MEETING
HEALTH & WELL-BEING BOARD
DATE AND TIME
THURSDAY 19TH SEPTEMBER, 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:

Councillors

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

Substitute Members

Councillor David Longstaff	Julie Pal	Mathew Kendall
Nicola Francis	David Riddle	

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

Andrew Nathan – Head of Governance

Governance Services contact: Policy Officer Claire Mundle 020 8359 3478
claire.mundle@barnet.gov.uk

Media Relations contact: Sue Cocker 020 8359 7039

ASSURANCE GROUP

ORDER OF BUSINESS

15.	Forward Work Programme for 2013/14	167 - 178
16.	Any Items the Chairman decides are urgent	

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Decisions of the Health and Well-Being Board

27th June 2013

AGENDA ITEM 1

Cllr Helena Hart (Chairman)

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

Substitute Members

Cllr David Longstaff	Mathew Kendall	Jay Mercer
David Riddle	Julie Pal	

Present
Emily Bowler

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

The minutes of the meeting held on 25 April 2013 were agreed as a correct record.

2. ABSENCE OF MEMBERS (Agenda Item 2): Selina Rodrigues – substituted by Julie Pal

The Chairman welcomed Cllr Reuben Thompstone, Cabinet Member for Education Children and Families who has replaced Cllr Andrew Harper on the Health and Well-Being Board. Cllr. Hart paid public tribute to Cllr Harper and thanked him for all his sterling work on behalf of the children and young people of Barnet. The Chairman also welcomed Mr. Paul Bennett, Delivery Director for NHS England North Central and East London. She welcomed Julie Pal substituting for Selina Rodrigues of Healthwatch and thanked Ms. Rodriges' predecessor the Link representative Mrs. Gillian Jordan for all her work and dedication.

3. WINTERBOURNE VIEW – UPDATE REPORT (Agenda Item 3):

The Chairman introduced this paper and praised the progress that had already been made locally on this agenda. The Chairman told the Board that there would be an in depth discussion about this work at the September Health and Well-Being Board meeting.

Dawn Wakeling talked through the requirements on Local Authorities to complete local stocktakes of progress to mitigate the risk of a repeat of Winterbourne View by the 5th July. She explained that there was already a draft in place in Barnet,

which will be sent on to the Chairman, John Morton and Andrew Travers to sign off.

Dawn Wakeling also explained that a critical aspect of the 'Concordat' that Local Authorities need to adhere to involves multi-disciplinary reviews being undertaken for all service users in NHS Learning Disability Hospital settings by June 2013. Dawn reported that 17 service users in Barnet had been identified as requiring a review. 16 had completed reviews by the end of May and the 17th person was placed just a few weeks before the June deadline so a review was not appropriate. 12 of the 16 have plans in place to be moved into local care settings already, whilst Ms Wakeling expressed confidence that the other 4 people will be re-housed in good time for the cut-off date of June 2014.

Dr Benjamin asked what guidance there was on supporting young people who were transitioning into adult services. Ms Wakeling explained that Barnet has a system in place to track those transitioning, and there is work taking place on developing single education, care and health plans for these people. More work is also taking place on the commissioning options for young people with complex needs, including children with special educational needs.

Kate Kennally welcomed the changes being made in the Children and Families Bill, which support young people through until they are 25, and includes their health needs. She explained that this will make a real difference for being able to develop the right behavioural support plans for young people with complex needs.

The Chairman suggested that care providers should be invited to attend the September meeting if the Report on the Local Stocktake has any implications for them.

RESOLVED

The Board noted the actions taking place locally to support delivery against the Winterbourne View Concordat.

The Board requested a Report on local progress to be taken at the September Board meeting, including the Stocktake from Dawn Wakeling (local providers will be invited to attend the meeting too if there are any implications for them arising from the forthcoming report).

4. REPORT OF THE BARNET HEALTH AND WELL BEING-BOARD/PARTNERSHIP BOARDS SUMMIT (Agenda Item 4):

The Chairman acknowledged the success of the Summit and noted that it was a vast improvement on previous arrangements. The Chairman also personally thanked Dr Stephens for staying for the whole event.

The Chairman also suggested that the Health and Well-Being Board should now consider ways to improve on the Summit to best meet the needs of both the

Health and Well-Being Board and the Partnership Boards and in light of the comments and suggestions that had been received from participants.

Emily Bowler, Customer Care and Business Manager from the Adult Social Care and Health Service, London Borough of Barnet, introduced this report and highlighted that the Summit had been a success. Ms Bowler advised that 93% of those who attended the event on May 29 reported that the Event was good.

Ms Bowler asked the Board to note that the next half-day informal Summit event will be held on November 5 at North London Business Park. The agenda for this event will be drawn up in partnership with the Health and Well-Being Board and the Partnership Boards.

Ms Bowler explained that her team is working on an action plan to take on board the feedback that had been given at the Summit and that she will be meeting with Kate Kennally and Claire Mundle to discuss an approach to deliver on this plan. She offered to feedback on next steps at the September meeting.

Kate Kennally asked what Partners had been asked to do following the publication of the report and how they will support delivery of the action plan. Ms Bowler explained that her team will be discussing the report at each Partnership Board meeting and agreeing next steps with the co-chairs of each Partnership Board.

Dr Andrew Howe asked how the Partnership Boards can support delivery of the Health and Well-Being Strategy. Ms Bowler advised that Public Health have been invited to attend the Partnership Board meetings and this could be a way to engage the Boards with the Strategy.

The Chairman advised that Healthwatch should also be working closely with the Partnership Boards. Julie Pal responded by saying that Healthwatch would welcome the chance to engage with the Partnership Boards. The Chairman requested that Ms Bowler and Ms Pal therefore work together on the Action Plan and feed back to the Health and Well-Being Board.

RESOLVED

The Board approved the Report and is in support of Ms Bowler working with Healthwatch to develop an Action Plan based on the Report.

The Board asked that Ms Bowler update the Health and Well-Being Board on progress on delivering this plan at the September Board.

5. SOCIAL CARE FUNDING (Agenda Item 5):

Dawn Wakeling, Director for Adults and Communities, presented a report on Social Care Funding. She explained that the Care Bill had been through pre-legislative scrutiny.

Ms Wakeling informed the Board of the key policy changes for Local Authorities:

- The national eligibility criteria for adults - the current thinking is that this should represent a steady state for local authorities
- Changes around carers - that their rights will be considered equally to the person been cared for.
- A prevention service that offers information and advice - that Local Authorities will be responsible.
- Capital means testing threshold up to £118k for residential and nursing care up from £23k - meaning many more people will have eligibility
- A duty to promote health and social care integration

Cllr Rajput advised that carers' rights will be enshrined in law which will have a bearing on how the Board deals with items going forward. He also advised that self-funders will be given an annual statement and a number will eventually reach the £72k cap on care costs, which will have a huge financial implication for the Council. He also said the changes to deferred payments for residential care will also have significant financial implications.

Mr Morton said that the new carer's rights are good news but this increases the risks and costs for healthcare. With personal health budgets being rolled out from April 2014, there will be increasing pressure on budgets for on-going care. Mr Morton advised working together closely with local authority processes to mitigate risk.

In response, Ms Wakeling said that people are not aware of the options available to them such as choices to plan their own care, and therefore enter residential care earlier. She said that people need to be aware of the options available, and advised that it was important to find new ways to help people stay engaged within the community to prevent them from becoming socially isolated (expanding on existing schemes like the Casserole Club).

Kate Kennally noted that these changes require local areas to re-examine the way people access services. She suggested having a conversation with carers at the same time as the person being cared for to avoid building additional cost in the system, and advised that this is a wide issue to rethink. Ms Kennally encouraged the Board to begin thinking about supporting people to make choices about their care, and proposing how the Health and Well-Being Board can be used effectively to support this agenda.

Ms Wakeling suggested a discussion outside of the Board meeting about care pathway work, and how the Integrated Care team can help plan and assess people's needs. Ms Wakeling welcomed input from the Clinical Commissioning Group and other partners on the Health and Well-Being Board.

Julie Pal, the CEO of Healthwatch, agreed to promote the agenda by involving the volunteer community and draw on opportunities provided by the voluntary and community sector.

Dr Benjamin suggested integrating carers and their GP's through locality meetings. Dr Stephens said that the North Locality Meeting has integration as a

standing item and suggested that the Council could use this slot to progress this work.

In response to a question from the Chairman, Ms Wakeling and Cllr Rajput said it would be useful to bring back the work programme and information briefings for GP's and carers at the next Health and Well-Being Board meeting.

Kate Kennally suggested that in order to approve the 4th recommendation in the report, the Health and Well-Being Board would need a steer from Ms Wakeling about how they can support the work. Ms Wakeling committed to thinking this through and bringing back a report to the September meeting.

Ms Kennally suggested that the financial implications of these reforms should be thought through at the Health and Well-Being Financial Planning Group.

RESOLVED

The Board noted the recommendations in the Report and requested that Dawn Wakeling bring an updated paper to the September Health and Well-Being Board meeting to help the Board think through how they can support this agenda.

6. BARNET CCG RECOVERY PLAN (Agenda Item 6):

The Chairman asked that the discussion particularly focus on how Barnet residents will be affected by the challenges and changes facing the Clinical Commissioning Group (CCG).

Dr Sumners introduced the Barnet CCG Recovery plan and advised of the CCG's commitment to improving quality. She explained that the Barnet, Enfield and Haringey Clinical Strategy and the potential acquisition of Barnet and Chase Farm by the Royal Free will support the CCG with its recovery plans.

Mr Morton advised of the Barnet CCG financial problems and advised that the allocated budget for the CCG dropped when the CCG took on different commissioning responsibilities from that of the PCT. The CCG deficit increased from 4% to 10%. He said he was optimistic that the next allocation round would leave the CCG in a better position.

Mr Morton explained that the CCG is aiming to reach financial balance by 2017/18.

Mr Morton explained that the CCG has spent less on mental health services and community services compared to other London boroughs, and wanted to increase investment in these areas moving forward.

Mr Morton outlined plans to reduce acute spend to the level expected of Barnet. He explained that it will be possible to reduce costs in obstetrics because the CCG was being overcharged for obstetrics activity, and the way obstetrics has been paid for has changed. Mr Morton also explained that Barnet Hospital has

become busier and a plan has been discussed and approved since 2007 with plans to reduce capacity in place by Nov 2013. Mr Morton explained to the Board that the plans to reduce acute spend were incredibly challenging and that the total expected costs to recover from acute providers is in the realm of £43 million.

Mr Morton also outlined the plans to move estate buildings that are not currently in use as a way to reduce estates costs. He explained that Barnet spends more money than other areas on estates, and that rationalising the Estate is a key part of the Recovery Plan. Paul Bennett from NHS England went on to advise that Finchley Memorial hospital and the Brunswick Park Health Centre have plans in place around relocation to support CCG recovery.

Paul Bennett explained that the 2% top slicing of CCG budgets in London had in some places, like Barnet, been very problematic for CCGs. He reassured the Board that NHS England would be working with the CCG and the allocations team to resolve this problem - which will hopefully involve this 2% coming back to the CCG within the next 6 months.

John Morton explained that the recovery plan the CCG have written has made the assumption that this 2% is coming back to them. This has yet to be formalised, and NHS England will need to confirm that this money will be available to the CCG.

Ms Kennally explained that before the Health and Well-Being Board can approve the Business Plan, the CCG would need to clarify if the Board will be approving the Plan on the basis of whether or not the business rules apply. Mr Morton agreed that it would be useful to have this formalised.

In response to a question from Dr Howe about consideration given in the plan to inequalities, Mr Morton explained that the Plan has been driven by the inequalities agenda, and that the CCG will need to measure the impact on equalities in partnership with Public Health.

RESOLVED

The Board approved the Barnet CCG Recovery Plan as set out in the report, but only on the basis that NHS England 'business rules' do not apply.

7. BARNET CCG INTEGRATED CARE PLAN FOR 13/14 (Agenda Item 7):

Mr Morton explained that this Plan accelerates work that is already in place, including the Rapid Response Service and the COPD service. He explained that the Plan recognises the need to enhance intermediate care services, and to work closely with the Local Authority.

Mr Morton emphasised the need for these changes to be implemented quickly and that the CCG will be discussing the plans with community providers to move this forward in this financial year.

Ms Wakeling supported the paper and integration from CCG partners and highlighted that the Community Care Model goes live next month. She recommended that the detail of how the plans will be delivered will be decided at the Health and Social Care Integration Board, and the Health and Well-Being Financial Planning Group.

The Chairman and Dr Sumners both commented that it was good to see that progress had been made and that an integrated service would very much benefit patients.

RESOLVED

The Board approved the recommendations outlined in the Barnet CCG Integrated Care outline plans for 2013/14.

8a. CONTRACT MANAGEMENT OF HEALTHWATCH BARNET (Agenda Item 8a):

Mathew Kendall, Assistant Director for Community and Wellbeing Adults and Communities, updated the Board on the contract management of Healthwatch Barnet and advised that it went live in April 2013.

Mr Kendall explained Healthwatch's statutory roles and responsibilities, and explained that the plan is to get a local identity for Healthwatch Barnet that is run by the community and that this would be a clear and different branding separate from CommUNITY Barnet. Mr Kendall explained that the intention is to ensure that residents are involved with the contract management.

Mr Kendall advised that monthly meetings will be held between the Council, Healthwatch Barnet and CommUNITY Barnet. He also advised that there will be a regular update after six months to report on how Healthwatch Barnet is providing services.

The Chairman referred to the "Service delivery" points listed on page 199 of the Contract management of Healthwatch Barnet report and highlighted that constructive feedback is very important.

RESOLVED

The Board noted the statutory functions of Healthwatch Barnet.

8b. HEALTHWATCH BARNET UPDATE (Agenda Item 8b):

Julie Pal delivered a presentation covering Healthwatch's objectives, achievements to date and plans for the coming months. Ms Pal explained how Healthwatch Barnet would engage with residents and enable partners to come to the Health and Well-Being Board to present updates. Ms Pal also advised how Healthwatch Barnet would collect evidence and present findings as decision

makers. Healthwatch Barnet and Barnet MENCAP will liaise further and look at services for learning disabled people.

Ms Pal reported that Healthwatch has been in existence for about 12 weeks and advised of plans to recruit volunteers and contractors.

The Chairman requested that progress with the Healthwatch Barnet programme is discussed at the next HWBB meeting in September and said it would also be helpful if the findings are shared with the partnership consortium.

The Chairman commented on the difficulties previously experienced in engaging the Asian community and highlighted the importance of involving all of the various communities. She asked what Healthwatch was doing to engage with various BME communities in Barnet. Julie Pal explained that engagement with this group has already begun. Julie Pal agreed to take this question from the Chairman back to her team to agree a dedicated work stream.

Ms Wakeling advised that Healthwatch Barnet has joined the Safeguarding Adults Board, and asked how information will be accessible to all of Barnet's residents. Ms Pal advised that a citizen advice line is available across the Borough but that Healthwatch needs to develop a communications plan to ensure the number is advertised effectively. Ms Pal welcomed help from the Health and Well-Being Board to tap into their communications networks to support this.

The Chairman, Mr Kendall and Dr Stephens all welcomed the progress that Healthwatch had made.

Dr Stephens questioned whether the recruitment drive for Healthwatch volunteers had been extended to children and parents, and if this section of the population are aware and if they are represented. Ms Pal agreed to check this and update the Health and Well-Being Board.

Dr Stephens also highlighted the importance of people taking responsibility and leadership for their own health. Ms Kennally recommended that Healthwatch Barnet communicates with the CCG to bring together the work and work in partnership. Ms Pal and Dr Stephens agreed to have a conversation outside of the meeting about how Healthwatch can support this agenda.

The Chairman reminded Healthwatch Barnet that they have signed up to the Health and Well-Being Strategy which very much focuses on helping people improve their own health.

Dr Sumners asked what mechanisms there are to record compliments as well as complaints about local services. Ms Pal agreed to take this question back to the consortium to discuss.

Kate Kennally asked that Healthwatch reframe the recommendations they have made in their paper to highlight the leadership role that Healthwatch have. Ms Kennally also encouraged the Board to work with Healthwatch to support them to be the "partner of choice" for information and advice.

Dr Stephens suggested that Healthwatch Barnet collates the views quantitatively; to illustrate the views of particular sections of the population of Barnet and this would help to interpret responses. Ms Pal agreed to consider this approach.

RESOLVED

The Board noted the progress being made by Healthwatch Barnet and requested that the recommendations in the paper be revised to reflect Healthwatch Barnet's leadership role.

The Board requested that Healthwatch feedback on the various issues discussed at future Board meetings.

9a. PRESENTATION FROM NHS ENGLAND ON ITS ROLE AND RESPONSIBILITIES/ THE NHS ASSURANCE FRAMEWORK (Agenda Item 9a):

Paul Bennett said that he welcomed the opportunity to be part of the Barnet Health and Well-Being Board, and said that it was important for NHS England, as a local commissioner, to be represented on Health and Well-Being Boards.

Mr Bennett reported that NHS England still needs to think through their working relationship with Health and Well-Being Boards.

The Chairman welcomed the involvement of NHS England, highlighting the role they have to play in delivering the Health and Well-being Strategy. The Chairman also requested that NHS England communicates with the Council about regeneration projects.

9b. THE NHS ENGLAND ASSURANCE FRAMEWORK: NATIONAL REPORT FOR CONSULTATION (Agenda Item 9b):

Mr Morton explained that this Report is to update the Health and Well-Being Board on NHS England's proposals for developing a system of "mutual assurance", and to ask the Health and Well-Being Board if they would like to respond to the Consultation Document jointly with the CCG, or whether the CCG should respond alone.

Mr Bennett invited the Health and Well-Being Board to comment on the proposed performance management system in the NHS England Assurance Framework: national report.

Andrew Howe requested that Mr Bennett give his team early sight of the plans for health visiting. He also asked Mr Bennett how NHS England planned to report on progress made locally on issues such as Immunisation. He requested that Mr Bennett come to a future Health and Well-Being Board meeting to discuss these issues.

Dr Howe also asked to discuss the response to the Consultation with Mr Morton outside of the meeting.

Ms Wakeling questioned the CCG and NHS England on assurance conflicts, and who is responsible for 'whole-system assurance'. In response, Mr Bennett reported that not all of the details have not been worked thorough properly and this is currently been worked on.

Dr Stephens highlighted that patient well-being is at the heart of all of the NHS proposals and that all parties need to direct their energies to this to overcome issues like conflicts of interest.

RESOLVED

The Board recommended Dr Howe prepare a joint response to the Consultation with the CCG on behalf of the Health and Well-Being Board.

10. PERFORMANCE MANAGEMENT FRAMEWORK FOR THE HEALTH AND WELL-BEING STRATEGY (Agenda Item 10):

Ms Kennally reported that this paper puts mechanisms in place to deliver on the Health and Well-Being Strategy agreed six months ago. Ms Kennally noted that there has been no progress on this to date and commended Claire Mundle and Dr Andrew Howe for writing this report.

The Chairman advised the first step is to ensure this takes place.

Ms Kennally recommended that the Health and Well-Being Board informs Claire Mundle of their performance contacts.

Mr Morton queried appendix A. Ms Kennally recommended a workshop to have a discussion and bring back as amendments to the strategy.

RESOLVED

The Board agreed to the proposals for managing performance of the Health and Well-Being Strategy and agreed for a full Annual Report against year one of the Health and Well-being Strategy to be bought to the November Board meeting.

The Board agreed that lead agencies will confirm the main performance contacts with Claire Mundle.

The Board agreed to bring proposals on amendments to Appendix A to the next meeting.

11. PUBLIC HEALTH INTELLIGENCE BRIEFINGS (Agenda Item 11):

Dr Howe introduced this report and outlined how inequalities have decreased for women and but have increased for men and this remains a challenge in Barnet.

Dr Howe encouraged the Health and Well-Being Board to look at their commissioning plans with these briefings to hand. Dr Howe highlighted that Barnet faired well compared to England for people living without long term illness.

Kate Kennally praised the reports and said they should make the refresh of the JSNA less arduous.

Dr Stephens asked Dr Howe to confirm the data she found that states a 10 million population increase in London. Dr Howe agreed to look into this.

Mr Morton said it was unacceptable that inequalities for men are going up, and suggested targeting resources by ethnicity and making efforts to support this group of men earlier. He encouraged colleagues to target resources more clearly along the lines of ethnicity to address the widening inequalities.

Dr Howe supported this approach and agreed that work on heart disease is key to this specific issue.

Dr Howe agreed to circulate to circulate the Public Health Intelligence Briefing on Health Life Expectancy to partners and other agencies.

Dr Howe also agreed to publicise information about health expectancy on the Public Health section on the Barnet intranet.

RESOLVED

The Board noted the development of the briefing papers.

12. PHARMACEUTICAL NEEDS ASSESSMENT (Agenda Item 12):

Dr Howe advised that the new Pharmaceutical Needs Assessment will be published by March 2015 and that the funding will be taken from the Public Health grant.

Dr Howe suggested that the new Pharmaceutical Needs Assessment be brought back to Health and Well-Being Board before the end of the financial year.

The Chairman recommended that the Public Health Team liaise with Healthwatch to complete this exercise.

Dr Howe confirmed that an outside agency will be employed to help.

RESOLVED

The Board noted its responsibility to carry out a refreshed Pharmaceutical Needs Assessment and approved the approach set out by Public Health in the paper.

13. CLINICAL COMMSIONING PROGRAMMES (Agenda Item 13):

Dr Sumners explained that this Report provides an update on the Clinical Commissioning Programmes in Barnet, which are aimed at delivering good quality services and better outcomes for patients. She advised that each proposal is led by one CCG board member.

RESOLVED

The Board noted the development of the CCP programme.

14. FORWARD WORK PROGRAMME (Agenda Item 14):

Ms Kennally advised that the Forward Work Programme is to be used for agenda planning. It will give the Board a strong focus on key objectives and support them working together as a partnership.

Ms Kennally encouraged each Organisation on the Health and Well-Being Board to look at the Forward Plan and decide what decisions and approvals related to their work programmes will need to go through the Board.

Ms Kennally pointed to the dates of the Partnership Board meetings that have been added to the Forward Work Programme and advised Organisations to note these meeting dates.

RESOLVED

The Board approved the approach to forward planning.

The Board agreed to send proposed amendments to the forward work programme to Claire Mundle.

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

There were none.

The meeting finished at 12.10 pm

Meeting	Health and Well-Being Board
Date	19th September 2013
Subject	**Use of Estates – Referral from the Health Overview and Scrutiny Committee to the Health and Well-Being Board**
Report of	Overview and Scrutiny Office
Summary of item and decision being sought	The Board is requested to consider the referral from the Health Overview and Scrutiny Committee as set out in the report.

Officer Contributors	Andrew Charlwood, Overview and Scrutiny Manager
Reason for Report	Referral from Health Overview and Scrutiny Committee to the Health and Well-Being Board.
Partnership flexibility being exercised	N/A
Wards Affected	All
Contact for further information:	Andrew Charlwood, Overview and Scrutiny Manager, 020 8359 2014, andrew.charlwood@barnet.gov.uk

1. RECOMMENDATION

1.1 That the Health and Well-Being Board reviews the reference from the Health Overview and Scrutiny Committee in relation to GP Services and the financial impact on the Barnet Clinical Commissioning Group (CCG) and determines an appropriate course of action.

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 Health Overview and Scrutiny Committee, 9 May 2013, GP Services – Brunswick Park Health Centre and Finchley Memorial Hospital

2.2 Health and Well-Being Board, 27 June 2013, Barnet CCG Recovery Plan

2.3 Health Overview and Scrutiny Committee, 4 July 2013, GP Services – Brunswick Park Health Centre and Finchley Memorial Hospital

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

3.1 Failure to utilise NHS estates in Barnet has financial implications for the CCG and will impact on delivering the CCG Recovery Plan, which has been developed to 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 None in the context of this report, but the Barnet CCG Recovery Plan identifies the main themes from the Barnet Joint Strategic Needs Assessment and how these will be managed.

5. RISK MANAGEMENT

5.1 To ensure that there is an effective oversight of this issue by the CCG and NHS England, the Health Overview and Scrutiny Committee have referred this matter to the Health and Well-Being Board to enable the Board to have oversight of theses ongoing estates issues.

6. LEGAL POWERS AND IMPLICATIONS

6.1 Section 194 of the Health and Social Care Act 2012 created Health and Well-Being Boards and sets out their remit as local authority committees, and their responsibilities.

6.2 Section 244 of the National Health Service Act 2006 and Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013/218; Part 4 Health Scrutiny by Local Authorities provides for the establishment of Health Overview and Scrutiny Committees by local authorities.

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

7.1 The CCG Recovery Plan, reported to the Health and Well-Being Board on 27 June 2013, details the financial implications of estates costs to the CCG. Estates costs affect the CCG's ability to invest in other services; Barnet CCG is currently spending 2% more than

the national average on estates (CCG Recovery Plan, May 2013). The CCG has identified that they need to reduce estates costs to deliver the CCG Recovery Plan by 2017/18. Barnet CCG estates costs for 2013/14 are £17.251 million and are significantly higher than for other CCG's in the North Central London area.

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 The issue of under utilised estates at the Brunswick Park Health Centre was included on the work programme of the Health Overview and Scrutiny Committee at the request of the Chairman of the East Barnet Residents Association. When this issue has been considered by the Committee, representations have been received from the Cabinet Member for Public Health and local Ward Members. The Cabinet Member for Public Health has also addressed the Committee.

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 The Health Overview and Scrutiny Committee considered the issue of the use of estates at the Brunswick Park Health Centre and Finchley Memorial Hospital at their meetings on 9 May and 4 July 2013. At those meetings, the Committee received representations from NHS England and NHS Property Services. Minute extracts from those meetings are set out in section 10 below.

10. DETAILS

10.1 The Health Overview and Scrutiny Committee agreed to submit a referral to the Health and Well-Being Board to consider the under-utilisation of NHS estates and the financial impact on the Barnet Clinical Commissioning Group (CCG). Minute extracts from the Health Overview and Scrutiny Committee held on 9 May and 4 July 2013 are set out below to inform the Board on the recent discussions that have taken place at Health Overview and Scrutiny Committee on this issue:

10.2 **Minutes of Health Overview and Scrutiny Committee: 9 May 2013**

The Committee received public comments from Mr Daniel Hope, Chairman of the East Barnet Residents Association, in relation to the Brunswick Park Health Centre. Members commended the work of the Association in highlighting this issue and seeking a resolution to enable GP services to return to the Brunswick Park Health Centre.

The Committee welcomed Neil Roberts (Head of Primary Care (North, Central & East London), NHS England) who provided an update on GP services at Brunswick Park Health Centre and Finchley Memorial Hospital.

Brunswick Park Health Centre

Mr Roberts reported that he had attended a meeting with the two displaced practices on 8 May 2013. Members noted that NHS Property Services, the landowners, had been unable to attend. Members noted that NCL London, the body which had been replaced by NHS England as of 1 April 2013, had failed to conclude negotiations in relation to the surgery.

The Committee were informed that NHS England and NHS Property Services had been working on a two track approach to returning services to the Centre. Track one was based on the two displaced practices (Dr Okonkwo and Dr Lakhani) merging, relocating back to the Health Centre and for the premises to be sold to the GPs. Track two was to

enter into an arrangement with Dr Okonkwo, with the centre being partially occupied. Members noted that unless the premises was fully occupied there would be an ongoing cost to the practice in relation to void space. It was noted that the preferred option was to enable the two practices to return at the same time.

Members questioned why the GPs were claiming in the local media that they would be subject to additional services charges for moving back into the Centre. Mr Roberts advised the Committee that service charges were governed by premises regulations which were defined by the District Valuer. It was noted that the last time that service charges had been levied was in 2009. Charges had been subject to inflationary increases which had resulted in the increased costs referred to by the GPs. He added that the GPs would be provided with a detailed breakdown of the figures.

Finchley Memorial Hospital

Mr Roberts updated the Committee on GP services at Finchley Memorial Hospital. He reported that the Chief Officer of Barnet Clinical Commissioning Group (CCG) had been updating local practices on the available space, adding that NHS England and NHS Property Services would soon be meeting with them too. Members noted that it was planned that all GP space at the hospital would be used.

Responding to a question regarding planning the location of GP practices, Mr Roberts advised the Committee that mapping software was used to identity local demand and capacity and that these measures were used to identify the preferred location for expanded or new practices. Members noted that the GP premises at Finchley Memorial Hospital were owned by LiftCo not NHS Property Services.

RESOLVED that:-

1. **the update from NHS England on GP Services and the Brunswick Park Health Centre and Finchley Memorial Hospital as set out above be noted.**

2. **NHS England be requested to provide the Committee with details of the cost of security at the Brunswick Park Health Centre.**

3. **NHS England and NHS Property Services provide an update report on the Brunswick Park Health Centre at the next meeting of the Committee.**

10.3 **Minutes of Health Overview and Scrutiny Committee: 4 July 2013**

Councillor Andreas Ioannidis addressed the Committee in relation to GP services at the Brunswick Park Health Centre. He advised the Committee that he been in discussion with the Divisional Director of NHS Property Services, Tony Griffiths, who had advised him that services could be reinstated within four to six weeks of the lease being signed. He added that NHS England and NHS Property Services had been in discussions with the GP practices and their legal representatives regarding possible lease terms. He expressed disappointment at the length of time it was taking to reinstate services at the Medical Centre and the cost of providing security at the premises.

The NHS England Deputy Head of Primary Care – North Central and East London, Fiona Erne, and the NHS Property Services Associate Director Estates and Facilities, Martyn Hill, updated the Committee on GP services at Brunswick Park Health Centre and Finchley Memorial Hospital.

Brunswick Park Medical Centre

In relation to the Brunswick Park Health Centre, the Committee were advised by Ms Erne that there were two issues in relation to the reinstatement of services. Firstly, there was the issue of entering into a lease agreement with Dr Okonkwo. Secondly, there was the issue of the possible purchase of the Medical Centre by Dr Lakhani. Discussions had taken place regarding the property issues with both practices. The Committee were informed that Dr Okonkwo had concerns regarding the proposed fees and the financial viability of the practice following a move into Brunswick Park Health Centre. It was noted that financial assistance from NHS England had been discussed.

Mr Hill reported that there had been an initial meeting between Dr Okonkwo and NHS Property Services. Members were advised that the main issue was the financial impact on the practice, rather than the lease terms. It was noted that there may also be slight delays with the installation of the IT system and medical equipment.

Mr Hill advised the Committee that Dr Lakhani had withdrawn from negotiations with NHS England and NHS Property Services as he was primarily interested in purchasing the Medical Centre and was not interested in entering into a lease arrangement. Following this withdrawal, NHS Property Services had commenced discussions with another practice regarding a possible co-location.

The Committee received public comments from Mr Daniel Hope, Chairman of the East Barnet Residents Association, in relation to the Brunswick Park Health Centre.

Responding to questions from the Committee regarding the potential for part of the practice to be empty if Dr Okonkwo moved back into the premises, Mr Hill advised the Committee that following the fire in 2010, the premises had been expanded and enhanced with a view to increasing turnover, improving services, delivering economies of scale and developing synergies. He added that there was room for two or three practices on site, with Dr Okonkwo expected to be using between 33 – 40% of the available space.

Referring to lease charges, the Committee questioned whether Dr Okonkwo would be required to subsidise empty space in the practice. Mr Hill advised Members that the Clinical Commissioning Group (CCG) were being recharged for empty space. It was noted that NHS Property Services were paying for the cost of security at the building.

Finchley Memorial Hospital

Ms Erne updated the Committee on GP services at Finchley Memorial Hospital. The Committee were advised that a financial assistance package had been agreed and that a Task and Finish Group would be established to facilitate the two practices moving in. It was anticipated that services would commence operations in approximately six months time.

Mr Hill reported that NHS Property Services had been working with the Hospital on estates utilisation, adding that he was aware of the issues with void spaces. The Committee expressed disappointment that there had been no agreement before the hospital had been constructed regarding services that would be provided from the site.

Cabinet Member for Public Health – Submission on GP Services in Barnet

At the invitation of the Chairman, the Cabinet Member for Public Health, Councillor Helena Hart, addressed the Committee on all the work that had been undertaken to try and facilitate the re-opening of the Brunswick Park Health Centre and the proper utilisation of the GP space at Finchley Memorial Hospital. Councillor Hart emphasised that the failure to re-open the Brunswick Park Health Centre and to utilise the GP space at Finchley Memorial Hospital were Estates issues which needed to be resolved by NHS England and NHS Property Services. She added that both situations have significant implications for Barnet's residents and the CCG.

The Committee were advised that the Health and Well Being Board would be examining the progress being made to address Estates issues in the context of the CCG's Recovery Plan. It was noted that as both NHS England and the CCG were represented on the Health and Well Being Board, the Board was well placed to examine how the wider NHS Estate was used to support the delivery of the Health and Well Being Strategy and to deliver value for the taxpayer.

RESOLVED that:-

1. **The Committee note the update on GP services at Brunswick Park Medical Centre and Finchley Memorial Hospital as set out in the agenda and as detailed above.**

2. **The Committee encourage NHS England and NHS Property Services to continue efforts to reinstate GP services at the Brunswick Park Medical Centre as soon as possible.**

3. **The Committee note the financial impact to the Barnet Clinical Commissioning Group and request that the Health and Well Being Board monitor progress on the provision of GP services at the Brunswick Park Medical Centre and Finchley Memorial Hospital as part of their wider review of the estates issue.**

10.4 The Health and Well-Being Board is requested to consider the referral and provide feedback to the next meeting of the Health Overview and Scrutiny Committee at their meeting on 3 October 2013.

11 BACKGROUND PAPERS

11.1 Health Overview and Scrutiny Committee, 9 May 2013, GP Services – Brunswick Park Health Centre and Finchley Memorial Hospital:
http://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=179&MId=6561&Ver=4

11.2 Health and Well-Being Board, 27 June 2013, Barnet CCG Recovery Plan:
http://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=177&MId=7557&Ver=4

11.3 Health Overview and Scrutiny Committee, 4 July 2013, GP Services – Brunswick Park Health Centre and Finchley Memorial Hospital:
http://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=179&MId=6562&Ver=4

Legal – LC
CFO – JH

Meeting	Health and Well-Being Board
Date	19th September 2013
Subject	**Quality & Safeguarding: learning from the Winterbourne View Stocktake**
Report of	Adults and Communities Director
Summary of item and decision being sought	In July 2013, every local area was required to undertake a stocktake on progress made locally in response to the Winterbourne View Concordat, published by the Department of Health in December 2012. This required a number of actions from local health and social care economies. This report provides the Board with an update on the local action and learning points in response to the stocktake and Concordat.

Officer Contributors	Dawn Wakeling, Adults and Communities Director Temmy Fasegha, Joint Commissioner Mental Health & Learning Disability Helen Duncan-Turnbull, Head of Integrated Learning Disability Service
Reason for Report	To update the Board on the learning from the stocktake exercise that took place in July 2013, and the actions that have taken place or are planned as a result of the stocktake.
Partnership flexibility being exercised	N/A
Enclosures	Appendix A – Barnet's systems for monitoring care quality Appendix B – Winterbourne View background paper 1 Barnet Stocktake Appendix C – Winterbourne View background paper 2 Letter from the LGA & NHS England Appendix D – Winterbourne View background paper 3 Ministerial letter to HWBBs re Winterbourne View
Wards Affected	All
Contact for further information:	Temmy Fasegha- Joint Commissioner Mental Health & Learning Disability (temmy.fasegha@barnet.gov.uk; 0208 359 2841)

1. RECOMMENDATION

1.1 That the Health and Well-Being Board notes the local learning of the stocktake exercise following the letter from the minister for care services dated 31 May 2013, which called for Health and Wellbeing Boards to take a leadership role with respect of local delivery against the Winterbourne View Concordat.

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

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

2.2 Health and Well-Being Board - Winterbourne View - Update report - 27 June 2013

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 'Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse' sets a framework for joint action and partnership working across the local authorities, the NHS and other agencies.

3.2 The adult safeguarding agenda links directly with the main themes of the Health and Well-Being Strategy 2012-15, especially *'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, heart and respiratory diseases. The number of young people with complex disabilities in the local population is rising, meaning that safeguards and quality assurance of care services for this group of people will remain highly important.

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, NHS Barnet Clinical Commissioning Group (CCG) and care providers. Although safeguarding must be the concern of all agencies working with vulnerable adults, the Local Authority is the lead agency and is responsible for the co-ordination of the multi-agency safeguarding board.

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 Adult safeguarding law has developed piecemeal and currently to great extent is policy and guidance led. Powers and duties to provide care or treatment or deal with the finances of those who lack capacity or who are mentally ill are contained in the Mental Capacity Act 2005, the Mental Health Act 1983 and the High Court's inherent jurisdiction.

6.2 Powers of intervention or prevention are contained in:

- National Assistance Act 1948
- Environmental/public health legislation
- Police powers of entry

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

7.1 The Integrated Community Learning Disability Service (CLDS), comprising health and social care professionals from the Council's Adults and Communities delivery unit, Central London Community Health Trust and Barnet, Enfield and Haringey Mental Health Trust; and the NHS Barnet CCG Continuing Health Care Team are responsible for coordinating and reviewing care plans of people with learning disabilities in social care and health placements. The Adults and Communities Supply Management Team and the NHS North and East London Commissioning Support Unit have responsibility for co-ordinating contract monitoring arrangements including quality monitoring of Council and NHS contracted services respectively.

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 The Barnet Learning Disability Partnership Board (LDPB), a multi-agency partnership bringing together people with learning disabilities (LD) and autism, family carers and professionals from the Council, NHS, voluntary sector and other services has played an important role in fostering a partnership approach to keeping people safe and in the development of learning disability commissioning priorities. The LDPB is co-chaired by a person with a learning disability. Five members of the LDPB are people with learning disabilities. The Partnership has supported the set up of the Learning Disability Parliament which is a key mechanism for engaging and consulting with people with learning disabilities in Barnet. MPs of the Barnet LD parliament have an open invitation to attend the LDPB as participant observers. The Board has active sub-groups of both family carers and people with learning disabilities who are full members of the board. The LDPB has taken an active interest in the Winterbourne View agenda and has scrutinised reports on this.

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 Barnet Safeguarding Adults Board (BSAB) 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. The Adult and Communities Director, in her role of Director of Adult Social Services, involves 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.

9.2 The BSAB has taken a close interest in issues arising from Winterbourne View and has received regular reports on the numbers of people with learning disabilities placed in hospital settings. The Board hosted a learning event for local service users, providers and commissioners on Winterbourne View, with the author of the

Winterbourne View Serious Case Review as the key speaker. The BSAB has reviewed local provision to establish if care settings such as Winterbourne view exist locally. The Board scrutinises local NHS care quality and safeguarding activity in all settings relating to people with learning disabilities.

10. DETAILS

10.1 The Local Stocktake, June 2013

10.1.1 Local areas were required to complete a stocktake of progress to deliver the Winterbourne View Concordat in June 2013. The stocktake drew heavily on Barnet's Winterbourne View action plan, which has previously been presented to the Board.

10.1.2 Barnet has taken these issues very seriously, evidenced by our taking action on it well before the publication of the Concordat, and this put us in a good position to respond to the requirements of the Concordat. In Barnet, there are currently 77 people on the LD register of people in receipt of NHS funded packages, of which 17 are in hospital settings and therefore fall within the scope of the Concordat. 1 of these is in an Assessment and Treatment Unit. Of these 17 people, all 17 people have been reviewed and 13 people have move-on plans in place. Move-on plans for the other remaining four people are currently being developed subject to individual clinical need. It is anticipated that all of the 17 people mentioned above will be moved by the national deadline of June 2014.

10.1.3 Barnet is fully committed to delivering the requirements of the Concordat because it had been aware of the issues and was monitoring this group of users for some time before the stocktake was required and so started from a solid base. Part of the learning from the Winterbourne View scandal is that health and social care commissioners need to ensure that their systems for monitoring care quality are robust. This relates to individual care plans, care providers and the wider care system. Barnet has established quality monitoring roles of the specific care and contracting teams in relation to this client group. It has also set out expectations for the Safeguarding Board and the multi-agency safeguarding procedures in keeping people safe. These are set out in more detail in Appendix A.

10.1.4 In addition, the stocktake has provided Barnet with a number of learning points that are now being taking forward to ensure the requirements of the Concordat are delivered as effectively as possible by the Borough.

10.2 Headline learning from the Stocktake

10.2.1 The Stocktake multi-disciplinary reviews of people with LD and autism who are in receipt of NHS funded packages of care in hospital settings were carried out by the Move-On Team and the CCG Continuing Health Care Team in partnership. Going forward, we should consider options for closer working between the integrated learning disability service and the CCG continuing healthcare team, as the group of users concerned in this stocktake are covered by both teams. This should include consideration of pooled budgets and efficiencies.

10.2.2 The stocktake also highlighted the need for the development of local care and support options for younger adults with complex needs. This is relevant to people placed in NHS settings but also the growing number of younger adults with complex needs. A scoping exercise will be carried out by children's services, adult social care and the CCG to develop project proposals for planning for the future for young

people with complex needs who are likely to require service interventions as they become adults. This work is being led by the Head of Service, Inclusion and Skills in Children Services and will involve the joint commissioners for Mental Health and Learning Disability and Children and Adolescent Mental Health. The scoping exercise is due to be undertaken by the end of autumn 2013.

10.3 Confidential Inquiry & 2012/13 Joint Health and Social Care Self-assessment Framework

10.3.1 The 2012/13 Learning Disability Joint Health and Social Care Self-assessment Framework (SAF) was launched in June. This was followed by the publication of two Department of Health reports into the findings of the confidential review into premature deaths of people with learning disabilities, *'Six Lives- Progress Report on Healthcare for People with Learning Disabilities'* and *'Government response to the Confidential Inquiry into premature deaths of people with learning disabilities'*. The 2012/13 SAF has been updated to provide further assurance about how health and care services are ensuring the safety of people with learning disabilities.

10.3.2 All local areas are required to complete the SAF and involve people and their carers as well as stakeholders in the evaluation process. Focus groups have been taking place since July to get local people's views. An event hosted by the Barnet Learning Disability Partnership Board is due to take place on 4 October 2013. The completed SAF is due for submission on 30 November 2013. This work is led by the Joint Commissioner for learning disabilities.

11. BACKGROUND PAPERS

11.1 Barnet Winterbourne View stocktake.

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

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

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CFO- JH

Appendix A: Barnet's systems for monitoring care quality

The integrated Learning Disability team includes social care, community health and mental health professionals to provide full multi-disciplinary support to this group of people. The dedicated Move-On team, funded from Council invest to save monies, has been working since spring 2012 with a remit to support people with Learning Disabilities move back into Borough and into more independent living. Progress reports have been presented to the Adults and Community Delivery Unit's Senior Management Team regularly and the CCG Clinical Risk and Quality Committee, a sub-committee of the CCG board which on behalf of the Board has overview functions in respect of safety, safeguarding and quality.

Barnet also already has a joint commissioner for learning disabilities, to maintain strategic oversight over this programme of work.

The Safeguarding Adults Board has been monitoring learning disabilities placements since the Winterbourne view scandal became public and the joint commissioner maintains a register of NHS funded placements. This focus should continue to provide assurance to all partners.

In addition it should be noted that the Council has an established working relationship with the Care Quality Commission to identify and act in situations where there are concerns about social care providers locally and there are local multi-agency systems for raising concerns about providers. The Council's quality and purchasing team undertakes unannounced monitoring visits of contracted social care providers and there is a programme of unannounced CQC inspections nationally. In addition, NHS England is establishing regional Quality Surveillance Groups which will review both qualitative and quantitative data on health care providers, in order to facilitate early action where there are quality concerns. NHS Barnet CCG has a quality and safety programme which includes requiring providers to demonstrate their response to the Francis Inquiry.

Winterbourne View Joint Improvement Programme

Initial Stocktake of Progress against key Winterbourne View Concordat Commitment

The Winterbourne View Joint Improvement Programme is asking local areas to complete a stocktake of progress against the commitments made nationally that should lead to all individuals receiving personalised care and support in appropriate community settings no later than 1 June 2014.

The purpose of the stocktake is to enable local areas to assess their progress and for that to be shared nationally. The stocktake is also intended to enable local areas to identify what help and assistance they require from the Joint Improvement Programme and to help identify where resources can best be targeted.

The sharing of good practice is also an expected outcome. Please mark on your return if you have good practice examples and attach further details.

This document follows the recent letter from Norman Lamb, Minister of State regarding the role of HWBB and the stocktake will provide a local assurance tool for your HWBB.

While this stocktake is specific to Winterbourne View, it will feed directly into the CCG Assurance requirements and the soon to be published joint Strategic Assessment Framework (SAF). Information compiled here will support that process.

This stocktake can only successfully be delivered through local partnerships. The programme is asking local authorities to lead this process given their leadership role through Health and Well Being Boards but responses need to be developed with local partners, including CCGs, and shared with Health and Wellbeing Boards.

The deadline for this completed stocktake is Friday 5 July. Any queries or final responses should be sent to Sarah.Brown@local.gov.uk

An easy read version is available on the LGA website

May 2013

Winterbourne View Local Stocktake June 2013			
1. Models of partnership	**Assessment of current position evidence of work and issues arising**	**Good practice example (please tick and attach)**	**Support required**
1.1 Are you establishing local arrangements for joint delivery of this programme between the Local Authority and the CCG(s)?	The Barnet Health and Wellbeing Board has overall strategic oversight for the delivery of the programme. This board is chaired by the Cabinet member for public health and includes the Cabinet member for adult social care, Chair and Chief Officer of the Barnet Clinical Commissioning Group (CCG) and the Director of Adult Social Services (DASS). The Barnet Safeguarding Adults Board (BSAB) and the Barnet Learning Disability Partnership Board also monitor this programme, with their respective remits for adult safeguarding and learning disability services. The programme is being delivered by the joint LBB and CCG commissioning team reporting to the DASS and CCG Chief Officer as joint sponsors. Progress reports are also reported to existing management groups and boards of the council and Clinical Commissioning Group. Progress reports on Winterbourne View including the Barnet Action Plan have been presented to the Health and Wellbeing Board (HWB) in November 2012 and in June 2013. The HWB signed of the Barnet Winterbourne Action Plan in November 2012. A further update is due later this year. The BSAB has already reviewed progress on several occasions.		No

1.2 Are other key partners working with you to support this; if so, who. (Please comment on housing, specialist commissioning & providers).	Children's services, special education, mental health services and specialist commissioning are working with us to support the programme through the Complex Needs Programme Board. Local authority commissioners already have good relationships with Barnet Homes, the Arm Length Management Organisation, and other local Housing Associations. The council and CCG have a track record of developing accommodation and support services with providers for people with complex needs, for example, recently opening Sarnes Court, a local supported living scheme for disabled people where all support is individually planned and purchased. The Integrated Learning Disability Service (consisting of Barnet Council social care, Central London Community Health NHS Trust and Barnet Enfield and Haringey Mental Health Trust) are working to conduct joint reviews and develop support plans for individuals, working with the CCG commissioner and continuing health care team.		No
1.3 Have you established a planning function that will support the development of the kind of services needed for those people that have been reviewed and for other people with complex needs?	A special project is being developed that will incorporate developing the commissioning approach spanning current patients, people in transition and those out of area. We plan to use the information from the reviews along with general LD population and transition data to create a joint needs assessment and set of commissioning intentions, building on existing analysis. e.g. people with complex needs already form part of the JSNA and Barnet Market Position Statement. The project is being designed to have short, medium and longer term priorities, the reporting lines will be as outlined in 1.1. The Learning Disability Partnership Board and stakeholders will be able to influence this process.		No

1.4 Is the Learning Disability Partnership Board (or alternate arrangement) monitoring and reporting on progress.	The Barnet Learning Disability Partnership Board is fully sighted on the project. Reports on local action in respect of Winterbourne View have been presented to the February, March and June meetings of the Board.		No
1.5 Is the Health and Wellbeing Board engaged with local arrangements for delivery and receiving reports on progress?	Yes. Refer to 1.1 and 1.4. A further report will be delivered to the HWB in November.		No
1.6 Does the partnership have arrangements in place to resolve differences should they arise.	The CCG and council have established an integrated commissioning programme and joint commissioning team, with a memorandum of understanding, which reflects commissioning developments in respect of complex care, focussed on repatriating out of area placements and preventing and/or reducing the need for 'Winterbourne View' type services. Both partners have a range of section 75 agreements (see 2.3) and have good track record of collaboration and joint commissioning. The Director of Adult Social Services (DASS) and CCG Chief Officer (CO) have regular 1-1 meetings.		No
1.7 Are accountabilities to local, regional and national bodies clear and understood across the partnership – e.g. HWB Board, NHSE Local Area Teams / CCG foray, clinical partnerships &Safeguarding Boards?	The various bodies referred to in this report have terms of reference that outline the governance arrangements, roles responsibilities and accountabilities.		
1.8 Do you have any current issues regarding Ordinary Residence and the potential financial risks associated with this?	The integrated learning disability service monitors 'ordinary residence' cases in respect of people with learning disabilities. Barnet faces significant challenges with respect of 'ordinary residence' due to the high number of supported living schemes and residential and nursing care homes situated in the borough.		

	There have been 24 requests for Ordinary Residence in the past year and it is anticipated that this is likely to increase due to trends in recent years for local residential care homes to deregister to become supported living and look for placements from outside the borough as well as from Barnet. We consider that there is a risk that the Winterbourne view programme may lead to an increase in referrals to Barnet schemes from other local authorities close to Barnet, seeking less restrictive placement options for people with learning disabilities.		
1.9 Has consideration been given to key areas where you might be able to use further support to develop and deliver your plan?	Establishment of collaborative commissioning and service development with other agencies (i.e. for the national programme to facilitate the development of collaborating approaches, to develop the critical mass required for commissioning new models of care)		Yes
2. Understanding the money			
2.1 Are the costs of current services understood across the partnership?	There is clarity about financial commitments for the client group across the CCG and Council, including a clear understanding of jointly funded services/initiatives. Over the past 3 years, we have produced an annual report with details of our spend across adult social care and health. Further work is required to profile expenditure on children and young people's services.		No
2.2 Is there clarity about source(s) of funds to meet current costs, including funding from specialist commissioning bodies, continuing Health Care and NHS and Social Care.	Yes. For each person listed on the learning disability register, details of funding sources and the amounts from the council, NHS CHC and other CCG budgets are included.		No
2.3 Do you currently use S75 arrangements that are sufficient & robust?	Yes. We have in place the following section 75 agreements: S75 Agreement for NHS Campus Reprovision- £1.7m (Contribution: CCG- £0.822m; LBB- £0.887m.)		No

	S75 Agreement for Integrated Learning Disability Services- £3.1m (Contribution: CCG- £1.9m; LBB- £1.2m) S75 Agreement for prevention services- £1.8m (Contribution: CCG- £0.747m; LBB- £1.1m) We will be considering further opportunities for pooling budgets as part of the project.		
2.4 Is there a pooled budget and / or clear arrangements to share financial risk.	Yes. (see above) The Section 75 agreements set out the obligations of partners, governance arrangements including how risks and benefits are shared.		No
2.5 Have you agreed individual contributions to any pool.	Yes. See 2.3		No
2.6 Does it include potential costs of young people in transition and of children's services.	A S.75 agreement is being developed for children's services for implementation in autumn 2013.		No
2.7 Between the partners is there an emerging financial strategy in the medium term that is built on current cost, future investment and potential for savings.	A review is currently underway to carry out some financial modelling and develop a financial plan for the commissioning and development of new services within current resources.		
3. Case management for individuals			
3.1 Do you have a joint, integrated community team.	Yes, there is an established integrated learning disability team of health and social care professionals with a clear service specification and eligibility criteria.		No
3.2 Is there clarity about the role and function of the local community team.			No
3.3 Does it have capacity to deliver the review and re-provision programme.	A "Move on" team has been established within the integrated service to ensure a continuous focus on reviewing out of area placements. The service successfully completed the multi-disciplinary reviews as required by the Department of Health by 31 May. There is a project structure to take forward actions following the reviews to ensure that those, inappropriately placed in 'Winterbourne View' type services are moved/resettled by 31 May 2014.	Yes move on team	No
3.4 Is there clarity about overall professional leadership of the review programme.	The Assistant Director Adult Social Care has professional leadership for the review programme. The Joint		No

	Commissioner (Mental Health & Learning Disability) for the LA/CCG supports the programme through developing local commissioning plans and reporting on progress on these through the relevant governance arrangements in the council and CCG		
3.5 Are the interests of people who are being reviewed, and of family carers, supported by named workers and / or advocates?	Yes, there are named case managers and advocates. A record is kept of a register of all people being reviewed.		No
4. Current Review Programme			
4.1 Is there agreement about the numbers of people who will be affected by the programme and are arrangements being put in place to support them and their families through the process.	Yes, there are 17 people[1] currently in hospital settings. Families and advocates are involved and all have named case managers based in the local learning disability integrated team and mental health services where appropriate.		No
4.2 Are arrangements for review of people funded through specialist commissioning clear.	There are 2 people funded through Specialist Commissioning, who are part of those identified in 4.1 above. Both have been recently reviewed.		No
4.3 Are the necessary joint arrangements (including people with learning disability, carers, advocacy organisations, Local Healthwatch) agreed and in place.	Yes. Information is communicated through the various boards and forums.		No
4.4 Is there confidence that comprehensive local registers of people with behaviour that challenges have been developed and are being used.	We have a local learning disability register in place which is maintained and updated by the integrated learning disability service. The register includes details of local case managers This is used to monitor out of borough and in borough support plans, track review progress and monitor delivery of individual move on plans. It is broader than people with behaviour that challenge services but this will be added as a specific category in the register. It covers those funded by the CCG and the council. Some mapping of this population is planned as part of a strategic needs assessment for		No

[1] Includes 4 people funded by council

	people with complex needs and challenging behaviour.		
4.5 Is there clarity about ownership, maintenance and monitoring of local registers following transition to CCG, including identifying who should be the first point of contact for each individual	Yes. We have a local learning disability register in place which is maintained and updated by the integrated learning disability service. The register includes details of local case managers.		No
4.6 Is advocacy routinely available to people (and family) to support assessment, care planning and review processes	Yes, we have a full range of advocacy services. Barnet commissions generic advocacy and statutory advocacy services including an Independent Mental Health Advocacy Service (IMHA) and Independent Mental Capacity Advocacy Service (IMCA) service. The IMCA service is jointly commissioned with the London boroughs of Enfield and Haringey. Work is underway to build on this arrangement to include commissioning of IMHA.		No
4.7 How do you know about the quality of the reviews and how good practice in this area is being developed.	Case managers receive monthly 1:1 line management as well as clinical/professional supervision as appropriate. Advocates and family members are involved in the review process to ensure that the reviews are holistic. Line managers undertake regular case audits of people's files and reviews as part of 1:1 supervision within the learning disability service. An annual independent case file audit monitors review quality of a sample of cases. We have recently introduced recording of the service user's '3 Wishes' at assessment and review/re-assessment stages and will be tracking achievement of these.		No
4.8 Do completed reviews give a good understanding of behaviour support being offered in individual situations.	Reviews give a holistic view of the individuals. All of the reviews have been undertaken jointly between health and social care, by the dedicated Move		No

	On Team. A specialist Community Nurse has reviewed behavioural and other health care plans.		
4.9 Have all the required reviews been completed. Are you satisfied that there are clear plans for any outstanding reviews to be completed.	All but one review has been completed. As at 31 May, we had reviewed 16 of the 17 people in a hospital setting. The outstanding review was as a result of the service user having been recently placed, being seriously unwell and the review will take place when the situation has stabilised. This situation is being monitored.		No
5. Safeguarding			
5.1 Where people are placed out of your area, are you engaged with local safeguarding arrangements – e.g. in line with the ADASS protocol.	The ADASS protocol is applied where the host local authority investigates any abuse allegations/alerts. Case managers liaise appropriately with those involved in leading investigations and instigating protection plans.		No
5.2 How are you working with care providers (including housing) to ensure sharing of information & develop risk assessments.	Case managers share all appropriate information that will assist any provider to deliver good quality safe care and support. The 'Quality in Care Homes' team funded through S256, has been set up to provide greater support to providers in order to improve service quality. There is a 'Providers Forum' in place to share learning and good practice		No
5.3 Have you been fully briefed on whether inspection of units in your locality have taken place, and if so are issues that may have been identified being worked on.	There is an effective liaison arrangement between the council, CCG and CQC to share intelligence and concerns. Formal liaison meetings with CQC take place every 3 months, plus 6 monthly with the DASS. Weekly reports on inspections by CQC are reviewed by Barnet Adult Social Care and action taken as appropriate. The CCG plans formal liaison meetings with CQC and with the provider. Any regional quality issues are discussed at our local quality surveillance group (QSG) .		No

	The DASS is the borough representative on the local QSG.		
5.4 Are you satisfied that your Children and Adults Safeguarding Boards are in touch with your Winterbourne View review and development programme.	There have been reports to the Safeguarding Adults Board with updates in January 2012 and January 2013 and are plans to take further updates to the SAB to report on progress. The Barnet Children's Safeguarding Board will be considering this at a future meeting.		NO
5.5 Have they agreed a clear role to ensure that all current placements take account of existing concerns/alerts, the requirements of DoLS and the monitoring of restraint.	Yes. Appropriate use of the MCA and DoLS have been key issues in the BSAB's consideration of local issues in respect of Winterbourne View. MCA and DoLS are also reported in the BSAB annual report. They are also addressed through reviews and case management by the integrated learning disability service. There is a system in place to collect intelligence on safeguarding concerns associated with providers in order to pro-actively take action as required.		No
5.6 Are there agreed multi-agency programmes that support staff in all settings to share information and good practice regarding people with learning disability and behaviour that challenges who are currently placed in hospital settings.	The BSAB has hosted a couple of multi-agency workshop events, bringing together providers, health and social care professionals and commissioners on Winterbourne in order to share good practice. This included a learning event led by Dr Margaret Flynn, author of the Winterbourne View serious case review. The council has commissioned and run two courses for health and social care staff who support people with learning disabilities in the community. The course, PROACT SCIP rUK® is a whole approach to working with adults with a learning disability. It follows the positive behaviour support model and focuses on proactive methods to avoid triggers that may lead to a person to present behavioural challenges to get their needs met. A total of 24 staff attended in 2012/13 from the private and voluntary sector with two more training sessions commissioned for 2013/14.	Yes	

5.7 Is your Community Safety Partnership considering any of the issues that might impact on people with learning disability living in less restrictive environments.	The Community Safety Partnership works to prevent hate crimes including development of 5 'safe places' across the borough. There are plans afoot to expand this arrangement into 10 other 'safe places'. The Community Safety Partnership and the LDPB are working with TFL to improve safety on public transport.		No
5.8 Has your Safeguarding Board got working links between CQC, contracts management, safeguarding staff and care/case managers to maintain alertness to concerns.	The BSAB includes representatives from all local NHS providers, the voluntary sector, the Police, Fire Service, CCG, the Council, CQC, LAS, Probation Services, care management, commissioning and others.		No
6. Commissioning arrangements			
6.1 Are you completing an initial assessment of commissioning requirements to support peoples' move from assessment and treatment/in-patient settings.	Yes, this exercise is underway and will build on the findings from the recent London-wide market position statement following the submission of the LD registers. This information is being uploaded to the council's online Market Position Statement microsite. An outline project brief setting out the scope of the project is to be presented to the next meeting of the Complex Care Board.		No
6.2 Are these being jointly reviewed, developed and delivered.	Yes, see 6.1.		No
6.3 Is there a shared understanding of how many people are placed out of area and of the proportion of this to total numbers of people fully funded by NHS CHC and those jointly supported by health and care services.	There is a complete register that details total numbers of people fully funded by NHS CHC and those jointly supported by health and care services including where they are currently receiving services. The register includes 76 people; 61 people are funded by NHS Continuing Health Care with 31 receiving additional funding through the council for their care; 4 are subject of a s75 agreement. The council also maintains a register of all people with LD and autism including out-of-area placements.		No

6.4 Do commissioning intentions reflect both the need deliver a re-provision programme for existing people and the need to substantially reduce future hospital placements for new people.	There is a high level policy commitment to re-provide for people and to avoid hospital admission. This is reflected in the joint commissioning work plan agreed by the Council and CCG.		No
6.5 Have joint reviewing and (de)commissioning arrangements been agreed with specialist commissioning teams.	Reviews of the 2 people funded through specialist commissioning has taken place. Further discussions are needed with Specialist Commissioning on (de) commissioning plans.		Yes
6.6 Have the potential costs and source(s) of funds of future commissioning arrangements been assessed.	Financial modelling and analysis is currently underway, that will be linked to a specific strategic needs analysis around the needs of people with complex needs and challenging behaviour.		No
6.7 Are local arrangements for the commissioning of advocacy support sufficient, if not, are changes being developed.	Yes. There is a generic advocacy service in place. We also have a joint arrangement with the London Boroughs of Enfield and Haringey for the commissioning of statutory Independent Mental Capacity Advocacy. We are planning to extend this arrangement to include the re-commissioning of the Independent mental Health Advocacy service.		No
6.8 Is your local delivery plan in the process of being developed, resourced and agreed.	Yes, a project brief has been developed and a project manager is in post.		No
6.9 Are you confident that the 1 June 2014 target will be achieved (the commitment is for all people currently in in-patient settings to be placed nearer home and in a less restrictive environment).	While we remain confident of meeting the 1 June target overall, it should be noted that there are 6 people with complex needs currently resident in Harperbury hospital who are the subject of Court of Protection Consent Orders regarding their residence. They have been resident there for over 15 years. The Court of Protection (CoP) Consent Orders will be a factor in determining speed of progress as regards to moves for this group. The Consent Orders were agreed with the Official Solicitor acting on behalf of the 6 people and		Yes

	their families who made a case against their being moved in 2011.		
6.10 If no, what are the obstacles, to delivery (e.g. organisational, financial, and legal).	See 6.9. The Consent Orders require the council to have involved and secured agreement with the Official Solicitors acting on behalf of the 6 people in respect of any plans to resettle them. The implementation of any move on plan for the 6 individuals will need to be progressed sensitively and plans presented to the CoP for final sign off.		
7. Developing local teams and services			
7.1 Are you completing an initial assessment of commissioning requirements to support peoples' move from assessment and treatment/in-patient settings.	Yes, this is being scoped not just in relation to current people in hospital settings, but to take account of young people in transition and social care out of area placements.		No
7.2 Do you have ways of knowing about the quality and effectiveness of advocacy arrangements.	There are contract monitoring meetings with the advocacy service providers to review contract and performance. In partnership with the London Borough of Enfield and Haringey, we are currently in the process of retendering the IMCA and IMHA services, which gives the opportunity to update service specifications in line with new guidance and practice. The IMCA service provider is also represented on the BSAB and provides regular updates on its work. We have a contract with the Barnet Centre for Independent Living (BCIL) and its partner organisations for a generic advocacy service. The contract is monitored regularly and against performance criteria and quality measures. Service users' feedback is included in the monitoring information required.		No

7.3 Do you have plans to ensure that there is capacity to ensure that Best Interests assessors are involved in care planning.	Yes. The Council has a number of Best Interests assessors (BIA) and has a programme of training for BIA and there is scope to procure BIAs on a freelance basis where the need arises. The Council and CCG have agreed a recurrent transfer from the CCG to support the new MCA supervisory responsibilities taken on by the Council since 1 April 2013.		No
8. Prevention and crisis response capacity - Local/shared capacity to manage emergencies			
8.1 Do commissioning intentions include an assessment of capacity that will be required to deliver crisis response services locally.	Our commissioning intentions include a review of our crisis services. Further work is being scoped to ensure effective access to people with learning disabilities and scope additional community response to prevent need of hospital admission in line with the Department of Health 'models of care'.		Yes
8.2 Do you have / are you working on developing emergency responses that would avoid hospital admission (including under section of MHA.)	See 8.1		No
8.3 Do commissioning intentions include a workforce and skills assessment development.	A specialist Safeguarding trainer offers tailored training to providers in the workplace.		No
9. Understanding the population who need/receive services			
9.1 Do your local planning functions and market assessments support the development of support for all people with complex needs, including people with behaviour that challenges.	A JSNA is in place and it includes a specific section on people with learning disabilities and autism. The JSNA is being updated. The council has a market position statement and is developing an online Market Position Statement microsite which will include information on needs and commissioning priorities targeted at providers. An exercise is underway to explore the capacity of providers on the supported living Framework Contract to meet the needs of people with complex needs.	Yes	No
9.2 From the current people who need to be reviewed, are you taking account of ethnicity, age profile and gender issues in planning and understanding future care	Yes.		No

services.			

10. Children and adults – transition planning			
10.1Do commissioning arrangements take account of the needs of children and young people in transition as well as of adults. 10.2 Have you developed ways of understanding future demand in terms of numbers of people and likely services.	Yes, there is a Transition Team to support young people moving into adult service between the ages of 16-18 years. There is a forum of managers from the disabled children's, SEN and Adults Teams, to track and discuss potential numbers of young people from the age of 14 who may need adult services. The Complex Care Board chaired by the Education Director (referred to above) has been constituted to oversee the development of pathways and service response for people with complex needs and young people in transition. A 'Transitions' database has been developed to track people including identifying current funding arrangements.		No
11. Current and future market requirements and capacity			
11.1 Is an assessment of local market capacity in progress. 11.2 Does this include an updated gap analysis. 11.3 Are there local examples of innovative practice that can be shared more widely, e.g. the development of local for to share/learn and develop best practice.	Yes, this is underway. The Council already has a Market Position Statement and a joint commissioning work programme. This will be further developed to support the Winterbourne View programme. This is underway as in 9.1. - Workshop learning events on Winterbourne View hosted by the SAB; - the Providers Forum supported by the council bring together health and social care providers t discuss and plan things of common interest; - the Move on Team in the integrated learning disability service focussed on undertaking reviewing and resettling people placed out-of-area.		No No No

Please send questions, queries or completed stocktake to Sarah.brown@local.gov.uk by 5th July 2013

This document has been completed by

Name	Dawn Wakeling, Adults and Communities, Director
	Temmy Fasegha, Joint Commissioner Learning Disabilities & Mental Health
Organisation	London Borough of Barnet
Contact	Temmy Fasegha, email temmy.fasegh@barnet.gov.uk; tel number: 0208 359 2841
Signed by:	Cllr Hart
Chair HWB	Chair of Health & Well Being Board
LA Chief Executive	Andrew Travers
CCG rep	John Morton, Chief Officer, CCG

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

DH 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

DH Department of Health

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!

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Meeting	Health and Well-Being Board	AGENDA ITEM 6
Date	19th September 2013	
Subject	**Tri-Borough Mental Health Commissioning Strategy**	
Report of	Chief Officer, Barnet Clinical Commissioning Group	
Summary of item and decision being sought	The Barnet, Enfield and Haringey Clinical Commissioning Groups have developed a 2-year tri-borough mental health commissioning strategy. The Strategy aims to ensure that local mental health services will support people in maintaining and developing good mental health and wellbeing; give people the maximum support to live full, positive lives when they are dealing with their mental health problems and help people recover as quickly as possible from mental illness. The Board is asked to note and comment on the tri-borough Mental Health Commissioning Strategy.	

Officer Contributors	John Morton, Chief Officer, Barnet CCG Temmy Fasegha- Joint Commissioner Mental Health
Reason for Report	The Board is asked to note and comment on the tri-borough Mental Health Commissioning Strategy
Partnership flexibility being exercised	None
Wards Affected	All
Enclosures	Appendix 1 – Adult and Older People Mental Health Services in Barnet, Enfield and Haringey Commissioning Strategy 2013/15
Contact for further information	Temmy Fasegha, temmy.fasegha@barnet.gov.uk, 0208 359 2841

1. RECOMMENDATION

1.1 That the Health and Well-being Board notes and comments on the tri-borough Mental Health Commissioning Strategy.

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 Health and Well-Being Board- held on 25th April, 2013 agreed the Barnet Clinical Commissioning Group Integrated Strategic and Operational Plan 2013 - 2015

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

3.1 The draft Mental Health Commissioning Strategy is aligned with and supports the delivery of the aims of the Barnet Health and Wellbeing Strategy, 'Keeping Well and Keeping Independent', the Barnet Clinical Commissioning Group Integrated Strategic and Operational Plan 2013 – 2015.

4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 Barnet's Joint Strategic Needs Assessment (JSNA)[1] shows that people with mental health problems experience significant health risks including obesity, diabetes, heart and respiratory diseases as well as lower life expectancy. In addition, they are much more likely to be socially excluded making up over 45% of Incapacity Benefit claimants.

4.2 The JSNA goes on to highlight a number of priority areas that the draft strategy seeks to address including:

- Improving identification and treatment of the physical health needs of people with severe mental illness;
- Promoting better access to work and other mainstream vocational opportunities;
- Undertaking local health initiatives aimed at engaging with the wide range of diverse groups, in particular those from BMER groups, to promote early identification and treatment of mental health conditions.

4.3 Detailed Equality and Health impact assessments will be undertaken for all specific commissioning projects arising from the implementation of the Mental Health Commissioning Strategy.

5. RISK MANAGEMENT

5.1 The Transformation Board is to be formed to oversee the implementation of the strategy including the development of a detailed action plan, which will be delivered within a project management approach, entailing completing, updating and reporting on risk logs and other project documents

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. Steps that may be

[1] Barnet Joint Strategic Needs Assessment- 2011

taken include providing information and advice, providing services or facilities designed to promote healthy living, providing services for the prevention, diagnosis or treatment of illness, providing financial incentives to encourage individuals to adopt healthier lifestyles, providing assistance (including financial) to help individuals to minimise any risks to health arising from their accommodation or environment, providing or participating in the provision of training for persons working or seeking to work in the field of health improvement, making available the services of any person or any facilities. In public law terms this *target* duty is owed to the population as a whole and the local authority must act reasonably in the exercise of these functions. Proper consideration will also need to be given to the duties arising from the Equality Act 2010 as mentioned above.

Due regard must also be given to the general public law duty set out in s149 of the Equality Act 2010.

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

7.1 Barnet CCG invests an estimated £35 million for the provision of mental health services in Barnet. Approximately £31 million of this investment is tied up in contracts with NHS trust providers including the Barnet, Enfield and Haringey Mental Health Trust.

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 The Barnet Mental Health Partnership Board (MHPB), a multi-agency partnership arrangement bringing together people experiencing mental health conditions, family carers and professionals from the Council, NHS, voluntary sector and other mainstream services has played an important role in shaping and developing the mental health strategy. The MHPB hosted two workshops sessions in May and July to review earlier drafts of the strategy and to comment on and identify key commissioning priorities. Members from the other four partnership boards were invited to the workshop sessions and a separate briefing session was held with members of the Older Adult Partnership Board in July. The Council's Adults and Communities Delivery Unit senior management team were briefed about the strategy in May and have commented on recent versions of the strategy.

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 The strategy has been shared widely with secondary mental health providers and at the last CCG public meeting held on 25 July 2013. Significantly, the strategy also reflects many of the priority areas identified in the CCG's Integrated Strategic and Operational Plan 2013 – 2015 presented to this Board on 25 April 2013.

10. DETAILS

10.1 The draft Mental Health Commissioning Strategy for adults and older people considers the delivery of mental health services in Barnet, Enfield and Haringey for the period of 2013-15. It sets out a number of key messages and commissioning priorities that will direct the delivery of services in the future. Reflecting the tri-borough commissioning arrangements across the Barnet, Enfield and Haringey CCGs, it also takes account of the different boroughs joint commissioning arrangements and local priorities. The strategy reflects the aims of Barnet's Health and Wellbeing Strategy focusing on prevention and early intervention, integration and personalised care provided closer to home.

10.2 The strategy aims to address the concerns raised by GPs, people using mental health services, borough partners and wider stakeholders about mental health services. In particular, the need for timely access to and good information about services and improved mental health support in primary care. Given the financial challenge faced by public sector services, the strategy also aims to ensure innovative, integrated, cost-effective and evidence-based services that meet the growing need of Barnet's population.

10.3 The strategy describes mental health provision in terms of a planned, stepped pathway approach. It recognises that improved effectiveness of early support and intervention in primary and community settings will reduce the dependency on more costly secondary and acute services. The stepped care approach is reflected in the 4 main tiers or themes:

- Health Promotion and Prevention
- Primary Care and Community Care
- Secondary mental health services
- Tertiary Services

10.4 The main commissioning priorities in the strategy include:

- development of integrated and enhanced primary care mental health services;
- Improving access to evidence based psychological therapies;
- improving Memory Clinics, care at home and in Care Homes for people with dementia, spanning early diagnosis and end of life care;
- ensuring effective care pathways and services for people with co-morbid conditions, for e.g. Autism, Attention Deficit Disorder and Personality Disorder;
- developing a local rehabilitation model for people requiring a prolonged period of hospital admission to reduce the current reliance on out-of-area placements;
- working collaboratively with partners, providers and the Council to prepare for the introduction of mental health Payment by Results in 2014/15.

10.5 The 3 CCGs have agreed to set up a 'Transformation Board' with representation from the Barnet, Enfield and Haringey Mental Health Trust, the CCGs and the London Boroughs of Barnet, Enfield and Haringey. The Transformation Board will be responsible for ensure the implementation of the commissioning strategy including the Mental Health Trust's Clinical Strategy published in the summer.

10.6 It is intended that the Transformation Board will establish four sub-groups with a range of representatives including people who use services mapped to the key themes of the strategy:

- Prevention and Health Promotion – Local Authority lead
- Primary Care and Community Services – GP lead
- Secondary Care –CCG lead
- Tertiary Service –Trust lead
- Recovery

11 BACKGROUND PAPERS

11.1 None attached.

Legal – JH
CFO – LC

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ADULT & OLDER PEOPLE MENTAL HEALTH SERVICES IN BARNET, ENFIELD & HARINGEY

COMMISSIONING STRATEGY 2013/15

Contents

1. EXECUTIVE SUMMARY

The Adult and Older People Mental Health Commissioning Strategy considers the delivery of mental health services in Barnet, Enfield and Haringey for the period of 2013-15. The strategy takes the mental health modernisation process forward by laying out a number of key messages and commissioning priorities that will direct the delivery of services in the future.

The three local authorities and CCGs have a joint responsibility for ensure that Mental Health services are commissioned for the population of BEH. Enfield CCG is designated as the lead CCG for taking forward Mental Health Commission on behalf of Barnet and Haringey.

The Strategy covers three very diverse boroughs in North/Outer London with unique population mix and unique challenges relating to Mental Health and wider health concerns in the community. However the challenges across the Boroughs have a number of common factors which are detailed in section 10 of this strategy.

The Strategy provides a framework for the continuing modernisation of mental health services and responds to a broad range of health and social needs. The shared vision is to improve the mental health and wellbeing of people living in Barnet, Enfield and Haringey and we will do this by ensuring we commission comprehensive, integrated and personalised services.

In particular these services will:

- Support people in maintaining and developing good mental health and wellbeing.
- Give people the maximum support to live full, positive lives when they are dealing with their mental health problems.
- Help people to recover as quickly as possible from mental illness.

In terms of wider commissioning activity, there will be a need to engage with Providers through market testing, to manage the process for shifting the emphasis to more community based support and interventions, which will mean moving activity from secondary mental health services back into primary care within an integrated, innovative stepped care model, closer to people's homes, based on cost effective evidence-based interventions.

2. COMMISSIONING PRIORITIES

- The need to further extend capacity in primary care to support people with mental health problems to stabilise in the community and wherever possible maintain or move back into paid work.
- Promote the use of individualised budgets.
- Prepare integration of all counselling and therapy services through the development of IAPT.
- The delivery of effective alternatives to hospital admission.
- Wherever possible deliver services as close to people as possible.
  This will involve reviewing clients currently placed out of district to ensure we are supporting people effectively to move on.
- Encourage the involvement of service users and carers at strategic planning, service review and development. Commissioners will actively work with the Mental Health Partnership Boards
- Emphasis on recovery valuing lived experience and fostering Peer leadership.
- Develop a Stepped Care Recovery Model to support individuals in the Community and reduce the numbers entering Secondary Care Mental Health Services
- Ensure the recommendations from the Francis Report are recognised locally and from

the cornerstone of commissioning priorities.

- Central emphasis on the Recovery Model and the promotion of mental health and wellbeing whilst supporting people in the community. The tenet of recovery and therefore the ethos of this Strategy is that it is not determined by cure or "clinical recovery". Instead it emphasises the unique journey of the individual living with mental health problems to build a life for themselves beyond illness. A person can recover their life without necessarily "recovering" from their illness, therefore there is an expectation that all services support the individual in maximizing their potential and supporting them in mainstream society, redefining recovery to incorporate quality of life a job, a decent place to live, friends and a social life.

3. THE NATIONAL AND LOCAL CONTEXT

There are a range of National Policy drivers which support and provide a context for this strategy, for example:

- NSF Five Years On – 2005
- Mental Health and Social exclusion report – 2004
- Choosing Health White Paper – 2004
- Our Health, our Care, our Say – 2006
- A new deal for Welfare – 2006
- Transforming Social Care – 2008
- Local Health and Well-being Strategies
- CCG Operating Plans
- Local Corporate Health and Social Care Objectives

However, the main driver for change in the National Mental Health Strategy "No Health without Mental Health" published in 2011, the key factors are detailed as follows:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have positive experience of evidence based timely interventions
- Fewer people will suffer avoidable harm and have confidence that services are safe
- Fewer will experience stigma and discrimination

In addition, there is the recent commitment from the Secretary of State, to move towards greater integrated health and social care in order to deliver better outcomes and efficiencies, so as to meet the current and future demographic challenges and relevant NICE guidelines.

4. THE STRATEGY

The Strategy describes mental health provision in terms of a planned, stepped pathway approach. It is recognised that improved effectiveness of early support and intervention in primary and community settings will reduce the dependency on secondary services.

The Commissioning Strategy considers 4 tiers reflecting the standards in the National Service Framework:

Tier One: Promotion and Prevention
Tier Two: Primary Care and Community Care
Tier Three: Secondary Mental Health Care

Tier Four: Tertiary services e.g. , Forensic Mental Health, Mother and Baby, Female Psychiatric Intensive Care

5. THE NATIONAL PICTURE OF MENTAL HEALTH AND WELLBEING

- Mental Health problems can affect anyone. Common mental health Problems are as frequent and common as physical disorders. Poor mental health significantly affects life choices and health outcomes.
- One in six of the population has a common mental health problem at any one time.
- WHO predict that depression will be the leading cause of disability internationally by 2020?
- Suicide is the most common cause of death in men under 35.
- Nationally, 900,000 people on incapacity benefit are off work because of mental health problems.
- The cost of mental health has been estimated at £77 billion per annum. People with mental illness are more likely to die prematurely than those without mental illness due to suicide but also death from respiratory and other illnesses.
- There is a well-documented correlation between poor mental and Physical ill health as well as a clear link to homelessness, substance misuse and dangers of a chaotic lifestyle. **Appendix 1** details the wider health challenges across the 3 Boroughs

6. FINANCIAL RESOURCES

The Department of Health publishes the outcome of the financial mapping exercise for adult and older people based on LIT self-assessment financial mapping returns. The overall spend by CCG on Adults and Older peoples Mental Health Services is as follows:

Investment		Weighted Population	Weighted Investment per head
Barnet	£47,223	277,61	£331.4
Haringey	£64,012	280,842	£619.2
Enfield	£50,657	256,909	426.8

Source 2011/12 DOH Financial Mapping Returns

By 2015/16 it is likely that Payment by Results will be applicable for the mental health services, and its introduction will completely change the way mental health services are funded. There will be national tariffs for treatments, currencies for treatments according to resource use and diagnosis and activity based funding. This will be a complex process and current information and activity data available is highly variable. However once the system has been introduced a key benefit is that there will be less need to negotiate the price of a service and more room for negotiation on quality and how best the service can meet the needs of the local population.

The above indicate the quantum of financial resource dedicated to the mental health services from health and social care. There have been a number of benchmarking exercises which have tried to establish whether this level of resource is adequate to meet local needs. However, it is difficult to establish whether such exercises take into account all available data and they tend to be utilised selectively, with Commissioners highlighting reports which seem to show a favorable level of investment and Providers highlighting reports showing the opposite and it is not always clear that data sources are comparable to enable an accurate analysis or comparison.

Therefore, given the relatively short period covered by the Strategy, along with the current economic circumstances and lack of clarity about the full introduction of payment by results for mental health, the assumption is that the level of resource will only show marginal change and it is therefore imperative that source resources are targeted effectively in this climate.

The services currently commissioned across the three Boroughs are detailed in Appendix 3

There has been significant debate over the balance of community and in- patient services related to appropriate balance and costs.

There has been significant improvement in the utilisation of both adult and older peoples' in-patient services in the recent past as the tables below demonstrate:

	April 2008	April 2009	April 2010	April 2011	April 2012
Barnet	114	63	59	48	36
Enfield	109	62	59	62	35
Haringey	109	71	70	55	43

Adult acute average length of stays (days)

These figures illustrate the overall reduction in in-patient activity and lengths of stay on the adult wards as a result of improved efficiency, productivity and reduced the number of emergency re-admissions and developed new alternatives to hospital admissions. The number of adult admissions has remained fairly consistent over the last four years, but lengths of stay and occupied bed days has reduced significantly. The opening of the 3 Recovery Houses and development of more service bases in the community will reduce the number of admissions and further reduce the lengths of stay.

In addition the absence of a local inpatient Rehabilitation Service as facilitated the gradual reduction in lengths of stay and improved bed utilisation.

The provision of adult acute mental health inpatient beds vary across the NHS from 15 per 100,000 population to 53 beds per 100,000 population. The median position nationally is 23 beds per 100,000 population.

BEH currently have 22 beds per 100,000 which is below the national median. As a London provider serving a population with higher than average deprivation this represents a comparatively efficient utilisation of in-patient resources.

The breakdown by Borough is a follows:

- Barnet **14** (amongst lowest nationally)
- Enfield **21.5**
- Haringey **32.5**

In terms of older people's acute in-patient mental health services, the occupied bed days have reduced by 58% in the last five years, as detailed below:

2007/8	2008/9	2009/10	2010/11	2011/12	2012/13
22,000	20,000	17,000	14,500	9,200	9,227

Acute older adults occupied bed days

There may be some scope for further reduction going forward but it is equally appropriate to

look at service efficiencies from community and complex care service lines

Additionally, it will be necessary to further understand the bed utilisation by CCGs as local provision does not mean local use given the movements of patients.

Commissioners and local authorities have also indicated that they wish to maintain a bed base in each borough which reduces but does not eliminate the possibility of savings by the reconfiguration of services. In particular, Barnet do not wish to see their residents disadvantaged by the further centralisation of services on sites in Enfield and Haringey.

7. LOCAL COMMISSIONING CONTEXT

The three CCGs have responsibility for commissioning health services whilst the local authorities commission social care services. In order to ensure that commissioning is integrated each Borough has a local Strategic Partnership Board tasked with taking forward the common agendas. The Partnership Boards include a wide range of local stakeholders including Councils, PCTs, service users, carers and voluntary organisations.

Services for people with mental health problems represent just a part of the wide range of services commissioned by Local Authorities and CCGs. Our strategy for mental health needs to be seen in the context of our wider aspirations to improve all the services that are commissioned. Each of the organisations has established clear goals and aspirations summarised below:

- Affordable and decent housing.
- People to be supported in taking responsibility for their own health.
- Good access to high quality health services.
- Supporting families and individuals who need it – promoting independence, learning and wellbeing.
- Improving the satisfaction of residents and businesses within the Borough as a place to live, work and study.
- Targeting health and social care at the most vulnerable, specifically people with mental health needs and disabilities.
- Increase the choice and control in decision making over their individual services for service users, patients and carers.
- Increase the individual and collective influence of service users, patients and carers in shaping future services.
- To focus services to maximise and maintain peoples' health, independence and inclusion.
- To develop and maintain accessible services including fully accessible premises and homes.
- To develop integrated community pathways and services by working in partnership and co-ordinating development and investment.
- To ensure a workforce that is trained, reliable and efficient and to work with the independent sector to ensure the same is true of their workforce.
- To focus on the quality of service provided to service users, carers and patients.
- Implement recommendations from the Francis Report.

Service Model for the Future

We wish to see a transformation model of care so there is increased focus on the Stepped Care Recovery Model, integrated care, effective Multidisciplinary Team Working and the aspirations sent out in the National Strategy. At the moment, mental health services are too

narrowly focused, not joined up and not addressing the needs of individuals.

Delivering an integrated model of care will be challenging but the range of services described below cover a range of mental health needs – health promotion and prevention, primary and community care, secondary mental health services and specialist mental health services.

a. Health Promotion and Prevention

- Campaigns to reduce stigma and promote inclusion
- Employment opportunities and training
- Promotion of good mental health in all environments
- Information on health and wellbeing
- Improved housing facilities
- Support at difficult times e.g. bereavement
- Support for Carers

b. Primary Care and Community care

- Skilled primary health care workers
- Access to GPs and support
- Advice on finding the right services
- Housing, benefits and employment advice
- Access to psychological therapy support
- Early Intervention in Psychosis Teams
- Integrated Community Mental Health Teams
- Crisis and Home Treatment Teams
- Adult ADHD Services
- Eating Disorder Services
- Personality Disorder Services
- Dementia Services

c. Secondary mental health services

- Access to hospital services for people in crisis
- Range of supported accommodation
- Day opportunities
- Care co-ordination

d. Tertiary Services

- Forensic inpatient services
- Mother and baby Services
- Eating Disorder Services

9. KEY PRIORITIES FOR CHANGE

Detailed below are the key cross Borough priorities for change in the delivery of mental health services that Commissioners will take forward up to 2015.

a. Primary Care

Continue the shift towards primary care provision, supporting the transfer of patients and interventions from secondary to primary care through the development of integrated and enhanced primary care provision and liaison services.

This will mean a continues shift in resources and manpower over a strategic period from secondary to primary care so the majority of Mental Health interventions take place in primary and community settings regardless of who is delivering them. These services will provide high

levels of intervention in community settings and further reduce reliance on inpatient services. This network of services could be subject to market testing should Commissioners wish to pursue such an option.

Improved support and access to primary care services

- **Stepped Care and Recovery Approach**: There should be appropriate resources to diagnose and treat mental health patients in primary care when clinically appropriate. Only when further input is required will patients be referred into secondary and/or specialist services.
- **Timely Access**: Patients will have prompt access to assessment, treatment and support. GPs will have access to prompt information, advice and management support.
- **Support increased Confidence**: The service will improve the confidence of GPs to provide care and treatment for people within a primary care setting by providing timely, robust assessments and recommendations.
- **Improved communication** between primary and secondary care; for example through liaison arrangements and agreed standards and protocols.
- **Improved trust** in the service provided by BEH by having experienced staff available to give advice, make decisions and smooth care pathways.
- **Ensure efficient throughput** by providing effective clinical assessments that give clear recommendations and support stepping down patients from secondary to primary care.

b. Improve Care Pathways

- Develop plansfrom the Maudsley International Review of In-patient services. This may include cross Borough whole system initiatives looking at care pathways, focusing on more effective accommodation pathways which will yield benefits to all partners.
- Ensure that service users do not experience difficulties in the transition between services e.g., CAMHS to adults and adults to older people services. Providers will focus on these transition points to ensure there are clear pathways which include specific support allowing people to manage the transition effectively.
- Ensure that care pathways are in place to meet the needs of people with co-morbid conditions such as autism and learning disabilities. Services should be accessible and adapted to meet the needs of those requiring specialist support.

c. Service users more in control of the service they receive

- Significant increase in the number of service users who are directly influencing their care through the use of personalised care budgets.
- Ensure packages of care are increasingly influenced by service users.
- Informed information to service users on what services are available and how they can be accessed.
- Ensure that service users are at the centre of service re-design and have a "clear journey" through services which are easily navigated.
- Recognition that the "expert patient model" approach and that service users are experts in mental health care by means of

their experiences in the mental healthcare system.

- Introduction of peer support arrangements in secondary mental healthcare to help bridge the gap between the mental health professional and service user.
- Enhances availability of information on mental health awareness and description of services available locally and how they are accessed.
- Support to carers and availability of family therapy services where appropriate to help service users to be supported and maintained in the community.
- Recognition of the role the third sector services can offer service users in terms of community maintenance and less stigmatising interventions.
- Recognition of the critical contribution carers make to the support and treatment of people with mental health problems. Preventative work with carers can reduce re-admissions and relapses as well as enhancing the effectiveness and efficiency of mental health services generally.

d. Improved support for people with physical and mental health problems

- Improving access to physical health services will mean regular health check-ups and an integrated approach between secondary and primary care services.
- Address the needs of people presenting with undiagnosed conditions by improving better access to psychological therapies.
- Emphasis on the overall wellbeing of the service users taking into account physical healthcare and a balance between medication and talking therapies.

e. CCG Quality and Safety Initiatives

- Work collaboratively to improve service line financial and activity data reporting.
- Work collaboratively to prepare for the introduction of payment by results.
- Work collaboratively on an agreed Service Quality Improvement agenda going forward, particularly in relation to the following:
  - Timely complaint investigations
  - Timely reporting of serious incidents
  - Timely investigation of serious incidents
  - Demonstrable organisational learning from serious incidents recommendations
    - Thematic reviews
    - National reports
    - Analysis of “near misses”
  - CQUIN targets achieved
  - Robust safe-guarding adults and children procedures
  - Action plans relating to CQC Alerts
  - Standardised access and timely interventions across all care pathways
  - Francis Recommendations
- Exploit the expertise of service users and secondary care staff in delivering mental healthcare to provide training opportunities for the diverse range of non-specialist mental

health staff associated in the delivery of effective mental health services.

- GPs and other Primary Care staff
- A&E staff
- Ambulance staff
- Primary Care reception and admin staff
- Police and Emergency services

f. Service Developments

Develop a Stepped Care Recovery Model which will involve a network of GPs, Primary Care Mental Health Workers IAPT, Crisis and Triage Teams working collaboratively to screen and assess people to maintain as many individuals as possible in Primary Care with the emphasis on reablement. The following two diagrams describe this approach.

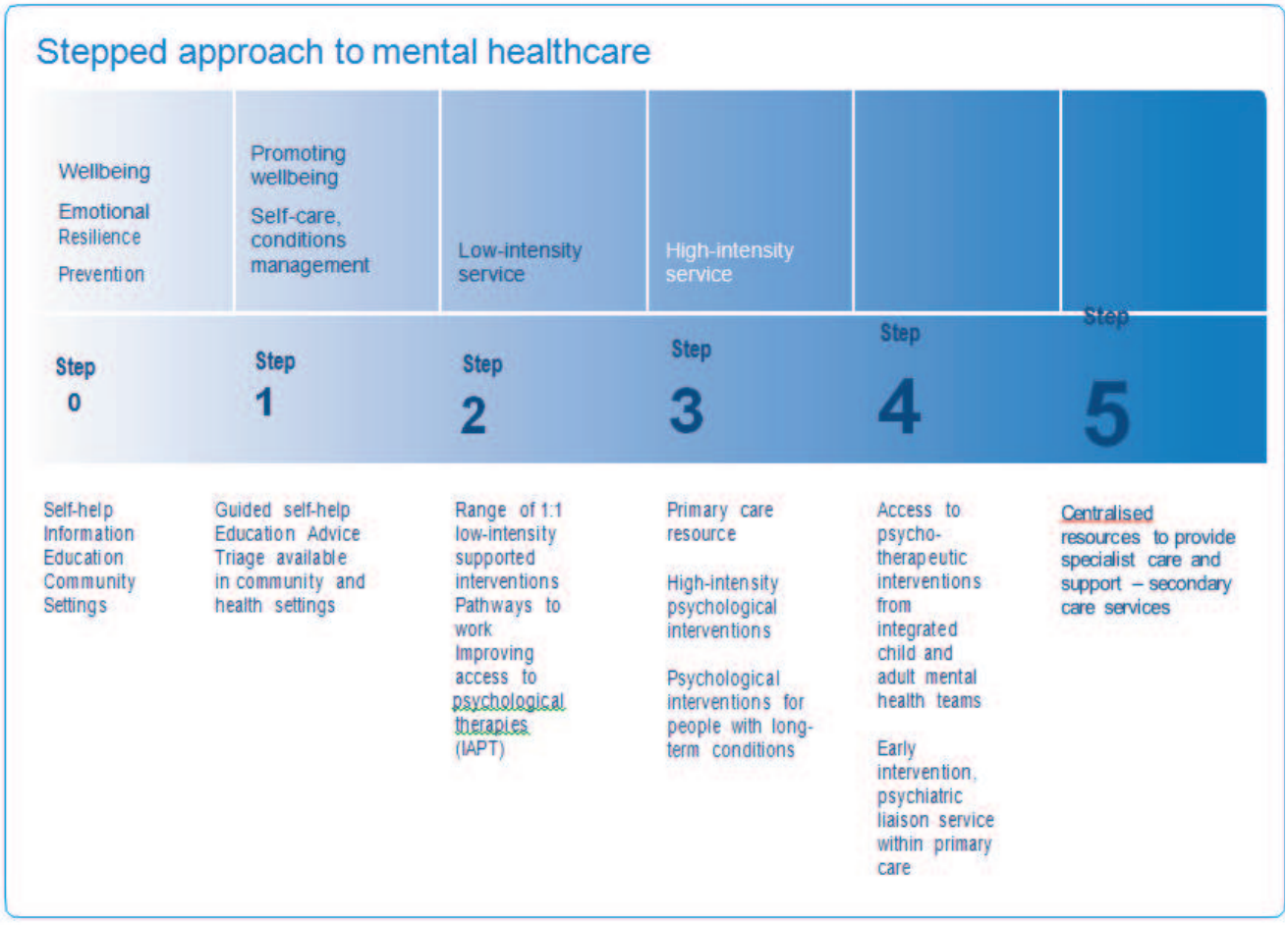
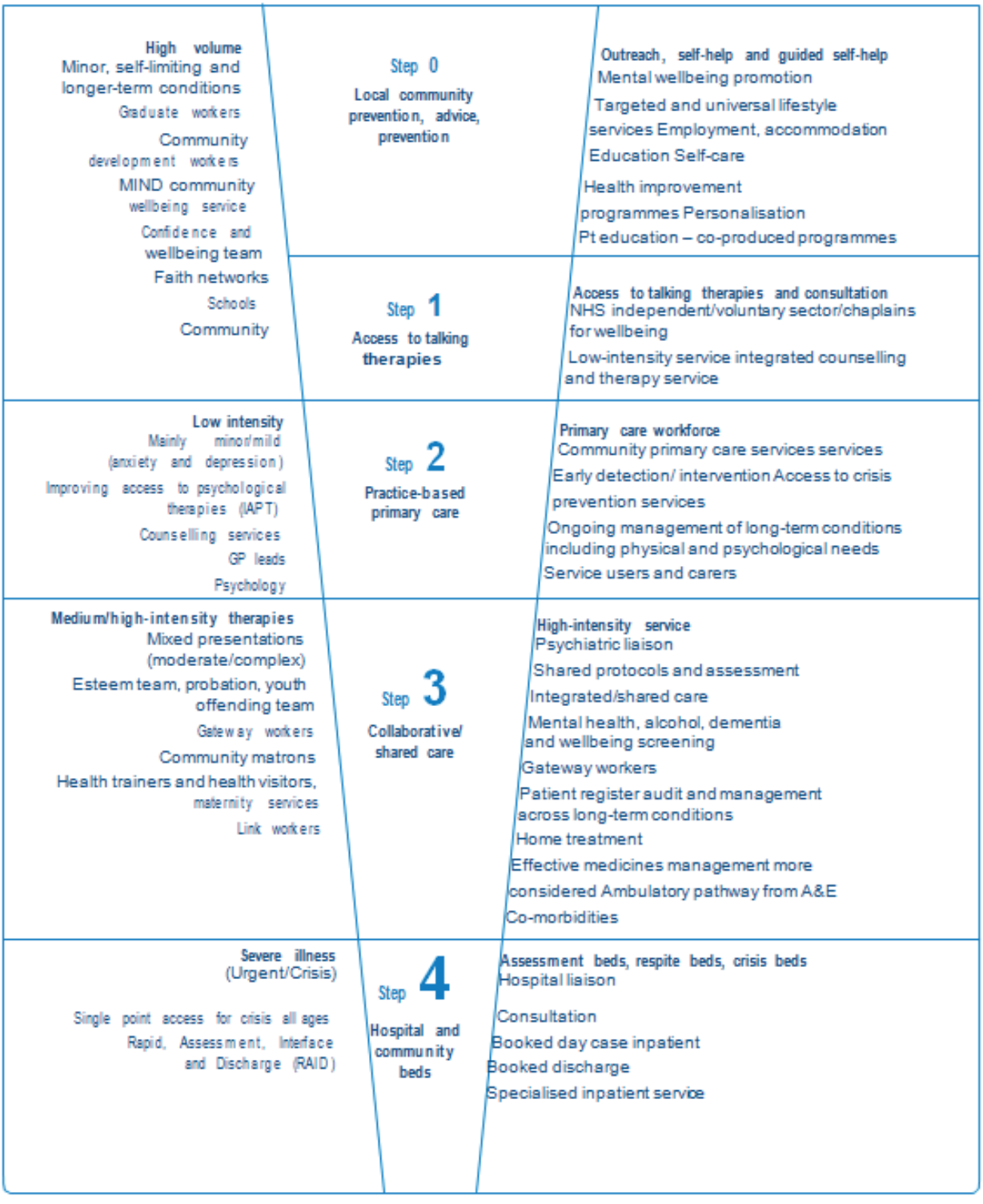


Figure 2: Integrated primary care and wellbeing model

This diagram depicts the I primary care mental health and wellbeing model. Within the model, people can step up or step down according to need.

Wellbeing is a theme at all levels through the model and access to programmes incorporating wellbeing and positive psychology is offered in a range of settings including faith, schools, children and family centres, health and community venues.



Key features would include:

- Improved access to mental health assessments for primary care referrals including extended / out of hour's services.

- Improved patient experience by working closely with service user advisory groups to design and develop better services with a more skill workforce.

- Home Treatment teams would work more closely with community assessment to keep people in primary care where possible.

- Improving the quality of the assessment by reviewing the skill mix of the assessment teams. Most experienced staff would be deployed in the assessment and triage function to formulate best treatment approach and ensure patients are seen in the most appropriate setting for their needs.

- Working closely with the Local Authorities to provide a stronger re-ablement function to facilitate, where appropriate, the management of those patients with social care needs in primary care.

- Benefits would include earlier assessment and improved signposting of patients into the most appropriate services to meet their needs with care managed in primary or community settings wherever possible. As well as improving patient experience and service quality, it would reduce the number of unnecessary admissions to hospital

- Assessment of all referrals from primary care and other referral sources (including police and other statutory services, emergency services and in-patient wards) of people who are not known to secondary care services. Referrals will be screened and in discussion with referrers, some will be signposted to alternative sources.

- Face to face assessment of referrals from primary care and other referral sources, with signposting or onward referral to other sources of treatment and support including IAPT.

- Extended hours to provide urgent assessment in primary care settings outside of traditional office hours.

- Linked working with Re-ablement services in the Local Authority to facilitate, where appropriate, the management of people with social care needs in primary care. Once this enhanced primary care service is in place consideration will be given to transferring all patients in clusters one to three from secondary to primary care. This will have an activity impact on secondary services and the expectation is that this will provide a Commissioner QIPP in 2014/15.

    - Reinstate the cross Borough adult ADHD services to previous activity levels and agree how this service is to be further developed.
    - Further expansion of IAPT provision and access to psychological therapies generally.
    - Continue to work towards the separation of functional and organic in-patient services for older people including the re- organisation of the Oaks unit and Ken Porter unit to ensure they are clinically sound and fit for purpose and work towards the development of a dementia care pathway.

- Continued Commissioner support for the redevelopment of the St Ann's site to provide high quality fit for purpose in-patient facilities.
- Develop a rehabilitation model locally for individuals requiring a more prolonged in-patient admission (12-18 months), this service is currently provided out of Borough which makes care co-ordination and family support problematic.

  In the meantime, the current Complex Care Panel will continue with revised Terms of Reference, focusing on 3 patient COHORTS. The expectation is that this provides financial benefits to Commissioners and Providers in 2013/14 and 2015/16 although it is accepted that the level of savings will taper as patients are placed in accommodation which is clinically and financially appropriate for their needs.
  Changes to the current configuration of services to enable the provision of a Personality Disorder Service across the 3 Boroughs
  The development of a local autism diagnostic service which will support other Community Teams and Primary care through training and consultation to better support people in the community

  Work collaboratively across health and social care to remodel the Day Hospitals for Older People
  Ensure improved access for people with a Learning disability or Autism to local Crisis or Home Treatment services including Acute beds as appropriate in order to provide care closer to home and reduce reliance on out of area placements

- Lead a formal consultation exercise to deliver a more appropriate service model for long term continuing care services. The new service will make support for older people more community based by developing services outside Hospital to support people who need long term care either in their own homes or Independent Sector provision. A smaller number of dementia treatment and assessment beds will be commissioned with a specific focus on intensive work with older people with challenging behavior or severe mood disorders to ensure they can continue to live at home with the support of appropriate community services. The expectation is that this provides a Commissioner QIPP in 2015/16.
- Implementation of the Barnet Dementia Action Plan with clearly defined pathways including early dementia detection and Memory services. A Dementia Hub will be developed comprising of multi-agency interventions and support for people with dementia and family and Carers. This will be a key service development and will provide some or all of the following

  - Memory Clinic service
  - Advice and support at the point of diagnosis
  - Alzheimer's services for people with high needs
  - Dementia Café
  - Carers Training
  - Support Groups
  - Tele-care/Tele-health

In partnership with Acute Commissioners lead the development of a Rapid Assessment Intervention and Discharge Service (RAID) at Barnet and Chase Farm, North Middlesex and Royal Free Hospital. This service will improve the quality of care, drive down lengths of stay and reduce admission rates across the whole spectrum of mental health co-morbidity in the acute hospitals including dementia, self-harm and substance misuse. There are two key components as follows:

- Direct assessment and treatment of patients presenting with overt mental health problems, allowing the acute Trust care

  Pathways to function smoothly and reduce unnecessary delays, similar assessment and treatment of patients who present with co-morbid health problems such as dementia.
- High quality education and support of Acute staff through both formal teaching and informal techniques, to rapidly train up Acute Trust staff in identification of patients who might benefit from liaison psychiatry input and improve their own care of such patients.

10. INDIVIDUAL BOROUGH PLANS

Individual Borough plans derived from local needs assessment, Commissioning Strategies and Partnership Board priorities display many similarities, the main themes of such plans are detailed below

10.1 Health Promotion and Prevention

Smoking cessation initiatives
Self directed support including the use of personal budgets Suicide prevention initiatives
Early intervention through health promotion work in schools and with families

10.2 Primary Care and Community care

Greater provision of integrated community treatment in Primary care

Training and support to GPs Improved access to IAPT
Improved support to individuals and carers in times of crisis

- Improving the interface between primary and secondary mental health care.
- Improving crisis response services
- Improve Memory Clinics, care at home and in Care Homes for patients with dementia, spanning early diagnosis and end of life care
- Ensure effective Care Pathways for people with co-morbid conditions eg Learning disabilities, Autism, Attention Deficit Disorder and Personality Disorder
- Development of enhanced Community based Dementia Services to address lower than expected ratio of recorded to expected levels of Dementia

10.3 Secondary Mental Health Services

- In partnership with Primary and Community Care Services develop admission avoidance schemes to address the high rate of hospital admissions for depressive and delusional disorders and schizophrenia
- Ensure an appropriate balance between inpatient and community Mental Health services.

10.4 Tertiary Services

- Develop a local rehabilitation model for patients requiring a prolonged period of hospital admission to reduce the current reliance on out of area placements
- Ensure there is a well-defined and effective Care Pathway between general mental health services and Specialist Forensic services

11. IMPLEMENTATION PLAN AND FINANCIAL OUTLOOK

It has been agreed to establish a Mental Health Transformation Board with representation from BEH, the CCGs and other Stakeholders. The Board will be chaired by the CCG Accountable Officer with the Lead for Mental Health working across the CCGs and the Mental Health Trust. The purpose of the Board will be to ensure the implementation of the Commissioning Strategy and other dependent initiatives such as the Trusts Clinical Strategy and Quality and Safety Review.

The first task of the Board will be to agree an implementation plan within three months of signing off the three Borough Strategy, the timescale for the delivery of the strategy is anticipated to between 18/24 months.

The Board will work to a PMO methodology, utilising a number of key workstreams reflecting local priorities to ensure the following:

- Oversee and monitor the delivery of the Reports as agreed by the Board.
- Oversee projects, activities and outputs in line with the Project Plans and deliverables, through the use of support and advice as required for each of the projects and highlight reports.
- Ensure Projects being taken forward align with the locally agreed strategies.
- Review risks through the use of a risk assurance framework ensuring that :
- robust clinical risk assessment and management is in place
- handover of documentation at the close of any programmed activity.

The Transformation Board will establish 4 sub-groups mapped to the key themes of this Commissioning Strategy as follows:

- Prevention and Health Promotion – Local Authority lead
- Primary Care and Community Services – GP lead
- Secondary Care –CCG lead
- Tertiary Service –BEH lead

As a consequence of the challenging financial position going forward all Stakeholders are likely to be identifying potential savings or efficiencies for reinvestment from the health economy with decommissioning and potential staff redundancies during service re-design.

At the outset therefore BEH and Commissioners need to agree the baseline for all service lines including indirect and overhead costs.

It is anticipated that every decommissioning decision will release some savings, though for small reductions these may be marginal. However, if the reduction is a substantial amount more significant savings, perhaps not all immediate should be released to Commissioners. This will apply to direct costs, indirect costs and organisational overheads.

The Transformation Board will have to ensure at the outset that potential savings required are not being double counted. BEH will have its own Cash Releasing Efficiency Savings and the CCGs their own QIPP targets and the initiatives to achieve both needs to be transparent. In line with the Francis recommendations the Board will need to assure itself that the QIPP/CIP plans have been through a rigorous Quality Impact Assessment to ensure that there is no adverse impact on quality and safety issues as detailed in the CCG Operating Framework.

CRES clearly relates to the ability of BEH to provide the same (or higher) level of activity for less income and the decommissioning of services is fairly clear. The grey area relates to provider led CRES, service re-design initiatives and Commissioner led re-design initiatives which may overlap with both parties anticipating the financial benefits realised.

It is therefore essential for the Transformation Board that CCGs and BEH are transparent in declaring their savings intentions and agreeing into which category each of these will fall and therefore where the savings will be attributed.

12. Next Steps

The Governance and Financial framework for the implementation of this Strategy needs to be established as soon as possible. The key milestones to doing so are as follows

Agree Terms of Reference for the Transformation Board **30/7/2013**.
Agree Commissioner QIPP and Provider CIPs **17/7/2013**

Joint meeting with BEH and CCG Executives and Senior Clinicians to agree the ground rules for working together going forward and the appropriate structures for doing so **30/7/2013**

In terms of the key service developments the milestones are as follows:

a) Primary Care Services

This strategy is intended to drive the majority of Mental Health interventions and support from secondary care into community based recovery settings in line with the Stepped Care Recovery Model outlined earlier.

This is a significant and crucial piece of work which will require detailed planning, consultation and careful implementation. This is therefore a major piece of work to be remitted to the Primary Care Sub group of the Transformation Board to be established in **September 2013**. It should be possible following due consultation and detailed planning to establish the new service by **June 2014**

b) RAID

Two Business Cases are required to develop this service which will need to dovetail together, one by the Provider and one by Commissioners- the latter with an emphasis on cost and potential financial and quality benefits going forward, offset against any upfront pump priming funding that may be required. These are to be completed by the end of **July 2013** and implementation remitted to the Secondary Care Sub Group with an expectation that the service is in place by **December 2013**

c) ADHD

The Clinic has now been re-established in line with the Commissioning Strategy and work has begun on how the service is to be further developed in light of local financial constraints of financial constraints. Activity and cost information is currently being analysed and this development should be remitted to the Primary and Community Services Sub group to be established in **September 2013**. It is anticipated that the expanded local service will be in place by **October 2013**

d) Older Persons Services Re-Configuration

Concern over quality issues on the Oaks unit has led to discussions already taking place about a new model of service which involves the separation of functional and organic inpatient services. A Steering group with Commissioner involvement is to be established to take this initiative forward, and this work needs to be completed by **October 2013**, given the concerns expressed. Monitoring of the impact of implementation should be remitted to the Primary and Community Services Sub Group to be established in **September 2013**.

e) Continuing Care Services re-configuration

This is primarily an Enfield issue, but not exclusively as any changes will impact on the other two Boroughs who do use the Oaks unit and also have a small number of patients on the associated Continuing Care Wards. The next step is a Paper to the Enfield CCG Transformation Board in **July 2013**, outlining the issues and suggesting options for taking forward this sensitive piece of work.

A full Business Case will need to written by **November 2013** to allow for a due period of formal consultation so that the new service can be in place by **October 2014** when the Contract with the current Provider comes to an end. This process is to be overseen by the Specialist Services Sub Group which is to be established in **September 2013.**

f) IAPT

Both Barnet and Enfield CCGs are undertaking work to determine how their IAPT services will meet the national targets by 2015. This may include additional investment and/or market testing.Both CCGs will be discussing this matter further in **July 2013** and the Primary and Community Services Sub Group to be established in **September 2013** will oversee the implementation of recommendations going forward.

g) Development of a Local Rehabilitation Service

This is a significant and complex piece of work which is in its infancy, external Clinical and Commissioning expertise may be required to further develop this initiative. The oversight of this work should be remitted to the Secondary care sub group to be established in **September 2013**. The first task is to produce a Proposal for a local model of service by **January 2014** for discussion and onward consultation with a view to establishing the local service by **October 2014**.

h) Development of Dementia Services

This piece of work is already well developed in Barnet and BEH have been asked by Commissioners to ensure that any changes to their older peoples services is complementary to and enhances the changes that are anticipated in Barnet. It would seem sensible therefore to bring those these two pieces of work together under the aegis of the Primary and Community Services Sub Group to be established in **September 2013** with a view to implementing the Barnet specific proposals by **April 2013** and assessing whether such service developments could be of benefit in the other two Boroughs

i) Autism and Learning Disability Developments

This piece of work is currently at an early stage and should be remitted to the Secondary Care Sub Group to develop these initiatives to ensure the new service model is established by **April 2014**

j) Day Hospital Remodelling

Again this work is in its early stages but could have significant implications across the 3 Boroughs and needs to be fully integrated and complementary to developments in Social Care Services. This piece of work needs to be led by the Primary and Community Services Sub Group, with an anticipated implementation date of **April 2014** following an inclusive Consultation Process

April 2013 – Updated 20 June 2013
Further updated 26th June 2013
Further updated 8th July 2013
Further updated 17th July 2013

Community Mental Health Profile 2013 for Barnet

Key

Regional average
Not significantly different to England
Significance Not Tested
England Average

Where percieved polarity:
Significantly worse than England
Significantly better than England

Where no percieved polarity:
Significantly lower than England
Significantly higher than England

	Wider Determinants of Health	Local value	Eng. Ave.	Eng. Worst*	England Range	Eng. Best*
1	**Percentage of 16-18 year olds not in employment, education or training, 2011**	4.1	6.2	11.9		1.9
2	**Episodes of violent crime, rate per 1,000 population, 2010/11**	12.7	14.6	34.5		6.3
3	**Percentage of the relevant population living in the 20% most deprived areas in England, 2010**	5.8	19.8	83.0		0.3
4	**Working age adults who are unemployed, rate per 1,000 population, 2010/11**	64.2	59.4	106.2		8.3
5	**Rate of hospital admissions for alcohol attributable conditions, per 1,000 population, 2011/12**	18.9	23.0	38.6		11.4
6	**Numbers of people (aged 18-75) in drug treatment, rate per 1,000 population, 2011/12**	2.8	5.2	0.8		18.4
	Risk Factors					
7	**Statutory homeless households, rate per 1,000 households, all ages, 2010/11**	1.83	2.03	10.36		0.13
8	**Percentage of the population with a limiting long term illness, 2001**	13.5	16.9	24.4		10.2
9	**First time entrants into the youth justice system 10 to 17 year olds,**	587	876	2,436		343

	2001 to 2011					
10	**Percentage of adults (16+) participating in recommended level of physical activity, 2009/10 to 2011/12**	8.5	11.2	5.7		17.3
Levels of Mental Health and Illness						
11	**Percentage of adults (18+) with dementia, 2011/12**	0.61	0.53	0.95		0.21
12	**Ratio of recorded to expected prevalence of dementia, 2010/11**	0.54	0.42	0.27		0.69
13	**Percentage of adults (18+) with depression, 2011/12**	8.46	11.68	20.29		4.75
14	**Percentage of adults (18+) with learning disabilities, 2011/12**	0.35	0.45	0.21		0.77

Treatment		**Local value**	**Eng. Ave.**	**Eng. Worst***	**England Range**	**Eng. Best***
15	**Directly standardised rate for hospital admissions for mental health, 2009/10 to 2011/12**	216	243	1,257		99
16	**Directly standardised rate for hospital admissions for unipolar depressive disorders, 2009/10 to 2011/12**	30.5	32.1	84.8		4.7
17	**Directly standardised rate for hospital admissions for Alzheimer's and other related dementia, 2009/10 to 2011/12**	53	80	226		5
18	**Directly standardised rate for hospital admissions for schizophrenia, schizotypal and delusional disorders, 2009/10 to 2011/12**	96	57	233		5
19	**Allocated average spend for mental health per head, 2011/12**	179	183	147		257

20	**Numbers of people using adult & elderly NHS secondary mental health services, rate per 1000 population, 2010/11**	2.5	2.5	0.0		9.6
21	**Percentage of referrals entering treatment from Improving Access to Psychological Therapies, 2011/12**	35.2	60.1	28.9		99.7
22	**Numbers of people on a Care Programme Approach, rate per 1,000 population, 2010/11**	7.7	6.4	0.3		17.1
23	**In-year bed days for mental health, rate per 1,000 population, 2010/11**	191	193	72		489
24	**Number of contacts with Community Psychiatric Nurse, rate per 1,000 population, 2010/11**	150	169	3		584
25	**Number of total contacts with mental health services, rate per 1,000 population, 2010/11**	330	313	31		823
Outcomes						
26	**People with mental illness and or disability in settled accommodation, 2011/12**	65.9	66.8	1.3		92.8
27	**Directly standardised rate for emergency hospital admissions for self harm, 2011/12**	121	207	543		52
28	**Indirectly standardised mortality rate for suicide and undetermined injury, 2010/11**	104	100	174		29
29	**Hospital admissions caused by unintentional and deliberate injuries in <18s, 2009/10**	79	123	217		68
30	**Improving Access to Psychological Therapies - Recovery Rate, 2011/12**	51.0	43.8	9.9		65.3

31	**Excess under 75 mortality rate in adults with serious mental illness, 2010/11**	596	921	1,863		210

* - For indicators 6, 20, and 22-25, there is no perceived polarity, so "lowest" and "highest" replace "worst" and "best"

Community Mental Health Profile 2013 for Enfield

Key


Regional average


Not significantly different to England


Significance Not Tested

England Average

Where percieved polarity:


Significantly worse than England


Significantly better than England

Where no percieved polarity:


Significantly lower than England


Significantly higher than England

Wider Determinants of Health		**Local value**	**Eng. Ave.**	**Eng. Worst***	**England Range**	**Eng. Best***
1	**Percentage of 16-18 year olds not in employment, education or training, 2011**	**4.2**	**6.2**	**11.9**		**1.9**
2	**Episodes of violent crime, rate per 1,000 population, 2010/11**	**15.0**	**14.6**	**34.5**		**6.3**
3	**Percentage of the relevant population living in the 20% most deprived areas in England, 2010**	**27.0**	**19.8**	**83.0**		**0.3**
4	**Working age adults who are unemployed, rate per 1,000 population, 2010/11**	**74.8**	**59.4**	**106.2**		**8.3**
5	**Rate of hospital admissions for alcohol attributable conditions, per 1,000 population, 2011/12**	**20.0**	**23.0**	**38.6**		**11.4**
6	**Numbers of people (aged 18-75) in drug treatment, rate per 1,000 population, 2011/12**	**5.2**	**5.2**	**0.8**		**18.4**
Risk Factors						
7	**Statutory homeless households, rate per 1,000 households, all ages, 2010/11**	**1.70**	**2.03**	**10.36**		**0.13**

8	Percentage of the population with a limiting long term illness, 2001	15.2	16.9	24.4		10.2
9	First time entrants into the youth justice system 10 to 17 year olds, 2001 to 2011	1,343	876	2,436		343
10	Percentage of adults (16+) participating in recommended level of physical activity, 2009/10 to 2011/12	9.3	11.2	5.7		17.3

Levels of Mental Health and Illness

11	Percentage of adults (18+) with dementia, 2011/12	0.41	0.53	0.95		0.21
12	Ratio of recorded to expected prevalence of dementia, 2010/11	0.36	0.42	0.27		0.69
13	Percentage of adults (18+) with depression, 2011/12	7.99	11.68	20.29		4.75
14	Percentage of adults (18+) with learning disabilities, 2011/12	0.38	0.45	0.21		0.77

Treatment		Local value	Eng. Ave.	Eng. Worst*	England Range	Eng. Best*
15	Directly standardised rate for hospital admissions for mental health, 2009/10 to 2011/12	259	243	1,257		99
16	Directly standardised rate for hospital admissions for unipolar depressive disorders, 2009/10 to 2011/12	30.9	32.1	84.8		4.7
17	Directly standardised rate for hospital admissions for Alzheimer's and other related dementia, 2009/10 to 2011/12	123	80	226		5
18	Directly standardised rate for hospital admissions for schizophrenia, schizotypal and delusional disorders, 2009/10 to	113	57	233		5

	2011/12					
19	**Allocated average spend for mental health per head, 2011/12**	**190**	**183**	**147**		**257**
20	**Numbers of people using adult & elderly NHS secondary mental health services, rate per 1000 population, 2010/11**	**2.8**	**2.5**	**0.0**		**9.6**
21	**Percentage of referrals entering treatment from Improving Access to Psychological Therapies, 2011/12**	**51.3**	**60.1**	**28.9**		**99.7**
22	**Numbers of people on a Care Programme Approach, rate per 1,000 population, 2010/11**	**10.1**	**6.4**	**0.3**		**17.1**
23	**In-year bed days for mental health, rate per 1,000 population, 2010/11**	**327**	**193**	**72**		**489**
24	**Number of contacts with Community Psychiatric Nurse, rate per 1,000 population, 2010/11**	**189**	**169**	**3**		**584**
25	**Number of total contacts with mental health services, rate per 1,000 population, 2010/11**	**432**	**313**	**31**		**823**
Outcomes						
26	**People with mental illness and or disability in settled accommodation, 2011/12**	**61.5**	**66.8**	**1.3**		**92.8**
27	**Directly standardised rate for emergency hospital admissions for self harm, 2011/12**	**84**	**207**	**543**		**52**
28	**Indirectly standardised mortality rate for suicide and undetermined injury, 2010/11**	**78**	**100**	**174**		**29**
29	**Hospital admissions caused by unintentional and deliberate**	**96**	**123**	**217**		**68**

	injuries in <18s, 2009/10					
30	Improving Access to Psychological Therapies - Recovery Rate, 2011/12	49.4	43.8	9.9		65.3
31	Excess under 75 mortality rate in adults with serious mental illness, 2010/11	884	921	1,863		210

* - For indicators 6, 20, and 22-25, there is no perceived polarity, so "lowest" and "highest" replace "worst" and "best"

Community Mental Health Profile 2013 for Haringey

Key


Regional average


Not significantly different to England


Significance Not Tested

England Average

Where percieved polarity:


Significantly worse than England


Significantly better than England

Where no percieved polarity:


Significantly lower than England

Significantly higher than England

Wider Determinants of Health		Local value	Eng. Ave.	Eng. Worst*	England Range	Eng. Best*
1	Percentage of 16-18 year olds not in employment, education or training, 2011	4.2	6.2	11.9		1.9
2	Episodes of violent crime, rate per 1,000 population, 2010/11	21.8	14.6	34.5		6.3
3	Percentage of the relevant population living in the 20% most deprived areas in England, 2010	55.9	19.8	83.0		0.3
4	Working age adults who are unemployed, rate per 1,000 population, 2010/11	85.1	59.4	106.2		8.3

5	**Rate of hospital admissions for alcohol attributable conditions, per 1,000 population, 2011/12**	**19.0**	**23.0**	**38.6**		**11.4**
6	**Numbers of people (aged 18-75) in drug treatment, rate per 1,000 population, 2011/12**	**6.6**	**5.2**	**0.8**		**18.4**
Risk Factors						
7	**Statutory homeless households, rate per 1,000 households, all ages, 2010/11**	**5.04**	**2.03**	**10.36**		**0.13**
8	**Percentage of the population with a limiting long term illness, 2001**	**14.7**	**16.9**	**24.4**		**10.2**
9	**First time entrants into the youth justice system 10 to 17 year olds, 2001 to 2011**	**1,488**	**876**	**2,436**		**343**
10	**Percentage of adults (16+) participating in recommended level of physical activity, 2009/10 to 2011/12**	**10.4**	**11.2**	**5.7**		**17.3**
Levels of Mental Health and Illness						
11	**Percentage of adults (18+) with dementia, 2011/12**	**0.25**	**0.53**	**0.95**		**0.21**
12	**Ratio of recorded to expected prevalence of dementia,**	**0.45**	**0.42**	**0.27**		**0.69**

	2010/11					
13	Percentage of adults (18+) with depression, 2011/12	7.41	11.68	20.29		4.75
14	Percentage of adults (18+) with learning disabilities, 2011/12	0.35	0.45	0.21		0.77

Treatment		Local value	Eng. Ave.	Eng. Worst*	England Range	Eng. Best*
15	Directly standardised rate for hospital admissions for mental health, 2009/10 to 2011/12	345	243	1,257		99
16	Directly standardised rate for hospital admissions for unipolar depressive disorders, 2009/10 to 2011/12	41.0	32.1	84.8		4.7
17	Directly standardised rate for hospital admissions for Alzheimer's and other related dementia, 2009/10 to 2011/12	73	80	226		5
18	Directly standardised rate for hospital admissions for schizophrenia, schizotypal and delusional disorders, 2009/10 to 2011/12	160	57	233		5
19	Allocated average spend for mental health per head,	209	183	147		257

	2011/12					
20	**Numbers of people using adult & elderly NHS secondary mental health services, rate per 1000 population, 2010/11**	**3.9**	**2.5**	**0.0**		**9.6**
21	**Percentage of referrals entering treatment from Improving Access to Psychological Therapies, 2011/12**	**55.2**	**60.1**	**28.9**		**99.7**
22	**Numbers of people on a Care Programme Approach, rate per 1,000 population, 2010/11**	**11.4**	**6.4**	**0.3**		**17.1**
23	**In-year bed days for mental health, rate per 1,000 population, 2010/11**	**366**	**193**	**72**		**489**
24	**Number of contacts with Community Psychiatric Nurse, rate per 1,000 population, 2010/11**	**232**	**169**	**3**		**584**
25	**Number of total contacts with mental health services, rate per 1,000 population, 2010/11**	**527**	**313**	**31**		**823**
Outcomes						
26	**People with mental illness and or disability in settled accommodation, 2011/12**	**60.4**	**66.8**	**1.3**		**92.8**

27	**Directly standardised rate for emergency hospital admissions for self harm, 2011/12**	**103**	**207**	**543**		**52**
28	**Indirectly standardised mortality rate for suicide and undetermined injury, 2010/11**	**123**	**100**	**174**		**29**
29	**Hospital admissions caused by unintentional and deliberate injuries in <18s, 2009/10**	**101**	**123**	**217**		**68**
30	**Improving Access to Psychological Therapies - Recovery Rate, 2011/12**	**44.8**	**43.8**	**9.9**		**65.3**
31	**Excess under 75 mortality rate in adults with serious mental illness, 2010/11**	**534**	**921**	**1,863**		**210**

*** - For indicators 6, 20, and 22-25, there is no perceived polarity, so "lowest" and "highest" replace "worst" and "best"**

LIT Comparative Report Adult Services LIT = Barnet

	LIT Investment by Direct Provider Type			
Direct Service Group	**£000's**	**NHS**	**Non Statutory**	**Social Services**
Access & Crisis Services	**£3,434**	£3,363	£0	£71
Accommodation	**£4,969**	£6	£4,963	£0
Carers' Services	**£154**	£0	£154	£0
Clinical Services	**£7,319**	£7,050	£269	£0
CMHTs	**£5,488**	£4,160	£0	£1,329
Continuing Care	**£2,359**	£957	£1,402	£0
Employment/Day/Resource Centres	**£1,034**	£0	£607	£428
Direct Payments	**£262**	£0	£262	£0
Home Support Services	**£958**	£0	£958	£0
Mental Health Promotion	**£0**	£0	£0	£0
Other Community & Hospital	**£977**	£977	£0	£0
Personality Disorder Services	**£41**	£41	£0	£0
Psychological Therapy Services (IAPT)	**£1,297**	£1,297	£0	£0
Psychological Therapy Services (NIAPT)	**£1,361**	£1,041	£319	£0
Secure & High Dependency	**£4,653**	£4,165	£487	£0
Services for MDO's	**£3**	£3	£0	£0
Support Services	**£527**	£0	£527	£0
Total Direct Services in £000's	**£34,835**	£23,060	£9,948	£1,828
Direct Costs	**£34,835**			
Indirect Costs / Overheads	**£3,524**			
Capital Charges	**£1,016**			
Total adult investment in £000's	**£39,376**			

LIT Comparative Report Older People LIT = Barnet

	LIT Investment by Direct Provider Type			
Direct Service Group	**£000's**	**NHS**	**Non Statutory**	**Social Services**
Care and repair - OPMH	**£0**	£0	£0	£0
Care for People in General Hospital	**£1**	£1	£0	£0
Carer's Services - OPMH	**£27**	£0	£27	£0
Emergency Services - OPMH	**£0**	£0	£0	£0
Intermediate Care - OPMH	**£0**	£0	£0	£0
Other Specialist MH Services - OPMH	**£4,588**	£4,290	£0	£297
Primary and Community Care				
- Day Services	**£633**	£322	£311	£0
- Homecare	**£0**	£0	£0	£0
- PCS	**£0**	£0	£0	£0
- Residential	**£1,524**	£0	£1,524	£0
- Specialist Housing	**£0**	£0	£0	£0
Special Groups - OPMH	**£5**	£5	£0	£0
Support Services - OPMH	**£0**	£0	£0	£0
Total Direct Services in £'000s	**£6,777**	£4,618	£1,861	£297
Direct Costs	**£6,777**			
Indirect Costs/Overheads	**£837**			
Capital Charges	**£234**			
Total OPMH investments in £'000s	**£7848**			

LIT Comparative Report Adult Services LIT = Haringey

	LIT Investment by Direct Provider Type			
Direct Service Group	**£000's**	**NHS**	**Non Statutory**	**Social Services**
Access & Crisis Services	**£4,457**	£3,581	£0	£876
Accommodation	**£11,462**	£0	£11,462	£0
Carers' Services	**£299**	£0	£269	£31
Clinical Services	**£6,600**	£6,600	£0	£0
CMHTs	**£5,580**	£4,284	£0	£1,297
Continuing Care	**£82**	£14	£68	£0
Employment / Day / Resource Centres	**£1,500**	£0	£498	£1,003
Direct Payments	**£195**	£0	£195	£0
Home Support Services	**£159**	£0	£159	£0
Mental Health Promotion	**£0**	£0	£0	£0
Other Community & Hospital	**£42**	£8	£34	£0
Personality Disorder Services	**£815**	£815	£0	£0
Psychological Therapy Services (IAPT)	**£959**	£283	£676	£0
Psychological Therapy Services (NIAPT)	**£1,306**	£1,246	£60	£0
Secure & High Dependency	**£10,382**	£10,382	£0	£0
Services of MDOs	**£295**	£295	£0	£0
Support Services	**£562**	£0	£562	£0
Total Direct Services in £'000s and %	**£44,697**	£27,509	£13,981	£3,206
Direct Costs	**£44,697**			
Indirect Costs / Overheads	**£3,654**			
Capital Charges	**£1,743**			
Total adult investment in £'000s	**£50,093**			

LIT Comparative Report Older People LIT = Haringey

		LIT Investment by Direct Provider Type		
Direct Service Group	**£000's**	**NHS**	**Non Statutory**	**Social Services**
Care and repair - OPMH	**£0**	£0	£0	£0
Care for People in General Hospital	**£0**	£1	£0	£0
Carer's Services - OPMH	**£0**	£0	£0	£0
Emergency Services - OPMH	**£17**	£17	£0	£0
Intermediate Care - OPMH	**£0**	£0	£0	£0
Other Specialist MH Services - OPMH	**£8,353**	£3,434	£4,920	
Primary and Community Care				
- Day Services	**£509**	£186	£315	£8
- Homecare	**£151**	£0	£151	£0
- PCS	**£287**	£0	£0	£287
- Residential	**£3,500**	£0	£3,390	£110
- Specialist Housing	**£222**	£0	£222	£0
Special Groups - OPMH	**£0**	£0	£0	£0
Support Services - OPMH	**£0**	£0	£0	£0
Total Direct Services in £'000s	**£13,040**	£3,637	£8,998	£405
Direct Costs	**£13,040**			
Indirect Costs/Overheads	**£710**			
Capital Charges	**£277**			
Total OPMH investments in £'000s	**£14,027**			

LIT Comparative Report Adult Services LIT = Enfield

	LIT Investment by Direct Provider Type			
Direct Service Group	**£000's**	**NHS**	**Non Statutory**	**Social Services**
Access & Crisis Services	**£3,996**	£3,258	£0	£738
Accommodation	**£2,245**	£0	£0	£2,245
Carers' Services	**£132**	£0	£80	£52
Clinical Services	**£7,836**	£6,119	£1,717	£0
CMHTs	**£4,726**	£3,423	£0	£1,303
Continuing Care	**£3,539**	£0	£3,539	£0
Employment / Day / Resource Centres	**£371**	£0	£0	£371
Direct Payments	**£46**	£0	£0	£46
Home Support Services	**£1,975**	£0	£36	£1,939
Mental Health Promotion	**£0**	£0	£0	£0
Other Community & Hospital	**£650**	£95	£0	£555
Personality Disorder Services	**£47**	£47	£0	£0
Psychological Therapy Services (IAPT)	**£1,453**	£543	£910	£0
Psychological Therapy Services (NIAPT)	**£1,272**	£824	£448	£0
Secure & High Dependency	**£6,446**	£6,210	£0	£236
Services of MDOs	**£159**	£159	£0	£0
Support Services	**£416**	£0	£347	£69
Total Direct Services in £'000s and %	**£35,309**	£20,678	£7,077	£7,554
Direct Costs	**£35,309**			
Indirect Costs / Overheads	**£3,491**			
Capital Charges	**£1,180**			
Total adult investment in £'000s	**£39,980**			

LIT Comparative Report Older People LIT = Enfield

	LIT Investment by Direct Provider Type			
Direct Service Group	**£000's**	**NHS**	**Non Statutory**	**Social Services**
Care and repair - OPMH	**£0**	£0	£0	£0
Care for People in General Hospital	**£0**	£0	£0	£0
Carer's Services - OPMH	**£0**	£0	£0	£0
Emergency Services - OPMH	**£0**	£0	£0	£0
Intermediate Care - OPMH	**£0**	£0	£0	£0
Other Specialist MH Services - OPMH	**£7,527**	£7,362	£0	£165
Primary and Community Care				
- Day Services	**£888**	£888	£0	£0
- Homecare	**£0**	£0	£0	£0
- PCS	**£0**	£0	£0	£0
- Residential	**£0**	£0	£0	£0
- Specialist Housing	**£0**	£0	£0	£0
Special Groups - OPMH	**£0**	£0	£0	£0
Support Services - OPMH	**£0**	£0	£0	£0
Total Direct Services in £'000s	**£8,415**	£8,250	£0	£165
Direct Costs	**£8,415**			
Indirect Costs/Overheads	**£1,616**			
Capital Charges	**£646**			
Total OPMH investments in £'000s	**£10,677**			

The services currently commissioned across the three Boroughs are detailed in Appendix 3 as

Barnet

Acute Care Beds **41**	Primary Care Mental Health Team
Psychiatric Intensive Care Beds **16**(3 Borough service)	CMHT **x 2** for older people
Functional Complex Continuing Care Beds **27**	Memory clinic / Day Hospital
Recovery Beds **12**	Complex Care Team **x 1**
Acute Assessment Centre	ADHD
Drug and alcohol Service	Community Rehab Team
IAPT	Wellbeing Clinic
Home Treatment Team	
Early Intervention Team	
Community Support & Recovery Teams **x 2**	

Accommodation Support

- Approximately 130 people in registered care homes, 140 places in dedicated accommodation and over 1,000 units with floating support. There is also a specialist recovery team to assist people in moving from registered homes to more independent living

Day Services

5 Centres

Other Support

- Advocacy support from MIND and Barnet Voice
- Carer support workers and support groups

Enfield

Acute Care Beds **51**	Primary Care Mental Health Team
Dementia Complex Continuing Care Beds **71**	136 Suite
Older Adults**24** (3 Borough)	CMHTs **x 2** for older people
Recovery Beds **12**	Memory Clinic / Day Hospital
Acute Assessment Centre	ADHD
Primary Care Mental Health Team	Community Rehab Team
IAPT	Wellbeing Clinic
Home Treatment Team	Complex Care Team
Community Support & Recovery Teams x 2	

Accommodation Support

- 30 Local Authority and residential care homes
- 22 homes providing supported housing
- Home support services

Day Services

- 4 Centres

Other Support

- Advocacy services e.g., from Ebony People's Association
- Information and advice services

Haringey

Acute Care Beds **50**	Early Invention Team
Specialist Beds **20** (Eating Disorder)	Community Support & Recovery Team
Recovery Beds**7**	Memory Clinic
Drug Advisory Service	CMHT **x 2** for older people
Intake Team (3 Borough Service)	ADHD
Acute Assessment Centre	Community Rehab Team
Primary Care Mental Health Team	Wellbeing Clinic
IAPT (Whittington)	Complex Care Team
Home Treatment Team	

Accommodation Support

- A range of accommodation and housing support services from the third sector and a range of supported housing schemes

Day Services

- 2 Centres

Other Support

- Advocacy services through MIND and Rethink plus Carers support provided by the Mental Health Carers Association
- Range of counselling services covering ethnic minority groups

In addition, the Trust provides the following:

- Specialist psychology, psychotherapy, OT, social care and other therapy services in the Community Mental Health teams
- Personality disorder and Complex Care Teams
- Support to learning Disability Services provided by the Local Authorities

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AGENDA ITEM 7

Meeting	Health and Well-Being Board
Date	19th September 2013
Subject	**Barnet CCG update: Barnet, Enfield & Haringey Clinical Strategy**
Report of	Barnet CCG Chief Officer
Summary of item and decision being sought	This paper provides a supplementary update to the Barnet Health and Well-Being Board on the implementation of the Barnet, Enfield and Haringey (BEH) Clinical Strategy. The paper will be supported by a verbal presentation given by the Director of BEH Clinical Strategy programme, which will provide a detailed update on progress. The programme remains on track to deliver the proposed changes in November 2013. The Board is asked to note the progress that has been made.

Officer Contributors	Siobhan Harrington, Director of BEH Clinical Strategy programme
Reason for Report	To supplement a verbal update to the Board on the implementation of the Barnet, Enfield and Haringey (BEH) Clinical Strategy.
Partnership flexibilities being exercised	N/A
Wards affected	All
Contact for further information	John Morton- NHS Barnet CCG Chief Officer john.morton@barnetccg.nhs.uk, 0203 688 1793

1. RECOMMENDATION

1.1 That the Health and Well-Being Board notes the content of this supplementary report and reflects on the presentation given by the Director of the Barnet, Enfield and Haringey (BEH) Clinical Strategy Programme, that provides an update on the Barnet, Enfield and Haringey (BEH) Clinical Strategy.

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 The programme provides periodic updates to Health and Well-Being Boards and Overview and Scrutiny Committees across Barnet, Enfield and Haringey. The previous update to the Barnet Health and Well-Being Board was on 27th June 2013.

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

3.1 The Barnet, Enfield and Haringey Clinical Strategy continues to work closely with key stakeholder groups to ensure links are maintained with community and primary care within the context of the Barnet Health and Well-Being Strategy and other commissioning documents.

4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 A full Equalities Impact Assessment has been carried out for the Barnet, Enfield and Haringey Clinical Strategy, and the results of this assessment will be discussed in the presentation given to the Board on the 19th September.

5. RISK MANAGEMENT

5.1 The programme's risk governance is managed by the Barnet, Enfield and Haringey Clinical Strategy Programme Board and risks are escalated to the Barnet, Enfield and Haringey CCGs where appropriate.

6. LEGAL POWERS AND IMPLICATIONS

6.1 There are no legal implications for this specific report. The Barnet, Enfield and Haringey Clinical strategy has been subject to judicial review previously and remains potentially subject to further judicial review.

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

7.1 In November and December 2012 NHS London approved the full business cases for capital investment at Barnet and Chase Farm NHS Hospitals Trust and North Middlesex University NHS Hospitals Trust respectively. A total of £114.6m was allocated to the two Trusts to implement the Barnet, Enfield and Haringey Clinical Strategy. Transitional costs have also been agreed with commissioners.

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 Communications and engagement is a key part of the programme and a detailed strategy and plan is in place, supported by the provider Trusts.

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 The Barnet, Enfield and Haringey Clinical Strategy programme engages with key stakeholders from BCF and NMUH Trusts through the governance arrangements.

10. DETAILS

10.1 The changes will see a capital investment of £114.6m to deliver:

- Expansion and redevelopment of emergency services at Barnet (BH) and North Middlesex Hospitals (NMUH) including dedicated paediatrics A&E
- Expansion and redevelopment of maternity and neonatal services at BH and NMUH including the expansion of midwife and consultant led birthing units at both sites,
- Development of GP-led urgent care services at Chase Farm (CF) Hospital, including co-located assessment centres for children and older people,
- Expansion of planned surgery at CF Hospital.

10.2 Delivery of the Barnet, Enfield and Haringey Clinical Strategy is a key enabler of improvements to quality of care at Barnet and Chase Farm Hospitals.

10.3 Work stream Progress

10.3.1 The four clinical work streams- Emergency, Urgent and Acute Care, Maternity, Paediatrics and Planned Care- continue to progress against delivery plans. Building works to deliver expanded capacity at both Barnet and North Middlesex hospitals continue at pace and to timetable. The recruitment campaign at North Middlesex is progressing well with a number of new appointments already confirmed.

10.3.2 Detailed transition plans are in development between both BCF and NMUH Trusts to document the daily and hourly activities required throughout the service transition period. These are being tested with external stakeholders including London Ambulance Service (LAS).

10.4 Communications and engagement

10.4.1 The programme has continued to enhance engagement over the summer months with particular focus on local GPs and clinicians to ensure that the new pathways are clear and understood. A ‘Choose Well’ campaign outlining the alternatives to A&E is underway with support from the Commissioning Support Unit.

10.4.2 Equality workshops have been undertaken across Barnet, Enfield and Haringey to engage with protected groups to understand the impact of the timing of the changes. This activity will support the CCGs in fulfilling their equality duty. Other activities include monthly newsletters, factsheets and engagement with stakeholder groups in Hertfordshire.

10.5 Assurance

10.5.1 The work of the Clinical Cabinet continues, conducting ‘deep dives’ into each of the clinical work streams to ensure that future services are fit for purpose and high quality and safety standards are maintained throughout the transition. Additionally the programme engaged with NHS England to undertake an external clinical

assurance review to assure progress and readiness for implementation in November. This will feed into a wider assurance piece by NHS England throughout the transition period.

10.6 Decision making

10.6.1 The programme is preparing for CCG decision-making on the implementation timescales on the 25th September 2013. This meeting in public will bring together the governing bodies of Barnet, Enfield and Haringey CCGs to determine whether the services are ready to transition in November.

10.7 Next Steps

10.7.1 Subject to the decision made by CCGs on 25th September 2013, the programme will continue to progress delivery plans and ensure the detail and risk around the transition in November is managed robustly. This will be supported by more focussed and targeted communications to ensure all stakeholders are clear about the changes.

11 BACKGROUND PAPERS

11.1 No additional background papers.

Meeting	Health and Well-Being Board
Date	19th September 2013
Subject	**Barnet CCG Update: Potential Acquisition of Barnet and Chase Farm Hospitals Trust by the Royal Free London NHS Foundation Trust**
Report of	Barnet CCG Chief Officer
Summary of item and decision being sought	This paper updates the Health and Well-Being Board on the potential acquisition of Barnet and Chase Farm (B&CF) Hospital Trust by the Royal Free Hospital (RF) NHS Foundation Trust
Officer Contributors	John Morton, Barnet CCG Chief Officer
Reason for Report	To update the Board on the potential acquisition of Barnet and Chase Farm (B&CF) Hospital Trust by the Royal Free Hospital (RF) NHS Foundation Trust.
Partnership flexibility being exercised	N/A
Wards Affected	All
Contact for further information	John Morton, Barnet CCG Chief Officer john.morton@barnetccg.nhs.uk, 0203 688 1793

1. RECOMMENDATION

1.1 That the Health and Well-Being Board notes the proposed acquisition of Barnet and Chase Farm (B&CF) Hospital Trust by the Royal Free (RF) NHS Foundation Trust, and the Barnet CCG engagement exercise on changes to the local health economy referred to in paragraph 8.1.

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 The acquisition process has a full governance structure which includes the Royal Free acquisitions board, a NHS Trust Development Agency acquisitions board and a commissioner steering group. These have been meeting monthly for the last 12 months, and the relevant Overview and Scrutiny Committees have been kept informed of progress.

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

3.1 The CCG's commissioning strategic plan and the CCG's recovery plan are superseded by the proposed acquisitions.

4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 The Joint Strategic Needs Assessment will inform the CCG's commissioning decisions. Proposals will be assessed for their impact on equality and diversity in line with the CCG's Equality Delivery System.

5. RISK MANAGEMENT

5.1 The CCG's management team will review the development and contents of the acquisition at regular intervals, identifying potential risks and mitigations. The CCG has recently reviewed its approach to programme management, and the concepts will be applied to the development of commissioning plans.

5.2 Key risks include capacity within the CCG and the availability of financial resources to commission services.

6. LEGAL POWERS AND IMPLICATIONS

6.1 The decision-making process on establishing a new NHS Foundation Trust is a strategic process with Monitor advising the Secretary of State for Health.

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

7.1 The CCG's commissioning strategic plan and the CCG's recovery plan see over the CCG's resourcing plans. These will be supported by the proposed acquisition.

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 Barnet CCG is planning an engagement exercise during late September and October 2013 to inform local people about changes to the health economy, set in the context of the CCG's recovery plan and NHS England's *A Call to Action*. As a key enabler for these

changes to the health economy, the potential acquisition will be included as part of the engagement.

8.2 The engagement exercise will include publication of an overview leaflet, two public events, media, online information and stakeholder briefings. Outcomes of the engagement will feed into the CCG's commissioning intentions.

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 The Governance structures established to support the merger ensure the full engagement and involvement with providers, commissioners, NHS England and the NHS Trust Development Agency.

10. DETAILS

10.1 About the proposal

10.1.1 As part of the Government's healthcare reforms, all NHS Trusts are required to become Foundation Trusts by April 2014. In July 2012, following an independent financial review, the Barnet and Chase Farm Hospitals NHS Trust board concluded that it could not become a Foundation Trust alone and it invited proposals from potential partners. The Royal Free was chosen as its preferred partner.

10.1.2 Under the proposal, Barnet and Chase Farm hospitals would become part of the Royal Free London NHS Foundation Trust. This larger Foundation Trust would manage the three main hospitals (Royal Free, Barnet and Chase Farm hospitals), as well as a number of outpatient services and specialist clinics at other hospitals.

10.2 Potential benefits

10.2.1 Clinicians and managers from both trusts have been looking together at how services could be provided more efficiently and effectively as one organisation. Early feedback suggests that a larger trust could provide improved quality and outcomes through co-ordinated and consistent care, develop as a centre of excellence and address the future financial challenges faced by the NHS.

10.2.2 <u>Co-ordinated and consistent care</u>

A larger pool of clinicians would be able to deliver better quality care and make sure patients are always treated in the right place at the right time by the right people. The new trust could also deliver a better experience for patients as there would be less administrative 'red tape' between services. For example providing seven day and 24 hour services will be more achievable across a larger organisation.

10.2.3 <u>A centre of excellence</u>

A much larger patient population would have greater ability to attract research funding. Wider training and career opportunities and the chance to work for a leading provider of healthcare, research and education would also help attract and retain the best staff.

10.2.4 <u>Addressing financial challenges</u>

Significant efficiencies could be made quickly such as improving or reducing the duplication of 'back office' functions. This would put money where it is needed – in delivering high quality frontline services. A larger trust would be more resilient to the changing NHS landscape of moving services closer to people's homes.

10.3 Impact on local services

10.3.1 The NHS is faced with the major challenges of using resources more efficiently and meeting the needs of an ageing population. In order to meet these challenges, we need to focus on preventing ill-health and providing more care closer to home so people do not have to visit hospital so often.

10.3.2 A single organisation would be better placed to adapt to this change and take advantage of the opportunities to provide better quality, modern day hospital care. Clinicians from both trusts are working with local commissioners to identify ways that services could be reshaped to better meet patients' needs and deliver a more financially sustainable model of care.

10.3.3 Alongside this, the Barnet Enfield and Haringey (BEH) Clinical Strategy will see obstetrics, paediatrics and emergency care concentrated at Barnet Hospital and North Middlesex Hospital; with Chase Farm Hospital developed as a specialist centre for elective care, outpatient, urgent care and diagnostics centre providing services from an improved estate.

10.3.4 Other than these planned changes, there are no major changes to the configuration of hospital services proposed as part of the acquisition. If any changes are identified in the future then the NHS would undertake engagement and consultation in line with statutory requirements.

10.4 Funding

10.4.1 Both trusts believe that additional funding would be needed in the short term to ensure that any new single organisation starts on a strong financial footing. The 2013/14 budget for Barnet and Chase Farm Hospitals NHS Trust shows a planned deficit of £16.4m. The trust will also receive significantly less income in future years as the CCG implements plans to provide more care outside hospitals and work with local authorities to integrate health and care services.

10.4.2 The Royal Free will seek transitional funding to help with the costs of the acquisition and to cover the shortfall in running costs until such a time as the new organisation can deliver a financially balanced position.

10.5 Engagement

10.5.1 Barnet CCG is planning an engagement exercise during late September and October 2013 to inform local people about changes to the health economy, set in the context of the CCG's recovery plan and NHS England's *A Call to Action*. As a key enabler for these changes to the health economy, the potential acquisition will be included as part of the engagement.

10.5.2 The engagement exercise will include publication of an overview leaflet, two public events, media, online information and stakeholder briefings. Outcomes of the engagement will feed into the CCG's 2013/14 commissioning intentions.

10.6 Next steps

10.6.1 The NHS Trust Development Authority is responsible for the assurance process, which involves four sequential Gateways. Each Gateway requires NHS Trust Development Agency approval and endorsement from the CCG's and the NHS Commissioning Board.

10.6.2 Business plans and financial models are currently being developed as part of the Gateway 3 documentation. The Royal Free board expects to submit its Gateway 3 documentation in autumn 2013.

10.6.3 Monitor will also undertake an external review to ensure the acquisition is in the best interests of patients and taxpayers. If the acquisition goes ahead a new Foundation Trust is expected to be created in spring 2014.

11 BACKGROUND PAPERS

11.1 None

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AGENDA ITEM 9

Meeting	Health and Well-Being Board
Date	19th September 2013
Subject	**Proposed revisions to the targets in the Health and Well-Being Strategy**
Report of	Director for People
Summary of item and decision being sought	This paper summarises the proposed revisions to the targets in the Health and Well-Being Strategy (2012-15). This follows an agreement by Board members at the 27th June 2013 Board meeting that revisions could be presented back to the Board if a clear rationale for changing the existing targets could be provided. The Board is asked to approve the proposed revisions.

Officer Contributors	Claire Mundle, Commissioning and Policy Advisor- Public Health/ Health and Well-Being
Reason for Report	This report seeks to finalise the reporting requirements in the Health and Well-Being Strategy. The request to revisit the targets in the existing Strategy was made by Health and Well-Being Board members at the 27th June 2013 meeting, where it was agreed that revisions to the existing targets could be proposed by Board members where an adequate rationale for doing so could be provided.
Partnership flexibility being exercised	None specifically arising from this report.
Wards Affected	All
Contact for further information	Claire Mundle, Commissioning and Policy Advisor, Claire.mundle@barnet.gov.uk, 0208 359 3478

1. RECOMMENDATIONS

1.1 That the Health and Well-Being Board approves the proposed revisions to the existing targets in the Health and Well-Being Strategy that are contained in this report, as set out in paragraph 10.5.

1.2 That the Health and Well-Being Board agrees to receive the first annual performance report of the Health and Well-Being Strategy at the next Health and Well-being Board meeting, on the 21st November 2013, for discussion and approval of next steps of delivery.

1.3 That the Health and Well-Being Board recognises its responsibility to report on the progress being made to deliver the Health and Well-Being Strategy to the Barnet Partnership Board, and agree for a copy of the performance report to be presented to the Barnet Partnership Board on the 7thNovember (ahead of the Health and Well-Being Board receiving the performance report), for their review and comment.

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 Well-Being Board.

2.2 Health and Well-Being Board 17 November 2011 – item 5- Developing the Health and Well-Being Strategy

2.3 Health and Well-Being Board 27 June 2013- item 10- Performance Management Framework for the Health and Well-Being Strategy

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

3.1 The performance targets set out in the Health and Well-Being Strategy (2012-15) set a clear direction of travel for all agencies in the Borough focused on delivering health and well-being objectives. A small number of the targets in the Health and Well-Being Strategy are also present in the Council's Corporate Plan (2013/14).

3.2 The CCG and public health work plans have been deliberately aligned to the objectives of the Health and Well-Being Strategy, as have the management agreements for each of the Council's delivery units, including Adults and Communities services (i.e. adults social care, prevention and early intervention and customer engagement services), Children's Services (i.e. Children's Centres and school services), and Development and Regulatory Services (i.e. environmental health, housing, licensing, planning services).

3.3 The process of revising the targets in the existing Health and Well-Being Strategy has encouraged all partners to consider how the targets in the Health and Well-Being Strategy align to their current priorities, and the exercise has

served to strengthen the alignment between the targets of the Health and Well-Being Strategy and those in individual service strategies and plans.

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 (JSNA), 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. The revised targets have paid similar due diligence to the results of the JSNA.

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. Revisions to the existing targets in the Strategy has served to ensure that performance is being judged on a stretching, evidence-based set of targets that will focus partners on delivering the best possible outcomes for Barnet's residents.

6. LEGAL POWERS AND IMPLICATIONS

6.1 Local authorities and clinical commissioning groups (CCGs) have equal and joint duties to prepare Joint Strategic Needs Assessments and Joint Health and Well-Being Strategies, through the Health and Well-Being Board, under the Local Government and Public Involvement in Health Act (2007) (amended by the Health and Social Care Act (2012)).

6.2 Under its terms of reference, Barnet's Health and Well-Being Board is charged with agreeing a Health and Well-Being strategy for Barnet, taking into account the findings of the Joint Strategic Needs Assessment and to performance manage its implementation to ensure that improved outcomes are being delivered.

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 be noted in performance reporting.

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 None specifically arising from the exercise of developing revisions to the targets in the existing strategy. However, it is important to note that a 12 week public consultation and engagement exercise took place between March and June 2012 to identify the priority areas for the Health and Well-Being Strategy. It is not the intention of this report to reduce the focus on the areas that were

identified as part of the original consultation exercise. The revisions seek to build on the original targets in the Strategy to ensure they are measurable.

8.2 Both Healthwatch and the Partnership Boards have important roles to play in delivering the objectives of the Health and Well-Being Strategy. Healthwatch, as a member of the Health and Well-Being Board, will be asked to approve the revisions presented in the paper, on behalf of service users and stakeholders.

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 Where Board Members and Lead Commissioners at the Council identified targets that needed re-consideration, the revisions have been developed through consultation with the providers who are delivering specific sections of the Health and Well-Being Strategy.

10. DETAILS

10.1 On 27th June 2013, the Health and Well-Being Board received a report on the development of a performance management framework to support delivery of the Health and Well-Being Strategy. Board Members approved the approach to performance measurement.

10.2 The Board discussed the allocation of responsibility for delivery of the targets in the Strategy, and received comments from Board Members on the existing targets in the strategy as part of this discussion. Board Members identified a need to review the targets in the Strategy to ensure through responsible delivery leads that the targets were still fit-for purpose.

10.3 The Board agreed to receive a further report that documents the proposed revisions to the existing targets in the Strategy where errors were noted, providing a clear rationale as to why the change is required.

10.4 The set of proposed revisions is included in the table below.

10.5 The Board is asked to approve the following proposed revisions:

Chapter 1: Preparing for a Healthy Life **Responsible Lead Agency: The Children's Trust** **Responsible Lead Commissioner: James Mass, Family & Community Well-being, London Borough of Barnet**		
Original target	Proposed revision	Rationale
All women in Barnet to access NICE compliant maternity care by 12 weeks gestation	To be confirmed by the CCG - please refer to the rationale.	It would not be possible to achieve a target of 100% for all maternity bookings at 12 weeks as it is dependent on a multitude of factors which are outside the control of commissioners and providers.

		Booking at 12 weeks is dependent on the expectant mother confirming her pregnancy before 10 weeks of gestation. For some women it's not appropriate for the GP to make a referral at that stage as they are considering whether indeed they would like to continue with the pregnancy or not. This in itself presents a delay in the process. The CCG is working with their providers through quality review meetings to agree that where they receive a referral before the 10 weeks gestation they work towards defining a booking target by 12 weeks, however this is predicated by patient choice. At this point in time the CCG has not finalised how the exception reporting for this target, including the numerator and denominator, will work. The CCG would like to confirm the target with the Health and Well-Being Board at a later date, but in the meantime will be able to confirm performance from the providers on a monthly basis (which will help the CCG to establish a baseline figure from which it can assess future performance in this area).
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%	Reduce the rate of obesity in children, specifically: reducing the proportion of children aged 4 to 5 classified as overweight or obese to 21.5% (remaining below the London average) Reduce the proportion of children aged 10 to 11	The target in its own right is completely acceptable. However, it has been proposed that the target is extended to cover both overweight and obesity (as it does in the Corporate Plan and Public Health Management Agreement) as this provides a more robust indication of the number of children and young people who could be at risk of developing obesity related health problems in later years.

	classified as overweight or obese to 33 % (London average)	
Reduce the number of children and young people misusing alcohol and drugs by 91% by 2014/15.	Reduce the number of young people admitted to hospital with alcohol specific conditions to below the most recent London average crude rate of 35.72 per 100,000.	The original target is assumed to have been written in error, as it is not realistic. The crude rate of young people being admitted to hospital with alcohol specific conditions in Barnet (over the 2008/09- 2010/11 period) was slightly higher than the London average during this period. The revised target aligns with a key measure within the Children and Young People's Plan to focus efforts on reducing alcohol misuse in young people.

Chapter 2: Wellbeing in the Community **Responsible Lead Agency: London Borough of Barnet (LBB)** **Responsible Lead Commissioner: Pam Wharfe, Director for Place, LBB**		
Original target	Proposed revision	Rationale
Reduce by 4.3% the number of young people who are not in education, employment or training	Maintain the percentage of 16 to 18 year olds who are not in education employment or training at below 4.1%	The current rate of NEETs in Barnet is 3.4% (in March 2013). The proposed revision aligns with the current target in the Education and Skills management agreement at Barnet Council, which seeks to retain a low level of NEETs (accounting for seasonal variations), whilst simultaneously working to reduce the number of children whose activity is not known to the Borough and improving the rate of children who are in education and training.

Chapter 3: How we live **Responsible Lead Agency: Barnet and Harrow Public Health** **Responsible Lead Commissioner: Dr Andrew Howe, Director of Public Health, Barnet and Harrow Public Health Service**		
Original target	Proposed revision	Rationale
Reduction of 20% in the number of people smoking in Barnet by 2016 in line with the London target.	Reduce prevalence by 20% from the 2010/11 baseline of 18.7% start over 5 years to get to 15%	The revision has been made to clarify the requirements of the target.

	by 2015/16	
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 of people aged between 40 and 74 who have received an NHS Health Check to 12.7% by 2013/14 and 25.7% by 2014/15. In five years our coverage should be 60%.	The NHS Health Checks programme did not begin in Barnet until October 2012. The revision has been made to clarify the achievable year on year increase in the number of people who have been offered an NHS Health Check, based on the start date of this programme in the Borough. The five year target of 80% has been amended to 60%, projected from the annual increase expected between 2013 and 2015.
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.	Year on year increase based on the 2009/10 baseline of people with a learning disability who have received an annual health check	There is currently no Directly Enhanced Services scheme for Mental Health Annual Health Checks. The CCG's ambition is to be able to confirm a measure on annual health checks for those with mental illness with the Board, but the Board is also asked to consider the use of another measure to assess local performance at supporting people with mental illness: *"The number of people who have depression and/or anxiety disorders who are offered psychological therapies"*

Chapter 4: Care When Needed **Responsible Lead Agency: Adult Social Care & Barnet CCG** **Responsible Lead Commissioner: Karen Ahmed, Later Life, London Borough of Barnet**		
Original target	Proposed revision	Rationale
That all people who have continuing healthcare needs are able to have a personal health budget by 1st April 2014	That all people who have continuing healthcare needs have access to a personal health budget by 1st April 2014	The proposed change clarifies the responsibilities of the CCG in delivering this target; that the priority is for the CCG to make sure that personal health budgets are accessible to people
The number of emergency admissions related to hip fracture	To remain the same at present, but the CCG requests to	The CCG is currently undertaking a scoping exercise with public health to revise the

in people aged 65 and over is reduced by 10% from the 2009/10 baseline of 457.3 by 2015	bring a revision to the Board in future based on the outcome of a review into an appropriate baseline measure	baseline measure for this target, to explore showing the number of inpatient admissions for fractured neck of femur for people over 65 as a percentage of the total older population.
Increase in the number of people who are receiving end of life care that are supported to die outside of hospital	No change to the target, however please refer to the rationale for an explanation of the current difficulties in reporting against this target.	The CCG would like to bring to the Health and Well-Being Board's attention that it is not currently possible to distinguish between hospital deaths and deaths in specialist palliative care units/ hospices that are based in hospitals. This means that an indicator showing hospital deaths will be an over-count and hospice deaths an under-count. The CCG asks the Board to be mindful of this when considering performance against this target.
The percentage of frail elderly people who are admitted to hospital three or more times in a 12 month period is reduced from 2009/10 baseline.	No change to the target, however please refer to the rationale for an explanation of the current difficulties in reporting against this target.	The target is valid. The Commissioning Support Unit (CSU) cannot generate a performance report on this target at present as it requires the team to use patient identifiable information which they do not have access to at the moment. The data issue is currently being addressed by NHS England. The CSU will be submitting an application to become an 'accredited safe haven' (ASH) which will enable them to process data. The application deadline for accreditation is on 30 September 2013.

10.6 The Health and Well-Being Board will receive the first performance report for the Health and Well-Being Strategy at the 21st November 2013 Board meeting. This report will set out:

- The actions that have taken place so far to deliver on the objectives of the Strategy
- The actions planned for the future to deliver on the objectives
- The progress being made towards achieving the targets of the Strategy
- The recommendations from responsible leads for delivery of the Strategy about how to ensure that the Strategy delivers the best possible outcomes for residents; including the proposals for additional locally measured

targets that will help delivery leads know whether they are meeting the objectives in the Strategy

10.7 The rationale for including additional targets in future developed out of the exercise to identify revisions to the existing targets. This process also encouraged delivery leads to consider the additional targets they could use to measure their progress against the objectives of the Health and Well-Being Strategy in future, to provide the Health and Well-Being Board with more detail about the positive outcomes to health and well-being that their work is achieving. It will also enable delivery leads to establish clear links between the various strategies that guide their work, such as the Children and Young People's Plan, and the Local Plan, by reflecting how the targets in other strategies and plans contribute towards the delivery of health and well-being objectives. Further, it is reflective of the fact that a number of important local work programmes to deliver on the objectives of the Strategy were not in existence at the time that the original Health and Well-Being Strategy was written and approved.

10.8 The Board is also asked to recognise its responsibility to report on the progress being made to deliver the Health and Well-Being Strategy to the Barnet Partnership Board. The Barnet Partnership Board formally oversees the work of the Health and Well-Being Board, including its delivery of the Health and Well-Being Strategy. The Board is asked to approve a process of performance reporting in which the performance report will be shared with the Barnet Partnership Board on the 7th November, for comment and review, before it is presented to the Health and Well-Being Board. It is hoped that this arrangement will add value to the performance monitoring process. Comments from the Barnet Partnership Board will be presented at the Health and Well-Being Board meeting on the 21st November, alongside the performance report.

11 BACKGROUND PAPERS

11.1 None attached.

Legal – SC
CFO – JH

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Meeting	Health and Well-Being Board
Date	19th September 2013
Subject	**NHS England's "Call to Action" Programme**
Report of	Chief Officer, Barnet Clinical Commissioning Group
Summary of item and decision being sought	To update the Health and Well-Being Board on the NHS England's "Call to Action" programme and Barnet CCG's plans to engage on the programme locally.

Officer Contributors	John Morton, Chief Officer, Barnet CCG
Reason for Report	To update the Health and Well-Being Board on the NHS England's "Call to Action" programme and to ask the Health and Well-Being Board if it wants to comment on local engagement plans.
Partnership flexibility being exercised	N/A
Wards Affected	All
Enclosures	Apendix A - Background Paper Call to Action
Contact for further information	John Morton, Chief Officer, Barnet CCG, john.morton@barnetccg.nhs.uk, 0203 688 1793

1. RECOMMENDATION

1.1 That the Health and Well-Being Board comments on the proposed local response to NHS England's "Call to Action" Programme.

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 NHS England's "Call to Action" programme is a national engagement exercise. All national partners below were signatories to the "Call to Action" document and have committed to preserving the values that underpin the NHS and supporting the development of locally-led responses:

- NHS Commissioning Assembly
- Monitor
- Public Health England
- Care Quality Commission
- NHS Trust Development Authority
- NHS Higher Education England
- National Institute of Health and Care Excellence
- Health and Social Care Information Centre
- Local Government Association

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

3.1 This is a strategic forward look and this will inform future goals rather than impact on existing activity however it would be anticipated there will be strong alignment between existing and future plans.

4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 The proposal will engage the public on the challenges in the national and local health economy, set in the context of Barnet CCG's Recovery Plan.

5. RISK MANAGEMENT

5.1 NHS England's "Call to Action" programme team will provide strategic advice, support and materials for local engagement.

6. LEGAL POWERS AND IMPLICATIONS

6.1 Not applicable.

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

7.1 Not applicable.

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 Two public engagement events are planned for 1 October 2013 (11.00 – 1.00 at St Paul's Hall, Long Lane, N3, and 7.00 – 8.30pm at Hendon Town Hall) to initiate a conversation on the national context and local strategic challenges.

8.2 An engagement booklet and feedback form is being developed and will be available at local events and on the NHS England website. The feedback form will weave in central questions proposed in a "Call to Action":

- How does NHS England release money from acute services to invest more in prevention, primary care and other community services?
- How does NHS England encourage people to take more responsibility for their health and put them in control of their own care?
- How does NHS England develop services that are genuinely centred on patients and not organisations?
- How does NHS England speed up centralisation of services where clinical evidence supports the benefits?
- How does NHS England use technology to deliver better outcomes and better value?
- What are the main barriers to local service transformation and what national solutions would address these?

8.3 To support local debate, NHS England is developing a series of products for localities to use as they see fit, fully involving their communities, voluntary sector organisations, staff and providers. The CCG will utilise these and promote national events, where relevant.

8.4 The engagement period is planned to last six-weeks and will inform the CCG's 2014-15 planning round and development of five year strategic plans.

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 Barnet CCG will continue to work with NHS England to ensure local engagement is aligned to the national process.

10. DETAILS

10.1 NHS England's "Call to Action" programme aims to:

- Build public awareness on the challenges in the "Call to Action" document published on 11th July 2013 and other more localised challenges as identified by commissioners;
- Generate a broadly consistent debate with the public, staff and stakeholders about how the NHS could meet these challenges, the priorities and the trade-offs this will require;
- Gather feedback and insights to inform future strategies and commissioning plans (for CCGs and for direct commissioning);
- Support the creation of public legitimacy for future commissioning decisions;
- Create a platform for future transformational change; and
- Include these transformational change plans within a five year strategic plan, submitted as part of the planning round for 2014/15.

10.2 The programme has identified seven key strategy work streams to provide the strategic framework for developing excellent local and national strategic plans that will deliver a sustainable NHS for the future.

1. The Case for Change

2. The Call to Action
3. Future scenarios
4. Specialised services commissioning
5. A strategic framework for Primary care commissioning
6. Transparency & public participation
7. Tools, levers and incentives

10.3 A “Call to Action” will be delivered through four strands nationally:

Title	Summary	Cascade	Dates	Output
Local activity led by CCGs, area teams & HWBs;	Engagement activity (e.g. events) with local partners, staff, patients and the public on the national context and local strategic challenges Generating feedback from public engagement and work with local partners to inform commissioning plans	Through calendars of local events developed by CCGs and area teams, and supporting local comms activity Through national and local engagement materials	Aug - Nov	Local feedback to inform 14-15 planning round and development of 5 year strategic plans
Resources	Commissioning, creating and publishing research, case studies and toolkits to help stimulate local debate An integrated planning template including strategic plan requirements	Through products issued for use locally during the main campaign phase Though NHS planning framework guidance	Aug - Nov	To inform 14-15 planning round and strategic plans
National engagement	Co-ordinating five national events that rotate across England	Through a national calendar of events and supporting comms	Sept - Dec	To build momentum and generate approaches for strategy and planning
A digital platform	A website to support the campaign	Website publicised through comms and engagement activity	July - Dec	Website

10.4 A “Call to Action” launched nationally on 11th July 2013, setting out current issues, identifying future challenges and establishing what a ‘do nothing’ scenario would look like in funding terms. This provided a backdrop for a nationwide engagement exercise, to

begin a public debate on the difficult questions, and to seek ideas and feedback that would be used as the basis for developing and agreeing future commissioning plans and five year strategic plans. Requests for co-design partners issued through Leadership Forum and Commissioning Assembly. These would help identify and develop supporting material. Teleconferences held with regions and area teams to share progress and next steps, and to request feedback and information on planned schedule of autumn activity.

10.5 In August, the plans for the programme are as follows:

- Co-design events held to share and develop further draft material re a "Call to Action"
- Requests to share details of local events cascaded via Area Teams so NHS England can build a live calendar of events to share with each other
- Engagement themes developed to help drive momentum and synchronise local and national conversations

10.6 It is important that localities (CCGs, NHS England area teams and Health and Well-Being Boards) take forward the debate with communities – so that discussions and decisions are made as close to patients as possible, and that the commissioning plans and strategies that emerge reflect local priorities. To support this debate, a series of products will be available for localities to use as they see fit, fully involving their communities, voluntary sector organisations, staff and providers. The local debate will lead to five year strategies being developed through 2014/15 strategic & operational planning.

10.7 The engagement themes of the "Call to Action" programme have been developed to maintain momentum and link the strategy work streams with the domain visions. During each month, various debates, events and material will be available to support discussions at all levels. Local teams will already have engagement plans in place and should therefore consider the engagement themes complementary to existing engagement plans.

- **Prevention**
  How can NHS England work together to prevent ill health and treat disease quickly?

- **Future Scenarios**
  (This will be a programme of stakeholder rather than a public engagement theme)

- **Valuing mental and physical health**
  How can NHS England ensure mental and physical health are valued equally?

- **Patients in control**
  How can NHS England support patients being in control of their health care

- **Well co-ordinated care**
  How can NHS England develop services centred on patients not organisations?

- **Learning from the best**
  How does NHS England identify, learn from and implement good practice in health?

10.8 The "Call to Action" is framed by the national context but informed by local priorities and challenges. It is designed so CCGs and area teams, in partnership with Health and Well-Being Boards, can ask the questions that will drive the development of the local commissioning response. There will also be consistent themes across the country. NHS England proposes 6 strategic questions, that they will ask through national activity, but which can also be weaved into local public engagement:

1. How does NHS England release money from acute services to invest more in prevention, primary care and other community services?
2. How does NHS England encourage people to take more responsibility for their health and put them in control of their own care?
3. How does NHS England develop services that are genuinely centred on patients and not organisations?
4. How does NHS England speed up centralisation of services where clinical evidence supports the benefits?
5. How does NHS England use technology to deliver better outcomes and better value?
6. What are the main barriers to local service transformation and what national solutions would address these?

These questions will need to be tailored in a way that is meaningful and resonates with communities, and generates useful feedback. NHS England would welcome views on the questions above.

10.9 This programme of work will take place alongside the Priorities and Spending Review Programme led by Barnet Council, and steps will be taken locally to ensure that these discussions are aligned. The Priorities and Spending Review will, like the "Call to Action" Programme, develop a set of proposals which will set out how the Council can transform its services to ensure they are sustainable over the course of the decade, in the face of continued austerity. The Priorities and Spending Review will be considering a number of similar questions to those outlined above in order to develop its proposals. It will be important that the Health and Well-Being Board support linkages to be made between the "Call to Action" and Priorities and Spending Review Programmes, to ensure that local service transformation planning across health and social care is sufficiently joined-up.

10.10 NHS England, London Region has launched a programme of work on "Call to Action" with the following aims:

- To provide linkage and input to the national programme
- To provide coordination of "Call to Action" engagement across London
- To communicate with and engage stakeholders at a London wide level
- To support CCGs in their local engagement activities
- To develop a London wide Case for Change
- To coordinate a series of pan-London engagement events across London to build on the local engagement carried out by CCGs

In order to do this the programme has been split into three phases:

Phase 1 (July – September)
Establish programme structure, develop resources and produce Case for Change
Phase 2 (October – December)
Support local engagement, collate and analyse information from engagement across London, provide initial outputs to support development of strategic plans
Phase 3 (Jan – March)
Agree key themes from local engagement, carry out pan-London engagement, provide outputs to support development of operating plans

The high level timeline is provided in section 11.0 Background papers

10.11 The following supporting resources will be made available by the programme:

Resources	Provisional release date
Start pack for CCG engagement	Week Commencing 2nd September
London Engagement plan	Week Commencing 2nd September
Full CCG support packs, including: • National Call to Action material • CCG specific data pack • Engagement framework • Template for collection of engagement outputs	Week Commencing 30th September
London financial modelling and scenarios	TBC
Case for Change for London	Week Commencing 30th September
Case for Change for Primary Care in London	October
Case for Change for Integrated Care in London	TBC
Report on collated London engagement	December

NHS England, London Region, have produced a pack that will be shared shortly. The below is a summary of the range of support available:

Face to face engagement	
• Principles of engagement • Sample event outline • Sample case studies • Participation guide Participation recourse (online from 25th September)	• How to run focus groups • Recruiting representatives • Template for representative application form • Template representative role description
Using Digital Media	**Recording Activity**
• Using My Health London • Guide to dialogue apps (free recourse) • Guide to citizen space (free survey resource)	• Calendar for events • Template for recording themes

10.12 There is a very compelling case that the NHS in London needs radical reform in the next few years. Communications activity will be designed to trigger debate amongst NHS stakeholders, commentators, and the public about solutions. The London case for change will provide stimulus for conversations with the media, MPs, voluntary sector, NHS leaders, and clinicians.

Key dates:

- September 2013 – pitch-rolling and planning
- October 2013 – case for change launch, leadership events, briefings
- Late/October – November 2013 – primary care, integrated care, cancer focus
- NHS England is looking for ideas for stories, event opportunities, social media activity etc. all welcome as part of pan-London debate

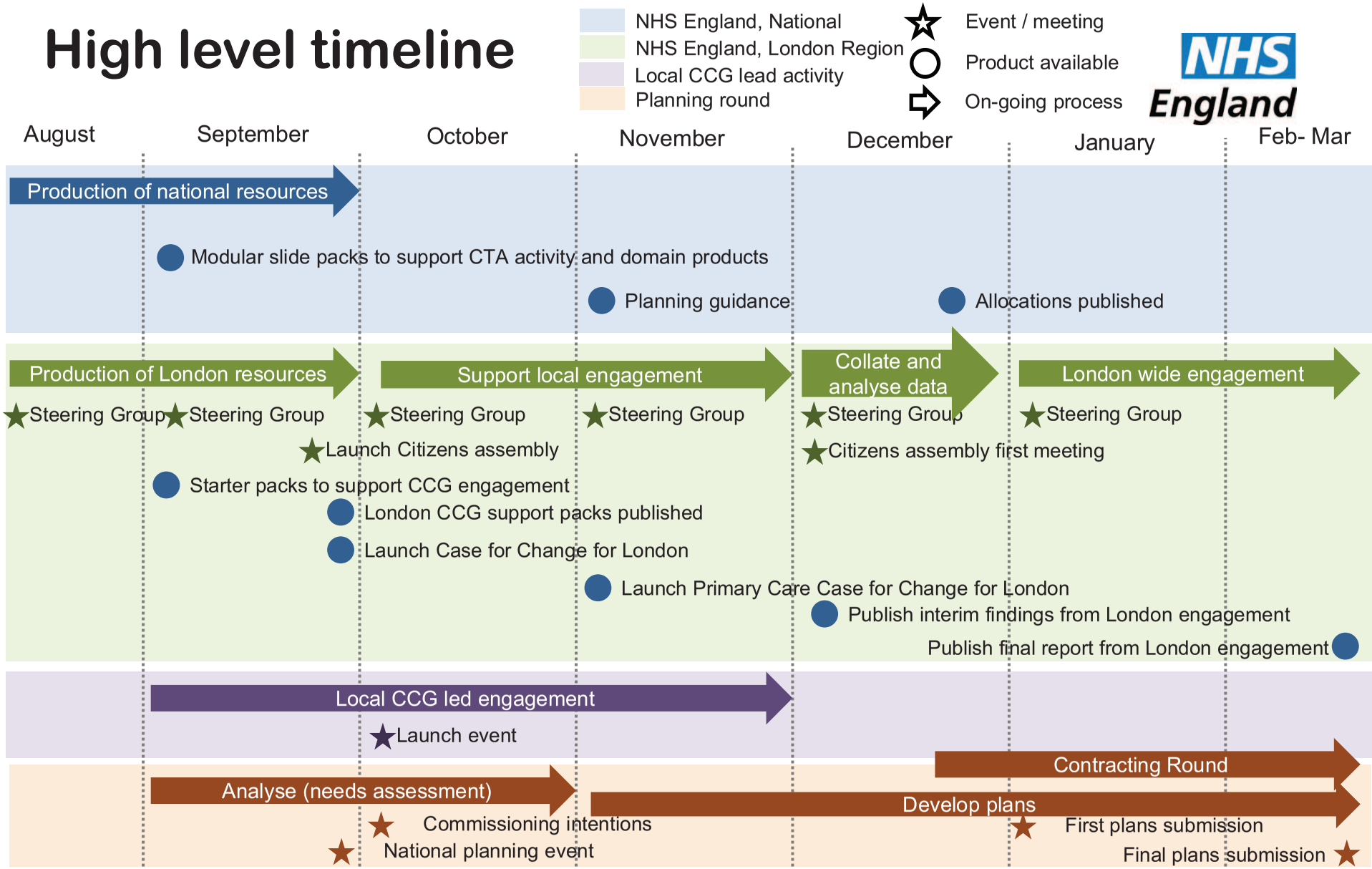
10.13 In summary, CCGs should be preparing themselves for engagement and planning for the following:

- Raising awareness with Health and Well-Being Boards, partners, staff etc.
- Booking events and making use of engagement opportunities
- Informing London Region of dates and details of engagement events
- Developing commissioning intentions for 2014/15 and 2015/16
- Developing plans for how to produce 3 to 5 year strategies

11 BACKGROUND PAPERS

11.1 A Call to Action – August update

High level timeline



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Meeting	Health and Well-Being Board
Date	19th September 2013
Subject	**CCG Commissioning Intentions**
Report of	Barnet CCG Chief Officer
Summary of item and decision being sought	This paper introduces the main themes from the CCGs commissioning intentions for 2014/15 and 2015/16 and seeks the view of the Health and Well-Being Board.
Officer Contributors	John Morton, Chief Officer, NHS Barnet CCG Owen Richards, Commissioning Support Director (Barnet) N&E London Commissioning Support Unit
Reason for Report	This report is for information, and provides the Board with the opportunity to signal areas for the CCG to consider when developing their commissioning intentions for 2014-16.
Partnership flexibility being exercised	N/A
Wards Affected	All
Contact for further information	John Morton – NHS Barnet CCG Chief Officer, john.morton@barnetccg.nhs.uk, 0203 688 1793

1. RECOMMENDATION

1.1 That the Health & Well-Being Board considers the key issues identified within this paper. Within the context of the CCG's strategy and that of the Health & Well-Being Board, colleagues are asked to identify any other areas for consideration by the CCG.

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 The meeting of the Health & Well-Being Board on 25 April 2013 considered the CCG's commissioning strategic plan.

2.2 The meeting of the Health & Well-Being Board on 27 June 2013 considered the CCG's Recovery Plan and proposals for the establishment of clinical commissioning programmes.

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

The CCG's commissioning intentions will be underpinned by the objectives contained in the Health & Well-Being Strategy and the CCG's Commissioning Strategic Plan.

4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 The Joint Strategic Needs Assessment will inform the CCG's commissioning decisions. Proposals will be assessed for their impact on equality and diversity in line with the CCG's Equality Delivery System.

5. RISK MANAGEMENT

5.1 The CCG's management team will review the development and contents of the commissioning intentions at regular intervals, identifying potential risks and mitigations. The CCG has recently reviewed its approach to programme management, and the concepts will be applied to the development of commissioning plans.

5.2 Key risks include capacity within the CCG and the availability of financial resources to commission services.

6. LEGAL POWERS AND IMPLICATIONS

6.1 The Health & Social Care Act 2012 established clinical commissioning groups, giving them the mandate to commission healthcare services for their registered populations. Other services previously commissioned by primary care trusts are now the responsibility of other partners in the Health & Well-Being Board, namely the London Borough of Barnet and NHS England.

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

7.1 The Commissioning Intentions set out how the CCG plans to use its resources to commission healthcare services. It will also align with jointly developed commissioning plans for vulnerable people.

7.2 Development of commissioning plans is a core part of the CCGs business and will be undertaken by its staff and clinicians, supported by the North East London Commissioning Support Unit.

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 The CCG will wish to work with local users and stakeholders as it develops its commissioning plans further.

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 Local providers are aware of the contents of the CCG's Commissioning Strategic Plan and the Recovery Plan. Through the clinical commissioning programmes, we will continue to refine our proposals, drawing on the skills and experience of local clinicians in primary and secondary care.

10. DETAILS

10.1 Introduction

10.1.1 Each year, NHS commissioning organisations are required to publish their outline commissioning plans for the coming year. Their purpose is two-fold – to signal the broad direction of travel, and secondly where significant change is proposed, to give a minimum of six months' notice to allow providers to address any workforce and contractual issues.

10.1.2 The CCG is currently developing its commissioning intentions for 2014/15 and 2015/16. The Health & Well-Being Board is central to the development of this document.

10.2 Key issues

10.2.1 At this stage in the commissioning cycle, the CCG will not be producing detailed plans for services and/or providers. These will be developed over the next few months, in partnership with local providers and other stakeholders. This work will be driven by the CCGs clinical commissioning programmes. However, the focus for our proposals will build upon the following areas.

10.3 Keeping Well, Keeping Independent

10.3.1 The CCG will use the objectives contained within the Health and Well-Being Strategy to underpin its commissioning activities.

10.4 Recovery Plan

10.4.1 The Board will be aware that the CCG has published a recovery plan, aimed at tackling the deficit it faces:

	Recovery Plan
Maternity	• Bedding in of new payment mechanisms for maternity services • Continuing to enhance the quality of care provided

Paediatrics	• Development of paediatric assessment units at both Barnet and Chase Farm sites
Elective	• Tackle high levels of GP and consultant to consultant referrals in cardiology • High volumes of activity in nephrology/rheumatology/ophthalmology/respiratory medicine/gastroenterology • Understanding and addressing why some patients stay longer than expected after waiting list surgery
Emergency care	• Implementing new ways of caring for urgent care patients by providing care closer to home, without the need for admission • Understanding and addressing why some patients stay longer than expected after emergency surgery • Developing an integrated assessment service (front door A&E) • Better management of the contract with the London Ambulance Service • Walk-in centre review
Mental health	• Implement the RAID model within acute hospitals, to ensure best care of people with mental health problems • Improving quality of care
Integrated care	• Continued implementation of new models for frail elderly • Review of utilisation of community hospitals
Contracts (enabler)	• Develop three year contracting strategy • Moves to upper quartile performance targets • Moves from national tariffs to local tariffs which share savings with providers • Services provided outside national tariff – better understanding of cost/activity; deep dives; benchmarking

10.5 Barnet, Enfield & Haringey Clinical Strategy

10.5.1 Assuming approval is given to the full implementation of the Strategy, the CCG will wish to continue to work closely with the Trust to ensure that the changes provide high quality care for local people.

10.6 Acquisition of Barnet & Chase Farm Hospitals by the Royal Free London Hospital

10.6.1 The CCG is working with both trusts to develop new pathways of care which would be followed by all clinicians across the hospitals within any new trust. Our commissioning

intentions will reflect these and any further work required to care for patients close to home.

10.7 Procurement pipeline

10.7.1 A number of the CCG's contracts are reaching the end of their term and will need to be reviewed and re-procured if necessary. These include:

- Open access diagnostics
- Referral management service

10.8 Partnership opportunities

10.8.1 With the creation of a new commissioning structure, the Health & Well-Being Board for Barnet offers an opportunity to align the commissioning intentions of the London Borough of Barnet, NHS England and the CCG. We need to use this forum to ensure that patients can access seamless services, grounded in our joint strategy as well as evidence of effectiveness and efficiency.

10.9 Recommendation

10.9.1 The Health & Well-Being Board is asked to consider the key issues identified within this paper. Within the context of the CCGs strategy and that of the Health & Well-Being Board, colleagues are asked to identify any other areas for consideration by the CCG.

11 BACKGROUND PAPERS

11.1 None

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AGENDA ITEM 12

Meeting	Health and Well-Being Board
Date	19th September 2013
Subject	**Minutes of the Financial Planning Subgroup**
Report of	Director for People
Summary of item and decision being sought	This report is a standing item which presents the minutes of the Financial Planning Subgroup and updates the Board on the joint planning of health and social care funding in accordance with the Council's Medium Term Financial Strategy (MTFS), the NHS Quality Improvement and Productivity Plan (QIPP), Barnet CCG's financial recovery plan, and the Council's Priorities and Spending Review.

Officer Contributors	Claire Mundle, Commissioning & Policy Advisor- Public Health/ Health & Well-Being
Reason for Report	To note the minutes of the previous two Financial Planning Group meetings
Partnership flexibility being exercised	The report encompasses partnership flexibilities such as those under Sections 75 and 256 of the NHS Act 2006.
Wards Affected	All
Enclosures	Appendix A: Minutes of the Financial Planning Group, 26th June and 8th August 2013
Contact for further information	Kate Kennally, Director for People, kate.kennally@barnet.gov.uk, 020 8359 4808

1. RECOMMENDATION

1.1 That the Health and Well-Being Board notes the minutes of the Financial Planning Group of 26th June 2013 and 8th August 2013 set out in Appendix A.

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 Cabinet, 14 February 2011– agreed partnership working for health in Barnet that proposed to delegate responsibility for the social care allocation through the NHS to the shadow Health and Well-Being Board via a section 256 agreement.

2.2 Cabinet Resources Committee, 2 March 2011 – approved criteria for the allocation of funds within the section 256 agreement and agreed high level spending areas to be overseen by the Health and Well-Being Board.

2.3 Health and Well-Being Board, 26th May 2011 – item 5 approved the establishment of the Financial Planning Group as a subgroup of the Health and Well-Being Board.

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

3.1 The Medium Term Financial Strategy (MTFS) and Priorities and Spending Review (PSR) of the Council and the NHS Quality, Innovation, Productivity and Prevention Plan (QIPP) and Financial Recovery Plan for Barnet CCG are aligned to both the achievement of the Sustainable Community Strategy objective of 'Healthy and Independent Living', and to the objectives of the Health and Well-Being Strategy. Underpinning the achievement of these strategies is the requirement to shift resources to the community with statutory services working alongside people to take greater responsibility for their own and their families' health.

4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 The MTFS has been subject to an equality impact assessment considered by Cabinet, as will the specific plans within the Priorities and Spending Review as these are developed. The QIPP plan has been subject to an equality impact assessment considered by NHS North Central London Board.

5. RISK MANAGEMENT

5.1 There is a risk that without aligned financial strategies across health and social care of financial and service improvements not being realised or costs being shunted across the health and social care boundary. The financial planning group has identified this as a key priority risk to mitigate through work to align timescales and leadership of improvement plans which affect both health and social care through the Health and Well-Being Board.

6. LEGAL POWERS AND IMPLICATIONS

6.1 The Council and NHS partners have the power to enter into integrated arrangements in relation to prescribed functions of the NHS and health-related functions of local authorities for the commissioning, planning and provision of staff, goods or services under Section 75 of the National Health Service Act 2006 and the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000. This legislative framework for partnership working allows for funds to be pooled into a single budget by two or more local authorities and NHS bodies in order to meet local needs and priorities in a more efficient and seamless manner. Funds pooled by the participating bodies into single budget can be utilised flexibly to support the implementation of commissioning strategies and improved service delivery. Arrangements made pursuant to Section 75 do not affect the liability of NHS bodies and local authorities for the exercise of their respective functions. The Council and CCG now have two overarching section 75 agreements in place.

6.2 The Act now allows for local authorities to provide services which improve the health of the population.

6.3 There is likely to be new guidance on integrated budgets shortly, which the Council and the CCG will need to be responsive to in the development of their plans.

6.4 NHS organisations also have the power to transfer funding to the Council under Section 256 of the National Health Service Act 2006, and the Council similarly has the power to transfer money to the NHS under Section 76 of the NHS Act 2006. These powers enable NHS and Council partners to work collaboratively and to plan and commission integrated services for the benefit of their population. The new integrated budgets arrangements replace the current use of Section 256 money although Section 256 will remain in place.

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

7.1 There is work underway to estimate the health and adult social care savings that integration across these services will bring, which will be completed in October 2013. These savings, once calculated, will be factored into the Quality, Innovation, Productivity and Prevention (QIPP) and CCG Recovery Plan in the NHS, and the Council savings requirements in the Medium-Term Financial Strategy and Priorities and Spending Review.

7.2 Projects and enablement schemes linked to Section 256 funding are reviewed by the Financial Planning subgroup to ensure that the projects have a clear programme of work and that approved business cases are adequately resourced to deliver the agreed outcomes.

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 None specifically arising from the previous two Financial Planning Group meetings, though the Financial Planning Group will factor in engagement with users and stakeholders to shape its decision-making in support of the Priorities and Spending Review, and Barnet CCG's financial recovery plan.

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 None specifically arising from the previous two meetings, though the Financial Planning Group will factor in engagement with providers to shape its decision-making in support of the Priorities and Spending Review, and Barnet CCG's financial recovery plan.

10. DETAILS

10.1 The Barnet Health and Well-Being Board on the 26th May 2011 agreed to establish a Financial Planning Group to co-ordinate financial planning and resource deployment across health and social care in Barnet. The financial planning group meets bi-monthly and is required to report back to the Health and Well-Being Board.

10.2 Minutes of the meeting of the Group held on 26th June 2013 and 8th August 2013 are attached at Appendix A.

10.3 The Health and Well-Being Board is asked specifically to note:

- The national announcement of a £3.8 billion Transformation Fund for health and Social Care Integration via pooled budget arrangements (see also '*Health and Social Care Integration- development of a target operating model for integrated care*' paper, also being presented at the 19th September 2013 Health and Well-Being Board meeting).

- The plans made on the 8th August 2013 to develop a high level target operating model for health and social care integration, which will consider how resources should be jointly spent in line with the requirements of the Transformation Fund, the Council's Medium Term Financial Strategy and Priorities and Spending Review, the CCG's Financial Recovery Plan and Quality, Innovation, Productivity and Prevention plans, and changes to the local health landscape through the Barnet, Enfield and Haringey clinical strategy. These proposals will be presented to the Financial Planning Group on the 17th October 2013.

- The development and approval of two overarching section 75 agreements for adults and children's services to underpin the arrangement for joint working between the NHS and local authority, which was commended by the Financial Planning Group.

11 BACKGROUND PAPERS

11.1 None attached to this report

Legal – LC
CFO – JH

Appendix A: Minutes of the Financial Planning Group, 26th June and 8th August 2013

Minutes from the Health and Well-Being Board – Financial Planning Group
Wednesday 26th June 2013
Hendon Town Hall
15.30 -17:30

Present:
(KK) Kate Kennally (Chair), Director for People, London Borough of Barnet (LBB)
(DW) Dawn Wakeling, Adults and Communities Director, LBB
(JH) John Hooton, Assistant Director of Strategic Finance, LBB
(JM) John Morton, Chief Officer, Barnet Clinical Commissioning Group (CCG)
(MO'D) Maria O'Dwyer, Director of Integrated Commissioning, Barnet CCG
(CC) Caroline Chant, Joint Commissioner- Older People & Sensory Impairment, LBB
(MT) Marshall Taylor, Interim Head of Prevention & Wellbeing, LBB
(CM) Claire Mundle, Policy & Commissioning Advisor, LBB

Apologies:
(MK) Mathew Kendall, Assistant Director, Adults & Communities, LBB
(SH) Stephen Hobbs, Interim Chief Finance Officer, Barnet CCG

	ITEM	ACTION
1.	**Priorities and Spending Review** JH introduced the paper that sets out the forthcoming Priorities and Spending Review (PSR) of Council's medium to long-term spending plans. The paper was presented to the Barnet Partnership Board on 23 May. A report will be going to Cabinet on the 18th July to agree to run the PSR as proposed in the paper. The PSR will ensure that the Council can meet the challenges presented by the further reduction to LA budgets announced in the 26 June Spending Review, and the continued period of austerity until 2019. The PSR will involve 3 work streams: finding efficiencies, implementing growth interventions, and service transformation and prioritisation. A London Borough of Barnet "network" is currently being established to support the PSR- identifying those people at an operational level who are gathering data on	

	Council spend/ future challenges/ the spending gap. The CCG has also completed a review of NHS properties. KK asked JH to give a steer on what actions in the PSR work plan that the HWB Finance Group could usefully oversee/ approve in the 3 meetings it has left in 2013. JH agreed to provide an answer to the Group on this following the meeting. The Group agreed that JH should use this meeting to look at the health and social care elements of the PSR JH explained that there is still quite a bit of time to explore options for the PSR before having to implement anything. Efficiency savings are however committed around integration, so LBB & the CCG need to make sure they has robust plans in place in QIPP and the medium to long-term financial plans to achieve this. DW reminded JH that the PSR needs to factor in the changes to social care funding and the new responsibilities for Adults services, which is not in current forecasting. KK also confirmed with the group that whilst the PH grant is ring fenced for the next 2 years, PH will be subject to the same PSR process as other areas. The focus for PH will have to be on early intervention and demand management (through other council services such as leisure and housing). JM commented on the value of thinking about "Total Place" as part of the PSR. There is a need for the PSR to think about the total additional costs associated with additional population growth (in part projected through the regeneration schemes). KK suggested that Cath Shaw and Andrew Howe could usefully share information about the indices being used to calculate demographic growth with the HWB Finance Group, to understand the demographic data that is driving bigger investment in some areas of spend. The Group showed strong support for the PSR but recognised that making it real will not be easy.	**JH to advise SH and others on how to use the HWB Finance Group can support PSR.** **JH to produce a project plan for the Group to support/ focus their work** **JH to account for these changes** **JH to share most recent census analysis with JM** **KK to liaise with Andrew and Cath** **JH to make sure MK and MO'D can comment on the PSR project plan in terms of what their teams can contribute**

2.	**<u>Section 256 (S256) and Health & Social Care Integration Funding</u>** DW talked through the historic picture of S256 spend, and the proposals for spend in 2013/14: <u>Line 1</u>: c. £1.29 million being carried forward from 12/13 (non-recurrent spend) Line 2: £989,000 winter pressures money (which was received late) (non-recurrent spend) <u>Lines 3d & 3e</u>: c. £800,000 current bids Total quantum to be determined by the Group= c. £3 million JM asked that the CCG is more involved in the plans to develop Quality in Care Homes teams. He also mentioned that he couldn't recollect seeing a number of the business cases for which money has already been allocated. The Group agreed that in future papers that come to the Group about the allocation of spend should already have been discussed with the CCG. LBB as budget holder should continue to produce these papers for the Group. JM talked through the CCG's 13/14 budgets to support integration and explained that the winter pressures funding was "virtually guaranteed" for them, amounting to c. £1 million. He explained that the marginal rate emergency tariff and emergency readmissions budgets are recurrent budgets but are variable, and fluctuate based on policy. The final figures have not been finalised. To give an indication about what has already been committed against these lines, JM explained that the CCG have been talking to providers about PACE & TREAT programmes under the marginal rate emergency tariff budget He also explained that some of the emergency readmissions budget has been committed across both acute providers. The Group recognised that health and social care integration will impact on emergency readmissions and that money needs to be invested for deployment through the Health and Social Care Integration Board. MT then talked to his paper on 'Health and Social Care	**DW will send round letter about section 256 for 2013/14 to HWB Finance Group** **DW to pick up discussion on quality in care home teams with MT, MO'D and JM** **DW to share existing business cases with the CCG** **SH to give the Group an indicative figure of the CCG budget lines: winter pressures/ margin rate emergency tariff/ emergency readmissions.** **MT to revise his**

	Integration Funding' which provides a narrative on the projected spend to support health and social care integration. He explained that business cases are being written to cover the unallocated spend in 2013/14 and the Group will be asked to approve each one (3 presented at the July meeting and 6 proposed to come to the August meeting). KK questioned this approach, and suggested that the HWB Finance Group needed to understand the size of the total resource that will be invested in Health and Social Care Integration before being able to decide what the money should be spent on. Before the CCG is able to confirm the total money that can be invested in integration, the HWB Finance Group will not be able to make decisions on spend. KK also suggested that the interviews being carried out by the health and social care integration board should help inform prioritisation. It was agreed that either the HWB Finance Group, or the Health and Social Care Integration Board, should prioritise what the money is spent on when the total quantum is known.	**paper based on the indicative figures provided by SH.** **JH to develop a standard template for reporting S256 money.**
3.	**<u>Section 75 (S75) agreements</u>** DW presented the paper on Section 75 agreements. This paper will still need to go to solicitors ahead of the Cabinet meeting in mid-July. DW explained that the proposal was for there to be an overarching document that could cover adults and children's services with schedules sitting behind it. The Group did not agree the template in its current format, but are in support of developing a standard approach. The Group suggested that where there is a statutory reason for use of a S75 (i.e. the pilot integration projects/ speech and languages services for children), there should be one. Where there isn't such a reason, another approach could be used. The Group suggested that there could be a standard front part to the S75 document, but with schedules drawn up individually to sit behind it, accounting for variable flexibilities, leadership and governance arrangements. The Group agreed that this approach should be tested for the existing integration pilots and	**DW to talk to MK and make sure he and MO'D have the same facts about how to take this work forward** **DW to revise the date the paper**

	speech and language services for children.	**goes to CRC.**
4.	**<u>Business Cases</u>** JM noted that the CCG QIPP Board has already approved the first two business cases. *Stroke Reviews* CC updated the Board on progress made with developing the stroke review programme. She explained that the team are currently working out what measures are in place already to assess who is in need of a stroke review. She explained that the team want to establish a link with risk stratification in primary care. *Dementia Hub Project* The Group noted that Cabinet Resources Committee have agreed the business case for dementia cafes. *Information for All* MT talked through the main elements of the proposals. He explained that this business case is a legacy of the Information and Advice Project from last year. KK noted the lack of reference to Healthwatch in the business case. She questioned if this business case should be given to Healthwatch as part of their contract. KK praised the element on digital inclusion. The business case was not approved in its current form.	**CC to agree final measures with MK and MO'D.** **MT to have a discussion with Healthwatch, BCIL and CAB about a coherent commissioning strategy around information giving.** **MT to consider the role of Capita in the plans.**
5.	**<u>Date of the next meeting</u>** 8th August, 11am-1pm, Board Room, NLBP	

Minutes from the Health and Well-Being Board – Financial Planning Group
Thursday 8th August 2013
NLBP
11.00 -13.00

Present:
(KK) Kate Kennally (Chair), Director for People, London Borough of Barnet (LBB)
(JH) John Hooton, Assistant Director of Strategic Finance, LBB
(JM) John Morton, Chief Officer, Barnet Clinical Commissioning Group (CCG)
(SH) Stephen Hobbs, Interim Chief Finance Officer, Barnet CCG
(KJ) Karen Jackson, Adult Social Care Assistant Director, LBB
(KA) Karen Ahmed, Later Life Lead Commissioner, LBB
(MT) Marshall Taylor, Interim Head of Prevention & Wellbeing, LBB
(EB) Emily Bowler, Customer Care Service Manager, LBB
(TF) Thomas Fennerty, Projects & Propositions, Agilisys
(ET) Elaine Tuck, Strategy & Projects Officer, Children's Services, LBB
(CM) Claire Mundle, Policy & Commissioning Advisor, LBB

Apologies:
(MK) Mathew Kendall, Assistant Director, Adults & Communities, LBB
(DW) Dawn Wakeling, Adults and Communities Director, LBB

AGENDA ITEM	ITEM	ACTION
2.	**<u>Update on actions</u>** <u>Outstanding items to take forward:</u> '*JH to send most recent census analysis with JM'* *'DW to pick up discussion on quality in care home teams with MT, M'OD and JM'* *'CC to agree final measures in stroke review'*: MT	 **Policy team to send to Maria O'Dwyer** **JH to also share growth projections up to 2020 with JM when ready** **DW to take this discussion forward** **MT to circulate**

	confirmed an early draft from PWC will be ready in the next 6 weeks, including updated costs and benefits model. *'MT to have a discussion with Healthwatch, BCIL and CAB about a coherent commissioning strategy around information giving'*	**report to group (after receiving endorsement from Maria O'Dwyer and Mathew Kendall)** **MT to revise business case in line with discussions with Healthwatch, BCIL and CAB**
3.	**<u>Priorities and Spending Review process</u>** JH talked through his presentation on the Priorities and Spending Review (PSR). He outlined timeline for completion and the governance arrangements overseeing the review. He explained that there will be a presentation on the PSR at the 4th September Partnership Breakfast. The group discussed the parallel financial challenge in the NHS. JM outlined the £65-70m savings needed by Barnet CCG over the next 5 years to reach financial balance. He also explained the CCG will lose £12-13m per annum from 15/16 from its budget to support integrated care (this local sum plays into the £20 billion spending gap to 2020 identified by NHS England). KK recognised the need to reflect the NHS saving challenge alongside the LA PSR process to reflect the total public services funding challenge over the course of the decade. JM told the group that NHS Property Services more willing to see what opportunities exist for collective savings. The group talked about the benefits of the CCG joining up with the LA to procure residential care services- KK is confident that the CCG will get savings from the joint approach, but acknowledged that the arrangement as likely to be cash releasing for the CCG rather than the LA.	

	The group also discussed the potential for savings in combining back office functions. Two-thirds of CCG's current running costs come from back office functions. KK explained that the Capita contract in the Council had been written in such a way to allow for other public services to buy back office functions from them. JM talked through the current scope for pooled budgets between the LA and CCG around care for frail elderly (which reflects c.70% NHS spend) and looked-after children. He thought that efforts to advance integration, through the Joint Commissioning Team, could also lead to savings for both the LA and CCG. The group agreed that they will run through the initial ideas for savings in the PSR at the October meeting. This will require finance meetings in advance, to understand both the Medium Term Financial Savings plans of the LA and the recovery plan of the CCG. The October meeting should cover: - Delivery savings stream (relationship with Capita) - Transformation savings stream (with size of the integrated care opportunity for the LA & CCG) JH to ask Rav Singh (PSR project manager) to set out in detail what is happening when and where for the PSR	**JH & SM to set up meetings to share plans/ discuss data exchange** **DW, JM & KK to give initial thought to this** **JH to request this information from Rav Singh**
4.	**<u>Section 75 agreements</u>** ET & TF talked through the Section 75 (S75) agreements for adults and children. They explained the only difference in content was in the aims and objectives section. Summary of approval process for S75 agreements to date: - Approach has been approved by Cabinet Resources Committee	

	- Document has been circulated for feedback and approval with officers across LBB and the CCG (including Finance, Insurance, HR, Information Governance, etc.) - Document has been approved by the CCG Audit Committee and the Cabinet Members for Children's Services, Adults and Performance & Resources for approval - New schedules will be approved by John Morton and Relevant Officers in Adults and Children's delivery units In terms of Adults schedules there are two that have been developed and are being approved by the relevant service leads. There are a number of existing s75 agreements in Adults – these may be reviewed and incorporated as schedules within the overarching s75 agreement as appropriate in future. The group discussed the need to define the relationship between the Joint Commissioning Unit (JCU) and Section 75 agreements (in case the JCU dissolves). The group agreed that the Section 75 agreement needs to be amended to reflect the clear dependency with the JCU: - The MoU notice period should match the S75 notice period. - Section 9.2.2 of the S75 agreement (on management costs) needs to make reference to the MoU for the JCU. - The JCU MoU should reference all the existing adults S75 schedules as well as the new ones. KK pointed out that there are typos in the documents and these should be corrected	**ET & TF to make changes to the S75agreements.**

	KK requested that the section on the partnership flexibilities that are being invoked through the agreement be made clearer and be put up front in the schedules in future agreements. The group agreed that section 9.26 in the document, detailing the timings for changes to the money available, should be explicit i.e. by February of each calendar year there should be an agreement about the inflation value that can be applied for the following year. Reductions should be agreed by September. This agreement should be added to the Children's schedule for speech and language therapy. The group praised the work that had gone into developing the Section 75 agreements.	
5.	**<u>Telecare Business Case</u>** MT talked through the business case. It aims to update and change internal processes at LBB to scale up telecare, and to develop a timetable with the CCG for creating a bigger telecare offer. JM said he was happy to support the business case in principal but suggested LBB should look at resources within the Joint Commissioning Unit to deliver this before going externally to recruit to post. KA agreed that this should be resourced from within the Joint Commissioning Unit (JCU). KA said the business case did not quantify the amount of work that needs to be done, or the level of difficulty to deliver a telecare offer at present. The group asked for clarity about what the work will be trying to achieve- what increase in telecare support will there be? How will this work support hospital discharge? The group wanted more confidence about the outcomes that will be delivered through the business case, and expects these to be developed. The group approved the business case, in principle, and agreed that the investment was needed to sort out the current problem with delivery.	

	The group asked MT to have a conversation with the JCU about their capacity to support this work in the long-term.	**MT to have a discussion with the JCU about internal capacity to support delivery of the work.**
6.	**<u>OBC Involvement, Engagement and Co-production</u>** MT talked through the proposals in the business case. The group raised concern that the OBC did not make clear calculations about return on investment that could be expected. The group also felt that this work could be duplicating the work of Healthwatch, and questioned whether this work could be seen as a priority must-do for investment given the significant financial challenges facing LBB and the CCG. The business case was not supported. KK asked the team to make the consequences of this clear both internally, and to Healthwatch in terms of the impact this decision will have on payments for reward and recognition. KK suggested that a distinction needed to be made between payment to Partnership Board members who dedicate on-going time to the Board, and those residents who turn up to one-off engagement events.	**MT & EB to feedback the outcome of this discussion to their team and to Healthwatch**
8.	**<u>Progressing the integrated budget discussion for 2014/15 and 2015/16</u>** JM presented the paper on health and social care integration following the national announcement in June that a £3.8bn pool of investment to support integrated care will be created. He explained that c. £12.4m from the CCG baseline budget will move into the integrated care budget (equating to 2/3^{rds} CCG community services budget). With this transfer in mind, the CCG recovery	

	programme will be unachievable in the original timeframe of 5 years. KK noted that the LA will also be about 3-4% worse off than expected. JM sought reassurance that the new Section 256 money would be used in part to fund genuine integrated care services rather than supporting only bottom-line local authority pressures. KK reassured that over half of the additional CCG budget being pooled is managed through PbR to support the hospital/ community interface, so would be tied into genuine integrated care endeavours rather than social care activities. The group discussed the need to make a list of requirements for what the integrated care money should be spent on, accounting for: - The CCG recovery plan - The Local Authority Medium Term Financial Strategy - The Care Bill - National Guidance on Section 256 spend - Vulnerable People's plan - Activity shifts from acute care to care closer to home - Metrics that will support delivery - Long Term Conditions Management - Rapid Response service and extended hours - Supporting access/delivery of services The decisions made over spend need to account for current and potential uses of: - Independent living fund - Funding to support carers	**KA to lead initial project team to develop these proposals by 17th October meeting.**

	- Disabled facilities grant - Social care capital programme The group agreed that the Joint Commissioning Unit would not have sufficient capacity to take this work forward on their own. The group agreed to appoint an "architect" to lead the process locally of developing proposals for use of the monies. An initial meeting is to be convened involving joint commissioning unit leads with Karen Ahmed, Later Life Lead Commissioner. The group agreed that c. £100k of the Section 256 money could be used to support the development of the commissioning plan for the pooled budget. Proposals and approach to be shared with John Morton, Dawn Wakeling and Kate Kennally by early September with progress to be monitored through the health and social care operational group. The group set the task for the 17th October 2013 meeting: that a paper outlining how the monies should be used, and what needs to be developed. This paper will then be finessed and signed off in February by the Health and Well-Being Board.	
7.	**<u>OBC Barnet Integrated Care</u>** JM talked through the business case. He explained that the CCG have a good model of rapid response but it needs extending to cover 7 days/ week and link to reablement services. There is also a good model of COPD, but a weak model of other long-term conditions management. Intermediate care provision is also weak. In addition, it was identified that a key priority for the system is to ensure that there is sufficient community based support across health and social care to support the implementation of the BEH clinical strategy in December 2013. The HWBB finance group agreed in principle that up to c£500k should be made available to support the extension of social care capacity and integration of intermediate care and enablement in advance of the December go live date for the transfer of services from Chase Farm to Barnet Hospital	**JM to work up these proposals to feed into integrated care programme design**

	JM also talked through the winter challenge and need for additional beds- JM is making a bid to London for support to purchase these. The CCG need absolute confidence and to provide assurance that the right system will be in place by October to support people through the winter period. The group agreed that the OBC for Integrated Care needs to be considered through the working group to finalise the proposals on integration to the next HWBB finance group as set out under item 6. The system needs to progress the capacity needed to support in-year challenges for the system, and be clear about what should be in the integrated care offer. This would be taken forward within the £500k outlined above.	
9.	**<u>CCG review of 256 spend as a record</u>** KK asked JH to work with Michael Miller to develop a reporting template for Section 256 spend which will then form a standing item at each HWBB finance group. SH to liaise with JH outside the meeting re the CCG analysis of historical position for the record	**JH to design template with Michael Miller**
15.	**<u>Date of the next meeting</u>** 17th October, 10am-12pm, Board Room, NLBP	

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Meeting	Health and Well-Being Board
Date	19th September 2013
Subject	**Health and Social Care Integration update: development of a target operating model for integration in Barnet**
Report of	Adults and Communities Director, LBB Barnet CCG Chief Officer
Summary of item and decision being sought	This report updates the Health and Well-Being Board on the local plans to develop integrated care and an integrated budget across Barnet CCG and Barnet Council, in response to both the recent government announcements about integrated care funding, and local financial challenges.

Officer Contributors	Karen Ahmed, LBB Later Life Lead Commissioner Claire Mundle, LBB Commissioning and Policy Advisor Tom Fennerty, Consultant, Agilisys Prema Mehta, Project Officer- Health and Social Care Integration
Reason for Report	This report presents a summary of the work taking place locally to develop integrated care and integrated budgets in line with national policy directives, and in response to national and local financial challenges. The Health and Well-Being Board is asked to approve the current plans to develop a target operating model for health and social care integration in Barnet. The Board is also asked to note its responsibilities to review the model at the November 2013 Board meeting, and to sign-off Barnet's integrated locality plan and budget before March 2014.
Partnership flexibility being exercised	The health and social care integration target operating model will direct the commissioning strategy, commissioning intentions, contracting approach with existing providers and development of business cases for integration projects that will benefit partners and these may include use of the partnership flexibilities available under section 75 of the National Health Service Act 2006, and the grant flexibilities under section 256 and section 76 of this Act.
Enclosures	Appendix 1: Briefing paper from London Councils on the Integration Transformation Fund
Wards Affected	All
Contact for further information:	Dawn Wakeling 0208 359 4290, dawn.wakeling@barnet.gov.uk John Morton, 0203 688 1793, john.morton@barnetccg.nhs.uk

1. RECOMMENDATIONS

1.1 That the Health and Well-Being Board approves the work plan to develop a high level Health and Social Care integration target operating model and integrated budget in Barnet.

1.2 That the Health and Well-Being Board receives an update report on progress to develop this model at the November Board meeting.

1.3 That the Health and Well-Being Board agrees to receive and ultimately sign-off jointly agreed locality plans and budgets for 2014-2016 ahead of March 2014.

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 In May 2012, the Health and Wellbeing Board endorsed the Health and Social Care Integration Strategic Outline Case, considered the proposed vision for integration; agreed the shared governance structure and integration initiatives, and endorsed the initial commitment of £1m by Barnet Council to fund the delivery of a local health and social care integration work programme.

2.2 On the 27th June 2013, the Health and Well-Being Board approved the Barnet CCG proposals to further develop integrated care, and these were also endorsed by the Health and Well-Being Integration Board on the 19th July.

2.3 On the 8th August, the Health and Well-Being financial planning group (the delegated sub-group of the Health and Well-Being Board responsible for overseeing and aligning the finances across health and social care to further integration) considered a paper on integrated budget proposals presented by the CCG, and made a decision to commission the development of a target operating model for health and social care integration. This decision was preceded by a discussion about changes in national policy, and the need to respond to local financial challenges (as set out in the body of this report).

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

3.1 The Health and Well-Being Strategy sets out the aspirations of the Health and Well-Being Board and its member organisations, including its aspirations to deliver integrated health and social care for Barnet's residents. The Health and Well-Being Board is responsible for promoting greater coordination of planning across health, public health and social care, and is accountable to the Barnet Partnership Board for delivery against this goal.

3.2 The plans to develop a target operating model for health and social care integration will support the delivery of the Council's medium term financial strategy and Priorities and Spending Review, both of which seek to secure the economic sustainability of the Council through to 2020. The operating model for integration has an equally important role to play in supporting delivery of Barnet CCG's financial recovery plan, which aims to secure financial balance for the organisation by 2017.

3.3 NHS Barnet CCG as a newly established organisation has developed with LBB input, and based on the Health and Well-Being Strategy, its strategic commissioning plan. The plans to develop a target operating model for health and social care integration will support the delivery of the plan and the associated CCG financial recovery plan.

3.4 Core to this proposal, and to the Health and Social Care vision to provide support to a typical Barnet resident - for these purposes called Mr Colin Dale, is the integration of health and social care support provided in Barnet, including health promotion education and prevention services.

4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 All identified opportunities for the integration of health and social care services in Barnet will be informed by an analysis of local and national data and evidence of what has been proven to work elsewhere. It will ensure that any subsequent work on integration is informed by the local population needs identified in the Joint Strategic Needs Assessment and the priorities for health improvement and wellbeing set out in the Health and Wellbeing Strategy. The three priorities driven by this needs assessment are set out in the CCG plan.

4.2 The benefits from the proposed programme of integration initiatives should enable partner organisations to identify more effective ways of meeting future demographic challenges that are facing the commissioning and delivery of health and social care services in Barnet, such as the aging population and substantial growth in the numbers of frail older people, and the growth in young families.

4.3 An Equalities Impact Assessment will be conducted for each health and social care integration initiative to determine its potential impact on different groups and communities in Barnet, including people within the protected characteristics of age, disability and gender as defined by the Equality Act 2010, such as older people and carers of older people or disabled people, and the requirement for any reasonable adjustment and or mitigating steps that can be put in train.

5. RISK MANAGEMENT

5.1 The evidence base for health and social care integration continues to grow. There is a need to pull together the various strands of local evidence and data into one place to ensure that there is a comprehensive evidence base from which to make decisions about the use of an integrated care budget. This risk will be mitigated by the development of a target operating model for integration which will consider both the costs and the expected shifts across both health and social care activity ahead of operationalising any further projects in Barnet. This model will consider evidence of best practice and on results from other integration projects, in order to inform its development. The creation of this target operating model will ensure that benefits measurement will be an essential component of integration project development and delivery.

5.2 Barnet CCG is recognised as one of the most financially challenged in the country. The CCG is likely to continue with a small number of conditions and directions in relation to financial plans. The CCG had a five year recovery plan which maintains spending levels in community and mental health services and reduces secondary care costs. The cost reduction is based on detailed analysis of activity and returning specific areas of over activity to expected norms. It is evidence based and has been accepted by NHS England. In addition it is recognised that Barnet and Chase Farm hospitals are not independently financially viable. The CCGs are considering a possible acquisition by the Royal Free Hospitals NHS Foundation Trust which will require commissioner transitional support for up to five years. Against this background the funding to the integration pooled budget, if seen as a transfer of NHS resources to the London Borough of Barnet, would be extremely challenging.

6. LEGAL POWERS AND IMPLICATIONS

6.1 The Council and NHS partners have the power to enter into integrated arrangements in relation to prescribed functions of the NHS and health-related functions of local authorities for the commissioning, planning and provision of staff, goods or services under Section 75 of the National Health Service Act 2006 and the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000. This legislative framework for partnership working allows for funds to be pooled into a single budget by two or more local authorities and NHS bodies in order to meet local needs and priorities in a more efficient and seamless manner. Funds pooled by the participating bodies into single budget can be utilised flexibly to support the implementation of commissioning strategies and improved service delivery. Arrangements made pursuant to Section 75 do not affect the liability of NHS bodies and local authorities for the exercise of their respective functions. The Council and CCG now have two overarching section 75 agreements in place.

6.2 The Act now allows for local authorities to provide services which improve the health of the population.

6.3 There is likely to be new guidance on integrated budgets shortly, which the Council and the CCG will need to be responsive to in the development of their plans.

6.4 NHS organisations also have the power to transfer funding to the Council under Section 256 of the National Health Service Act 2006, and the Council similarly has the power to transfer money to the NHS under Section 76 of the NHS Act 2006. These powers enable NHS and Council partners to work collaboratively and to plan and commission integrated services for the benefit of their population. The new integrated budgets arrangements replace the current use of Section 256 money although Section 256 will remain in place.

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

7.1 This paper outlines the work being undertaken to estimate the health and adult social care savings that integration across these services will bring, which will be completed in October 2013. These savings, once calculated, will be factored into the Quality, Innovation, Productivity and Prevention (QIPP) and CCG Recovery Plan in the NHS, and the Council savings requirements in the Medium-Term Financial Strategy and Priorities and Spending Review.

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 A communications working group has been set up by the Health and Social Care Integration programme, consisting of Communication Officers from the eleven organisations that are part of the Health and Social Care Integration programme. The working group will consider communication to residents, service users and staff groups at programme and project level. This strategy will provide key guidance to the Health and Well-Being financial planning group as to how, when and with whom it will be most appropriate to engage on the target operating model once it has been developed.

8.2 Early engagement with Healthwatch for forthcoming Health and Social Care Integration projects is currently being discussed.

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 Provider organisations represented at the Health and Social Care Integration board have been involved in the development of both the strategic outline business case for the integration programme, and the subsequent integrated commissioning plans. These recognise the important role providers have to play in improving levels of integration an innovation within the local system of care and this is reflected in the prioritisation of a health and social care summit which seeks to engage providers in the transformation of health and social care in Barnet through integration.

10. DETAILS

10.1 Executive Summary

10.1.1 The Council and the CCG already have a vision for integrated care which is aligned with the national aspiration for integration set out by the Government. They are delivering this through the Health and Social Care Integration programme. Further detail about this programme has been provided through the recent documents referred to in section 2.2 above, and is also explained in section 10.6 below.

10.1.2 The announcement in the June 2013 Spending Round of a pooled budget of £3.8 billion nationally for health and social care systems in 2015/16 has significant implications for health and social care integration, and has a bearing on the development of the local programme. The funding will be largely sourced from existing health and social care funding and being moved in to an integrated budget, and will enable local integration to develop at greater scale and pace, and support local areas to develop economic sustainability plans in partnership. The funding has been made available by the Government on the proviso that local authorities and CCGs develop clear plans for delivery over the next two financial years (2014/15 and 2015/16).

10.1.3 In response to this announcement, the Health and Well-Being financial planning group has commissioned a piece of work to develop a target operating model for integrated health and social care that supports the realisation of the vision for integrated care in Barnet, supports efforts to secure the financial sustainability of the Council and the CCG, and identifies the next steps for the existing integration programme.

10.1.4 In Barnet, the decision making over Section 256 monies already takes place through the Health and Well-Being Board and the financial planning group, so local practice is already in line with the new requirements. The Board is asked to approve the approach set out in the paper that will be taken locally to develop a target operating model for integration, and planned use of the pooled budget.

10.2 Update on national policies: Spending round health settlement 2015-16

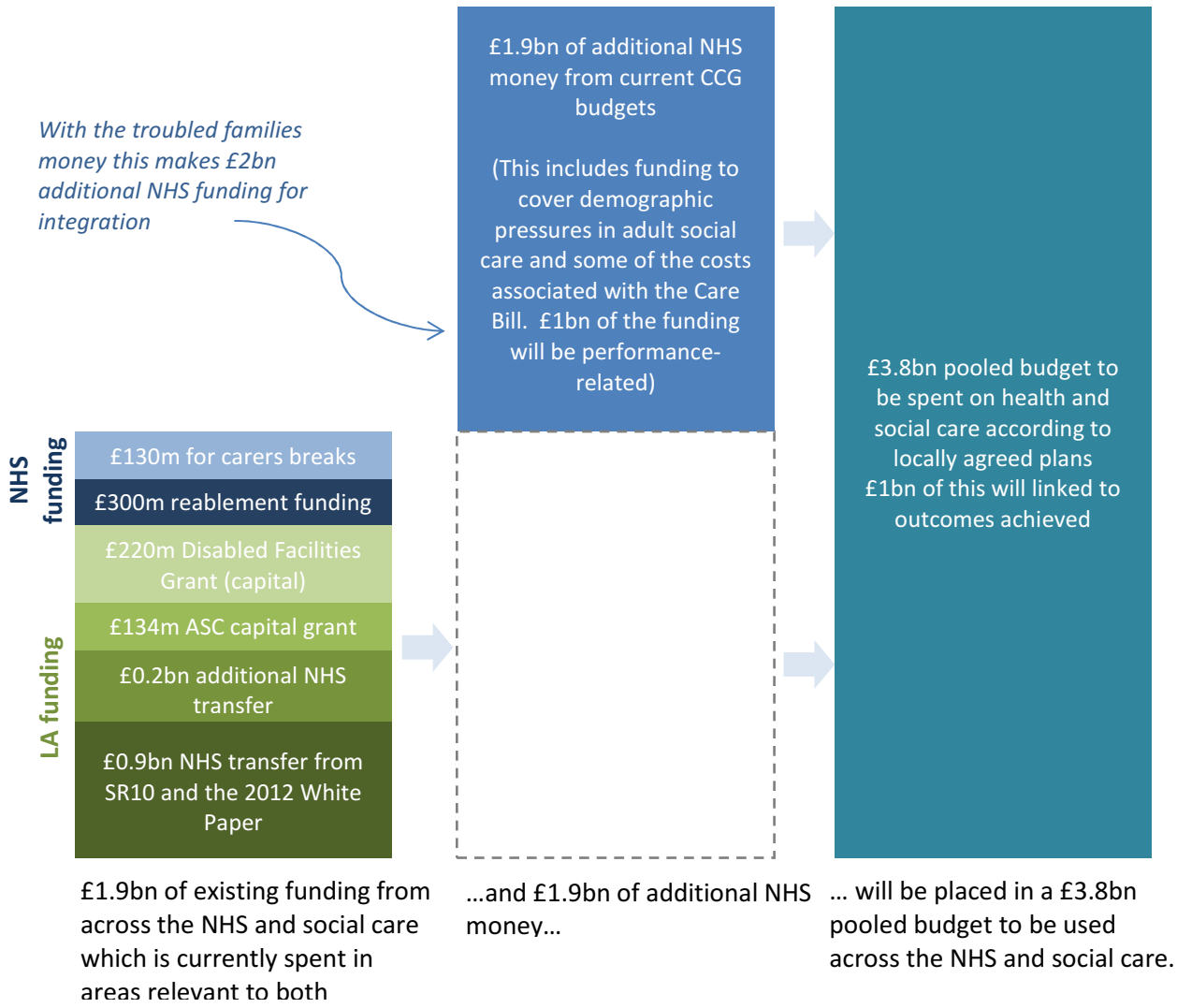
10.2.1 The June 2013 Spending Round announced that the NHS, Department for Communities and Local Government and the Department of Health will pool £3.8bn of funds for investment in the integration of health and social care (the “Integration Transformation Fund”). However, there is very little new money being allocated to support integration; the vast majority of resources will come from existing NHS budgets (the NHS will contribute c£3.4bn towards the Transformation Fund, compared to the £0.9bn the NHS currently transfers to support integration with social care).

10.2.2 The national £3.8bn Integration Transformation Fund will be a pooled fund, funded from:

- The £0.9bn of funding NHS England planned to transfer to fund social care in 2014-15
- An additional £0.2bn of investment in 2014-15 (to be agreed as part of mandate discussions for 2014-15 with DH)
- DH and other Government Department transfers of £0.4bn (capital grants)
- CCG pooled funding of:
    - Reablement funding of £0.3bn; *and*
    - Carers' break funding of £0.1bn
    - Core CCG funding of £1.9bn

The total amount of the fund for Barnet still needs to be confirmed. Barnet CCG has made an estimate that the total potential Barnet CCG contribution to pooled integrated budget could be up to £21.8M before capital grants; however, this figure has not been confirmed by local or national partners.

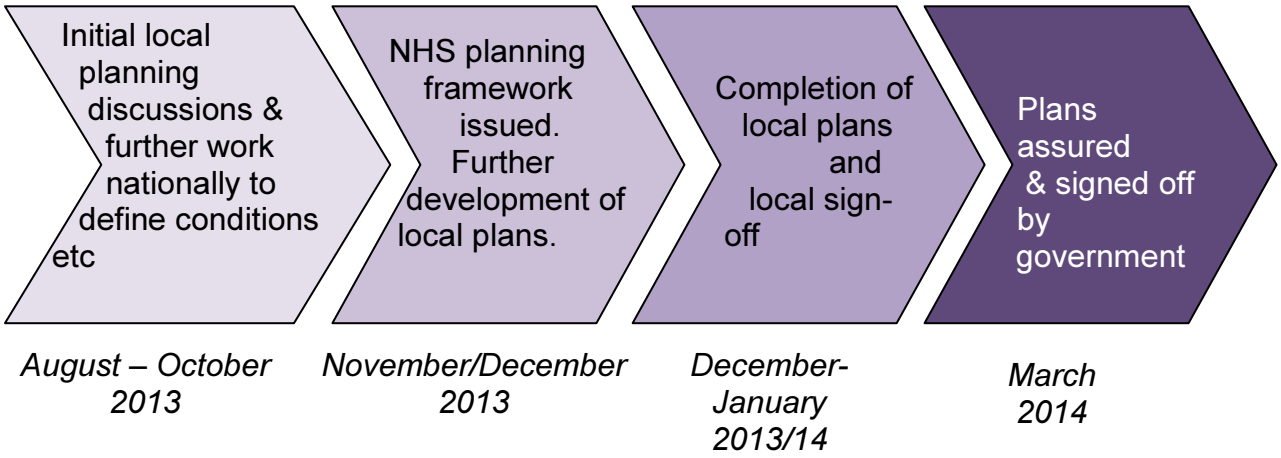
These transfers of money have also been set out in the diagram below, set out in a recent briefing paper from London Councils (also attached as Appendix 1):



10.3.3 CCGs and Councils will need to jointly develop a two-year locality plan that details how the pooled budget will be spent. This plan will need to be assured and signed-off by the

Health and Well-Being Board in early 2014 and by central government by March 2014. Plans must demonstrate how they meet the set of requirements listed in Appendix 1, at which point part of the funding for integration will be released. The second part will only be released once central government is satisfied with local performance achieved from use of the money.

10.3.4 The broad timetable for the plans, as set out in the London Councils briefing paper, is:



10.4 Update on local financial challenges

10.4.1 This national direction has been given at a time when there are significant financial challenges facing the local authority and CCG in Barnet, which will last until at least 2020. Both organisations have already recognised the role that the integration of health and social care will play in driving financial efficiencies and securing economic sustainability, as documented in their core financial savings plans:

- The Council's Medium-Term Financial Strategy makes reference to the savings that can be realised through health and social care integration: the Council needs to reach its c£75m savings target by 2015, before undertaking a further c£70m saving programme (known as the Priorities and Spending Review) between 2016 and 2020.
- The CCG financial recovery plan contains plans for integration in frail elderly; urgent care; and continuing care pathways: Barnet CCG needs to make up to £50m savings over the next 5 years to reach financial balance. Approximately £12.4m will be transferred from the CCG to the local authority from 2015 to fund integrated care. Unless properly managed, this transfer could lead to very significant underfunding of some CCG commissioned community services.

10.4.2 There is a risk that the financial savings plans set out above will not be achieved unless there is a focus on integrated commissioning and delivery, which will, among other areas, involve actively exploring estate rationalisation; the opportunities for sharing back-office functions; and the development of single electronic patient record.

10.5 The local policy response: development of a Health & Social Care Integration Delivery Model for Barnet

10.5.1 Barnet has already spent a substantial period of time developing its integration agenda between health and social care locally, which means there is information data and on-going work already available to support the development of the target operating model. For example, the Health and Social Care Integration Board, which brings together a range of local health and social care partners, has as part of its development work already developed and approved an integrated care concordat that sets out a shared

vision for integrated care in Barnet. A Joint Commissioning Unit has been established and is being operationalized so that it can deliver on the plans approved by the Integration Board. However, whilst the Joint Commissioning Unit will have a key role in implementing the integrated care system, there is now additional requirements for a more detailed articulation of the vision into a structure that can inform allocation of spend based on agreed priorities that achieve the overarching vision within the necessary timescales.

10.5.2 As such, and in response to the national direction and the local financial pressures set out above, Barnet's Health and Well-Being Financial Planning Group has identified the need to develop a headline health and social care integration target operating model for the Borough. This work will join up the Health and Social Care Integration projects into a coherent whole, developing them so that they are fit for the future, and ensure that financial flows across the whole system are reasonable. Barnet already has the core of the Target Operating Model in its Older People's Integrated Care Service project, which bases its model on risk stratification, care navigators and Multi-Disciplinary Team case management. The target operating model will draw on this and other existing work to create a coherent model for integrated care in the Borough.

10.5.3 Karen Ahmed, Later Life Lead Commissioner at LBB, will lead the process locally of developing proposals for use of the pooled budget. The Health and Well-Being Financial Planning Group has agreed to release up to £100k if required to support the Lead Commissioners in this design work (for employing external consultants to support the project if deemed necessary).

10.5.4 This modelling work will outline:

- A shared statement of requirements (from which to design the new model)
- Underpinning activity and spend data across acute, intermediate, primary, community, residential and social care (which will be used to support the modelling work that will inform the future model)
- An analysis of the funding streams that fall within the Integration Transformation Fund and proposals for how this will be managed.
- The evidence base of what works, and what is already working elsewhere, with particular focus on demand management (*stopping people from entering the system unnecessarily*); treatment and intervention (*supporting people in and out of the system safely and efficiently*); rehabilitation and reablement (*supporting people out of the system to maintain independence and reduce future need for service use*) and workforce development.
- A set of proposals to inform the development of a target operating model. These will include the spearhead projects already underway by the Health and Social Care Integration Programme and options identified by the Health and Social Care Integration Board through the recent set of interviews to identity priority pieces of work (see Section 10.6 below).
- The model will also, where appropriate, make reference to the integrated services that already exist in Learning Disabilities and Mental Health, plus the established integrated commissioning of prevention, voluntary sector and equipment services.
- The model will also make suggestions for 'future proofing' the local health and social care integration system, including a coherent set of governance arrangements across the LA and CCG to support the delivery of this work.

10.5.5 The model will be developed by a Reference Group appointed across the NHS and the Council, who will call on external expertise as required. The Group have already identified a number of external contacts who will be able to provide support to the development of the model.

10.5.6 The intention is to submit the initial proposals for the model to the Health and Well-Being Finance Group for consideration on the 17th October. The model will also be presented to the Health & Social Care Integrated Care Board at the end of October 2013. It is proposed that the HWBB receive an update report on the work in November 2013, and receive a final draft of the locality plan in January 2014.

10.6 The supportive function of the Health and Social Care Integration Programme

10.6.1 The target operating will, as mentioned, need to reference the existing projects that are already taking place as part of the Health and Social Care Integration programme. The delivery of both Health and Social Care Integration spearhead projects within the Programme is well underway. The training that has formed part of the Care Homes Pilot is being delivered to care homes and additional support such as the portal has been set up. Recruitment of staff for the Older People Integrated Care Service is in progress and multi-disciplinary meetings between practitioners are now running on a regular basis.

10.6.2 A business case for a shared record is currently being developed and shall be considered by the Integrated Care Programme Board for delivery in October. There is the possibility of NHS monies being available for part funding the project. An “Expression of Interest” has been completed and the decision will be known soon.

10.6.3 Overarching Section 75 agreements for both Adults’ and Children’s health and social care services have also been developed between the Council and the CCG. An overarching agreement contains all the ‘generic’ terms that are required as part of any agreement and the principles by which services will be commissioned and managed. It provides a platform for the Council and the CCG to robustly manage and finance new and existing integrated services. Specific arrangements for each integrated service will be covered in schedules that will be appended to the overarching agreement.

10.6.4 Separate (but near identical) overarching agreements cover children’s services and adults services. This will allow for different approval and sign-off processes that incorporate the differing governance arrangements existing in adults and children’s services. It will accommodate the different policies and strategies that each service area is subject to.

10.6.5 The Agreement will act as an enabler for the robust management of the integrated health and social care services that will be delivered through the development of the overarching model of integrated care.

11 BACKGROUND PAPERS

11.1 None attached to this report.

Legal – LC
CFO – JH

Appendix 1: Briefing paper from London Councils on the Integration Transformation Fund

£3.8BN INTEGRATION TRANSFORMATION FUND 2015/16

LONDON COUNCILS BRIEFING NOTE

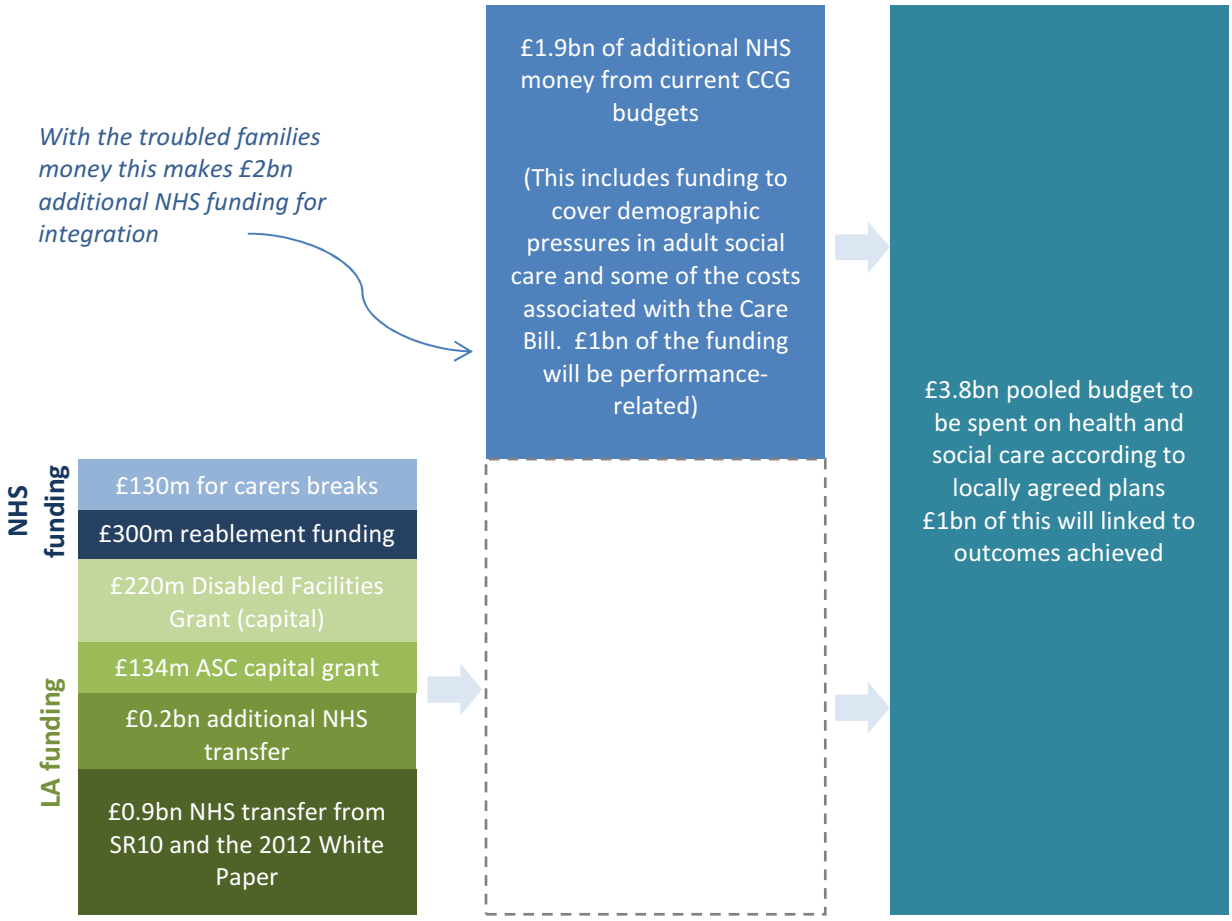
The Spending Round 2013 announced a pooled budget of £3.8 billion for local health and care systems in 2015/16. This is now being referred to as the "Integration Transformation Fund".

What is the Integration Transformation Fund for?

The government's stated goal is to get local health and care partners to work more closely, through creating a pooled budget in every area. This follows the publication of the National Vision on health and care integration, which defined integration from the perspective of the individual. The fund is intended to support an increase in the scale and pace of integration. It is clearly also a mechanism for promoting joint planning for the sustainability of local health & care economies.

Where does the money come from?

In reality, little of this is new money. The fund is made up as follows:



£1.9bn of existing funding from across the NHS and social care which is currently spent in areas relevant to both

…and £1.9bn of additional NHS money…

… will be placed in a £3.8bn pooled budget to be used across the NHS and social care.

The additional £1.9 billion NHS funding will be drawn from current CCG budgets. Given existing demographic pressures & efficiency requirements, CCGs are likely to have to make cuts in existing services to release this money. Although the basis on which this will be taken from individual CCGs is not yet clear, as an initial rough planning guide CCGs have been advised to start considering how to free up around £10 million each.

In addition to this £3.8bn, DCLG have included in the overall grant settlement for local authorities £188m for pressures from the closure of the Independent Living Fund and £285m for the introduction of deferred payments from April 2015 and the transition to the capped cost funding policies flowing from the Dilnot report that will take effect from April 2016 once the Care Bill has been passed into law. The NHS has also contributed £70m to the Troubled Families programme.

The Spending Round also announced a further £200m transfer from the NHS to social care in 2014/15, in addition to the £900m already committed.

How the funding will come to local areas?

The 2015/16 funding will be a pooled budget between local authorities and CCGs. CCGs will use funds from their normal allocation to create it.

This means that there will be no automatic transfers of any funding to boroughs, as has been the case with the NHS c.£900m annual transfers in recent years (s256 transfers). However, it will be possible for money to be transferred to councils by local agreement, as part of local plans.

The basis for determining local shares of the £3.8bn has not yet been decided. However, it has been suggested that the same broad splits as used for the s256 allocations is a reasonable planning proxy for most of the funding.

DCLG are specifically considering how to handle the Disable Facilities Grant capital element of the fund allocations, in the light of local authorities' statutory responsibilities.

Local partners will be able to put additional funding into the pooled budget from their existing allocations if they want to do so.

Two year plans

Access to the Integration Transformation Fund in 2015/16 will be dependent on agreement of a local 2-year plan for 2014/15 and 2015/16. The plans will need to be agreed by March 2014.

As well as covering the way in which the Integration Transformation Fund will be used locally in 2015/16, the plans will also need to set out how the £200m additional transfer to local authorities in 2014/15 will be used to make progress on priorities and build momentum.

The plans will need to be jointly agreed between key partners – as well as local authorities and CCGs, this will include local clinicians. Health & Wellbeing Boards will have to sign off the plans.

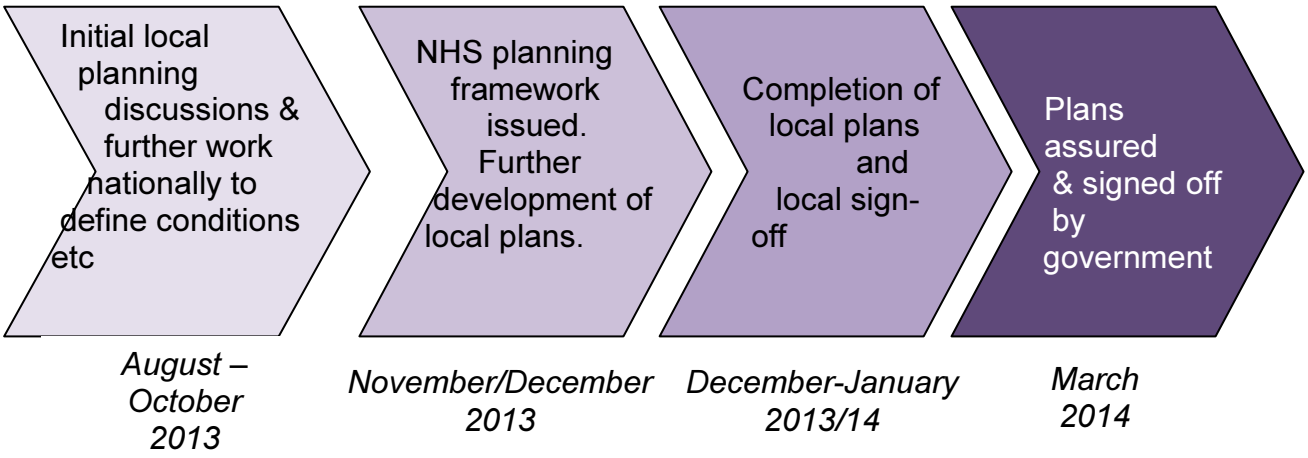
As well as being locally agreed, Ministers have decided that they will oversee and sign off the plans (DH, DCLG and HM Treasury Ministers all have an interest in this). The LGA and NHS England are developing proposals about how this can be done in an efficient and proportionate way. NHS England's role in either local or national agreement has not yet been clarified.

Joint LGA/NHS England guidance has been published clarifying that the plans should be developed in the context of:

- local joint strategic plans;

- other priorities set out in the NHS Mandate and NHS planning framework due out in November/December. (CCGs will be required to develop medium term – currently expected to be 3-5 years – strategic plans as part of the NHS Call to Action);
- the announcement of integration pioneer sites in October, and forthcoming integration roadshows.

The broad timetable for the plans is:



Conditions for the plans

Funding will only be given on the condition that services are commissioned jointly and seamlessly between the CCG and councils, on the basis of their agreed local plan.

The following national conditions will need to be addressed in local plans:

- plans to be jointly agreed;
- protection for social care services (not spending);
- as part of agreed local plans, 7-day working in health and care to support patients being discharged and prevent unnecessary admissions at weekends;
- better data sharing between health and social care, based on the NHS number (it is recognised that progress on this issue will require the resolution of some Information Governance issues by the Department of Health);
- ensure a joint approach to assessments and care planning;
- ensuring that, where funding is used for integrated packages of care, there will be an accountable professional (ref. Jeremy Hunt's recent request for views on improving care for the vulnerable elderly, that will culminate in some announcements expected in October)
- risk-sharing principles and contingency plans if targets are not met – including redeployment of funding if local agreement is not reached; and
- agreement on the consequential impact of changes in the acute sector.

How will the £1bn performance-related element work?

As part of their plans, local areas will need to set outcome goals and monitor delivery against these during 2014/15 and 2015/16. £1bn of the total fund will be based on achievement of these goals. This funding is likely to be unlocked in two tranches – half in April 2015 on the basis of performance in 2014/15, and the second half in autumn 2015 on the basis of performance in the first part of the financial year.

The outcome measures will be a mix of national requirements and local choice. The national requirements are yet to be determined, but early discussions include eg. delayed discharges.

Issues that still need to be resolved

There are a range of issues that still need to be clarified on which the government, LGA , NHS England and other national partners are working – and which London Councils will continue to seek to influence. These include:

- allocation of funds;
- national conditions, including definition, metrics and application (including whether the performance-related element of the funding will be based on 'all-or-nothing' achievement of outcomes);
- risk-sharing arrangements;
- assurance arrangements for national sign-off of the plans and subsequent monitoring;
- analytical support, eg shared financial planning tools and benchmarking data packs.

Action that boroughs and their partners can start to take now

Given the timescale for the preparation and agreement of plans on which this will all hang, and the aspirations for the strategic ambition of these plans, the earlier local thinking and discussions start the better.

Some of the issues that boroughs should start considering with their partners are:

- the basis that existing local plans and priorities – joint and individual – provide as a starting point for their Integration Transformation Fund plan, and early identification of further analytical needs and joint strategy development so these can be got underway as soon as possible;

- the implications of the way the fund has been drawn together on current planning and budgeting intentions eg in CCGs the need to free up the additional money to put into the fund and for local authorities the need to recognise that the s256 monies will no longer form an automatic transfer;

- the process for developing the plan and securing local sign-off, including through the Health & Wellbeing Board;

- how to handle engagement with clinicians and acute trusts – particularly given that in most parts of London individual trusts will need to engage in several local area plans;

- what community and patient engagement to include as part of the development of the plan.

* * * * *

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Meeting	Health and Well-Being Board	AGENDA ITEM 14
Date	19th September 2013	
Subject	**Growth and Regeneration Programme**	
Report of	Director for Public Health	
Summary of item and decision being sought	To provide an overview of Barnet's regeneration programme, and make proposals for how the Health and Well-Being Board should contribute to shaping it.	

Officer Contributors	Cath Shaw, Lead Commissioner, Enterprise & Regeneration, London Borough of Barnet
Reason for Report	To establish how the Board will support the regeneration programme to ensure that it contributes to Health and Well-Being outcomes.
Partnership flexibility being exercised	n/a.
Wards Affected	Initially Childs Hill, Colindale, Edgware, Golders Green, Mill Hill, Underhill and West Hendon
Contact for further information	Cath Shaw (020 8359 4716, cath.shaw@barnet.gov.uk)

1. RECOMMENDATION

1.1 That the Health and Well-Being Board endorses the proposed approach to engagement in regeneration as set out in paragraphs, 10.1-10.11.

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 None specific to this report.

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

3.1 The *Well-being in the Community* theme of the Health & Well-Being Strategy emphasises the role of the regeneration schemes in creating places that promote health and wellbeing, both by thinking through specific physical attributes (such as the design of open spaces, or the provision of health centres) and by creating pleasant enjoyable places to live. At a very basic level, improving the quality of housing is an important contributor to health and well-being. In addition, both the physical regeneration schemes and the elements of the programme focused on skills and enterprise offer opportunities to increase resident employment, which in turn promotes health and wellbeing.

4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 Growth and regeneration projects must comply with the requirements of the Public Sector equality duty at s149 of the Equality Act 2010 (wherein public authorities must in the exercise of their functions have due regard to the need to eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the 2010 Act).

5. RISK MANAGEMENT

5.1 Establishing a dialogue between the Health and Well-Being Board and the Council regarding the growth and regeneration programme will help to ensure that health and well-being benefits from the programme are maximised. The development of this relationship does not present any risks to the Council or the Board, as identified in Section 10 of the report.

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 target duty on the local authority to take such steps as it considers appropriate for improving the health of people in its area. The regeneration programme contributes to fulfilment of this duty by providing services or facilities designed to promote healthy living and helping individuals to minimise any risks to health arising from their accommodation or environment. In public law terms this *target* duty is owed to the population as

a whole and the local authority must act reasonably in the exercise of these functions.

6.2 Due regard must also be given to the general public law duty set out in s149 of the Equality Act 2010.

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

7.1 To be contained within existing regeneration programme resources as set out in the Council's agreed budget.

8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 Each regeneration project has within it a specific stakeholder and resident engagement programme.

9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 The Council's "in-flight" growth and regeneration projects are all delivered by third party providers – either housing associations or private sector developers – and governed by Principal Development Agreements (PDAs) that crystallise the Council's and Developer's delivery and financial expectations in relation to the particular scheme. Any input by the HWBB into existing schemes will need to be in the context of these PDAs.

9.2 From 1st October 2013 the programme will be delivered on the Council's behalf by a Joint Venture Company (JVCo) established between the Council and Capita Symonds Limited. The importance of the growth and regeneration programme in supporting the *Wellbeing in the Community* theme of the Health and Wellbeing Strategy has been discussed with the JVCo senior team, who are supportive of the agenda.

10. DETAILS

10.1 This paper sets out how the Health and Well-Being Board might provide input into the Council's growth and regeneration (G&R) programme, both now and in the future.

10.2 The current Growth and Regeneration Programme comprises nine projects, more detail of which is included in Appendix A:

1. Stonegrove Spur Road
2. Colindale
3. Grahame Park
4. Mill Hill East
5. West Hendon
6. Dollis Valley
7. Granville Road
8. Brent Cross Cricklewood

9. Promoting Skills & Enterprise, including Town Centres

10.3 The impact of the Programme on health and well-being is significant and far-reaching. It is currently scheduled to deliver:

- 23,500 new homes
- 450 jobs in the next five years
- 10 new schools
- 3 new and 1 replacement health centres
- New parks and play facilities, improved access to the Welsh Harp reservoir, and enhanced walking and cycling routes

10.4 In order to maximise the benefit of the programme to local communities, the Health and Well-Being Board will have an important role to play across a number of issues, including:

- Advising on appropriate provision of high quality community infrastructure, and in particular securing commitment to primary health facilities that meet the needs of existing and new communities.

- Ensuring that opportunities for physical activity are incorporated into masterplans for new communities, for example through cycling and walking routes, parks, play areas and green gyms
- Commenting on Health Impact Assessments
- Recognising the potential contribution of regeneration schemes to local employment.

Primary Care facilities and community infrastructure

10.5 The current regeneration includes commitments to a new health centre at Mill Hill East, and to re-provision of the existing health centre at Grahame Park. There is also recognition of the need to deliver new health facilities at Colindale and Brent Cross Cricklewood, and a commitment to review health provision in the A5 corridor in light of the planned development at West Hendon.

10.6 Members of the Board can play a key role in ensuring that NHS England Commissioning arrangements and the development of plans for new communities are brought together in a timely way to ensure that developments include the facilities that communities need.

10.7 The programme also includes commitments to re-provide a number of community facilities, for example at Dollis Valley and Stonegrove Spur Road.

Physical activity

10.8 In creating new places, we have an excellent opportunity to promote physical activity through good design. In particular introducing high-quality, safe, useable parks and play areas, and walking and cycling routes, from the early stages of delivering a new community can instil good habits from the very

beginning. Members of the Board will have important expertise to add to the development of masterplans, particularly for the latter stages of development Colindale and Grahame Park, and in implementing the major new development at Brent Cross Cricklewood.

Health Impact Assessments

10.9 Health Impact Assessments are generally undertaken for large scale development proposals providing an analysis of the impact of schemes on health and wellbeing. Most recently an assessment was undertaken for the West Hendon regeneration project[1].

10.10 Members of the Health and Well-Being Board will be invited to comment on future Health Impact Assessments.

Employment and Skills

10.11 The link between work and well-being is well established, and recognised in the *Well-Being in the Community* Theme of the Health and Well-Being Strategy. The Council and partners have undertaken a number of initiatives to promote employment, both through ensuring that physical regeneration schemes offer construction and longer term opportunities, and through its Skills, Employment and Enterprise Action Plan.

10.12 A particular focus for employment and skills work has been on 16-18 year olds not in education, employment or training (NEETs) and on unemployment among 18-24 year olds. Although it is difficult to separate the effects of specific initiatives from wider economic trends, it is important to note that youth unemployment in Barnet is back down to pre-recession levels.

10.13 In response to Welfare Reform, the Council and its partners (notably Job Centre Plus, Barnet Homes, Housing Associations and Barnet and Southgate College) have set up a Steering Group which aims to understand and manage the impacts of changes to the welfare system, including by ensuring that residents have the support they need to access work. The lessons learned from this work will be used to inform our approach to tackling worklessness in Barnet, and as part of a wider partnership of West London authorities.

11 BACKGROUND PAPERS

11.1 None.

Legal – LC
CFO – JH

[1] A copy can be found at www.west-hendon.co.uk. The assessment forms chapter 13 (pp 470-547) of Volume 1 of the Environmental Statement.

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AGENDA ITEM 15

Meeting	Health and Well-Being Board
Date	19th September 2013
Subject	**Forward Work Programme for 2013/14**
Report of	Director for People
Summary of item and decision being sought	To present the current work programme for 2013/14 for the Health and Well-Being Board to comment on.

Officer Contributors	Claire Mundle, Commissioning and Policy Advisor- Public Health / Health and Well-Being
Reason for Report	To enable 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.
Enclosures	Appendix A - Health and Well-Being Board Forward Work Plan for 2013/14
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

1. RECOMMENDATION

1.1 That the Health and Well-Being Board proposes any necessary additions and amendments to the forward work programme for 2013/14 (attached at Appendix 'A').

2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 Health & Well-Being Board- Governance - 25th April 2013

2.2 Health & Well-Being Board- Forward work plan - 31st January 2013

2.3 Health & Well-Being Board- Forward work programme for 2013/14 - 27th June 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 the Health and Well-Being Board and the key projects that have been identified as priorities by the Board at its various meetings and development sessions.

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.

6.2 The Public sector equality duty at s149 of the Equality Act 2010 will apply to CCGs and local authorities who as public authorities must in the exercise of their functions have due regard to the need to eliminate discrimination, harassment , victimisation and any other conduct that is prohibited by or under the 2010 Act.

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 Members of the Health and Well-Being Board but the Health Overview & Scrutiny Committee also has the opportunity to refer matters to the Board.

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 27th June 2013, the Health and Well-Being Board considered a draft forward work programme for 2013, and approved the proposed approach to forward planning. The approach 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

10.2 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,

objectives set out in the Health and Well-Being Strategy, and comments from Board members following the 27th June 2013 meeting.

10.3 Board Members are asked to continue to review the forward work programme contained in this report on a regular basis 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.

10.4 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.

10.5 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.

11 BACKGROUND PAPERS

None

Legal – SC
CFO – JH

Appendix A
Health and Well-Being Board Forward Work Plan for 2013/14

MONTH	HWBB DATE	AGENDA ITEMS	DECISION SOUGHT	REPORT OF	HWBB FINANCE GROUP MEETING	PARTNERSHIP BOARDS MEETING
September	19th September 2013	**Quality & Safety:** assurance report on local response to Winterbourne View Health Overview & Scrutiny Committee referral on the use of NHS estates Update on Barnet, Enfield & Haringey Clinical Strategy Update on the potential acquisition of Barnet & Chase Farm Hospitals by the Royal Free Hospital.	For discussion For decision For information For information	Adults & Communities Director Cabinet Member for Public Health CCG Accountable Officer CCG Accountable Officer	25th September	Physical and Sensory Impairment Partnership Board: 11th September Learning Disability Partnership Board: 17th September Carers' Strategy Partnership Board: 25th September
		Performance: Health and Well-being Strategy: refreshed plans for performance monitoring	For decision	Director for People		
		Strategy: Tri-Borough Mental Health Commissioning Strategy Update Update on NHS England's 'call for action'	For discussion For discussion	CCG Accountable Officer CCG Accountable Officer		
		Commissioning: Barnet CCG	For decision	CCG		

MONTH	HWBB DATE	AGENDA ITEMS	DECISION SOUGHT	REPORT OF	HWBB FINANCE GROUP MEETING	PARTNERSHIP BOARDS MEETING
		commissioning intentions		Accountable Officer		
		Partnerships: HWBB & regeneration: effective partnership working	For discussion	Director for People		
		Integration: Health & Social Care Integration update: developing a target operating model for integration Report from the HWB Financial Planning Group	For decision For information	Adults & Communities Director; CCG Accountable Officer Director for People		
October					17th October	Mental Health Partnership Board: 8th October Older Adults Partnership Board: 24th October
November	21st November 2013	**Quality & Safety:** Progress report on immunisations and screening Adult Safeguarding Annual report Children's Safeguarding Annual report	For discussion For discussion For discussion	NHS England Adult & Communities Director The Children's Trust		
		Performance: Annual report:	For decision	Director of		

MONTH	HWBB DATE	AGENDA ITEMS	DECISION SOUGHT	REPORT OF	HWBB FINANCE GROUP MEETING	PARTNERSHIP BOARDS MEETING
		Health & Well-Being Strategy Annual report from the Director of Public Health: Physical Activity	 For information	Public Health Director of Public Health		
		Strategy: Refreshed JSNA Alcohol strategy Public mental well-being action plan BEH clinical strategy update; the potential acquisition of Barnet and Chase Farm Hospitals by the Royal Free Hospital update	For discussion For discussion For discussion For information	Director of Public Health Director of Public Health Director of Public Health CCG Accountable Officer		
		Commissioning:				
		Partnerships: Report from the Partnership Boards Summit	For discussion	Adults & Communities Director		
		Integration: Health & Social Care Integration update: developing the locality plan Report from the HWB Financial Planning Group	For discussion For information	Adults & Communities Director; Chief Officer Barnet CCG Director for People		

MONTH	HWBB DATE	AGENDA ITEMS	DECISION SOUGHT	REPORT OF	HWBB FINANCE GROUP MEETING	PARTNERSHIP BOARDS MEETING
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:** Quality & Safety in the NHS update HealthWatch report on quality and safety in the NHS	For discussion For discussion	CCG Accountable Officer HealthWatch		Mental Health Partnership Board: 9th January
		Performance: Improving Children's Health- a progress report on the CYPP priorities Report on progress against the Primary Care Strategy	For discussion For discussion	Director of Public Health CCG Accountable Officer		Older Adults Partnership Board: 23rd January
		Strategy: Update on the Care & Support Bill & local action plan Tobacco Control strategy	For discussion For discussion	Adults & Communities Director Director of		

MONTH	HWBB DATE	AGENDA ITEMS	DECISION SOUGHT	REPORT OF	HWBB FINANCE GROUP MEETING	PARTNERSHIP BOARDS MEETING
		Update on the LBB Priorities and Spending Review BEH clinical strategy update; the potential acquisition of Barnet and Chase Farm Hospitals by the Royal Free Hospital update	For discussion For information	Public Health Director for People CCG Accountable Officer		
		Commissioning: Approving CCG/PH/LBB commissioning plans for 2014/15 Approving the investment plan for the integrated corporate budget (the locality plan)	For decision For decision	Director of Public Health; Adult & Communities Director; CCG Accountable Officer Adult & Communities Director; CCG Accountable Officer		
		Partnerships: Report from PH England on their role & relationship with the HWBB Update progress report from Healthwatch & LBB commissioners	For discussion For discussion	PH England Healthwatch; Adults & Communities Director		

MONTH	HWBB DATE	AGENDA ITEMS	DECISION SOUGHT	REPORT OF	HWBB FINANCE GROUP MEETING	PARTNERSHIP BOARDS MEETING
		Integration: Report from the HWB Financial Planning Group	For information	Director for People		
February					13th February	
March	20th March 2014	**Quality & Safety:** Francis report- one year on	For discussion	CCG Accountable Officer		Carers' Strategy Partnership Board: 5th March
		Performance: TBC				Physical and Sensory Impairment Partnership Board: 7th March
		Strategy: Priorities and Spending Review and implications for health and well-being	For discussion	Director for People		Learning Disability Partnership Board: 18th March
		Commissioning: TBC				
		Partnerships: Report from CQC on their role and relationship with HWBBs	For discussion	CQC		
		Integration: Implementation of the integrated care locality plans Report of the HWB financial planning group	For discussion For information	Adults & Communities Director; CCG Accountable Officer Director for People		

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

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