenced with an offer of c.£196.8m, some £16.7m lower than the FY12/13 forecast out-turn.

Of this contract reduction £6.7m is related to productivity metrics for:

- A&E Conversion ratio;
- Daycase to Outpatient ratio;
- Consultant to Consultant referral rate; and
- First to Follow Up ratio.

Activity with the acute providers is seen by the CCG as the primary opportunity for QIPP. Whilst part of the QIPP opportunity results from providing alternative provision, and therefore reducing activity , a large part of the opportunity presents itself through improving the negotiation of provider contracts (of which the acute providers are the largest element) and effectively managing the contracts, and agreed metrics, following agreement. In particular it is looking to Support Trusts to achieve better procurement to deliver commissioner and provider savings including non-tariff drugs whilst:

- Using contract levers to drive quality improvement including incentives/penalties whilst maintaining focus on provider performance to ensure achievement of national & local KPIs.
- Further developing & implementing effective QIPP, CQUIN & productivity metric programs to drive service improvement through the use of appropriate ratios to manage patient pathways, including outpatient contacts
- Developing challenges to support fair reimbursement to providers for high quality patient pathways, including avoiding inappropriate acute admission.
- Monitoring delivery of the productivity and QIPP challenges through the PMO

In negotiating acute provider contracts the CCG is the contract lead for the Royal Free, CLCH and RNOH Contracts with other CCGs leading with its remaining providers.

The ‘cluster’ negotiation of contracts is a challenge for the CCG given its financial position which drives a need for greater opportunities to be delivered from its contracting arrangements. As a result the CCG is seeking to drive robust collaborative contracting arrangements agreed with local CCGs and supported by the CSU.

V. Recovery plan - Projects for FY15

Supporting Work Programmes

Contract Negotiation and Management

CCG Lead: Steve Hobbs (Chief Financial Officer) **Clinical Lead: Dr Subel, Dr Frost and Dr Wagman**

Future contracting strategy:

Building on the FY14 contracting round, and focussing on best practice, future contract strategy will seek to:

- Develop an overall 3 year contracting strategy approach underpinned by our commissioning plans and start to signal the scale of contract value change envisaged .
- Work with our providers to agree an agreed contract change phasing approach based around the scale of income/cost change that can be feasibly delivered in year.
- Focus providers on moving to upper quartile performance targets e.g. for out-patient follow up
- Include upper ceiling caps into known areas of potential high activity cost variance eg consultant to consultant referral, 0-1 admissions, direct access to diagnostic areas, critical care episode costs.
- In areas where we are planning major pathway change –e.g. the development of emergency ambulatory care pathways that avoid in – patient admission , we will seek to move away from current PbR tariffs and agree a new local tariff structure that 'shares' the savings profile and hence incentivises the provider to provide the new type of pathways.
- Align Barnet with our partner CCGs on both contractual changes and performance metrics to provide a stronger consolidated position.

This strategy will continue to:

- Involve GP leads in setting contract performance parameters (e.g. service quality , efficiency , shared activity management approaches).
- Require clear provider KPIs aligned to our commissioning and financial plans. In particular non -cute contracts will contain SMART objective driven KPIs to manage productivity/ efficiency , service quality, patient experience and outcomes.

In respect of Block/non-PbR contracts we, working with the CSU, will:

- Undertake a programme of joint work with providers to understand the activity and cost profile and outcomes associated with the portfolio of services commissioned to review the effective value of particular services as part of our priority based funding exercise.
- In conjunction with providers , ensure regular benchmarking of non PbR services.
- Pursue a targeted programme of deep dive review on areas of expenditure / services where provider costs appear to be high.

Appendix 2: Barnet Enfield and Haringey (BEH) Clinical Strategy Update

Barnet Enfield and Haringey (BEH)
Clinical Strategy
June 2013 Update By Barnet CCG

1. This paper provides an update from NHS Barnet Clinical Commissioning Group on progress of the implementation of the planned changes set out in the BEH Clinical Strategy including current issues and next steps.

2. From 1 April 2013 the programme is hosted by Enfield CCG on behalf of Barnet Enfield and Haringey CCGs, with Liz Wise as the Senior Responsible Officer. The programme team continues with Siobhan Harrington as Programme Director.

3. The programme is currently on track to deliver the planned changes by the proposed date of November 2013. Appendix 1 includes the governance structure for the programme.

4. Workstreams update. There are four joint clinical workstreams that meet regularly and are responsible for the delivery of the detailed programme changes. The senior responsible officers for each joint workstream report directly to the programme board.

Emergency Care
The emergency care workstream is chaired by the Director of Operations from North Middlesex University Hospital Trust. It includes implementation of urgent care centres and acute hospital pathways as well as emergency care across both Trusts. London Ambulance Service is also involved in this workstream. A key milestone has been to ensure that urgent care centres are in place in all three hospital sites from April.

Maternity and neonates
The maternity and neonates workstream is chaired by the Director of Planned Care at Barnet and Chase Farm Hospitals NHS Trust. There has been work to capture and track bookings across both Trusts and agreement on booking processes which have started in April. The model of care for maternity has been agreed including maintaining maternity outpatient services at Chase Farm post implementation of the planned changes.

Communications have been disseminated regarding the planned changes to GPs and stakeholders and a publicity campaign has started to inform the public about where they can book their birth beyond November 2013, should the changes be made then.

The Trusts are working through the detail of their workforce plans. Both Trusts will be meeting the agreed 2013 London Quality and Safety standards as a result of the changes and will have 98 hours of labour ward consultant cover in place from the date of implementation.

Paediatrics
The paediatric workstream is now chaired by the Director of Nursing from Barnet and Chase Farm Hospitals NHS Trust. The workstream is currently finalising the service model for the paediatric assessment unit on the Chase Farm site to be ready from November, should the changes be made then. Detailed workforce plans are now in place and work has started to consider the communications needed regarding the changes. The changes will enable a new service model for paediatric emergencies which give greater and swifter access to Consultant input.

Planned care
The changes planned with regard to planned care are within Barnet and Chase Farm Hospitals NHS Trust and will result in complex surgery taking place at Barnet Hospital and less complex surgery taking place on the Chase Farm Hospital site. Detailed plans are in place. The clinicians recently delivered a presentation to the Clinical Cabinet and spoke of the benefits of the changes to patients, in that having planned care only on the Chase Farm site will result in fewer cancellations for patients, the meeting of quality and safety standards and better training opportunities for staff. Both an internal and external communications plan is being developed.

There are also enabling workstreams of workforce, estates, finance, communications and engagement, all of which report into the BEH Clinical Strategy programme board. Each Trust has a BEH Clinical Strategy focused programme board which meet monthly to track the trust's plans and progress.

5. The work of the clinical cabinet

The clinical cabinet meets monthly and has a key role in assuring quality and safety through the transition as well as ensuring the services being established are established effectively and safely. The group is chaired by Dr Nicholas Losseff, the programme medical director, past Medical Director at NHS North Central London and now a NHS England Clinical Director. The membership of the clinical cabinet includes the nursing and medical directors of both Trusts and the lead GPs from each CCG. The cabinet reviews a clinical scorecard reporting on the four domains of performance, patient experience, serious incidence and workforce; the group review a clinical risk register and also conduct a series of deep dives in to each of the workstreams on a rolling programme.
As part of this work they are also focused on the detail of the delivery plans and securing an external clinical assurance process.

6. Current issues

6.1 Workforce. There are significant workforce changes planned to enable the service changes to happen. Barnet and Chase Farm Hospitals NHS Trust are currently consulting with staff and the North Middlesex University Hospitals NHS Trust have commenced an extensive recruitment campaign.

6.2 Capacity planning. There is a focus in all three boroughs on working on the detail of capacity planning, building on work that usually takes place to consider plans for winter. There was a workshop held on 22 May across Barnet, Enfield and Haringey with colleagues from Hertfordshire where there was a presentation on the experiences of last year alongside consideration of the changes being planned for the year ahead. All

boroughs agreed to reinvigorate their processes for capacity planning and to enable the conversations now ensuring that both social services and community services are engaged in considering the implications of the changes.

6.3 Quality and safety through transition. The work of the clinical cabinet continues. The last Deep Dive considered maternity and neonatal services.

6.4 Enfield Council and public concerns. As Board members are aware these planned changes have been difficult for some local people and work continues on communications and engagement to explain why these planned changes are to take place , the benefits they will bring, and listening to people's views and concerns. Over the last three months there has been BEH Programme attendance at various area fora, Transport User groups, Overview and Scrutiny Committees, and Health and Wellbeing Boards, as well as Practice visits. This engagement will continue.

6.5 The assurance process that will inform CCGs and Trusts that it is safe to implement the changes is being confirmed. The programme office is working with colleagues from NHS England. The process started at the beginning of May and will run alongside the work of the clinical cabinet involving visiting sites and talking with clinicians and other staff. There will be an interim report and then a challenge meeting in early September at NHS England which will result in a letter to the CCGs to inform their decision at the end of September. The three CCGs will look at this together with all other relevant evidence and will make a decision about timing of the implementation of the proposed service moves.

7. Next steps

• Building work continues at both Barnet Hospital and the North Middlesex University Hospital sites
• Recruitment campaign at the North Middlesex University Hospitals Trust underway.
• Continued focus on quality and safety of services now.
• Factsheets being finalised explaining the planned service changes.
• Practice engagement.
• Governance discussion to agree external assurance process and plan for the decision making meeting for CCGs at the end of September.
• Ongoing communication and engagement with the public.
- Campaign regarding planned maternity changes followed by a campaign informing people of the planned emergency care changes.

This page is intentionally left blank

Appendix 3: Acquisition of Barnet and Chase Farm by the Royal Free update

1. Introduction

This report provides an update from the NHS Barnet Clinical Commissioning Group Board on the current progress being jointly made between commissioners, Barnet & Chase Farm Hospital and the Royal Free NHS FT in respect of the proposed acquisition by the Royal Free NHS FT of Barnet and Chase Farm Hospital.

In July 2012 the Barnet and Chase Farm Board concluded that it was not likely to become a foundation trust alone and invited competitive proposals from potential partners to create a larger foundation trust. The Royal Free NHS FT was subsequently formally accepted as its preferred partner. Subsequently, discussions have been ongoing since last autumn between Barnet and Chase Farm Hospitals NHS Trust (BCF) and Royal Free London NHS FT about the potential for the Royal Free FT to manage the three hospitals as a single organisation.

The Royal Free NHS FT approved a Strategic Outline Business case (SOC) in February 2012 and is now planning to consider the Outline Business case (OBC) in July 2012.In doing so they will require beforehand the joint support of local commissioners. If approved the NTDA will then undertake due diligence on the OBC before it being considered by Monitor and CCP.

This paper summarises the progress made to date and outstanding requirements in respect of: clinical provision and pathway redesign, finance and activity input to the OBC, governance, decision making and communications & engagement.

2. Key Merger Principles

The following 'key parameters' for the merger have been developed jointly by the Royal Free NHS FT and local CCG representatives and have been signed off by the commissioner acquisition steering group.

1. ***Maximum demand management, top decile efficiency in hospitals, all resulting in commissioner savings enabling CCGs to achieve their financial duties***

a)Standardisation of clinical thresholds across integrated primary, community and secondary care services ; all GP referrals through choose + Book
b)Emphasis on evidence based medicine
c)Increased management of long term conditions in primary care within the current primary care strategy
d)Integration of community providers' services across primary and secondary care
e)Investment in appropriate integrated assistance technology across providers as an alternative to face-to-face consultations
f)Work with Local Authorities to support integrated care models including physical and mental health integration
g)Locally-delivered high quality and integrated models of care are the services of choice for patients
h)Consultant delivered effective triage

2. ***Structural change, all enabling reduction in CCGs' outgoings***

a)New models of planned care delivery allow fixed and variable costs within the hospital to be reduced
b)Appropriate use of community-based resources/locations for eg community hubs

c)An appropriate estates footprint to match the clinical model – all services
d)Shared patient/client records across the health and social care system within appropriate information governance arrangements in place

3. ***Incentivisation, all linking the parties together to act in concert towards achieving sustainable future***

a)Commissioning for outcomes
b)Delivering a payment and reward transaction system to support the clinical role
c)Ensure stability of the Healthcare economy during transition
d)To have completely delivered by April 2019

3. Clinical Provision and Pathway Transformation

3.1 A joint clinical vision is being developed based upon the current relevant CCG commissioning strategies together with a narrative about the benefits for patients from a merged organisation. The main focus will be on implementing local integrated care strategies and specifically for both Barnet and Enfield CCGs ensuring that these are closely aligned to their financial recovery plans.

3.2 This work will need to build on the positive outcomes and energy generated at the clinical pathway workshops held in late early May between primary and secondary care clinicians in the CCGs, Royal Free and Chase Farm Hospitals. These workshops developed the first tranche of proposed new pathways which now need to be worked up in more detail and proceed to redesign and implementation at pace.

The proposed lead CCGs for developing the new pathways are as follows:

- Barnet CCG – Cardiology, Respiratory and Gynaecology
- Enfield CCG (with East & North Herts & Herts Valleys CCGs) – MSK/Pain/Rheumatology
- Camden CCG - Colorectal/GI/Hepatology

3.3 By definition this will require cross organisational collaboration and alignment of clinical and managerial effort. In order to facilitate this pathway development work, a clinical transformation group of lead primary and secondary care clinicians is proposed to be established, to be chaired by Dr Sue Sumners, CCG Chair, Barnet CCG.

4. Finance activity OBC requirements

4.1 The current timeline is for the OBC for the proposed acquisition to be considered by the Royal Free Board at the end of July 2013 and therefore a joint signed letter of support from commissioners has been requested by 18th July.

4.2 The OBC needs to include a detailed 10 year (first 5 years developed in detail, with assumptions rolled forward to year 10) activity and financial model for the proposed new merged trust which is 100% aligned with existing commissioner plans and also demonstrates a balanced financial position for the merged Trust within an agreed time-frame (likely to be c.5 years).

4.3 Commissioners with an interest include: NHS England, Barnet, Enfield, Camden, East and North Herts, Herts Valleys CCGs and to a lesser degree Islington & Haringey CCGs.

4.4 All CCGs are planning for significant reductions in secondary care spend – in line with integrated care/out of hospital strategies. The planned activity reductions are greatest in Barnet and Enfield which are reflective of CCG deficit positions and current high levels of acute activity and historic imbalance within the health economy.

5. Finance activity modelling

5.1 As a key part of the finance activity modelling NHS E and CCG CFOs have been asked to quantify target top level required commissioner activity & finance reductions (ie: future income vs. current income)

5.2 Detailed planning now needs to progress regarding how and where these activity reductions will be delivered ie: POD/site specific, as well as the impact of integrated care and clinical pathway redesign proposals. The Royal Free NHS FT is leading this work and CCGs via their CSDs have been asked to provide briefing materials to support this modelling work**.** In addition, bilateral meetings are being arranged and it is proposed to hold a workshop event on 26th June to review this work and ensure that the Royal Free OBC modelling work aligns with CCG commissioning assumptions.

5.3 In respect of provider economics, the Royal Free NHS FT is developing plans to reduce expenditure in line with reduced income through back office and operational clinical service delivery redesign. It is proposed that they will provide a progress report at the 26th June workshop referred to above.

5.4 Transitional support is likely to be required by the new merged organisation in order to address historic deficits at BCF and while it still works to deliver the cost savings required in response to commissioner activity plans. The OBC will seek to quantify the level of transitional support required and identify the timeline for the new organisation to achieve financial balance.

6. Governance and decision making

6.1 An informal discussion was held with both the NHS England & the TDA leads for North London on 29th May to discuss respective organisational roles and responsibilities going forward, the decision making process and mechanism in respect of transitional support. A follow up meeting on the latter is being organised as a priority as this is likely to be a key issue and will need absolute alignment on the position between CCGs and NHS England on level and source of transition funding required.

6.2 Commissioner sign off of the OBC will be required in order to:

- confirm support for clinical vision and expected clinical benefits for patients
- sign off activity and financial assumptions – ie: confirm alignment with commissioning activity plans and agree provider assumptions re: delivering balanced provider I&E position, including indicative transitional support requirements.

6.3 The expectation is that CCGs will sign a joint letter of support confirming the above by mid July to support RF Board decision making process scheduled for the end of July and TDA assurance processes scheduled for August.

7. Communications and engagement

7.1 The Royal Free NHS FT and CCG`s are currently developing a communications and engagement strategy and key messages for internal and external stakeholders. These are now being finalised and an action plan developed in order to ensure key priorities and an overall approach for June/July (ie: OBC stage) is achieved.

7.2 A regular communications workstream with representatives from the Royal Free NHS FT, Jonathan Street and CSU (on behalf of CCGs) is being established.

7.3 A more comprehensive engagement phase is being planned for the autumn and FBC development stage.

Meeting	Health and Well-Being Board
Date	27 June 2013
Subject	**Barnet Clinical Commissioning Group – Integrated Care Plan for 13/14**
Report of	Chief Officer, Barnet CCG
Summary of item and decision being sought	This paper is for the Health and Well-Being Board. The Board is asked to consider and approve the Barnet CCG Integrated Care approach and outline plans for 13/14.

Officer Contributors	Maria O'Dwyer, Barnet CCG Director of Integrated Commissioning, Barnet CCG
Reason for Report	The Board is asked to consider and approve the Barnet CCG Integrated Care approach and outline plans for 13/14.
Partnership flexibility being exercised	N/A
Wards Affected	All
Contact for further information	Maria O'Dwyer, Barnet CCG Director of Integrated Commissioning, MariaODwyer@barnetccg.gov.uk

1. RECOMMENDATION

1.1 The Health and Well-Being Board is asked to consider and approve the Barnet CCG Integrated Care outline plans for 13/14 (attached as Appendix 1) subject to agreeing the implementation as outlined in 7 below.

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 This paper has been developed with Clinical leads and is based on national best practice guidelines as identified by research and guidance available nationally including from Kings Fund. The proposal provides more detail of the strategy outlined in the CCG strategic plan and recovery plan both of which have been approved by the governing body.

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

3.1 The intention is for the work to be jointly commissioned and it will therefore impact on joint workplans. The plan sets out the Barnet Clinical Commissioning Group vision, strategic objectives and clinical commissioning programmes and explains how these reflect the key themes from the Barnet Joint Strategic Needs Assessment. It confirms how these will support the implementation of the Health and Well-Being Strategy and the achievement of the NHS Mandate and NHS Constitution standards.

4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 As the proposals develop full needs assessments and equality impact assessments will be considered.

5. RISK MANAGEMENT

5.1 Risks identified within the plan will be managed through the Barnet Clinical Commissioning Group Board Assurance Framework and Risk Register.

6. LEGAL POWERS AND IMPLICATIONS

6.1 Section 12 of the Health and Social Care Act 2012 introduces section 2B to the NHS Act 2006. This imposes a new target duty on the local authority to take such steps as it considers appropriate for improving the health of people in its area.

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

7.1 The proposals will require funding for specific projects which will be dealt with on a project basis through the Health and Well-Being finance group and the Integration Board. Further work is required to agree the implementation through the Health and Social Care Integration Board and the Health and Well-Being finance group

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 Each Clinical Commissioning Programme project will consider communication and engagement with users and partners.

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 Each Clinical Commissioning Programme project will consider membership from providers and communication and engagement with providers.

10. DETAIL

10.1 Introduction

NHS Barnet CCG continues to be committed to improving the quality and outcomes of the services we commission for the people of Barnet. As identified in the Recovery plan Barnet CCG has ambitious plans to improve patient experience and safety and reduce costs. To do this we need to undertake some significant changes in how care is delivered in the community to align primary, secondary and community services; in other words providing the right care in the right place at the right time. To support this approach care pathways will be designed to deliver opportunities to prevent a decline in well-being and independence. This also includes offering patients and their family and carers control and choice in the way those needs are met, and to offer a range of early intervention and support services linked to the individual. The aim will be, with Social Care and key stakeholders, to have a seamless system in place, working at a local level, to support people both in a crisis and with long term conditions.

Barnet recognises a key challenge as its elderly population is set to rise by 21% over the next 10 years. Assuming that there are no changes in the existing care pathway and that this group continues to access services at the current rates there will be significant pressure on both the health and social care system; so changes in how care is delivered are essential to improve patient care and alleviate future pressures. To support this Barnet CCG and LBB have been working together to develop joint commissioning and to streamline commissioning activity through an agreed shared / joint work programme. The key opportunities will be:

- To develop consistent, quality and outcome focused commissioning programmes and projects across health and social care
- To deliver sustainable recurring efficiency saving across Health and Social Care commissioning with a focus on value for money and quality in line with Council and CCG financial sustainability plans.

The attached paper outlines the CCG's identified priorities that will form part of the work plan which will need further project development and funding to achieve delivery.

10.2 Planned approach

<u>Barnet Model</u>

Central to the future delivery model in Barnet is the development of a fully integrated care team based in each locality. Integral to this development will be joint working with Social services to develop support and appropriate interventions available to patient/customers remaining in the community, for example through enablement services. The teams will incorporate health and social care and will address patient need through a single point of access. The locality based teams will be designed to support and manage care from self-management through periods of crisis, and into end of life pathways where necessary. A number of services (existing and new) will be aligned to

link with the locality based teams providing a seamless flow for patients (These services are outlined in the attached paper and diagram on page 9).

This framework will help to ensure that patients avoid hospital admission where possible, and are able to return home following a hospital episode as soon as possible, with appropriate support to maintain independence. The models will, as stated previously, support in managing Barnet's increasing ageing population and increases in the number of people with multiple long-term conditions.

10.3 Recommendation

The Health and Well-Being Board is asked to consider and approve the Barnet CCG Integrated Care outline plans for 13/14.

11. BACKGROUND PAPERS

None

Integrated Care in Barnet

Introduction

Barnet Clinical Commissioning Group and the London Borough of Barnet have been working together to give greater numbers of people in Barnet, of all ages, the opportunity to live healthy, active lives; to help prevent avoidable illnesses, and to manage long term conditions more effectively. Barnet is initially looking at elderly population which is set to rise by 21% over the next 10 years and assuming there are no changes in the existing care pathway and this group continues to access services at the current rates there will be significant pressure on both the health and social care system so changes in how care is delivered are essential to improve patient care and alleviate future pressures.

Many people with long term conditions are often at risk of deteriorating health, reduced wellbeing and lack of independence. This can lead to an increase in hospital admissions, more extensive involvement of health/social care and reduction in control of their own lives. From an individual point of view people want to manage their own lives and remain independent, retaining contact with family, friends and support networks. Barnet CCG and the London Borough of Barnet aim to support people to have the best possible quality of life in a setting at or close to home for as long as possible. From a systems perspective, providing Hospital and Residential care for this group represent significant financial cost to both health and social care budgets. The challenges faced in Barnet in relation to meeting these needs are mirrored in other London Boroughs and across England.

To support these patients, we will continue to redesign and integrate services to meet the population's health and social care needs and to meet people's changing aspirations. Care pathways will be designed to deliver opportunities to prevent a decline in well-being and independence, to offer patients and their family and carers control and choice in the way those needs are met, and to offer a range of early intervention and support services linked to the individual. We will do this by designing integrated Health and Social Care systems and teams working at a local level to support people both in a crisis and with long term conditions. The Health teams will include primary, community and secondary care and we will commission community services which support primary care in delivering this new system.

NHS Barnet CCG working with the London Borough of Barnet is committed to developing a range of long term conditions and rapid response services building on existing progress and expects to see considerable progress in implementation during 2013 to 2016 reflecting a significant reduction in hospital activity as set out in the CCG's strategic commissioning plan.

The London Borough of Barnet and Barnet CCG are committed to the vision of the Barnet Health and Social Care Concordat:

Health & Social Care Concordat

We will work together tirelessly to deliver the Barnet vision of integrated care so that Mr. Colin Dale and others like him enjoy better and easier access to services.

Care integration in Barnet will place people and their carers at the heart of a joined up health and social care system that is built around their individual needs, delivers the best outcomes and provides the best value for public money.

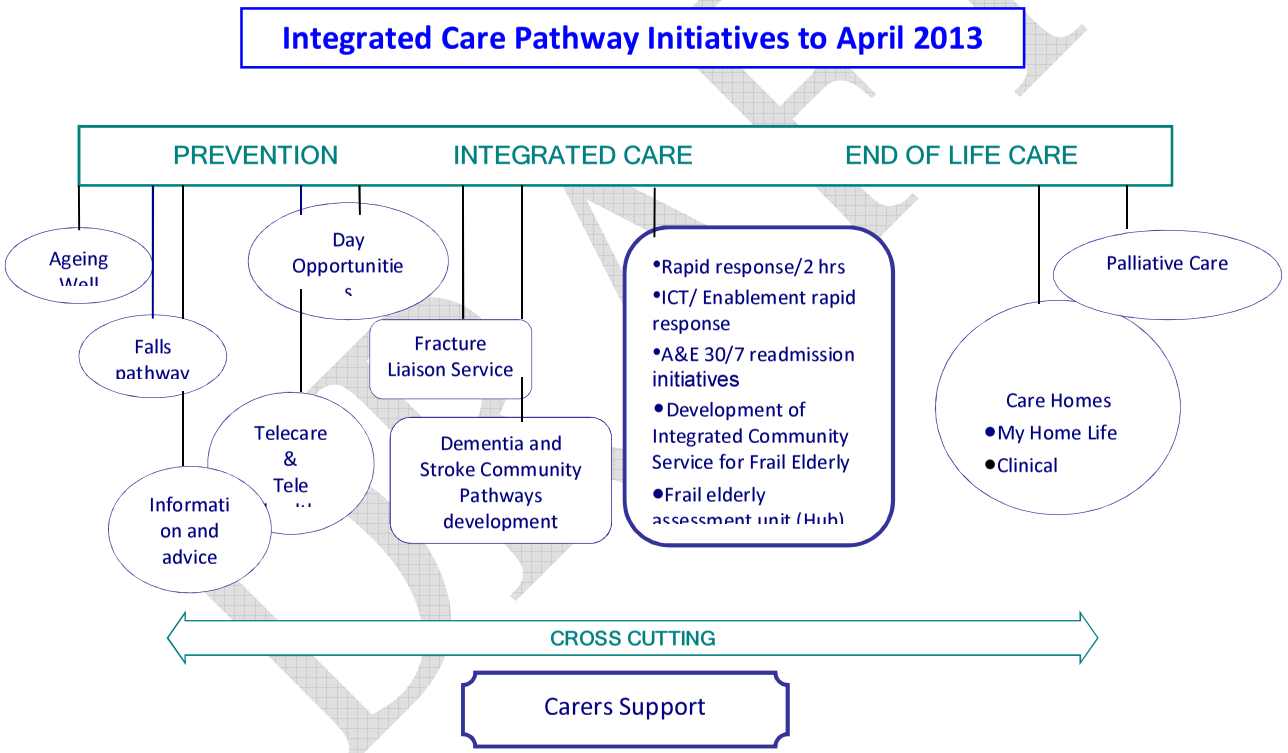
Mr. Dale deserves the best care, at the right time and the right place. When Mr. Dale needs treatment, support or care, he will cross organisational boundaries effortlessly, supported by professionals who take responsibility for his whole care and treatment journey, regardless of who they work for

For Mr Colin Dale this will mean:

1. He has enough information and support to allow him to look after himself as much as possible without having to rely on others
2. His care is planned so that when he becomes ill he knows that he can get help quickly to manage his illness and to keep him out of hospital where possible
3. He knows who to call when he needs help and they know all about him
4. If he has to go to hospital he knows that care and support will be put in place to allow him to come home as soon as possible
5. If he needs a care home in the future he knows that it will give him the best possible quality of life
6. Care towards the end of his life will be co-ordinated and will allow him to die in the place that he chooses
7. He knows that everyone providing his care is well supported and the system helps them to learn from each other and develop better care for others

Current Picture

In 12/13 there were a number of engagement events to ensure that general practice, secondary care and social care professionals had the opportunity to consider the options for redesign of the care pathways for frail and elderly people. As a result a number of initiatives have commenced or are currently being implemented. The diagram below illustrates the current programme for the Integrated Care Pathway to date for older adults, with flows to projects.



Key achievements to date include:

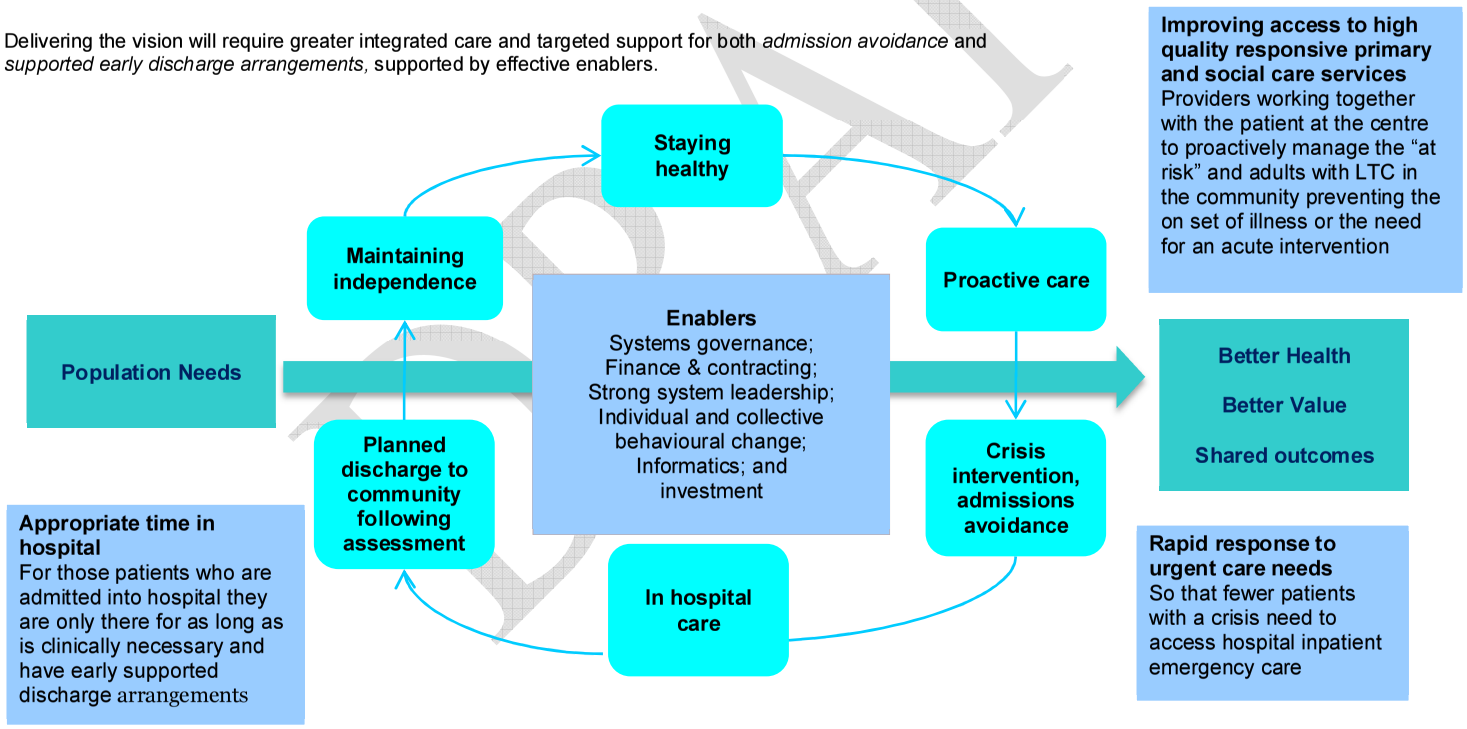
- Intermediate Care Team 2 hour Rapid Response service operational initiating early intervention in the community with primary care
- Procurement of Risk stratification tool identifying those at risk in the community and where intervention may be required
- Care Navigators being recruited to proactively support general practice to review and assess their frail and elderly population. Intervention, to implement a preventative plan and ensure that individuals are appropriately sign posted to services and facilitated to access support where required
- Multi-Disciplinary Team arrangements agreed to allow for higher risk individuals, identified through risk stratification and managed by care navigators, to be referred for detailed review and active management of a care plan
- Palliative Care Service in place (PCSS)
- TREAT service at A&E at Royal Free Hospital to prevent admission, and geriatrician input at Barnet A&E
- Redesign of Falls Pathway and Fracture Liaison Service
- Redesign and improved integrated service specification for Dementia care including early diagnosis via memory clinic
- Improvements agreed and planned for the care of Patient who have had a stroke including, identification and treatment of those at risk, improved early support discharge capacity and improved follow up reviews
- Advance care planning pilot for Barnet GPs completed in Care Homes
- Care Homes pilot (building on themes of My Home Life) commenced. Pilot aims to establish strategies and appropriate support to reduce hospital admissions and support the development of better care standards in managing patient care in Care Homes

Integrated Care Delivery Model for 2013-14 Onwards

Evidence from similar projects across the country illustrates that there are many differing ways to integrate care. However, a consistent factor is that successful integration is best achieved through whole-system working focussing on a specified set of agreed objectives and outcomes as outlined in the diagram below. Inherent in all models is maintaining independence and self care management , managing complex care in the community, rapid response to urgent care needs and coherent discharge from acute hospital admissions to the community with support.

Integrated Pathway

Delivering the vision will require greater integrated care and targeted support for both *admission avoidance* and *supported early discharge arrangements,* supported by effective enablers.



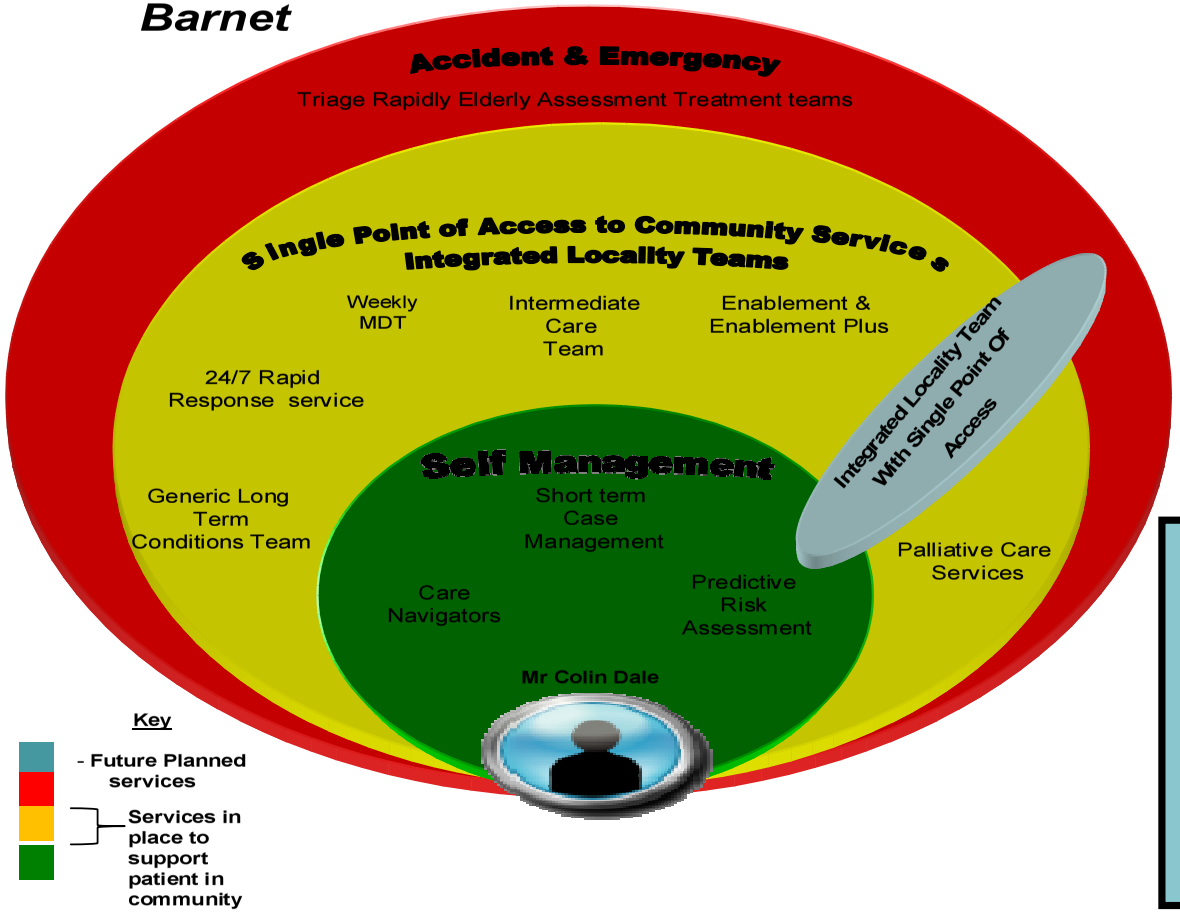
Barnet Model

Central to the future delivery model in Barnet is the development of a fully integrated care team based in each locality. The teams will incorporate health and social care and will address patient need through a single point of access. The locality based teams will be designed to support and manage care from self-management through periods of crisis, and into end of life pathways where necessary. A raft of services (existing and new) will be aligned to link with the locality based teams providing a seamless flow for patients. Integrated teams will include primary, community and secondary care services and the CCG will commission a range of services to support primary /community services in delivering these plans.

This will also involve working closely with and integrating with LA social care services. This framework will help to ensure that patients avoid hospital admission where possible, and are able to return home following a hospital episode as soon as possible with appropriate support to maintain independence. The models will, as stated previously, support in managing Barnet's increasing ageing population and increases in the number of people with multiple long-term conditions.

The Barnet model is represented below and tables indicate where Barnet is in terms of current development going into place and the planned Actions to take forward to 2013/14:

Integrated Care In Barnet



- Generic Long Term Conditions Team
- Advanced Care Planning
- Older Adults Assessments Clinic
- Expand Rapid Response to 24/7
- Robust Assessment at A&E Barnet Hospital
- Review Discharge Arrangements From Secondary Care
- Fracture Liaison Service
- Falls Service
- Stroke Service
- Dementia Hub With Memory Service
- Care Homes Pilot
- Telehealth / Telecare
- Care Home Support

Service Development

Building on the work of the Kings Fund and linking it to the Barnet delivery model we have highlighted below some of the key areas of focus for commissioning of integrated care in Barnet through to 2015. This prioritisation draws out the areas where greatest impact is needed to create an environment that will support the development of integrated care; and outlines how the work is supported by rationale, evidence, impact assessment and examples of good practice from elsewhere.

Progress in Barnet has been framed in line with these priorities highlighting current and planned projects, and programme focus for 2013-14 and beyond. This section is outlined in **bold** at the end of each section

Care coordination through integrated health and social care teams	
What is it?	Creating patient-centred care that is more co-ordinated across care settings and over time, particularly for patients with long-term chronic and medically complex conditions who may find it difficult to 'navigate' fragmented health care systems. Providing the appropriate, timely and co-ordinated crisis care to prevent admissions and to support end of life care pathways
Why is it Important?	• Co-ordination of care for people with complex chronic illness is a global challenge. Driven by broad shifts in demographics and disease status, long-term conditions absorb by far the largest, and growing, share of health care budgets • Co-ordination of care for patients with complex needs and long-term illness is currently poor, and those with long-term conditions have a lower quality of life • Patients are frequently admitted to hospital when it is not clinically justified because of a lack of alternative options • A&E attendances continue to grow with a 30% increase between 2003/4 and 2011/12 • Two thirds of people would prefer to die at home, but in practice only one-third actually do • Costs of caring for people at the end of their lives is estimated to run into billions of pounds (National Audit Office 2008)
What is the Impact?	• Robust evidence on health outcomes is limited, but improved care co-ordination can have a significant effect on the quality of life of older frail people and people with multiple long-term conditions and hospital

	admissions. • Highly integrated primary care systems that emphasise continuity and co-ordination of care are associated with better patient experience. • Impact on costs and cost-effectiveness is less easy to predict and is likely to be low in the short term given the upfront investments required. However, health systems that employ models of chronic care management tend to be associated with lower costs, as well as better outcomes and higher patient satisfaction
How to do it	There is no one model of care co-ordination, but evidence suggests that joint commissioning between health and social care that results in a multi-component approach is likely to achieve better results than those that rely on a single or limited set of strategies and include : • a move to community-based multi-professional teams based around general practices that include generalists working alongside specialists • a focus on intermediate care, case management and support to home-based care • joint care planning and co-ordinated assessments of care needs • personalised health care plans and programmes • named care co-ordinators who act as navigators and who retain responsibility for patient care and experiences throughout the patient journey • Clinical records that are shared across the multi-professional team. • Clearly defined signposting routes Care for Older People in Torbay provides a good example of the kind of change required. Torbay established five integrated health and social care teams organised in localities aligned with general practices. Care co-ordinators support older people following an emergency hospitalisation, helping them to receive the intensive support required to enable them to live at home. Northamptonshire Integrated Care Partnership focused on helping patients remain independent for longer and creating personalised care plans for high-risk individuals that aimed to reduce admissions to hospital. It developed a new community-based service for patients at the end of life and a multidisciplinary care service for older people to support independent living in the community
Currently implemented	• ***Rapid response service established. Operating over 7 days from 8am to 10pm. Referrals accepted Monday – Friday only***

in Barnet	• ***Risk stratification tool being rolled out to GP practices*** • ***Palliative Care Service in place*** • ***Advance care planning pilot completed in Care Homes*** • ***Care Home pilot underway building on 'My Home Life'***
What we plan to do in Barnet	• ***Extend the rapid response service to 8am-10pm 7 days per week 2013-14*** • ***Introduce care navigators to proactively manage patients in the community with transparent management plans back to GP and linking to signposted services Q1 2013-14*** • ***Establish weekly multidisciplinary team reviews for complex patients Q1 2013*** • ***Establish shared patient /client care records to ensure a robust and integrated approach to care management*** • ***Set up Fragility clinic at FMH to include with input and co-location of Geriatricians, psyhogeratrics ,OT, Physio, Memory Clinic, Parkinson's and Diabetic clinic so patient can have coordinated approach during one visit . Q3 2013-14*** • ***Develop Integrated locality care teams supporting Long Term Conditions and Rapid Response including COPD, Heart Failure, Stroke, Dementia and End of Life Care Q3 2013-14*** • ***Establish single point of access to locality based integrated care team 2014-15*** • ***Comprehensive Falls Service roll out Q2 13-14*** • ***Stroke pathway re-design implemented Q2-3 2013-14*** • ***Dementia hub planned Q2-3 2013-14*** • ***Assess and support the use of integrated care services by Care Homes (eg Rapid Response) Q3 2013-14*** • ***Link IAPT with delivering service to those with long term condition*** • ***Establish robust Older People's assessment at Barnet A&E 13-14*** • ***Review discharge process to ensure smooth transition between hospital and home 14-15*** • ***Review current process/pathway for community palliative care and link with enablement and expand services Q2 2013-14*** • ***Implement advance care planning across all care agencies, including primary care 13-14***

Self-Management & Primary Care (including prevention)			
	Self-Management	**Prevention**	**Managing ambulatory Care – sensitive conditions**
What is it?	Self-management support can be seen in two ways - as a range of techniques and tools to help patients choose healthy behaviours; and a fundamental transformation of the Patient–caregiver relationship into a collaborative partnership	Taking action to reduce the incidence of disease and health problems within the population, either through universal measures that reduce lifestyle risks and their causes or by targeting high-risk groups.	Ambulatory care-sensitive (ACS) conditions are chronic conditions for which it is possible to prevent acute exacerbations and reduce the need for hospital admission through active management, such as vaccination; better self-management, disease management or case management; or lifestyle interventions. Examples include heart failure, diabetes, asthma, epilepsy and hypertension.
Why is it Important?	•Around 15 million people in England have one or more long-term conditions. The number of people with multiple long-term conditions is predicted to rise by a third over the next ten years • People with long-term conditions are the most frequent users of health care services, accounting for 50 per cent of all GP appointments and 70 per cent of all inpatient bed days.	•More systematic primary prevention is critical in order to reduce the overall burden of disease in the population and maintain the financial sustainability of the NHS. • It is estimated that 80 per cent of cases of heart disease, stroke and type 2 diabetes, and 40 per cent of cases of cancer could be avoided if common lifestyle risk factors were eliminated. • Addressing this clustering, and its socioeconomic determinants, is likely to reduce inequalities and improve	•Despite admission being largely preventable, a significant proportion of all acute hospital activity is related to ACS conditions. In England ACS conditions accounted for 15.9 per cent of all emergency hospital admissions in 2009/10 • There is significant variation in how effectively ACS conditions are managed – emergency admissions per head vary more than two-fold between local authority areas after adjusting for the differences in age, gender and deprivation

	• Treatment and care of those with long-term conditions accounts for 70 per cent of the primary and acute care budget in England • Around 70–80 per cent of people with long-term conditions can be supported to manage their own condition	overall population health.	•These admissions are costly. The total cost to the NHS in 2009/10 was estimated at £1.42 billion for a core set of 19 ACS conditions
What is the Impact?	• Self-management has potential to improve health outcomes in some cases, with patients reporting increases in physical functioning • Self-management can improve patient experience, with patients reporting benefits in terms of greater confidence and reduced anxiety. • Self-management has been shown to reduce unplanned hospital admissions for chronic obstructive pulmonary disease and asthma and to improve adherence to treatment and medication and further evidence that this also translates into cost savings.	•Primary prevention is an excellent use of resources compared with many treatments. Of more than 250 studies on prevention published in 2008, almost half showed a cost of under £6,400 per quality-adjusted life year and almost 80 per cent cost less than the £30,000 threshold used by the National Institute for Health and Clinical Excellence for cost effectiveness • Community-level campaigns to improve health behaviours, such as No Smoking Days, have been found to be very cost-effective (£82 per life year gained)	•Maintaining wellness and independence in the community prevents deterioration in conditions and therefore results in better health outcomes. • Emergency admissions to hospital are distressing, so better management that keeps people well and out of hospital should lead to a better patient experience. • According to The King's Fund estimates, emergency admissions for ACS conditions could be reduced by between 8 and 18 per cent simply by tackling variations in care and spreading existing good practice. This would result in savings of between £96 million and £238 million. This calculation may significantly underestimate potential

			savings as admission rates in all areas are significantly above what should be achievable.
How to do it	There are a number of well-established self-management programmes that aim to empower patients to improve their health and the evidence indicates the importance of ensuring the intervention is tailored to the condition e.g • Structured patient education can be beneficial for people with diabetes • people with depression may benefit more from cognitive and behavioural interventions. • Other plans with patients could include the opportunity to co-create a personalised self-management plan which could include patient and carer education programmes, use of	Evidence-based interventions include: supporting individuals to change behaviours, for example, through brief advice during a consultation; systematic community interventions in schools to reduce childhood obesity; and regulatory actions, such as controlling the density of alcohol outlets . In many areas, a strategic approach using a combination of interventions at the individual and societal level is likely to be most effective. NHS England, acting in its new role as the single purchaser of NHS primary care, has an important opportunity to ensure that primary prevention is implemented systematically and at scale.	Early identification of ACS patients is crucial if their management is to be successful. GPs are well placed to do this through the use of risk stratification tools and clinical decision support software within GP practices. Some progress can be made through relatively simple measures such as expanding vaccination, where available, to prevent the onset of a condition. For other ACS conditions (chronic and acute aggravated conditions), commissioners will need to encourage active disease management. A review of evidence (Purdy 2010) suggests that many evidence-based self-management interventions should be implemented and evaluated locally eg• support for self-management for those with long-term conditions. In addition, it also suggested that improvements in the quality of primary care are needed,

	telecare, medicines management advice (as examples		to manage people without the need for secondary care intervention
Currently implemented in Barnet	• ***Provide limited patient expert diabetic education programme*** • ***Joint working with LBB on Advice and Information Strategy programme to develop trusted information centres for patients and web portals***	• ***Public Health Barnet leads an effective Smoking Cessation Service has established*** • ***Flu and Pneumococcal vaccination programme***	• ***Good established management of COPD in Community including pulmonary rehab and case management*** • ***Increasing dietetics support*** • ***Falls Pathway redesigned and agreed by Stakeholders***
What we plan to do in Barnet	• ***Develop self management programmes following on from the implementation of the risk stratification tool eg diabetes*** • ***Identify and introduce additional support to strengthen primary care management of long term conditions*** • ***Multi-disciplinary Inhaler improvement project*** • ***Provide framework***	• ***To develop further prevention programmes in collaboration with partners, particularly public health*** • ***Integrate key primary prevention messages throughout pathways.*** • ***Implementing the use of the GRASP tool in primary care to identify and treat those at risk of stroke*** • ***Implement Fracture Liaison Service*** • ***Increase dietetic support in Community***	• ***Identify and implement ACS pathways*** • ***Improve long term condition management of ACS conditions in Community particularly Heart Failure*** • ***Review discharge process to ensure smooth transition between hospital and home*** • ***LBB Care Homes pilotIntegrated Care in Barnet draft 170613***

	(inclusive of IT support) to link self management plans to local integrated teams in terms of crisis management		

Meeting	Health and Well-Being Board	AGENDA ITEM 8a
Date	27 June 2013	
Subject	**Contract management of Healthwatch Barnet**	
Report of	Assistant Director, Community and Wellbeing, Adults and Communities	
Summary of item and decision being sought	To explain how the performance of Healthwatch Barnet will be monitored in 2013/14. The Health and Well-Being Board are asked to give their views on whether any improvements can be made to the arrangements set out in this report.	

Officer Contributors	Emily Bowler, Customer Care Service Manager, Adults and Communities Mathew Kendall, Assistant Director, Community and Wellbeing, Adults and Communities
Reason for Report	To discuss how the performance of Healthwatch Barnet will be monitored in 2013/14.
Partnership flexibility being exercised	N/A
Wards Affected	All
Contact for further information	Emily Bowler, Customer Care Service Manager, 020 8359 4463, Emily.bowler@barnet.gov.uk

1. RECOMMENDATION

1.1 That the Health and Well-Being Board review the statutory functions of Healthwatch Barnet (that officially launched on the 21st May 2013), and assess the progress made locally to date, in light of these statutory duties.

1.2 That the Health and Well-Being Board discuss the progress being made by Barnet Council to manage the contract with CommUNITY Barnet for the delivery of Healthwatch Barnet and identify areas where improvements can be made.

1. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 Health and Well-Being Board- Healthwatch Update- 25 April 2013

2.2 Health and Well-Being Board- Healthwatch procurement- 26 July 2012

2.3 Cabinet Resources Committee, Monday 25 February - *to deliver Barnet Healthwatch in the sum of £592,083 (£197,361 per annum) be awarded to Community Barnet with an expiry date of 31 March 2016, with the option for a further extension of up to two years in accordance with the contract (total contract value £986,805)*

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

3.1 Healthwatch Barnet will be the primary vehicle through which users of health and care in the Borough will have their say and engage with statutory services. These should ensure that there are clearly person-focused approaches to meeting the objectives in the Health and Well-Being Strategy 2012-15.

3.2 Healthwatch Barnet are statutory members of the Barnet Health and Well-Being Board and have a responsibility to ensure that user views are represented in and considered by the Health and Well-Being Board work programme, and the Health and Well-Being Strategy.

3. NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 CommUNITY Barnet's Equalities Policy provides satisfactory evidence that they can comply with the public sector equality duty as set out in the 2010 Equality Act.

4.2 One of the specific objectives in the tender specification, endorsed by the Health and Well-Being Board, was to engage all parts of the community including those traditionally underrepresented communities – specifically young people and disabled people - and harder to reach communities and support their participation. A method statement was supplied and evaluated, and this will be monitored as part of the contract.

4. RISK MANAGEMENT

5.1 There is a risk that Healthwatch will not be delivered effectively and will not represent good value for money. This risk has initially been mitigated by making it clear in tender documents what the Council and its health partners are looking for in a successful Healthwatch, and will continue to be mitigated through rigorous contract monitoring and regular meetings with the providers.

5. LEGAL POWERS AND IMPLICATIONS

6.1 Part 14 of the Local Government and Public Involvement in Health Act 2007 (as amended by the Health and Social Care Act 2012) together with regulations govern the establishment of Healthwatch, its functions and the responsibility of local authorities to commission Local Healthwatch.

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

7.1 The contract sum received is £592,083, representing £197,361 per annum. The contract will commence on 1 April 2013 and expire on 31 March 2016. The contract provides for a further extension of up to two years which, if implemented, would give a total contract value of £986,805.

7. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 The Healthwatch contract includes targets for engagement and representation. Healthwatch Barnet will use a range of methods and forums to engage with residents, which will include networks, partnership boards, patient and public meetings, the Signposting service and online and social media. Healthwatch staff and volunteers are currently liaising with organisations and individuals in all these areas. An engagement plan will be developed in consultation with Healthwatch Members and residents, and will be presented for consultation and feedback at the Healthwatch Launch.

8. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 Healthwatch Barnet is represented on the Health and Well-Being Board, the Clinical Commissioning Group (CCG) and Central London Community Health. Healthwatch Barnet will build on the positive relationship developed by the LINk with the CCG and will develop a similarly strong relationship with Central London Community Health and Public Health. It is envisaged that Healthwatch Barnet will work closely with the providers, to support health campaigns and initiatives but to also interact on strategic developments for health and social care in the Borough.

9. DETAILS

10.1 <u>Background</u>

10.2 The key roles of a local Healthwatch are to:

- Ensure that the views and feedback from people who use services, carers and members of the public are integral to local commissioning (as LINK currently, but embedded further into the system e.g. through being a statutory member of the Health and Well-Being Board);
- Provide support to people and help them to make choices about services. In particular, those who lack the means or capacity to make choices; for example, helping them choose which GP to register with;
- Help people to make complaints;
- Provide intelligence for Healthwatch England about the quality of providers

10.3 The duties of Healthwatch, set out in the Health and Social Care Act (2012), have been summarised by the Department of Health as follows:

- Local Healthwatch will have a seat on the new statutory health and wellbeing boards, ensuring that the views and experiences of patients, carers and other service users are taken into account when local needs assessments and strategies are prepared, such as the Joint Strategic Needs Assessment (JSNA) and the authorisation of Clinical Commissioning Groups. This will ensure that local Healthwatch has a role in promoting public health, health improvements and in tackling health inequalities
- Local Healthwatch will enable people to share their views and concerns about their local health and social care services and understand that their contribution will help build a picture of where services are doing well and where they can be improved
- Local Healthwatch will be able to alert Healthwatch England to concerns about specific care providers
- Local Healthwatch will provide people with information about their choices and what to do when things go wrong; this includes either signposting people to the relevant provider, or itself providing (if commissioned by the local authority), support to individuals who want to complain about NHS services
- Local Healthwatch will provide, or signpost people to, information about local health and care services and how to access them
- Local Healthwatch will provide authoritative, evidence-based feedback to organization's responsible for commissioning or delivering local health and social care services
- Local Healthwatch can help and support Clinical Commissioning Groups to make sure that services really are designed to meet citizens' needs
- Local Healthwatch will have to be inclusive and reflect the diversity of the community it serves. There is an explicit requirement in the Health & Social Care Act that the way in which a local Healthwatch exercises its functions must be representative of local people and different users of services, including carers.

(http://healthandcare.dh.gov.uk/what-is-healthwatch/)

10.4 Healthwatch Barnet will need to be assessed against these duties through the contract management arrangements put in place by Barnet Council, as the service commissioner.

10.5 Aims of contract between Barnet Council and Healthwatch Barnet

10.6 The aims for Healthwatch Barnet set out in its contract with Barnet Council state the following:

- Healthwatch is the eyes and ears in the community and provide constructive feedback and criticism to help provide better services
- Healthwatch acts on complaints and concerns over quality and unsatisfactory patient/ user experience
- Healthwatch works with all the groups and networks representing and supporting users of services to champion user voice and coordinate co-production

10.7 Service delivery

10.8 Healthwatch Barnet will be assessed against the following areas (as set out in the contract):

- User engagement and delivery of products
  - Gathering feedback, views, research, information and experiences
  - Supplementing with evidence from Enter and View visits
  - Delivering outputs and products that improve services against an annual plan for engagement- developed with input from residents, communities, Health Overview and Scrutiny, Health and Wellbeing board and commissioners.

- Information, advice and signposting
  - Quality information, advice and signposting provision on a range of health and social care subjects
  - Accessible services
  - Requires significant infrastructure and best value is likely to be found from partnering with an established provider

- User controlled service delivery
  - Credible provision that users/ customers trust
  - Demonstrable user control of service

10.9 Key principles

10.10 The contract between Barnet Council and Healthwatch Barnet is underpinned by the following key principles that are set out in the contract document:

- Healthwatch Barnet should use web-based communication and engagement platforms where possible to free up resources for face to face interactions for those who need them most

- Healthwatch Barnet should make use of existing channels for user and carer involvement where possible and avoid duplication of activities or structures. New structures should only be created following identification of gaps in existing structures. Reducing bureaucratic structures to a minimum will free up resources for engagement activities with a broader range of people- many of whom do not wish to attend meetings on an on-going basis.
- Healthwatch Barnet should make sure it uses a range of forms of engagement to ensure its approach is inclusive of the needs of all residents
- Healthwatch Barnet should be representative of Barnet's diverse communities
- Healthwatch Barnet should make use of volunteers to supplement paid staff inputs and bring in the expertise and experience of Barnet residents

10.11 The contract

10.12 The Healthwatch Contract was awarded by Cabinet Resources Committee on 25 February 2013 to CommUNITY Barnet**.** The Healthwatch contract value is £197,361 per annum. The contract will commence on 1 April 2013 and expire on 31 March 2016; the contract sum received is £592,083. The contract provides for a further extension of up to two years which, if implemented, would give a total contract value of £986,805.

10.13 The Adults and Communities Delivery Unit hold responsibility for the Healthwatch Contract:

- Contract sponsor – Mathew Kendall, Assistant Director (Community and Wellbeing)
- Contract Manager – Emily Bowler, Customer Care Service Manager, with support from Marshall Taylor, Head of Prevention and Wellbeing.

10.14 To ensure successful implementation of the Healthwatch Contract, the Council has provided dedicated resource and support. The Contract Management meetings are held monthly with representatives from the Council and Healthwatch Barnet**.** These meetings will decrease to quarterly as soon Healthwatch Barnet is fully established and all services are running effectively**.** Regular email and phone contact in between meetings with Contract Manager and Head of Healthwatch Barnet to ensure on-going support.

10.15 Focus on these early contract monitoring meetings has been on:

- Agreeing contract (including Terms of Conditions, schedule)
- Agreement of payment by results schedule with a pro-rata payment per quality Enter and View visit
- Agreeing Performance Monitoring Framework (copies of this will be supplied at the Health and Well-Being Board meeting on the 27th June 2013)

- Creating a clear Year 1 implementation work plan
- Agreeing a detailed work plan for implementation
- Clarity on governance arrangements – with specific focus on Healthwatch developing a new steering group separate to CommUNITY Barnet or any other organisations. The tender specifies that the group should be made up from a consortium of partners and residents, with the majority of the group being residents and users. The group should be responsible for identifying all key themes and potential projects for Healthwatch and will report and be accountable to the Board of Directors of 'Healthwatch Barnet'.
- Ensuring clear branding has been used to promote Healthwatch Barnet to clearly define separate identify to CommUNITY Barnet
- Data protection and information governance

11 BACKGROUND PAPERS

11.1 None.

Legal – CE
CFO – JH

This page is intentionally left blank

AGENDA ITEM 8b

Meeting	Health and Well-Being Board
Date	27 June 2013
Subject	**Healthwatch Barnet Update**
Report of	Healthwatch Barnet
Summary of item and decision being sought	This paper provides an update on Healthwatch Barnet and comments on how it will work with the Health and Well-Being Board and provides an initial response to the Francis Report. The report is for comments from Members and for noting.

Officer Contributors	Selina Rodrigues, Head of Healthwatch Barnet Julie Pal, Chief Executive CommUNITY Barnet
Reason for Report	To provide an update on key milestones and activities, governance and to identify key points for Healthwatch Barnet's role on the Health and Well-Being Board.
Partnership flexibility being exercised	N/A
Wards Affected	All
Contact for further information	Selina Rodrigues, Head of Healthwatch, 020 8364 8400, Selina.rodrigues@healthwatchbarnet.co.uk

.

1. RECOMMENDATION

1.1 For noting and any comments.

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 At its meeting of 25 April 2013, the Health and Well-Being Board noted a paper from Healthwatch Barnet on its establishment and initial activity.

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

3.1 Through its representation on statutory bodies and its ongoing relationship with health and social care fora and residents, Healthwatch Barnet will contribute to the development of the Health and Well-Being Strategy and other relevant strategies and initiatives.

4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 One of the key aims of Healthwatch Barnet is to ensure the views and experiences are heard and represented of those group with protected characteristics under the Equality Act and seldom-heard communities and individuals. Healthwatch Barnet is developing an Engagement Strategy which will contain an Action Plan and targets for engagement with key communities.

5. RISK MANAGEMENT

5.1 A risk register was submitted as part of the tender documents and issues are identified through Healthwatch Barnet's monthly workplan reviews.

6. LEGAL POWERS AND IMPLICATIONS

6.1 Section 182 to 184 of the Health and Social Care Act 2012 and regulations subsequently issued under these sections, govern the establishment of Healthwatch, its functions and the responsibility of local authorities to commission local Healthwatch.

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

7.1 Healthwatch Barnet has been allocated funding of £197,361 per annum.

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 A communications strategy is in development and will be presented in due course.

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 An Engagement Strategy is in development and further details are provided in this paper and accompanying presentation.

10. DETAILS

10.1 Introduction

This paper builds on the update presented to Barnet Health and Well-Being Board on 25 April 2013 and accompanies the PowerPoint presentation attached.

This report summarises the key points Healthwatch Barnet believe will be of interest to the Barnet Health and Well-Being Board.

Since the last update to the Board a number of key achievements have taken place:

- Successful launch of Healthwatch Barnet at Jewish Care on 21 May 2013
- Dissolution of Barnet LINk on 31 March 2013
- Recruitment drive for residents to become Healthwatch Barnet volunteers
- Development and presentation of a draft Engagement Strategy to the Transition Steering Group and Partners consortium.
- Transfer of Barnet LINk volunteers to Healthwatch Barnet.
- Meeting with a range of key statutory and voluntary sector stakeholders

10.2 Healthwatch Barnet guiding principles

Following the launch of Healthwatch Barnet the following principles will guide its delivery and practice.

- to be a **strong, local citizen voice**, **making a difference** to health and social care provision for the people of Barnet
- to collect the **real voice** of Barnet people
- to provide a platform from which **diverse and seldom listened to voices** from across the borough can be heard
- to set the standard for **excellent public engagement**
- to become a **respected and credible** organisation
- to work in **partnership** across all sectors of health and social care
- to gather and analyse meaningful and robust **local evidence and intelligence** to present to influential decision makers
- to be **unafraid to challenge** service providers and commissioners so that the people in Barnet have **timely and good quality information** and advice

10.3 Key activities to be undertaken between June – September 2013

The following key activities will be completed. Further details are provided in the body of this paper.

- Healthwatch Barnet is fully operational;
- Engagement Strategy and Communications Strategy published;
- Healthwatch Barnet Workplan and three month priorities are published on website. Healthwatch Barnet would like further information on the statutory services' commissioning plans. This will enable it to develop a longer term workplan, based on activity related to consultation and co-production.
- New three-month programme of Enter and View Programme is established;
- New cohort of Enter and View volunteers are recruited and trained and undertake visits;
- Liaison with Barnet Mencap to train people with learning disability to become Enter and View volunteers;
- Recruitment, induction and training of the Healthwatch Barnet Engagement Group and Healthwatch ambassadors

10.4 Governance principles

CommUNITY Barnet is the organisation contracted to deliver Healthwatch Barnet. As required by statute, it has a separate legal identity from the funding organisation, Barnet Council. Delegated responsibility from CommUNITY Barnet's Board of Trustees for the operational delivery of Healthwatch Barnet will sit with CommUNITY Barnet's CEO.

Healthwatch Barnet follows the Healthwatch England branding protocols and has its own dedicated website, email address and branding. This is evident from the website and the accompanying presentation.

It is important to underline that Healthwatch Barnet staff/CommUNITY Barnet CEO will have key responsibility and final decision-making. Anything else would be inappropriate accountability and an undue burden on volunteers. However, resident, patient and service-user involvement is core to the structure and delivery mechanisms of Healthwatch Barnet.

This will be achieved in the following ways:

- As the contract holder, CommUNITY Barnet Trustees/CEO is the lead accountable body for Healthwatch Barnet. There will be a dedicated Board member for Healthwatch Barnet, who has lived patient experience.
- An Engagement Group will be recruited, with key responsibility for helping to identify priorities, giving guidance to project teams and for providing feedback on business and strategic plans.
- Healthwatch project teams will consist of volunteers, Healthwatch Barnet staff and partners. Two examples are the Healtwatch Enter and View Team and the GP Project Group, which consistent of active volunteers and are chaired by a volunteer.

10.5 Activity to date

Engagement and consultation
The Launch of Healthwatch Barnet took place on 21.05.13 with one hundred and ten people present - residents, Healthwatch volunteers and representatives from the statutory sector. The Panel was a range of key representatives from the health and social care sectors in Barnet including the Chief Operating Officer for the CCG, the Chairperson of Barnet and Chase Farm NHS Trust, the Director for Public Health in Barnet and Harrow, the volunteer Chairperson of Barnet LINk/Transition Steering Group and the volunteer Chairperson of the Healthwatch GP Group and the Head of Healthwatch Barnet. Participants fed back that Healthwatch Barnet should be transparent, challenging and engage with under-represented communities.

Healthwatch Barnet is undertaking consultation with residents and communities
The key questions raised with residents have included:

- "How can Healthwatch Barnet best listen and represent you?"
- "What are your key comments or concerns about health and social care in Barnet?"

To date, consultation has taken place with sixteen groups and communities, focusing on those that have not traditionally been consulted on health and social care services, such as the Gipsy, Roma Traveller community, Barnet Refugee Service, Barnet African Caribbean Association, Bi Polar Group, Britsom, Burnt Oak Network and Graham Park residents. Ongoing feedback and comments were captured through the Healthwatch Barnet launch, Barnet Council's Partnership Board Summit as well as the individual health and social care Partnership Boards.

These responses will be analysed and used to inform the Healthwatch Barnet priorities and its Engagement and Communications Strategies.

Active projects. These projects have developed in response to resident's feedback or research into the health and social care needs of under-represented groups.

- Developing relationships of trust and engagement with Gypsy, Roma, Traveller community and Barnet Refugee Services. Gathering feedback on their experience of primary and secondary care (form filling can be a barrier; prejudice; lack of recognition of extended family networks; inappropriate use of young family members as translators).
- Young People's focus groups.
- General Practitioners' Group. In liaison with the CCG, we will present our recommendations and good practice on GP appointments, to the Local Medical Council, the Practice Managers Group and the CCG Board and will produce a toolkit for patients to use with their Patient Participation Groups. Healthwatch Barnet will also promote good practice for key communities, including the Carers Checklist; for people with learning disabilities; accessibility and positive engagement with the Lesbian Gay Bisexual and Transgender community.

- Enter and View Programme. Five visits have taken place in April and May, including residential care for older people and acute wards for people with mental health conditions. Healthwatch Barnet will liaise with Barnet Mencap to train people with learning disabilities to do Enter and View visits.

Information, Advice and Signposting Service
This was launched in April 2013 through Barnet CAB using their dedicated information and advice line. A focused communications and promotion plan is currently being scoped with the Healthwatch Barnet consortium.

Delivering robust evidence
A Research and Data Analyst will be recruited to the Healthwatch Barnet team. This role will:
- Analyse public data on national and local health outcomes and priorities; complaints; quality and risk;
- Establish a programme of community research which will identify key themes and trends arising from resident, patient and service-user feedback;
- Support Healthwatch Barnet to present clear evidence-based findings to the Health and Well-Being Board, the supporting overview and scrutiny committees as well as the Clinical Commissioning Board to assist them to make informed strategic commissioning decisions.

Liaison with statutory partners
- To date Healthwatch Barnet has met with a number of key stakeholders including Barnet CCG; Central London Clinical Health; LBB Public Health; LBB Adults and Communities. A key part of the conversation has been to establish the commissioning and consultation timelines so that this information can be circulated to local residents and so that Healthwatch Barnet can consider appropriate means of consultation and co-production. To date the information provided does not provide enough detail.
- Mental Health Commissioning Strategy. Healthwatch Barnet is awaiting its publication as residents and service users are keen to understand the commissioning intentions. Healthwatch Barnet has been advised this will be available in July 2013
- Initial feedback from residents to Healthwatch Barnet has been a request for more on the new NHS structures, its key responsibilities and the new complaints processes. Healthwatch Barnet has already made contact with Voiceability – however confusion remains about the inter-relationship between the hospital based PALs service and the NHS complaints provider.

10.6 Relationship between Barnet Health and Well-being Board and Healthwatch Barnet – recommendations

As the local champion for health and social care representing the collective voice of people who use services and the public, Healthwatch Barnet will use its position on the Health and Well-Being Board to raise any issues with health

and social care services, supported by evidence collected through engagement with local communities.

We will be discussing further partnership arrangements with the Council's lead commissioners. This will include developing a framework protocol which includes the Health and Well-Being Board, Partnership Boards and the relevant overview and scrutiny committees, on agenda planning and prioritisation; information sharing; roles and responsibilities; pre-meetings etc.

10.7 Response to the Francis Report

The following issues were highlighted by the Francis Report related to (all) LINks: tensions about understanding governance responsibilities; lack of support and training to volunteers; lack of clarity about decision-making roles; ensuring there is a truly representative voice for health and social care users. Healthwatch Barnet considers it has addressed these areas and detail is provided within this paper.

The following are Healthwatch Barnet's key observations on the Francis report and makes the following recommendations. Healthwatch Barnet has developed a constructive relationship with the CCG and met with senior staff and Board members. Due to restricted timescales, it has not been possible to discuss the recommendations of this paper with the CCG, but Healthwatch Barnet welcomes comments at this meeting and thereafter.

"No culture of listening to patients." (Summary 1.9).

- Healthwatch Barnet partners/targets will address this through its structured programme of engagement and representation.

"There should be many ways in which the patient voice can be heard effectively" (6.471)

No culture of listening to patients. Methods of registering a comment or complaint must be accessible and easily understood (Recommendation 109)

We recommend that:

- CCG convenes a focus group to map and develop the ways in which the patient voice will be heard by the range of service providers across Barnet and to map and review patient engagement. This will help identify gaps, make effective use of resources and avoid duplication.
- CCG convene a working group on the complaints process to ensure that accessible information is presented to patients and service users (with Healthwatch Barnet representation).
- CCG co-ordinate a communications plan across all health and social providers demonstrating the implementation of the recommendations from the Francis Report.

Again, we highlight that restricted timescales have prevented discussions about this with the CCG and we are keen to be hear their response.

Guidance should be given to promote the coordination and co-operation between local Healthwatch, Health and Wellbeing Boards and local government scrutiny committees. (Recommendation 147)

- See our comments on protocol above.

The complexities of the health service are such that proper training must be available to the leadership of local Healthwatch as well as, when the occasion arises, expert advice." (Recommendation 14)

- Induction and training of the new Engagement Group will include Governance; Code of Conduct; Overview of health and social care structures, key policy developments and challenges. LBB has offered places on their Partnership Board training in October.
- There will be training on campaigning and community research for volunteers.
- Healthwatch England has scheduled Train the trainer for Enter and View (July 2013). North London Local Healthwatch have identified areas where further guidance and training is needed, including Independent Advocacy Service service; HWBB; data collection and will request this from Healthwatch England.

Quality, care and patient safety

- Healthwatch Barnet is keen to see the proposed action plan from the CCG on its response to the Francis Report. From this, it will review the actions and timescales and comment accordingly. Healthwatch Barnet recommends that the CCG co-ordinates a communication campaign around the action plan for residents so that they can understand the actions, timescales, proposed changes and the CCG's monitoring and review.

11 BACKGROUND PAPERS

11.1 None

Legal –
CFO –

AGENDA ITEM 9b

Meeting	Health and Well-Being Board
Date	27 June 2013
Subject	**The NHS England Assurance Framework: national report for consultation**
Report of	Chief Officer, Barnet Clinical Commissioning Group
Summary of item and decision being sought	Update on the NHS England Assurance Framework and for the plans to respond to the draft framework by Barnet CCG

Officer Contributors	John Morton, Chief Officer, Barnet CCG
Reason for Report	To update the Health and Well-Being Board on the NHS England Assurance Framework and to ask the Health and Well-Being Board if it wants to comment on the proposed performance management system. The CCG would be able to include any comments in its own response or as a joint response.
Partnership flexibility being exercised	N/A
Wards Affected	All
Contact for further information	John Morton, Chief Officer, Barnet CCG, john.morton@barnetccg.nhs.uk

1. RECOMMENDATION

1.1 That the Health and Well-Being Board comments on the proposed performance management system.

1.2 That the Health and Well-Being Board confirms with the CCG if it would like to include any comments in the CCG's own response, or complete a joint response.

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 This is a national report for consultation.

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

3.1 The proposal provides assurance proposals for the NHS and Public Health in England.

4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 Not applicable.

5. RISK MANAGEMENT

5.1 The assurance framework will contribute to overall assurance processes in the NHS and Local Government.

6. LEGAL POWERS AND IMPLICATIONS

6.1 Section 12 of the Health and Social Care Act 2012 introduces section 2B to the NHS Act 2006. This imposes a new target duty on the local authority to take such steps as it considers appropriate for improving the health of people in its area.

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

7.1 Not applicable.

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 The proposal provides assurance proposals for the NHS and Public Health in England and is for consultation.

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 The proposal provides assurance proposals for the NHS and Public Health in England and is for consultation.

10. DETAIL

10.1 CCG Assurance framework 2013/14 for consultation.

10.2 NHS England published the CCG Assurance framework 2013/14 on 7th May 2013 as an outline proposal for consultation and to set out interim arrangements.

10.3 This is an important document for the CCG and for Local Authorities and a summary is set out over the next four pages. The CCG will need to develop with the Commissioning Support Unit the performance reporting and management systems to underpin this assurance framework for the CCG.

10.4 Introduction

10.5 The assurance process identifies how well CCGs are performing against their plans to improve services and deliver better outcomes for patients, as well as working together to assess how they can realise their full potential and provide support on that journey.

10.6 The paragraphs below describe NHS England's outline proposal and interim arrangements for the assurance framework which they intend to discuss widely with CCGs and other key stakeholders, over the coming months. The definitive assurance framework for 2013/14 will be published in the autumn. The expectations that the framework will continue to evolve as CCGs and the wider commissioning system continue to develop over future years.

10.7 The framework is designed to give assurance that CCGs are delivering quality and outcomes for patients, both locally and as part of the national standards, as well as being the basis for assessing that CCGs are continuously improving from the start point of authorisation. Of necessity, it therefore looks at both the CCGs performance and its health.

10.8 NHS England assumes that CCGs will wish to publish their progress against their locally agreed plans and hence their performance on delivering key standards and outcomes to their local population. The performance aspect of assurance will be based on this published information.

10.9 It will be important that an interim process is in place to monitor CCGs during their first few months. This document outlines how NHSE will do this through 'checkpoints' in July and October which we propose will be used as pilots to inform how similar checkpoints operate in the long term.

10.10 NHSE proposes that the framework is built on a clear set of principles:

- The approach will always place the assurance of quality for patients, both today's' and future generations, at the heart of the process
- The approach will promote the accountability of CCGs to their local populations
- Support CCGs to develop ambitious plans for improvement; a key feature will be the identification of the support a CCG needs to realise its full potential
- There should be a clear, consistent basis on which any NHS England support or intervention is predicated. The underpinning principle should be to support the CCG to deliver good outcomes
- The approach will focus heavily on the role of CCGs in securing patient and public engagement
- The approach should only use information that CCGs need to manage their own business and to demonstrate accountability to their local populations
- The process will continually evolve in collaboration with CCGs, HWBs,

patients and the public
- The output of CCG assurance should be proportionate and transparent

10.11 NHS England is committed to a new style of working with CCGs, working in partnership, not hierarchy. They have already begun work with CCGs, and NHS Clinical Commissioners, to co-create shared expectations of the behaviours that will enable effective relationships to drive improvements. NHSE will support CCGs to be high performing organisations, working together as a co-commissioner of services for local populations, but providing the right assurance to patients and the public that CCGs are good commissioners. NHS England will only intervene in the few circumstances when this is necessary. This will require a fundamental cultural shift and a mind-set change for many working within the healthcare system.

10.12 To commission high quality care successfully, NHSE will need to promote engagement, transparency and successful relationships between all involved in the delivery of health and care services. This is in order to realise our collective vision of a health system shaped by patient and citizen participation and designed with improved outcomes and patient experience at its heart. Future iterations of the assurance framework will significantly increase the focus on patient experience as we develop a completely fresh approach to transparency, and patient engagement and insight. New organisations call for a consciously new approach with emphasis on a mature and equal conversation between CCGs and NHS England, informed by rich sources of evidence.

10.13 Key sources of such evidence are highlighted in the planning guidance, *Everyone Counts: Planning for Patients 2013/14* which makes a number of offers to support the successful development of the system's ability to commission high quality care, including the development of care.data - a modern knowledge service for the NHS.

10.14 This proposal is focussed firmly on CCG assurance. Alongside this NHS England also needs to consider mutual assurance which is fundamental to the on-going relationship between NHS England and CCGs as co-dependent commissioners of NHS services. In designing mutual assurance, NHS England needs to consider interventions with local authority commissioners as they commission public health services for their population as well as social care. The model of mutual accountability must be anchored within the local Health and Well-Being Board (HWBB). HWBBs play a key role in bringing organisations together for the mutual interest of their population. It is the place where all key commissioners of health and social care services come together alongside other vital stakeholders to hold each other to account to local people for their use of public money and the results they deliver. NHS England will explore with CCGs, local authorities, HWBBs and other key stakeholders how they can best develop this approach to mutual assurance.

10.15 NHS England will also ensure that the same level of scrutiny is applied to its own direct commissioning responsibilities. This will be developed along the same timeframe, and apply parallel principles to assure organisational health and performance of NHS England in its capacity as a commissioner, using the same assurance framework as CCG assurance wherever this is practicable. What is important is that practical, mutual assurance takes place at the same time through a unified and coherent process. NHS England will be working through the engagement exercise to build this into the final process.

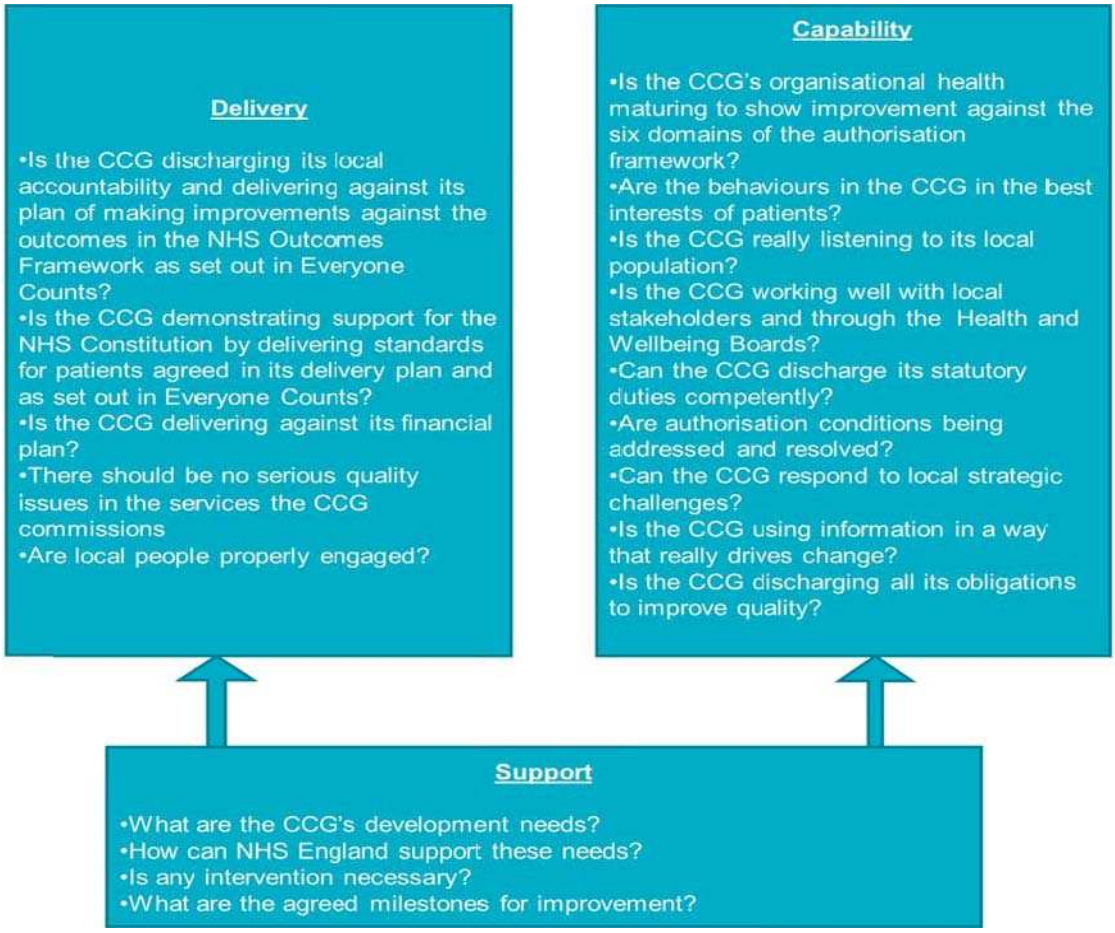
10.16 Core elements of assurance

10.17 NHS England proposes that the process should have three main elements.

Delivery – ensuring that the CCG is delivering for its population the full range of outcomes and standards (both national and local) agreed in its plan.

Capability – ensuring the CCG is set up to serve patients and communities effectively, both now and for future generations with the required skills and knowledge, and is exhibiting the appropriate behaviours.

Support – determining the nature and level of support a CCG needs to be a great commissioner.



10.18 For the most part, assurance about delivery against plan will be undertaken through a series of quarterly checkpoints and will be based on information which it is expected a CCG would wish to make available publicly as part of its responsibility for local accountability. This will include delivery against its agreed strategic plan, which will include the standards in the NHS Constitution, and improvement against the Outcomes Framework as set out in section two of Everyone Counts. It will also assess that the CCG is on track financially. Whilst these checkpoints will mainly be about the assurance of performance, there will also be some assessment of capability in these quarterly checkpoints.

10.19 Capability will be assessed on an annual basis, and will be based on and build upon the authorisation process. NHS England will review the CCG's organisational health with a particular focus on its relationship with patients and the public, its capacity to assure quality and its behaviours with key stakeholders. It will inevitably draw on the outputs of the checkpoints but it will also be a key opportunity to review whether the CCG is dealing with local strategic challenges.

10.20 The final stage will be to identify support needs. The expectation is that the majority of CCGs will receive support from NHS England on an informal basis and that this will be integral to the on-going relationship between organisations. However, this proposed assurance framework will provide the mechanisms by which NHS England would use its statutory powers to intervene where there were serious concerns.

10.21 The weblink to the consultation is attached:
http://www.england.nhs.uk/wp-content/uploads/2013/05/ccg-af.pdf

11. BACKGROUND PAPERS

None

Meeting	Health and Well-Being Board
Date	27 June 2013
Subject	**Performance Management Framework for Health and Well-Being Strategy**
Report of	Director for People
Summary of item and decision being sought	This report updates previous proposals for a performance management framework which would allow the Health and Well-Being Board the opportunity to monitor performance regularly against a number of key objectives set out in the Health and Well-Being Strategy.

Officer Contributors	Claire Mundle, Commissioning and Policy Advisor- Public Health / Health and Well-Being
Reason for Report	To meet the requirements of the Health and Well-Being Board's Terms of reference 'To agree a Health and Well-Being Strategy for Barnet taking into account the findings of the Joint Strategic Needs Assessment and performance manage its implementation to ensure that improved outcomes are being delivered'.
Partnership flexibility being exercised	N/A
Wards Affected	All
Contact for further information	Claire Mundle, Commissioning and Policy Advisor, Public Health / Health and Well-Being, 020 8359 3478, Claire.mundle@barnet.gov.uk

RECOMMENDATIONS

1.1. That the Health and Well-Being Board approves the proposed approach to the development of a performance management framework for monitoring the delivery of the Health and Well-Being Strategy.

1.2. That the Health and Well-Being Board agrees with the proposal for the Health and Well-Being Board Performance Group to support the performance monitoring of the Health and Well-Being Strategy. The proposed performance group will be of similar standing to the Health and Well-Being Board Financial Planning Group, i.e. an officer group focused on the implementation of the Health and Well-Being Strategy and reporting progress back to the Board.

1.3. That the Lead Agencies represented at the Health and Well-Being Board confirm named performance contacts to sit on the Health and Well-Being Performance Group.

1.4. That the Health and Well-Being Board endorses the allocation of Lead Agency responsibilities in relation to the strategy set out in Appendix A.

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 Health and Well-Being Board 17 November 2011- item 6- Performance Management Framework for Health and Wellbeing Board.

2.2 Health and Well-Being Board 17 November 2011 – item 5- Developing the Health and Wellbeing Strategy

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

3.1 The agreed performance objectives have been set out in the Health and Well-Being Strategy (2012-15).

3.2 The CCG work plan has been deliberately aligned to the objectives of the Health and Well-Being Strategy.

4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 The targets within the Health and Well-Being Strategy have been set based on the results of the Joint Strategic Needs Assessment, which considers health and social care outcomes across all of Barnet's population groups, and pays particular attention to the different health inequalities that exist in the Borough.

5. RISK MANAGEMENT

5.1 An effective system of performance management mitigates the risk that the Health and Well-Being Board is not actively managing performance against

key objectives, or is being inefficient in devoting resources to the measurement of non-priorities.

6. LEGAL POWERS AND IMPLICATIONS

6.1 None specifically arising from this report.

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

7.1 None specifically arising from this report. However where relevant financial performance or implications will also be noted.

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 Healthwatch will play an important role in ensuring that the Health and Well-Being Strategy is making a difference, and in advising lead agencies on how the voices of users and carers can feed in to the performance management of the Strategy.

8.2 The Partnership Boards will be formally supported by the Health and Well-Being Board to take forward the objectives of the Strategy through the twice annually Partnership Board Summits.

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

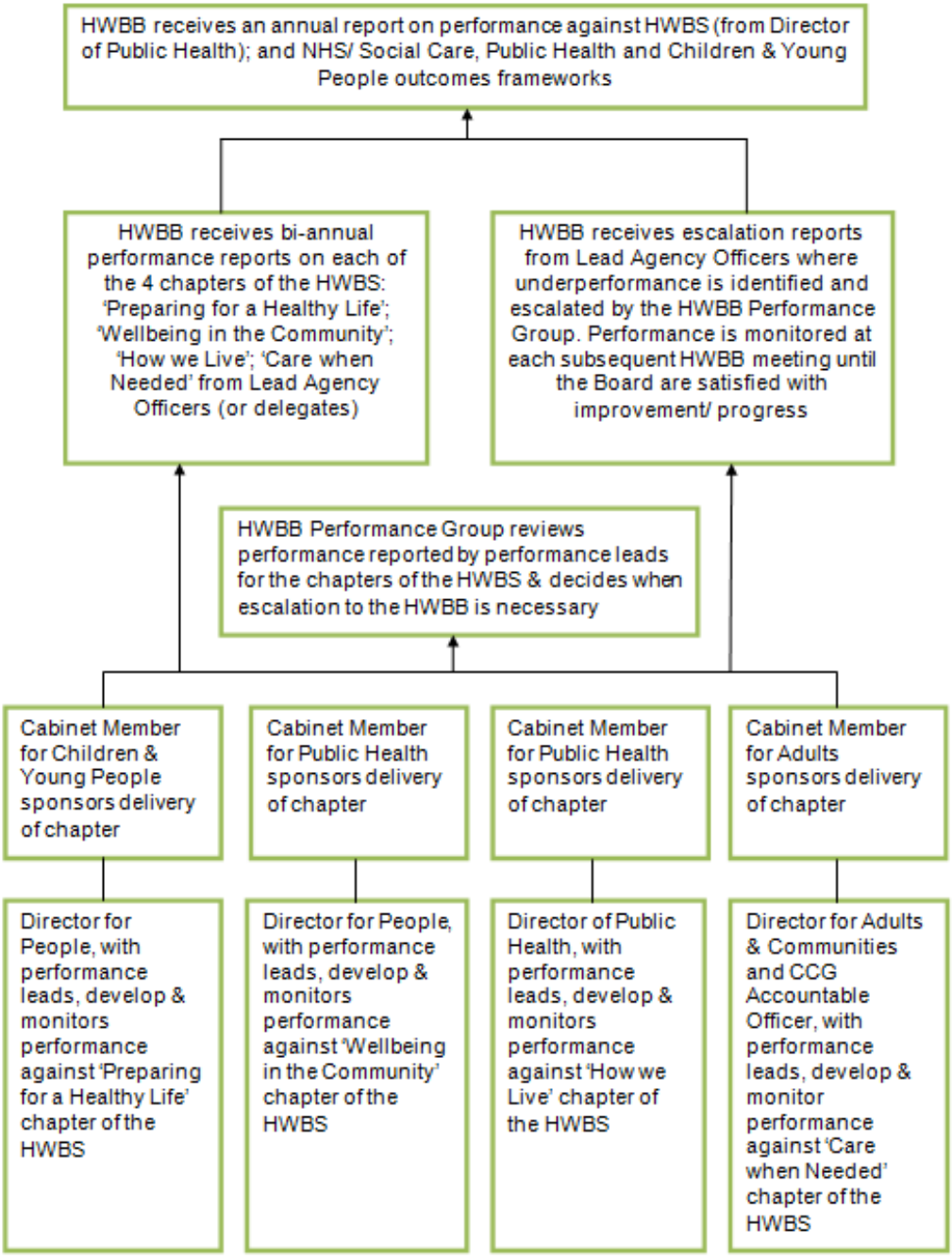
9.1 The framework has been developed in conjunction with the Public Health team.

10. DETAILS

10.1 This report focuses on the development of a performance management framework for the Health and Well-Being Strategy (HWBS). The Strategy contains a clear set of indicators, for which a number of delivery agencies- the Barnet Children's Trust, the London Borough of Barnet (LBB), Public Health Barnet, Barnet Clinical Commissioning Group (CCG) and Barnet Adult Social Care Services- are named responsible leads for performance.

10.2 A robust approach to performance management to support the HWBS has not yet been agreed. There is an immediate need to develop a performance framework against which delivery of the HWBS can be judged.

10.3 The proposed approach to monitoring performance is set out below:



10.4 It is suggested that this process is monitored through the presentation of bi-annual performance reports at Health and Well-Being Board (HWBB) meetings for each of the 4 chapters of the HWBS- *Preparing for a Healthy Life; Wellbeing in the Community; How we Live*; and *Care when Needed*. It is proposed that these presentations will take place in May and November of each calendar year.

10.5 At the November 2012 Health and Well-Being Board meeting, these reports will be fronted by an (annual) assessment of overall performance against the Strategy, compiled by the Director of Public Health and the Commissioning and Policy Officer for Public Health / Health and Well-Being. This comprehensive review of performance will be used to:

- Inform the commissioning intentions of the Public Health team and the CCG for the following year (giving the report a strong strategic purpose; complementing the commissioning cycle)
- Review the Health and Well-Being Strategy and ensure that it continues to be fit for purpose

10.6 The full (annual) performance report should be published as a stand-alone document that the general public and other interested parties can access easily. The report should also be presented at the Barnet Partnership Board, to which the Health and Well-Being Board is accountable.

10.7 Each of the four chapters of the Strategy will be endorsed by the appropriate Cabinet Member. The Cabinet Member will work in partnership with the relevant Lead Agency Officer to oversee performance against their chapter of the Strategy.

It is proposed that these arrangements are as follows:

HWBS Chapter	**Cabinet Member Sponsor**	**Lead Agency Officer**
Preparing for a Healthy Life	Cabinet Member for Children & Young People	LBB Director for People
Wellbeing in the Community	Cabinet Member for Public Health	LBB Director for People
How we Live	Cabinet Member for Public Health	Director of Public Health
Care when Needed	Cabinet Member for Adults	CCG Accountable Officer; LBB Adults & Communities Director

10.8 The progress reports will be prepared and presented by the Lead Agency Officer (or a delegated lead) with additional service delivery leads invited along to comment on progress where this is appropriate. The reports will follow a standardised performance reporting template, which will be developed by the Commissioning and Policy Officer for Public Health / Health and Well-Being.

10.9 In order to be able to provide these progress updates, each Lead Agency Officer will be expected to track their teams' progress against the Strategy on an on-going basis. It is recommended that each Lead Agency Officer is supported by the Commissioning and Policy Officer for Public Health / Health and Well-Being to develop the performance monitoring framework that will support their chapter of the Strategy. There will be a workshop set up with Lead Agency Officers and relevant members of their teams to establish the frameworks.

10.10 It is proposed by this paper that following the workshop, the Lead Agency Officers are supported to monitor progress with the support of a Health and Well-Being Board Performance Group. The proposed performance group will be of similar standing to the Health and Well-Being Board Financial Planning Group, i.e. an officer group focused on the implementation of the Health and Well-Being Strategy and reporting progress back to the Board.

10.11 The performance frameworks should be designed and completed by September 2013, to allow time for the Director of Public Health and the Policy and Commissioning Officer to review the progress that has been made and produce an overall assessment of performance that will be bought to the November 2013 meeting. It is suggested that the performance monitoring frameworks are audited at least annually to ensure they are fit for purpose. Efforts should be made by each Lead Agency Officer to identify where they are duplicating performance reporting and escalate this to the Health and Well-Being Board Performance Group so that the design of this performance framework can be finessed over time.

10.12 The performance leads who support each Lead Agency Officer should attend the Health and Well-Being Board Performance Group. They will present verbal updates on progress, and report any slippages in performance to the Group. The Health and Well-Being Board Performance Group will work with the Lead Agency to rectify slippages where possible. The Performance Group will support Lead Agency Officers to escalate performance issues to the Health and Well-Being Board, for the Board to review and decide on a remedial course of action. The Health and Well-Being Board will then continue to receive reports from the Lead Agency at each meeting until performance has improved to an acceptable level (to be agreed on a case-by-case basis by the Board).

10.13 The objectives and targets set in the HWBS have also been deliberately aligned to the priorities in the Public Health, NHS and Social Care Outcomes Frameworks (and will in future account for the Children's and Young People's Outcomes Framework). It is proposed that the relevant Lead Agencies representing Public Health, the NHS, Social Care and Children's Services, respectively, bring reports to the Health and Well-Being Board annually to report on progress against these national priorities.

11 BACKGROUND PAPERS

None

Legal - CE
CFO - AD

Appendix A: Health and Well-Being Strategy Objectives and Indicators

Preparing for a Healthy Life. Lead Agency: the Children's Trust

OBJECTIVES	RESPONSIBLE LEAD(S)	INDICATORS	DATA SOURCE(S)
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	Barnet CCG; Barnet & Harrow Public Health	All women in Barnet to access NICE compliant maternity care by 12 weeks gestation Reduce the smoking in pregnancy rate from 10% to below the London average of 7.5%	Barnet CCG Director of Public Health
Increase the take up of immunisations, particularly the MMR pre-school booster	NHS England	Maintain Immunisation rates at above national and regional target rates with preschool immunisations covering at least 90% of all children of Barnet.	NHS England
Expand the Family Nurse Partnership initiative to support families who are experiencing significant challenges.	NHS England		
Expand the community budgets programme for children to provide early intervention for children from families with the most complex needs.	The Children's Trust; LBB Family Services Director	Include an additional 705 families with complex needs in the community budget programme - where there is a decrease in the number and range of interventions from statutory organisations	LBB Family Services Director
Reduce obesity in children and young people by working with schools, community groups and parents to promote healthy eating and increase the use of active and sustainable school travel plans and the range of organised physical activities available	Barnet & Harrow Public Health	Reduce the rate of obesity in reception year school children from 11% to be better than the London average. Reduce the rate of obesity in year 6 children from 17.5% baseline towards the England best of 10.7%	Director of Public Health

Embed Active Lifestyles programmes in primary and secondary schools to encourage healthy lifestyles for parents and children.	Barnet & Harrow Public Health		
Design and implement a range of interventions designed to reduce risk taking behaviour in children including Sexual Health and substance misuse that are delivered through statutory and voluntary partners.	Barnet & Harrow Public Health	Reduce the number of children and young people misusing alcohol and drugs by 91% by 2014/15.	Director of Public Health
Effectively plan for transition from children's services to adult services.	LBB Education and Skills Director; LBB Adults and Communities Director	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.	LBB Education and Skills Director; LBB Adults and Communities Director

Wellbeing in the Community. Lead Agency: London Borough of Barnet

OBJECTIVES	RESPONSIBLE LEAD(S)	INDICATORS	DATA SOURCE(S)
Use the Council's planning and licensing processes to create a built environment that is conducive to healthy living choices such as. walking and the accessibility of safe open spaces	LBB Development & Regulatory Services		
Review the opportunity to deliver wider health and well-being objectives through the Borough's regeneration schemes	LBB Enterprise & Regeneration Lead Commissioner; Barnet & Harrow	Reducing the average length of time spent by households in short-term nightly purchased accommodation to 26 weeks through the implementation of our Regeneration Strategy and a target of 25 vulnerable people moving to	LBB Housing & Environment Lead Commissioner; LBB Adults and Communities Director

	Public Health	more independent living by 2012/13, 20 people by 2013/14 and a further 25 people by 2014/15.	
Reduce social isolation, especially amongst older people, through schemes that enable the sharing of skills and experience	LBB Later Life Lead Commissioner; LBB Schools, Skills & Learning Lead Commissioner		
Maximise training and employment opportunities, through the Regeneration Strategy for those furthest from the labour market to access new job opportunities.	LBB Enterprise & Regeneration Lead Commissioner	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.	LBB Adults and Communities Director
Work with private landlords and tenants to bring private rented accommodation up to the Decent Homes Standard	LBB Housing & Environment Lead Commissioner		
Target advice and financial support to enable vulnerable and elderly residents to improve their homes in relation to thermal efficiency	LBB Housing & Environment Lead Commissioner		
Work in partnership with local employers and other statutory organisations to ensure a range of training and education opportunities and flexible working opportunities are available that will support people into work with a particular focus on young people who are not in education, employment or training and disabled adults.	LBB Enterprise & Regeneration Lead Commissioner; LBB Schools, Skills & Learning Lead Commissioner	Reduce by 4.3% the number of young people who are not in education, employment or training	LBB Family Services Director

This will be encouraged through local apprenticeships for young people and the Right to Control programme for disabled adults undertaken in partnership between the Council and Job-Centre Plus.			
Work with local community leaders, community groups and service providers to develop mutual support between citizens using people's strengths and experiences to increase inclusion into local communities, overcome language barriers and develop stronger inter-generational support.	LBB Family & Community Wellbeing Lead Commissioner; LBB Later Life Lead Commissioner	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	LBB Later Life Lead Commissioner (Equalities Lead)
Working across the Public Sector, in partnership with the Voluntary Sector and community groups, to ensure the availability of information and advice on a range of health and wellbeing related choices	LBB Later Life Lead Commissioner; Healthwatch Barnet		

How we live. Lead Agency: Public Health

OBJECTIVES	RESPONSIBLE LEAD(S)	INDICATORS	DATA SOURCE(S)
Discourage uptake of smoking in children by working with partners in education and community groups and to increase the range of people within the public and private sector trained to provide smoking cessation advice.	Barnet & Harrow Public Health		
Encourage and enable smokers to quit, and people who are overweight and obese to lose weight	Barnet & Harrow Public Health	Reduction of 20% in the number of people smoking in Barnet by 2016 in line with the London target.	Director of Public Health

Promote healthy eating through working with local food suppliers, restaurants, public houses, places of entertainment and similar commercial enterprises to help to increase the availability of, and choice for healthy foods and drinks	Barnet & Harrow Public Health; LBB Development & Regulatory Services		
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	Barnet & Harrow Public Health; Barnet CCG	Year on year increase based on the 2009/10 baseline of people aged between 40 and 74 who have received an NHS Health Check. In five years our coverage should be 80% Year on year increase based on the 2009/10 baseline of people with a learning disability and those with a mental illness who have received an annual health check.	Director of Public Health Barnet CCG
Make better use of the range of green spaces and leisure facilities in the Borough to increase levels of physical activity. This is being supported by the Council undertaking a Strategic Review of Leisure Opportunities to explore the ways in which residents use their leisure time and the role of the Council's services (parks, green spaces, leisure centres, community centres etc) in promoting health and well-being	Barnet & Harrow Public Health; LBB Street Scene; LBB Director for People	3% increase in the number of adults participating in regular physical activity by 2015.	Director of Public Health
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.	LBB Development & Regulatory Services		

		Increase breast screening uptake and improve coverage to exceed the target of 70% by 2015	NHS England
		Increase uptake of bowel cancer screening to meet national indicator of 60% by 2015	NHS England
		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%	Director of Public Health

Care when needed. Lead Agency: Adult Social Care & Barnet CCG

OBJECTIVE	RESPONSIBLE LEAD(S)	INDICATORS	DATA SOURCE(S)
Develop neighbourhood and community based support networks for older people providing information, and support on range of leisure, health, housing and support issues in the Borough.	LBB Adults and Communities Director; Later Life Lead Commissioner		
Early identification and actions to reduce the impact of disease and disability	LBB Adults and Communities Director; Barnet CCG	The balance of spend on older people in both the NHS and Social Care has been realigned to provide a greater focus on prevention.	Health & Wellbeing Board Financial Planning Group
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	LBB Adult Social Services; Barnet CCG	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.	LBB Adults and Communities Director; Barnet CCG
Extensively roll out tele-health and tele-care solutions to provide a cost effective way of supporting more people in their own homes.	LBB Adults and Communities Director; Barnet		

	CCG		
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.	LBB Adults and Communities Director	That all people who have continuing healthcare needs are able to have a personal health budget by 1st April 2014	Barnet CCG
Develop the offer for supporting Barnet residents in care homes including continence management, wound care, medicine reviews and assessments to improve quality of care and dignity of residents and reduce admissions to hospitals.	LBB Adults and Communities Director; Barnet CCG	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.	Barnet CCG
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.	LBB Adults and Communities Director; Carers Strategy Group	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	LBB Adults and Communities Director
Ensure that local residents are able to plan for their final days and to die at home if they would prefer. Work will need to be undertaken to build the skills and capacity in the community to provide support for those dying and those family members who care for them.	Barnet CCG	Increase in the number of people who are receiving end of life care that are supported to die outside of hospital	Barnet CCG; LBB Adults and Communities Director
		Increase the percentage of people aged 65+ who are still at home 91 days after discharge into rehabilitation services to 87% in 2013 with a stretch target to reach 90% by 2015.	LBB Adults and Communities Director; Barnet CCG

Appendix B: Proposed officer membership for the Health and Well-Being Board Performance Group

- Commissioning and Policy Officer- Public Health / Health and Well-Being, LBB
- Performance lead: Barnet and Harrow Public Health team
- Performance lead: Barnet CCG
- Performance lead: Adults and Communities
- Performance lead: The Children's Trust
- Joint Commissioner: Older People
- Joint Commissioner: Mental Health and Learning Disabilities
- Joint Commissioner: Children's Services

AGENDA ITEM 11

Meeting	Health and Well-Being Board
Date	27 June 2013
Subject	**Public Health Intelligence Briefings**
Report of	Director of Public Health
Summary of item and decision being sought	These briefings are the first in a series of briefings on the indicators within the Public Health Outcomes Framework (PHOF). The briefings cover inequalities, life expectancy and healthy life expectancy. The briefings are for information only.

Officer Contributors	Carole Furlong, Public Health Consultant Sarita Bahri, Public Health Analyst
Reason for Report	To update the Health and Well-Being Board on the development of the Public health Intelligence Briefings on the indicators within the Public Health Outcomes Framework. Specifically, this report focuses on the briefings that have been produced on inequalities, life expectancy and healthy life expectancy.
Partnership flexibility being exercised	None
Wards Affected	All
Contact for further information	Carole Furlong, Public Health Consultant, Carole.furlong@harrow.gov.uk

1. RECOMMENDATION

1.1 That the Health and Well-Being Board notes the development of these briefings and considers how these briefings can assist delivery against the Health and Well-Being Strategy.

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 None

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

3.1 The Public Health Outcomes are relevant to the Health and Well-Being Strategy. These briefings provide background and further analysis of the overarching indicators in the Public Health Outcomes Framework.

4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 These briefings will complement the Joint Strategic Needs Assessment and can be used when planning new programmes of work/ evaluating existing programmes of work to ensure that programmes of work are focused on reducing health inequalities across the Borough.

5. RISK MANAGEMENT

5.1 None

6. LEGAL POWERS AND IMPLICATIONS

6.1 None

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

7.1 The information in these briefings can be used to target existing programmes to maximise health improvement and reduce inequalities across the Borough. This will in turn improve the quality of people's lives resulting in a potential saving for services due to a reduction in service usage. Where existing programmes are targeted an analysis will be done to quantify the value of the savings.

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 None

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 None

10. DETAILS

10.1 These Public Health Intelligence briefings are produced by the Public Health Intelligence Team of the joint Barnet and Harrow Public Health Service. They are based on the data published by Public Health England, the Office of National Statistics or the Health and Social Care Information Centre as part of the Public Health Outcomes Framework. The briefings will be produced throughout the year.

10.2 The Public Health Outcomes Framework provides a series of indicators that are used to give a picture of health and health inequalities between Boroughs. There are two overarching indicators: average life expectancy and within borough inequalities in life expectancy.

10.3 The purpose of the briefings is to provide Health and Well-Being Board members with information on the Public Health Outcomes Framework indicators and to look in depth at where inequalities lie within the Borough. This information can be used to inform other strategies and commissioning plans to reduce inequalities. It complements the Joint Strategic Needs Assessment.

10.4 The first briefing covers inequalities. It gives background on what affects population health; explains the indicator (the Slope Index of Inequality); and looks at the direction that the indicator is taking. The report shows that the inequalities in life expectancy are decreasing in women but increasing in men

10.5 The second briefing covers life expectancy. It looks at life expectancy at birth and shows that it is increasing. The briefing also looks at difference in life expectancy at birth between Boroughs and within the Boroughs of Barnet and Harrow. The report then looks at life expectancy at age 65 and trends in life expectancy at 65. This data is not available at a sub-Borough level.

10.6 In the other briefings we have demonstrated that people are living longer but we need to look at whether people are living longer in good health or in poor health. The third briefing looks at Healthy Life Expectancy. The people of Barnet live longer on average than England as a whole and spend more of their lives without a long term illness.

10.7 The next set of briefings will look at wellbeing indicators.

10.8 The briefings are attached to this report below:

11 BACKGROUND PAPERS

None

Legal- CE
CFO- AD

Public Health Intelligence Briefing (PHIB)

Issue # 1

Health Inequalities

Introduction

The Barnet and Harrow Public Health Intelligence team will produce a series of briefings throughout the year. Based on the Public Health Outcomes Framework (PHOF) these briefings will aid colleagues in understanding the fundamentals of each indicator, and enabling the interpretation of Barnet and Harrow's health outcomes. This first briefing presents Health Inequalities, the domain for Life Expectancy and Healthy Life Expectancy, which are the overarching indicators for the PH framework and will follow in the second and third briefing in this initial series of health briefings.

The Department of Health sets out the agenda for tackling health inequalities in its report Equality Objectives Action Plan September 2012 – December 2013 with the first objective focussing on "Better health outcomes for all" .To reduce health inequalities and advance equality in the early years of life as part of the drive to improve outcomes in health.

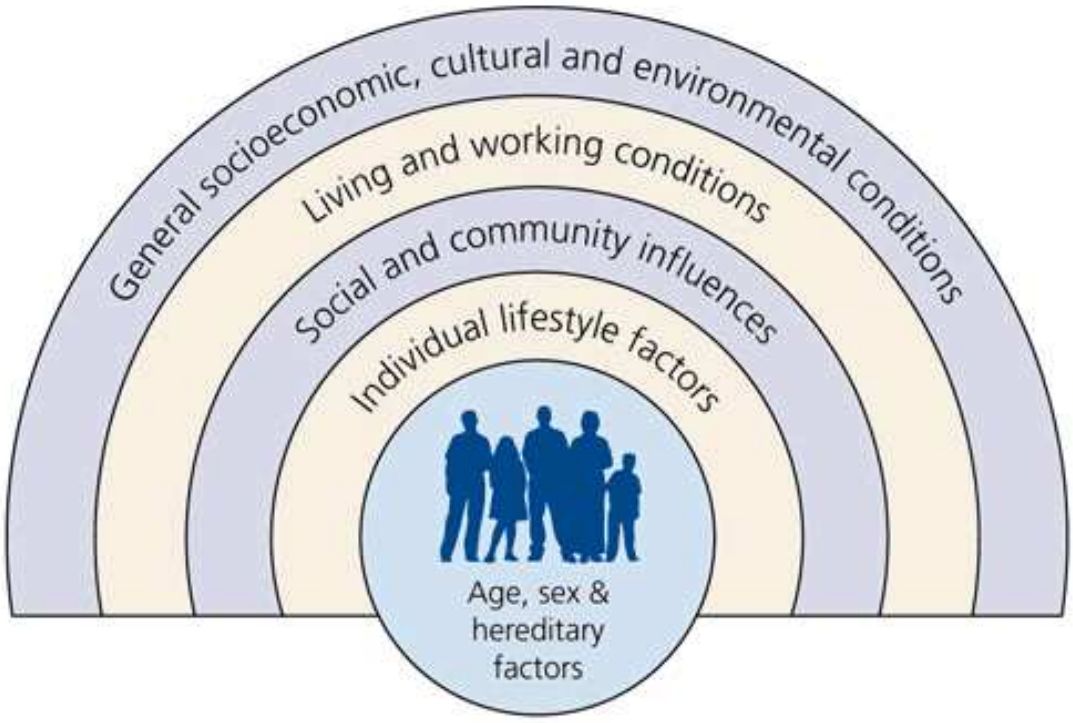
These objectives reflect the indicators of the Public Health Outcomes Framework (PHOF) with health inequalities and equalities dimensions. The PHOF focuses on achieving positive health outcomes for the population and reducing inequalities in health. It is not a performance management framework with a target driven regime, instead it reflects a comprehensive range of those evidence based actions that can be taken to improve public health for all. The sixty-six indicators in the framework provide the measures that will provide an overview of how likely we are to increase

Life Expectancy (LE) and in particular healthy life expectancy (HLE), therefore reducing health inequalities.

Health Inequalities

Health inequalities are defined as the differences in health status or the distribution of health determinants between different population groups. Why some individuals are more or less prone to ill-health than others has practical implications for public health. There is evidence to suggest that a combination of factors (things that make people healthy or not) ranging from social and economic environment including the physical environment, to a person's individual characteristics and behaviours (lifestyle factors) can affect their health and the health of communities. Such factors are known as the social or "wider" determinants of health which can be summarised in the widely used Dahlgren and Whitehead's Determinants of Health model, Figure 1. The model depicts the many layers affecting a person's health.

Figure 1: Determinants of Health Model



Source: G Dahlgren and M Whitehead

The social determinants of health which are the collective set of conditions in which people are born, grow up, live and work include housing, education, financial security, and the built environment as well as the health system. Examples of how they link to health are:

- Income and social status - higher income and social status are linked to better health. The greater the gap between the richest and poorest people, the greater the differences in health.
- Education – low education levels are linked with poor health, more stress and lower self-confidence.
- Health services - access and use of services that prevent and treat disease influences health
- Physical environment – safe water and clean air, healthy workplaces, safe houses, communities and roads all contribute to good health. Employment and working conditions – people in employment are healthier, particularly those who have more control over their working conditions
- Social support networks – greater support from families, friends and communities is linked to better health. Culture - customs and traditions, and the beliefs of the family and community all affect health.
- Genetics - inheritance plays a part in determining lifespan, healthiness and the likelihood of developing certain illnesses. Personal behaviour and coping skills – balanced eating, keeping active, smoking, drinking, and how we deal with life's stresses and challenges all affect health.
- Gender - Men and women suffer from different types of diseases at different ages.

It is now widely accepted that these social determinants are responsible for significant levels of health "inequities". So whilst some health inequalities are the result of natural biological differences or free choice, others are beyond the control of individuals or groups and could be avoided. Inequalities in the social determinants of health lead to inequalities in the health outcomes. Improving health requires a focus on preventing diseases and ill health and promoting healthy behaviours. Evidence shows that inequalities in health largely reflect inequalities in society.

There is considerable evidence connecting health outcomes with these social determinants and emphasising the importance of prevention of ill health, such as the Black Report (1980), the Acheson Report (1998) and the Wanless Report (2004) which make clear that:

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

In Michael Marmot's *Fair Society Healthy Lives, 2008*, a direct correlation between socioeconomic status and health outcomes is highlighted. The report proposed the most effective evidence-based strategies for reducing health inequalities in England from 2010. Marmot's work on inequalities stressed that there was a social gradient in health – the lower a person's position the worse his or health. Action should focus on reducing the gradient.

Recent UK policy describes a partnership approach to health, between people and government, with the individual, communities and government all having responsibilities for safeguarding and promoting health. This suggests an acceptance that there is a wide range of influences on health other than the individual level.

The Public Health Outcomes Framework reflects the focus we wish to take not only on how long we live – our life expectancy, but how well we live – our healthy life expectancy, at all stages of the life course. The framework uses both a measure of life expectancy and healthy life expectancy so that we are able to use the most reliable information available to understand the nature of health inequalities both within areas and between areas.

Before we can address health inequalities properly, we need to know how to measure and monitor them and how we can identify where they occur. One measure of within area inequalities is the Slope Index of Inequality.

Slope Index of Inequality (SII)

The Slope Index of Inequality (SII) is a measure of health inequalities in life expectancy at birth *within* a local area. Two measures are required to construct the indicator:

a) Socioeconomic deprivation – SII uses the Index of Multiple Deprivation (IMD) scores ranked into ten equal groups (deciles)
b) Life Expectancy at birth within each decile – LE is estimated from mortality data and population estimates

It represents the gap in years of life expectancy between the “best-off” and “worst-off” within a local authority by providing a description of the extent of inequality in each area.

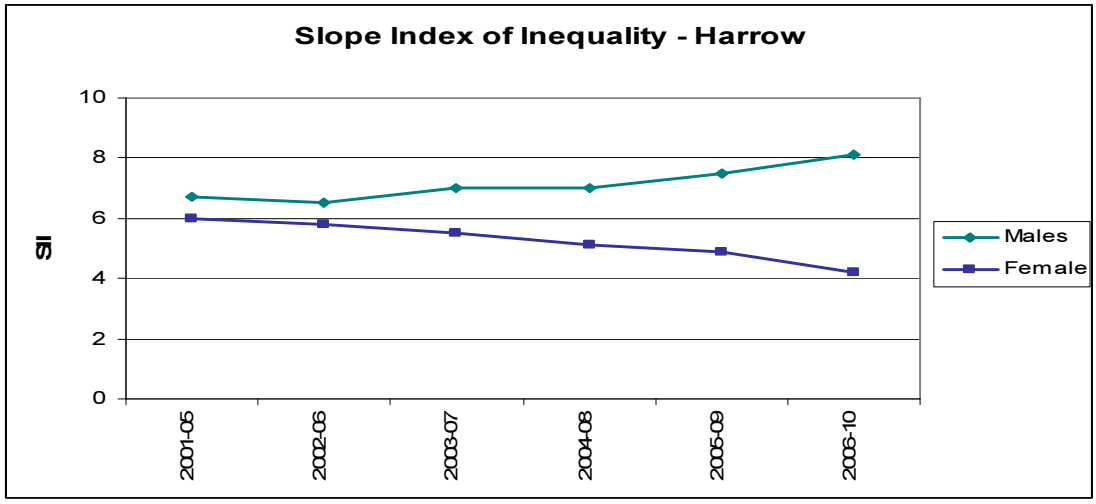
In an area where there are few inequalities *within* the area the SII will be small. It is important that this indicator is not looked at in isolation as an area where everyone is deprived or where everyone is affluent will have similar small SII.

Trends in SII – Harrow and Barnet

The data for Harrow and Barnet shows that the inequalities in women in Harrow and Barnet have decreased over the past six years but have increased for men over the same period.

The difference in life expectancy in women in the most deprived areas in Harrow was 6 years lower then in the most affluent areas, but has decreased to 4 years. For men the gap started at less than 7 years but has widened to over 8 years. This change over time and the difference between male and females living in Harrow can be seen in the graph in Figure 2, below.

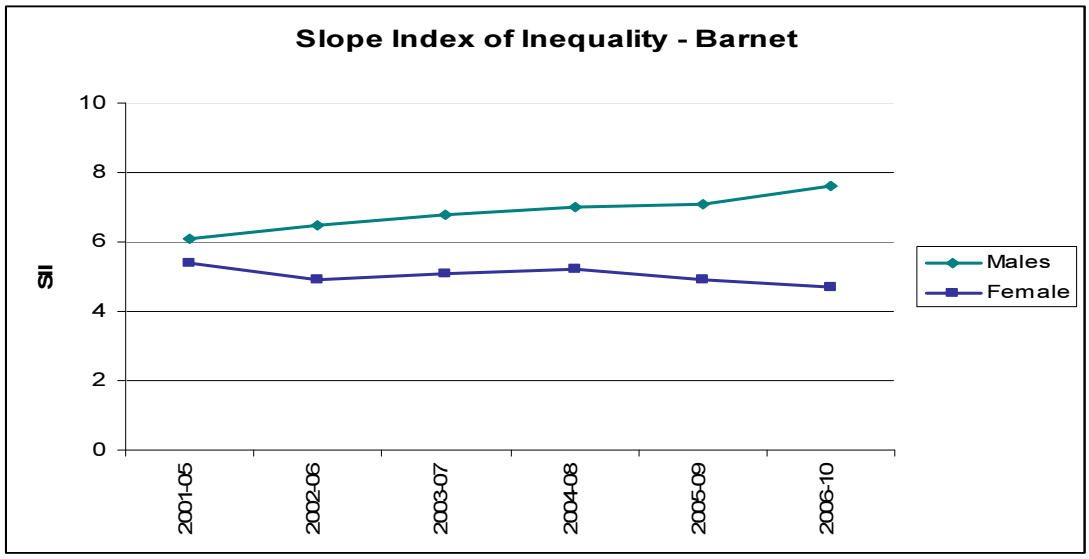
Figure 2: Trend in the Slope Indices of Inequalities for Harrow, 2001-05 to 2006-10



Source: Public Health Observatories

Figure 3 shows the graph for both males and females in Barnet, where the difference in life expectancy in women in the most deprived areas in Barnet was also around 6 years lower than the most affluent areas, and have since decreased to just under 5 years. However, similar to Harrow, in Barnet the difference in life expectancy for men has also increased to just less than 8 years.

Figure 3: trend in the Slope Indices of Inequalities for Barnet, 2001-05 to 2006-10



Source: Public Health Observatories

For the current period, 2006-10 both Harrow and Barnet's SII values are similar to those regionally and nationally. The SII reported for men in London is just over 7 years, and under 5 years for women. Across England, it is around 9 years and just also under 5 years.

Clearly, some areas have more diverse populations than others, in terms of deprivation, as life expectancy and deprivation are strongly correlated, local authorities with a wider range of deprivation will tend to have greater ranges of life expectancy and therefore a large Slope Index of Inequality.

Summary

In this first briefing, the Public Health Outcomes Framework was introduced presenting Health Inequalities. As a result of the wider determinants of health, within the Health Inequalities framework, there is evidence to show that an individual's gender, socio-economics status, and environment amongst others all have an impact on their health. The Slope Index of Inequalities demonstrated that as a result of the varying deprivation across both Harrow and Barnet boroughs, inequalities exist in Life Expectancy, depending on where you are resident within the boroughs. It further showed that inequalities in women have decreased but increased for men. These Health Inequalities are explored further for Life Expectancy and Healthy Life

expectancy, in the briefings to follow. Life Expectancy and Healthy Life Expectancy are the overarching indicators for the Public Health Outcome Framework, encompasses a further sixty-six sub indicators.

Public Health Intelligence briefing #2 will look at Life Expectancy.
For further information or to request a future topic for PHIBs please contact Carole Furlong, Consultant in Public Health

Public Health Intelligence Briefing (PHIB)

Issue # 2

Life Expectancy

Key Findings

- Life expectancy at birth in Barnet and Harrow is higher than the regional and national averages for both males and females in the boroughs and compares well with statistical neighbours
- Life expectancy is increasing in Barnet and Harrow and forecasted to increase further, in line with national trends
- There are significant within borough inequalities in life expectancy seen across both boroughs

Introduction

This is the second Public Health Intelligence Briefing for Barnet and Harrow, presenting Life Expectancy. In the first release Health Inequalities were introduced which form the domain for Life Expectancy and Healthy Life Expectancy, as the overarching indicators for the Public Health Outcomes Framework for which then each subsequent indicator follows.

Life expectancy at birth

Life expectancy is the estimated number of years a new born baby can expect to live for a particular area and time period, therefore it is an estimate of the average number of years a new-born baby would survive if he or she experienced the age-specific mortality rates for that area and time period throughout his or her life. It is a

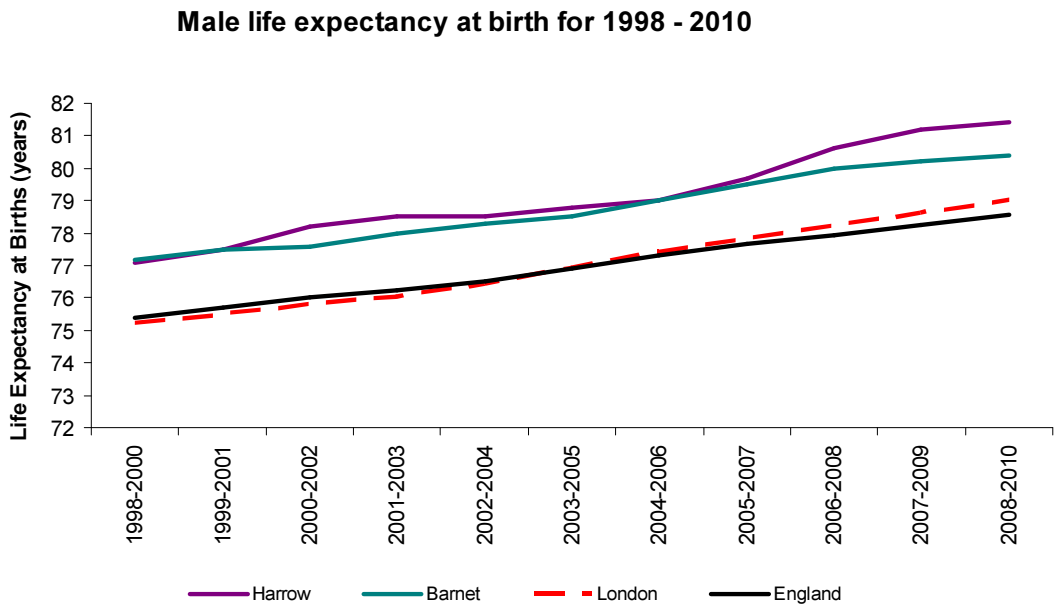
good summary indicator of the population's health and is linked to social circumstances and influenced by deprivation experience throughout life. Therefore a baby born into a home with parents that are well educated and financially prosperous has a better chance of living longer (and without disease and disability) than a baby born to parents who are not. In England people living in the poorest areas will die an average of 7 years earlier than those living in the richest areas. This is, in a large part because the social and economic inequalities in our society are reflected in, and help to determine, our health outcomes.

Trends in Life Expectancy at birth

For the period 2008-2010, the average life expectancy at birth for men in Harrow was 81.4 years and 84.8 years for women. In Barnet, for the same period life expectancy was 79.5 years for men, and 83.2 years for females. Both in Harrow and Barnet, the average male and female life expectancies at birth exceed the London and England averages. Where for London the average male life expectancy is 79.0 years, and for females 83.3 years and for England the average male life expectancy is 78.58 and female 82.27 years for the same time period. The trend over time, for both Harrow and Barnet in life expectancies at birth can be seen in the following graphs, Figures 1 and 2 for both male and female life expectancies respectively, compared against London and England. The graphs show how the trends locally as well as regional and national life expectancies at birth, have increased, and are forecasted to increase further.

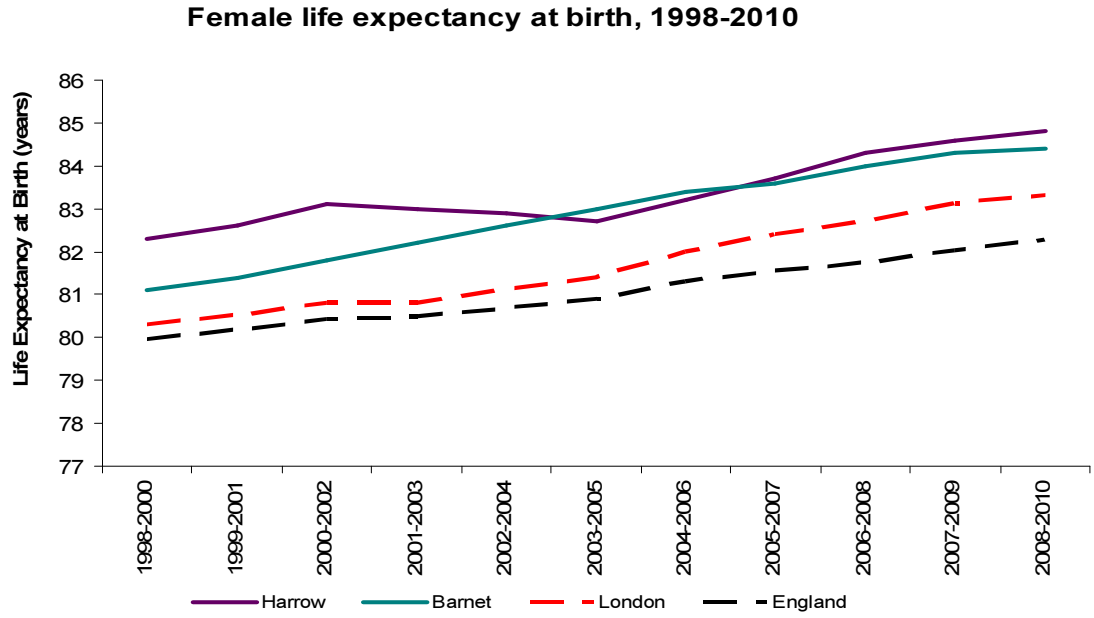
In general, females have a higher life expectancy than males; this inequality can be explained by a number of factors, for example higher rates of obesity, alcohol consumption and smoking amongst men are all statistically associated with increased risk of mortality and morbidity. Life expectancy in males has increased at a slightly higher rate than for females in recent years causing an overall narrowing of the gender gap. In part this may be due to changes in lifestyle, such as more rapid declines in rates of alcohol consumption and smoking amongst males compared with females.

Figure 1: Trends in Male Life Expectancies in Harrow, Barnet, London and England



Source: Office for National Statistics

Figure 2: Trends in Female Life Expectancies in Harrow, Barnet, London and England

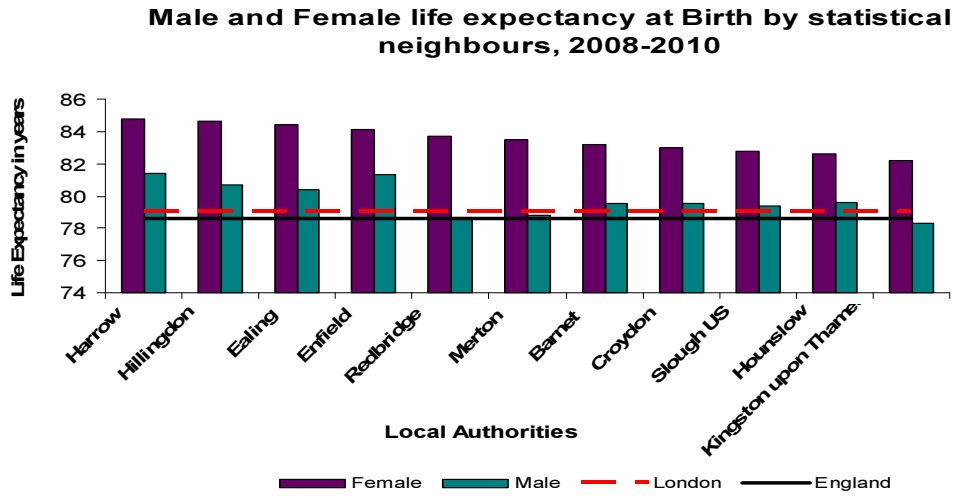


Source: Office for National Statistics

Inequalities in Life Expectancy between Boroughs

The graph in Figure 3 showing Harrow and Barnet male and female life expectancies at birth, against their statistical neighbours, show that Harrow has the highest female life expectancy at birth, and second highest male life expectancy at birth when comparing with other local authorities. Barnet is placed 6th behind Harrow for female life expectancy. Each local authority is grouped into statistical neighbours by the Office of National Statistics based on their similar characteristics. The statistical neighbours provide a method for benchmarking progress, allowing comparisons to be drawn.

Figure 3: Male and Female Life Expectancy at birth compared with Harrow and Barnet Statistical Neighbours



Source: Office for National Statistics

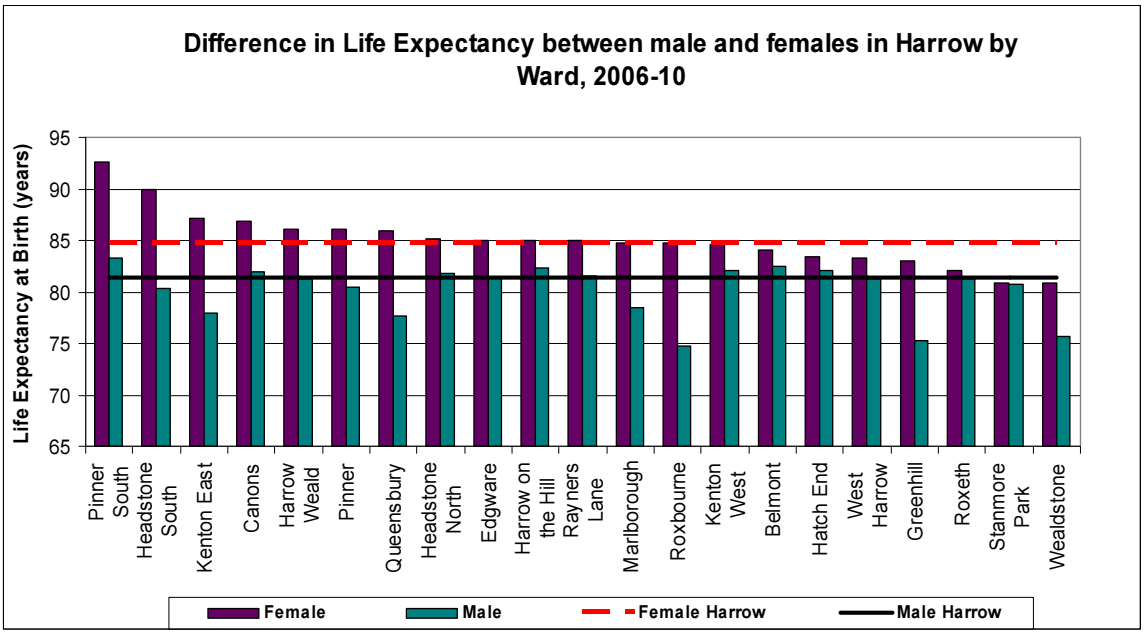
Within Borough Inequalities

Whilst life expectancy in Harrow and Barnet is better than the national and regional averages and compare favourably to their statistical neighbouring boroughs, this information does not represent the true picture. There are disparities between areas within both Harrow and Barnet, and it is only when we look at life expectancy at ward level across the boroughs can we see the inequalities across Harrow and Barnet. Ward level mapping is used to highlight the differences and in order to compare Harrow and Barnet male and female life expectancy, the scales used for the purposes of the mapping are the same. Therefore, for males in Harrow and Barnet, this ranges from 76.20 to 83.60 years and for females 82.80 to 96.60 years.

Inequalities in Harrow

In Harrow, a woman living in the Pinner South ward can expect to live up to twelve years longer than a woman in the Wealdstone ward, as can be seen by the graph in Figure 4.

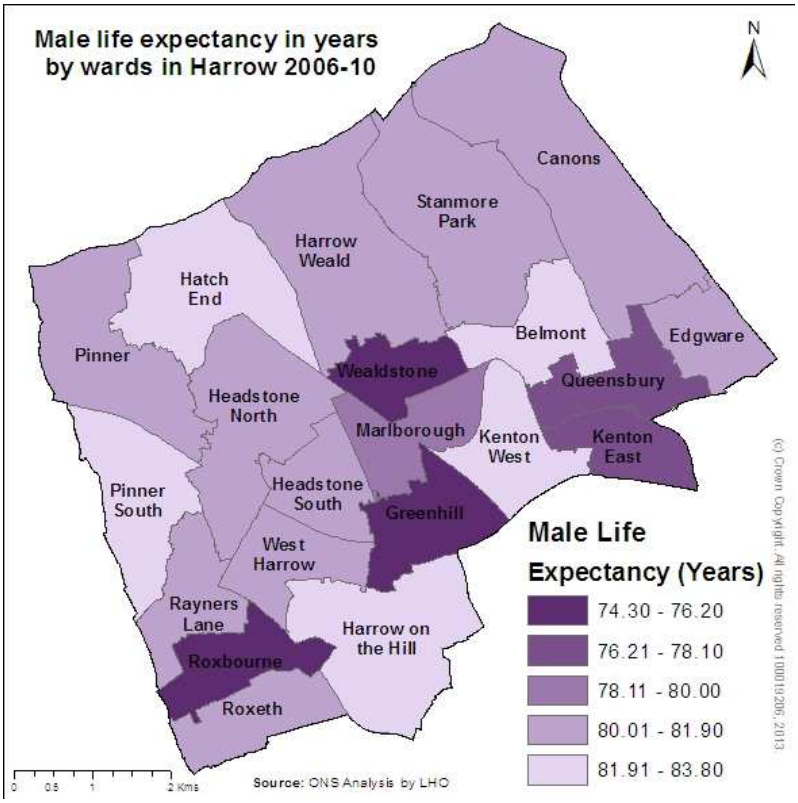
Figure 4: Differences in Life Expectancy between males and females by Harrow Ward



Source: Office for National Statistics

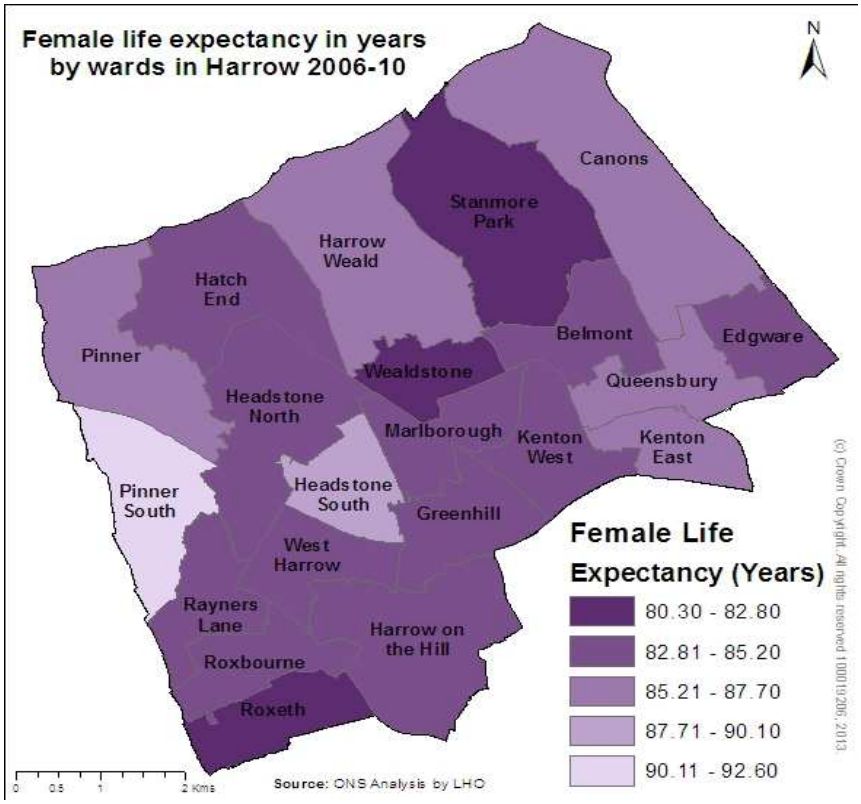
This is further displayed in the maps showing Harrow wards with life expectancy at birth for males Figure 6 and females Figure 7 below. The maps show the differences across the borough, with the darker shaded areas highlighting wards that have lower life expectancy.

Figure 5 Map to show male life expectancy at birth by Harrow wards



Source: ONS Analysis by LHO produced by Harrow GIS Team

Figure 6 Map to show female life expectancy at birth by Harrow wards

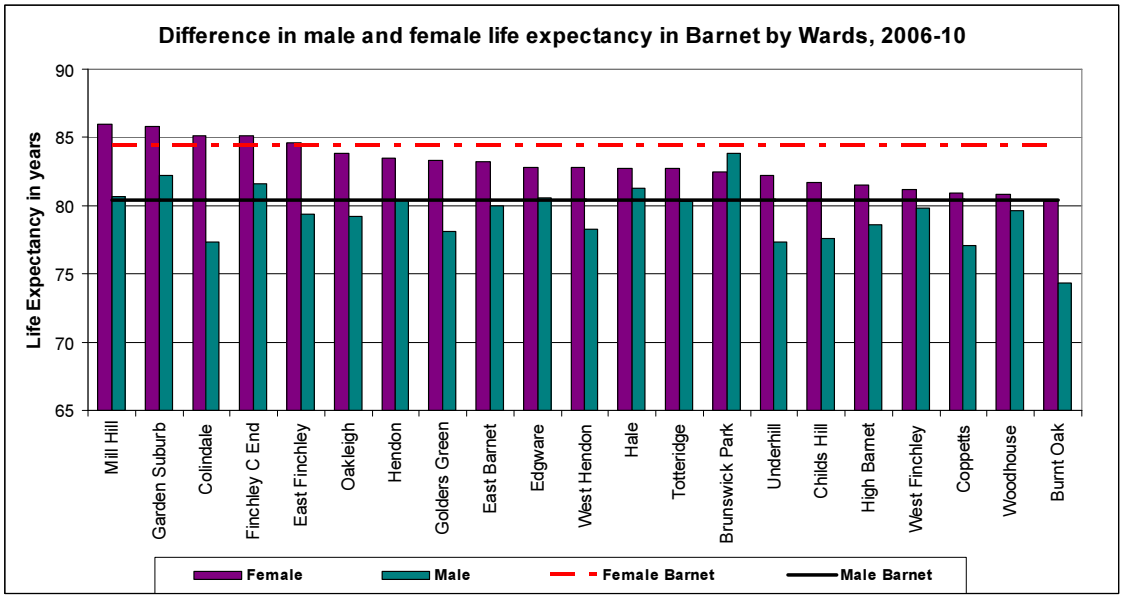


Source: ONS Analysis by LHO produced by Harrow GIS Team

Inequalities in Barnet

Although the gap between wards is narrower in Barnet, there are still disparities. A woman living in the Mill Hill ward in Barnet can expect to live six years longer than a woman living in the Burnt Oak area shown in the graph in Figure 7.

Figure 7 Differences in Life Expectancy between males and females by Barnet Wards

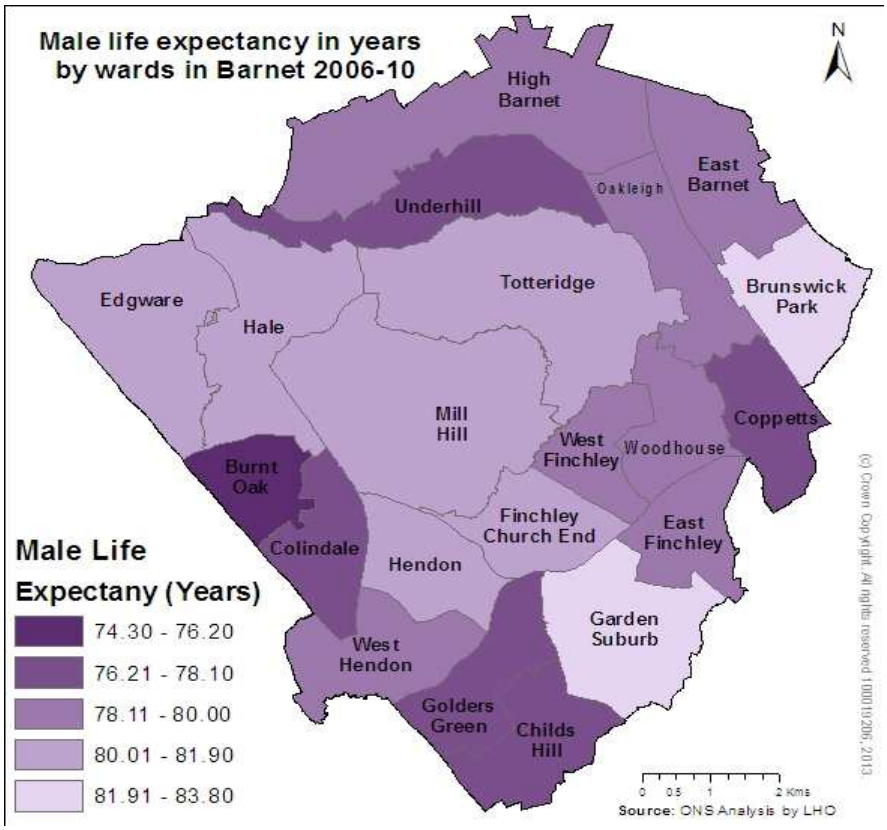


Source: Office for National Statistics

Male and female life expectancy at birth can be further seen in the maps in Figures 8 and 9, by wards.

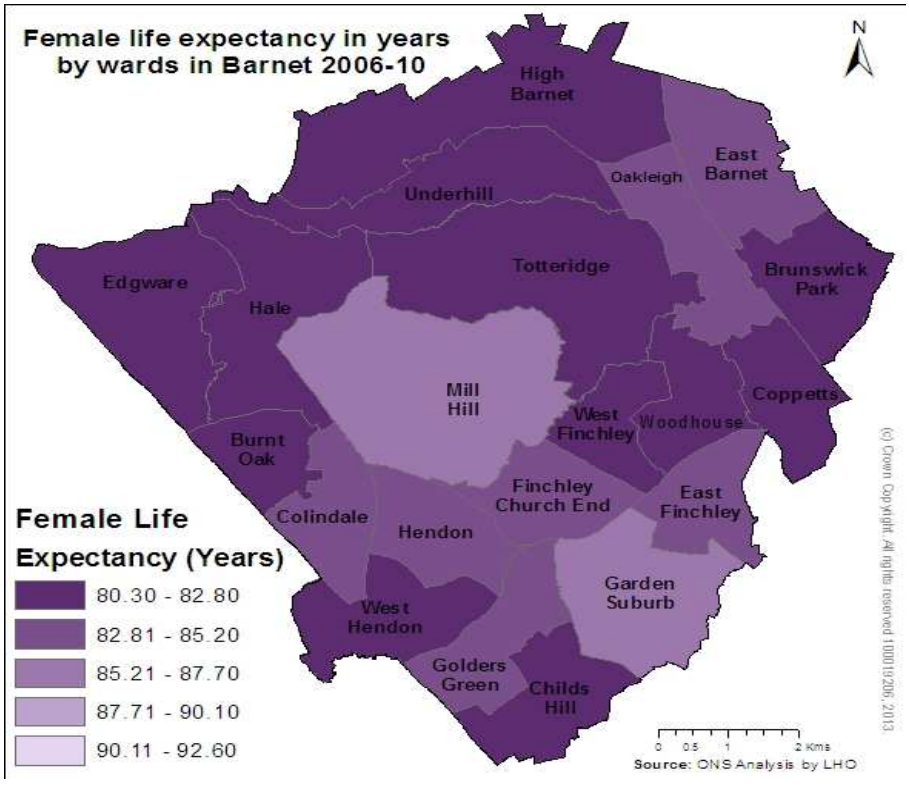
Hence, whilst the overall life expectancy at birth for a borough may be high, which is the case for both Harrow and Barnet, the graphs and maps displaying life expectancy at birth by ward highlight the *within* area inequalities.

Figure 8 Map to show male life expectancy at birth by Barnet wards



Source: ONS Analysis by LHO produced by Harrow GIS Team

Figure 9 Map to show female life expectancy at birth by Barnet wards



Source: ONS Analysis by LHO produced by Harrow GIS Team

Life Expectancy at age 65

In the UK, the number of people aged 65 and over is projected to rise by nearly 50% in the next 20 years. Harrow has one of the highest proportion of those aged 65 and over amongst its neighbouring boroughs, at 14.1% and Barnet at 13.3%, both higher than London at 10.3%. In the future, there is a further projected increase in those over the age of 65 in both Harrow and Barnet with an overall increase of around 22% for Harrow and 18% for Barnet by 2025. The general increases that we are seeing in the older population groups are important to highlight for the effective planning and provision of appropriate health services within primary and secondary care, as well as those services offered in the community, as there is evidence to show that these age groups represent a greater demand for care, and use a greater proportion of health services compared to other age groups.

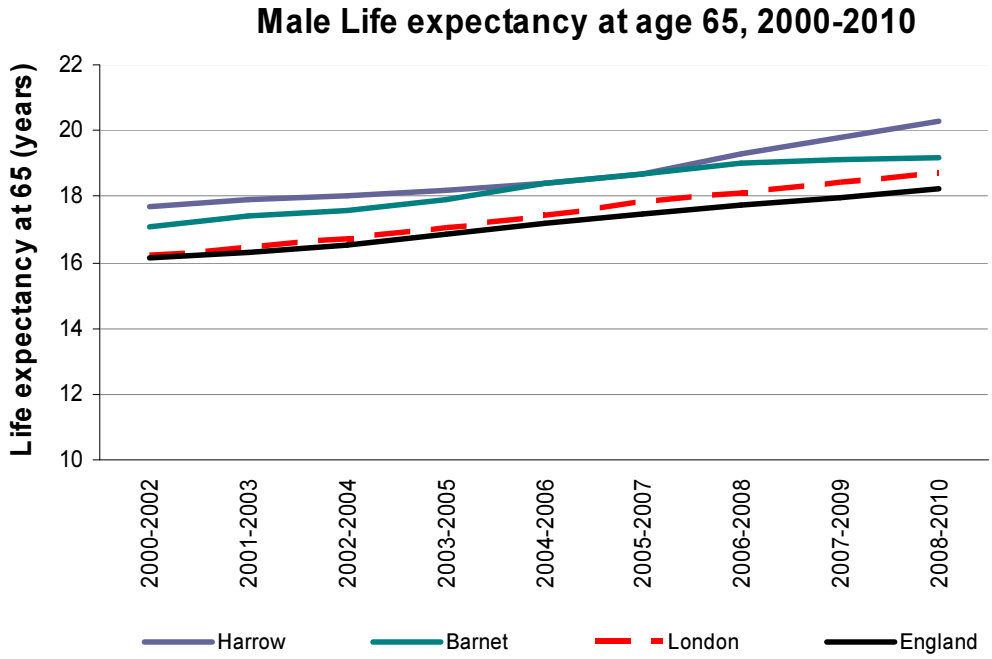
As people age, their life expectancy actually increases. Each year you live means that you have survived all sorts of causes of death. So your life expectancy at 65 is not the same as it is was at birth.

Trends in Life Expectancy at 65

Males at age 65 in Harrow could expect to live for a further 20 years and in Barnet 19 years compared to around 18 years for London and England as a whole. By contrast, females in Harrow and Barnet at age 65 could expect to live for a further 22 years compared to 21 years in London, and 20 years in England. The graphs below, Figures 10 and 11 show the trends over time for both Harrow and Barnet, when compared to London and England.

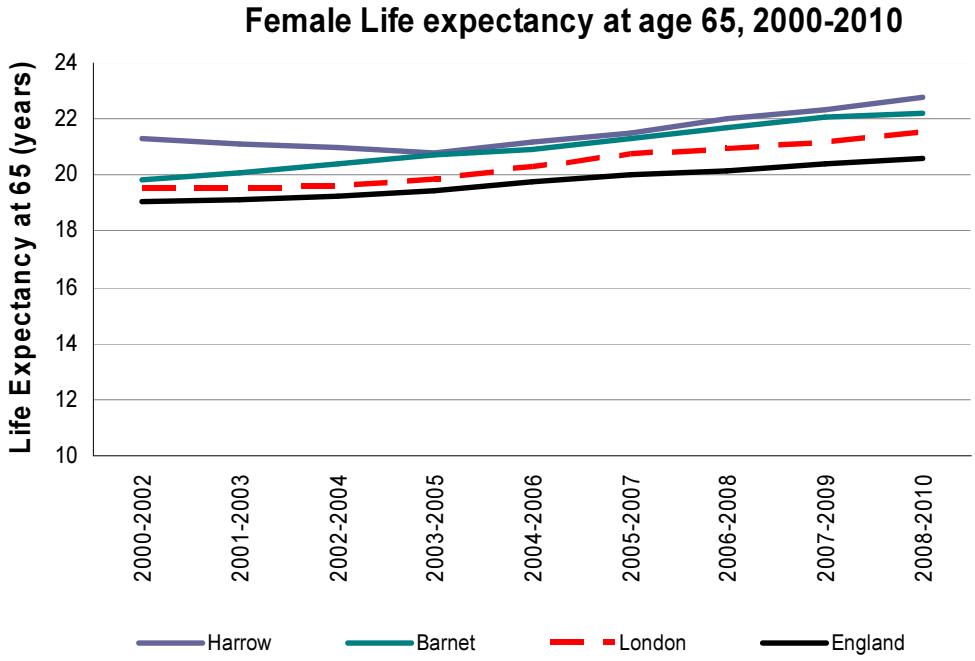
As life expectancy continues to increase it is important to ask whether these additional years in life are being spent in favourable health states or prolonged poor health and dependency. Healthy life expectancies help us to address this question by adding a dimension of quality of life to estimates of life expectancy.

Figure 10: Trends in Male Life Expectancies at 65 in Harrow, Barnet, London and England



Source: Office for National Statistics

Figure 11: Trends in Female Life Expectancy at 65 in Harrow, Barnet, London and England



Source: Office for National Statistics

Summary

This second Public Health Intelligence Briefing presented Life Expectancy, and we have shown that overall life expectancy compares well in Harrow and Barnet, for both at birth and at age 65 when compared to their statistical neighbours, as well as regionally and nationally.

However, we have also demonstrated, there are *within* area inequalities as a result of the wider determinants of health, i.e. an individual's gender, socio-economic status etc. highlighted by the Slope Index of Inequalities in the first briefing.

As life expectancy continues to increase it is no longer just a question of how long a person can live, but more so whether these additional years of life are spent in favourable health states and it is the estimates of Healthy life expectancy that will provide us with more information.

Public Health Intelligence Briefing #3 will cover Healthy Life Expectancy.
For further information or to request a future topic for PHIBs please contact
Carole Furlong, Consultant in Public Health

Public Health Intelligence Briefing

Issue # 3

Healthy Life Expectancy

Key Findings

- Healthy life expectancy adds a dimension of quality of life to estimates of life expectancy
- Although both men and women in Harrow live longer than they do in Barnet, London, and England, a greater proportion of their life is spent with a disability or a limiting persistent illness.
- Men and women in Barnet live longer lives and spend a greater proportion of their lives free from disability or long term limiting illnesses than their counterparts in London and across England as a whole.

Introduction

As life expectancy continues to increase, it is important to ask whether these additional years in life are being spent in favourable health states or prolonged poor health and dependency. Healthy life expectancy help us to address this question by adding a dimension of quality of life to estimates of life expectancy, and this is further explored in this third Public Health Intelligence Briefing.

Healthy Life Expectancy

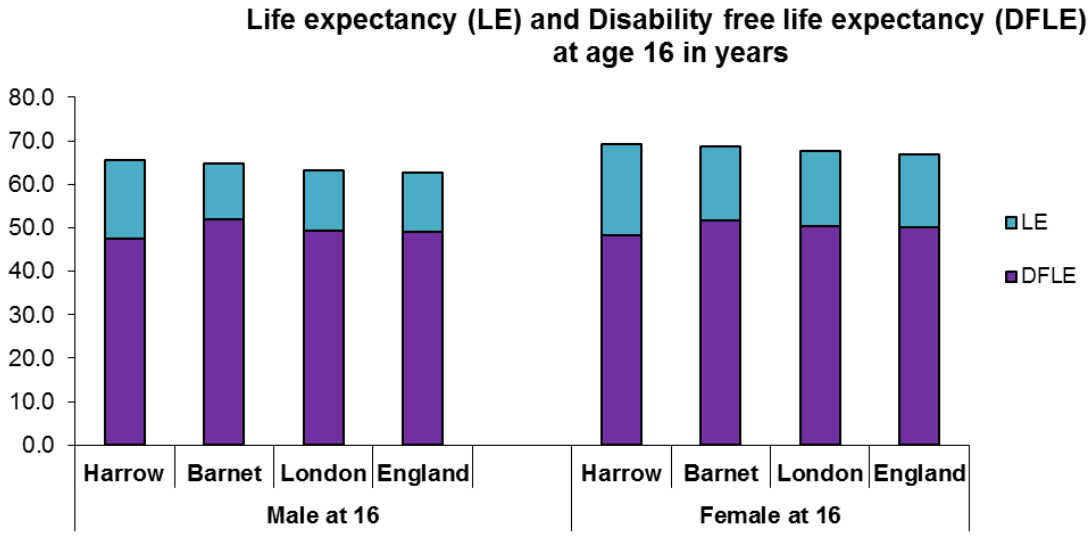
In the UK, at birth people can expect to spend more than 80 per cent of their lives in very good or good general health. This falls to around 57 per cent of their remaining life by age 65. People in England generally spend the more of their lives free from a limiting persistent illness or disability; than do people in Scotland and Northern Ireland.

With an aging population, healthy life expectancy adds a dimension of quality of life to estimates of life expectancy, allowing us to look more holistically at life expectancy. The Office of National Statistics (ONS) routinely publishes two types of health expectancy estimates nationally; Healthy Life Expectancy (HLE), defined as the number of years an individual can expect to spend in very good or good general health, and Disability Free Life Expectancy (DFLE), defined as the number of years an individual can expect to spend free from a limiting persistent illness or disability.

Although these are not yet routinely available at local authority level, the ONS has produced experimental statistics for Life Expectancy (as we have seen in the previous briefings) and DFLE at age 16 and 65. We have used these data to calculate the HLE data for the boroughs. The following graphs below in Figures 1 and 2 show the proportion of Life Expectancy spent in disability/long term Illness, and disability free for Harrow and Barnet compared to London and England age 16 and 65.

Figure 1 illustrates that, in London, a young man on his 16th birthday can expect to live for a further 63.2 years and can expect around 78 per cent of his life to be disability free/free from long term illness. A young woman, at the same age can expect to live for a further 67.6 years and with around 74 per cent of these years disability free/free from long term illness.

Figure 1: Life Expectancy and Disability free life expectancy and Life at age 16, 2007-09



Source: Office for National Statistics

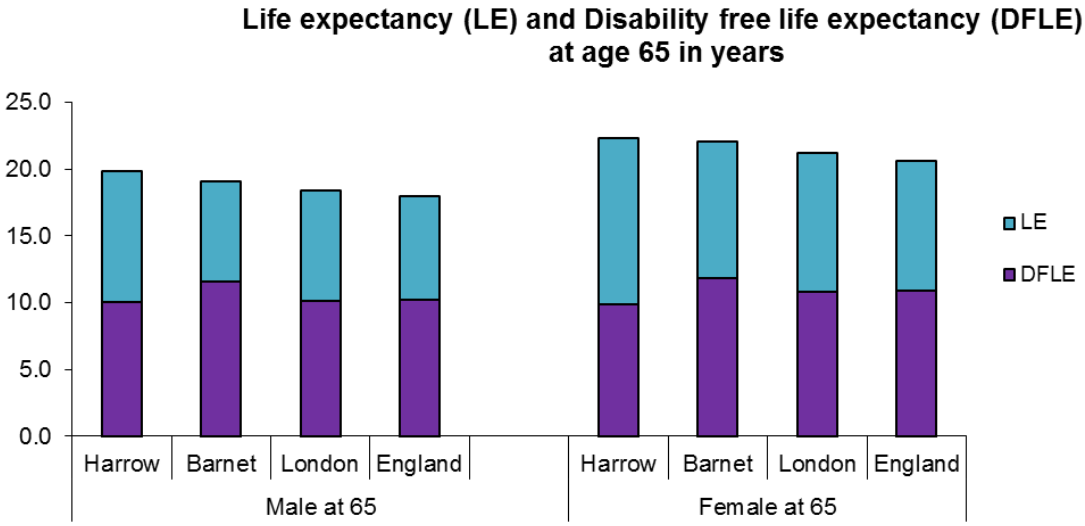
In Harrow, although at the same age a young man can expect a life expectancy of 65.7 years, only 72 per cent is of it is estimated to be disability free/free from long term illness. For a young women in Harrow, even less (69 per cent) of her life expectancy of 69.1 years is expected to be disability free/free from long term limiting illness.

Looking at the same statistics for young men and women in Barnet, although they don't expect to live quite as long as their Harrow neighbours, a higher proportion of their lives (80.3 per cent for men and 75 per cent for women) is likely to be disability free/free from long term limiting illness.

In figure 2, we show LE and DFLE at age 65. We can see that at age 65, men in Harrow can expect to live around 50 per cent and women 44 per cent of their lives disability free. Again Barnet shows an increase in the proportion of disability free life expectancy, at 60 per cent for men, and 53 per cent for women disability free. Compared to London, both men and women in Harrow can expect to live longer but for less of these additional years will be disability free. Barnet men and women at 65 can again expect to live longer and spend more of their lives disability free than their

fellow Londoners. These data suggest that there may be greater pressure on health and adult social care in Harrow

Figure 2: Proportion of Disability free life and Life with Disability/Long Term illness at age 65, 2007-09



Source: Office for National Statistics

Can we explain the differences?

We have seen that people in Harrow spend more of their lives with a disability/long term illness than Barnet, London or England. Although this cannot be conclusively explained, we hypothesise that at least part of the difference is due to the ethnic diversity that we see in Harrow. Over 50 per cent of Harrow's population comprises residents from the South Asian ethnic groups and these groups are forecasted to grow further. Diseases such as diabetes, stroke or coronary heart disease have higher prevalence in this group compared to England. This is further confirmed by the GP prevalence data which shows that 7.1% of patients were diagnosed as having diabetes in Harrow compared to 5.25% in London and 5.4% in England. Despite the high prevalence in Harrow, diabetes is managed well in primary care, which may mean that people live with the disease for longer.

At present, statistics at ward level are not available for Healthy Life Expectancy, therefore Disability Free Life Expectancy, hence currently it is not possible to further

identifying areas within Barnet or Harrow that have low proportions of life disability free/free from chronic illness.

Summary

This third briefing followed on from Health Inequalities and Life Expectancy briefings (Public Health Intelligence Briefings 1 and 2), which showed that whilst Harrow and Barnet compare well in terms of Life Expectancy against other boroughs, there are *within* borough inequalities. Presenting Healthy Life Expectancy in this briefing highlights that whilst overall Life Expectancy may be above the regional and national averages, it is the number of years that are spent disability free/free from a long term limiting illness that actually adds quality of life to an individual's life.

Although both men and women in Harrow live longer than they do in Barnet, London, and England, a greater proportion of their life is spent with a disability or a limiting persistent illness. Some of this may be explained by the high rates and good management of diabetes in the South Asian community in Harrow

Men and women in Barnet live longer lives and spend a greater proportion of their lives free from disability or long term limiting illnesses than their counterparts in London and across England as a whole.

The next Public Health Intelligence Briefing is to be released in July 2013, and will cover wellbeing indicators. For any queries relating to PHIB, please contact Carole Furlong, Consultant in Public Health.

This page is intentionally left blank

AGENDA ITEM 12

Meeting	Health and Well-Being Board
Date	27 June 2013
Subject	**Pharmaceutical Needs Assessment**
Report of	Director of Public Health
Summary of item and decision being sought	This paper informs the Health and Well-Being Board of its responsibility for Pharmaceutical Needs Assessment; the status of the current document and the plans for the next Pharmaceutical Needs Assessment.

Officer Contributors	Carole Furlong, Public Health Consultant
Reason for Report	The Health and Well-Being Board is asked to note the plans by the Barnet and Harrow Public Health team to refresh the Pharmaceutical Needs Assessment
Partnership flexibility being exercised	N/A
Wards Affected	All
Contact for further information	Carole Furlong, Public Health Consultant, carole.furlong@harrow.gov.uk

1. RECOMMENDATION

1.1 That the Health and Well-Being Board notes its responsibility to undertake Pharmaceutical Needs Assessment as detailed within the report.

1.2 That the Health and Well-Being Board approves the plans by the Public Health team to refresh the Pharmaceutical Needs Assessment

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 None

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

3.1 The Pharmaceutical Needs Assessment is the document that the NHS uses when deciding if new pharmacies are needed and to make decisions on which NHS funded services need to be provided by local community pharmacies.

3.2 The Pharmaceutical Needs Assessment is informed by the Sustainable Communities strategy plans. It can however be used as part of the Joint Strategic Needs Assessment (JSNA) to inform future commissioning strategies.

4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 The current Pharmaceutical Needs Assessment will be marked as 'inadequate' by NHS England for not fully covering the protected characteristics in the Equalities Act. Although the current Pharmaceutical Needs Assessment may have considered equalities legislation, it was not explicit in the report. The new Pharmaceutical Needs Assessment will cover the equalities legislation by reporting on the age, gender and ethnicity of pharmacists; the protected characteristics of those stakeholders and service users in the consultation; and any issues raised with regards to protected characteristics and service delivery, access and potential new services, if any, will be identified.

5. RISK MANAGEMENT

5.1 N/A.

6. LEGAL POWERS AND IMPLICATIONS

6.1 Health and Well-Being Boards are statutorily required to produce a Pharmaceutical Needs Assessment. These requirements are set out in Section 128A of the NHS Act 2006, as amended by Section 206 of the 2012 Health and Social Care Act. The Department of Health has laid regulations for undertaking Pharmaceutical Needs Assessments in Regulations 3 - 9 and

Schedule 1 of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.

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

7.1 The Pharmaceutical Needs Assessment is a statutory function of the Health and Well-Being Board. The budget OF £60k for carrying out the Pharmaceutical Needs Assessment has been included in the Public Health grant from Department of Health.

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 Full communications plan and stakeholder engagement will be undertaken as part of the Pharmaceutical Needs Assessment. The Regulations require that consultation take place with a specified list of persons and bodies.

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 Provider engagement will be undertaken as part of the Pharmaceutical Needs Assessment. The Regulations require that consultation take place with a specified list of persons and bodies.

10. DETAILS

10.1 The Pharmaceutical Needs Assessment is a new requirement for local authorities and must be completed by end of March 2015.

10.2 The current Pharmaceutical Needs Assessment, completed by Barnet PCT in 2011/12, will be on Barnet Council's website by July 2013. NHS England has undertaken an independent assessment of the current Pharmaceutical Needs Assessment but the Public Health team do not yet have the full results. The Public Health team believe the current Pharmaceutical Needs Assessment has been assessed as being 'mostly good' or 'adequate', but that it will be marked as 'inadequate' for not fully covering the protected characteristics in the Equalities Act. Although the current Pharmaceutical Needs Assessment may have considered equalities legislation, it was not explicit in the report. The new Pharmaceutical Needs Assessment will cover the equalities legislation by reporting on the age, gender and ethnicity of pharmacists; the protected characteristics of those stakeholders and service users in the consultation; and any issues raised with regards to protected characteristics and service delivery, access and potential new services, if any, will be identified.

10.3 The Public Health team will lead on the Pharmaceutical Needs Assessment and aim to have the revised version completed by April 2014.

10.4 Funding for the Pharmaceutical Needs Assessment is covered by the public health ring-fenced grant.

10.5 Background

The Health and Social Care Act (2012) changed the responsibilities for commissioning of pharmaceutical services to meet the new provider landscape. From April 2013:

- The Department of Health will continue to have the power to make regulations
- The NHS Commissioning Board – now NHS England – has the responsibility to commission pharmaceutical services taking into account the local need for services. If someone wants to provide NHS pharmaceutical services, they are required to apply to the NHS to be included on a pharmaceutical list and must prove they are able to meet a pharmaceutical need. This is commonly known as the NHS "market entry" system.
- Local Health and Well-Being Boards (HWBBs) have the responsibility to undertake Pharmaceutical Needs Assessments.

10.6 The Pharmaceutical Needs Assessment is the document that the NHS uses when deciding if new pharmacies are needed and to make decisions on which NHS funded services need to be provided by local community pharmacies.

10.7 As a valuable and trusted public health resource with millions of contacts with the public each day, community pharmacy teams have the potential to be used to provide services out of a hospital or practice environment and to reduce health inequalities[1]. In addition, community pharmacies are an important investor in local communities through employment, supporting neighbourhood and high street economies, as a health asset and as a long term partner.

10.8 The preparation and consultation on the Pharmaceutical Needs Assessment should take account of the JSNA and other relevant strategies. However, the Pharmaceutical Needs Assessment cannot be subsumed as part of these other documents (but can be annexed to them).

10.9 The National Health Service (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 came into force on the 1st April 2013. These Regulations are made under s.128A of the National Health Service Act 2006 (see Appendix 1). Health and Wellbeing Boards (HWBBs) will be required to produce the first Pharmaceutical Needs Assessment by the 1st April 2015 with revised assessments within three years thereafter. If there are significant changes to the availability of pharmaceutical services since the publication of its Pharmaceutical Needs Assessment within this time, the HWBBs are required to publish a revised assessment as soon as is reasonably practical unless it is satisfied that making a revised assessment would be a disproportionate response to those changes. The HWBBs can if necessary, publish supplementary statements to the Pharmaceutical Needs Assessment as necessary.

[1] "*Healthy lives, healthy people*", the public health strategy for England (2010)

10.10 **The Current Barnet Pharmaceutical Needs Assessment**

The current Pharmaceutical Needs Assessment was undertaken and published by Barnet PCT in 2011/12. It has not been altered since this time but at least two supplementary statements have been published to reflect some minor alterations either in population need or in pharmacy provision.

10.11 NHS England has commissioned an independent company to look at the quality of the current Pharmaceutical Needs Assessments to ensure that they comply with the legal guidance. This report has not yet been circulated but the public health service has reviewed the content of the existing Pharmaceutical Needs Assessment. We expect that NHS England will grade the majority of the Pharmaceutical Needs Assessment as 'good' or 'satisfactory'. There may be one area where the report is inadequate and that is on the compliance with the Equalities Act (see 10.2).

10.12 **Future Plans**

The current Pharmaceutical Needs Assessment will be uploaded to the Barnet Council website together with an updated map of local pharmacy services.

10.13 The Public Health team will commission an expert company to develop the Pharmaceutical Needs Assessment prior to the deadline in 2015. It will be undertaken simultaneously with the Pharmaceutical Needs Assessment for Harrow. This will be managed as a single project which will reduce the management costs.

10.14 The high level plan for the Pharmaceutical Needs Assessment (led by the Public Health team) is as follows:

- Agree scope by July 2013
- Develop specification by August 2013
- Commission a company to undertake the assessment by October 2013
- Pharmaceutical Needs Assessment finalised by April 2014.

11. BACKGROUND PAPERS

None.

Legal- CE
CFO- AD

Appendix 1: Section 128A of NHS Act (2006), as amended by Health Act (2009) and Health and Social Care Act (2012)

128A Pharmaceutical needs assessments

(1) Each Health and Well-being Board must in accordance with regulations--

(a) assess needs for pharmaceutical services in its area, and

(b) publish a statement of its first assessment and of any revised assessment.

(2) The regulations must make provision--

(a) as to information which must be contained in a statement;

(b) as to the extent to which an assessment must take account of likely future needs;

(c) specifying the date by which a Health and Well-being Board must publish the statement of its first assessment;

(d) as to the circumstances in which a Health and Well-being Board must make a new assessment.

(3) The regulations may in particular make provision--

(a) as to the pharmaceutical services to which an assessment must relate;

(b) requiring a Health and Well-being Board to consult specified persons about

1. specified matters when making an assessment;

(c) as to the manner in which an assessment is to be made;

(d) as to matters to which a Health and Well-being Board must have regard when making an assessment.

Meeting	Health and Well-Being Board
Date	27 June 2013
Subject	**Clinical Commissioning Programmes**
Report of	Chief Officer, Barnet Clinical Commissioning Group
Summary of item and decision being sought	This paper provides an update on Clinical Commissioning Programmes in Barnet, for information

Officer Contributors	John Morton, Chief Officer, Barnet CCG
Reason for Report	This paper provides an update on Clinical Commissioning Programmes in Barnet, for information
Partnership flexibility being exercised	N/A
Wards Affected	All
Contact for further information	John Morton, Chief Officer, Barnet CCG, John.Morton@barnetccg.nhs.uk

1. RECOMMENDATION

1.1 That the Health and Well-Being Board notes this report for information.

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 The Clinical Commissioning Programmes proposals have been considered and approved by the Barnet CCG Governing Body.

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

3.1 The Clinical Commissioning Programmes Terms of Reference allow for engagement with strategic partners.

4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 Each Clinical Commissioning Programme and projects arising therefrom will consider the requirement for needs assessment and equalities impact assessments.

5. RISK MANAGEMENT

5.1 Risks identified within the plan will be managed through the Barnet Clinical Commissioning Group Board Assurance Framework and Risk Register.

6. LEGAL POWERS AND IMPLICATIONS

6.1 Section 12 of the Health and Social Care Act 2012 introduces section 2B to the NHS Act 2006. This imposes a new target duty on the local authority to take such steps as it considers appropriate for improving the health of people in its area.

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

7.1 The Clinical Commissioning Programmes will make a significant contribution to managing local NHS finances.

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 Each Clinical Commissioning Programme project will consider communication and engagement with users and partners.

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 Each Clinical Commissioning Programme project will consider membership from providers and communication and engagement with providers.

10. DETAIL

10.1 Summary

10.2 The PCT`s work was largely driven by the productivity elements of QIPP and the CCG are determined to ensure we deliver quality and innovation which will in turn drive

productivity. The CCG are moving to a Clinical Commissioning Programme (CCP) delivery model which covers comprehensively the range of services we commission. These are clinically and managerially led with each CCP supported by a GP Board member as clinical strategic lead, a senior manager and project management team. The two directors of commissioning (Integration and Clinical) will support the six CCPs.

10.3 Each CCP will, working with partners, providers, the local authority, patients and the public, review the needs assessments, current service delivery and outcomes in order to decide which services within each portfolio need to be reviewed and in what priority. These will form the projects to be delivered in year by the project teams. This will encompass the delivery of QIPP and be supported by the project management office (PMO).

10.4 The proposal to develop clinical commissioning programmes sets out a way to ensure our commissioning adequately covers the services that we are responsible for. CCPs need to be grouped in ways which people recognise and, collectively, these need to cover the whole health system which we have responsibility for. However, the health system is complex and each approach taken to dividing up into manageable parts has both advantages and disadvantages.

10.5 The integrated plan and 'plan on a page' set out the strategic priorities for the CCG. In this context there is a very strong focus on:

- Transformational change of the health system through provision of integrated care for patients with complex needs. Through proactive identification, care planning and integrated management of care for patients with complex needs we will seek to avert crises, thus reducing the unplanned use of acute care;

- Reduction in elective acute care through robust management of referrals, and redesign of care pathways to provide upstream early intervention, a greater range of care in a primary care setting, and community based alternatives to acute care.

- This will require new ways of working; to provide robust foundation for a rebalanced system, we are restructuring the work of the CCG, and our team, into Clinical Commissioning Programmes (CCPs), which reflect the objectives set out in our plan on a page.

10.6 Introduction

10.7 The CCG is responsible for commissioning population-based general health care services for the registered population. While the CCG does not have direct responsibility for specialist, public health and primary care contracting, we will have a fundamental interest in ensuring these services are commissioned well for our population.

This proposal to develop clinical commissioning programmes sets out a way to ensure our commissioning adequately covers the services that we are responsible for.

10.8 Approach

10.9 CCPs need to be grouped in ways which people recognise and, collectively, these need to cover the whole health system which we have responsibility for. However, the health

system is complex and each approach taken to dividing up into manageable parts has both advantages and disadvantages. These are set out below:

10.10 Organisational Commissioning

The approach to contracting is currently organisational. We contract with different provider organizations based partly on the care groups (Acute, community, mental health, orthopaedics etc.) or on geography (general hospital services from Barnet and Chase Farm and the Royal Free Hospitals), which is largely driven by patient choice. An alternative approach would be to commission on organisational type such as community, mental health and acute. Arguably this is aligned to the current approach which recognises the organisations over the patient and treats the disease in steps rather than in pathways. This has resulted in most patient care spend being on the acute step and less on the primary and community phases.

10.11 Disease Groups

Medicine can generally be divided into disease groups, organic systems, or "Specialities". Examples are cardiovascular (including diabetes and renal), gastroenterology, urology, MSK etc. Setting CCPs up in this way would enable detailed review of each area. However, this requires some generic grouping, I.E mental health, health promotion and prevention etc.) A further weakness of this approach is dealing with cross cutting themes such as emergency care and older people's care which cross all disease groups. This approach can also generate a large number of CCPs, depending on the disease groups.

10.12 Care groups

A further approach may be to consider care groups, or settings of care, with each care group leading on a range of disease groups which largely, but not exclusively, fall within the care group. This would allow the CCPs to work on a sensible grouping of clinical services and relate to specialist clinicians/providers in a manageable way.

Suggested care groups would be as follows:

- Health promotion and prevention
- Children, families and maternity
- Elective acute care/General Surgery
- Urgent acute care/General Medicine
- Long term conditions /Older peoples services
- Mental health including learning disability

10.13 Health promotion and prevention

10.14 The responsibility for commissioning and delivery has moved to the local authority and public health England. However it is recognised that the impact of smoking and obesity on general health is immense. CCGs should be commissioning for every health contact to be a public health contact. This will not be a large CCP as the budgets have moved to Public Health, however, it is recommended that it is an area worth time-specific focus. The CCP would also oversee the CCG relationship with public health.

10.15 Children and Family (Including maternity)

A healthy start in life and emotional health and wellbeing underpin the future health of the population. Barnet CCG will commission children's' services jointly with the local authority and work across physical care and emotional health and wellbeing. As we will want to see close integration between secondary care and community services, this CCP would lead on secondary care children's and maternity commissioning. The CCP will require good partnerships with local authorities, schools, providers and health visitors to 2015 with the national commissioning.

10.16 Elective Acute Care/General Surgery (Arguably to include community out-patient services)/General Surgery

This CCP will work with pathways which most commonly present as planned procedures in a hospital setting. This could include the following planned treatments:

- Orthopaedics (MSK and Pain)
- Urology
- Vascular
- Neurology
- ENT
- Opthalmology

This CCP will require good partnerships with acute and community providers with an emphasis on general surgery and orthopaedics.

10.17 Urgent Acute Care/General Medicine

This group will work in the pathways which most commonly present in an urgent or emergency setting.

There will be strong links and overlap with long term conditions /older people and mental health. This group is differentiated by an immediate or imminent need for assessment, diagnosis and treatment in a way which could not have been planned or predicted. This could include:

- Cardiology, including Diabetes and Renal
- Respiratory
- Gastroenterology
- Trauma

This CCP will lead the emergency and urgent care network and have good partnerships with the urgent care providers (Ambulance, out of hours and 111), acute and community providers and mental health providers.

10.18 Long Term Conditions/ Older Peoples Services

This CCP will lead on integrated care across the health sectors including social care. The CCP will lead on pathways where most of the care will be provided in a community or primary care setting. This will be joint working with the London Borough of Barnet.

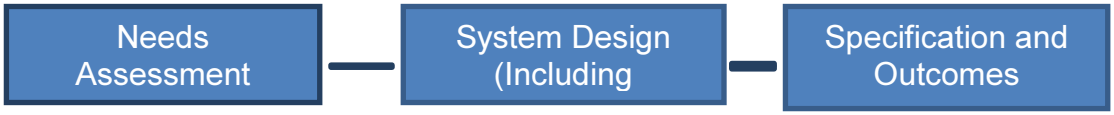
The care service will be based on generic community teams supporting people meeting planned (LTC) and unplanned (Crisis/Step up) care at home or in a community setting. The service design will provide community services which support primary care and work together to support the more complex needs in community settings.

10.19 Mental Health

The CCP will have the brief to develop a commissioning strategy for mental health service and to ensure stronger contract management and procurement so that safe and acceptable mental health services are provided to Barnet residents. This CCP will jointly commission services with the London Borough of Barnet and will work closely with all providers including third sector provision. This is the largest CCP and may require two GP board leads.

10.20 CCP Organisation

10.21 Each CCP will be led by a GP board member (some may have two) and be supported by a senior project manager reporting to a director. The CCP will work on the initial phases of the commissioning cycle.



The CSU will take responsibility for processing, contracting and reviewing projects.

10.22 Each CCP team will be responsible for delivering the relevant projects in each annual operating plan, working with partners and providers. This includes engagement, consultation and impact assessments.

10.23 Whilst it will be for each CCP to determine detailed methodology, it is expected that regular CCP discussions will be held with providers and other stakeholders to shape and progress plans and pathways. The CCP will identify and prioritise projects for implementation in current and future years.

10.24 For 2014/15 and beyond the overall CCG priorities will be set by the CCG members, the CCG governing body, the health and wellbeing board and the public. This will be achieved by considering the CCP programmes and prioritising investment and disinvestment.

10.25 Summary

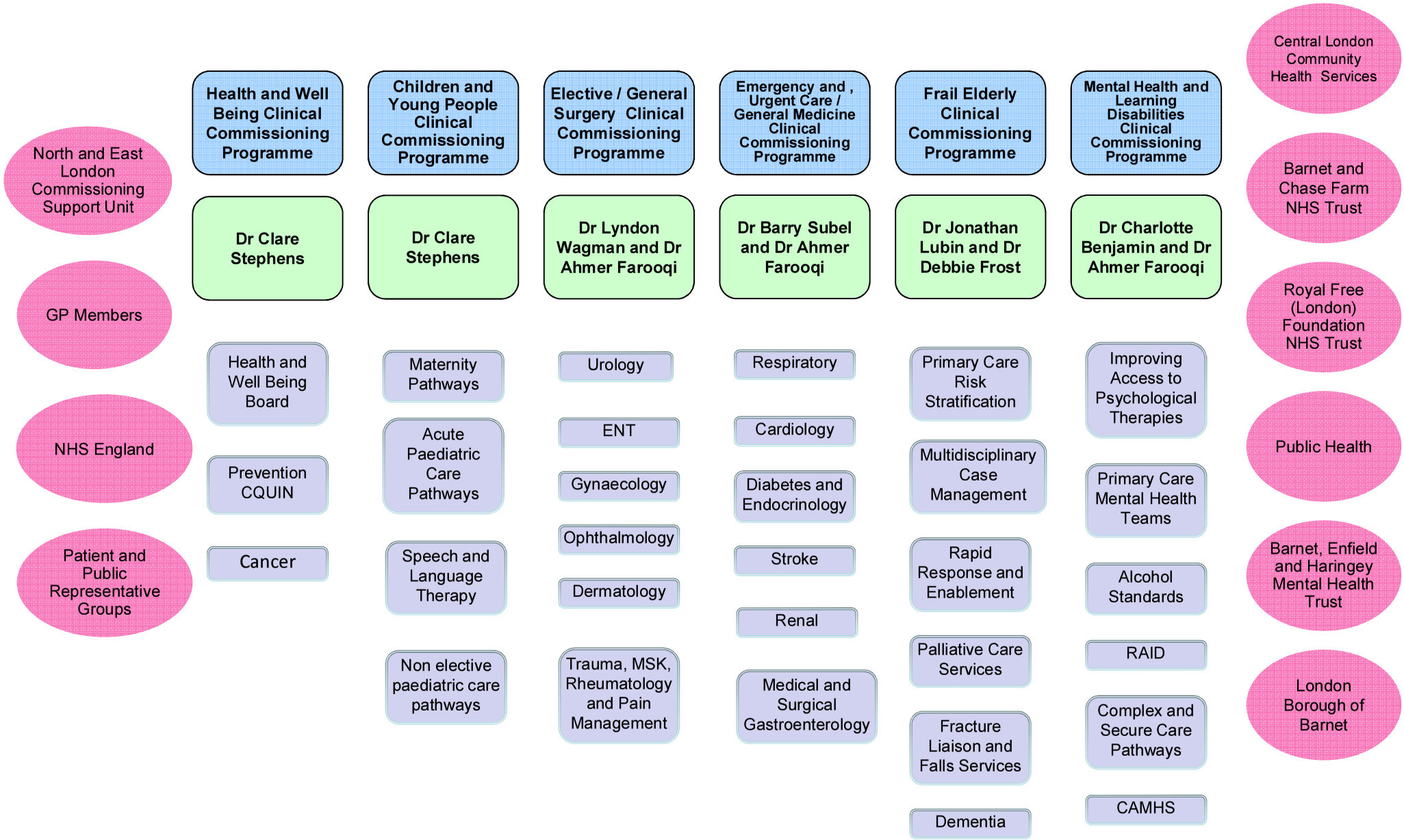
The proposal sets out a comprehensive approach to commissioning general health services, assessing needs reviewing services and prioritising and implementing changes. The Health and Well-Being Board is asked to note the proposals.

11. BACKGROUND PAPERS

None

This page is intentionally left blank

Barnet CCG Clinical Commissioning Programmes



This page is intentionally left blank

AGENDA ITEM 14

Meeting	Health and Well-Being Board
Date	27 June 2013
Subject	**Forward Work Programme for 2013/14**
Report of	Director for People
Summary of item and decision being sought	To present a proposed work programme for 2013/14 for the Health and Well-Being Board to comment on.

Officer Contributors	Claire Mundle, Commissioning and Policy Officer- Public Health / Health and Well-Being
Reason for Report	To allow the Health and Well-Being Board to schedule a programme of agenda items that will fulfil its remit
Partnership flexibility being exercised	The items contained in the work programme will individually take forward partnership flexibilities, including the powers Health and Well-Being Boards have assumed under the Health and Social Care Act 2012.
Wards Affected	All
Contact for further information	Claire Mundle, Commissioning and Policy Officer- Public Health / Health and Well-being, 020 8359 3478, Claire.Mundle@Barnet.gov.uk

1. RECOMMENDATION

1.1 That the Health and Well-Being Board proposes additions and amendments to the proposed forward work programme for 2013/14 (attached at Appendix 'A').

1.2 That the Health and Well-Being Board reviews the six strategic areas for the forward work programme set out in this paper, and endorses this approach to forward planning.

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 Health & Wellbeing Board- Governance- 25th April 2013

2.2 Health & Wellbeing Board- Forward work plan- 31st January 2013

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

3.1 The forward work programme has been designed to cover both the statutory responsibilities of Health and Well-Being Boards and the key projects that have been identified as priorities by the Board at its various meetings and development sessions.

3.2 Approval and performance management of the Health and Well-Being Strategy has been included within the work programme and, when adopted, the Strategy will be the most significant determinant of future work programmes.

4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 None specifically arising from this report- but all items of business listed in the forward programme and presented at the Health and Well-Being Board will be expected to bear in mind the health inequalities across different parts of the Borough and will aim to reduce these inequalities. Individual and integrated service work plans sitting within the remit of the Health and Well-Being Board's work will need to demonstrate how the needs analysis contained in the Joint Strategic Needs Assessment (JSNA) has influenced the delivery options chosen, including differential outcomes between different communities.

5. RISK MANAGEMENT

5.1 A forward work programme reduces the risks that the Health and Well-Being Board acts as a talking shop for the rubber stamping of decisions made elsewhere, or does not focus on priorities. It ensures that all decisions formally within the Board's statutory duties, Terms of Reference and other key issues relating to local health and care services are considered.

6. LEGAL POWERS AND IMPLICATIONS

6.1 Health and Well-Being Boards have a number of statutory duties designated through the Health and Social Care Act (2012) that will inform what items should be taken to the Health and Well-Being Board meetings. These statutory duties are attached as Appendix B.

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

7.1 None specifically arising from this report

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 The forward work programme will be set by the Health and Well-Being Board, but Healthwatch through their membership of the Board have the opportunity to refer matters or suggest agenda items.

8.2 The twice yearly Partnership Board Summits will provide opportunity for the Health and Well-Being Board to engage with each of the Partnership Boards on the content of the forward work programme.

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 None at this stage.

10. DETAILS

10.1 At its meeting on 25 April 2013, the Health and Well-Being Board considered a draft forward work programme for 2013, and requested an updated version of the work programme for the June meeting. The forward work programme attached to this report supersedes the previous work programme and suggests a refreshed schedule of reports and items for 2013/14, reflecting the Board's statutory requirements, agreed priorities and objectives set out in the Health and Well-Being Strategy.

10.2 The forward work programme is currently in draft form. Board Members are asked to review the proposed programme contained in this report and identify gaps and opportunities for both their own organisations and others, whose work is relevant to the strategic priorities of the Health & Well-Being Board.

10.3 A revised forward work programme will be formally published following discussion on this item at the Board meeting. There will be flexibility at later stages to move agenda items between Board meetings.

10.3 A copy of the draft forward work programme is attached at Appendix 'A' for the Board's comments. The forward work programme also notes the dates of the Health and Well-being Board Financial Planning Group meetings, and those of the individual Partnership Boards.

10.4 It is proposed that the reports bought to each Health and Well-Being Board meeting should span six key strategic areas of the Board's remit:

- Quality & Safety
- Performance
- Strategy
- Commissioning
- Partnerships
- Integration

10.5 The Health and Well-Being Board is asked to review these strategic areas and endorse this approach to forward planning.

11 BACKGROUND PAPERS

None

Legal – SC
CFO – AD

Appendix A: Proposed Health and Well-Being Board Forward Work Plan for 2013/14 (for comment)

MONTH	HWBB DATE	AGENDA ITEMS	LEAD	HWBB FINANCE GROUP MEETING	PARTNERSHIP BOARDS MEETING
July					Older Adults Partnership Board: 18th July Mental Health Partnership Board: 25th July
August				8th August	
September	12th September 2013	**Quality & Safety:** progress reports on local response to Winterbourne View & the Francis Inquiry	Adult & Communities Director; CCG Accountable Officer		Learning Disability Partnership Board: 17th September
		Performance: Public Health Annual Report (physical activity)/ public health intelligence briefings	Director of Public Health		Physical and Sensory Impairment Partnership Board: 20th September
		Strategy: Improving mental well-being in Barnet	Consultant of Health Improvement, Public Health		Carers' Strategy Partnership Board: 25th September
		Commissioning: progress reports on Public Health and CCG work plans/ report from the HWB Finance Group	Director of Public Health; CCG Accountable Officer		
		Partnerships: Report from CQC on their role & relationship with the HWBB; communications strategy for the HWBB; report from the	CQC; Commissioning & Policy Officer; Older Adults Partnership Group		

		Older Adults Partnership Group			
		Integration: Health & Social Care Integration update; work plan of the LBB joint commissioning team	Adult & Communities Director; CCG Accountable Officer		
October				17th October	Mental Health Partnership Board: 8th October Older Adults Partnership Board: 24th October
November	21st November 2013	**Quality & Safety:** Health Protection Assurance report	Director of Public Health		
		Performance: Annual report: Health & Wellbeing Strategy; report on progress against the Primary Care Strategy	Director of Public Health; CCG Accountable Officer		
		Strategy: Refreshed JSNA; update on the Care & Support Bill & local action plan	Head of Public Health Intelligence; Adult & Communities Director		
		Commissioning: Draft CCG, PH & Barnet Council commissioning intentions/ report from the HWB Finance Group	Director of Public Health; CCG Accountable Officer; Adult & Communities Director		
		Partnerships: Report from the Partnership Boards Summit/ presentation on the refreshed Barnet Compact	Director for People; Lead Commissioner for Later Life		

		Integration: Update on the Integrated Commissioning plan; Draft work programme for Health & Social Care integration in Barnet 2014/15	Adult & Communities Director; CCG Accountable Officer		
December				12th December	Physical and Sensory Impairment Partnership Board: 4th December Learning Disability Partnership Board: 10th December Carers' Strategy Partnership Board: 11th December
January	23rd January 2014	**Quality & Safety:** Annual Safeguarding Board report	Adult & Communities Director		Mental Health Partnership Board: 9th January
		Performance: Improving Children's Health- a progress report on the CYPP priorities; report against the NHS, SC & PH outcomes frameworks	The Children's Trust; Public Health; Director of Public Health; Adult & Communities Director; CCG Accountable Officer		Older Adults Partnership Board: 23rd January
		Strategy: Presentation of Tobacco Control and Alcohol strategies	Consultant in Health Improvement, Public Health		
		Commissioning: Sign-off CCG, PH & Barnet Council commissioning intentions &	Director of Public Health; CCG Accountable Officer;		

		review of draft work plans/ report from the HWB Finance Group	Adult & Communities Director		
		Partnerships: Report from PH England on their role & relationship with the HWBB; report from the Carers Strategy Group; report from the Physical & Sensory Impairment Partnership Group	PH England; Carers Strategy Group; Physical & Sensory Impairment Partnership Group		
		Integration: Health & Social Care Integration update	Adult & Communities Director		
February				13th February	
March	20th March 2014	**Quality & Safety:** Francis report- one year on	CCG Accountable Officer		Carers' Strategy Partnership Board: 5th March
		Performance:			Physical and Sensory Impairment Partnership Board: 7th March
		Strategy: Results of the Public Services Review and implications for health and wellbeing	Director for People		Learning Disability Partnership Board: 18th March
		Commissioning: Report from the HWB Finance Group	Director for People		
		Partnerships: Report from the Learning Disabilities Partnership Group; report from the Mental Health Partnership Group	Learning Disabilities Partnership Group; Mental Health Partnership Group		
		Integration:			

Appendix B: Statutory duties of Health and Well-Being Boards

Taken from *Health and Wellbeing Boards: a practical guide to governance and constitutional issues* (Local Government Association 2013) (http://www.local.gov.uk/c/document_library/get_file?uuid=ca8437aa-742c-4209-827c-996afa9583ca&groupId=10171):

Functions of boards

The Health and Social Care Act 2012 gives health and wellbeing boards specific functions. These are a statutory minimum and further functions can be given to the boards in line with local circumstances. The statutory functions are:

- To prepare Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs), which is a duty of local authorities and clinical commissioning groups (CCGs).
- A duty to encourage integrated working between health and social care commissioners, including providing advice, assistance or other support to encourage arrangements under section 75 of the National Health Service Act 2006 (ie lead commissioning, pooled budgets and/or integrated provision) in connection with the provision of health and social care services.
- A power to encourage close working between commissioners of health-related services and the board itself.
- A power to encourage close working between commissioners of health-related services (such as housing and many other local government services) and commissioners of health and social care services.
- Any other functions that may be delegated by the council under section 196(2) of the Health and Social Care Act 2012. For example, this could include certain public health functions and/or functions relating to the joint commissioning of services and the operation of pooled budgets between the NHS and the council. Such delegated functions need not be confined to public health and social care. Where appropriate, they could also, for example, include housing, planning, work on deprivation and poverty, leisure and cultural services, all of which have an impact on health, wellbeing and health inequalities.

This page is intentionally left blank