| **MEETING** |
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| **HEALTH & WELL-BEING BOARD** |
| **DATE AND TIME** |
| **THURSDAY 23RD JANUARY, 2014** |
| **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)

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

**Substitute Members**

| | | |
| --- | --- | --- |
| Cllr David Longstaff | David Riddle | Dr Jeff Lake |
| Julie Pal | Mathew Kendall | Nicola Francis |

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

**Andrew Nathan – Head of Governance**

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

Media Relations contact: Sue Cocker 020 8359 7039

**ASSURANCE GROUP**

## ORDER OF BUSINESS

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**Decisions of the Health & Well-Being Board**

21 November 2013

Members Present:-

AGENDA ITEM 1

Cllr Helena Hart (Chairman)

| | | |
|---|---|---|
| *Kate Kennally | *Cllr Sachin Rajput | *Cllr Reuben Thompstone |
| *John Morton | *Dr Clare Stephens | *Julie Pal |
| *Paul Bennett | | |

* denotes Members present.

Also in attendance:

Dr Jeff Lake
Dawn Wakeling
Maria O'Dwyer
Elsie Lyons
Siobhan Harrington
Claire Mundle
Dr Debbie Frost
Dr Maggie Luck
Nicola Francis
Dr Philippa Curran

## 1. MINUTES OF THE PREVIOUS MEETING

**RESOLVED that the minutes of the meeting held on 19th September 2013 be agreed as a correct record.**

## 2. ABSENCE OF MEMBERS

Apologies for absence were received from:

Dr Andrew Howe
Dr Sue Summers
Dr Charlotte Benjamin
Mr David Riddle

## 3. DECLARATION OF MEMBERS' INTERESTS

There were none.

## 4. HEALTH AND WELL-BEING STRATEGY (2012-15) - FIRST ANNUAL PERFORMANCE REPORT

The Chairman noted the significance of the role played by Healthwatch who are, in effect, the voice of service users and carers and the importance they played in feeding into the Strategy's formulation. The Chairman also noted the success of the Partnership Boards' Catch Up Meeting on the 5th November - which had centred on promoting physical activity - and emphasised her delight at the level of turnout.

Dr Jeff Lake (Public Health, substituting for Dr Andrew Howe) presented the attached Report and noted the significant amount of work undertaken on it; specifically noting the changes to the Health and Social Care system (pages 15-17) as well as the summary of key actions which have taken place to deliver the Strategy so far (beginning on page 17.) Dr Lake also outlined the Performance RAG (Red, Amber and Green) ratings and noted the significant progress that had been made as well as those areas where improvements were still needed.

However, in terms of horizon scanning (looking ahead to potential areas of concern) Dr Lake advised that the most recent data suggests a worsening trend with performance relative to other areas (page 24 – 26).

The next section of the report, Dr Lake noted, outlined what the priorities were going to be over the coming year. Dr Lake emphasised that this was the first Annual Report of the Health and Well-Being Strategy and he hoped that the format and content was useful to Health and Wellbeing Board Members.

Finally, Dr Lake highlighted the recommendations made for the next period (page 30-41) against each of the four chapters of the Strategy. These recommendations centred on Immunisation; Health Visiting and School Nursing; Community Well-being (incorporating social isolation and cold hazards); supporting residents into employment; reducing the current high levels of tuberculosis, tackling increased rates of high risk drinking, integrated social care services and developing self-care arrangements in the Borough.

Mr John Morton welcomed the report and noted the areas of progress outlined, highlighting the concerns expressed by General Practitioners about the levels of tuberculosis in the Borough and the agreement to commission work to put an action plan in place to tackle the growing problem.

However, Mr Morton queried where Mental Health would fit into the action areas and emphasised the importance of Mental Health as a strategic issue and the need for it to be incorporated into the Strategy.

The Chairman concurred with the views expressed over the importance of tackling Tuberculosis. She also noted concerns over the increasing rates of Diabetes in the Borough and requested that some emphasis be placed on this.

Healthwatch noted the strength of the report and felt that it could assist with consultation work – both with Children and Young People and Older Adults.

Mr Morton queried if the provision of further demographic data as well as community profiling would be useful. Colleagues concurred and Dr Lake noted that this was an area which could be picked up on ***(Action: Dr Lake).***

Ms Kennally noted the helpfulness of the work completed in the Report and that it demonstrated the commitment of it to the Health and Well-Being Strategy. The

recommendations in the Report are essential to the process of identifying and responding to needs in the Borough.

Ms Kennally highlighted the importance of reviewing the targets and measures for Mental Health; however, the data relating to this was not collectable from the CCG and therefore had to be removed from the original list of targets in the Strategy. Ms Kennally welcomed the CCG's identification of Mental Health as a priority area.

Ms Kennally also requested that the revisions of indicators in the Children and Young People's Plan be formally overseen by the Health and Well-Being Board, with the objective of creating a single set of measures across the two strategic documents.

Ms Kennally also noted the involvement of NHS England with screening and immunisations – it is essential that this remains a priority and that all local partner agencies work together on this.

Paul Bennett noted that NHS England is addressing the immunisations data challenge by commissioning a data transfer from GP practices to Child Health Information Services. A number of GP practices would be piloting this before it was rolled out across the Borough. Although confidence was expressed that the rates have not dropped, concerns were noted that there may be some data inaccuracies.

Mr Bennett noted the challenges on how all partner agencies were to work effectively together, particularly entering into the next planning round; and the requirement for CCGs to produce five year commissioning plans and two year operational plans to accomplish this. Mr Bennett stressed the importance of ensuring the plans were right and ensuring continuity. CCGs are encouraged to identify key strategic planning groups and work needs to be undertaken in specific Boroughs and with key stakeholders to make sure every CCG has plans for the longer-term: although, it was noted, the position has improved considerably since last year.

Ms Kennally emphasised the strong partnership between the CCG and the Council, and welcomed views from NHS England as the Commissioner of local services. Paul Bennett acknowledged that NHS England needed to work with local Public Health and CCG colleagues to make sure local plans were aligned with the national priorities.

Dr Stephens highlighted (on page 25 of the performance report) child poverty and was encouraged that the rate for this was dropping. However she noted that Barnet did still represent one of the largest proportions of child poverty in London due to its size, and therefore there is a need to challenge the perception of the Borough – and all agencies need to be mindful of the pressure faced in correcting this.

Dr Stephens raised concerns over the increasing rates of melanoma. This was noted in the context of the national problem. Dr Stephens noted that the London Borough of Islington had run a successful public information campaign. She also raised concerns around the increasing number of tanning salons and questioned if this could be addressed as a future priority for the Board.

Dr Stephens also queried the issue of Shisha and the need for dialogue with NHS England due to the highly toxic levels in the substances involved with the pipes (compared to ordinary cigarettes). There is currently no legislative view as to how this should be managed. The Chairman noted that this was also a problem in Harrow as well as London generally and would require a national solution.

Dr Lake noted that increased melanoma rates were a national issue; but the increasing number of salons would be looked into by the Public Health team and Shisha by Carol Furlong. Dr Stephens agreed that a national approach would be required to address rising melanoma rates and Mr Bennett agreed to take back to NHS England for consideration. Ms Kennally agreed and noted that these issues could be addressed through Public Health and schools. She asked for more information about what the Tobacco Control Alliance would be doing, and also stressed that allegiance with Public Health England would be needed to tackle these issues properly.

Dr Frost noted the need for better information on immunisation and risk profiles, along with clarification of responsibility for delivering immunisations. Dr Frost noted the importance of identifying groups that may be missed. Mr Bennett noted that NHS England have picked up on this, however intelligence and information needs to be better collated and targeted.

Ms Wakeling noted the current situation around influenza vaccinations for older people which was a 'live issue' (e.g. through the Preparing for winter campaign). Influenza vaccinations are published on a weekly basis and Barnet currently stands at 58% vaccinated, which is on track from last year.

Mr Morton noted that, overall, there were a large number of examples of working pragmatically to meet challenges and of effective partnership working and noted that the CCG were working with others to seek quick resolutions to problems where they arise elsewhere.

**RESOLVED that page 12 of the report, the recommendations are agreed (1.1 and 1.2) with additional identification of a Mental Health priority to take forward in the second year of the Strategy.**

## 5. BARNET AND HARROW ON THE MOVE - ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH 2013

Dr Lake presented the (attached) Annual Report, noting that it was the first to be published and outlined the significance of the physical activity priority. The Report is organised around a 'life course' approach and distinct focuses on young people, adults and older people. Recommendations are made for actions to improve the physical activity of all groups considered in the report. Dr Lake noted that a Public Health Challenge is to be launched via a blog, along with an awards programme – partners are asked to contribute towards this and actions are identified appropriately in the relevant sections.

Councillor Thompstone noted the quality of the report.

Councillor Rajput queried what the 'status' of the report is, who is the intended audience and who it would be disseminated to. Dr Lake advised that the report is an independent document but the team would need to look at how it fits in with other strategic documents and processes in the Borough. There are, potentially, links to be made with the issue of encouraging public engagement, which fits in with what Barnet is seeking to accomplish.

Ms Wakeling commended the use of good examples and encouraged the use of further examples around special initiatives for older people/special needs (e.g. commissioned


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leisure centres). Ms Wakeling suggested that a useful information spread was required which can be disseminated along to a range of network groups. Dr Lake agreed to pick this up with Ms Wakeling outside of the meeting ***(Action: Dr Jeff Lake).***

Councillor Rajput noted the importance of promoting physical activity and mental well-being. Councillor Rajput queried how the one hundred and fifty minutes of physical activity mentioned in the Report would be quantified and achieved, given the different population groups, such as disabled people, who need to be encouraged to be more active. Dr Lake agreed to provide an overview of different indicators and how these are calculated. ***(Action: Dr Jeff Lake).***

Ms Kennally informed the Board that she had been delegated as the Council's Physical Activity Lead and that analysis was currently being undertaken by the Public Health team to complete a through needs assessment around barriers to physical activity which will support the development of a business case, that would be ready by June 2014.

Dr Frost highlighted concerns about the lack of resources and facilities in deprived areas and the importance of general practitioners giving advice on free activities to patients. The Chairman encouraged Board Members to promote the use of the new Marked and Measured Routes in parks across the Borough and of the new free Outdoor Gyms to be introduced early in 2014.

Mr Morton welcomed the Report and raised two points (linked to pages 46 and 47): the link between deprivation and exercise is clear but the lack of access to data and information makes this correlation hard to understand – he asked for greater detail on how the Public Health team intends to target deprivation. The Chairman concurred with this point.

Dr Curran noted that exercise was essential in terms of cardiac rehabilitation, and stressed that volunteers and the Third Sector played an essential role in improving physical activity rates in Barnet.

Dr Stephens advised that it was difficult to deliver gymnastics through after-school clubs, as part of the Primary School Sports Premium, which was particularly useful for musculo-skeletal ailments and queried if it would be possible to use this premium in a more targeted way within schools to direct funding towards certain activities. Dr Lake advised that gymnastics was important and provision for this was being encouraged.

Ms. Kennally noted that Barnet had excellent gymnastics facilities at Hendon that should be considered as part of this Strategy. Ms. Kennally also noted that the Sports and Physical Activity review will establish stronger links with Sports Governing Bodies.

**RESOLVED that the Report be accepted in its entirety.**

## 6. JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)

Dr Lake presented this item on behalf of Public Health, outlining the six refreshed needs assessments that complement rather than replace the original JSNA, and notified the Board of the issues around sign-off for these as well as their format. Dr Lake explained that there will be a rolling programme of themed reports- totalling 6 per year.

Mr Morton advised that the Board would need to consider how this is then taken forward in terms of a more detailed data analysis at Lower Super Output Area where possible (e.g. to demonstrate the considerable variation in Mental Health status, and access to services). Mr Morton also noted that there were other significant issues relating to Mental Health which did not come across in the Report and which would require further work to bring out. Mr Morton welcomed the format and the approach, as well as the opportunity for regular review, advising that further work was required between Public Health and CCG to develop these documents.

Ms Kennally commented that the JSNA does not necessarily pick up on vulnerable children and deprivation, as well as essential safeguarding issues. She questioned what further exploration would be required to understand these issues. Ms Kennally highlighted the need for a sense of how the information presented is being used and that she had received mixed reviews from stakeholders which would need to be addressed.

Ms Kennally further commented that all aspects of the JSNA would need to be supplemented with up-to-date analysis by 2015 to make this a fair process. Ms Kennally also queried what the relationship would be between the updated information and what is currently in the Health and Well-Being Strategy – and how this would lead onto a structured decision-making process.

The Chairman welcomed the Document, noting it was well presented and simple to understand. However, the Chairman advised that she was not minded to agree with the Delegated Powers approach (Chairs' Action) Recommendation, stating that as it was a 'living' document, it would require regular updating and the Health and Well-Being Strategy to be amended to take account of this. Therefore any alterations should come back to the Board for meaningful discussion and decision.

Dr Curran noted the need to focus in on some of the numbers presented in the JSNA refreshes (e.g. the number of people with cardiovascular diseases); emphasising the need to understand the figures when setting out the commissioning intentions. Ms Kennally suggested that recommendations be noted and when the JSNA refreshes returned to the Board, they needed to include further analysis in order for them to be signed off.

The Chairman queried if this would be able to be signed off in January 2014 and Ms Kennally urged the Board to commit to this deadline to enable active planning. Dr Lake noted the comments on data update requirements as well as the need for clarity on processes and will update the documents accordingly.

**RESOLVED that:**

1. **The Public Health Team provides the information as requested above in preparation for the updated refreshes of the JSNA coming to the next Health and Well-Being Board in January 2014.**

2. **The recommendation that Chair's Action be used to sign off on the supplements and updates not be accepted and that all JSNA updates are tabled at future Health and Well-Being Board meetings.**

## 7. PUBLIC MENTAL WELL-BEING WORK PLAN

***Ms O'Dwyer and Ms Lyons joined the Board for this item.***

Dr Lake presented this item, which is based on the Commissioning Mental Well-Being tool kit, which will allow consideration to be given to the programmes that make a contribution to mental well-being. Dr Lake advised that the Plan had been presented to the Mental Health Partnership Board and links in to the Tri-Borough Mental Health Strategy. The Local Authority will lead on the Intervention and Prevention Workstream to support the delivery of this Strategy. The Mental Well-being document summarises where Public Health is positioned in relation to this Strategy at present.

The Chairman commended the report for its clarity and noted the emphasis on the work plan included (page 223), particularly in relation to pre and post-natal programmes.

Ms Lyons endorsed the emphasis on early years but suggested that what was missing was 'who is doing what, and how?' She asked if teachers recognised their role in supporting this work plan and questioned if they have the time and the skills to deliver their actions.

Dr Stephens agreed with Ms Lyon's point and advised that Public Health would need to form part of the wider agenda with implications for the existing programmes in place. Dr Lake stressed that this is the public health work going on which supports the broader agenda, such as the CAHMS review.

Ms Wakeling also noted that there was a Partnership Working Group on Mental Health focusing on employment and noted that this would need to be incorporated into the programme. Dr Lake agreed to pick this up with Ms Wakeling outside of the meeting to ensure he is adequately sighted on what is going on ***(Action: Dr Jeff Lake).***

Ms O'Dwyer raised the issue of the Family Nurse Partnership coming to an end and how the work resulting from this should be continued. Ms O'Dwyer also raised concerns on: how physical health care should be targeted; and how alcohol and substance abuse should be managed.

The Chairman concurred that the Work Plan needed to address how health checks could be specifically targeted at mental health need. Dr Lake explained that there is confusion between the NHS Health Checks and annual mental health checks, which are led by primary care. Dr Lake agreed that this was an issue that needed to be picked up.

Ms Lyons noted that there was very little information in the plan about mental health in GP surgeries.

Ms Kennally stressed that she was interested in ensuring that the voice of the local resident is strongly involved in delivery of this plan, and that Healthwatch and the Mental Health Partnership Board should support this.

Dr Stephens commented that the (page 225) key activities the Public Health Team have initiated sections of the Plan needs to reflect partnership working the with the Metropolitan Police for item seven and, possibly, item three for helping with primary school education.

**RESOLVED that the Board accepts the proposals presented in the Public Mental Well-Being Work Plan and the Public Health Team notes the comments made above.**

## 8. BARNET MULTI-AGENCY SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2012-13 AND SAFEGUARDING STRATEGY 2013-15

Councillor Rajput presented the Adults Safeguarding annual report asking the Board to approve it in its entirety. He outlined the key messages in the report.

Councillor Thompstone then presented the Children's Safeguarding Board's Annual Report, noting its key elements.

Dr Curran queried if female genital mutilation was being considered as part of the safeguarding process and Ms Kennally noted that this was an issue in Barnet, noting the work which was being done in Schools and other areas to address this.

The Chairman commented that it was essential to have sign-up on the issues raised on page 361 of the report from all hospitals in the Borough and outlined the desirability to have greater involvement from the two NHS Trusts on this matter. Ms Wakeling and Mr Morton concurred, noting that there are mechanisms in place through the monthly Clinical Quality Meetings with the Trust to hold them to account and that this is raised with them on the agenda for the next Clinical Commissioning Group Board. Ms Wakeling highlighted that training is on the Safeguarding work plan for 2013-15 which should be raised with NHS providers.

Mr Morton finally noted that there was an issue around engagement with NHS partners and consideration needs to be given as to how this is addressed.

**RESOLVED that the Board accepts the Reports presented and consideration be given to engagement with NHS partners in ensuring effective Safeguarding.**

## 9. CHILDREN'S SAFEGUARDING ANNUAL REPORT

Discussed under item 8 above.

## 10. DISABLED CHILDREN'S CHARTER FOR HEALTH AND WELL-BEING BOARDS

Ms Kennally presented the paper outlining the reasons why the Board should agree, in principle, to sign up to the Disabled Children's' Charter. She outlined the new statutory responsibilities outlined in the Children and Families Bill, and specific concerns in Barnet that autism rates are rising and that stakeholders in the Borough would like to see improvements in the care for disabled children. Ms Kennally urged for the paper's recommendations to be adopted and advised that it would require leadership from the Board to ensure that the Charter correctly addresses the needs and requirements of disabled children.

Ms Kennally noted further positive aspects of signing the Charter in terms of cementing the Board into completing work in this area and understanding the need for an evidence-based approach and engaging directly with stakeholders.


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The Chairman pointed out that the Children's Trust Board should carry forward a number of the Charter's recommendations and also noted the work the Children's Trust Board had already carried out to involve children and young people.

**RESOLVED that the Board agrees to sign up, in principle, to the Disabled Children's' Charter.**

## 11. CARE BILL - UPDATE REPORT

Ms Wakeling noted that the Bill will be enacted in the Spring of 2014 and will focus on funding reform. Local Authorities are currently awaiting the Government's response to the Consultation. Regulations and Secondary Legislation will also be required to implement this.

Ms Wakeling asked the Board to note the funding reform implications for Barnet presented in the Care Bill paper.

Ms Kennally concurred and emphasised that it was essential that the proposals for funding reform be noted. A formal report on how integrated care for frail elderly in the Borough is going to be developed will be presented for the January 2014 Board and proposed models will need to take account of the requirements surrounding the Care Bill.

**RESOLVED that the Board duly noted the funding implications of the Care Bill and that a formal report on the development of integrated care proposals that address these funding implications be presented at the next Board meeting in January 2014.**

## 12. JOINT COMMISSIONING UNIT COMMISSIONING INTENTIONS - ADULTS & COMMUNITIES DELIVERY UNIT / BARNET CLINICAL COMMISSIONING GROUP (CCG)

Mr Morton and Ms Wakeling presented this item, which represents the work plan for the Joint Commissioning Unit. It was noted that the commissioning intentions connect well with the Health and Well-Being Strategy and will support the resolution of some issues discussed under previous agenda items.

Ms Kennally added that the paper should be amended to include the Children and Families Bill, as well as ADHD and autism. ***(Action: Mr Morton and Ms Wakeling).***

**RESOLVED that Commissioning intentions of the Joint Commissioning Unit be noted by the Board.**

## 13. MINUTES OF THE FINANCIAL PLANNING SUBGROUP

The minutes were noted by the Board.

**RESOLVED that the minutes of the Financial Planning Sub-Groups 25th September, 2013 and 17th October, 2013 be noted.**

## 14. BARNET, ENFIELD & HARINGEY CLINICAL STRATEGY - UPDATE

Ms Harrington joined the Board for this item and made a visual presentation on the progress of the clinical strategy which was well received.

Mr Morton formally recorded his thanks to Ms Harrington and her team for the successful completion of this work. The Chairman concurred and formally recorded her own congratulations.

Ms Kennally asked Ms Harrington to provide the Board with the key metrics the Board could use to track the benefits of the clinical strategy over the coming years. Ms Harrington welcomed this suggestion ***(Action: Ms Harrington)***

Concerns and confusion was expressed over the receipt by Ms Wakeling of a letter from Mr Nicholson of NHS England which appeared unfairly critical of the Borough's progress on Social Care performance. Ms Kennally asked Mr Morton and Ms Wakeling to obtain metric headline data indicating that systems are working well and highlighted the need to strongly refute Mr Nicholson's assertions. ***(Action: Mr Morton and Ms Wakeling).***

Ms Wakeling noted that several Boroughs have received similarly worded letters in relation to this and Barnet had also received a contradictory congratulatory letter from Mr Nicholson's office as well. Ms Wakeling outlined Barnet's involvement in relation to this, noting that she was not aware of any implications of follow-up requirements resulting from this piece of correspondence.

The Chairman queried if it would be helpful if a formal response to Mr Nicholson's letter was drafted. Mr Morton advised that he would be providing a formal response which would rigorously refute the contents of the letter received. ***(Action: Mr Morton).***

Ms Harrington welcomed the suggestions and comments made by the Board in terms of the progression of the Clinical Strategy and would take these forward to the Handover Board.

**RESOLVED:**

1. **The Board noted formal thanks and congratulations to Ms Harrington and her team for the very near completion of the Strategy.**

2. **Ms Harrington notes the comments and suggestions made by the Board and feeds these into the Handover Board**

3. **Mr Morton drafts a robust response to Mr Nicholson's letter.**

## 15. BARNET CCG UPDATE - POTENTIAL ACQUISITION OF BARNET AND CHASE FARM HOSPITALS TRUST BY ROYAL FREE HOSPITAL NHS FOUNDATION TRUST

Mr Morton updated the Board on the potential acquisition of Barnet and Chase Farm hospital, advising that national negotiations were taking place involving the Department of Health which was taking time. Mr Morton noted that further progress should be made by the time of the next Health and Well-Being Board when he would provide a fuller

report on the subject. Overall, however, the acquisition appears to be on track, subject to national negotiations.

Ms Kennally highlighted the need for clarity in terms of the timetable and when the acquisition was likely to go ahead. Mr Morton advised that the official date was 1 April, 2014 but this was now likely to be deferred to July, 2014.

**RESOLVED:**

1. **Mr Morton presents an update report on the progress of the potential acquisition of Barnet and Chase Farm hospital at the January, 2014 meeting.**

## 16. FORWARD WORK PROGRAMME

The Plan was discussed and Ms Kennally highlighted concerns that the Board was probably now at saturation point in terms of the number of agenda items and papers being presented at Board meetings and suggested that some of this work could be delegated to other Boards.

Ms Kennally suggested that items which the Board is only required to note be considered in a different way.

The Chairman noted that for NHS England/Partnership items, these items would require full discussion and that the Board would not be in a position to cut items short (dependent, upon the availability of NHS England Representatives to the Board), and the agenda for January 2014 was looking to be full. Mr Morton concurred and advised that he would seek to ensure Mr Bennett's full attendance at the next Health and Well-Being Board meeting.

Ms Kennally noted that there were no necessary amendments to be made to the twelve month programme (apart from a single item to be added and the associated need for consideration as to how this will be taken forward).

**RESOLVED:**

1. **Mr Morton seeks to obtain the full attendance at the January 2014 Board of Mr Bennett.**

2. **Consideration to be given as to how agenda items for the Board to 'note' can be taken forward.**

3. **Miss Mundle to give consideration to the additional item to be added to the twelve month plan.**

## 17. ANY OTHER ITEMS THAT THE CHAIRMAN DECIDES ARE URGENT

Following on from the Meeting of the Health and Well-Being Board on 19 September 2013, the Chairman requested a full verbal update from Paul Bennett of NHS England on the whole situation regarding the Mobile Breast Screening Unit at Finchley Memorial Hospital.

Mr Bennett advised the Board that the situation had improved from the last meeting. He said that a number of lessons had been learnt from the withdrawal of the Unit but reported that there were still a number of outstanding issues. These included the inadequate electricity connection as well as the potential costs being incurred due to the ownership of the site passing to Community Health Partners and the systems of charging at a commercial rate (problems with this have been identified across the Country).

Mr Bennett further noted that NHS England is looking into making it more economically viable to provide the Mobile Breast Screening Unit service and will be working with local stakeholders to make this so. Critical lessons have been learnt from not working with local stakeholders first time round.

The Chairman informed the Board that she had obtained confirmation from Dean Patterson at CHP that they intended to put the Mobile Unit back on site at Finchley Memorial on 30 November 2013 with Screening due to recommence by 2 December, 2013. However she was still waiting for formal confirmation of the actual re-commencement. The Chairman also noted problems with issuing letters to potential service users, particularly those who had been re-directed to St. Michael's Hospital in Enfield.

**RESOLVED that Mr Bennett checks the progress in relation to the Mobile Breast Screening Unit and provides an up-to-date report at the next meeting.**

The meeting finished at 12.30 pm


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AGENDA ITEM 5

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| Meeting | Health and Well-Being Board |
| Date | 23rd January 2014 |
| **Subject** | **Quality and Safety at Barnet, Enfield and Haringey Mental Health Trust** |
| Report of | Strategic Director for Communities |
| Summary of item and decision being sought | This paper informs the Health and Well-Being Board of the actions being taken by the Chairman of the Health and Well-Being Board, Barnet CCG and the local authority, to respond to the quality and safety issues on a number of Older People's Wards at Barnet, Enfield and Haringey Mental Health Trust, raised by a recent report from the Care Quality Commission. |

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| Officer Contributors | Claire Mundle, Policy and Commissioning Advisor, London Borough of Barnet |
| Reason for Report | To update the Board on the work taking place locally to address quality and safety concerns at Barnet, Enfield and Haringey Mental Health Trust. |
| Partnership flexibility being exercised | Not applicable |
| Wards Affected | All |
| Status (public or exempt) | Public |
| Contact for further information | Kate Kennally, Strategic Director for Communities, London Borough of Barnet<br>Kate.kennally@barnet.gov.uk |

## 1. RECOMMENDATION

**1.1 That the Health and Well-Being Board considers and approves the recommendations (that will be presented verbally at the Board meeting on the 23rd January) on an appropriate course of action to address the quality and safety concerns at Barnet, Enfield and Haringey Mental Health Trust.**

## 2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 Health and Well-Being Board- 25th April 2013- the Board discussed the CCG's approach to monitoring quality and safety among Barnet's health providers, in response to the publication of the Francis Report. The Board resolved to receive further reports detailing how all relevant players in the system are working together to implement the recommendations of the Francis report.

2.2 Health and Well-Being Board- 19th September 2013- the Board considered the Barnet, Enfield and Haringey Tri-Borough Mental Health Commissioning Strategy. During discussion on this item, the Chairman of the Health and Well-Being Board noted that there had previously been concerns about performance at the Barnet, Enfield and Haringey Mental Health Trust, and questioned whether those issues had been resolved. Mr Morton (Chief Officer of Barnet CCG) advised the Board that one of the performance issues had been around access to urgent care services, and that this had improved significantly. There had also been some progress to improve the other key issue of continuity of care. Mr Morton explained that the CCG was meeting with the Trust on a monthly basis to improve performance in this area.

2.3 Health Overview and Scrutiny Committee- 12th December 2013- NHS Quality Accounts: mid-year update- Councillor Helena Hart raised concerns following publication of the CQC's report in November 2013 about the quality of care provided at Barnet, Enfield and Haringey Mental Health Trust.

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

3.1 Barnet's Health and Well-Being Strategy (2012-15) sets out the Borough's ambitions to deliver high quality and safe health and social care services to residents that enable them to *Keep Well* and *Stay Independent* throughout the course of their lives. The Health and Well-Being Board has recently reviewed the progress being made to deliver the objectives of the Health and Well-Being Strategy, and formally agreed that improving mental health and wellbeing in Barnet would be a priority for the Board over the course of the second year of the Strategy.

3.2 Barnet, Enfield and Haringey Clinical Commissioning Groups have developed a 2-year Tri-Borough Mental Health Commissioning Strategy, and will work closely with Barnet, Enfield and Haringey Mental Health Trust to ensure effective delivery of this Strategy. The Strategy aims to ensure that local mental health services will support people in maintaining and developing good mental health and well-being; 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.

## 4. NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 Barnet's thematic JSNA refresh on mental health (2014) highlights that the prevalence of mental illness in Barnet is higher than the England average and has slightly increased over the past 5 years at a similar rate to that of England. Mental health issues can result in social isolation, loneliness or disrupted relationships, or can be the catalyst for these problems. People with mental health problems also experience significant physical health risks including obesity, diabetes, heart and respiratory diseases and have lower life expectancy.

4.2 The Health and Well-Being Board have formally committed to focus on mental health as one of its priorities during Year 2 of the Health and Well-Being Strategy, to ensure that the needs of those with mental health problems in the Borough are supported as well as possible.

4.3 The Equality Act 2010 requires that public bodies, in exercising their functions, have due regard to the need to (1) eliminate discrimination, harassment, victimisation and other unlawful conduct under the Act, (2) advance equality of opportunity and (3) foster good relations between persons who share a protected characteristic and persons who do not share it.

4.4 Racism, homophobia and other forms of discrimination affect mental health and can be an underlying cause of mental health problems. The promotion of mental well-being will contribute to addressing inequalities.

## 5. RISK MANAGEMENT

5.1 There is a risk that vulnerable residents in Barnet who are using the inpatient services on three of Barnet, Enfield and Haringey's Mental Health Trust's wards do not receive high-quality, safe care, unless performance concerns raised by CQC are adequately addressed.

5.2 The Health and Well-Being Board has an important role to play in mitigating risks to the quality and safety of local health and social care services. The Board has a responsibility to strengthen the democratic legitimacy of the NHS by involving democratically elected representatives and patient representatives in commissioning decisions alongside commissioners across health and social care. Health and Well-Being Boards should provide a forum for challenge, discussion, and the involvement of local people; the purpose of raising the quality and safety issues documented in the recent CQC report on older people's inpatient wards at Barnet, Enfield and Haringey Mental Health Trust is to engage the Board in a focused discussion on this issue and agree a collective approach across local organisations to addressing the concerns.

## 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. 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.

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 Barnet CCG invests an estimated £35 million for the provision of mental health services in Barnet. Approximately £31 million of this investment is committed 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 None at this stage.

## 9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 Barnet CCG meets regularly with Barnet, Enfield and Haringey Mental Health Trust, and the CCG commissioners in Enfield and Haringey to address quality and safety concerns.

9.2 In addition, the 3 CCGs across Barnet, Enfield and Haringey 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 tri-borough commissioning strategy including Barnet, Enfield and Haringey's Mental Health Trust's Clinical Strategy.

## 10. DETAILS

10.1 Barnet, Enfield and Haringey Mental Health NHS Trust are commissioned by Barnet, Enfield and Haringey Clinical Commissioning Groups (CCGs) to provide a range of mental health services at Chase Farm hospital. These include the following inpatient services: acute assessment wards for adults, continuing care wards for people with dementia and cognitive impairment, forensic wards, a specialist forensic ward for people with a learning disability, a rehabilitation ward, and a forensic intensive care service for people in the boroughs of Barnet, Enfield, Haringey, Camden and Islington.

10.2 In March 2013, in response to concerns, the CQC conducted an inspection on 3 wards that provide care to older people: Oaks, Cornwall Villa and Silver Birches. The CQC provides the full report of their inspection on their website - a link to the report (published on the 23rd May: http://www.cqc.org.uk/node/315856).

10.3 The Care Quality Commission (CQC) then conducted a routine inspection on the following wards at Chase Farm Hospital in late September 2013: Oaks, Silver Birches, Cornwall Villas and Bay Tree. The CQC published its inspection report in November 2013, which concluded that the Barnet, Enfield and Haringey Mental Health Trust had not implemented the learning from the earlier inspection in Oaks Ward to the other older adult wards. A link to this report can be found in the Background Documents section of this report.

10.4 Local commissioners have been working systematically with the Trust to address CQC's concerns. Since the earlier inspection on these wards, the CCGs have been collaborating with Safeguarding leads from the 3 Councils through a "Provider Concerns" meeting chaired by the London Borough of Enfield to ensure that safeguarding concerns are addressed by Barnet, Enfield and Haringey Mental Health Trust. There is also a Clinical Quality Review Group (CQRG) chaired by the Director of Quality – Enfield CCG (as the lead commissioner). The CQRG includes clinical and joint commissioners across the 3 CCGs, the Commissioning Support Unit and Barnet, Enfield and Haringey Mental Health Trust managers and meets on a monthly basis. The group provides monitoring oversight and assurance on quality and safety issues.

10.5 In July 2013, the CQRG set up an Operational Group to review progress on the implementation of the Oaks Service Improvement Plan (established to address specific safeguarding concerns raised by CQC during their visit to Oak Ward). Barnet CCG has recently reported that the Trust has been making steady progress towards meeting the objectives within the plan.

10.6 The quality issues that have been raised by these CQC reports are also being managed through the CCG's Contract Monitoring Framework with the Trust. Barnet CCG has planned a series of "Walk the Pathway" visits shortly with the Trust and has invited LBB colleagues to join these visits to facilitate collaboratively improved assurance in these areas.

10.7 Following publication of CQC's report in November 2013, Barnet's Cabinet Member for Public Health, who is also Chair of Barnet's Health and Well-Being Board, wrote formally to both the Chairman of Barnet, Enfield and Haringey Mental Health Trust and the lead commissioner at Enfield CCG, to express her concerns with the findings outlined in the this report, and she has requested further reassurance that there is action taking place to address the concerns that have been raised.

10.8 A meeting has been scheduled between senior officers across the local authority and Barnet CCG, and the top team at Barnet, Enfield and Haringey Mental Health Trust for Friday the 17th of January 2014. This meeting will provide an ideal opportunity to ensure that all partners are clear on the issues; the roles and responsibilities of each of the parties and how performance and improvement will be monitored. The meeting will also allow for the identification and agreement as to what the recommendations should be to the Barnet Health and Well-Being Board. There will be verbal feedback at the Health and Well-Being Board meeting on the 23rd January 2014 on the recommendations that are agreed on the 17th January 2014.

10.9 The Chair and Chief Executive of Barnet, Enfield and Haringey Mental Health Trust have been invited to attend the Health and Well-Being Board meeting on the 23rd January to engage with the Board on this matter. Barnet CCG has suggested the Board could usefully focus the discussion on the 23rd January around two key areas, set out below:

1. How the Trust specifically aims to address the issues in the recent CQC report, and also those issues relating to the broader set of concerns and recent inspections in the past year.
2. How the London Borough of Barnet and Barnet, Enfield and Haringey Mental Health Trust can improve communication and engagement on quality issues through, for instance, the London Borough of Barnet Safeguarding Board, and the Tri-Borough Commissioning Strategy.

## 11 BACKGROUND PAPERS

11.1 Care Quality Commission (November 2013), *Inspection Report: Chase Farm Hospital.* Available at: http://www.cqc.org.uk/sites/default/files/media/reports/RRP16_Chase_Farm_Hospital_INS1-954998402_Scheduled_23-11-2013.pdf

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AGENDA ITEM 6

| | |
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| Meeting | Health and Well-Being Board |
| Date | 23rd January 2014 |
| **Subject** | **Francis Inquiry Update** |
| Report of | Barnet CCG Chief Officer |
| Summary of item and decision being sought | An update on the Government's response to Mid Staffordshire NHS Trust. It also includes the main recommendations from that report which have significance for the CCG and sets out Barnet CCG's progress to assess its current priorities. |

| | |
|---|---|
| Officer Contributors | Vivienne Stimpson, Director of Quality and Governance<br>John Morton, Chief Officer, Barnet CCG |
| Reason for Report | To provide assurance to the Health and Well-Being Board that the CCG continues to consider and reflect on the implications of the Mid Staffordshire NHS Trust reports and system wide change necessary to improve patient safety, clinical effectiveness and patient experience. |
| Partnership flexibility being exercised | None |
| Wards Affected | All |
| Status (public or exempt) | Public |
| Contact for further information | Vivienne Stimpson, Director of Quality and Governance Barnet CCG<br>Vivienne.stimpson@barnetccg.nhs.uk |

## 1. RECOMMENDATION

**1.1 That the Health and Well-Being Board notes and supports the steps Barnet CCG is taking to address the findings of the Mid Staffordshire Inquiry. This report details the government's response to the inquiry into the events at Mid Staffordshire NHS Trust and the broad system wide changes underway to address its findings.**

## 2. RELEVANT PREVIOUS DISCUSSION AND WHERE HELD

2.1 Barnet CCG Board meeting held on 4th April 2013

2.2 Barnet Clinical Quality and Risk Committee in March 2013

2.3 Barnet CCG Board on 4th July 2013

2.4 Barnet CCG Board on 28th November 2013

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

3.1 The specific issues outlined in this report will assist the Health and Well-Being Board to deliver all key priorities in the Health and Well-Being Strategy. They will inform more specific commissioning plans developed both by the Council and Barnet Clinical Commissioning Group.

## 4. NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 Barnet Joint Strategic Needs Assessment includes information on health outcomes for the local population.

4.2 Equalities implications will be addressed through implementing the Francis report and add context to Francis recommendations.

## 5. RISK MANAGEMENT

5.1 The CCG needs to ensure the recommendations from this inquiry are fully considered in its role as a commissioning organisation.

## 6. LEGAL POWERS AND IMPLICATIONS

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

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

7.1 Additional resources may be needed to implement some of the recommendations in its report. These will need to be prioritised against CCG/LBB commissioning intentions and where appropriate funded from within existing NHS and local authority budgets.

## 8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 A report was presented to the CCG Board in July and November 2013 to begin to engage with stakeholders.

## 9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 All providers are required to prepare a response to the Francis Report.

## 10. INTRODUCTION

10.1 Initial Response to the Francis Inquiry Recommendations: Phase I

The Francis report highlighted that despite monitoring systems in place, failure to provide safe care had taken place at Mid Staffordshire NHS Trust over a long period of time. The immediate concern was to identify if similar quality and patient safety failures existed at other trusts. As a result the Keogh review was instigated where hospitals with high mortality rates were visited as part of a special inspection. It also set in motion a programme of initiatives that aim to achieve a culture change to a more caring and compassionate NHS and create safeguards to prevent, or for early detection of trusts failing in their provision of good quality of care.

In the first phase the focus was on creating greater transparency and supporting the CQC in developing and setting up a new inspection and surveillance regime so that quality and safety failure would be detected earlier. The Government started formulating legislation and actions to address failing trusts and commissioned leadership programmes for nurses and midwives, clinicians and managers to equip the NHS workforce with skilled leaders, with the right values, behaviours and competencies, across all levels of the system as well as strengthening the patient's voice. The following initiatives have been implemented prior to the formal Government Response to the Francis Report which was released on 19 November 2013.

10.2 Greater Transparency and Availability of Quality Data

To increase transparency and availability of quality data NHS England published clinical outcomes, including mortality data, by consultant, for 10 medical specialties, and has begun to publish data on the Friends and Family Test. It further announced the extension of the Friends and Family Test (FFT) to mental health, community and GP settings by the end of December 2014 to cover all NHS services by the end of 2015.

Barnet CCG is presently in discussion with all providers regarding their preparations for implementing the FFT across a wider range of services as part of the 2014/15 National Commissioning for Quality and Innovation (CQUIN) incentive. On-going assurance is also being undertaken regarding the results of the FFT across inpatient, A&E and Maternity services for 2013/14. Results will be published nationally in February 2014.

The need for better monitoring of patient safety and quality of care was addressed by the CQCs implementation of a new risk surveillance system and inspection regime. This involved:

- Appointment of 3 Chief Inspectors by the Care Quality Commission (CQC) for:

- Hospitals
- Adult social care
- Primary care

- Commencing the first wave of inspections for 18 Trusts
- Consulting on and implementing a new system of ratings to be used for inspections and a method of on-going surveillance for quality of care
- Consulting on and use in "shadow form" a new set of fundamental standards. Once approved by parliament, the fundamental standards will enable prosecutions of providers to occur in serious cases, where patients have been harmed because of unsafe or poor care, without the need for an advanced warning notice.

10.3 Changes to CQC Inspections and Risk Surveillance

In July 2013, a new CQC inspection regime was introduced. This included expert-led inspections with greater emphasis on listening to patients, service users and staff. Inspection visits will also take place at night and at weekends, with more unannounced inspections.

Mental health inspections will begin with wave one pilots in January to March 2014; followed by a second wave in April to June 2014. Ratings will be published from October 2014 for the NHS and January 2015 for the independent sector. Adult social care will also be included in inspection which will begin with wave one pilots in spring 2014 followed by a second wave in summer 2014. All social care services will have been rated by March 2016.

The Care Quality Commission is now using a surveillance system to rate hospitals' quality of care in bands ranging from outstanding to inadequate. For this the services are being risk assessed and those found to have higher risk scores will then be inspected. CQC's surveillance uses 3 sets of indicators to determine this risk. The first set will include mortality rates, Never Events and results from staff and patient surveys, as well as information from the public. This set of indicators trigger action by inspectors. The second set of indicators contains a wider range of data that supports and provides explanations for information in the first set. This includes nationally comparable information such as results from clinical audits and information from accreditation schemes. Information from people who use services, including whistle-blowers, is used when deciding where to inspect.

The first set of bandings was published in October 2013. All Trusts have been categorised into one of six summary bands, with Band 1 representing the highest risk and band 6 the lowest risk. Barnet and Chase

Farm Hospitals have been categorised into band 3, Royal Free Hospital NHS Foundation Trust have been categorised as band 2 and Royal National Orthopaedic Hospital has been given a banding of 5. All risks and elevated risks that have been identified as a result of the bandings have been discussed with Providers at the clinical quality review group meetings.

By the end of 2015 the Care Quality Commission will have conducted inspections of all acute trusts. There will be 4 categories of judgements following CQC inspections:

1. Outstanding: sustained high quality care over time across most services, together with good evidence of innovation and shared learning.

2. Good: the majority of services meet high quality standards and deliver care which is person-centred and meets the needs of vulnerable users.

3. Requires Improvement: significant action is required by the provider to address concerns.

4. Inadequate: serious and/or systematic failings in relation to quality.

Trusts aspiring to Foundation Trust status will have to achieve 'good' or 'outstanding' under the Care Quality Commission's new inspection regime to be authorised. Monitor and the Care Quality Commission will also implement a joint registration and licensing system in April 2014.

Failure to meet fundamental standards as identified through the CQC inspection and surveillance will initiate the failure regime. Clinical unsustainability will be grounds for failure procedures, including placing organisations in special measures, just as financial unsustainability is at present. The Care Quality Commission, NHS England, Monitor and the NHS Trust Development Authority will publish further guidance on how they will work together to address quality issues after April 2014. The new inspection and surveillance regime is currently operating in "shadow form". Pending parliamentary approval, changes to CQC risk ratings and application of special measures and failure regimes in failing trusts will be confirmed through the Care Bill.

10.4 Addressing 'Failing' Providers

The Government has started legislating to give greater independence and extend powers of intervention to the CQC. Expert inspections of hospitals with the highest mortality rates, led by the NHS Medical Director, have been undertaken and revealed unacceptable standards of care. Eleven hospitals were placed into 'special measures'. Legislation to introduce a responsive and effective failure regime which addresses failing providers is being progressed through Parliament. Quality failures are being given the same importance as financial failures.

10.5 Leadership and Accountability

New nurse and midwifery leadership programmes have been developed. By April 2015 10,000 nurses and midwives will have attended the programmes. A fast track leadership programme to recruit clinicians and external talent to top jobs in the NHS in England has been launched.

By the end of the 2013, 96% of senior leaders and all Ministers at the Department of Health will have time in health and care settings and gained frontline experience. The government has announced that every hospital patient is to have the name of their responsible consultant and nurse above their bed. The Government also intends to introduce a named accountable clinician for people receiving care outside hospitals, starting with vulnerable older people.

10.6 Commissioning

NHS England has published guidance to commissioners, *Transforming Participation in Health and Care*, on involving patients and the public in decisions about their care and their services.

10.7 Response to Francis Inquiry by NHS Barnet CCG

In the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (February 2013), Robert Francis QC, the Inquiry Chair, called for a 'fundamental culture change' across the health and social care system to put patients first at all times. Set out in 290 recommendations, the inquiry called for action across six core themes: culture, compassionate care, leadership, standards, information, and openness, transparency and candour. Following the initial publication of the Francis Inquiry earlier in 2013, the government formally accepted 281 of the 290 recommendations from the public inquiry. 'More openness, greater accountability and a relentless focus on safety'. At this time, Barnet CCG formulated a response that addressed all recommendations specific to commissioner responsibilities and this was set out in an action plan that was submitted to Barnet CCG Governing Body in July 2013.

Progress has been made in the following themed areas. Each area covers a number of the original recommendations outlined as specific to commissioning organisations.

10.8 Accountability/Oversight and Leadership

The CCG proposed that in relation to embedding the values and principles demonstrated within the NHS Constitution, it would work with providers to ensure that quality schedules are met as part of the contracting process. The CCG requests monthly performance reports from all its providers. These reports contain the metrics that demonstrate provider performance in delivering the NHS constitution to patients around access, quality and safety of health services and dignity in care.

Providers are also including data that relate to workforce indicators in their reporting to commissioners as part of the quality schedules within the standard contract. They include data on agency use, staff appraisal, staff absence and are monitored on a quarterly basis. Providers that are not do this are being strongly encouraged by commissioners to do so.

Issues relating to patient safety and reported serious incidents are discussed monthly at each clinical quality review group held between commissioners and providers as part of the contractual process. Providers are encouraged to discuss organisation-wide learning as a result of the investigations carried out, as well as the development of mechanisms for feeding back to staff to encourage an open and transparent reporting process for near misses and safety concerns.

Barnet CCG Director of Quality and Governance recently met with Royal Free Hospital to take further evidence regarding outstanding action plans in response to a number of grade 2 legacy Never Events. (A function transferred to CCGs from NHS London as part of the transition). The meeting was extremely positive and the Trust fielded a number of clinical experts to present the required evidence. The Trust's feedback was that they really valued the opportunity to meet with commissioners as well as the opportunity to discuss learning from safety incidents across various service lines.

10.9 A Systematic Approach to Performance and Management and Standard Setting

In relation to the policing of compliance with standards, direct observation of practice, direct interaction with patients, Barnet CCG are working collaboratively with their commissioning partners to conduct regular 'walk the pathway visits' to provider organisations that will facilitate direct observation of patient care. Visits already

undertaken have received positive feedback from providers and have fostered a more open discussion between providers and commissioners in relation to the quality of commissioned services.

Plans are in place for a regular schedule of visits throughout 2014/15. Barnet CCG Director of Quality and Governance recently conducted a walkthrough with senior clinicians at Central London Community Healthcare NHS Trust. This followed concerns that were raised by a member of the public and a subsequent review by the Director of Nursing into the standards of care provided on inpatient wards at Edgware Community Hospital. This has enabled commissioners to become more directly involved in the way providers are working to meet standards across a number of healthcare settings including the development of a more open dialogue across the system regarding how commissioners can support providers to do this.

## 11.0 COLLATION OF SOFT INTELLIGENCE AND PATIENT FEEDBACK

A number of the recommendations made in the inquiry relate to the need to deliver a more effective response to complaint management. Information regarding complaints is routinely discussed at clinical quality review group meetings, and patient feedback from other sources is triangulated with complaints data to gain a better understanding of the patient's experience of services and where they may be pockets of concern that need further investigation, including possible themes that may be emerging. All Barnet providers are collecting data on real time patient feedback through the Friends and Family Test and the outcome of this is discussed at the clinical quality review group meeting on a quarterly basis along with complaints data. North and East London CSU is developing a provider complaints dashboard to include all metrics that relate to complaints management. This will allow for comparison of provider performance across the North Central London sector as well as across Barnet.

The CCG has also implemented a 'Purple Card' system across all Barnet GP practices that allows for real time information to be collected from patients regarding any concerns that they may have about their experience of healthcare services received locally. The results of these are reviewed by the CCG's governance team and monitored for any emerging trends. These are also discussed at the CCG's Clinical Quality and Risk Committee. A number of other sources are also used to gather patient feedback such as Care Connect and the CCG is working with its partners to triangulate this data with a range of sources received through more formal channels such as provider complaints.

### 11.1 Commitment to Review the Organisational Culture

This theme sets out the principles on openness, transparency and candour. All healthcare providers across Barnet CCG have now submitted evidence of their maturity matrixes and Trust responses to the Francis inquiry that have been approved at Trust Board level. A visible focus is evidenced at clinical quality review meetings in relation to provider responsibility to delivering a programme of cultural change across the system and the need to work more closely with their commissioners. All providers have now shared their plans for responding to the inquiry with the CCG.

Barnet CCG have included a clause in all their Job Descriptions and contracts of employments regarding the duty of candour for staff. The CCG are also working on a 'Being Open' policy that will set out in detail the responsibility that the CCG has regarding this duty of openness with the public.

## 12.0 UPDATE TO GOVERNMENT RESPONSE TO THE MID STAFFORDSHIRE NHS FOUNDATION TRUST PUBLIC INQUIRY

This is the second Government response to the Francis Inquiry, *Hard Truth: The journey to putting patients first* (November 2013) which now provides a detailed response to the 290 Inquiry recommendations.

The response also addresses six independent reviews which the Government commissioned to consider some of the key issues identified by the Inquiry:

- *Keogh Review*
- *The Cavendish Review*
- *Berwick Report*
- *Review of the NHS Hospitals Complaints System*
- *Challenging Bureaucracy* (led by the NHS Confederation)
- *The report by the Children and Young People's Health Outcomes Forum*

12.1 Formal Response to the Francis Recommendation: Phase II

In its formal response to the Francis recommendations, published on 19 November 2013, the Government accepted nearly all recommendation made in the Final Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. It recognised that the measures being put in place are only the start of a process to fundamentally change the culture to ensure safe and compassionate care across the whole of the NHS. This together with putting in place measures to identify early failing services, measures to turn them around, accountability and when necessary, criminal sanctions. The new measures, as identified in the response, in combination with the phase 1 initiatives are to provide the necessary safeguards to prevent catastrophic failure of services as seen in the Mid Staffordshire NHS Trust.

The measures are summarised below:

12.2 Workforce and Safe Staffing Levels

Staffing levels will be a core element of the CQC's registration regime.

12.3 Publishing Ward Level Staffing

From April 2014, and by June 2014 at the latest, NHS Trusts will be required to publish ward level information on whether they are meeting their staffing requirements. Actual versus planned nursing and midwifery staffing will be published every month; and every six months Trust boards will be required to undertake a detailed review of staffing using evidence based tools. The first of these will take place by June 2014 and Trusts will be required to set out what evidence they have used to reach their conclusions. The second review, to be undertaken by December 2014, will use National Institute for Health and Care Excellence (NICE) accredited tools.

12.4 NICE Produced Guidance on Safe Staffing Levels

By summer 2014, NICE will produce independent and evidence based guidance on safe staffing, and will review and endorse associated tools for setting safe staffing levels in acute settings. Similar tools will then be developed for non-acute settings.

12.5 Student Nurses

Student nurses will now be required to work as health care assistants for a year prior to entering NHS funded clinical education programmes. Health Education England will be introducing values-based recruitment.

12.6 Care Certificate for Healthcare Assistants and Social Care Support Workers

This will be implemented to ensure the right fundamental training and skills to give personal care to patients and service users. The Government has commissioned Health Education England to lead this work with Skills Councils and other delivery partners.

12.7 Staff Engagement, Health and Well-being

The Department of Health has commissioned the Social Partnership Forum to develop guidance for employers on good staff engagement which will contribute to developing positive cultures of safe compassionate care.

## 13.0 ACCOUNTABILITY

13.1 Accountability across the System

In the report, the Government states its intention to have in place a clear and well-functioning system of accountability. NHS organisations and all parts of the health and care system are to be held more accountable than before to ensure the conditions for creating a culture of safe, compassionate care.

13.2 Trust Boards

In addition to the ratings and inspections led by the CQC, the Boards of Trusts are responsible for holding both their own organisation to account and accounting to the public about its performance.

13.3 CCGs

NHS England will hold clinical commissioning groups to account for quality and outcomes and for their financial performance, and will have the power to intervene where there is evidence that they are failing, or are likely to fail, in their functions.

13.4 Fit and Proper Person's Test

Monitor already requires providers not to appoint as a Director any person who is an undischarged bankrupt, individuals who have served a prison sentence of three months or longer during the previous five years, and disqualified Directors. The introduction of a new fit and proper person's test for Board level appointments is based on the Professional Standards Authority's publication Standards for Members of NHS Boards and Clinical Commissioning Group governing bodies in England will

be CQC regulated. It will enable the CQC to bar directors who are unfit, from individual posts at the point of registration. This will apply to providers from the public, private and voluntary sectors. NHS England will explore the development of parallel arrangements for CCGs.

13.5 Performance Management of Very Senior Managers in Hospitals for Failures in their Organisations

On occasion (but not always) performance management for failures in their organisation of very senior managers should result in the removal from a senior role. The Government, Care Quality Commission, the NHS Trust Development Authority and Monitor are to continue to work with NHS Employers and other interested and responsible organisations to strengthen the way that existing mechanisms operate through the redrafting of the Very Senior Managers model contract.

13.6 Wilful Neglect Applicable to Individuals and Organisations

In *A Promise to learn- A Commitment to act* Professor Don Berwick's paper recommended that there should be a new criminal offence 'in the very rare cases where individuals or organisations are unequivocally guilty of wilful or reckless neglect or mistreatment of patients'. The Government has endorsed this recommendation and will consult on proposals for legislation shortly.

## 14.0 OPENNESS AND TRANSPARENCY

14.1 Duty of Candour

Subject to Parliamentary approval, from 2014 every organisation registered with the Care Quality Commission will be expected to meet a new duty of candour. Additionally individuals will be held to a professional duty of candour through changes to professional codes and guidance. This is to include "near misses" where the professional regulators will develop new guidance to make it the professionals' responsibility to report 'near misses' for errors that could have led to death or serious injury, as well as actual harm, at the earliest available opportunity. The Professional Standards Authority will advise and report on progress with this work.

14.2 Reduction or Removal of Indemnity Cover in Breaches of "Duty of Candour"

The Government will consult on proposals about whether Trusts should reimburse a proportion or all of the NHS Litigation Authority's compensation costs when they have not been open about a safety incident. Where the NHS Litigation Authority finds that a Trust has not been open with patients or their families about a patient safety incident which turns into a claim, it could have the discretion to reduce or remove that Trust's indemnity cover for that claim. The NHS Litigation Authority will continue to make compensation payments due to patients.

14.3 A New Criminal Offence for Supplying or Publishing False or Misleading Information

Subject to Parliament, the Care Bill will make a criminal offence for the supplying, publishing or otherwise making available certain types of information that is false or misleading, where that information is required to comply with a statutory or other legal obligation. This will be applicable to care providers and to directors and senior managers who have consented or connived in (or are negligent in relation to) an offence committed by a care provider.

## 15.0 COMPLAINTS

15.1 Visible and Accessible Complaints Process

Hospitals are to make their complaints process more visible and accessible, including setting out more clearly and visibly:

- how to make a complaint
- how to get independent local support and
- informing patients of their right to complain to the Ombudsman if they remain dissatisfied

15.2 Trust Chief Executives and Boards to Take Greater Personal Responsibility for Complaints

Trust Chief Executives and Boards will be expected to take personal responsibility for complaints, for example by signing off letters and through receiving an update at each board meeting. Directors with responsibility for patient safety will be expected to give an update on complaints at each Board meeting. The Department of Health will work with NHS England to determine the most effective mechanism to achieve this. Board reports are to include the 'narrative and not just the numbers', so Boards can identify themes and recurring problems, and take action. Chief Executives are also to ensure greater clinical involvement is provided in handling complaints. This could be through offering patients a conversation with the nurse or doctor involved in the complaint, if that is something the patient wants.

15.3 Quarterly Publication of Complaints Data

Detailed information on complaints and lessons learned to be published quarterly, and looked at by CQC. This is to include the number of complaints received as a percentage of patient interventions, the number of complaints the hospital has been informed have subsequently been referred to the Ombudsman and the lessons learned and improvements made as a result of complaints. The Health and Social Care Information Centre will put complaints data into the existing NHS electronic data collection system, better enabling comparison between hospitals. Complaints will be a key part of the new Chief Inspector of Hospitals' inspections.

15.4 DH and NHS England to Obtain Feedback on Complaints Handling Satisfaction Directly from Patients

The Department of Health and NHS England are to introduce a regular and standardised way of asking people who have made a complaint how satisfied people are with the handling of their complaint, to enable comparison between hospitals.

## 16.0 REDUCING THE BUREAUCRATIC BURDEN

The bureaucracy review led by the NHS Confederation recommended three main ways to reduce unnecessary bureaucratic burden by:

- Understanding, reducing and actively policing the volume of requests from national bodies
- reducing the amount of effort it takes providers to respond to information requests
- increasing the value derived from information that is collected.

## 17.0 DIGITAL TECHNOLOGY TO REDUCE THE BUREAUCRATIC BURDEN

NHS England has introduced a Clinical Bureaucracy Index and Audit of Digital Maturity in Health and Care to support trusts in tracking how well they are using digital technology to reduce the burden of information collection on front line staff compared to their peers

## 18.0 STREAMLINING AND REDUCING THE BURDEN OF NATIONAL DATA REQUESTS

The Department of Health and every arm's length body signed a concordat for reducing the administrative burden arising from national requests for information. The concordat aims at ensuring that national requests for information are undertaken using a single transparent process and that there are significant year on year reductions in the cost and burden caused by requests for information to the front line.

## 19.0 BARNET CCG RENEWED ACTION PLAN

Further to the most recent publication detailed in the second part of this report, it is recognised that although the CCG have taken a number of steps in meeting their responsibilities to address the recommendations initially set out in the Francis report, due to the system-wide changes that are now in place since the later part of 2013 and those that are planned for 2014, a refreshed CCG plan is required. This is to ensure that Barnet CCG meet their own responsibilities as well as supporting the whole system in delivering the required changes. In response to all the proposed changes outlined above as well as work that has already taken place since early 2013, the CCG is leading a North Central London provider led workshop that will bring together all NCL providers and commissioners to enable the sharing and learning required to continue to drive up patient standards through a focus on continual quality improvement.

## 20.0 CONCLUSION

The Francis report identified that the disturbing events at Mid Staffordshire NHS Foundation Trust reflected wider systemic problems. The Government is addressing these by taking a broad, system wide approach to enable cultural change and through the implementation of the measures described in the response, to prevent such catastrophic failures of patients in future.

In supporting a programme of organisational and cultural change on such a transformation scale Barnet CCG has taken their responsibility extremely seriously and will continue to work with partner organisations to deliver the required change and to prevent further health care failings as identified at Mid Staffordshire.

## 21.0 BACKGROUND DOCUMENTS

None

| | |
|---|---|
| Meeting | Health and Well-Being Board |
| Date | 23rd January 2014 |
| **Subject** | **Healthwatch Barnet Update** |
| Report of | Healthwatch Barnet |
| Summary of item and decision being sought | This paper provides the Board with an update on Healthwatch Barnet's key actions and activities. |

| | |
|---|---|
| Officer Contributors | Selina Rodrigues, Head of Healthwatch Barnet<br>Julie Pal, Chief Executive Community Barnet |
| Reason for Report | This report provides the Health and Well-Being Board with:<br>• Information about the key actions to be undertaken by Healthwatch Barnet and where it requests input from statutory organisations.<br>• An update on priority activities for Healthwatch Barnet<br>• A summary of Barnet resident responses on health and social care<br><br>Barnet Mencap, one of Healthwatch Barnet charity partners, will provide a verbal summary of the research to date with people with learning disabilities. |
| Partnership flexibility being exercised | N/A |
| Wards Affected | All |
| Status (public or exempt) | Public |
| Contact for further information | Selina.rodrigues@healthwatchbarnet.org.uk 020 8364 8400. |

## 1. RECOMMENDATION

**1.1 That the Health and Well-Being Board notes this update report and provides comments on its content.**

## 2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 At its meeting of 25 April 2013, the Health and Well-Being Board noted a paper from Healthwatch Barnet on its establishment and initial activity. At its meeting on 26 June 2013, the Health and Well-Being Board noted a paper from Healthwatch Barnet on its activities and priority future actions.

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

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

## 4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 One of the core aims of Healthwatch Barnet is to ensure the views and experiences are heard and represented of those group with protected characteristics under the Equality Act, and with under-represented communities and individuals. Healthwatch Barnet runs targeted activities with people from protected groups (as defined in the Equality Act 2010) and its work is further enriched by our developing engagement programme with children and young people and older adults.

## 5. RISK MANAGEMENT

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

## 6. LEGAL POWERS AND IMPLICATIONS

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

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

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

## 8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 Healthwatch Barnet has distributed its Communications Strategy, which is also publicly available on the Healthwatch Barnet website.

## 9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 Healthwatch Barnet has distributed its Engagement Strategy, which is also publicly available on its website.

9.2 Healthwatch Barnet is meeting its contractual targets for engaging with a wide range of diverse communities.

## 10. DETAILS

### 10.1 INTRODUCTION

### 10.2 Healthwatch Barnet management and operational structure

10.3 Healthwatch Barnet is part of a new national network, led by Healthwatch England. It was established by the Health and Social Care Act 2012 and aims to give users of health and social care services a powerful voice locally and nationally. Healthwatch Barnet is the independent voice for residents of Barnet on health and social care.

10.4 Community Barnet is the organisation contracted to deliver Healthwatch Barnet. However, Healthwatch Barnet has its own distinct identity, strategic and operational plans, staff and volunteers and dedicated stand-alone communication and marketing materials. Healthwatch Barnet is a consortium of charity partners which ensures a broad reach to Barnet's diverse communities. The partners are Citizens Advice Bureau (which operates the information, advice and signposting service for residents), Advocacy in Barnet, Age UK, Barnet Carers Centre, Barnet Mencap, Community Barnet's Children and Young People Team and Parenting Consortium, Barnet Centre for Independent Living, Home-Start Barnet, Jewish Care and Mind in Barnet.

10.5 Healthwatch Barnet staff team consists of the full-time Head of Healthwatch, the Volunteer and Projects Officer, Communications Officer and Engagement Officer (all part-time). The post of part-time Policy and Research Officer is currently being recruited.

### 10.6 HEALTHWATCH BARNET'S VISION, AIMS AND OBJECTIVES

10.7 Healthwatch Barnet's vision is for a thriving, active community of residents, patients, volunteers and organisations that contribute to the development of quality health services in the Borough. Healthwatch Barnet will:

- have a powerful relationship with Barnet residents, volunteers and service-users to gather and represent their views and experiences and capture and present the voices of under-represented communities;
- promote and support the involvement of people in the monitoring, commissioning and provision of local care services;
- signpost individuals to advice and information to help them make informed choices about their health and social care.

10.8 Healthwatch Barnet delivers a range of projects which are both determined by its statutory responsibilities or developed in direct response to national or local evidence and need.

10.9 Healthwatch Barnet has a seat on the Health and Well-Being Board and Barnet CCG Board, through which it reports on experience and evidence of local residents on the quality and delivery of health and social care.

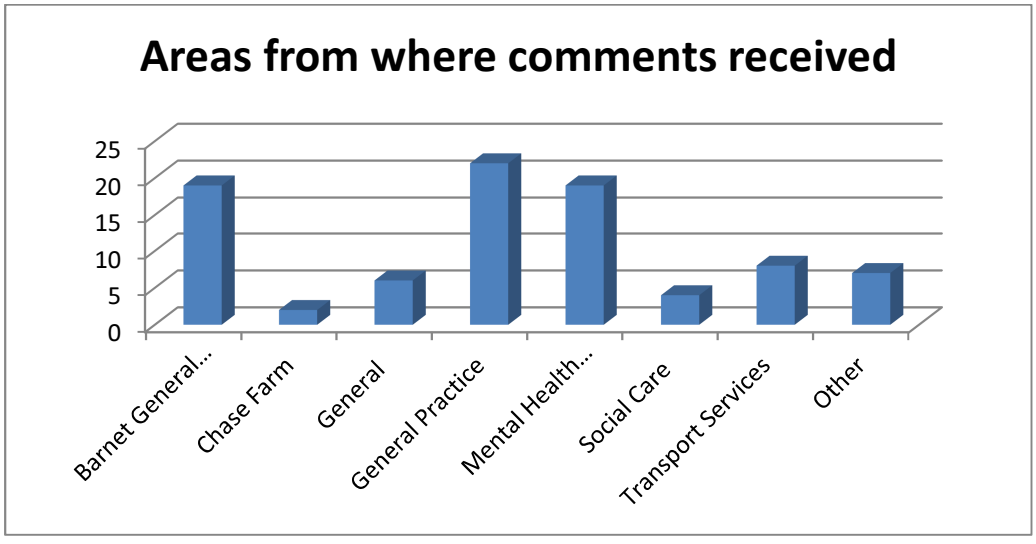
10.10 **REPRESENTATION OF USER VOICE AND EXPERIENCES**

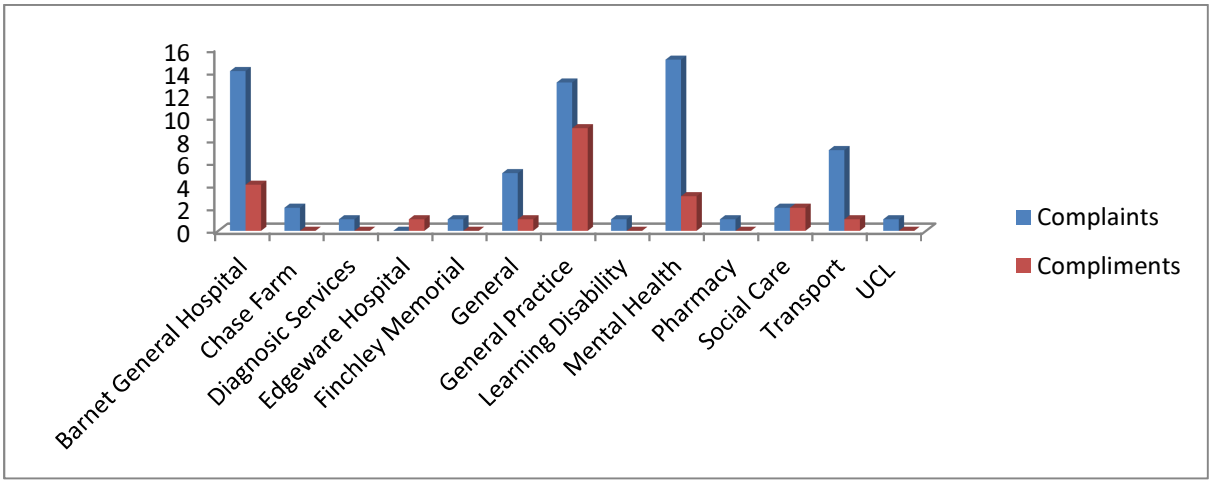
10.11 **Healthwatch Barnet Reach and Engagement (On-going)**

10.12 To date, Healthwatch Barnet, supported by the extensive reach of its partner organisations have reached 23,383 contacts, providing information and updates about Healthwatch. Staff have met with or attended the events, including internal business meetings and public community meetings, of 63 charity and community organisations, (757 contacts), to present information, and receive feedback on Healthwatch Barnet activity to date and to gather residents' experiences of health and social care. From January, Healthwatch Barnet ambassadors are available to meet with community groups to gather experiences of health and social care.

10.13 **Data summary**

10.14 Healthwatch Barnet has received 86 comments, compliments or complaints about health and social care services. A summary of this feedback is presented below.






10.15 The initial feedback predominantly relates to health rather than social care. Respondents highlighted concerns about access to GP appointments; noise on wards and support to patients using ward facilities; concern about attitudes of staff to different communities; translation services and GP expertise on mental health; hospital transport. The compliments primarily related to the quality of staff liaison with patients.

10.16 It is important to emphasise that this initial feedback is anecdotal. Healthwatch Barnet aims to increase the volume and range of feedback on services through a number of communication tools and will present further detailed data in due course.

10.17 **Action:** Although the feedback is not conclusive at this stage, action is underway in these areas. The Healthwatch Barnet GP Project focuses on the appointment system; Healthwatch Barnet is liaising with the CCG on key communities with which to consult on its Equality Strategy; and the CCG is focusing on GP expertise on mental health. Healthwatch Barnet is keen to receive any further guidance from statutory bodies on how it can input into effective hospital transport.

**10.18 The Healthwatch Barnet Engagement Group (on-going)**

10.19 This is an advisory forum, comprising of ten volunteer residents, who represent a range of Barnet's communities. Its role is to provide expertise, feedback and informed opinions on Healthwatch Barnet's priorities and projects and members contribute to projects, events and activities. It has positively contributed by identifying and developing work with older adults and the hospital enter and view visits and in developing the scope of Healthwatch Barnet's public meeting in November. The volunteers also represent Healthwatch Barnet on a range of statutory committees, including the Partnership Boards, hospital patient forums and CCG strategy groups.

10.20 The Engagement Group plan to deliver a formal response to Healthwatch England's national consultation on rights and responsibilities.

10.21 Healthwatch Barnet Engagement Group is keen that Healthwatch operates as an effective, active organisation that contributes to real change in services, and does not merely listen to and report on residents' views.

**10.22 Healthwatch Barnet Public Meeting, Listening and Responding**

10.23 The aims of this event, outlined by Councillor Hart, were to update residents on our activities as part of Healthwatch Barnet's commitment to represent and be accountable to local people and for residents to be informed of health developments, including Barnet Council Public Health review of the Joint Strategic Needs Assessment and Barnet CCG's work to monitor the quality of services in the Borough. A member of the Engagement Group also spoke passionately about user-voice and why residents should get involved. In addition to a question and answer session, participants could booked one-to-one sessions with Healthwatch and Barnet Citizens Advice Bureau to relate their experiences of health and social care and to receive specific advice from the CAB. Participants could also get information and guidance from organisations such as Jewish Care, Barnet Mencap, Barnet Carers Centre, and Voiceability and from HWB Enter and View and GP Groups. Evaluation forms, completed by a third of participants, were uniformly positive, with a third of respondents taking further action as a result of the event.

10.24 **Enter and View (On-going)**

10.25 Healthwatch Enter and View (E+V) representatives have statutory powers to enter health and social care premises to observe and assess the nature and quality of services and obtain the views of the people using those services. Healthwatch Barnet review care homes for older people and services for people with mental health conditions and will be commencing E+V visits to hospital wards in January 2014. The reports are sent to the manager of the facility. In addition, for residential care, reports are then sent to Barnet Council Safeguarding Overview and Scrutiny Committee and to senior social care and safeguarding officers of the Council. Reports on health services are sent to the Health Overview and Safeguarding Committee and senior CCG staff. All reports are sent to the Care Quality Commission and the Care Quality and Safeguarding Teams in Barnet Council, with whom Healthwatch Barnet meet quarterly. All reports are published on the Healthwatch Barnet website.

10.26 The Enter and View Group is chaired by a volunteer and volunteers actively develop the priorities and activities for the programme. To date we have undertaken twenty-one E+V visits to different locations.

10.27 **Residential care homes**

10.28 Two-thirds of the care homes Healthwatch Barnet have visited have made changes as a result of recommendations from the E+V visit. Urgent issues of concern have been highlighted directly to the Council's Care Quality Team.

10.29 Two care homes did not respond to recommendations to check that residents can summon staff quickly and easily. Of these, one home was subsequently inspected by the CQC and one was re-visited by the Enter and View team.

10.30 Residents and staff have commented that it is difficult to arrange dentist or doctor visits when treatment is needed for one resident.

10.31 Residents expressed concerns about food in three settings, with only one care home confirming the issue would be rectified. There were a number of comments about activities, including the need to provide activities, particularly regular physical exercise. Five out of the nine providers said they would follow this up.

10.32 As there are emerging trends regarding visits from dentists and doctors, food and activities, the Enter and View Team will explore and follow this up in more detail, with guidance from the CQC. Residents and staff from three care homes wished to note that the new online parking ticket system was not considered user-friendly especially for older people who were visiting their relatives. Healthwatch Barnet has raised the outstanding issues with Barnet Council Care Quality Team and will follow this up at the next quarterly meeting.

**10.33 Mental health**

10.34 The E+V teams have visited the Ken Porter, Barnet General and Thames ward within the Denis Scott unit in Edgware Hospital and also received feedback from three people after the visit. Patients and relatives commented positively on individual staff and observed that activity had improved for patients in Ken Porter ward. However concern was expressed about the lack of physical and other stimulating activity for patients, the quality of food and it was noted that all complaints and compliments should be recorded, including oral feedback from patients and relatives. This was reported to the Health Overview and Scrutiny Committee in December 2013. The Head of Healthwatch Barnet and Community Barnet Chief Executive Officer are due to meet with representatives from Barnet, Enfield and Haringey Mental Health Trust.

10.35 Healthwatch Barnet is very concerned about the Care Quality Commission reports on mental health wards at Chase Farm hospital and has asked the Health Overview and Scrutiny Committee to indicate if there are further areas it would be useful for Healthwatch Barnet to research or about which to gather service-users' feedback

10.36 **GP Group (On-going)**

10.38 The Healthwatch GP Group was established in response to residents' concerns about the GP appointment system. It is chaired by volunteers who are actively involved in developing the priorities and activities for the group.

10.39 Its first report, *Patient Access to GP Appointments* examined patients' experience of the appointment system was launched at a joint LINk/CCG public meeting in November 2012. The second report, *The GP Appointment System, The Way Forward* presented the staff viewpoint and identified the improved systems and communications that some practices had implemented, to positive effect. It also highlighted concerns about physical access into and in the buildings. This was presented to the informal CCG Board meeting, to the Practice Manages Forum and the Local Medical Committee in the autumn. A representative from the LMC commented the report "was a breath of fresh air". Through the winter, HealthwatchBarnet will meet with practice managers to encourage appropriate access and communication for people with physical and learning disabilities (in partnership with Sense and the Physical and Sensory Impairment Partnership Board) and to help develop communication plans to inform patients on how to use the GP service appropriately, maximising access to appointments.

10.40 Healthwatch Barnet recognises that the volume of patient need and appointment times are a challenge to the NHS nationally. Barnet CCG has supported the GP Groups' aims and activities to date. Healthwatch Barnet requests NHS England London region and Barnet CCG's continued support in encouraging GPs to implement simple and low-cost and no-cost changes that will produce a better quality experience for patients.

10.41 **People with learning disabilities (Oct 2013 – Feb 2014)**

10.42 Barnet Mencap has carried out focus groups, individual sessions and surveys with people with learning disabilities, their families and carers. A verbal report will be presented by the Chief Executive of Barnet Mencap to the HWBB meeting and a full written report will be presented to Health and Well-Being Board members, Barnet CCG and Lead Commissioners in early February 2014.

10.43 Healthwatch Barnet and Barnet Mencap will then request a formal response from relevant statutory partners or providers to their report with details of how the recommendations will be followed up, alternatives suggested or explanations as to why changes cannot be implemented.

**10.44 Older Adults (Jan to Mar 2014)**

10.45 Healthwatch Barnet is at the project planning stage for its consultation and engagement with older adults. The projected growth of Barnet's older adults population means that we need to establish mechanisms of engagement now so that we can reach the current cohort but also those who are projected to enter this cohort over the next 10 years. Healthwatch Barnet is liaising with Barnet Council's Later Life Lead Commissioner to identify specific feedback that would be helpful, to inform future development or commissioning.

10.46 **Community Barnet Children and Young People (Jan to Apr 2014)**

10.47 A Healthwatch project team, which includes young people, will deliver a mini road show to approximately one hundred and fifty young people, to gather their views on health issues and social care issues, visiting key fora, such as the Youth Board, young carers, sixth form colleges, sports clubs and faith youth groups and young people with disabilities and who use mental health services An online survey has also been developed. It is anticipated that the findings will be presented at an event led by young people in late March/early April 2014. A dedicated Healthwatch Barnet web-page for children and young people will be created.

10.48 **Community Barnet Children and Young People/Gypsy, Roma, Traveller/Munya (Jan to Mar 2014)**

10.49 Healthwatch Barnet has met with the Gypsy Roma Traveller community, which meets in High Barnet and Munya, the Irish Traveller group, based in Collingwood. We are encouraging CCG and hospital leads to engage with the High Barnet group. In partnership with Healthwatch Barnet and the Royal Free Hospital, Munya will devise a community event to raise awareness of diabetes.

10.50 **Home-Start Barnet consultation (Feb – Mar 2014)**

10.51 Home-Start Barnet support families with young children. It will carry out focus groups with parents in Barnfield, Canada Villa and Grahame Park, to include questions about maternity services, presenting to and referral by GPs to maternity services, caesarean sections, induced labour, post-natal care and the promotion and take-up of birthing centres. These areas have been developed in consultation with Barnet CCG commissioning lead for maternity and children services.

10.52 **Barnet Centre for Independent Living (Feb-Mar 2014)**

10.53 BCIL will undertake community research into residents' experience of the complaints process in Barnet, Enfield and Haringey Mental Health Trust during 2014. This is in response to comments about the effectiveness of the service. It will align with Healthwatch Barnet's overall review of and report on complaints systems in the Borough (see below).

10.54 The outcome and recommendations from these consultations will be taken up with relevant providers and statutory partners.

**10.55 Communications (On-going)**

10.56 Healthwatch Barnet has a fully functioning website, which is updated weekly, and charity partners also promote events, activities and consultations. Regular Twitter messaging takes place weekly. Coverage of Healthwatch Barnet has appeared in Barnet First, Your Life and Barnet Times. The Enter and View Programme is also featured in Barnet Council's Social Care Connect portal. Publicity about Healthwatch Barnet has been disseminated to GPs, hospitals, pharmacists and dentists and through the Community Barnet CYP network.

10.57 Healthwatch Barnet aims to increase its local and regional profile through concerted marketing and promotional initiatives in the next months.

10.58 **INVOLVEMENT OF LOCAL PEOPLE IN COMMISSIONING, MONITORING AND PROVISION OF SERVICES**

10.59 **Healthwatch Barnet liaison with statutory services**

10.60 Healthwatch Barnet staff have communicated these priorities and activities through meetings, its newsletter and website to statutory sector partners (including Barnet CCG, Barnet Council and health and social care providers) to charity sector organisations and residents.

10.61 Although a key role for Healthwatch Barnet is to question and challenge service providers and commissioners, we are also keen to work in partnership with statutory commissioners and providers to develop and deliver high-quality, effective patient engagement.

10.62 To support this, Healthwatch Barnet request that the Barnet CCG and Barnet Council share their commissioning and engagement plans during their developmental stage so that we could dovetail these activities with our own engagement plans. By taking this approach we would hope to reduce the risk of engagement/consultation fatigue for service users and patients.

10.63 **Barnet Health and Social Care Integration (HSCI) Programme**

10.64 Healthwatch Barnet is working in partnership with the Health and Social Care Integration Programme. Healthwatch Barnet has delivered two focus groups to date; there are plans for the HSCI Programme to utilise Healthwatch Barnet's networks to further consult on key project proposals, systems and operations.

10.65 **HSCI Focus Group: Branding Identity Focus Group (Nov 2013)**

10.66 Healthwatch Barnet organised eight resident volunteers to participate in this focus group, led by Barnet Council. Barnet Council asked Healthwatch volunteers for their feedback on new branding; the group created a new strapline, which they recommended the Council uses.

10.67 **HSCI Focus Group: Frail elderly and long-term conditions (Dec 2013)**

10.68 Healthwatch Barnet organised nine volunteer residents to participate in this focus group, led by Ernst and Young on behalf of Barnet Council and Barnet CCG. The consultants noted that the group was representative of Barnet communities and the input "very valuable in providing insight into the experiences of service users and patients". Key recommendations from the focus group included:

- Carer or service-users' input is an integral part of the development of services. It's important that this engagement is meaningful and not lip service and as such, regular feedback to the participants on the development of services is important.
- Dedicated, named key contacts are essential to patients/service-users being supported and informed on services. In addition, accessible high-street locations are vital to ensure good awareness and take-up of health and social care. Transport is key to communities accessing services, particularly those less active and residents with lower incomes. Support services and effective communication are essential to ensure diverse communities understand the availability of services.
- IT and other processes and systems must be joined up between health and social care.
- The charity sector provides a range of wellbeing and prevention services so should be consulted and involved in the development of future health and social care integration.
- Budget-holders safeguard their budgets. People are referred to other services, only to be told there is no funding or they are not entitled to medical or social care.

10.69 **Public Health Heath Checks Review (Nov 2013)**

10.70 Healthwatch Barnet organised seven volunteer residents to participate in this focus group, to identify the barriers to and ways to increase the take-up of Health Checks. The consultant commented that the Healthwatch Barnet has a "strong well-established network of people from various backgrounds who are able to engage intelligently and assertively in discussions around health."

10.71 **Barnet CCG Equality Strategy**

10.72 Healthwatch Barnet has identified and will provide some of the networking and consultation links for the CCG Equality staff. To date, Barnet CCG has confirmed meetings with the new Barnet Migrant and Refugee Forum and the Supplementary Schools Forum (both supported by Community Barnet). We are also recommending that the CCG engages with Munya (the Irish Traveller movement) and the Gypsy, Roma Traveller project, the Parenting Consortium and the children and young people's network, to ensure there are responses from a range of Barnet communities.

10.73 As part of the essential good practice in engagement, Healthwatch Barnet requests that the HSCI programme and commissioners provide timely feedback to the focus groups details of how the recommendations will be followed up, alternatives suggested or explanations as to why changes cannot be implemented

**10.74 Complaints and patient feedback**

10.75 The Healthwatch England Annual Report 2012/13 stated that three out of five people don't know how to give feedback on services. As reported to the

Health and Well-Being Board in July 2013, Barnet residents are confused about the new NHS structures, including the new processes for proving compliments, comments and complaints to health service providers. The Government review of the complaints process, "Putting Patients Back in the Picture" published in October 2013, highlighted similar issues.

10.76 Healthwatch Barnet undertook a mystery shopping exercise at GP surgeries to see how easy it is for patients to give comments/compliments/complaints. We visited eleven practices (which is 15% of those in Barnet). Of these, seven had no information about how to give feedback or make complaints; six provided leaflets that they handed out when asked and two asked for the contact details of the enquirer before they would give any information (we think this is bad practice).

10.77 Healthwatch Barnet will be contacting these surgeries to recommend that feedback systems are implemented and publicised and will carry out follow-up visits. The CCG will be requested to provide a reminder about complaints and feedback systems through the GP e-bulletin.

10.78 Healthwatch England is leading a national project to improve the complaints process. To support this Healthwatch Barnet will therefore produce a short report on patient experiences, including succinct case studies, to be presented to providers for their response. Healthwatch Barnet will also then circulate the report to Healthwatch England, NHS England (London region), the CQC, CCG Board and staff and the Health and Well-Being Board.

10.79 Healthwatch Barnet is currently recruiting a new Policy and Research Officer. This post will be central to our monitoring of local providers performance and will also support our community research function.

10.80 **Statutory sector engagement**

10.81 Healthwatch Barnet has met with patient engagement leads within the CCG, Barnet and Chase Farm Hospital and The Royal Free Hospital.

10.82 Healthwatch Barnet will liaise with Barnet CCG and providers to understand, support and respond to their developing engagement plans.

**10.83 SIGNPOSTING INDIVIDUALS TO ADVICE AND INFORMATION**

10.84 This service is provided by Barnet Citizens Advice Bureau. The rate of usage of this service is in line with other providers nationally. A communications group has been established across the consortium to further push the ‘Healthwatch’ brand – this is also a key priority for Healthwatch England. The key themes that have emerged through this service include enquiries about NHS charges, prescription charges and low income subsidies. Requests for the location of health and social care services has been lower than expected. Due to a system change at the CAB, updated details of the service can’t be included in the paper, but a verbal update will be provided at the meeting.

## 11 BACKGROUND PAPERS

11.1 None

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AGENDA ITEM 8

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|---|---|
| Meeting | Health and Well-Being Board |
| Date | 23rd January 2014 |
| **Subject** | **Contract management of Healthwatch Barnet** |
| Report of | Adults and Communities Director |
| Summary of item and decision being sought | To provide an update on the performance of Healthwatch Barnet since its establishment in April 2013. The Health and Well-Being Board are asked to give their views on whether any improvements can be made to the arrangements set out in this report. |

| | |
|---|---|
| Officer Contributors | Sarah Perrin, Interim Customer Care Service Manager, Adults and Communities<br>Mathew Kendall, Assistant Director, Community and Wellbeing, Adults and Communities |
| Reason for Report | To discuss how the performance of Healthwatch Barnet has been monitored since its establishment in April 2013 and how it will be monitored in 2014/15. |
| Partnership flexibility being exercised | N/A |
| Wards Affected | All |
| Status (public or exempt) | Public |
| Contact for further information | Sarah Perrin, Interim Customer Care Service Manager,<br>020 8359 3487, sarah.perrin@barnet.gov.uk |

## 1. RECOMMENDATIONS

**1.1 That the Health and Well-Being Board notes the progress of Healthwatch Barnet in relation to its statutory functions.**

**1.2 That the Health and Well-Being Board reviews the progress being made by Barnet Council to manage the contract with CommUNITY Barnet for the delivery of Healthwatch Barnet and comments as appropriate.**

## 2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

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

2.2 Health and Well-Being Board- Healthwatch Barnet Update- 27th June 2013.

2.3 Health and Well-Being Board- Healthwatch procurement- 26th July 2012.

2.4 Cabinet Resources Committee, Monday 25 February 2013 - *to deliver Barnet Healthwatch in the sum of £592,083 (£197,361 per annum) be awarded to Community Barnet with an expiry date of 31 March 2016, with the option for a further extension of up to two years in accordance with the contract (total contract value £986,805).*

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

3.1 Healthwatch Barnet is the primary vehicle through which users of health and care in the Borough have their say and engage with statutory services. Healtwatch Barnet is the consumer champion voice for health and social care users in Barnet and ensured that their voices and concerns are heard.

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

## 4. NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

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

4.2 One of the specific objectives in the tender specification, endorsed by the Health and Well-Being Board, was to engage all parts of the community including those traditionally underrepresented communities – specifically young people and disabled people - and harder to reach communities and support their participation. This is an area which is monitored as part of the contract.

## 5. RISK MANAGEMENT

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

5.2 The contract monitoring meetings were on a monthly basis following Healthwatch Barnet's official launch in May 2013. This frequency helped clarify aspects of the contract monitoring framework, and assist, where necessary, in the development of Healthwatch Barnet's work plan. From November 2013 contract monitoring meetings are being convened on a quarterly basis.

5.3 The contract monitoring meetings between council Officers and the Head of Healthwatch Barnet and Chief Executive of CommUNITY Barnet use the performance framework to review the progress that Healthwatch Barnet is making on delivering the targets that have been set. The meetings also ensure that action plans are in place to meet any indicators that might need to be addressed further. The meetings offer the opportunity to discuss any issues and emerging risks.

## 6. LEGAL POWERS AND IMPLICATIONS

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

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

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

## 8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 The Healthwatch contract includes targets for engagement and representation. Healthwatch Barnet uses a range of methods and forums to engage with residents, which includes networks, partnership boards, patient and public meetings, the Signposting service and online and social media. Healthwatch staff and volunteers are currently liaising with organisations and individuals in all these areas. An engagement plan has been developed in consultation with Healthwatch members and residents.

8.2 The Healthwatch Barnet Engagement Strategy sets out that Healthwatch Barnet will:-

- Work with residents and health and social care service users to listen to their views and experiences.
- Liaise with health and social care providers to ensure that the views of people are heard.

8.3 The Healthwatch Barnet's Engagement Activity Plan outlines that a Healthwatch Engagement Group would be set up and this has been completed. This group comprises of 10 volunteers and reports to and is supported by Healthwatch Barnet staff.

8.4 The Engagement Activity Plan also proposed that through their Communication Strategy Healthwatch Barnet would be promoted as the consumer voice for health and social care users and that this would be achieved through a number of methods such as:

- Establishing a dedicated website with Healthwatch specific branding where information, advice and signposting is provided.
- Cascading information through the Healthwatch Barnet Twitter and Facebook accounts.
- Publishing a monthly newsletter.
- Delivering the Information, Advice and Signposting service.

8.5 One of the key challenges for Healthwatch Barnet since its official launch has been establishing itself as a new organisation that is separate from CommUNITY Barnet and that it is resident led. Whilst Healthwatch Barnet is reaching many of the targets in its Engagement strategy (as detailed above), this area will continue to be regularly reviewed in contract monitoring meetings.

8.6 Healthwatch Barnet held a public meeting on 26th November 2013 to update residents about their progress, and outline some of their key priorities over the next six months.

## 9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

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

## 10. DETAILS

10.1 <u>Background</u>

The key roles of a local Healthwatch are to:

- Ensure that the views and feedback from people who use services, carers and members of the public are integral to local commissioning.
- Provide support to people and help them to make choices about services. In particular, those who lack the means or capacity to make choices; for example, helping them choose which GP to register with;
- Help people to make complaints;
- Provide intelligence for Healthwatch England about the quality of providers.

10.2 The duties of Healthwatch, set out in the Local Government and Public Involvement in Health Act 2007 s221 as amended and in the Health and Social Care Act (2012), have been summarised by the Department of Health as follows:

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

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

10.3 Healthwatch Barnet is assessed against these duties through the contract management arrangements put in place by Barnet Council, as the service commissioner.

10.4 Aims of contract between Barnet Council and Healthwatch Barnet

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

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

10.5 Service delivery

Healthwatch Barnet is assessed against the following areas (as set out in the contract):

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

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

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

10.6 Key principles

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

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

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

10.7 <u>The contract</u>

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

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

- Contract sponsor – Mathew Kendall, Assistant Director (Community and Wellbeing).
- Contract Manager – Sarah Perrin, Interim Customer Care Service Manager, with support from Andrea Breen, Head of Prevention and Wellbeing.

10.9 To ensure successful implementation of the Healthwatch Contract, the Council has provided dedicated resource and support. The Contract Management meetings were held monthly following the launch of Healthwatch Barnet, and from November 2013 these meetings are held quarterly. Regular email and telephone contact between meetings with the Contract Manager and Head of Healthwatch Barnet ensures on-going support.

10.10 Key activities, achievements and outputs:-

- Contract monitoring meetings have taken place as per the agreed scheduling with all performance reports being received by Council Officer's from Healthwatch Barnet.

- Year One work plan was specified and agreed and Healthwatch Barnet have been working to this.

- Some of the recommendations arising from Enter and View visits have been implemented, such as more staff wearing name badges within residential care homes, improving activities for residents in care homes, raising concerns where menus may need improvement.

- Healthwatch Barnet volunteers carrying out Enter and Views undertook training specific to this task and received half a day's training on safeguarding procedures.

- Over the next 6 months Healthwatch Barnet will be developing its work plan for year two and submitting its annual report. The annual report will allow Healthwatch Barnet to showcase its achievements, identify any areas for improvement, and share their vision for the year ahead.

- Healthwatch Barnet has been involved in a number of consultations. This included a survey asking people with Learning Disabilities about their experiences of using health services. They are working with Barnet CCG and the council to carry out a consultation with older people as part of the Integrated Health and Social Care project.

- Healthwatch Barnet have so far engaged with 661 contacts (this was by the end of Quarter 2) and has a target of engaging with 1000 people by the end of year one.

- Healthwatch Barnet have engaged with small and/or marginalised communities with poor health outcomes, such as the Gypsy, Roma, Traveller community and people with learning disabilities through the Barnet Mencap project. They plan to consult with children and young people and older adults during Quarter 3.

- The information advice and signposting service is operational and is receiving positive feedback. This service is currently provided by Barnet Citizens Advice Bureau and the current rate of usage of this service is in line with other providers nationally. The key themes that have emerged through this service include enquiries about NHS charges, prescription charges and low income subsidies. From April 2013 to mid-November 2013 the Information advice and signposting service has received 200 calls.

- A key priority moving forward is for Healthwatch Barnet to enhance their information, advice and signposting service. Contract monitoring meetings will explore this priority further over the next six months.

## 11 BACKGROUND PAPERS

11.1 None.

Legal – LC
CFO – JH

AGENDA ITEM 9

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| Meeting | Health and Well-Being Board |
| Date | 23rd January 2014 |
| **Subject** | **Minutes of the Financial Planning Sub-group** |
| Report of | Strategic Director for Communities |
| Summary of item and decision being sought | This report is a standing item which presents the minutes of the Financial Planning Sub-group and updates the Board on the joint planning of health and social care funding in accordance with the Council's Medium Term Financial Strategy (MTFS) and Priorities and Spending Review (PSR), and Barnet CCG's Quality Improvement and Productivity Plan (QIPP) and financial recovery plan. |

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| Officer Contributors | Claire Mundle, Commissioning & Policy Advisor- Public Health/ Health & Well-Being |
| Reason for Report | To note the minutes of the previous Financial Planning sub-group meeting on the 13th December 2013. |
| 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 |
| Status (public or exempt) | Public |
| Contact for further information | Kate Kennally, Strategic Director for Communities, kate.kennally@barnet.gov.uk, 020 8359 4808 |
| Appendices | Minutes of the Financial Planning Group, 13th December 2013. |

## 1. RECOMMENDATION

**1.1 That the Health and Well-Being Board notes the minutes of the Financial Planning Group of 13th December 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 sub-group 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 sub-group has identified this as a key priority risk to mitigate, and the group works to align timescales and leadership of relevant work plans which affect both health and social care.

## 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 Under the Health and Social Care Act 2012, a new s2B is inserted into the National Health Service Act 2006 introducing a duty that each Local Authority must take such steps as it considers appropriate for improving the health of the people in its area. The 2012 Act also amends the Local Government and Public Involvement in Health Act 2007 and requires local authorities in conjunction with their partner CCG to prepare a strategy for meeting the needs of their local population. This strategy must consider the extent to which local needs can be more effectively met by partnering arrangements between CCGs and local authorities, and at 195 there is a new duty-- Duty to encourage integrated working:

*s195 (1) A Health and Wellbeing Board must, for the purpose of advancing the health and wellbeing of the people in its area, encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner.*
*s195 (2) A Health and Wellbeing Board must, in particular, provide such advice, assistance or other support as it thinks appropriate for the purpose of encouraging the making of arrangements under section 75 of the National Health Service Act 2006 in connection with the provision of such services.*

6.3 As yet, there is no express provision in statute or regulations which sets out new integrated health budgets arrangements, and so the s75 power remains.

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 Ernst and Young were commissioned by the Financial Planning sub-group to estimate the health and adult social care savings that integration across these services will bring. This work will be completed during January 2014, to inform both the Better Care Fund application, and the locally set saving plans and investment priorities (i.e. the MTFS and PSR for the local authority, and QIPP and the financial recovery plan for the CCG).

7.2 Projects and enablement schemes linked to Section 256 funding are reviewed by the Financial Planning sub-group 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 In August 2013, the Financial Planning sub-group commissioned Ernst and Young to develop the integrated care model for frail elderly/ people with long term conditions. Ernst and Young developed a Stakeholder Engagement Plan to make sure that they consulted with relevant stakeholders to develop the model for integrated care. They have conducted a number of workshops over the past three months to engage with users and stakeholders and actively used this feedback to inform the detail of the model they produced.

8.2 The Financial Planning sub-group will also 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 Ernst and Young have engaged with providers to shape the integrated care model through a series of workshops to inform the detail of their work. The most recent version of their model was presented to the Health and Social Care Integration Board on the 8th January 2014, for their comments and approval.

9.2 The Financial Planning sub-group will also 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 sub-group to co-ordinate financial planning and resource deployment across health and social care in Barnet. The financial planning sub-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 sub-group held on the 13th December are included in Appendix A.

10.3 The Health and Well-Being Board is asked to note the progress that has been made to develop an Outline Business Case for health and social care integration. The work has focused on the services that are needed to support frail elderly residents, and those with long-term conditions.

10.4 Ernst and Young were commissioned to lead this piece of work on behalf of the local authority and CCG. Since developing a high-level model in Phase 1 of their commission, they have worked with local partners to fulfil the following brief (Phase 2):

- Mapping current service expenditure across health and social care
- Assessing the interventions/ service changes that will support the delivery of a successful model (this will include identifying examples of good practice from elsewhere that can be included in the model)
- An options appraisal of the delivery vehicles that will support the model with recommendations on the preferred option

10.5 The Financial Planning sub-group delegated responsibility for this work to a Health and Social Care Integration Steering Group, led by the Adults and Communities Director, and the Chief Officer of Barnet CCG. The Group met formally for the last time with Ernst and Young on the 8th January 2014, to review the latest draft of the Outline Business Case and agree future actions required to complete this work. The intention is for this Outline Business Case to be completed during January 2014, at which point the commission with Ernst and Young will come to an end.

10.6 The Outline Business Case will inform both the Better Care Fund application (that will be submitted to NHS England on the 14th February 2014), and Barnet's locally set saving plans and investment priorities (i.e. the MTFS and PSR for the local authority, and QIPP and the financial recovery plan for the CCG). The Financial Planning sub-group will use the Outline Business Case to make its future investment decisions, and will as such be a key strategic driver for spend across health and social care over the coming years.

10.7 The Health and Well-Being Financial Planning Group met on the 13th January 2014 to review the draft Better Care Fund submission that will be presented to the Health and Well-Being Board on the 23rd January 2014. The Financial Planning Group considered what the size and scope of the Better Care Fund should be; the definition of protecting social care services; the relationship between the Public Health commissioning intentions and the Better Care Fund; and local performance measures. The recommendations from these discussions will be presented to the Health and Well-Being Board on the 23rd January.

10.8 The Health and Well-Being Financial Planning Group also noted that an updated schedule to the Section 75 agreement for frail elderly has been developed for sign-off by Barnet CCG and the London Borough of Barnet by the end of January 2014.

## 11 BACKGROUND PAPERS

11.1 None.

Legal – LC
CFO – JH

**Minutes from the Health and Well-Being Board – Financial Planning Group**
**Friday 13th December 2013**
**NLBP**
**9.30 -11.30am**

**Present:**
(KK) Kate Kennally (Chair), Director for People, London Borough of Barnet (LBB)
(JM) John Morton, Chief Officer, Barnet Clinical Commissioning Group (CCG)
(MOD) Maria O'Dwyer, Director for Integrated Commissioning, Barnet CCG
(DW) Dawn Wakeling, Adults and Communities Director, LBB
(MK) Mathew Kendall, Assistant Director, Adults & Communities, LBB
(HMG) Hugh McGarel-Groves, Chief Finance Officer, Barnet CCG

**In attendance:**
(NS) Neil Sartorio, Director, Ernst & Young (E&Y)
(JB) James Beard, Senior Consultant, E&Y
(HS) Helen Sunderland, Senior Manager, E&Y
(KA) Karen Ahmed, Later Life Lead Commissioner, LBB
(AD) Anisa Darr, Head of Finance, LBB
(CM) Claire Mundle, Policy & Commissioning Advisor, LBB

**Apologies:**
(JH) John Hooton, Assistant Director of Strategic Finance, LBB
(EW) Edith Wellwood, Advisor, E&Y

| | ITEM | ACTION |
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| 2. | **Update on actions**<br><br>MK- The shared care record has not yet gone as a paper to the Council's Customer and Information Management Board but will go as a paper in the New Year<br><br>MOD- Maria will take forward Ian Fisher's action to identify a lead at the CCG to take forward the review of the shared care record from the previous meeting<br><br>MK- Section 256 paperwork was signed off by DW and JM and submitted to NHS England (NHSE). MK understood that NHSE need to confirm they are happy with the submission before we can begin invoicing. KK suggested we should start invoicing NHSE for the money. MOD agreed to follow this up and report back to the group. DW to prepare invoice.<br><br>DW raised that winter pressures funding has not yet been received, and said both organisations were now running at risk as a result. JM advised the money may go to Barnet and Chase Farm hospital. | **MK**<br><br>**MOD**<br><br>**MOD/ DW** |

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| | MOD- MOD & KJ have not yet written a S75 schedule yet for spend of 700k. MOD said work had focused on contract variations with CLCH so far and that they were working to complete this work by end Jan 2014. MOD & JM will pick up with AD what the actual spend on reablement will be. | **MOD, JM, AD** |
| **3.** | **<u>Section 256 Spend</u>**<br><br>MK reported a £0.5m underspend and a total of £1.2m uncommitted spend of the S256 monies this year. He said he would be taking forward discussion about how to carry over this underspend/ the uncommitted funds with MOD and AD.<br><br>HMG flagged that the CCG is also forecasting an unanticipated non-recurrent surplus at year end. HMG to discuss further with AD a joint approach to carry forward any underspend, to support integration.<br><br>DW/ MK explained that the high level of uncommitted funds is the result of an expectation of full year spends and a reality of time lags with recruitment and tendering processes.<br><br>KK reflected that this meant the group needed to factor in the right resources/ capacity to deliver work at scale and pace in future.<br><br>MOD updated the group that there should now be some spend against the children's budget line and also against rapid response.<br><br>DW raised that some of the money is used to cover core social care costs, and that she was starting to see pressure in areas such as mental health, learning disabilities and dementia. She said the group may need to decide to use some of the S256 underspend to fund these pressures.<br><br>KK suggested we needed to understand our historic S256 underspend so that we could make future assumptions about what will be spent in year. HMG and AD agreed to pick this up, to help the group agree some principles over S256 spend in future. | **MK, MOD, AD**<br><br>**HMG/AD**<br><br>**HMG, AD** |
| **4.** | **<u>LBB contribution to future joint budget</u>**<br><br>AD presented her paper which calculates the assumed Barnet quantum of the Better Care Fund.<br><br>AD had modelled that the Barnet allocation is estimated to be approximately £22m.<br><br>HMG questioned the £1.2m additional NHS transfer in Barnet in the model AD agreed to pick this up with HMG outside of the meeting. However it was noted that the allocation is expected week commencing 16th December 2013.<br><br>AD and HMG also agreed to meet at the time that the Better Care funding for Barnet was announced to check the assumptions in the paper against the confirmed total and report back to the group<br><br>JM suggested that if the NHS total was c.£14m, the CCG would not be able to fund this from the strands of funding listed in the Better Care Fund model. He said the gap would need to be filled from the community health or mental | **AD/ HMG**<br><br>**AD/ HMG** |

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| | health budgets with services attached to it. | |
| **5.** | **<u>Ernst and Young Integrated Model progress update</u>**<br><br>E&Y fed back about the **outputs from the design groups** and agreed to feedback back this output to the design group itself. E&Y explained that the outputs from the groups were still being drawn up into the detail of the integrated care model, and would be presented to the Steering Group next Tuesday (17th December).<br><br>E&Y talked through the **financial modelling** that had been completed. The group discussed the different approaches taken by the CCG and LA to calculate information to go into this model. The CCG also feedback that their figures look lower than expected because of difficulties to disaggregate acute figures by age group.<br><br>MOD said that she hadn't validated the CCG data yet and could spot inaccuracies in the model presented to the group. MOD also fed back that she wanted further voluntary sector contracts included (such as MIND). She agreed to pick this up with E&Y.<br><br>**The group agreed to take a pragmatic approach to validation and to make sure that all assumptions that were being made about the data were clearly stated in the model.**<br><br>The group recognised the importance of outlining in the model the services that were core to the model, and the services that surround the model, to be absolutely clear on scope. They agreed that assumptions made about community mental health and home care, for example, needed to be consistent from both sides. MK explained that an 80:20 assumption had been used in the MDT model about older people's spend in social care and that this could be used in this model too.<br><br>The group also agreed the importance of working out where savings will accrue, relative to the investment put into the model.<br><br>HMG asked E&Y to consider what other CCGs, who were not facing financial challenges like Barnet CCG, would put into an integrated care funding pot. HMG also suggested that the model should assume that the CCG has a balanced budget, and could make use of PWCs work with the CCG to inform what this would look like. HMG said that PWC had identified opportunities for activity shifts that should be shared with E&Y.<br><br>JM stated that he would be very happy to move more money into the Better Care Fund, but said that he wasn't sure what the risk appetite was across the CCG and LBB to make the pot larger.<br><br>E&Y then talked through their list of **commercial options** and opened up a discussion with the group.<br><br>MOD aid she thought Option 2 (alliance contracting) would have most benefit, based on her research of the New Zealand Canterbury model. E&Y highlighted that it would be possible to have a "pre-alliance" phase to bring partners together and establish new ways of working before entering into a full alliance. | **E&Y**<br><br>**MOD**<br><br>**HMG to share PWCs work when ready** |

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| | DW suggested the group needed to be clear on the commissioning approach before deciding on the contractual model.<br><br>The group discussed Option 3 (lead provider model) and distinguished between appointing a lead provider who provides services and sub-contracts with other providers; and a lead provider who manages a partnership of providers but isn't necessarily the principle provider.<br><br>The group discussed both the higher level of competition in social care than in health care, and the possibility of a managed transition away from current providers.<br><br>The group also looked at Option 4 and talked about the work being taken forward on value based commissioning, that aligns with this model.<br><br>JM suggested different contracts would be used for different parts of the model: outcomes based commissioning with a lead provider; PbR to manage transitions with existing providers; and block contracts.<br><br>The group discussed using a blend of options 2 and 4.<br><br>KK highlighted that it was interesting that the group had not really considered use of a new joint venture, and asked the group to consider how innovative they were being.<br><br>MK said that LBB and the CCG still needed to work on developing their relationship and agreeing between the organisations what they want to achieve.<br><br>**The group agreed that E&Ys work was not going to suggest a preferred commercial option but that it would present options for the group to take forward.**<br><br>KK proposed that the group needed to agree some underpinning commissioning principles from the E&Y work. She said the group needed to understand how well the current system had been delivering on its objectives. She also asked E&Y to include examples of where things hadn't worked in the outline business case so Barnet could learn from the mistakes made elsewhere. | **E&Y** |
| **6.** | **<u>AOB</u>**<br><br>The Better Care Fund submission is being written by Karen Spooner and Rodney D'Costa, and being supported by DW, MK, MOD, and JM.<br><br>DW fed back that they have a meeting scheduled on the 20th December to look at the funding application with E&Ys business case to hand.<br><br>This application will also be presented to the Health and Social Care Integration Board on the 8th January, with the final Better Care Fund submission considered at the January Health and Well-being Board financial planning group. | |

| | | |
|---|---|---|
| **11.** | **<u>Date of the next meeting</u>**<br><br>**Monday 13th January, 11.30am-1pm, Board Room, NLBP** | |

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|---|---|
| Meeting | Health and Well-Being Board |
| Date | 23rd January 2014 |
| **Subject** | **Better Care Fund (formerly the Integration Transformation Fund)** |
| Report of | Barnet CCG Chief Officer / Adults and Communities Director |
| Summary of item and decision being sought | This report presents a working draft of the Better Care Fund (BCF) plan an ambitious statement for achieving a transformation in integrated health and social care in Barnet. The BCF is a single pooled budget to support health and social care services to work more closely together in local areas, covering the period 2014/15 – 15/16. |

| | |
|---|---|
| Officer Contributors | Rodney D'Costa and Karen Spooner, Heads of Service for the Joint Commissioning Unit |
| Reason for Report | This report is presented to the Health and Well-Being Board for comment and agreement. The timing for the BCF is aligned with the CCG 2-year operational plan cycle which requires that a draft of the BCF plan needs to be submitted to NHS England by 14th February 2014 as part of Barnet CCG's Strategic and Operational Plan; with a revised/final version required by 4th April 2014. |
| Partnership flexibility being exercised | None |
| Wards Affected | All |
| Status (public or exempt) | Public |
| Contact for further Information | Rodney D'Costa and Karen Spooner<br>rodney.d'costa@barnet.gov.uk Telephone 020 8359 4304<br>karen.spooner@barnetccg.nhs.uk Telephone 020 3688 1836 |
| Appendices | Draft BCF plan |

## 1. RECOMMENDATIONS

**1.1 That the Health & Well-Being Board comments on the draft BCF plan and proposes amendments.**

**1.2 That the Health and Well-Being Board identifies public health investments that will feed into Tier 2 of the proposed shared model between Barnet Council and CCG for delivering integrated care across Barnet.**

**1.3 The Health and Well-Being Board agrees that any material changes made following the Health and Well-Being Board meeting are signed off by the Health and Well-Being Board Chair following prior endorsement of the BCF plan by the Chief Officer of Barnet CCG and the Cabinet Member for Adult Services in Barnet Council, before submission of the draft Plan to NHS England by 4th April 2014.**

## 2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 The meetings of the Health and Well-Being Board on 19th September and 21st November 2013 discussed health and social care integration and the Integration Transformation Fund (which then became the BCF). Additionally the 21st November meeting (Agenda Item 10) discussed NHS England's "Call to Action" Programme, part of a national engagement exercise designed to build public awareness of the challenges facing health and social care in order to create a platform for future transformational change. The BCF represents part of the government's response to this challenge.

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

3.1 The BCF plan is a single pooled budget to support health and social care services to work more closely together in local areas. It is an important enabler to take the integration agenda forward at scale and pace, acting as a significant catalyst for change. The Plan therefore complements the work of the Health and Social Care Integration Board as well as the 2012-15 Health and Well-Being Strategy's twin overarching aims (*Keeping Well*; and *Keeping Independent*). Barnet Council's / CCG's Joint Commissioning Unit (JCU) will also play a key role in helping to deliver the Plan.

## 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 Well-Being Strategy.

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 in the Borough.

4.3 Equality and Diversity issues are a mandatory consideration in decision-making in the Council pursuant to the Equality Act 2010. This means the Council and all other

organisations acting on its behalf must have due regard to the equality duties when exercising a public function. The broad purpose of this duty is to integrate considerations of equality and good relations into day to day business, requiring equality considerations to be reflected into the design of policies and the delivery of services and for these to be kept under review.

4.4 The specific duty set out in s149 of the Equality Act is to have due regard to need to:

(a) Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
(b) Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
(c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.
(2) A person who is not a public authority but who exercises public functions must, in the exercise of those functions, have due regard to the matters mentioned in subsection (1).

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

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

4.7 The final BCF plan will therefore include an Equality Impact Assessment and Public Health will be asked to consider whether a Health Impact Assessment is required.

## 5. RISK MANAGEMENT

5.1 Barnet Council / CCG projects are delivered within a project management and governance framework whereby individual and aggregate project risks are identified, reported and managed by Programme Management Offices and the senior management teams within the CCG and Adults & Communities Delivery Unit (A&CDU). There are no specific risks relating to this report. Projects that form part of the BCF Plan will be subject to the aforementioned governance process.

## 6. LEGAL POWERS AND IMPLICATIONS

6.1 In 2015/16 the BCF (the Fund) will be allocated to local areas, where it will be put into pooled budgets under Section 75 joint governance arrangements between CCGs and councils. *(Note: Section 75 of the NHS Act, 2006, provides for CCGs and local authorities to pool budgets*). A condition of accessing the money in the Fund is that CCGs and Councils must jointly agree plans for how the money will be spent, and these plans must meet certain requirements. Funding will be routed through NHS England to protect the overall level of health spending and ensure a process that works coherently with wider NHS funding arrangements.

6.2 The Department of Health (DH) will use the Mandate for 2015/16 to instruct NHS England to ring-fence its contribution to the Fund and to ensure this is deployed in specified amounts at local level for use in pooled budgets by CCGs and local authorities.

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

6.4 The DFG has been included in the Fund so that the provision of adaptations can be incorporated in the strategic consideration and planning of investment to improve outcomes for service users. DFG will be paid to upper-tier authorities in 2015/16. However, the statutory duty on local housing authorities to provide DFG to those who qualify for it will remain. Therefore each area will have to allocate this funding to their respective housing authorities (district councils in two-tier areas) from the pooled budget to enable them to continue to meet their statutory duty to provide adaptations to the homes of disabled people, including in relation to young people aged 17 and under.

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

6.6 DH and the Department for Communities and Local Government (DCLG) will also use Section 31 of the Local Government Act 2003 to ensure that DH Adult Social Care capital grants (£134m) will reach local areas as part of the Fund. Relevant conditions will be attached to these grants so that they are used in pooled budgets for the purposes of the Fund. DH, DCLG and the Treasury will work together in early 2014 to develop the terms and conditions of these grants.

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

7.1 The BCF Plan details the financial contributions from Barnet CCG / Council which comprise the single pooled budget that will be used to support health and social care working more closely together to deliver integrated outcomes for patients and service users. The Table in paragraph 10.6 sets out the allocations as advised by NHS England.

## 8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 The BCF Plan details the extensive engagement undertaken with service providers as well as public engagement with patients and service users.

## 9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 See paragraph 8.1.

## 10. DETAILS

10.1 It should be noted that the BCF plan attached to this report represents a working draft. The final version needs to be submitted to NHS England by 4th April 2014. Any material

changes to the draft following this Health and Well-Being Board meeting will therefore need to be signed off by the Health and Well-Being Board Chair following prior endorsement of the BCF plan by the Chief Officer of Barnet CCG and the Cabinet Member for Adult Services at the London Borough of Barnet, before submission of the final plan to NHS England. Governance procedures for monitoring implementation of the final BCF plan will need to be considered and proposals will be brought to a future meeting of the Health and Well-Being Board by officers.

10.2 As part of compiling the BCF plan Barnet CCG and Council commissioned Ernst & Young LLP (EY LLP) to recommend a shared model for integrated care across Barnet. The key recommendations from EY LLP for the proposed integrated service model, which was developed jointly between Barnet Council / CCG through a design group which included representation from providers, Partnership Boards and other stakeholders, include a five-tier model for frail elderly and people living with long term conditions, with self-management applicable for all tiers and for all types of care and support. The five tiers can be summarised as: (i) self-management; (ii) health and wellbeing services; (iii) access services including primary care and social care assessment; (iv) community based intensive services; and (v) residential, nursing and acute services.

10.3 The Health and Well-Being Board will want to note the model's proposals in the context of future public health commissioning intentions. In particular that tier (ii) of the integration model should include public health grant funding and that commissioning intentions of public health need to be informed by this model.

10.4 This section outlines the BCF, the draft plan for which is contained as an Appendix to this report. NHS England provided a template which all CCGs / Councils are required to use in completing the BCF plan. The template includes setting out the six national conditions which the Spending Round established for access to the Fund. The assurance process for the BCF plan includes sign-off by local Health and Well-Being Boards plus on-going overseeing of the plan. Where Health and Well-Being Boards are not satisfied on the plan then a process of local government and NHS peer challenge – facilitated by NHS England and the Local Government Association – will kick in. Government Ministers will give the final sign-off to plans and the release of performance related funds (paragraph 10.3 refers).

10.5 The £3.8bn Better Care Fund (formerly the Integration Transformation Fund) was announced by the Government in the June 2013 spending round, to ensure a transformation in integrated health and social care. The BCF is a single pooled budget to support health and social care services to work more closely together in local areas. It encompasses a substantial level of funding to help local areas manage pressures and improve long term sustainability. The Fund will be an important enabler to take the integration agenda forward at scale and pace, acting as a significant catalyst for change. However there is widespread recognition that most of the BCF is not new or additional resources, but the reallocation of existing service provision budgets to a new pooled budget format. The BCF is intended to provide an opportunity to improve the lives of some of the most vulnerable people in our society, giving them control, placing them at the centre of their own care and support, and, in doing so, providing them with a better service and better quality of life. The Fund will support the aim of providing people with the right care, in the right place, at the right time, including through a significant expansion of care in community settings. This will build on the work already underway in Barnet.

<u>What is included in the BCF and what does it cover?</u>

10.6 At a national level, the Fund provides for £3.8 billion worth of funding in 2015/16 to be spent on health and care to drive closer integration and improve outcomes for patients and service users and carers. In 2014/15, the Government has announced that in addition to the £900m transfer already planned from the NHS to adult social care, a further £200m will transfer to enable localities to prepare for the BCF in 2015/16. The following Table summarises the position for Barnet. It should be noted that allocation of funding (£1bn of the £3.8bn) is also partly dependent upon a performance element i.e. achieving specified targets in 2015/16. Note: footnote 2 to the Table below clarifies that the DFG and ASC Capital grant amounts in 2015/16 represents additional CCG funding. The total amount for DFG and ASC capital in 2015/16 therefore is £1.066m and £0.806m respectively.

**Table**

**Department of Health Better Care Fund 2015/16**
**NHS Barnet CCG**

| | | | | 14/15 | | | | | | 15/16 | 15/16 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | LA | LA | NHSE | All | LA | LA | CCG | CCG | CCG | All | NHSE / CCG |
| £000s | Disabled Facilities Grant (1) | Adult Social Care Capital Grant (1) | S256 / SR10 Transfer | Sub Total | Disabled Facilities Grant (2) | Adult Social Care Capital Grant (2) | Reablement | Carers Breaks | Additional funding | Total | Transfer to BCF |
| | *Notified* | *Estimated* | *Notified* | | *Notified* | *Notified* | *Estimated* | *Estimated* | *Notified* | | |
| England | 180,000 | 129,059 | 1,100,000 | 1,409,059 | 40,000 | 4,582 | 300,000 | 130,000 | 1,930,000 | 3,813,641 | 3,460,000 |
| Barnet | 875 | 778 | 6,634 | 8,287 | 191 | 28 | 1,860 | 806 | 12,240 | 23,412 | 21,540 |
| Barnet as % | 0.49% | 0.60% | 0.60% | 0.59% | 0.48% | 0.60% | 0.62% | 0.62% | 0.63% | 0.61% | 0.62% |

**Notes:**
1. Reablement / Carers Breaks estimated from PCT 11/12 target allocations.
2. CCG additional funding per NHS England Total Allocations 15/16.

10.7 LBB and Barnet CCG have been working on the BCF proposals for the last six months and have engaged widely with members, boards and providers as well as patients and service users. We have jointly engaged external support to develop a new model of care which will underpin the delivery of this transformation. This is based on much of the work which is already underway, however is a fundamental root and branch review of the approach to integrated care in Barnet. The report supporting this will be issued in mid-January and is summarised in some detail in the draft BCF plan.

10.8 There is a requirement that CCGs and Councils must engage from the outset with all providers, both NHS and social care (and also providers of housing and other related services), likely to be affected by the use of the fund in order to achieve the best outcomes for local people. The plans must clearly set out how this engagement has taken place. Providers, CCGs and councils must develop a shared view of the future shape of services, the impact of the Fund on existing models of service delivery, and how the transition from these models to the future shape of services will be made. This should include an assessment of future capacity and workforce requirements across the system. CCGs and councils should also work with providers to help manage the transition to new patterns of provision including. It is also essential that the implications for all local providers are set out clearly for Health and Well-Being Boards and that their agreement for the deployment of the Fund includes agreement to all the service change consequences.

10.9 A principal challenge for Barnet is managing the aspirations of the BCF against a backdrop of a financially challenged CCG and a local authority under the financial constraints applying to local government and with the emerging additional costs of the

Care Bill. The BCF proposals are built on transforming services through integrated care and releasing savings through efficiency and effectiveness rather than cuts. Recognising that much of the BCF funding will come with services already provided this is going to be particularly challenging in the local setting.

## 11.0 BACKGROUND PAPERS

11.1 Better Care Fund – Letter and Guidance, published 20th December 2013, GOV.UK

Legal – LC
CFO – JH

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# Barnet Better Care Fund

## Draft Submission. Version 4.3

| | |
|---|---|
| Local Authority | Barnet Council |
| Clinical Commissioning Group | NHS Barnet |
| Boundary Differences | Coterminous, however, the GP-registered population includes patients who reside in another LA's area. Barnet's integrated care model includes these patients. |
| Date to be agreed at Health & WellBeing Board | 23.01.14 |
| Date Submitted | 08.01.14 |

| | | |
|---|---|---|
| Minimum required value of BCF pooled budget: | 2014/15 | £6,634,000 |
| | 2015/16 | £23,412,000 |
| Total agreed value of pooled budget: | 2014/15 | |
| | 2015/16 | |

| **Authorisation and Sign Off** | |
|---|---|
| **Signed on behalf of the Clinical Commissioning Group** | NHS Barnet CCG |
| **By** | John Morton |
| **Position** | Chief Operating Officer |
| **date** | 23-Jan-14 |
| | |
| **Signed on behalf of the Local Authority** | London Borough of Barnet |
| **By** | tbc |
| **Position** | |
| **date** | |
| | |
| **Signed on behalf of the Health & Wellbeing Board** | |
| **By Chair of the HWB:** | Councillor Helena Hart |
| **Position** | Lead Member - Health and Chair of HWB |
| **date** | 23-Jan-14 |

## Service provider engagement

*Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it*

The **Better Care Fund (BCF)** plan has its foundations in the **Barnet Health & Social Care Concordat** – a clearly articulated vision for integrated care agreed by all partners at the Health Wellbeing Board (HWB). The concordat itself was co-designed by the partner members of the **Health & Social Care Integration Board (HSCIB)** and hence provides the over-arching strategy for delivery endorsed fully by service provider recognition and support.

The plan brings together work in progress in individual organisations (health, social care and voluntary sector), joint work being undertaken through the work programme of the HSCIB and emerging priorities as identified in a newly developed **Integrated Health & Social Care Model** co-produced with partners.

For key schemes already underway, such as the Older People's Integrated Care project and Rapid Response, service providers are active participants within established frameworks to work collaboratively to design, implement and manage services with commissioners. This occurs through a variety of mechanisms such as operational co-production, steering group memberships and front-line delivery.

Service provider involvement in the Integrated Health & Social Care Model has been achieved through participation in the 'as-is' mapping of current provision and spend, development of a target operating model, and by involvement in a series of design workshops which focussed on opportunities and operational deliverables. This has brought realism to the plan and shared ownership through a commitment to improve care for the people of Barnet. This will continue with providers being engaged in validating and developing the plans for implementation as we move forwards. The development of the Integrated Health and Social Care Model has been formally supported by providers as key members of the HSCIB.

A joint commissioner and provider forum exists in the form of the **Clinical Commissioning Programme for Integrated Care**. This will be further aligned to form a core part of the service provider engagement vehicle moving forwards. With the Health and Social Care Integration Board running alongside, our plan embeds service provider engagement at both operational and strategic levels.

## Patient, service user and public engagement

*Please describe how patients, services users and the public have been involved in the development of this plan, and the extent to which they are party to it*

Patients and service user views are integral to the Vision for Integrated Care in Barnet and will serve as a benchmark to measure our success in delivering plans that truly impact on areas that are important to our residents. The formation of the **Joint Commissioning Unit** offers real opportunity to build further on this by enabling a shared platform for bringing together health and social care perspectives and resources.

Engagement continues both in relation to the plan itself and, more locally on an ongoing basis with respect to individual service areas, for example, dementia. Our track record highlights initiatives such as our Ageing Well project which has been developed from the ground up with local people, in response to needs identified by the community. We also regularly draw on experiences and feedback gained at CCG public engagement events and in broader project-based consultation exercises such as Guiding Wisdom for Older People.

Through workshops with Older Adults Partnership Board members, Healthwatch facilitated forums, interviews and surveys, the Integrated Health & Social Care Model has been built taking into account the calls from local residents to increase co-ordinated care to enable them to live better for longer. The co-chair of the Older Adults Partnership Board is also a member of the design group.

Further under-pinning this and developing further the work of National Voices, Barnet is participating in a value-based outcomes commissioning programme with other CCGs in North Central London. With patient and service user participation from the outset, this will equip commissioners to change the way in which they do business to achieve patient-centred goals.

External scrutiny has been given to the over-arching plans for Integrated Care through presentation at CCG public board meetings and through an elected member scrutiny exercise at Barnet Council.

Moving forward, we will use the existing Older Adults Partnership Board framework as the key patient and public representative group with involvement from service users, carers, Healthwatch and voluntary sector. In addition, we will continue to utilise other opportunities such as the CCG public engagement mechanisms and Barnet Older People's Assembly, to ensure that patient and user perspective is reflected in all our programmes as they develop.

## Related documents

*Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition*

| **Document or Information Title** | |
|---|---|
| Barnet Health and Social Care Concordat | Available on request |
| Barnet Integrated Health and Social Care Model 2013 | |
| Barnet Health & Well-Being Strategy | |
| Barnet Council Corporate Plan | |
| Barnet CCG Integrated Strategic and Operational Plan (ISOP) | |
| Barnet CCG Recovery Plan | |
| Health and Social Care Integration Board Terms of Reference | |
| Health and Social Care Integration Board Programme Governance | |
| Barnet, Enfield & Haringey Clinical Strategy | |
| Older People Integrated Care business case | |
| OBC for shared care records, rapid care and SPA, winter pressures plan if needed | |

# VISION AND SCHEMES

## Vision for Health and Care Services

*Please describe the vision for health and social care services for this community for 2018/19. - What changes will have been delivered in the pattern and configuration of services over the next five years? What difference will this make to patient and service user outcomes?*

**Background and Context**

The £3.8bn Better Care Fund was announced by the Government in the June 2013 spending round, to ensure a transformation in integrated health and social care. The Better Care Fund (BCF) is a single pooled budget to support health and social care services to work more closely together in local areas.

The Fund will be an important enabler to take the integration agenda forward at scale and pace, acting as a significant catalyst for change. The Better Care Fund is intended to provide an opportunity to improve the lives of some of the most vulnerable people in our society, giving them control, placing them at the centre of their own care and support, and, in doing so, providing them with a better service and better quality of life. It encompasses a substantial level of funding to help local areas manage pressures and improve long term sustainability.

The Fund will support the aim of providing people with the right care, in the right place, at the right time, including through a significant expansion of care in community settings. This will build on the work already underway in Barnet.

A principal challenge for Barnet is managing the aspirations of the BCF against a backdrop of a financially challenged CCG and a local authority under the financial constraints applying to local government, and with the emerging additional costs of the Care Bill. Local demographic and infrastructure changes, including re-configuration of acute services and a high number of residential and nursing homes create additional pressures which must be addressed.

**The Vision**

The Vision for Health and Social Care services in Barnet centres one **Mr. Colin Dale** who represents a typical user of health and social care services in Barnet. He is an 82 year old gentleman living in Oakleigh. He has multiple needs and medical conditions and is receiving a range of services and support from health, social care and the voluntary sector. He has been admitted to hospital twice in the last year and on both occasions his family have felt that the system has not worked very well together and that the responsibility for his overall care and support is not properly co-ordinated and they find it difficult to know who is responsible for what. Mr. Dale's wife died 10 years ago and he lives alone with his dog, Sally. His daughter, Louise and her family live in East Finchley.

**What do Mr. Dale and his family want for him when he needs help?**

- A single point of contact
- Quick and responsive services
- To tell their story once
- Professionals and services that talk to each other.

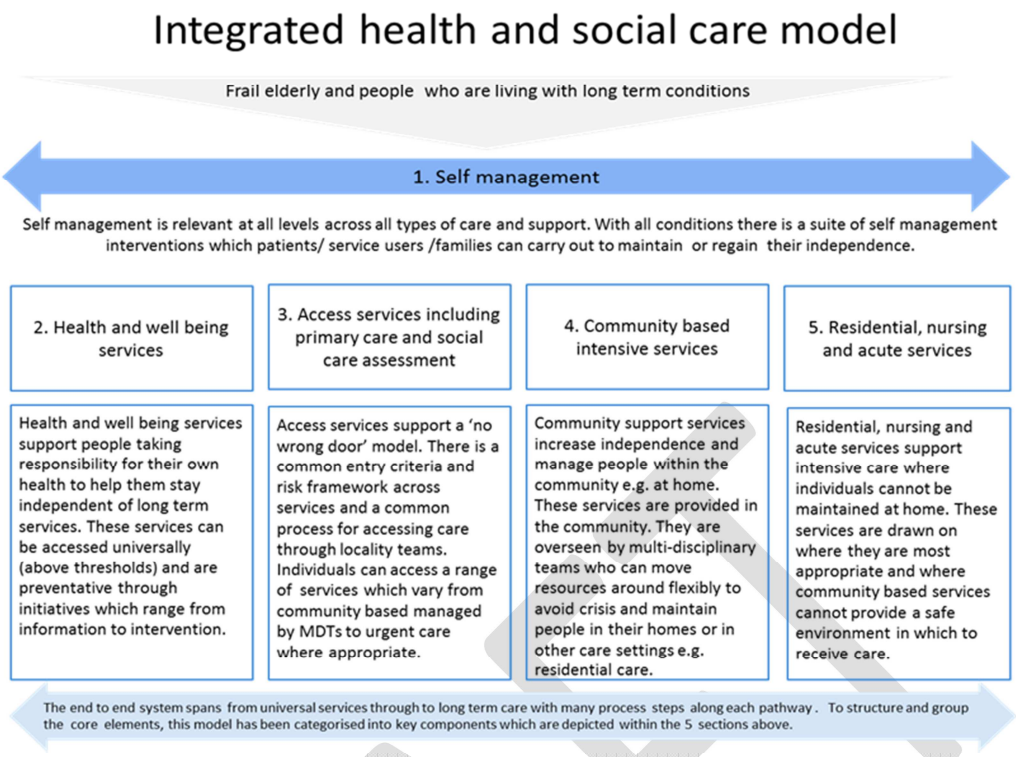
The **concordat Vision** agreed by all parties of the Health and Social Care Integration Board states:

**Care integration in Barnet will place people and their carers at the heart of a joined up health and social care system that is built around their individual needs, delivers the best outcomes and provides the best value for public money. Integrated care will be commissioned by experts in collaboration with care providers and delivered seamlessly by a range of quality assured health, social care, voluntary and private sector organisations.**

The Vision aligns with the over-arching aims of the Better Care Fund (BCF) including the national conditions and is under-pinned and supported by a number of key strategies owned both at an individual organisational level and through a system-wide approach. These include:

- **Barnet Health & Well-Being Strategy** that aims to reduce health inequalities by focusing on how more people can 'Keep Well' and 'Keep Independent'; recognizing that this can only be achieved through a partnership between residents and public services. At the heart of this Strategy is the ambition that all Barnet's residents will be able to live as healthily and as independently as possible for as long as possible by:
    - **Keeping Well** – A strong belief in 'prevention is better than cure' including a focus on supporting people to adopt healthy lifestyles to prevent avoidable disease and illness.
    - **Keeping Independent** – This aims to ensure that when extra support and treatment is needed, it is delivered in a way which enables people to get back up on their feet as soon as possible supported by health and social care services working together.
- Both the **Barnet Council Corporate Plan** and the **Barnet CCG Integrated and Strategic and Operational Plan** echo these themes through outcome-based commitments to work with partners and residents to :
    - Promote a healthy, active, independent and informed over 55 population in the borough to encourage and support our residents to age well.
    - Commission and manage quality services focused on patients' needs
    - Manage demand in the most cost-effective way
    - Sustain a strong partnership between the local NHS and the Council, so that families and individuals can maintain and improve their physical and mental health.

Recent work to develop a **Barnet Health and Social Care Integration model** has strengthened this further with the Vision for Services pictorially represented below. It consolidates existing work being undertaken and provides a clear direction of priorities and delivery for the future. This turns the Vision into a tangible reality for delivery via a 5 tiered model of care with future-proofing to meet short and longer term health and social care strategic plans including those to deliver integrated care at scale and pace. It advocates a consequential shift of activity and costs from reliance on acute care and care home placements towards prevention and self-management.




In **3-5 years time** we will have developed a fully integrated health and social care system for the frail and elderly population through implementation of a whole systems approach that:

- Delivers on expected patient outcomes meeting the changing needs of the people of Barnet
- Enables people to have greater choice and autonomy on where and how care is provided
- Empowers and enables the population to access and maximise effectiveness of preventative and self-management approaches to support their own health and wellbeing
- Creates a sustainable health and social care environment which enables organisations to work within resource limits
- Reduces overall pressures in hospital and health budgets as we shift from high-cost reactive to lower cost prevention and self-management services
- Listens and acts upon the view of residents and providers to make continued improvement

In addition, we will have fully explored the opportunities arising from the Better Care Fund from extension of the scope beyond the current target group – for example into services for residents with learning disabilities.

## Integration Aims & Objectives

*Please describe your overall aims and objectives for integrated care and provide information on how the integration transformation fund will secure improved outcomes in health and care in your area. Suggested points to cover:*
*• What are the aims and objectives of your integrated system?*
*• How will you measure these aims and objectives?*
*• What measures of health gain will you apply to your population?*

The overall aims and objectives for Integrated Care can be extracted from the Health & Social Care concordat.

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

This will ensure that:

• People in Barnet will feel like they are dealing with one care organisation
• They will have access to accurate information which will enable them to make informed choices and take responsibility for their health and wellbeing
• They will be able to get the right care and treatment quickly without having to deal with lots of people
• Personal information will only have to be provided once and will be shared securely with other organisations involved in the person's care
• Care will be provided safely by well-trained teams, at home or at a place that is convenient for them
• Someone will always take responsibility for making sure care is coordinated and the person being cared for, their family and carers, are kept informed
• People will be supported to be as independent of public services as possible through a local care system that encompasses prevention, self-care and supportive communities

These are challenging ambitions – and rightly so – as they represent the right thing to do for Mr. Dale. We also recognise that there needs to be significant change to current service provision to enable these ambitions to be realised. This journey has started and from 2014-15 we will see:

- Increased activity from the newly formed Joint Commissioning Unit in exploring potential and taking forward joint commissioning and procurement projects
- Our community providers expanding existing services and introducing new models of care focussed on case management and care at home
- Implementation of a community point of access for health and social care services
- Expansion of 7 day services
- Targeted work with care homes to address demand arising from our local position of net importer of residents to over 100 establishments
- Further integration of emergency and planned activity in hospitals with community care to support discharge and avoid admission, actioned in collaboration with the new Clinical Commissioning Programmes at the CCG
- GPs collaborating into networks for provision of more localised services targeted at their populations

Measuring success against the aims and objectives will be key in understanding the impact of Health and Social Care Integration programmes both from organisational perspectives, but more importantly to assess whether change makes things better for Mr Dale. An over-

arching set of outcome measures have been drawn from the Health and Social Care Integration Model utilising the value-based outcomes approach and existing targets within the current Health & Social Care outcome frameworks.

## What does this vision mean in practice for Mr Colin Dale and residents of Barnet?

1. **People and their families are supported to manage their own health and wellbeing wherever they can and for as long as possible:**

   **Mr Colin Dale will:**
   - Be supported to have a high quality of life and increase his self -care skills
   - Have support focused to his assets and interests, building on these to stay well and independent for as long as possible
   - Have access to information and education on healthy living and staying well including:
     - Access to prevention services
     - Access to national and local self–help and support models such as expert patient/carer groups and *Breathe Easy* to support self-managemen
   - Be able to easily access up to date information from one place about what support is available

2. **There is no wrong door principle to access advice and support. Primary care and social care assessment will identify early and proactively target those at risk of becoming frail or unwell. When necessary a support package focused around the individual will be put in place that optimises his skills, increases quality of life and prevents deterioration.**

   **Mr Dale will**
   - Understand what is happening, what his choices are and be fully supported to stay at home or in a home based setting
   - Be able to work with staff to involve his carers and/or a wider family network to ensure they understand what is happening, what the choices are and be involved in decision making as appropriate
   - Only have to tell his / his carer(s) story once due to a single assessment process
   - Receives the right kind of support at the right time from skilled professionals
   - Have a care navigator who ensures seamless transitions through the system including from community service to hospital when required

3. **Intensive community based intensive are readily accessible and react quickly to need**

   **Mr Dale will**
   - Understand what is happening, what his choices are and is fully supported to stay in control as far as possible (as will his carers and/ or family)
   - Be able to access advice and support through one number
   - Have single care plan and review for his support
   - Have access to a multi skilled rapid care service who can provide appropriate and timely support to prevent things getting worse and help regain independence
   - Have access to service that can help him have a better experience of hospital discharge when returning home or to a home based setting, with a focus on regaining health, wellbeing and independence
   - Be able to access appropriate specialist resources and services where required

**4. Ensuring quality long term care is provided in the most appropriate setting by a workforce with the right skills**

**Mr Dale will**

- Have access to a range of alternatives to residential care such as accessible housing or extra care housing and support to provide suitable alternatives to residential care
- Be supported, with his family and/or carer where appropriate to continue to build self-management skills and regain independence as far as possible
- Be treated with respect and dignity
- Have access to people with the right skills at the right time to ensure his health and wellbeing is maintained or improved
- Experiences seamless continuity of care across primary care, community care and the hospital
- Be able to experience a dignified death in the place of his choice

## Description of Planned Changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:
1. The key success factors including an outline of processes, end points and time frames for delivery
2. How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

The London Borough of Barnet (LBB) and Barnet CCG have been working on proposals to underpin the BCF for the last six months and have engaged widely with members, boards and providers, as well as patients and service users. We have jointly engaged external support to develop a new model of care **(Health and Social Care Integration model)** which forms the foundation for the delivery of this transformation.

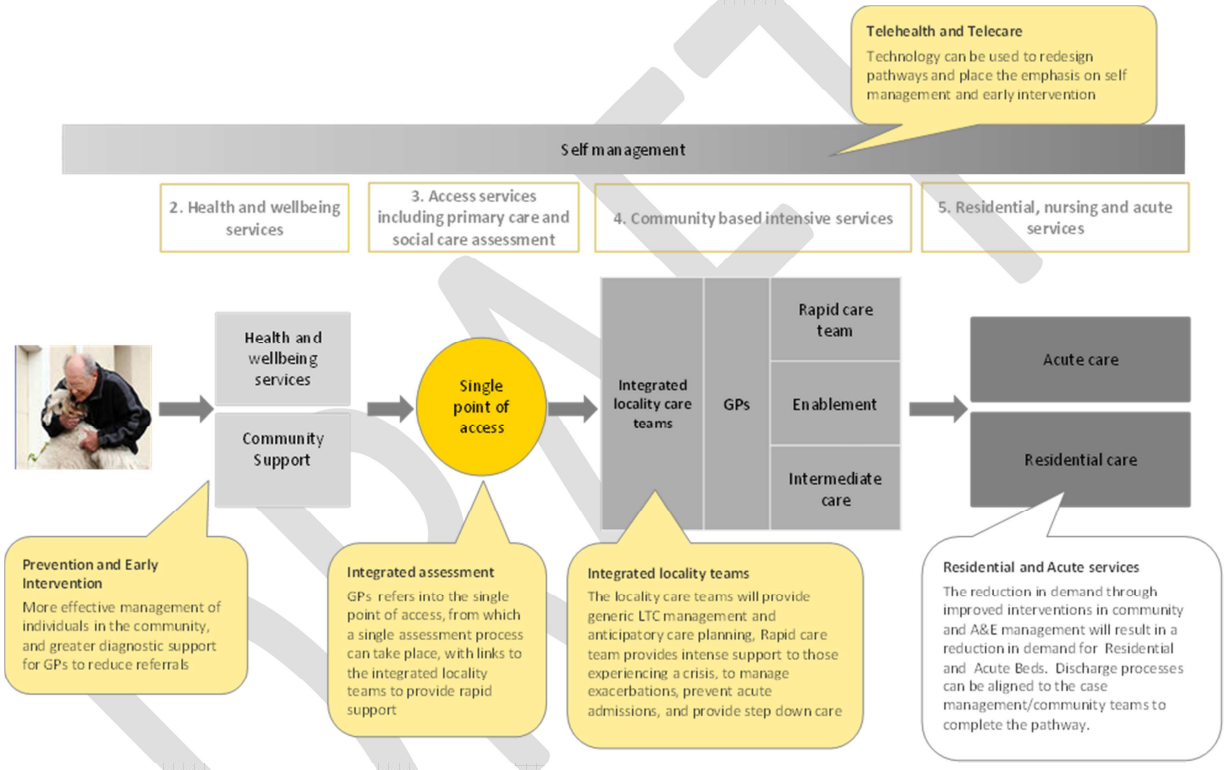
The BCF proposals are built on transforming services through integrated care to improve outcomes for the people of Barnet, while releasing savings through efficiency and effectiveness. The recognition that much of the BCF funding will come with services already provided is going to provide particular challenge to delivery in the local setting.

While good progress has been made on the two spearhead projects (Older People's Integrated Care and Quality in Care Homes projects) we would recognise this has been limited in scope and has at times been challenging as partnership working has developed. Our approach moving forwards will be to drive integrated health and social care delivery into a higher gear, focussing entirely on commissioning of the BCF services. This work is already underway with the projects developed during 13/14 and is currently extending to encompass rapid care services, single point of access, shared care records and locality based integrated care teams.

The **Joint Commissioning Unit (JCU),** with strong senior management leads from both organisations, formed in August 2013 and will be the central hub for delivery of much of the BCF work plan. The Unit operates in accordance with a programme management approach with over-arching governance from the Health & Social Care Integration Board (HSCIB) and

integrated Project Management Office support. These provide the framework to ensure that priority is given to projects which align with Health & Social Care strategy while giving assurance that projects deliver on time, in full and are of an appropriate quality.

The Health and Social Care Integration model builds on the progress to date and provides a framework for investment and delivery of integrated care over the next 3-5 years. It outlines the ambition, and articulates the scale and pace required to meet the needs of the changing population of Barnet. It also builds on our successful experiences in winter planning, especially in 13-14, which embedded the commitment to 7 day working for health and social care. Core to the model is a focus on prevention, single point of access, risk stratification and appropriate care at the right time through locality based integrated care teams and rapid care provision. Correlating with the 5 tiered model, the pictorial representation below illustrates the new journey for Mr Dale through a co-ordinated care system and how this improves his outcomes.




The key components of the integrated service can be consolidated as follows:

## Developing greater self-management (Tier 1)

**What will this achieve?**

Enhanced personalisation of health and social care through:

- Promoting and enabling independence through self-management
- Promoting the co-design and production of services with service users, patients and carers

**How will this be delivered?**

- Patient education and awareness raising on how to manage conditions, e.g. expert patient programmes
- Development of an enhanced risk stratification approach to search GP registers and identify

individuals at risk

- Prevention coordinators to support the self-management / targeted prevention agenda. The coordinators would be locality based and linked to the GP surgeries as a way of raising the profile of the whole range of services available to increase self-management
- Expanding the self-management offer to at risk groups. Developing specialist strategies aligned to specific population needs e.g. stroke, dementia awareness
- Enhancing professional knowledge about prevention and self-management tools and what is available in order to reduce dependency on GPs and diverting people to more self-management routes. This is closely linked to the offer described in tier 2, the development of a catalogue and an education programme for professionals to highlight the range support available
- Increasing the use of technology to support self-care in the community such as telecare and telehealth

## Promoting Health and Wellbeing initiatives and building the capacity of individuals and communities to reduce demand (Tier2)

**What will this achieve?**

This tier focuses on promoting the population's health and wellbeing and equity of access to support and enable people to stay healthy and lead active lives. It requires coordinated support activities that reduce the barriers experienced by people and improves their social well-being. These include activities that build up and grow personal and physical resilience, develop and maintain social networks, increase skills and employment opportunities, encourage healthy lifestyles and support from families and friends who provide care.

It will support increased community capacity to build resilience including self-help initiatives, volunteer support networks, local community organisations that offer assistance and non-traditional support. This also covers preventative services.

**How will this be delivered?**

- Accessible centralised information and signposting about the whole range of services available to increase prevention and self- management (as described above in the 'self-management 'section above)
- Market development in the voluntary sector
- Implementation of an enhanced Ageing Well Programme

## Improving access via a 'No Wrong Door' approach (Tier 3)

**What will this achieve?**

The vision for this tier is to ensure that there is 'no wrong door' for frail older people and those with long term conditions. There is a single common access process linked to urgent care response capability. Service users, patients and carers can access multi-disciplinary triage as part of a single access process operating across multiple locations. There is a common assessment framework which links to universal access points.

**How will this be delivered?**

**The 'in flight' and planned business cases relevant to this tier include**:

**Community point of access**: this will be a central hub for adult referrals, appointments and queries. Accepting referrals for patients and services within the target group, they will be triaged into two streams - urgent and routine. Urgent referrals will be sent directly to the Older Peoples Assessment

Unit (Rapid Care Service) for clinical triage and clinical decision making to ensure a timely response from the correct pathway. Routine referrals will be clinically triaged and be sent to the locality (including LTC) or specialist teams for assessment or management. Over time, social care services and voluntary sector services will be built into this model to reduce the need for different arrangements for other health and social care providers.

**Risk Stratification:** Build upon the existing model for risk stratification to identify frail elderly at risk of needing care; and to develop a proactive and anticipatory care plan that will enable people to stay out of hospital longer and continue living independently.

**Locality Based Integrated Care teams**: Introduce 3 locality teams to incorporate community nursing, care navigators, social care, intermediate care, IAPT and generic LTC nurses. These will offer a range of services as part of agreed pathways to meet the needs of people registered with GP practices within the locality. With GPs, they will manage the interface between early diagnosis with LTC and episodes of related ill-health by providing the pivotal point of contact and ensuring that patients are supported to manage their care. This will be provided through delivery of lower level support, access to prevention and voluntary sector services, or anticipatory care planning. Roles will be distributed according to the patient need drawing on the skills and competencies within the team. In essence, they will provide '*the glue'* between the patient, the GP and community intensive support by enabling seamless transitions between periods of well-being to illness with a continued focus on the patient.

**Shared care record**: The business case is for an information repository providing a single holistic view of an individual's health and social care that will be accessible 24/7 from any location, wherever staff are working. By collating information from different organisations' systems, this will enable everyone (staff and patient/service user alike) to have a single shared view and will also prevent service users from having to provide information multiple times to different practitioners.

**Key components of the model in tier 3 are:**

- Risk Stratification
- 'No wrong door' principle which will be delivered though a single point of access
- Development of Integrated Locality Teams linked to primary care and Rapid Care.
- Single assessment process and 'trusted assessor' approach
- Building stronger links between GPs, Community and Acute nursing and Locality Teams.
- ICT architecture which supports information sharing, e.g. single shared record

## Investing in community intensive support (Tier 4)

**What will be achieved?**

Community intensive support services increase independence and promote the management of people within their community. A weekly MDT will provide a more intensive approach to managing complex cases by planning care across multiple providers. This will link to Integrated Locality Teams, particularly care navigators, to ensure that they can move resources around flexibly to avoid crises and maintain people in their homes or in other care settings within the community, e.g. residential care. This will be under-pinned by a rapid care service that will provide intensive home-based packages of care to support people in periods of exacerbation or ill-health.

**The 'In flight' and planned business cases that relate to this tier include:**

**Multi-Disciplinary Team Meetings**: A weekly meeting that will allow higher risk individuals, identified through risk stratification or other methods, to be referred for detailed review and input from the wider group of health professionals. Ongoing care will be co-ordinated by the care navigators. The target

group is people with short term health and social care conditions, long-term and /or complex conditions, or at the end of life. The planned co-ordination of care across health, social and voluntary care sectors, with a focus on self-care, education, early detection and intervention and the use of telecare will be the key to success.

**Rapid Care service**: the business case is to expand the existing The Older Peoples Assessment Unit (OPAU) by increasing clinical capacity and developing a community based ambulatory assessment, diagnostic and treatment service to prevent A&E admission is being implemented. This is to bring together the existing teams, rapid response, COPD, heart failure, diabetes, PACE, falls, and ESD stroke teams. Development will focus on 4 clinical pathways: Exacerbation management, long term condition complications, deterioration leading to an immediate need for palliation, and ambulatory assessment, diagnostics and treatment. This is a key development in strengthening the tier 4 services needed to reduce tier 5 activity.

**How will this be delivered?**

**Key components of the model include:**

- Multi-disciplinary teams to review and assess complex patients at risk of admission to introduce care plans and link to services to keep them at home
- Rapid Care who can provide intensive support to individuals quickly when needed, as an alternative to hospital care
- Development of Enablement, Intermediate and Respite Care.
- Development of enabling technology.

## Reducing the demand for hospital based, residential and nursing home care (Tier 5)

**What will this achieve?**

Reducing the demand for residential and acute care is a primary focus as Barnet has a significantly high level of bed based care. Care home supply in the Borough is one of the largest in Greater London. Within Barnet, there are 95 residential and 23 nursing homes registered with the Care Quality Commission. There is also a higher than average number of people referred by GP's to acute care.

The focus of the Integrated Model is therefore balanced towards tiers 1 – 4 to reduce demand for residential and acute care. However, there will still be a requirement for these services in circumstances where community care and support is not a viable option.

**The 'In flight' and planned business cases relevant to this tier include:**

- The significant progress made across Health and Social Care in addressing this through:
    - My Home Life
    - Care homes pilot
    - Quality in Care Homes Team
    - PACE and TREAT

**How will this be delivered?**

**Hospital non-acute beds:**

The key components of the model for acute services include:

- Use of ambulatory care pathways, to prevent admissions.
- Creating a robust interface between consultants and the integrated health and social care

services to facilitate step sideways and step down to more appropriate care closer to home.
- Better joint discharge planning with social care input to ensure services are in place to support step down and reduce out of hours discharges.
- Use of hospital networks to provide improved access to centres of excellence and other specialist skills.
- Partnership with acute providers to optimise use of specialist resources and facilities.
- Development of clear referral protocols to optimise productivity of elective care and outpatient clinics and other aspects of acute care.

**Residential Care:**
The recent 'My Home Life' report identified a key theme in feedback from care home managers[1] as poor co-ordination between health professionals and care homes with regard to discharge of residents, inappropriate placements within homes and lack of understanding of the role of care homes. Focus needs to be on ensuring that admissions to residential care are appropriate, better inter professional coordination and efficiency of discharge planning.

The key components of the model for residential care**:**
- Invest in more step up and step down intermediate care with access via rapid care teams.
- Develop clearer protocols so that residential care staff are clear about when to escalate concerns.
- Implement widespread up-skilling of care home staff, particularly in medical skills to reduce the need to admit to hospital.
- Target quality improvement work in care homes and expanding the quality in care homes team.
- Develop a robust set of quality measures above and beyond what can be assessed by CQC, including a KPI on hospital attendances that do not result in admissions.
- Develop a 'care homes scorecard' also based on locally agreed quality measures.
- Improve the GP offer to care homes and strengthen their and community nursing presence via use of contracts.
- Ensure out of hours GPs are linked into the care home service model, but with an initial focus on getting the "in hours" service right and extending to 7 day cover
- Link the MDT in with PACE/ TREAT and rapid response models.

GPs are pivotal to the delivery of the plan as they are the centre for organising and co-ordinating people's care. We will work with NHS England to deliver the new arrangements under the **General Medical Services contract** for 14-15 to further strengthen the role of primary care in the provision of more personal care for older people and those with complex health needs. New contractual developments to focus on a named, accountable GP for people aged 75 and over, flexibilities in delivering out-of-hours services and a new enhanced service to reduce unplanned admissions will offer opportunities to link directly with the plan and focus on integrating services locally. These will be considered in the context of 7 day provision linking with our out of hours provider.

In line with the **Barnet CCG Primary Care Strategy,** we have invested in IT infrastructure for GPs and on increased working with Community Pharmacy. Our GPs have begun to develop networks and we will invest in initiatives to address demand management issues and to support the management of more complex care in Primary Care.

We recognise that the changes will require a phased and managed approach working with partners. An overview of the anticipated timeline is:

[1] London Validation Report, My Home Life (November 2012)

**Jan – Mar 14**

- Continue with planned programme projects such as older peoples integrated care and rapid care
- Validate Health and Social Care Integration model and complete full business case to inform BCF investment for 15-16 including development of locality based integrated care teams
- Work with partners to co-design detailed operational delivery models including phasing of delivery
- Establishment investment profile from other parties, e.g. public health, into the Health and Social Care model to influence delivery of the BCF
- on an North Central London level continue with the value-based outcome work to further inform commissioning and contracting options

**April – March 2015**

- Complete detailed planning including milestones and specifications for implementation of early phase plans including testing models and sharing learning
- Establish benefits tracking mechanism to effectively monitor delivery of outcomes
- Establish and monitor financial flows
- Establish a mechanism to capture user views to effectively feed in use perspective to inform progress and continued improvement
- Develop later phase plans

**From April 2015**

- Use preparation from planning to implement and deliver plans through 15-16 with fully agreed BCF investment
- Fully functioning benefits tracking and financial monitoring model to monitor progress and outcomes

## Implications for the Acute Sector

*Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.*

Our two primary providers of acute hospital services are Barnet and Chase Farm NHS Trust and Royal Free NHS Foundation Trust. Extensive re-configuration of local infrastructure and service provision is currently underway. As outlined in the **Barnet, Enfield & Haringey Clinical Strategy**, changes of Chase Farm hospital site have resulted in shifts in demand and activity. Barnet Hospital has its own financial challenges and a proposed acquisition by the Royal Free is being taken forward. Partnership working in relation to implementation of

these plans has resulted in solid working relationships which have allowed us to test elements of the BCF plan particularly over the winter period of 13-14.

The Barnet Integrated Strategic and Operational Plan and Recovery Plan 2013 set out the challenges related to the local spend on acute hospital services. We spend about £43M more than other London Boroughs for the same population and, recognising the issue, are already taking steps to address this through an extensive service re-design and QIPP programme. In this context we have a very strong focus on:

- Transformational change of the health system through provision of integrated care for patients with complex needs as defined in the BCF plan. Through proactive identification, care planning and integrated management of care for patients with complex needs we will seek to avert crises, thus reducing the unplanned use of acute care;

- Reduction in elective acute care through robust management of referrals, and redesign of care pathways to provide upstream early intervention, a greater range of care in a primary care setting, and community based alternatives to acute care.

The business case for the ongoing Older Peoples Integrated Care (Frail Elderly) programme outlines potential reductions in attendances at A&E, emergency admissions, and length of stay. It is recognised that this will increase over the lifetime of the project with financial modelling in the initial years being conservative, with greater savings once fully embedded. Overall savings for 2014/15 are estimated to £639,377 and £904,165 in 2015/16.

Throughout this work stakeholders, including acute providers, have been kept informed of the CCG's commissioning issues through regular provider events to engage them in the work of the CCG, Clinical Commissioning Programmes and through Clinical Quality and Risk meetings with provider Trusts. We have worked hard to establish a partnership approach to local service delivery to ensure that we maintain quality and work collaboratively in implementation.

The Barnet Integrated Health and Social Care model provides greater ambition in terms of movement of costs and services away from acute and residential care through the provision of a framework for future delivery at scale and pace. It recognises both the NHS costs and the associated cost to social care of admissions to care home directly to the acute setting. Modelling in the outline business case makes assumptions on relative percentage shifts in activity over 3 years with re-investment in prevention, self-management and community based intensive services. . Further validation by the CCG and LBB is planned for January 2014, including testing assumptions on quantification of shift with providers. As part of the design groups, acute providers have been integral to shaping the model by influencing where service improvements would benefit patients and where efficiencies could be achieved.

Given the financial position of the Barnet health economy, significant emphasis will be applied to delivery of these targets through a shared plan with providers. Non-delivery must be seen in the context of an anticipated funding gap in Health and Social Care, and will manifest as multiple organisations running in deficit and reduced services. Further discussions will ensue with regard to commissioning options to support the plan, to include how we maintain stability in our provider landscape and risk share across the system.

## Governance

*Please provide details of the arrangements are in place for oversight and governance for progress and outcomes*

Strong Governance exists in Barnet across both Health and Adult Social Care. This includes the Health & Wellbeing Board (HWB) and its Finance sub-group; and the Health & Social Care Integration Board (HSCIB). Underpinning this is a shared Programme Management Office (PMO) and a Joint Commissioning Unit (JCU) comprising staff from both Barnet CCG and Council (Adults & Communities). While this is currently working well, there is a recognition that this will need to be re-aligned over the next few months to manage the changes associated with the BCF pooled budget.

The **Barnet Health & Social Care Concordat** articulates a clear vision and strategy for integrated care and this was agreed by all partners at the HWB. The Concordat itself was designed by partner members of the HSCIB.

We have regular meetings between our council cabinet member responsible for health and our CCG chair, together with regular meetings involving the senior management teams of Barnet CCG and Council (Adults & Communities). Our transformational plans and programmes are formally discussed and approved at local borough governance levels within the local authority and CCG.

The following embedded files refer to the relevant Terms of Reference for the governance framework operating in Barnet.

HWBB Final Terms of Reference.docx

Paper 2 Health Social Care Integratic

HSCIB Programme Governance vFinal.d

# NATIONAL CONDITIONS

## Protecting social care services

*Please outline your agreed local definition of protecting social care services.*

In Barnet, protecting social care services means delivering on the Health and Well-Being targets of Keeping Well and Keeping Independent, making sure that those in need receive timely and effective support, whilst managing increased demand and financial pressures. The BCF, as agreed by all partners, provides the platform for future investment and planning for health and social care with a central priority on outcomes for our people. Our commitment to the Barnet Health and Social care Integration Model clearly demonstrates that the BCF will make a positive difference to social care services, and outcomes for service users, compared to service plans in the absence of the funding transfer.

*Please explain how local social care services will be protected within your plans.*

The principles for protecting local social care services will be delivered through the following:

- Strategic direction for the BCF to take into account existing and future commissioning plans of the CCG and local authority and to have due regard to the Joint Strategic Needs Assessment (JSNA)
- An agreed shared governance framework for spend and management of the Better Care Fund with membership from health and social care. To include an approval process for services with appropriate input from relevant parties. Oversight and governance provide by the Health & Well-Being Board
- Services delivered through a jointly owned integrated care model with emphasis on maintaining people with health and social care needs in the community. Modelling to measure impact upon and reflect changes in demand to social care services with a view to maintaining or increasing where necessary
- Maintaining and developing services for carers
- Maintaining current FACs eligibility of substantial and critical, and through meeting needs of national eligibility criteria from April 2015
- Where possible move to joint commissioning of services via an agreed framework e.g. care home beds, enablement
- Working with local authority and providers to manage demand to ensure optimal usage of social care service provision
- Embed social care services within integrated delivery models to flex operational efficiencies and build services with greatest impact on people utilising the most appropriate care choice. Example would be delivery of reablement services through locality based integrated care teams
- Ensuring that additional demands for social care which can be attributed to increased out of hospital healthcare are considered for funding as part of the pooled budgets

## 7-day services to support discharge

*Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy)*
*Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.*

There are national and local drivers in place to establish 7 day working for health and social care, and to implement future plans which enable seamless transition of people into and out of hospital throughout the full week. This was clearly articulated at the design phase of the Health and Social Care Integration Model, both by service users and providers; and is a key theme through Health and Well-Being strategy and out of hospital care plans.

With a recognition that although have made significant progress, we need to enhance further the scope and reach of services already in place, we have taken the opportunity in recent months to test a number of initiatives for 7 day provision with additional funding available via winter pressures and Barnet, Enfield & Haringey clinical strategy. Using the evaluation of effectiveness of these initiatives, we will develop a forward plan to provide a consistent 7 day offer which can flex according to demand.

A range of current and planned services support this namely:

- Our district nursing and intermediate care services currently operate over 24 hours on a small scale. This will be extended into locality based integrated care teams with additional capacity for overnight coverage for ongoing care where necessary, including the use of night sitters where necessary
- We have recently increased the access hours of the community based rapid response team to accept referrals 7 days per week from GPs, out of hours services, care homes and acute teams providing intensive support for up to 120 hours
- Tracker nurses working within acute trusts are currently working 7 days per week identifying those who could be transferred home and supporting discharge
- Supported assessment, triage and discharge arrangements within local acute trusts including Urgent Care Centre (UCC), ambulatory care pathways, PACE, TREAT and RAID have recently been implemented and are all planned to offer 7 day provision from Jan 2014
- A work in progress is the development of protocols between services to support smooth transition and optimal care for patients to move home quickly, for example between rapid response and the UCC
- From Jan 2014, social work teams will be available 7 days per week within A&E departments to support care planning for transfer home and to understand and assess demand and impact for future plans
- Systems have been re-aligned to ensure that care packages can be accessed from our main providers throughout the weekend to initiate new packages of care and for changes to existing.
- Barnet is operating a managed system for Delayed Transfers of Care throughout the winter period, involving all providers. This is proving successful in facilitating, unblocking reasons for delay and allowing for transfer throughout the 7 days period
- A number of initiatives have been implemented within the acute trusts that impact of 7 day staffing particularly to support discharge. Examples include occupational therapy and access to pharmacy. These will require evaluation for future planning.
- By April 2014, we will have implemented the Barnet community point of access which will provide effective and safe referral point to facilitate discharge over 7 days
- Our out of hours GP cover is provided by Barndoc. Further work is required to strategically link and strengthen pathways between both Barndoc and primary care in general to ensure that appropriate services are in use over 7 days
- Early work is also underway to implement alternative care pathways with London Ambulance Service to facilitate avoided admissions

To support the above a clear communication strategy will be developed to give an over-arching view of the services available and to stream-line referrals and transitions across interfaces.

## Data-sharing

*Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.*

Most NHS acute and community health providers already currently use the NHS number extensively as the primary identifier for patients. This will also be strengthened in primary care with requirements under the new arrangements for the GMS contract for 14-15.

*If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by*

*Adult social services is in the process of adopting this. For example a **Shared Care Records** project is already underway, as agreed by the HSCIB, which will use the NHS number as the primary identifier for service users.*

*Please confirm that you are committed to adopting systems that are based upon Open APIs and Open Standards (i.e. secure email standards, interoperability standards (ITK))*

We are committed to using systems based upon Open Application Programming Interface and Open Standards.

*Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements , professional clinical practise and in particular requirements set out in Caldicott2.*

Barnet Council / CCG operate within an established Information Governance framework, including compliance with the IG Toolkit requirements and the seven principles in Caldicott 2. The contract documents used by Barnet CCG to commission clinical services conform to the NHS standard contract requirements for Information Governance and Information Governance Toolkit Requirement 132. Barnet CCG as a commissioner and to the extent that it operates as a data controller is committed to maintaining strict IG controls including mandatory IG training for all staff, and has a comprehensive IG Policy, Framework, IG Strategy and other related policies. Information Governance arrangements and the IG Framework conform to the IG Toolkit requirements in Version 11 of the IG Toolkit, including clinical information assurance as set out in requirement 420 and the requirements for data sharing and limiting use of Personal Confidential Data in accordance with Caldicott 2.

## Joint-assessments and accountable lead professional

*Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional.*
*Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional*

A number of existing and planned models will ensure that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional.

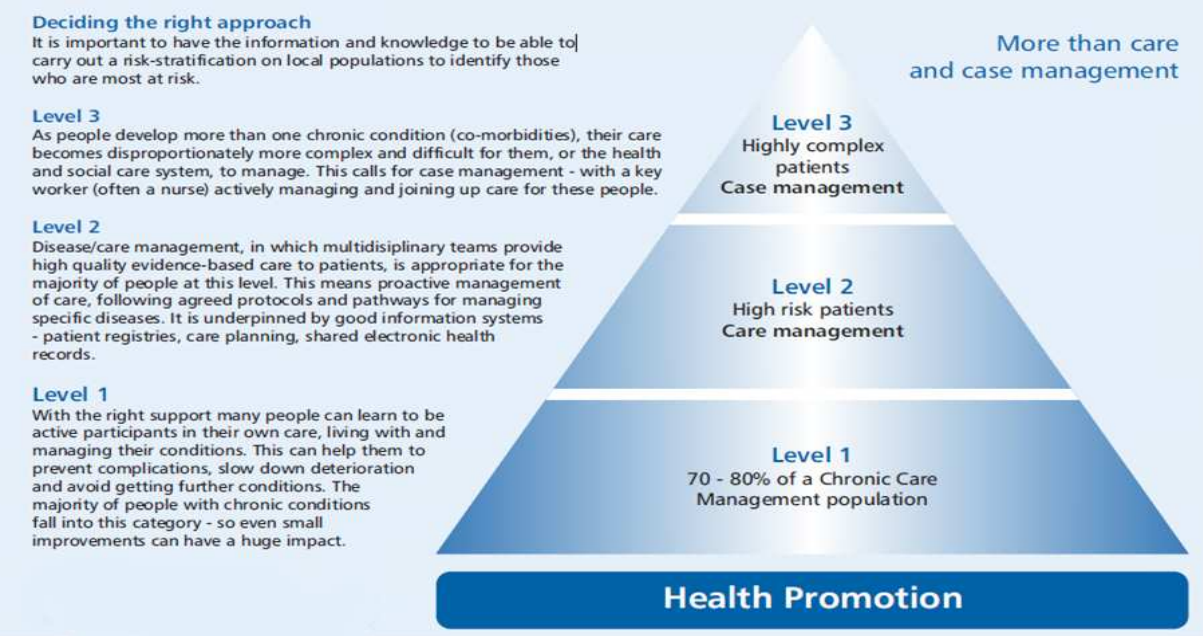
Key elements include:

- Use of risk stratification in primary care to identify those most at risk of admission to ensure that they are actively case managed. This calls upon practice intelligence and third-party data regarding utilisation of other services e.g. accident and emergency
- A weekly multi-disciplinary team meeting that provides a formal setting for multidisciplinary assessment and health and social care planning for very complex high risk patients who require specialist input. This accepts referrals from multiple sources including primary, secondary and social care and results in collective ownership of a planned care approach.
- A care navigation service which supports GPs with risk stratification and provides the care co-ordination role following MDT assessment.
- Planned changes to the GP contract for 14-15 whereby enhanced services are being introduced that aims to improve services for patients with complex health and care needs, who may be at high risk of unplanned admission to hospital. In particular, to case manage vulnerable patients (both those with physical and mental health conditions) proactively through developing, sharing and regularly reviewing personalised care plans, including identifying a named accountable GP and care coordinator
- Planned introduction of locality based integrated care teams incorporating health and social care with anticipated streamlining of care according to patient need rather than referral point. This will also bring into play a generic long term condition approach which will enable early identification and care planning for future management of exacerbations

This programme of work sits within the older people integrated care project and, as such has an existing agreed format for assessment, allocating lead professional, planning care and monitoring success measures of interventions. This will develop further within this programme to ensure that as services grow that assessments remain fit for purpose and allocate responsibilities appropriately.

Risk stratification of our population is key to enable us to better ensure that the right people receive proactive case management in a cost effective manner and to allow us to focus case management on individuals that will benefit most.

The most accurate method of identifying individuals at risk of a non-elective admission is through predictive models that use statistical algorithms to predict an individual's level of future risk. These individuals are at the highest risk of a non-elective admission (that is the top 5% of the risk pyramid) as reflected in Level 3 of the Kaiser Permanente's Pyramid




**Kaiser Permanente's Pyramid**

As part of the Older Peoples Integrated Care project a Risk Stratification tool has been procured and plans were in place for it to be utilised on a minimum cohort of 50,000 people, targeting those residents within the frail and elderly group to:

- Identify frail and elderly patients at risk of future A&E attendances and unplanned admissions
- Screen for the most important conditions including, but not limited to, long term conditions affecting frail and elderly people
- To provide GPs with a robust approach in understanding the variation in risk of future A&E attendances and hospital admissions across their local population
- To provide robust reports which allow practices to identify patients for review for case management interventions and multi-disciplinary team case conferences.

Although recent national information governance issues have hindered progress with the usefulness of the automated United Health HealthNumerics-RISC® tool we have identified a local work-around solution linked to the NHS England DES for GPs. In 13-14 a minimum of 2% of GP registered patients will be risk profiled using information available to primary care including: the RISC tool, the Urgent Care Dashboard and local practice searches, for example those identified as frequent attenders in Primary Care. To embed a holistic approach across a range of physical and mental health issues we have maintained a wide target group (within the frail and elderly cohort) to include patients already on or requiring initiation on pathways of care across a range of clinical areas such as end of life or palliative care, dementia, chronic disease, mental health and learning disabilities. It is anticipated that between 0.5% and 1% of the patients identified through this process may benefit from more active case management, and will have a joint care plan put in place.

Our approach moving forwards will include:

- Agreeing an approach for risk stratification for future years to further increase the number of residents who are identified through this method to prevent avoidable admission and better care

- fully implementing and integrating the guidance on joint assessments and accountable lead professional currently awaited from NHS England as part of the GMS contract changes for 14-15

- To further embed the framework for stratifying Barnet patients according to the four risk levels (as below), that will determine prioritisation of care planning and, where relevant, screening for the most important conditions affecting elderly people.

| | Requires Action Plan? | Frequency of review | Access to Rapid Response | Active Management |
|---|---|---|---|---|
| Highest Risk | Yes – Plan may include points to be picked up by community, social or specialist services. | Monthly | Yes | Yes |
| High Risk | Yes – Plan may include points to be picked up by community, social | Quarterly | Yes | No |
| Medium Risk | Yes – May include another GP review within a defined follow up period, navigation services may improve coordination of interventions | Quarterly | Yes | No |
| Low risk | Not required. Patient may benefit from information via navigation services | Annual | Yes | No |

## OUTCOMES AND METRICS

*For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.*

| |
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| |

*For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below*

| |
|---|
| |

*For each metric, please provide details of the assurance process underpinning the agreement of the performance plans*

| |
|---|
| |

*If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined*

| |
|---|
| n/a |

| Metrics | | Current Baseline (as at….) | Performance underpinning April 2015 payment | Performance underpinning October 2015 payment |
|---|---|---|---|---|
| *Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population* | *Metric Value* | 492.96 | N/A | |
| | *Numerator* | 243 | | |
| | *Denominator* | 49294 | | |
| | | ( April 2012 - March 2013 ) | | ( April 2014 - March 2015 ) |
| *Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services* | *Metric Value* | 83.10% | N/A | |
| | *Numerator* | 331 | | |
| | *Denominator* | 398 | | |
| | | ( Oct 2012 - Dec 2012 ) | | ( April 2014 - March 2015 ) |
| *Delayed transfers of care from hospital per 100,000 population (average per month, attributable to social care and both)* | *Metric Value* | 1.8 | | |
| | *Numerator* | 5 | | |
| | *Denominator* | 274,300 | | |
| | | ( April 2012 - March 2013 ) | ( April - Dec 2014 ) | ( January - June 2015 ) |
| *Avoidable emergency admissions (composite measure)* | *Metric Value* | | | |
| | *Numerator* | | | |
| | *Denominator* | | | |
| | | *( TBC )* | ( April - Sept 2014 ) | ( October 2014 - March 2015 ) |
| *Patient experience Patient experience (Adult Inpatient Survey 2012 - overall experience Q68, measure on a score of 0 - 10, 10 being best performance)* | | Barnet and Chase Farm = 7.7<br>Royal Free = 7.7 | N/A | |
| | | (Sept 12 - Jan 13) | | *( insert time period )* |
| *Service user experience Adult Social Care survey - overall satisfaction, those that replied extremely, very or quite* | | 87% | N/A | |
| | | Feb-13 | | *( insert time period )* |
| *[local measure - please give full description ]* | *Metric Value* | | | |
| | *Numerator* | | | |
| | *Denominator* | | | |
| | | *(insert time period )* | *( insert time period )* | *( insert time period )* |

# FINANCE

*For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16*

| Organisation | Holds the pooled budget? (Y/N) | Spending on BCF schemes in 14/15 | Minimum contribution (15/16) | Actual contribution (15/16) |
|---|---|---|---|---|
| Local Authority | | | £1,872,000 | |
| CCG | | £6,634,000 | £21,540,000 | |
| **BCF Total** | | **£6,634,000** | **£23,412,000** | |

*Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.*

| |
|---|
| |

| Contingency plan: | | 2015/16 | Ongoing |
|---|---|---|---|
| Outcome 1 | Planned savings (if targets fully achieved) | | |
| | Maximum support needed for other services (if targets not achieved) | | |
| Outcome 2 | Planned savings (if targets fully achieved) | | |
| | Maximum support needed for other services (if targets not achieved) | | |

*Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.*

Finance schemes summary. for draft 4.

# KEY RISKS

*Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers*

| Risk | Risk Rating | Mitigating Actions |
|---|---|---|
| 1. Shifting of resources to fund new joint interventions and schemes will destabilise current service providers, particularly in the acute sector | High | • An impact assessment will be required for the Health and Social Care Integration model to allow for greater understanding of the wider impact across the Barnet health economy<br>• Ongoing stakeholder engagement including co-design and transitional planning |
| 2. Baseline data supporting our plan relies on current assumptions. If they are incorrect it means that our financial and performance targets for 2015/16 onwards are unachievable. | High | • Validation of modelling in Health and Social Care Integration model extending into opportunities and costs for operational delivery<br>• Continued monitoring of assumption base-lines to identify trends early |
| 3. Organisational and operational pressures will restrict the ability of the local workforce to deliver the plans in accordance with the requirements. | High | • Embed the work of the joint commissioning unit with the programme to deliver projects<br>• Work with providers to co-design and seek shared opportunities for delivery<br>• If necessary invest in pump-prime activity to drive the plan at an early stage<br>• Consider alternative commissioning options |
| 4. Planned improvements in the quality of care and in preventative services will not result in the expected reductions in acute and nursing / care home activity, impacting the overall funding available to support core services and future schemes. | High | • Preventative work plans to be founded in a robust evidence base to maximise probability of success<br>• Widespread stakeholder engagement to embed communication messages and hence increase uptake<br>• Continued monitoring of outcomes to assure delivery with governance arrangements to enable service adjustments as required |
| 5. The introduction of the Care Bill, currently going through Parliament and expected to receive Royal Assent in 2014, will result in a significant increase in the cost of care provision from April 2016 onwards that is not fully quantifiable currently and will impact the sustainability of current social care funding and plans. | High | A Care Bill Work Programme involving Officers from across the Council and including Lead Member representation has been established to evaluate the financial and non-financial impact of the Care Bill and related mitigating actions. The Council will also be participating in an LGA/ADASS sponsored survey in January 2014. This utilises a model developed by Surrey County Council to help assess the current and expected costs of implementing the Care Bill in particular the cap on people's care costs and the universal offer of deferred payment agreements from April 2015 and April 2016 respectively. |

| | |
|---|---|
| Meeting | Health and Well-Being Board |
| Date | 23rd January 2014 |
| **Subject** | **Public Health Commissioning Intentions 2014-15** |
| Report of | Director of Public Health for Barnet and Harrow |
| Summary of item and decision being sought | The paper contains the commissioning intentions for Public Health in Barnet for 2014-15. The intentions will support the delivery of statutory requirements and the provision of discretionary services within the Local Government Public Health remit. The intentions align with the priorities within the Barnet Health and Well Being Strategy and represent the Council's Public Health contribution to delivery of the Strategy. The Board is asked to note its content. |

| | |
|---|---|
| Officer Contributors | Brian Jones, Barnet and Harrow Public Health Service |
| Reason for Report | To advise the Health and Well-Being Board of the Public Health Service commissioning intentions for 2014-15. |
| Partnership flexibility being exercised | None |
| Wards Affected | All |
| Status (public or exempt) | Public |
| Contact for further information: | Brian Jones, Public Health Service, Harrow Council<br>Brian.Jones@Harrow.gov.uk<br>020 8966 5542 |

## 1. RECOMMENDATION

**1.1 That the Board notes the Public Health commissioning intentions for 2014-15.**

## 2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 Not applicable.

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

3.1 The proposed commissioning intentions align with and support delivery of the Health and Well-Being Strategy and the commitments outlined in this first annual performance report of the Strategy, presented at the Board in November 2013.

3.2 Specifically the four themes of the Health and Well-Being Strategy are supported by various Public Health programmes and initiatives as summarised in the table below:

| | Preparation for Healthy Life | Well-Being in the Community | How we Live | Care when Needed |
|---|---|---|---|---|
| Sexual Health | ✓ | | ✓ | |
| School Nursing including NCMP | ✓ | ✓ | | |
| Drugs | ✓ | ✓ | ✓ | ✓ |
| Alcohol | ✓ | ✓ | ✓ | ✓ |
| Health Checks | | ✓ | ✓ | ✓ |
| Smoking cessation | ✓ | ✓ | ✓ | ✓ |
| Healthy weight and healthy eating | ✓ | ✓ | ✓ | |
| Lifestyle Interventions | ✓ | ✓ | ✓ | ✓ |
| Employment | | ✓ | ✓ | |
| Self Care | | ✓ | ✓ | ✓ |
| Active Leisure (Leisure Centres) | ✓ | ✓ | ✓ | |

3.3 The proposed commissioning intentions support public health's responsibilities in delivery of the Health and Wellbeing Strategy.

The first annual performance report of the Health and Well-being Strategy, presented to the Health and Well-Being Board in November 2013, outlined the following priority areas for new and/or additional public health investment in

2014 (either with public health taking a lead investment role or providing supporting investment to other services):

- Developing of a new model for health visiting and school nursing services ahead of 2015-16
- Limiting social isolation
- Supporting residents into employment
- Tackling increasing and higher risk drinking in the Borough
- Developing self-care initiatives that will help residents maintain their independence

## 4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 The commissioning intentions align with the Barnet Health and Well-Being Strategy which is based on the population health needs identified in the Joint Strategic Needs Assessment (JSNA). The Joint Strategic Needs Assessment considers health and social care outcomes across all of Barnet's population groups and pays particular attention to the different health inequalities that exist in the Borough.

## 5. RISK MANAGEMENT

5.1 Final values for some contracts are subject to final agreement. Work is in hand to contain spending on those contracts for open access services.

5.2 Externally provided services are subject to contract management and performance scrutiny to ensure effective and appropriate delivery of service.

## 6. LEGAL POWERS AND IMPLICATIONS

6.1 The 2012 Health and Social Care Act imposes duties on councils to deliver a number of public health functions.

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

7.1 The Public Health commissioning intentions will be entirely financed by the ring-fenced Public Health allocation to Barnet Council from central government as announced on 10th January 2013 for the financial years 2013-14 and 2014-15.

7.2 The Department of Health (DH) allocated £14,335,000 to Barnet Council for the financial year 2014-15. This figure includes the previous separate allocation for DIP (Drug Intervention Programme) Drug and Alcohol funding but not the MOPAC element (London Mayor's Office for Policing and Crime) which, it is expected, will be paid separately to the Council. This budget will allow public health mandatory requirements to be met, core services to continue and the introduction of new services to develop in response to local needs.

## 8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 The commissioning intentions in the paper are derived from the Joint Strategic Needs Assessment and consultation with various stakeholders during the production of the Barnet Health and Well Being Strategy.

## 9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 As 8.1 above.

## 10. DETAILS

10.1 The major services commissioned by the public health team to meet its mandatory duties are: increasing access to NHS Health Checks, sexual health and family planning, and the national child measurement programme (delivered as part of the school nursing service).

10.2 Other services commissioned include: improving recovery outcomes for drug and alcohol users (building on year on year improvement in outcomes in Barnet); reducing the number of people who smoke (and targeting the single biggest preventable killer), healthy weight initiatives for children and adults; and community well-being initiatives.

10.3 Areas of new investment in 2013-14 will continue to be funded in 2014-15. These are: Children's Centre investments, parenting support, support for first time mothers, breastfeeding, children's oral health, Barnet Healthy Schools Programme (physical activity, emotional wellbeing, nutrition, sexual health, substance misuse and discouraging smoking), workplace health promotion and employment support, outdoor gyms, older people's physical activity opportunities and the Winter Well programme.

10.4 The prevention of ill health investments are based on three principles:

<u>Primary prevention extends disease free life and supports the compression of morbidity (i.e. people will be supported to live healthy lives for longer)</u>
Life expectancy has increased significantly in recent years but so has the prevalence of chronic degenerative disease. If life expectancy increases at a faster rate than increase to disability-free life expectancy (i.e. later onset of chronic disease), the period that people live with chronic disease and their demands on services will increase. To avoid this there needs to be substantial delays in the onset of disability in later life. This is achieved through primary prevention that promotes the widespread adoption of healthier lifestyles, coupled with social changes that support these lifestyles. Investment in secondary prevention, i.e. preventing illness becoming more severe, aims to prevent deteriorating health and escalating need for services.

<u>Investing early in the life course will deliver greatest returns</u>

Whilst the public health investments cover the whole life course it is recognised that the greatest cumulative returns are achieved from intervention in early years and childhood (Marmot Review, 2010),

Supporting elderly people to improve their ability to look after themselves will improve their health and minimise their need for care outcomes, and allow funding to be re-invested in prevention rather than cure
As set out in Barnet's Health and Well-Being Strategy, *"In both the NHS and Adult Social Care, the spending profile is skewed towards acute hospital and residential based care. Better care and support can be delivered in people's own homes avoiding admissions to hospital, promoting choice in end of life care through integrated working across health and social care, joining up services around the individual and providing good support to family carers to sustain them in their caring role."*

10.5 The following table gives concrete examples of what these principles mean in practice and what is intended in Barnet in 2014/15.

| **Public Health area** | **Services expanding/ increasing primary prevention** |
|---|---|
| Early years | Development of single children's health offer (with transition of health visiting from the NHS to local authorities in 2015): investing in pre- and post- natal support and develop parenting skills programmes and tackling obesity in early years |
| Mental health | Investment to build emotional resilience and wellbeing in schools and Ageing Well community networks. |
| Physical activity | Environmental improvements and behavioural interventions building on existing investment (outdoor gyms and marked routes, Healthy Weight initiative in Children's Centres) with appropriate links to primary care |
| Employment | Public health work includes development of targeted services to help people into work with a particular lead on addressing health related concerns e.g. drugs and alcohol |
| Older people | Contributing investment to delay onset of ill health, supporting expansion of self-care, maintaining mobility and tackling social isolation |

10.6 In 2014 – 15 new areas for investment are:

Return to work/ Unemployment and health
Building on experiences of commissioning employment support for residents affected by welfare reform, a broader programme of support into work will be developed in conjunction with other Council initiatives. The protective health benefits of employment and the detrimental consequences of unemployment are well recognised and these investments have the potential to deliver health benefits whilst containing costs to the Council and its partners.

Supporting people with long term health conditions – self care
This investment will be used to develop a programme to support self care for people living with long term conditions in the community. It will align with and enhance the self care and prevention components of the integrated care programme.

Alcohol Intervention
This will be used to support the Alcohol strategy and fund a range of initiatives including health information and awareness raising campaigns, licensing, brief intervention and additional alcohol treatment services.

Ageing Well
The Ageing Well investment will continue and extend supporting the neighbourhood projects in East Finchley and Burnt Oak. These are projects which connect with local older people in those areas and support them in identifying local issues and developing local responses to address them. These include tackling isolation, mental health, and physical activity.

Further investment in Outdoor Gyms
Subject to satisfactory evaluation of the first tranche of outdoor gyms and marked and measured routes which should be operational in early 2014, it is intended that further infrastructure investment will follow in the financial year 2014-15.

Public Health promotion and campaigns
A programme of pro active press releases will be conducted. Physical activity promotion will be a particular focus in 2014-15 with a Fit and Active Barnet (FAB) campaign launching in the New Year and running alongside the Director of Public Health Physical Activity Challenge.

10.7 The budget for 2014-15 is:

| | | |
|---|---|---|
| **Health Checks** | **573,425** | |
| **Sexual Health** | **4,368,461** | |
| **National Child Measurement and other Schools work** | **1,083,508** | |
| **Drug Misuse** | **1,091,933** | |
| **Alcohol Misuse** | **1,637,899** | |
| **Tobacco control** | **688,249** | |
| **Physical Activity** | **680,000** | |
| **Barnet Public Health** | **2,304,056** | **Includes continued funding of new investment from 2013/14, new investment in 2014/15, and contingency funds** |
| **Non Payroll** | **569,265** | **Includes PH Service** |

| | | |
|---|---|---|
| | | **infrastructure costs payable to Harrow council** |
| **Payroll** | **1,426,610** | **Includes funding contribution to the Barnet Council graduate placement scheme** |
| **Budget** | **14,423,406** | |

## 11 BACKGROUND PAPERS

11.1 None

Legal – LC
CFO – JH

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| | |
|---|---|
| Meeting | Health and Well-Being Board |
| Date | 23rd January 2014 |
| **Subject** | **Joint Strategic Needs Assessment (JSNA)** |
| Report of | **Director of Public Health** |
| Summary of item and decision being sought | The production of a JSNA is a requirement of the Health and Well-Being Board. These 6 reports are re-presented to the Board with amendments made in response to the Board and the partnership forum Autumn update.<br>The Board are asked to accept these reports. |

| | |
|---|---|
| Officer Contributors | Carole Furlong, Consultant in Public Health and the Barnet and Harrow Knowledge and Intelligence Team |
| Reason for Report | The production of a JSNA is a requirement of the Health and Well-Being Board. |
| Partnership flexibility being exercised | N/A |
| Wards Affected | Whole Borough |
| Status (public or exempt) | Public |
| Contact for further information | Carole Furlong, Consultant in Public Health, carole.furlong@harrow.gov.uk |
| Appendices | Appendix A: Children and Young People JSNA<br>Appendix B: Dementia JSNA<br>Appendix C: Maternity and Infant Health JSNA<br>Appendix D: CVD JSNA<br>Appendix E: Diabetes JSNA<br>Appendix F: Mental Health JSNA |

## 1. RECOMMENDATION

**1.1 That the Health and Well-Being Board accepts the draft reports and notes the actions to further refresh the JSNA.**

## 2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 The reports are a refresh of the Joint Strategic Needs Assessment which supports 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 report supports the Health and Well-Being Strategy and other strategies by providing analysis of local issues upon which the strategies can be written.

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## 4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 The Equality Act 2010 places specific and general duties on service providers and public bodies. This includes having due regard to the equality implications when making policy decisions around service provision.

4.2 The individual needs assessment reports benchmark Barnet against England and London and where possible give more local analyses. This has been done with respect to equalities for example, age and gender specific rates, if the data supports this level of analysis. If data is available to cover disability then this will be included in future version. However, it must be noted that, for the majority of datasets, equalities groups are not recorded and therefore they do not support this analysis.

## 5. RISK MANAGEMENT

5.1 None identified.

## 6. LEGAL POWERS AND IMPLICATIONS

6.1 Section 196(1) The Health and Social Care Act 2012 requires that the functions of the CCGs and local authorities of preparing a Joint Strategic Needs Assessment and a Joint Health and Well-Being Strategy be discharged by the Health and Well-Being Board. Local authorities, CCGs and NHS England must have regard to these documents when exercising their functions.

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

7.1 The reports identify the current status of the population and the current and future needs. They do not have financial implications. It is through the Health and Well-Being Strategy that health and social care commissioners should demonstrate how local priorities have been informed by the findings of the JSNA.

## 8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 The reports have been complied with contributions from commissioners.

8.2 The reports were discussed at the Partnership Summit meeting on 5th November 2013 and have been shared the respective CCG clinical leads for their input.

## 9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 See 8.2.

## 10. DETAILS

10.1 The JSNA will be refreshed as a rolling programme of themed reports. There will be two main formats for the reports. The first will be detailed briefings based on specific national Public Health Outcome Framework Indicators (the first three of which have already come to the Barnet Health and Well-Being Board) and the second will be thematic reports. The papers submitted today are thematic reports.

10.2 In addition, the Annual Report of the Director of Public Health will contribute to the knowledge base and quarterly data updates on all of the Public Health Outcome Framework indicators will be produced as they are released by Public Health England.

10.3 This refresh includes six themed reports on Cardiovascular Disease; Children; Dementia; Diabetes; Maternity and Child health; and Mental Health.

10.4 These reports were presented to the Board as drafts in November 2013. They have been reformatted to incorporate explanation of the data and how to interpret the spine charts. The stakeholder views have been added. The reports were sent to the CCG and were updated where comments were received.

10.5 Each report includes

- A summary of key messages;
- Local data and maps with commentary and explanation of each of the graphs and maps. The data within the reports covers population demographics; risk factors and determinants that contribute to the topic (which may be lifestyle, societal, service or environmental); health outcomes and non-health outcomes.
- Benchmarked data in the form of a spine chart (a graphical representation a range of indicators which can be compared to the London and England averages and the range across England);
- A final page of stakeholder views from the Autumn Catch up of the Partnership Boards on 5th November 2013.

10.6 Future reports under the JSNA umbrella are in progress. These include

- A thematic report on vulnerable children/children in need
- A needs assessment on child and adolescent mental health services
- A needs assessment on adults with autistic spectrum disorder including Asperger's syndrome (due to start in early February 2014)

10.7 A JSNA Programme Board is to be set up. As the JSNA is being coordinated by the joint public health service, this will be organised jointly with Harrow Council. It needs the input of the different partners so that the work can be considered as a joint piece of work. Representatives from adult social care, children's services, housing, planning, culture, leisure and environmental health have been invited to be part of the programme board in addition to the CCG and Healthwatch partners. An additional voluntary sector representative will be sought. The remit of this Programme Board is:

- to ensure that all partners are fully engaged in the development of the JSNA;

- to identify data and data sources and to establish the necessary data sharing agreements to support the development of the JSNA;
- to identify and prioritise the work programme for future updates in 2014;
- to determine the extent to which it is necessary to aim for consistent outputs across different topic areas;
- to agree what can be delivered within available resources ensuring an agreed delivery schedule and identifying if/where additional capacity needs to be secured;
- to consider how the evidence presented in local needs assessments, development plans and commissioning plans, will contribute to the general picture of need in the borough in the 2015 JSNA
- to develop the work plan for the next full JSNA which will be developed in 2015 so that it informs the development of the next health and wellbeing strategy which is due in 2016.

10.8 Following sign off by the Health and Well-Being Board, these reports will be added to the Council website so that they are accessible to partners, stakeholders and the public.

## 11 BACKGROUND PAPERS

11.1 None

Legal – LC
CFO – AD

# JSNA Data Refresh 2013/14 Children and Young people Barnet

This profile has been created to provide a snap shot of child health in Barnet. This is designed to help the local authority and health services improve the health and well-being of children and tackle health inequalities.

## Key Messages

### Changes in population

Almost a quarter of people in Barnet are aged 18 or less. By 2025, children and young people (CYP) population will increase by 18% - a further 16,000 young people.
34% of Barnet CYP are from a white ethnic group.

### Child Poverty

The level of children living in poverty in Barnet (21.2%) is above the England average (20.6%) and below the London average (26.7%).

### Life expectancy

The life expectancy for boys living in Barnet is 80.8, while for girls it is 84.2. The longest life expectancy for boys is in Brunswick ward (83.8 years) and for girls in Mill Hill (86 years).

### Health outcomes

Outcomes for children in Barnet are better than those of London and England as a whole.

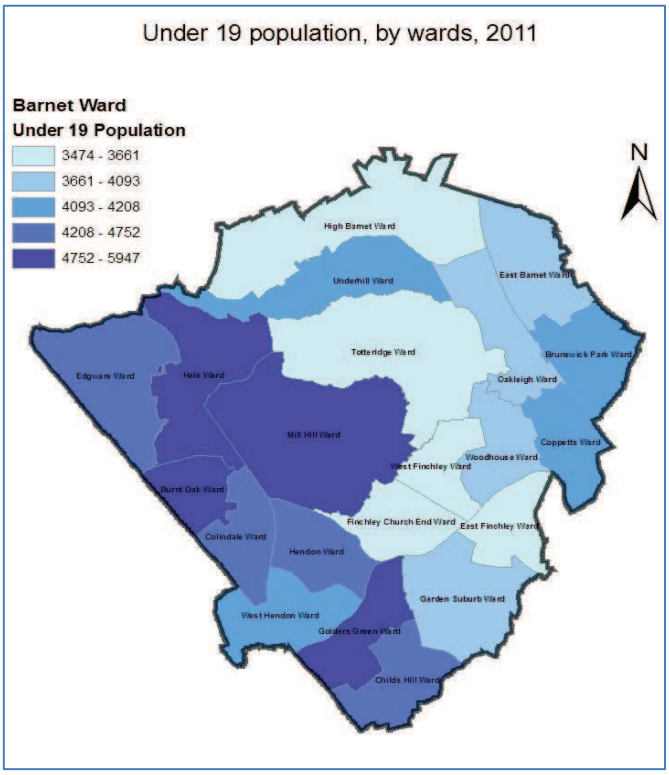
### Non-health outcomes

Young people in Barnet have higher educational attainment and fewer are not in education, employment or training (NEET) than the London and England averages.

### Strategy

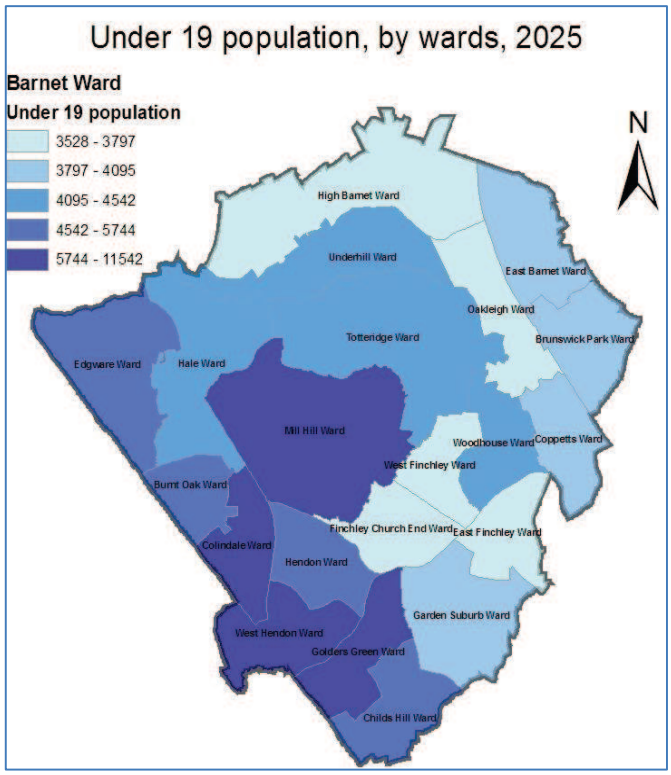
Barnet's children and young people plan has six themes which will support children, young people and their families to lead happy and successful lives. These are:

1. Early years
2. Primary
3. Secondary
4. Preparation for adulthood
5. Early intervention and prevention
6. Targeting resources to narrow the gap

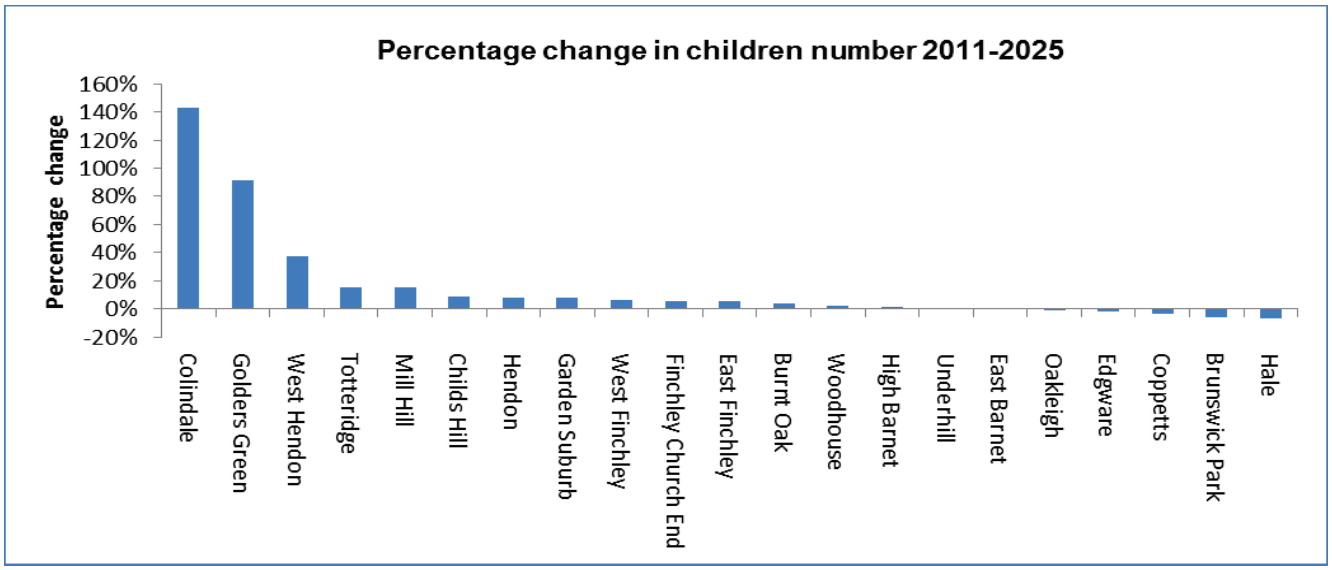


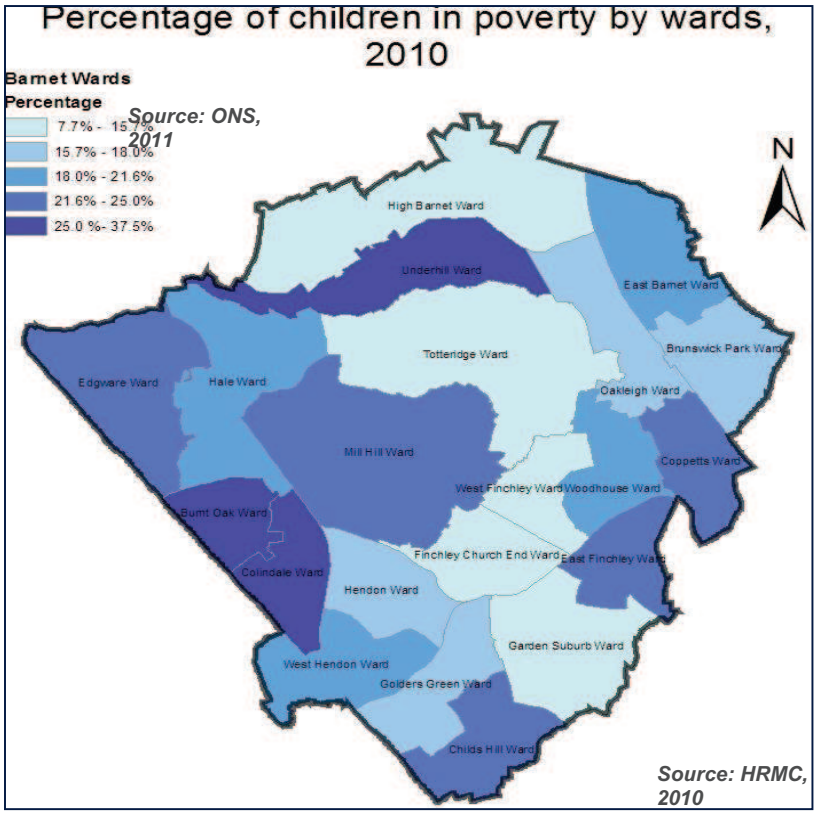

Of the people 364,000 in Barnet, 90464are children and young people aged less than 19 years. So, almost 1 in 4 of the Barnet population are under 19.

The distribution of the under 19 population is not even across the borough. The map shows there is a high number of the children and young people who come from Golders Green, while High Barnet has the lowest population of children and young people.




Across Barnet, there is projected to be an increase in the under 19 population. However, the increase in the under 19 population is not even across the borough, for example, the number of children and young people in Hale and Brunswick Park wards will decrease by more than 10% by 2025, while it is predicted that the population in both Colindale and Golders Green wards will increase by 143% and 92% respectively.



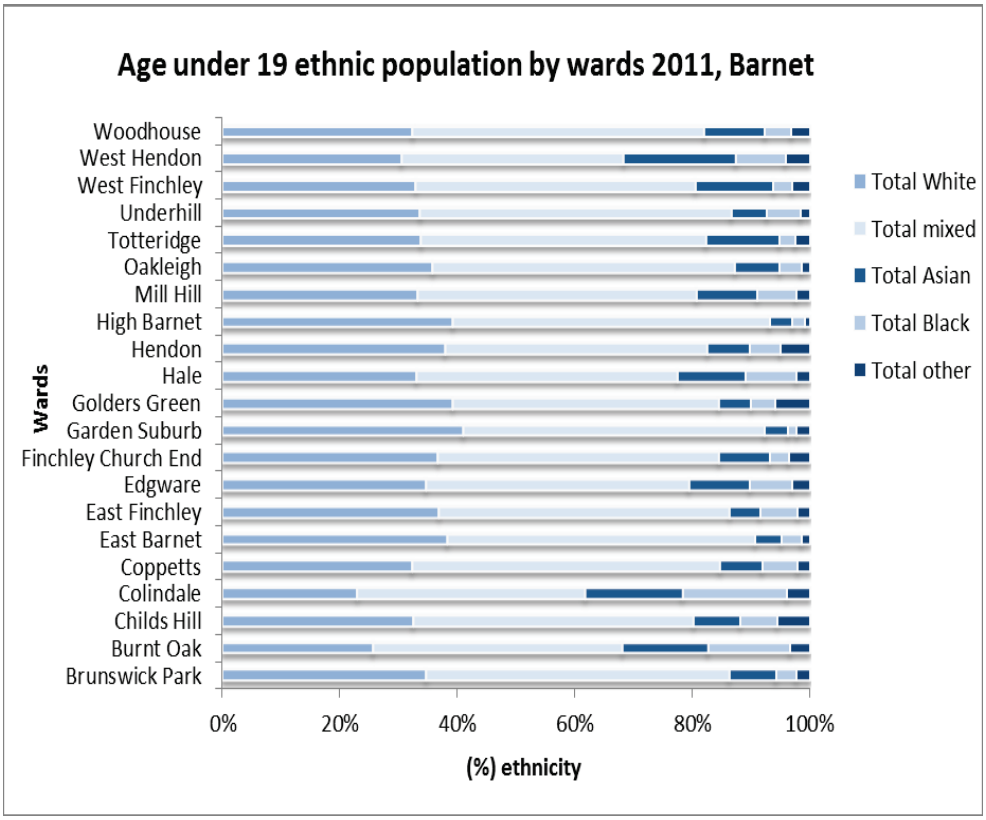



The Marmot Review (2010) suggests there is evidence that childhood poverty leads to premature mortality and poor health outcomes for adults. Reducing the numbers of children who experience poverty should improve these adult health outcomes and increase healthy life expectancy.

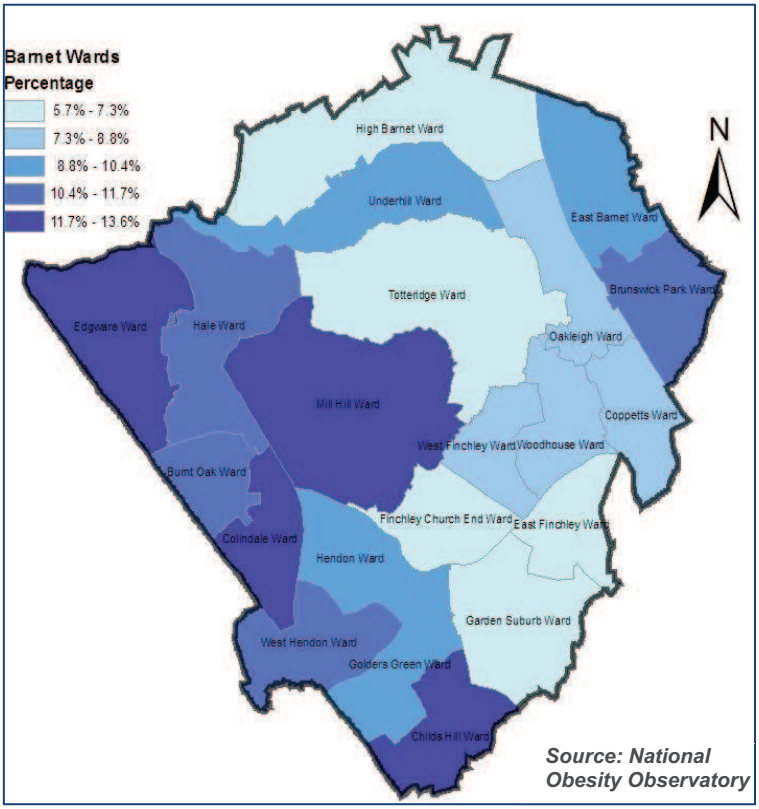
Children in poverty is defined as the percentage of children aged under 16 in low income families (children living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income).

Barnet has a higher level of poverty (21.2%) than the England average (20.6%) but it is lower than the London average (28%) Children in Poverty are not evenly distributed across the borough. The children in poverty rate in Colindale ward (37.5%) is highest and is lowest in Gardern Suburb Ward (7.7%).

Barnet is a very ethnically diverse borough. The ethnicity of children and young people varies by ward. Golders Green ward has the highest proportion (45%) of children and young people who have a mixed ethnicity. Golders Green also has the highest proportion (39%) of children of white ethnicity. Burnt Oak has the highest proportion (14%) of children of Asian ethnicity.



**Prevalence of obesity in reception by wards 2009/2010 – 2011/2012**

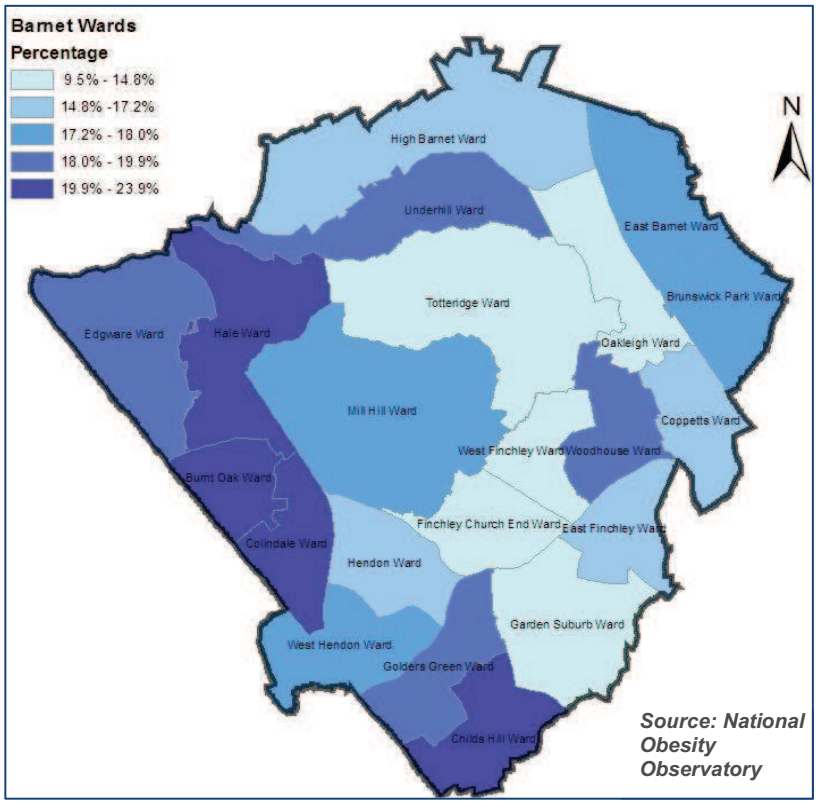


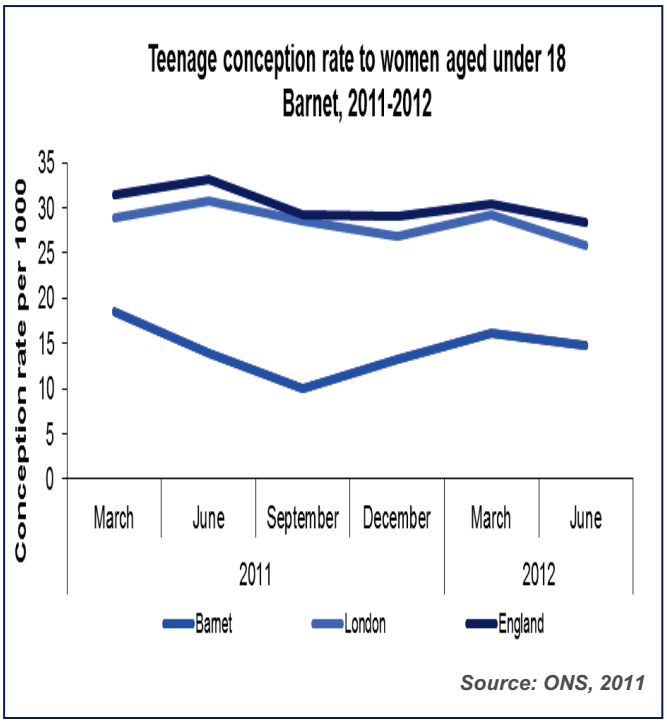

There is concern about the rise of childhood obesity and of such obesity persisting into adulthood. The risk of obesity in adulthood and risk of future obesity-related ill health are greater as children get older. The health consequences of childhood obesity include: increased blood lipids, glucose intolerance, Type 2 diabetes, hypertension, increases in liver enzymes associated with fatty liver, exacerbation of conditions such as asthma and psychological problems such as social isolation, low self-esteem, teasing and bullying.

The rate of obesity in reception children (aged 4-5) in Barnet is, 9.6%. This is similar to England level (9.5%) and lower than London (11.0%).The rate is highest in Edgware (12.7%), and lowest in East Finchley (5.8%).

By year 6 (aged 10-11) the obesity level in Barnet (19.1%) is lower than both London (22.5%) and England (19.2%) . However, rates in Burnt oak and Hale Wards are highest with 23.9% while Gardern Suburb ward has the lowest obesity level with 9.5%

**Prevalence of obesity in Year 6 by wards 2009/2010 – 2011/2012**






Teenage pregnancy is associated with poorer outcomes for both young parents and their children. Teenage mothers are less likely to finish their education, are more likely to bring up their child alone and in poverty and have a higher risk of poor mental health than older mothers. Infant mortality rates for babies born to teenage mothers are around 60% higher than for babies born to older mothers. The children of teenage mothers have an increased risk of living in poverty and poor quality housing and are more likely to have accidents and behavioural problems.

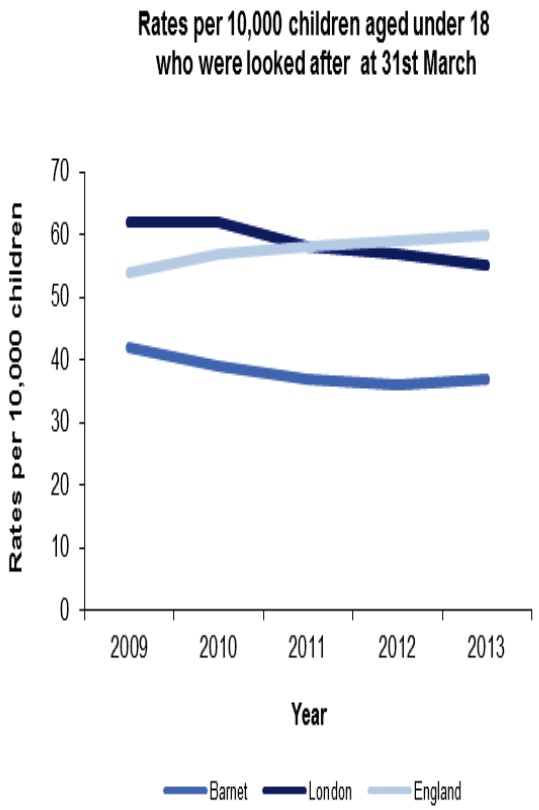
Teenage pregnancy rates have been consistently lower in Barnet than those of London and England.

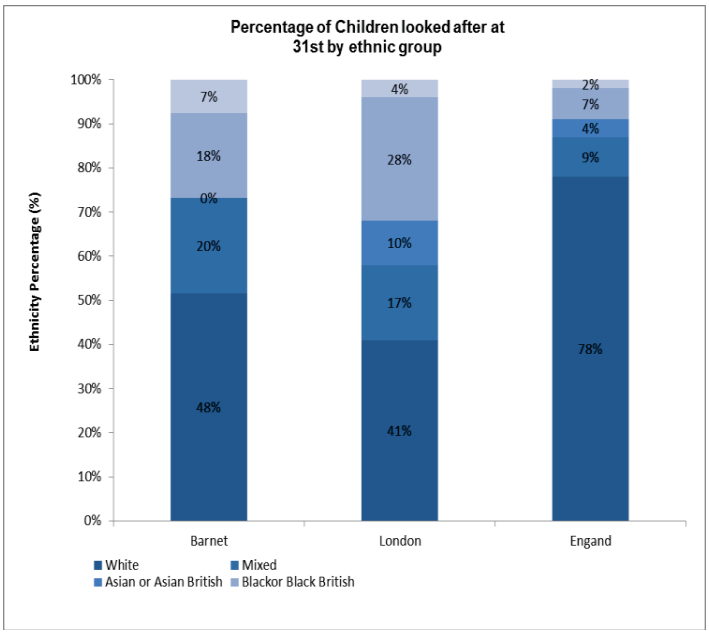
The term 'looked-after children and young people' is used to mean those looked after by the State where the Children Act 1989 applies, including those who are subject to a care order or temporarily classed as looked after on a planned basis for short breaks or respite care.

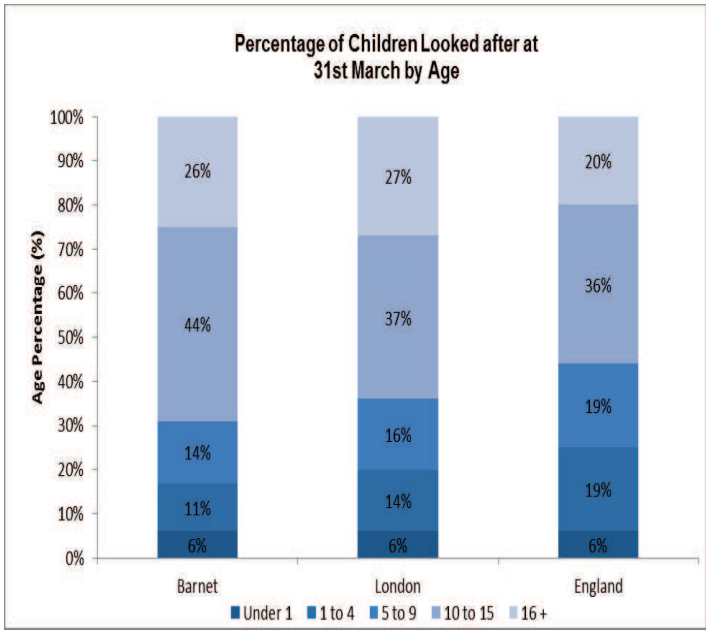
The rate of children looked after under the age of 18 in Barnet has been consistently lower than both London and England average for the past 5 years.

There is greater ethnic diversity in looked after children in Barnet with children of white ethnicity over represented. The age profile of Barnet's looked after children are also different to that of London and England. There is a higher proportion in the 10-15 age groups.

The health of looked after children will be examined in more detail in the report on vulnerable children.



# Understanding the Spine Chart

### The Spine chart

The spine chart is a way of demonstrating a lot of information on a single diagram.

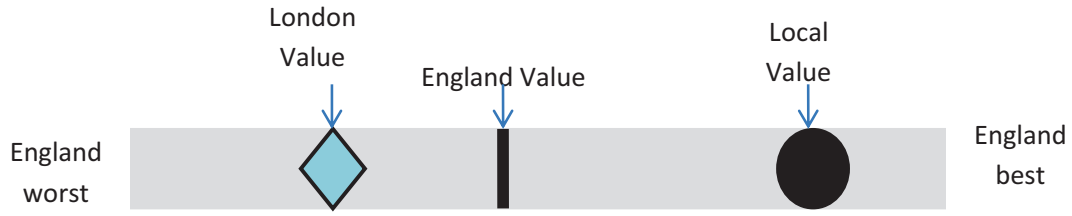
The indicators in the spine chart are generally one of three sorts:

- an indicator of higher or lower need
- an indicator of better or worse performance
- an indicator of better or worse outcomes

The "spine" is the line running down the centre. This is the England average for each indicator. The grey bar shows the range of values in local authorities across England.

Values to the **right** of the England average are better performance or outcomes or of lower need.

Values to the **left** of the England average are worse performance or outcomes or of more need.




### Direction of travel indicator

⇧ Indicator has improved since last year i.e. Improvement in performance or decrease in need

⇩ Indicator has worsened since last i.e. decrease in performance or increase in need

⇔ No change since previous year

**Green** indicates that, according to the latest data, the area is either performing better or has lower need than England average

**Red** indicates that, according to the latest data, the area is performing at least 2% worse or has at least 2% greater need than the England average.

**Amber** indicates that, according to the latest data, the area is performing worse or has greater need but is within 2% of the England average.


| | Indicator | Direction of travel | Local Value | Eng Avg | Eng Worst | England Range Worse Higher OUTCOME NEEDS Better Lower | Eng Best |
|---|---|---|---|---|---|---|---|
| 1 | Infant mortality | ↑ | 3.5 | 4.3 | 8.0 | | 1.1 |
| 2 | Child mortality rate | ↑ | 10.3 | 13.7 | 23.7 | | 7.5 |
| 3 | MMR Immunisation (by age 2 years) | ↑ | 92.7 | 91.2 | 78.7 | | 97.2 |
| 4 | Diphtheria, tetanus, polio, pertussis, Hib immunisations (by age 2 years) | ↑ | 96.9 | 96.1 | 85.7 | | 97.2 |
| 5 | Children in care immunisations | ↑ | 87.5 | 83.1 | 0.0 | | 100.0 |
| 6 | Acute sexually transmitted infections (including Chlamydia) | NA | 26.2 | 35.6 | 75.2 | | 19.9 |
| 7 | Children achieving a good level of development at age 5 | ↔ | 69.0 | 63.5 | 51.5 | | 76.5 |
| 8 | GCSE achieved (5A*-C inc. Eng and maths) | ↑ | 69.2 | 59.0 | 31.9 | | 81.0 |
| 9 | Not in education, employment or training( age 16-18) | ↓ | 4.1 | 6.1 | 11.8 | | 1.6 |
| 10 | First time entrance to the youth justice system | ↑ | 587.1 | 876.4 | 2436.3 | | 342.9 |
| 11 | Children living in poverty (aged under 16 years) | ↑ | 21.2 | 21.1 | 45.9 | | 6.2 |
| 12 | Family Homelessness | ↑ | 1.8 | 1.7 | 7.4 | | 0.1 |
| 13 | Children in care | ↑ | 36.0 | 59.0 | 150.0 | | 19.0 |
| 14 | Children killed or seriously injured in road traffic accidents | ↑ | 9.3 | 22.1 | 47.9 | | 4.4 |
| 15 | Low birth weight | ↓ | 7.5 | 7.4 | 11.0 | | 5.0 |
| 16 | Obese children(4-5 years old) | ↑ | 10.2 | 9.3 | 14.8 | | 4.3 |
| 17 | Obese Children(10-11 years old) | ↓ | 19.1 | 18.9 | 27.5 | | 10.2 |
| 18 | Participation in at least 3 hours of sport/PE | ↔ | 53.5 | 55.1 | 40.9 | | 79.5 |
| 19 | Children tooth decay | ↔ | 0.5 | 0.7 | 1.5 | | 0.2 |
| 20 | Teenage conception rate( aged under 18 years) | ↑ | 19.1 | 34.0 | 58.5 | | 11.7 |
| 21 | Teenage mothers | ↑ | 0.3 | 1.3 | 2.8 | | 0.3 |
| 22 | Hospital admission due to alcohol specific condition | ↓ | 36.6 | 61.8 | 154.9 | | 12.5 |
| 23 | Hospital admission due to substance misuse(age15-24 years) | ↓ | 41.1 | 69.4 | 186.3 | | 25.7 |
| 24 | Smoking in pregnancy | ↑ | 5.2 | 13.3 | 30.0 | | 2.9 |
| 25 | Breastfeeding initiation | ↓ | 91.8 | 74.8 | 41.8 | | 96.0 |
| 26 | Breastfeeding at 6-8 weeks | ↓ | 75.4 | 47.2 | 19.7 | | 82.8 |
| 27 | A&E attendances (0-4 years) | ↓ | 498.7 | 483.9 | 1187.4 | | 136.3 |
| 28 | Hospital admissions due to injury (age under18) | ↑ | 74.2 | 122.6 | 211.1 | | 72.4 |
| 29 | Hospital admission for asthma (age under19) | NA | 131.2 | 193.9 | 484.4 | | 73.4 |
| 30 | Hospital admission for mental health conditions | ↓ | 118.0 | 91.3 | 479.7 | | 22.6 |
| 31 | Hospital admission as a result of self- harm | ↑ | 60.2 | 115.5 | 311.9 | | 26.0 |

# Spine Chart Data Sources

| | Year | Data description | Other sources of information or data |
|---|---|---|---|
| 1 | 2009-2011 | Mortality Rate per 1000 live births | IC website |
| 2 | 2009-2011 | Directly standardised rate per 100,000 | Chimat |
| 3 | 2011/2012 | percentage of children immunised against MMR | Chimat |
| 4 | 2011/2012 | Percentage children completing a course of immunisation against diphtheria, tetanus, polio, pertussis and Hib | Chimat |
| 5 | 2012 | Percentage of children in care with up-to-date immunisations | Department of Education |
| 6 | 2011 | Acute STI diagnoses per 1,000 | Chimat |
| 7 | 2012 | Percentage of children achieving a good level of development within Early Years Foundation Stage Profile | Department of Education |
| 8 | 2011/2012 | Percentage of pupils achieving 5 or more GCSEs or equivalent including maths and English | Chimat |
| 9 | 2011 | Percentage not in education, employment or training as a proportion of total age | Department of Education |
| 10 | 2010/2011 | Rate per 100,000 | Chimat |
| 11 | 2010 | Percentage of children aged under 16 living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income | HRMC |
| 12 | 2011/2012 | Statutory homeless households with dependent children or pregnant women per 1,000 households | Chimat |
| 13 | 2012 | Rate of children looked after at 31 March per 10,000 | Department of education |
| 14 | 2009-2011 | Crude rate of children age 0-15 years who were killed or seriously injured in road traffic accidents per 100,000 population, | Chimate |
| 15 | 2011 | Percentage of live and stillbirths weighing less than 2,500 grams | IC website |
| 16 | 2011/2012 | Percentage of school children in Reception year classified as obese | NCMP |
| 17 | 2011/2012 | Percentage of school children in Year 6 classified as obese | NCMP |
| 18 | 2009/2010 | Percentage children participating in at least 3 hours per week of high quality PE and sport at school age | Public Health England |
| 19 | 2008/2009 | Weighted mean number of decayed | Chimat |
| 20 | 2010 | Under 18 conception rate per 1,000 | Department of education |
| 21 | 2011/2012 | Percentage of delivery episodes where the mother is aged less than 18 years | Chimate |
| 22 | 2008/2011 | Crude rate per 100,000 | Lape |
| 23 | 2009/2012 | Directly standardised rate per 100,000 | Chimat |
| 24 | 2011/2012 | Percentage of mothers smoking at time of delivery | HSCIC |
| 25 | 2011/2012 | Percentage of mothers initiating breastfeeding | PHOF |
| 26 | 2011/2012 | Percentage of mothers breastfeeding at 6-8 weeks | PHOF |
| 27 | 2010/2011 | Crude rate per 1000 | Right care |
| 28 | 2011/2012 | Crude rate per 100,000 | Public Health England |
| 29 | 2011/2012 | Crude rate per 100,000 | Chimat |
| 30 | 2011/2012 | Crude rate per 100,000 | Chimat |
| 31 | 2011/2012 | Crude rate per 100,000 | Chimat |

# Stakeholder views

### On disability

"More data is needed on children with disabilities and emotional wellbeing"

"Additional information on social services to show support for parents with learning disabilities children."

"Information on schools that provide the best support for children with learning disabilities."

### On crime and violence

"We need some information about crime data on children – how it impacts them and how many are involved in criminal activity".

"A data set joining together parental ill-health and substance misuse and domestic violence and linked to outcomes for children is needed."

### On service integration

"Experience of children's / adults service are to involve the whole family. Develop liaison work to address this initially, but would see this as integrated in the longer term."

### Other

"Children's tooth decay data is missing"

# JSNA Data Refresh 2013/4 Dementia Barnet

Dementia is a clinical syndrome characterised by a widespread loss of mental function, including memory loss, language impairment, disorientation, change in personality, self-neglect and behaviour which is out of character. Dementia has many underlying causes. The most common cause of dementia is Alzheimer's disease, followed by vascular dementia.

## Key messages

### Dementia Prevalence

It is estimated that 8% of people aged 65 years and over and 24% of people aged over 85 years in Barnet have some form of dementia. Nine out of ten people with dementia in Barnet are over 75.

The number of people aged 65 years and over in Barnet is projected to increase by 20% by 2020. Life expectancy is also increasing. This means there will be more people with dementia in the future in Barnet.

The projected number of people with dementia within Barnet is forecast to increase by 24% over the coming 8 year period compared to only 19% across London.

Due to the increasing life expectancy in men, the largest increase in dementia (28%) will be in males aged 75 and over.

### Dementia and Ethnicity

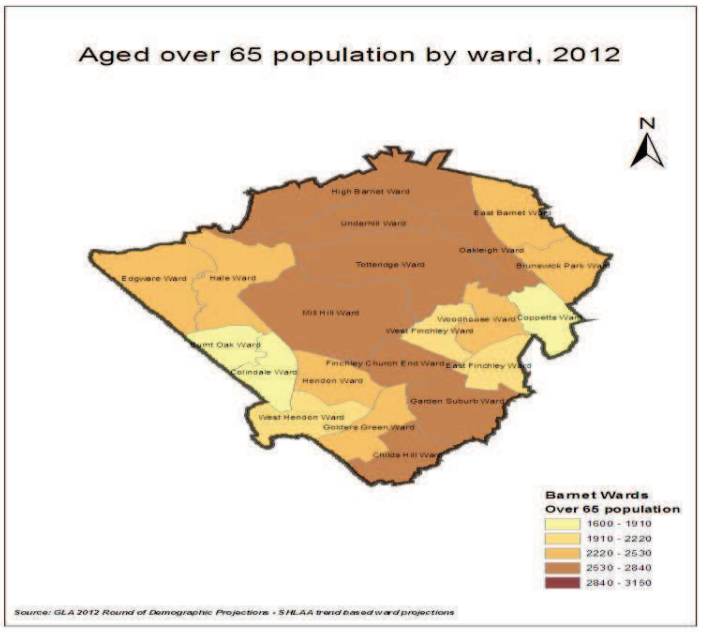
In Barnet approximately 80% of the population aged 65 and over are White. The largest ethnic minority group is Asian/ Asian British (13% of the 65+ population). Barnet will see an increase in the ethnic diversity of their older populations and thus a greater proportion of people with dementia will be from Black and Minority ethnic groups in the future

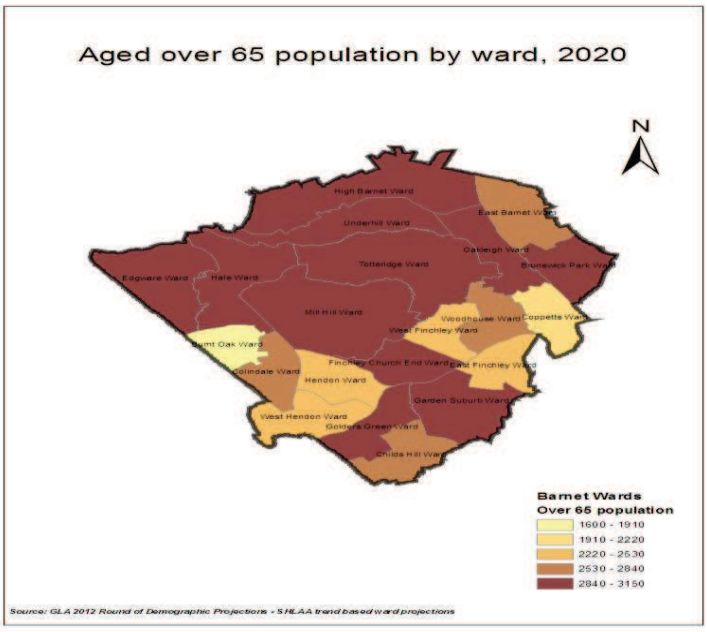
### Dementia Action Plan

Barnet has a Dementia Action Plan. This has mapped local services against the National Dementia strategy and identified gaps. A number of actions have been agreed including:

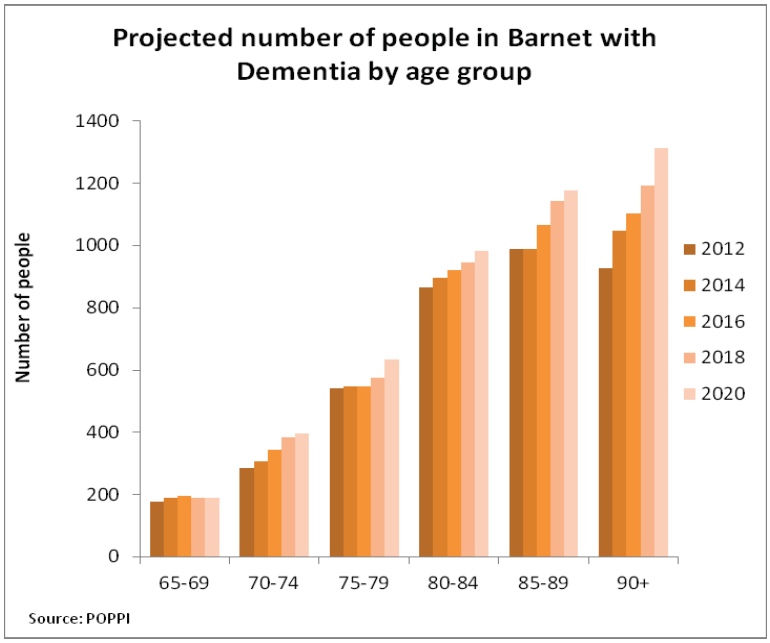
- Improving public and professional awareness
- Provision of good quality information
- Good quality early diagnosis and intervention

# Local Data




The number of people aged 65 years and over in Barnet is projected to increase by 20% between 2012 and 2020.This increase in population in this age range will have an impact on the projected number of people with dementia.

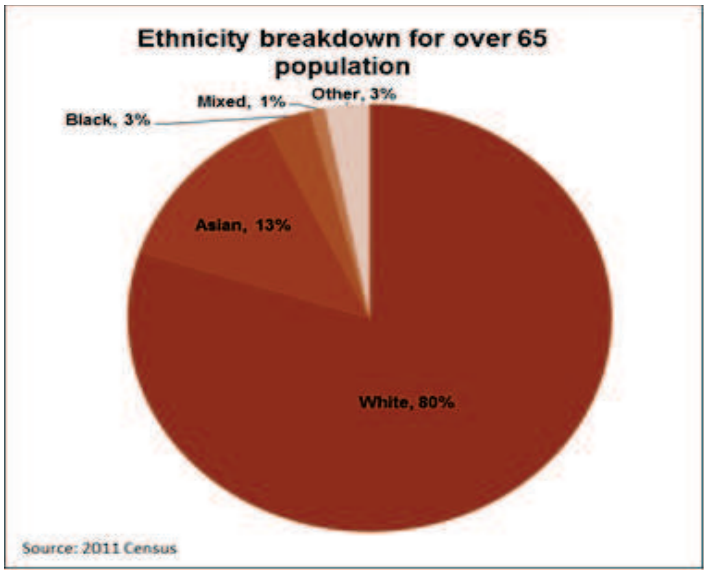


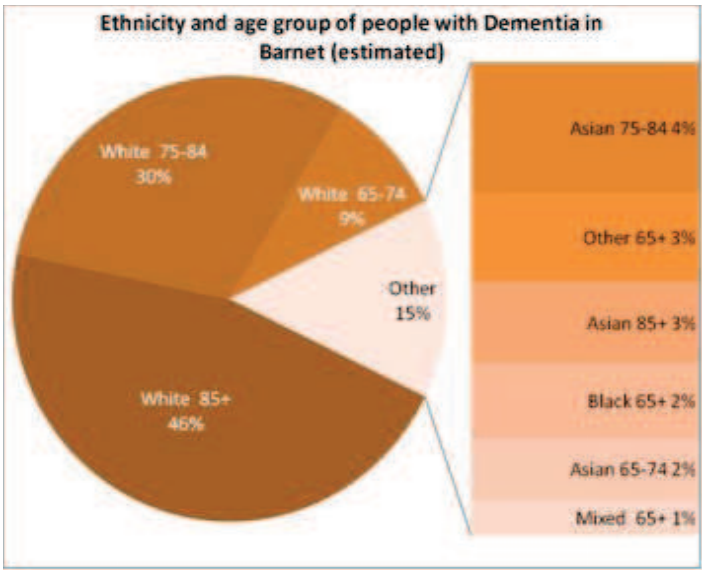

People are living longer and in Barnet the number of people in the older age groups is forecast to increase over the coming decade. This means that the number of people with dementia will also increase. Currently there are 3,784 people with dementia in Barnet. By 2020, this figure is projected to increase to 4,696 people with dementia in Barnet.

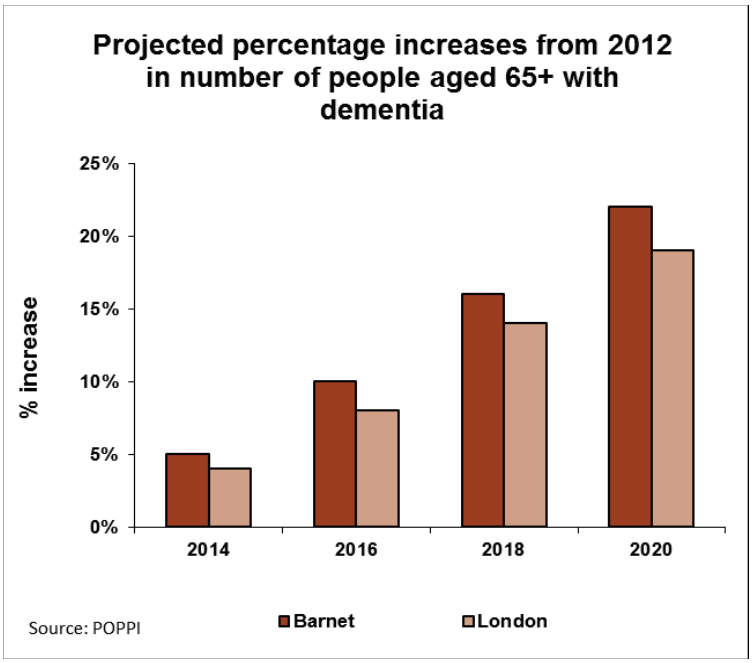
A number of risk factors have been identified which increase an individual's risk of developing dementia. These risk factors include smoking, alcohol consumption and high cholesterol. Tackling these risk factors will help to prevent people from developing dementia in the future. These factors are considerable public health problems in their own right, and affect many other diseases apart from dementia.

There is no data that is specific to Barnet for the underlying cause of dementia. It is likely that the proportions of people with the various underlying causes of dementia are similar to those seen nationally. Of note, Korsakoff's syndrome, which is related to excessive alcohol consumption, is noted to be a small but increasing cause of early-onset dementia in Barnet.

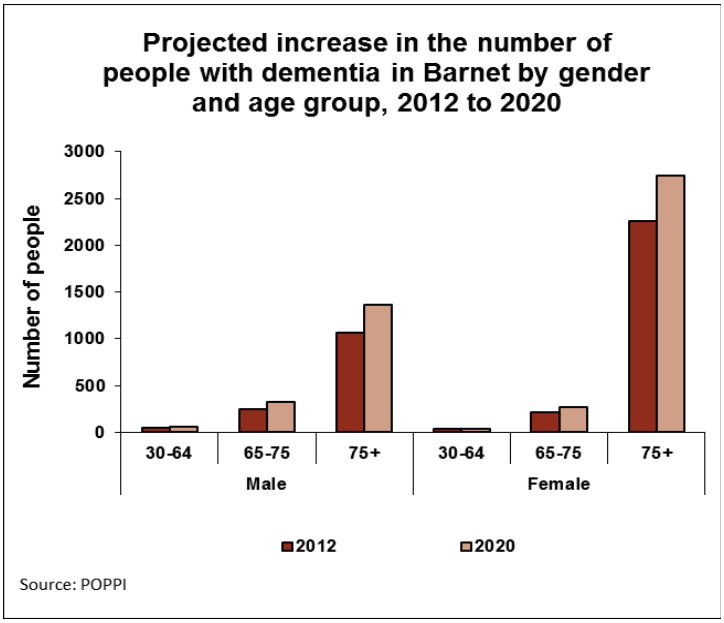
Barnet has a very ethnically diverse population. The different ethnic groups have different age profiles. The White ethnic group has a greater proportion of older people than the different Black and Minority Ethnic (BME) Groups. Due to this age profile, the majority of people with dementia are currently of White ethnicity. As Barnet's population ages, the proportion of people in older age groups who are from Black and Minority Ethnic Groups will increase and there are likely to be many more people from BME groups.




The projected number of people with dementia within Barnet is forecast to increase by 24% by 2020 compared to only 19% across London. The average annual increase in the number of people with the disease in Barnet is 6% according to the projections. Specific attention will need to be paid to relatively high risk groups when developing local services. This includes ensuring that early identification and intervention services are equitably provided and meet the needs of different ethnic groups, homeless people, those with learning disabilities, people with HIV, travellers, substance misusers, prisoners, people who live alone, people in socially deprived areas and others who may have particular needs. It is also important that commissioning plans incorporate a sensitivity analysis by using more than one set of projections.




The prevalence of dementia increase with age, from 1.5% in men aged between 65-69 years to 27.9% of men aged over 90 years. The prevalence in women also increase with age, but is less marked than in men aged 65-69 and 70-74 years (1% and 2.4% respectively). However, in the older age ranges the prevalence is higher than in men, rising to 30.7% of women aged over 90 years.

Overall, 2,308 patients are recorded on GP practice registers as having dementia across Barnet. This equates to about 61% of the total number of people estimated to have dementia in Barnet.

While it is not expected that everyone with dementia would appear on GP registers, the current coverage amounts to a third of the population with dementia unrecorded. There may be many reasons why primary care registers under-record the level of dementia. Patients with early dementia are most likely to be missing from the lists either due to them not attending the surgery or due to lack of early detection/screening in general practice. Diagnoses are likely to increase with the new expansion of the health checks programme which will include screening for early dementia.

Once diagnosed, GPs should review each patient with dementia on an annual basis. In 2012, 80% of those registered as having dementia in Barnet had been reviewed in the previous 15 months

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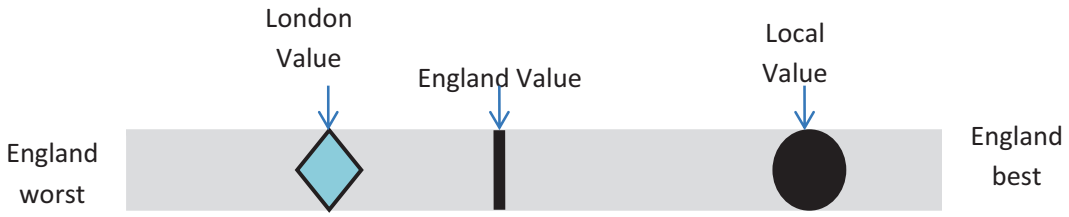


### Direction of travel indicator

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⇩ Indicator has worsened since last i.e. decrease in performance or increase in need

⇔ No change since previous year

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**Amber** indicates that, according to the latest data, the area is performing worse or has greater need but is within 2% of the England average.

## Spine chart

| | Indicator | Direction of travel | Local Value | Eng Avg | Eng Worst | England Range Worse Higher OUTCOMES NEED Better Lower | Eng Best |
|---|---|---|---|---|---|---|---|
| 1 | Percentage of aged over 65 population | | 13.3 | 16.5 | 25.2 | | 6.1 |
| 2 | Percentage of aged over 75 population | | 3.3 | 3.9 | 3.9 | | 1.5 |
| 3 | Percentage of the population with a limiting long term illness, 2001 | | 13.5 | 16.9 | 24.4 | | 10.2 |
| 4 | Percentage of adults (18+) with dementia, 2011/12 | | 0.6 | 0.5 | 1.0 | | 0.2 |
| 5 | Ratio of recorded to expected prevalence of dementia, 2010/11 | | 0.5 | 0.4 | 0.3 | | 0.7 |
| 6 | Percentage of adults (18+) with depression, 2011/12 | | 8.5 | 11.7 | 20.3 | | 4.8 |
| 7 | Percentage of adults (18+) with learning disabilities, 2011/12 | | 0.4 | 0.5 | 0.8 | | 0.2 |
| 8 | Percentage of patients diagnosed with dementia whose care has been reviewed in the previous 15 months - achievement | | 79.6 | 79.5 | 74.5 | | 88.3 |
| 9 | Percentage of patients diagnosed with dementia whose care has been reviewed in the previous 15 months - exception rate | | 6.4 | 8.0 | 22.9 | | 4.0 |
| 10 | Directly standardised rate for hospital admissions for Alzheimer's and other related dementia, 2009/10 to 2011/12 | | 53.0 | 80.0 | 226.0 | | 5.0 |
| 11 | People with mental illness and or disability in settled accommodation, 2011/12 | | 65.9 | 66.8 | 1.3 | | 92.8 |

# Spine chart data sources

| | Year | Data description | Other sources of information or data |
|---|---|---|---|
| 1 | 2011 | Percentage of over 65 population | ONS 2011 census |
| 2 | 2011 | Percentage of over 75 population | ONS 2011 census |
| 3 | 2001 | Proportion of people, usually resident in the area at the time of the 2001 Census who had a limiting long-term illness | ONS 2011 census |
| 4 | 2011/12 | Proportion of patients with dementia in a GP registered population | Health and social care information centre |
| 5 | 2010/11 | Proportion of recorded over expected people with dementia | POPPI website |
| 6 | 2011/12 | Proportion of adults diagnosed with depression in a GP registered population | Health and social care information centre |
| 7 | 2011/12 | Prevalence of Learning Disabilities | Health and social care information centre |
| 8 | 2012/13 | Percentage of patients diagnosed with dementia whose care has been reviewed in the previous 15 months - achievement | Health and social care information centre |
| 9 | 2012/13 | Percentage of patients diagnosed with dementia whose care has been reviewed in the previous 15 months - exception rate | Health and social care information centre |
| 10 | 2009/12 | DSR per 100,000 of hospital admissions for Alzheimer's and other dementias | HES, HSCIC, ONS |
| 11 | 2011/12 | People with mental illness and or disability in settled accommodation | POPPI website |

# Stakeholder views

A discussion of the topic was held at the Autumn Partnership Catch up in November 2013. The following is a summary of comments from the day.

## On Dementia

People in Barnet felt that “more awareness is needed” on dementia, as well as the need to provide a “positive profile.”

“We need to do more ethnic monitoring as representation quite low”

## On services for people with dementia

“There needs to be more information for vulnerable carers with dementia, and what exactly happen with in the 6 weeks pathway.”

“We need more information on referrals as the number of people with dementia is going up as well as safeguarding alerts going for people with Dementia”

“We need more Dementia Cafes as they are a great thing, they need to be held in all localities.”

“More work needs to be done with Care Homes, like provide activities which help people come alive.”

“People with dementia and their carers need to be signposted to the support they need – especially to get all the legal issues sorted out.”

# JSNA Refresh 2013/14 Maternity & Infant Health

## Barnet

Giving a child the best start in life is important to the individual child but also to society in general. Parents and carers impact cannot be underestimated. A child's early life affects their wellbeing and quality of life not only during their childhood but throughout their life – and indeed into the next generation

## Key messages

### Demographics

On average there are around 5,000 births in Barnet each year. Just over a third of all births are to women between the ages of 30-34 years, and 55% of them are from the White ethnic group. Only 2% of all pregnancies in Barnet are under the age of 19 years. Whilst the projected trend of women of childbearing age is expected to increase, the number of live births and the fertility rate is decreasing. The highest fertility rate is seen in the Burnt Oak and Golder's Green wards.

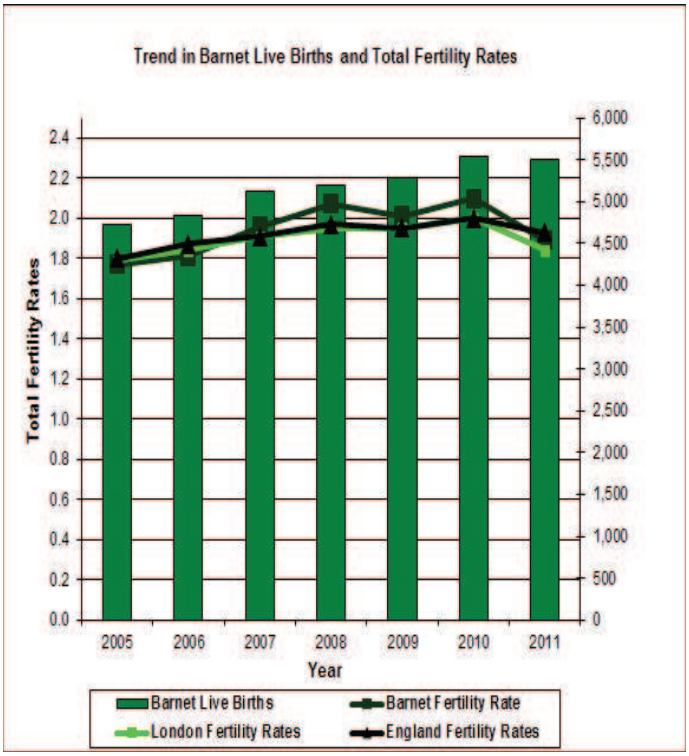
### Infant & Maternal Health

Whilst in Barnet, Low Birth Weight, and Infant Mortality is significantly lower than both the regional and national averages, analysis of local data shows that Infant Mortality Rates are highest in the Burnt Oak and Woodhouse wards. The proportion of babies born with a low birth weight is highest amongst women resident in the Burnt Oak, Woodhouse and Edgware wards. Smoking in pregnancy is significantly higher than the regional average with 7% of pregnant women smoking at the time of delivery.

### Service Use

Breastfeeding initiation in Barnet is amongst the highest seen in the country at 91.2%, and continuation rates are similar to the national and regional averages. However, only 42.6% of pregnant women in Barnet have an antenatal assessment by the 12$^{th}$ week of pregnancy which is amongst the lowest rates in London and significantly lower than England average. Both elective and emergency caesarean deliveries are significantly higher than the national averages.

# Local Data



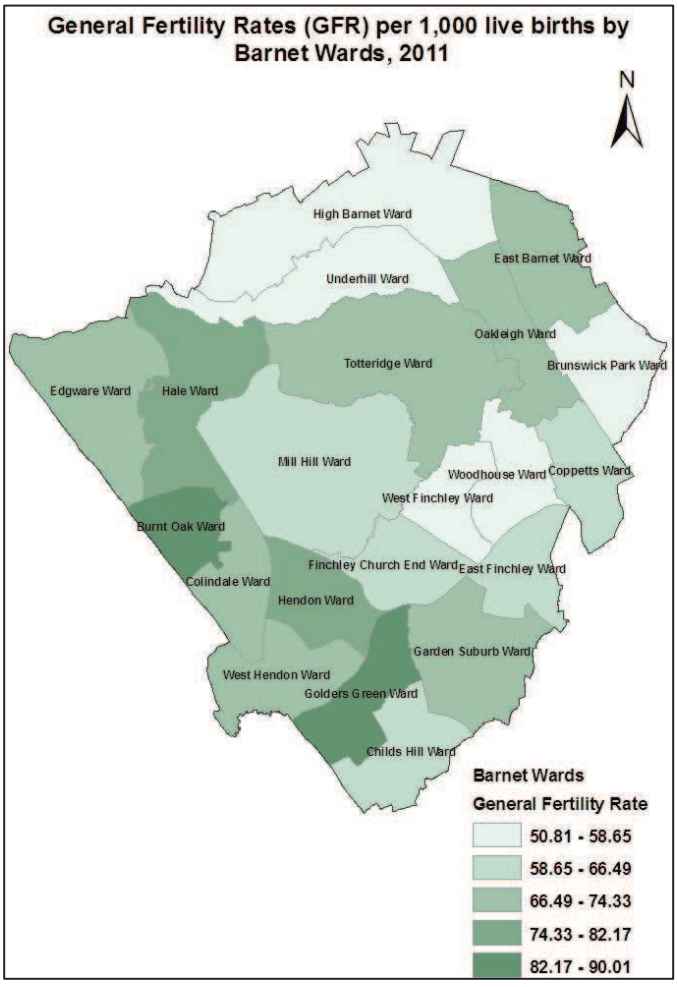

Source: Office of National Statistics, 2011

## Births and Fertility Rates

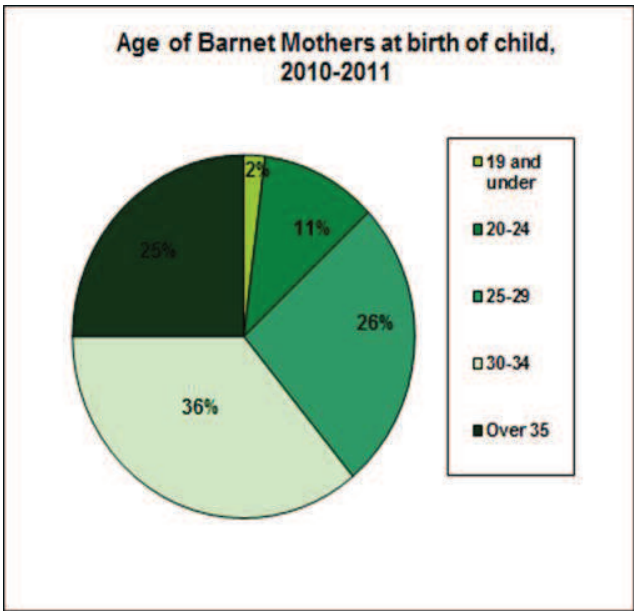
Total fertility rates are a single measure of fertility representing the average number of children each woman would be expected to have in a group of women if current age-specific patterns of fertility persisted throughout their childbearing life. The total fertility rate in 2011 was equivalent to each woman in Barnet having 1.89 children, compared to 2.1 in 2010. In England as a whole, total fertility rates have increased from 1.82 in 2006 to 1.99 in 2010. In Harrow, since 2006 we are seeing rates between 1.9 and 2.1 children.

## Fertility Rates by Ward

The General Fertility rate GFR, that is the rate of births per 1,000 women of childbearing age can be presented at ward level, and is highest amongst the wards of Golder's Green, 90.02 births per 1,000 women, followed by Burnt Oak ward 86.3 and Hale ward at 79.4. The lowest fertility rate is seen in Hale ward in Barnet, at 50 births per 1,000 women. Barnet as a whole has a GFR of 69 births per 1,000 women compared to London which is 66.5, and England 64.2 in 2011.




Source: Office for National Statistics, 2011



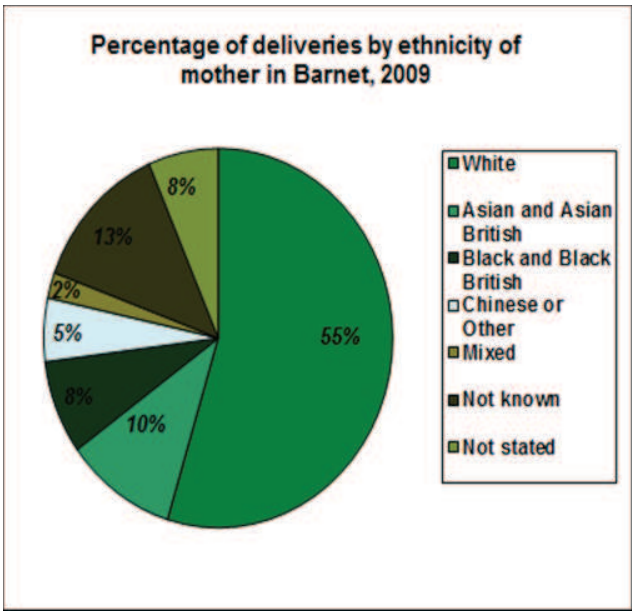

Source: Office for National Statistics 2011

## Age of Mother

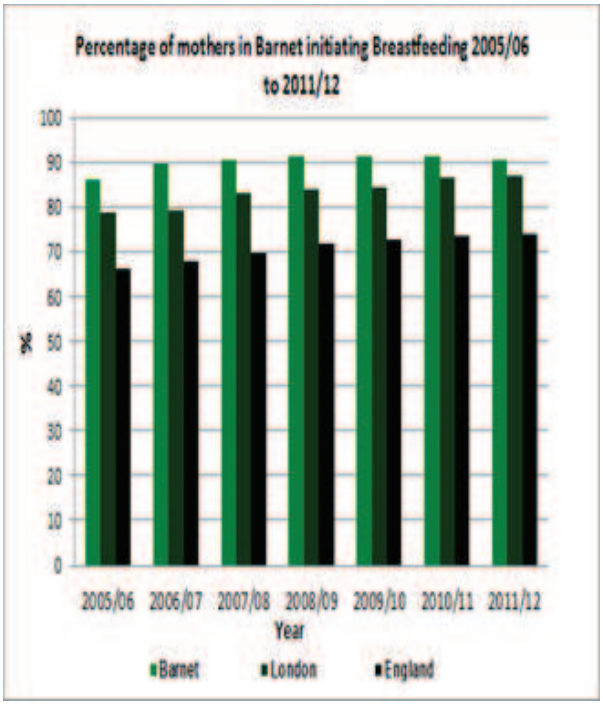
Analysis of women giving birth in Barnet during 2010-1011 shows that the highest proportion of deliveries were to women aged 30-34 years old, accounting for 35.9% of all deliveries. Mothers and their babies at the lower and upper age bands are at greater risk. Older mothers present a series of different challenges; they have a greater chance of developing medical disorders such as diabetes, high blood pressure or other chronic diseases.

## Ethnicity of Mother

There are a number of reasons why the ethnicity of mothers in a local area may have an influence on the needs which the services provided must meet. Certain conditions are known to be more common in particular ethnic groups. Mothers and their families who have recently moved to the UK may have difficulties reading or speaking English, and different cultural norms may exist. In 2009, 31% of all women aged 16-59 years in Harrow were from the black and minority (BME) ethnic groups.




Source: Hospital Episode Statistics, HSCIC 2013




Source: Department of Health, 2013

## Infant Mortality Rates by Ward

Infant mortality rates refer to the number of deaths within the first year of life per 1,000 live births. Wide variations in rates are often seen annually due to the small numbers of events. For this reason 3 year rolling averages are used to even out the variation. The three-year rolling average for Barnet has been calculated at ward level. It shows that the wards of Woodhouse and Burnt Oak have the highest infant mortality rates for the 2008-11 period, at 9.5, and 7.8 infant deaths per 1,000 live births. This is considerably higher than the Barnet average at 4.5 per 1,000 live births which compares well to the England average of 4.6 per 1,000 births.

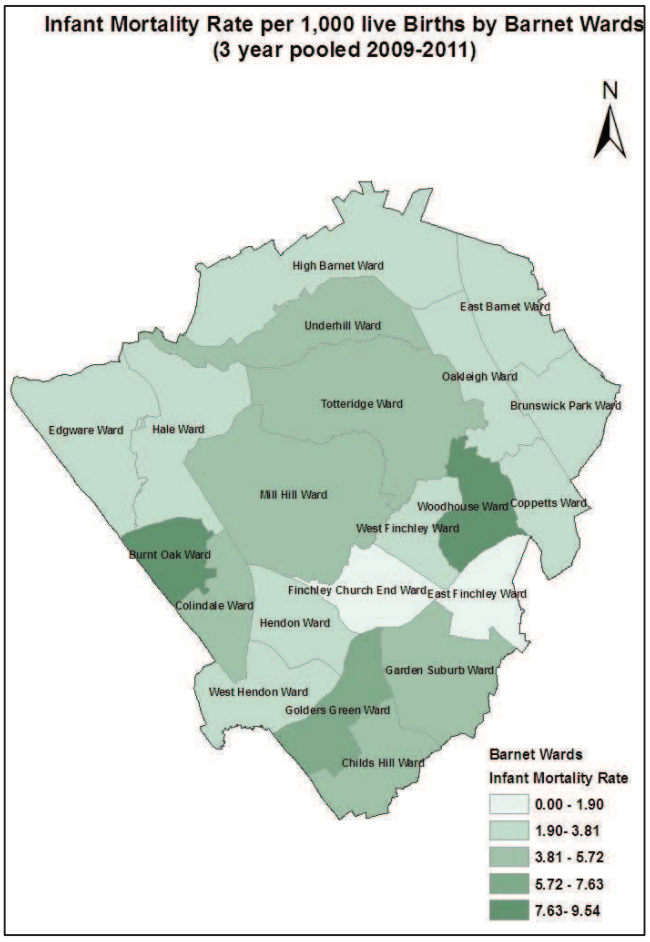
## Breastfeeding Rates

There is substantial evidence and published research to show that breastfeeding has clear health benefits for both mothers and infants. These benefits have been summarised by NICE 2002 and include:

Breastfed babies are less likely to suffer from gastroenteritis or admitted to hospital for diarrhoea and respiratory infections.

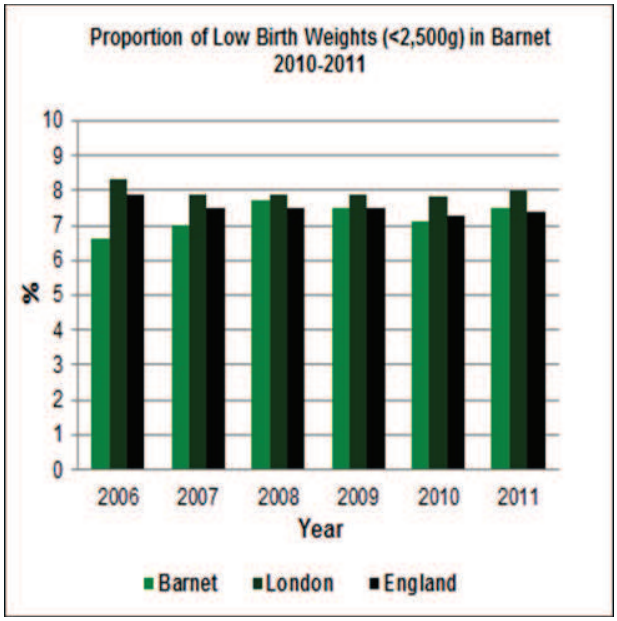
Mothers who do not breastfeed may have an increased risk of certain cancers.

Breastfeeding initiation rates in Barnet remain high, at around 90%, compared to London at 87% and England at 74%. Continuation of exclusive and partial breastfeeding at 6-8 weeks in Barnet is around 75%, and 44% for exclusive breastfeeding.




Source: Office for National Statistics, 2011

## Proportion of Low Birth Weight Babies

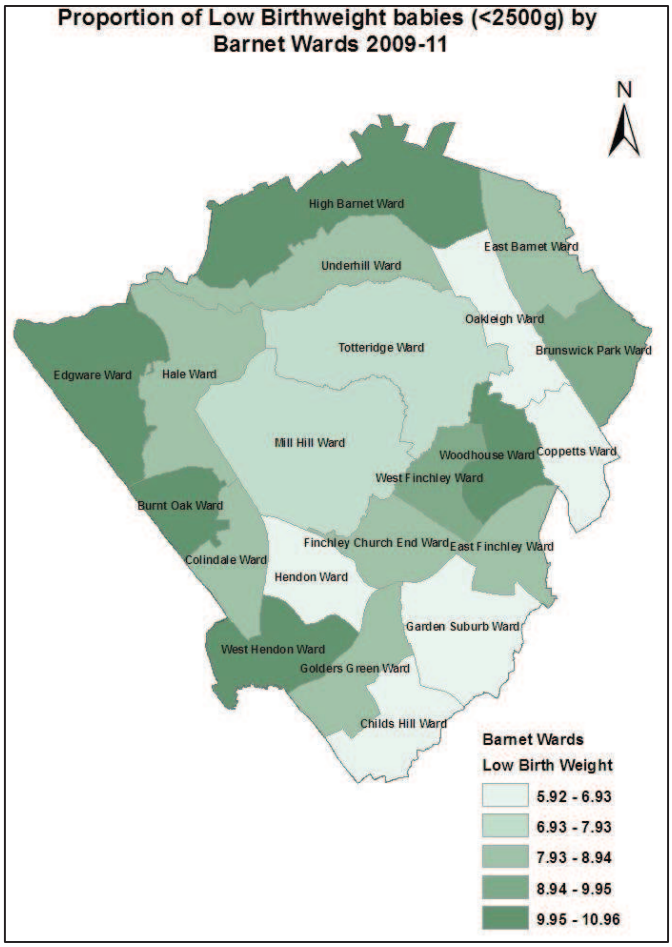



Source: Office for National Statistics, 2011

Low birth weight is closely associated with foetal and neonatal mortality and morbidity, inhibited growth and cognitive development, and chronic diseases later in life (UNICEF and WHO, 1992). A baby's low weight at birth is either the result of preterm birth (before 37 weeks of gestation) or due to restricted foetal (intrauterine) growth. Low birth weight has been defined by the World Health Organisation as weight at birth less than 2,500 grams. In 2011, the proportion of babies of low birth weight in Barnet was 7.5 percent, higher than the 7.1 percent seen in 2010. Barnet compares favourably to both regional and national proportion of low birth weight, which in London it is 8 percent and England 7.4 percent.

## Low Birth Weight by Ward

Low birth weight at ward level for Barnet however shows variations. The highest rates are seen in the Edgware ward at 11.0 percent, and Burnt Oak ward at 10.9 percent.




Source: Office for National Statistics, 2011

## Understanding the Spine Chart

### The Spine chart

The spine chart is a way of demonstrating a lot of information on a single diagram.

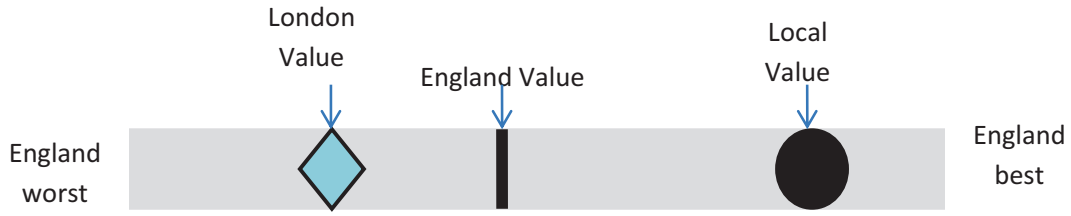
The indicators in the spine chart are generally one of three sorts:

- an indicator of higher or lower need
- an indicator of better or worse performance
- an indicator of better or worse outcomes

The "spine" is the line running down the centre. This is the England average for each indicator. The grey bar shows the range of values in local authorities across England.

Values to the **right** of the England average are better performance or outcomes or of lower need.

Values to the **left** of the England average are worse performance or outcomes or of more need.




### Direction of travel indicator

⇧ Indicator has improved since last year i.e. Improvement in performance or decrease in need

⇩ Indicator has worsened since last i.e. decrease in performance or increase in need

⇔ No change since previous year

**Green** indicates that, according to the latest data, the area is either performing better or has lower need than England average

**Red** indicates that, according to the latest data, the area is performing at least 2% worse or has at least 2% greater need than the England average.

**Amber** indicates that, according to the latest data, the area is performing worse or has greater need but is within 2% of the England average.

# Spine Chart


| | Indicator | Direction of Travel | Local Value | Eng Avg | Eng Worst | England Range OUTCOMES NEED (Worse Lower – Better Higher) | Eng Best |
|---|---|---|---|---|---|---|---|
| 1 | Women of childbearing age | ↓ | 22.8 | 18.7 | 29.7 | | 9.5 |
| 2 | Births | ↑ | 68.6 | 65.5 | 113.9 | | 24.4 |
| 3 | Total period fertility | ↑ | 1.9 | 1.9 | 3.2 | | 0.7 |
| 4 | Births to women aged >35 | ↑ | 25.0 | 19.2 | 41.6 | | 7.7 |
| 5 | Births to women aged >40 | ↔ | 5.5 | 3.9 | 9.7 | | 0.0 |
| 6 | Teenage pregnancy | ↑ | 24.0 | 30.7 | 69.4 | | 14.6 |
| 7 | Teenage pregnancy for under 16 year olds | ↑ | 3.7 | 6.7 | 13.3 | | 1.5 |
| 8 | Early antenatal assessment | ↑ | 68.5 | 72.7 | 4.3 | | 88.0 |
| 9 | Early antenatal assessment recording | ↓ | 80.7 | 73.9 | 0.3 | | 99.3 |
| 10 | Smoking during pregnancy | ↑ | 4.8 | 12.7 | 32.5 | | 3.1 |
| 11 | Abortions (<10 week gestation) | ↔ | 83.8 | 77.9 | 85.1 | | 60.6 |
| 12 | Inpatient admissions before delivery | ↓ | 1.6 | 1.0 | 2.5 | | 0.3 |
| 13 | Admissions of babies under 14 days | ↔ | 43.2 | 51.5 | 182.3 | | 19.2 |
| 14 | Births in NHS hospitals | ↑ | 93.9 | 97.0 | 99.4 | | 65.7 |
| 15 | Births at home or midwifery unit | ↓ | 17.8 | 13.0 | 0.0 | | 98.6 |
| 16 | Unplanned transfer to hospital | ↑ | 43.2 | 36.9 | 100.0 | | 0.0 |
| 17 | Inductions | ↔ | 14.6 | 17.2 | 37.5 | | 0.2 |
| 18 | Normal deliveries | ↔ | 58.0 | 61.4 | 45.9 | | 76.3 |
| 19 | Caesarean deliveries | ↓ | 29.3 | 24.0 | 38.9 | | 11.8 |
| 20 | Elective caesareans | ↔ | 10.5 | 9.6 | 19.4 | | 4.9 |
| 21 | Emergency/Other caesareans | ↔ | 16.3 | 14.4 | 22.2 | | 54.7 |
| 22 | Vaginal birth after caesareans | ↔ | 23.0 | 30.5 | 18.7 | | 80.9 |
| 23 | Midwives | ↓ | 28.4 | 31.5 | 15.2 | | 7.9 |
| 24 | Obs and Gynae consultants | ↓ | 2.7 | 2.6 | 0.2 | | 7.0 |
| 25 | Consultant:Midwife ratio | ↓ | 10.0 | 12.1 | 187.2 | | 0.0 |
| 26 | Multiple births | ↓ | 3.7 | 1.3 | 6.0 | | 1.3 |
| 27 | Premature births | ↔ | 10.1 | 12.3 | 63.9 | | 0.0 |
| 28 | Length of hosiptal stay after delivery | ↔ | 1.8 | 1.7 | 4.9 | | 0.9 |
| 29 | Breastfeeding intiation | ↓ | 85.4 | 74.0 | 39.0 | | 92.3 |
| 30 | Breastfeeding continuation | ↑ | 76.6 | 47.2 | 19.2 | | 83.1 |
| 31 | Perinatal mortality (<7days+stillbirth) | ↑ | 6.0 | 7.5 | 19.2 | | 3.2 |
| 32 | Neonatal mortality (<28 datys) | ↑ | 2.4 | 3.0 | 19.2 | | 0.0 |
| 33 | Infant mortality (<1 year) | ↑ | 3.5 | 4.3 | 19.2 | | 1.2 |
| 34 | Low birth weight(<2500g) | ↓ | 7.5 | 7.4 | 11.5 | | 3.9 |
| 35 | Very low birth weight (<1500) | ↔ | 1.5 | 1.4 | 3.3 | | 0.0 |
| 36 | Total maternity spend | ↑ | 2,729 | 2,389 | 9,955 | | 2,389 |
| 37 | Maternity Spend Primary Care | ↔ | 92 | 392 | 0 | | 2,010 |
| 38 | Maternity Spend Secondary Care | ↔ | 9,863 | 5,091 | 9,863 | | 2,265 |

Spine chart preparation based on West Midlands Public Health Observatory Spine Chart Tool version 4, Analysis by the Clinical Health Intelligence Team, Public Health England

# Spine chart data sources

| | Data description | Year | Other sources of information or data |
|---|---|---|---|
| 1 | % female pop aged 15-44 years | 2012 | Mid year estimates (ONS) |
| 2 | Birth rate per 1,000 female population aged 15-44 years | 2012 | ONS |
| 3 | Average number of children | 2012 | ONS |
| 4-5 | % total births | 2010-11 | ONS |
| 6 | Conceptions per 1000 pop aged 15-17 | 2009-11 | Department for Education |
| 7 | Conceptions per 1000 population aged under 16 | 2009-11 | Department for Education |
| 8 | % assessed within 12 weeks where antenatal assessment recorded at delivery | 2012 | Department of Health |
| 9 | % maternities where antenatal assessment recorded at delivery | 2012 | HES/NHS Comparators |
| 10 | % mothers smoking at time of delivery | 2012-13 | Department of Health |
| 11 | NHS and private abortions < 10 weeks gestation as a % of all abortions | 2011 | NHS Comparators |
| 12 | Ratio of antenatal admissions not related to delivery | 2011-12 | NHS Comparators |
| 13 | Rate of emergency admissions per 1,000 population 0-13 days | 2011-12 | HSCIC |
| 14 | % total births | 2011-12 | HSCIC |
| 15 | % total births | 2011-12 | NHS Comparators |
| 16 | % deliveries with an unplanned transfer to hospital | 2012-13 | NHS Comparators |
| 17-21 | % total deliveries | 2010-2011 | HES/London Health Programmes |
| 22 | % vaginal deliveries after a prior caesarean section | 2012-13 | NHS Comparators |
| 23 | No.FTE midwives per 1,000 births | 2010-11 | Annual Workforce Census/HES |
| 24 | No. FTE Obs &Gynae consultant per 1,000 births | 2010-11 | Annual Workforce Census/HES |
| 25 | No. of midwives per consultant | 2010-11 | Annual Workforce Census/HES |
| 26 | Multiple births as a % of total births | 2010 | ONS/London Health Programmes |
| 27 | % births with gestation of less than 37 weeks, 2009/10 | 2009-10 | HES/London Health Programmes |
| 28 | Total no.of bed days and average no.of days spent in hospital after delivery per delivery | 2009-10 | HES/London Health Programmes |

# Stakeholder Views

A discussion of the topic was held at the Autumn Partnership Catch up in November 2013. The following is a summary of comments from the day.

## On disability

"One of the things we need to see is information on the numbers of babies born with disabilities and the numbers of mothers who have disabilities too. We need to look at what information is given to mothers with a disability when they are pregnant and the quality of their care. We also need to look at what information is given to new parents of babies with disabilities by the hospital and the GPs."

## On prevention and early intervention

"Early interventions and prevention are vitally important and we need to see what's available and how easily people can access it."

"Smoking in pregnancy might have improved but too many women still smoke. We need to look at where there are different delivery models for this service."

## On improving care in pregnancy

"The CCG should contract with the hospital so there's better continuity of care. Women should be able to see the same midwife throughout their pregnancy."

"Mental health data needs to be linked to maternity data so that women can be supported better. If we knew about this then we could develop appropriate services."

"A data set joining together parental ill-health and substance misuse and domestic violence and linked to outcomes for children is needed."

## On Services

"Would like more information on emergency and elective caesarean section and the reasons why women chose to have a caesarean"

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# JSNA Data Refresh 2013/14 Cardiovascular Disease Barnet

Cardiovascular diseases (CVD) are the main cause of death in the UK causing around 147,300 deaths in England in 2010 (around a third of all deaths). Around 45% of all deaths from CVD are from coronary heart disease (CHD) and more than a quarter from stroke (27%). CHD is the most common cause of death in England and Wales (15%of all deaths in 2010)

## Key messages

### Population

Cardiovascular disease increases significantly after the age of 40 years. The percentage of the population aged 40 or over in Barnet is expected to increase slightly over the next ten years.

### Mortality

Cardiovascular disease (heart disease and stroke) is the largest cause of death in Barnet and the second largest cause of death after cancer in people aged under 75 years. The early death rate from cardiovascular disease are significantly lower than the national rate, and have decreased by 63.1% since 1995. However, coronary heart disease still causes more than 1 in 8 of all deaths in both age categories.

### Risk Factors

Rates of smoking, high risk drinking and obesity are lower than the London and national averages. These are the key to reducing incidence and mortality from CVD..

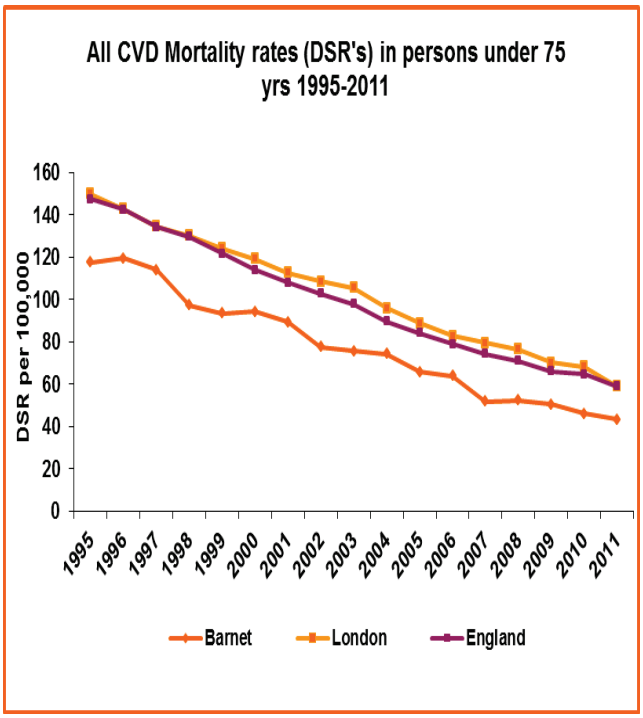
### Treatment

Treatment for both heart attack and stroke (especially for heart attack) is more effective than it was 10 years ago. Revascularisation rates are similar to those of England as a whole. Emergency admission rates for CHD are significantly lower than the national rates, but for stroke the Barnet rate is significantly higher than national rate. Evidence shows that specialist units have better outcomes.

### Discharge home

Stroke patients under 75 years are less likely to be discharged back to their usual place of residence compared to the national picture.

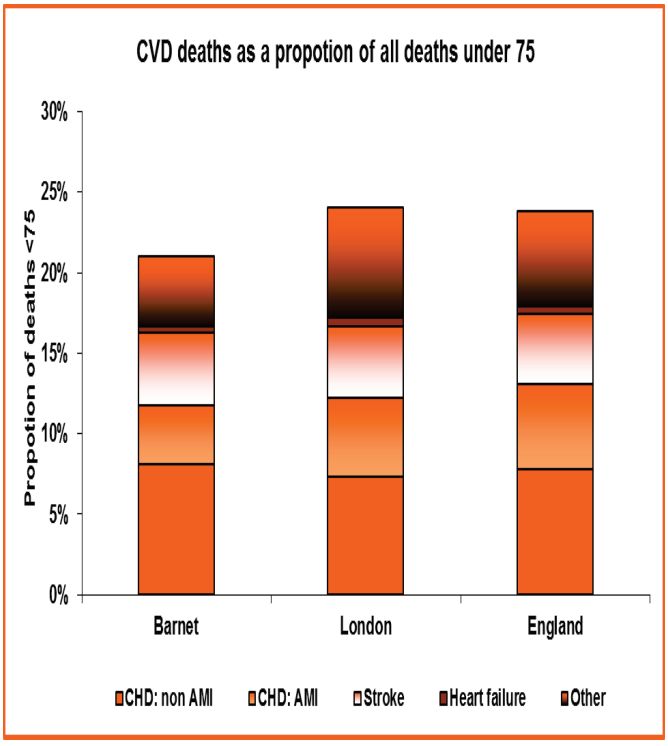
# Local Data



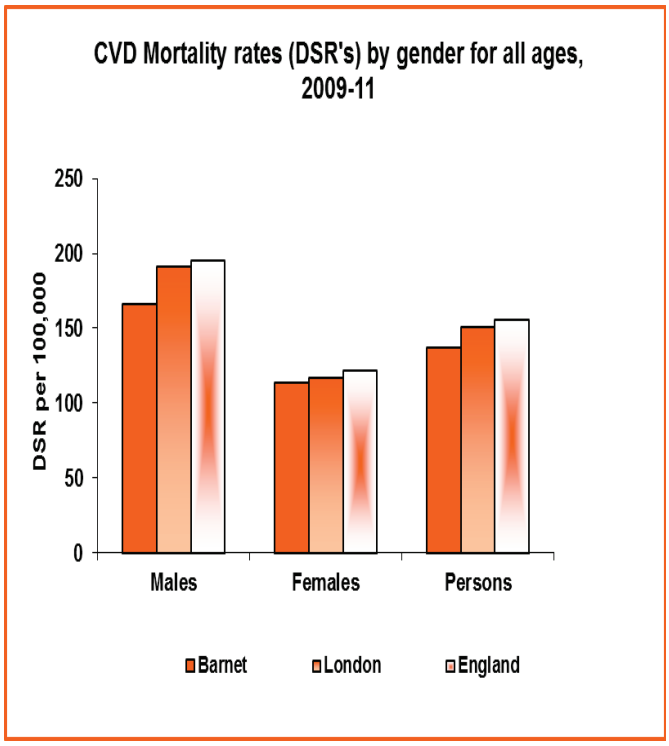

## Mortality

The Public Health Outcomes Framework has an objective of reducing the numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities. One of the key indicators for this objective is early mortality from CVD.

In 2014 the early CVD mortality rate in Barnet for persons under 75 years is predicted to be reduced by half compared to 10 years ago. The percentage of CVD deaths as a proportion of all deaths was 21% for people aged under 75 years and 38.1% for people aged 75 and above.

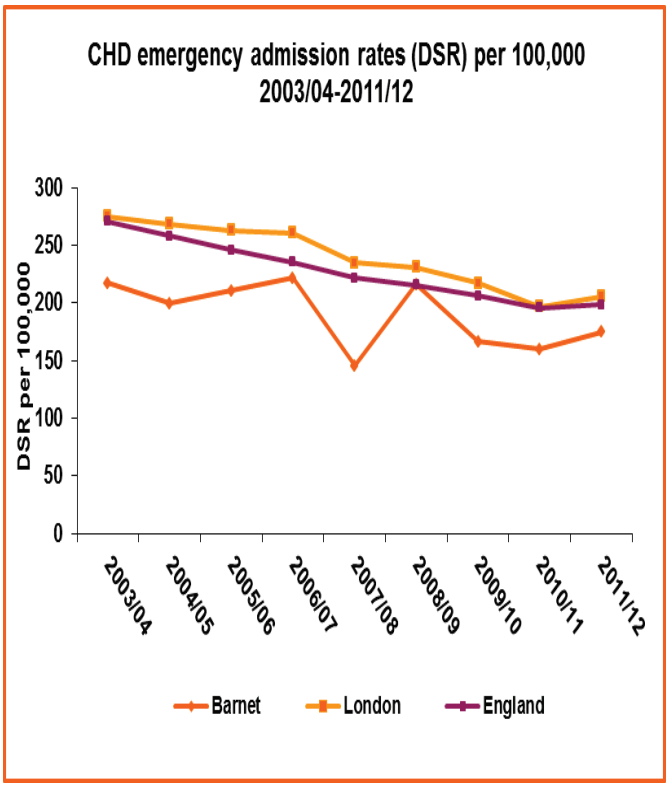



CHD makes up the biggest proportion of total deaths (within CVD) for both males and females. In 2014, the mortality rate for CHD in Barnet is predicted to be reduced by half for males and females compared to 10- years ago.




CVD mortality rate in Barnet for all persons was significantly lower than London and England.

For all ages the male CVD mortality rates in

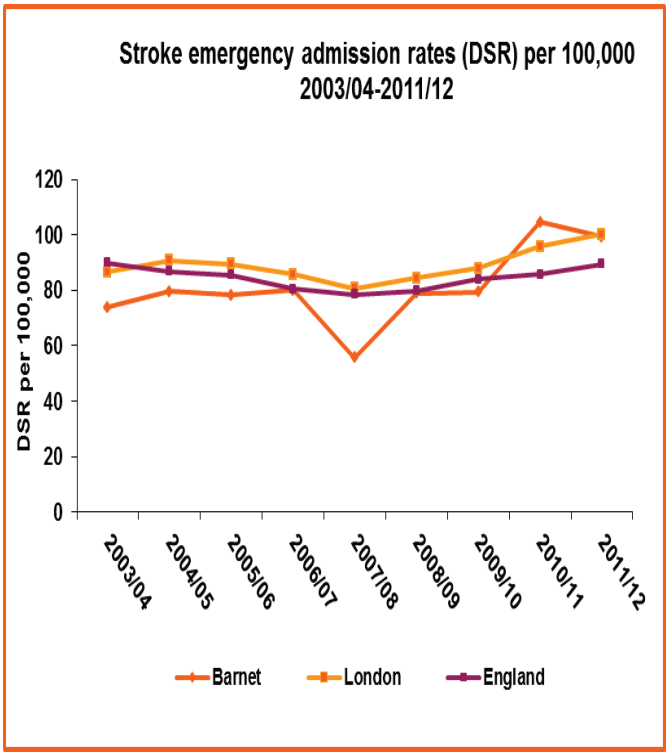


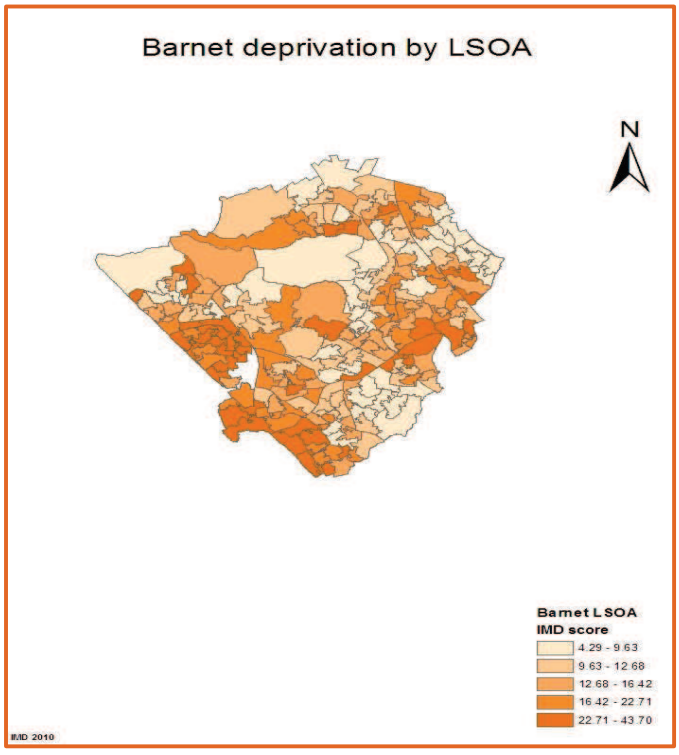

## Emergency Hospital admissions

Emergency admissions for CHD in Barnet are significantly lower than those of London and England. They are higher in men than in women. Over the past eight years, rates have decreased by12.3% whereas in London and England rates have reduced by a quarter.

Emergency admissions for stroke in Barnet are higher than England and lower than London, also Barnet has the lower emergency readmissions within 30 days compared to national average.

Emergency admissions for heart failure are higher than England but significantly lower than London. Over the past eight years, rates have decreased by 2%. Approximately half of deaths from heart failure occurred in the usual place of residence in Barnet.




5.7% of the Barnet population live in the most deprived national quintile and 11.9% of the population in the least deprived national quintile.

## Procedures

Angiography procedures in Barnet are significantly lower than London and lower than England. Male angiography rates are 2.1 times greater than female. Over the past eight years, rates have increased by 18.1% where as England and London they have increased by 8.4% and decreased by 0.7% respectively.

The angioplasty procedures in Barnet are significantly lower than London and England. Male angioplasty procedures are 4.1 times greater than female.

Non-elective angioplasty in Barnet has increased by 20.8% compared to 2004/05 and the Elective procedures have decreased by 6%.

Valve procedure rates in Barnet are higher than the network average and higher than England.

## Lifestyle behaviours

Smoking: Using data from the Integrated Household Survey it is estimated that 17.5% of the population in Barnet smoke. This is lower than the estimated proportion in London and England.

Increasing and high risk drinking (combined): It is estimated that 20% of the population in Barnet have increasing or high risk drinking behaviour. This is slightly lower than London and lower than England.

Adult obesity: Using modelled estimates from the Health Survey for England, it is estimated that 17.9% of the adult population in Barnet are classified as obese. This is lower than London and England.

## Quality and Outcomes Framework

GPs record information on whether their patients have CHD or have a stroke. The prevalence for CHD in Barnet is higher when compared with London and England

The observed prevalence for stroke in Barnet is higher than London but lower than England.

The prevalence for hypertension in Barnet is in line with London but lower than England. The gap between recognised and treated hypertension and actual hypertension levels in the community have been long recognised.

## Understanding the Spine Chart

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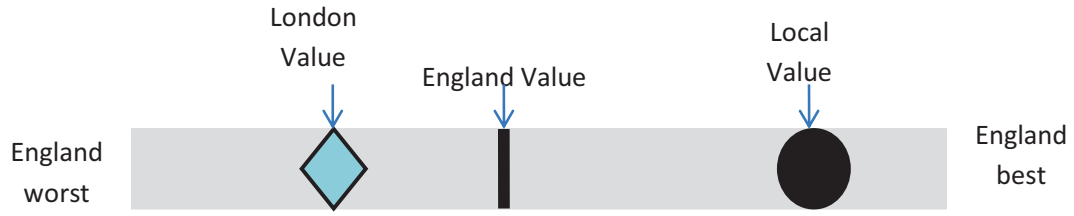



### Direction of travel indicator

⇧ Indicator has improved since last year i.e. Improvement in performance or decrease in need

⇩ Indicator has worsened since last i.e. decrease in performance or increase in need

⇔ No change since previous year

**Green** indicates that, according to the latest data, the area is either performing better or has lower need than England average

**Red** indicates that, according to the latest data, the area is performing at least 2% worse or has at least 2% greater need than the England average.

**Amber** indicates that, according to the latest data, the area is performing worse or has greater

## Spine Chart


| Indicator | Direction of travel | Local Value | Eng Avg | Eng Worst | England Range | Eng Best |
|---|---|---|---|---|---|---|
| 1 Early cardiovascular mortality (<75 yrs) | ↑ | 43.4 | 58.8 | 107.0 | | 34.3 |
| 2 Stroke mortality | ↓ | 29.3 | 34.5 | 50.8 | | 23.0 |
| 3 Estimated % smokers (16+) | ↓ | 18.7 | 20.7 | 31.0 | | 14.0 |
| 4 Estimated % obese (16+) | ↑ | 17.9 | 24.2 | 30.7 | | 13.9 |
| 5 % of long term conditions who smoke | ↓ | 13.1 | 17.4 | 27.2 | | 10.0 |
| 6 Obs/Exp CHD prevalence | ↔ | 0.6 | 0.6 | 0.8 | | 0.3 |
| 7 Obs/Exp Hypertension prevalence | ↔ | 0.4 | 0.5 | 0.5 | | 0.3 |
| 8 CHD emergency admissions | ↓ | 174.9 | 198.3 | 366.4 | | 124.4 |
| 9 Stroke emergency admissions | ↑ | 99.5 | 89.5 | 160.2 | | 48.7 |
| 10 30 day mortality in STEMI | ↓ | 11.0 | 8.7 | 20.6 | | 0.0 |
| 11 % stroke discharged to usual residence | ↓ | 53.9 | 77.9 | 56.7 | | 97.5 |
| 12 % HF who die at usual place residence | NA | 53.2 | 58.5 | 99.0 | | 19.2 |
| 13 Angiography rates | ↑ | 266.3 | 278.2 | 676.0 | | 122.3 |
| 14 Revascularisation rates | ↑ | 128.7 | 140.5 | 249.3 | | 87.1 |

## Spine chart data sources

| | Data description | Other sources of information or data |
|---|---|---|
| 1 | Directly standardised rate per 100,000, 2011 under 75 | Health and Social Care Information Centre, PHO annual deaths extract, ONS |
| 2 | Directly standardised rate per 100,000, 2011 | Health and Social Care Information Centre, PHO annual deaths extract, ONS |
| 3 | Percentage estimate of smokers , 16+, 2006-08 | Integrated Household Survey |
| 4 | Percentage estimate of obese adults, 16+, 2006-08 | Health Survey for England |
| 5 | Percentage of those registered with long-term conditions who smoke, 2010/11 | Quality and Outcomes Framework 2011/12 |
| 6 | Ratio of 2011/12 CHD QOF disease registers to estimated prevalence in 2011 | Quality and Outcomes Framework 2011/12 |
| 7 | Ratio of 2011/12 hypertension QOF disease registers to estimated prevalence in 2011 | Quality and Outcomes Framework 2011/12 |
| 8 | Directly standardised rate per 100,000, 2011/12 | HES, Health and Social Care Information Centre |
| 9 | Directly standardised rate per 100,000, 2011/12 | HES, Health and Social Care Information Centre |
| 10 | Percentage, 2011 | MINAP |
| 11 | % of all patients diagnosed with stroke under 75, 2011/12 | HES, Health and Social Care Information Centre |
| 12 | Percentage of deaths due to heart failure at their usual place of residence 2007-2011 | PHO annual deaths extract, ONS |
| 13 | Directly standardised rate per 100,000, 2011/12 | HES, Health and Social Care Information Centre |
| 14 | Directly standardised rate per 100,000, 2011/12 | HES, Health and Social Care Information Centre |

# Stakeholder views

## On Services

There were general concerns about the accessibility of some services for stroke patients with particular reference to rehabilitation and therapy services..

Early supported discharge was favoured but it was stressed that

“early supported discharge needs to mean just that – discharge backed up by the support services – otherwise people will suffer.”

“Regular review is important – so something can be done if the person starts to deteriorate”

## On prevention

Prevention was a strong theme in the discussion.

“We need to acknowledge that the root causes of CVD are : smoking, diet and exercise – and it needs to start in childhood, with families and in maternity services.”

“There should be a greater focus on dietary advice and its importance in preventing people getting heart disease and stroke.”

“Smoking is the biggest cause and too many young people start – if we can stop that we stand a better chance of reducing the death rates in future.”

# JSNA Data Refresh 2013/14 Diabetes Barnet

Diabetes is a common life-long health condition. There are 3 million people diagnosed with diabetes in the UK. Type 2 diabetes is a largely preventable disease strongly associated with obesity and is closely linked to cardiovascular disease.

The NHS Health Checks programme is offered to people aged 40-74. It aims to help lower your risk of developing diabetes, heart disease and stroke.

## Key messages

### Demographic

Diabetes rates increase with age and are associated with obesity. Although diabetes is common in all communities, people of South Asian and Caribbean origin have higher chances of developing diabetes and develop it at a younger age and at a lower level of obesity than the white population.

The aging population and expected increase in black and minority ethnic groups in the next 20 years is likely to lead to an increase in the number of people with diabetes.

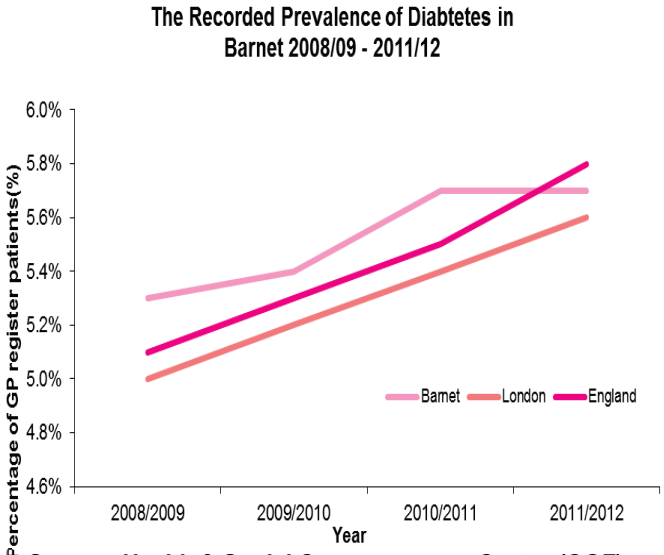
### Diabetes Prevalence

Barnet has a relatively low prevalence rate of diabetes compared to England. Although it is slightly higher than London. The projection suggest it will continue steadily rising. The obesity prevalence in Barnet is 7.5%, which is lower than London and England, but it is an issue that needs to be addressed.

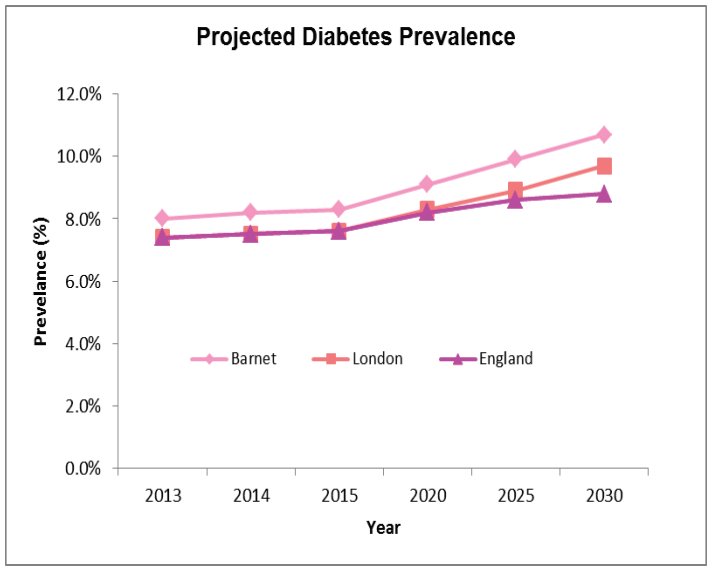
### Health Outcomes

People living with diabetes may have to deal with short-term or long-term complications as a result of their condition. Long and short-term complications can impact on a wide variety of parts of the body including eyes, heart, kidneys, nerves and feet. In Barnet people with diabetes were 62.1% more likely to have a heart attack and 23.5% more likely to have a stroke. However, diabetes is generally well managed in Barnet and the rates for all diabetes complications are amongst the lowest in England.

# Local Data



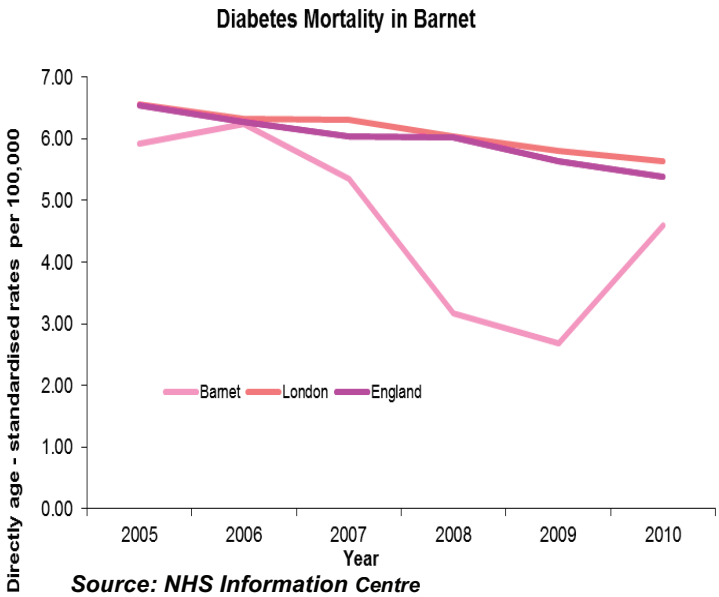

***Source: Health & Social Care Information Centre (QOF)***



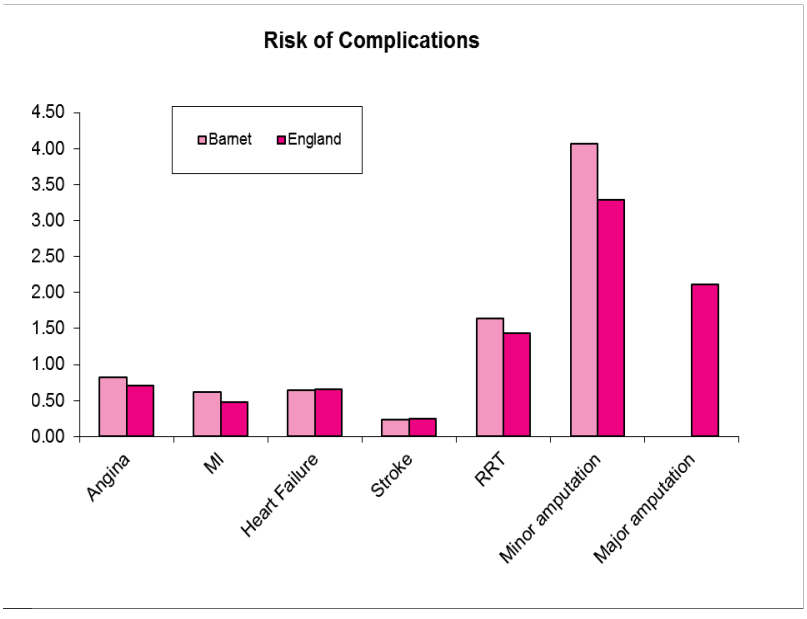

***Source: Yorkshire and Humber Health Intelligence***

## Diabetes prevalence

Over 17,000 (5.7% of the adult population) people aged 17 years and older diagnosed with diabetes in Barnet. It has been estimated the prevalence of diabetes is 7.9%. This would mean that there are around 6,000 people with undiagnosed diabetes in Barnet.




***Source: NHS Information Centre***



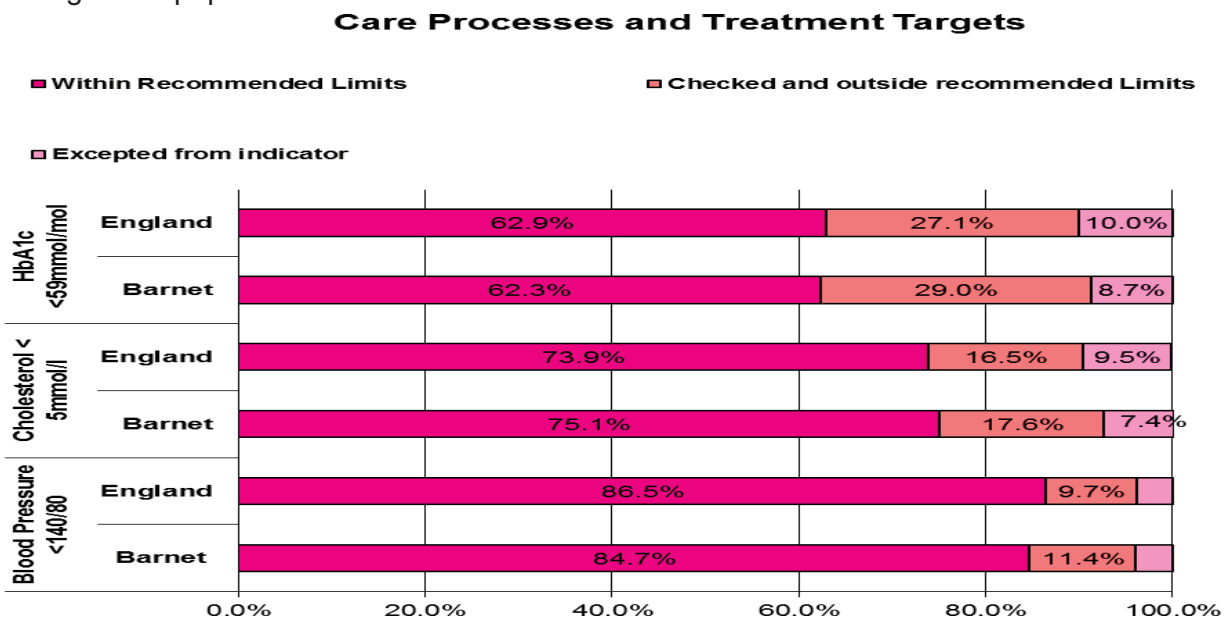

***Source: Yorkshire and Humber Health Intelligence***

## Deaths from Diabetes

Death rates from diabetes in Barnet are on average lower than those of London and England which implies that diabetes is well managed in Barnet.

## Management of Diabetes

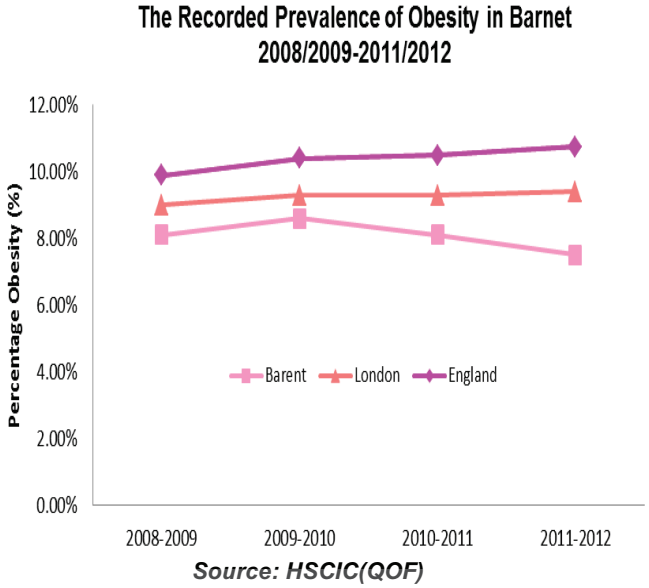
Rates of both good blood glucose and good blood pressure control in people with diabetes in Barnet are similar to the London rates and higher than the national rates. Long term improvement in blood glucose control is considered to have beneficial effects on the onset and progressions of complications. The National Diabetes Audit collates data that identifies the additional risk of diabetic complications and mortality in people with diabetes compared to the general population. Those with diabetes in Barnet were 4 times more likely (407%) to have minor amputation compared to the general population and 0.62 (62.1%) more likely to have a heart attack. They were also 0.64 (64.3%) more likely to have a hospital admission related to heart failure and 0.36 (36.3%) more likely to die than the general population in the same area.



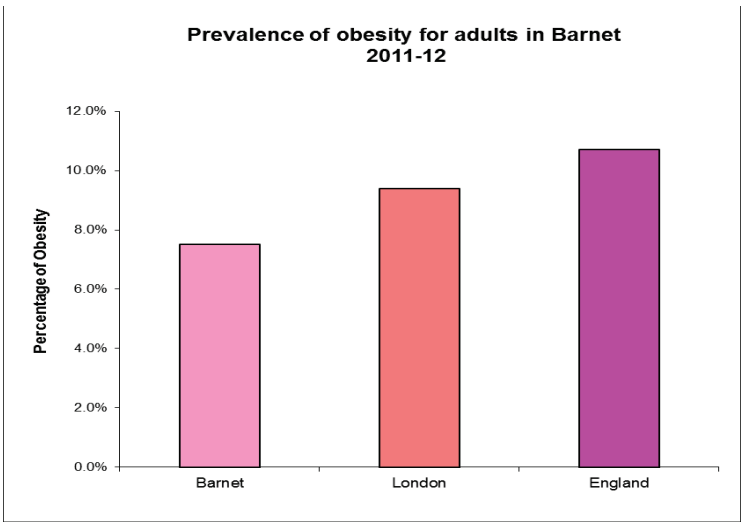

*Source: Yorkshire and Humber Health Intelligence*

## Obesity

There is a known association with obesity and type-2 diabetes. Obesity prevalence in Barnet is 7.5%. This is less than the London and England averages. As obesity is a risk factor for diabetes this is something that needs to be addressed. One aspect of obesity management is the level of physical activity. Rates of physical activity in Barnet are low in both children and adults. More than 9 out of 10 adults in Barnet do not take part in the recommended level of physical activity.




*Source: HSCIC(QOF)*




*Source: Yorkshire and Humber Health Intelligence*

# Local Data

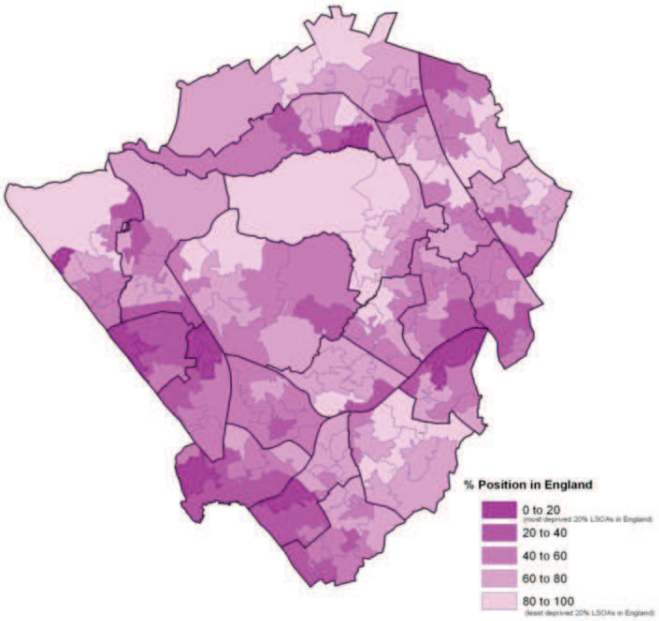
## Population

Age is a significant influence in diabetes prevalence. Type 1 diabetes is usually diagnosed in childhood but the prevalence of Type 2 diabetes increases steadily after the age of 40 years. Diabetes prevalence is also higher in areas with higher rates of deprivation. People living in the 20% most deprived neighbourhoods in England are 56% more likely to have diabetes than those living in the least deprived areas.

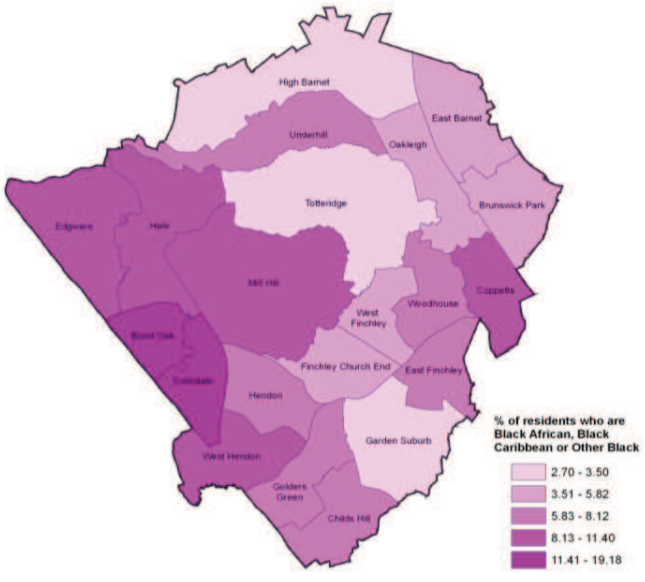
## Ethnicity

Ethnicity is also a key factor in diabetes prevalence. People from Asian and black ethnic groups are more likely to have diabetes and tend to develop the condition at younger ages. The maps provided give the prevalence of black and Asian ethnic minorities showing which areas to target for diabetes awareness in the borough of Barnet.

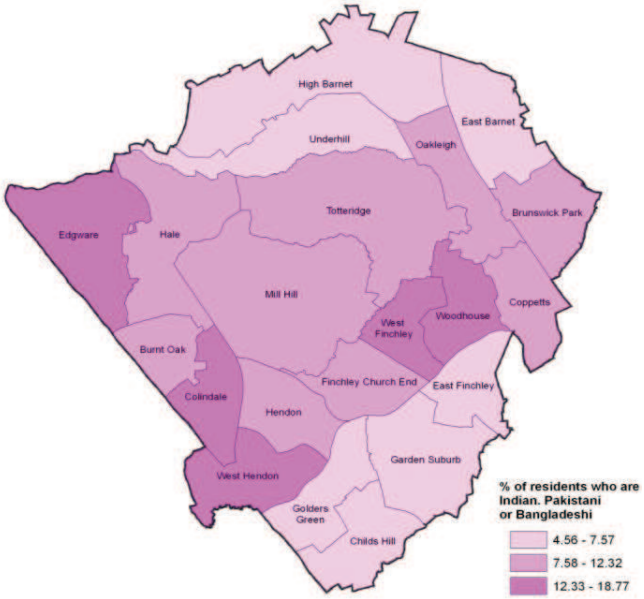
**Multiple Deprivation in Barnet**
Source: 2010 Indices of Deprivation, CLG




**Percentage of Residents in Barnet who are Black African, Black Caribbean or Other Black**
Source: 2011 Census, Table KS201EW, ONS, Crown Copyright




**Percentage of Residents in Barnet who are Indian, Pakistani or Bangladeshi**
Source: 2011 Census, Table KS201EW, ONS, Crown Copyright



## Understanding the Spine Chart

**The Spine chart**

The spine chart is a way of demonstrating a lot of information on a single diagram.

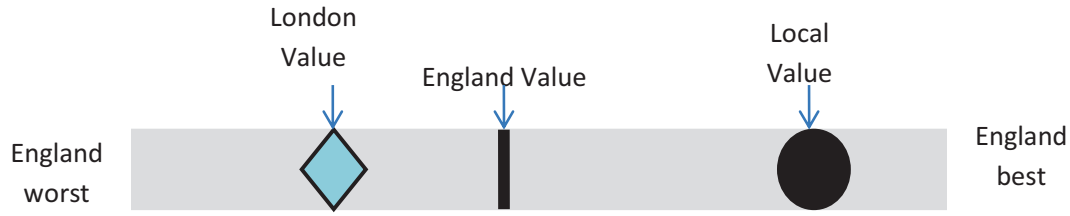
The indicators in the spine chart are generally one of three sorts:

- an indicator of higher or lower need
- an indicator of better or worse performance
- an indicator of better or worse outcomes

The "spine" is the line running down the centre. This is the England average for each indicator. The grey bar shows the range of values in local authorities across England.

Values to the **right** of the England average are better performance or outcomes or of lower need.

Values to the **left** of the England average are worse performance or outcomes or of more need.




**Direction of travel indicator**

⇧ Indicator has improved since last year i.e. Improvement in performance or decrease in need

⇩ Indicator has worsened since last i.e. decrease in performance or increase in need

⇔ No change since previous year

**Green** indicates that, according to the latest data, the area is either performing better or has lower need than England average

**Red** indicates that, according to the latest data, the area is performing at least 2% worse or has at least 2% greater need than the England average.

**Amber** indicates that, according to the latest data, the area is performing worse or has greater need but is within 2% of the England average.

# Spine Chart


| | Indicator | Direction of Travel | Local Value | Eng Avg | Eng Worst | England Range Worse OUTCOMES Better Higher NEED Lower | Eng Best |
|---|---|---|---|---|---|---|---|
| 1 | Percentage of aged over 65 population | ⇔ | 13.3 | 16.5 | 25.2 | | 6.1 |
| 2 | Percentage of aged over 75 population | ⇔ | 3.3 | 3.9 | 3.9 | | 1.5 |
| 3 | Percentage of population with a limiting long term illness, | ⇔ | 13.5 | 16.9 | 24.4 | | 10.2 |
| 4 | Asian Ethnicity: Indian, Pakistani or Bangladish | ↓ | 10.0 | 5.6 | 0.0 | | 35.7 |
| 5 | Black Ethnicity: Black African, Black Carribbean or Other Black | ↓ | 7.7 | 3.5 | 0.1 | | 27.2 |
| 6 | IMD | ↓ | 16.4 | 21.7 | 0.5 | | 87.8 |
| 7 | Diabetes Prevalence 17+ | ⇔ | 5.7 | 5.8 | 9.4 | | 3.4 |
| 8 | Obesity Prevalence 16+ | ↑ | 7.5 | 10.7 | 15.8 | | 6.1 |
| 9 | Obese children (age 4-5 years) | ↓ | 9.4 | 8.5 | 14.5 | | 5.8 |
| 10 | Obese children (age 10-11 years) | ↑ | 18.7 | 19.2 | 27.8 | | 12.3 |
| 11 | Participation in at least 3 hours of sport/PE | ⇔ | 53.5 | 55.1 | 40.9 | | 79.5 |
| 12 | Children's tooth decay (at age 12) | ⇔ | 0.5 | 0.7 | 1.5 | | 0.2 |
| 13 | The proportion of adults participating in recommended levels of physical activity | ⇔ | 8.5 | 11.1 | 18.2 | | 5.7 |
| 14 | Mortality from diabetes: directly standardised rate, all ages, 3-year average | N/A | 3.5 | 5.7 | 19.8 | | 3.1 |
| 15 | Mortality from diabetes Directly age-standardised rates <75 years | N/A | 1.5 | 2.5 | 8.7 | | 0.1 |
| 16 | Mortality from diabetes: directly standardised rate, 1-44 years, 3-year average | N/A | 0.3 | 0.5 | 1.9 | | 0.0 |
| 17 | Blood pressure in patients with diabetes mellitus: percent, 17+ years 150/90 or less | ↑ | 88.2 | 89.9 | 92.7 | | 86.3 |
| 18 | Blood pressure in patients with diabetes mellitus: percent, 17+ years 140/80 or less | ↑ | 68.5 | 70.7 | 78.8 | | 64.3 |
| 19 | Cholesterol levels in patients with diabetes mellitus is 5 mmol/l or less. 17+ years | ↑ | 81.0 | 81.7 | 86.8 | | 75.2 |
| 20 | Controlled blood glucose levels (7.5 or less) in patients with diabetes mellitus | ↑ | 68.3 | 69.9 | 70.6 | | 60.1 |
| 21 | Blood glucose levels 8 or less in patients with diabetes mellitus: 17+ years | ⇔ | 76.7 | 78.7 | 84.4 | | 70.6 |
| 22 | Blood glucose levels 9 or less in patients with diabetes mellitus: 17+ years | ⇔ | 85.3 | 88.6 | 92.2 | | 82.1 |
| 23 | Proportion of patients with diabetes mellitus who have a record of retinal screening 17+ | ↑ | 91.4 | 91.9 | 95.9 | | 85.4 |
| 24 | Proportion of of patient aged 18+ with chronic kidney disease in a GP registered population. | ↓ | 3.1 | 4.3 | 9.0 | | 1.6 |
| 25 | Smoking Cessation advice to patients with any or any combination of: coronary heart disease, stroke or TIA, hypertension, diabetes, COPD. | ⇔ | 93.4 | 92.9 | 90.5 | | 96.5 |
| 26 | Hospital procedures: lower limb amputations in diabetic patients: all ages | ↑ | 5.6 | 11.6 | 21.8 | | 0.00 |

# Spine Chart Data Sources

| | Data description | Year | Other sources of information or data |
|---|---|---|---|
| 1 | Percentage of aged over 65 population | 2011 | Office of National Statistics (ONS) Census 2011 |
| 2 | Percentage of aged over 75 population | 2011 | Office of National Statistics (ONS) Census 2011 |
| 3 | Percentage of population with a limiting long term illness, | 2011 | Office of National Statistics (ONS) Census 2011 |
| 4 | Asian Ethnicity: Indian, Pakistani or Bangladesh | 2011 | Nomis |
| 5 | Black Ethnicity: Black African, Black Caribbean or Other Black | 2011 | Nomis |
| 6 | IMD | 2011 | Gov.uk |
| 7 | Diabetes Prevalence 17+ | 2011/12 | Health & Social Care Information Centre (hscic) |
| 8 | Obesity Prevalence 16+ | 2011/12 | Health & Social Care Information Centre (hscic) |
| 9 | Obese children (age 4-5 years) | 2011/12 | Child and Maternal Health Intelligence Network (chimat) |
| 10 | Obese children (age 10-11 years) | 2011/12 | Child and Maternal Health Intelligence Network (chimat) |
| 11 | Participation in at least 3 hours of sport/PE | 2009/10 | Child and Maternal Health Intelligence Network (chimat) |
| 12 | Children's tooth decay (at age 12) | 2008/09 | Child and Maternal Health Intelligence Network (chimat) |
| 13 | The proportion of adults participating in recommended levels of physical activity | 2009-2011 | Health & Social Care Information Centre (hscic) |
| 14 | Mortality from diabetes: directly standardised rate, all ages, 3-year average | 2008-2010 | Health & Social Care Information Centre (hscic) |
| 15 | Mortality from diabetes Directly age-standardised rates <75 years | 2008-2010 | Health & Social Care Information Centre (hscic) |
| 16 | Mortality from diabetes: directly standardised rate, 1-44 years, 3-year average | 2008-2010 | Health & Social Care Information Centre (hscic) |
| 17 | Blood pressure in patients with diabetes mellitus:17+ years 150/90 or less | 2011/12 | Health & Social Care Information Centre (hscic) |
| 18 | Blood pressure in patients with diabetes mellitus: 17+ years 140/80 or less | 2011/12 | Health & Social Care Information Centre (hscic) |
| 19 | Cholesterol levels in patients with diabetes mellitus is 5 mmol/l or less. 17+ years | 2011/12 | Health & Social Care Information Centre (hscic) |
| 20 | Controlled blood glucose levels (7.5 or less) in patients with diabetes mellitus | 2011/12 | Health & Social Care Information Centre (hscic) |
| 21 | Blood glucose levels 8 or less in patients with diabetes mellitus: 17+ years | 2011/12 | Health & Social Care Information Centre (hscic) |
| 22 | Blood glucose levels 9 or less in patients with diabetes mellitus: 17+ years | 2011/12 | Health & Social Care Information Centre (hscic) |
| 23 | Proportion of patients with diabetes mellitus who have a record of retinal screening in the previous 15 months. | 2011/12 | Health & Social Care Information Centre (hscic) |
| 24 | Proportion of patient aged 18+ with chronic kidney disease in a GP registered population. | 2011/12 | Health & Social Care Information Centre (hscic) |
| 25 | Smoking Cessation advice to patients with any or any combination of the following conditions (co-morbidity): coronary heart disease, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma | 2011/12 | Health & Social Care Information Centre (hscic) |
| 26 | Hospital procedures: lower limb amputations in diabetic patients: all ages | 2011/12 | Health & Social Care Information Centre (hscic) |
| 27 | Proportion of adults participating in recommended physical activity | 2011/12 | Health & Social Care Information Centre (hscic) |

# Stake holder views

A discussion of the topic was held at the Autumn Partnership Catch up in November 2013. The following is a summary of comments from the day.

### On Diabetes

Need a better understanding on “how to prevent diabetes for people of South Asian and Caribbean origin”

More “Info on ethnicity and diabetes – more info on differences between Barnet’s ethnic communities and health conditions”

### On Early Intervention and prevention

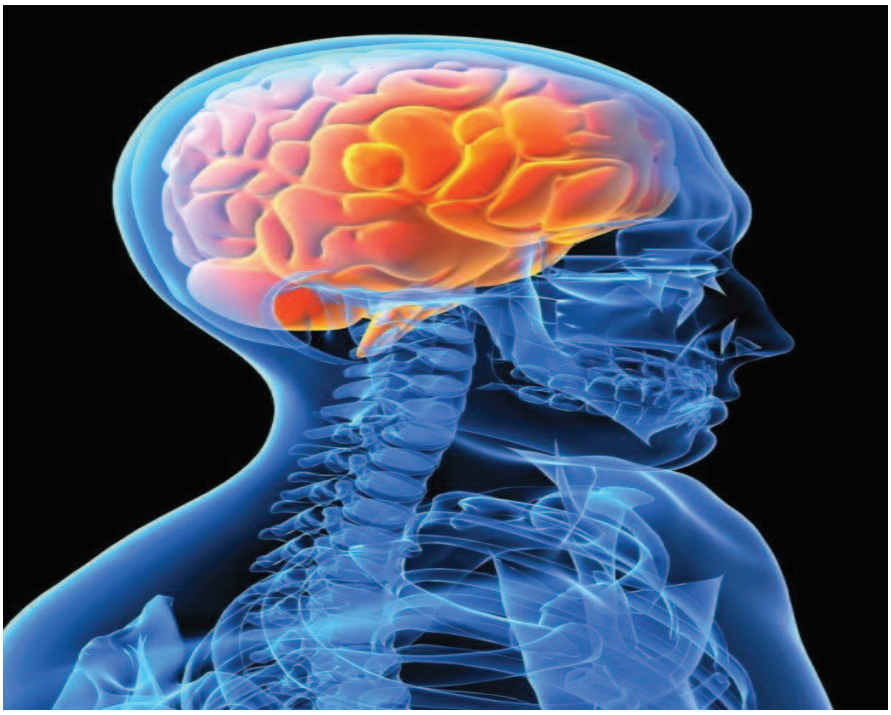
“Early intervention is needed in terms of diabetes prevention and dietary advice.”

“Early intervention – early questions on diet”

### On improving care in Diabetes

Better signposting is need showing what “Barnet’s health services are doing and what should be next steps.”

“Greater focus needed on dietary advice to prevent complications developing.”



# JSNA Refresh 2013/14 Mental Health & Wellbeing

Being healthy mentally doesn't mean that you don't have a mental health problem, it does mean that you are able to make the most of your potential, cope with life, and play a full part in your family, workplace, community and among friends. Mental health is just as important as good physical health. There is a clear *association between wellbeing, good mental health and improved outcomes for people of all ages and* social classes. Mental health and wellbeing are important because:

- Poor mental health and wellbeing can have an impact on every area of a person's life; physical health, education, employment, family, relationships, and the effects can last a lifetime. It plays an important part in contributing to and maintaining health and social inequalities.
- Good mental health and wellbeing are associated with improved outcomes for individuals including longevity, physical health, social connectedness, educational achievement, criminality, maintaining a home, employment status and productivity.
- Mental health is not simply the absence of mental illness. People recovering from mental health conditions can have a positive state of wellbeing, while those who do not have a mental health condition may experience low levels of wellbeing

## Key messages

### Mental Illness in Barnet

The prevalence of mental illness in Barnet is higher than the England average and has slightly increased over the past 5 years at a similar rate to that of England

### Risk factors for poor mental health

There are low levels of unemployment and of violent crime in Barnet.

### Independent living and health self-assessment

The rate of social care assistance to live independently has increased at a rate that exceeds those of London and England.

The rate of mortality due to suicide and undetermined injury in Barnet is higher in men than in women. There has been a moderate decline among men and a slight decline in the rate among women.

### Overall mental health and wellbeing

People with higher well-being have lower rates of illness, recover more quickly and for longer, and generally have better physical and mental health. Overall health and wellbeing in Barnet is good, with 80.1% of people saying that they have

good or very good health and wellbeing.

The rates of people reporting low levels of mental wellbeing or high levels of anxiety is higher than the England average but slightly lower than the average for London.

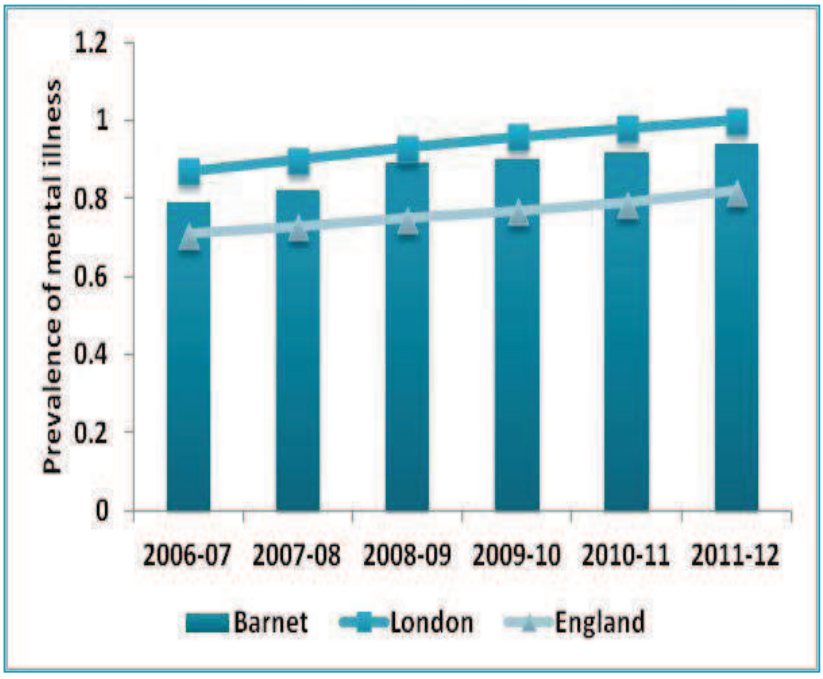
### Local Priorities

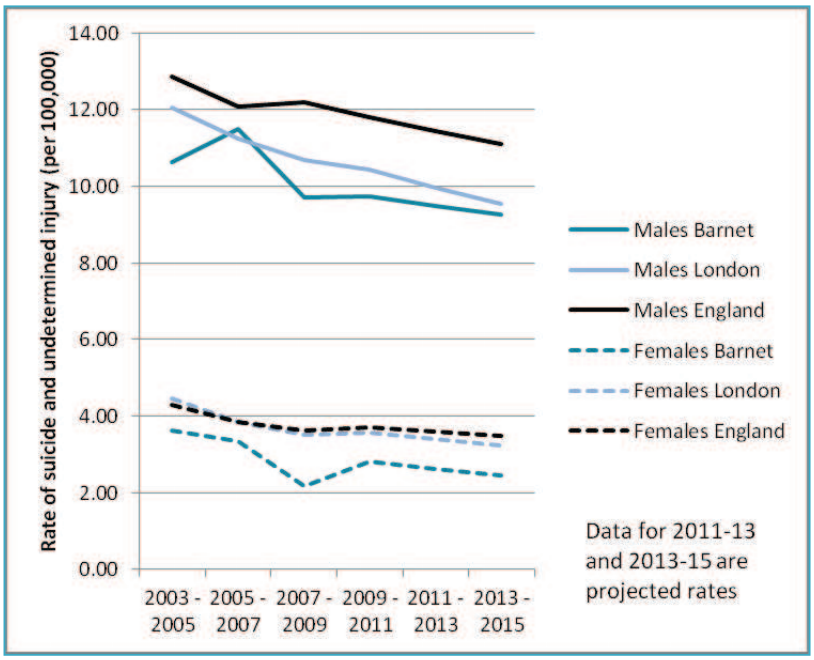
Mental health and wellbeing priorities for Barnet include actions on unemployment, increase access to drug treatment for adults in need, increase physical activity to the recommended levels and increase access to services that support people with mental health issues.

## Local Data

### Prevalence of mental health problems

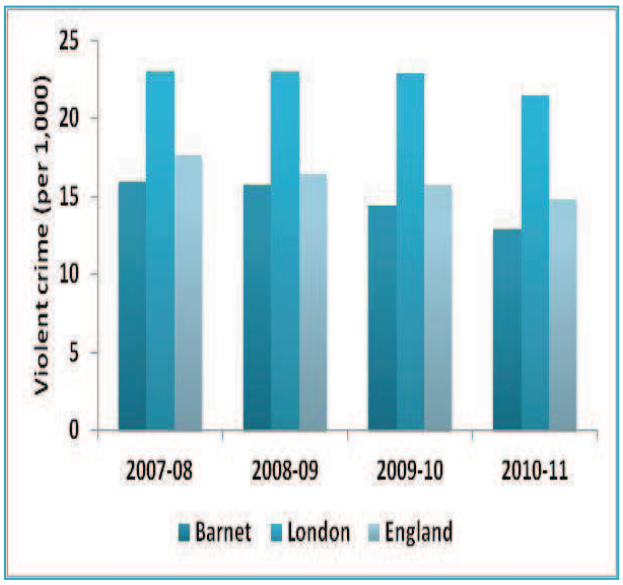
The prevalence of mental illness in Barnet has slightly increased from 0.79% in 2006/07 to 0.94% in 2011/12. The prevalence in Barnet is lower than London but higher than England. The national and regional prevalence in mental illness has also increased. The steepest increases were observed between the 2008/09 and 2011/12 this period coincides with the global economic crisis which may have contributed to the slightly higher levels of mental illness prevalence particularly in 2008/09 where the prevalence was closer to that of London.




### Deaths

Deaths rates from suicide and undetermined injury in Barnet is almost three times higher in men than in women. The peak in men was observed in 2005/07 and has since declined. Mortality among women on the other hand has been considerably more variable with a peak in 2003/05. Mortality due to suicide or undetermined injury is predicted to stabilize in both genders.



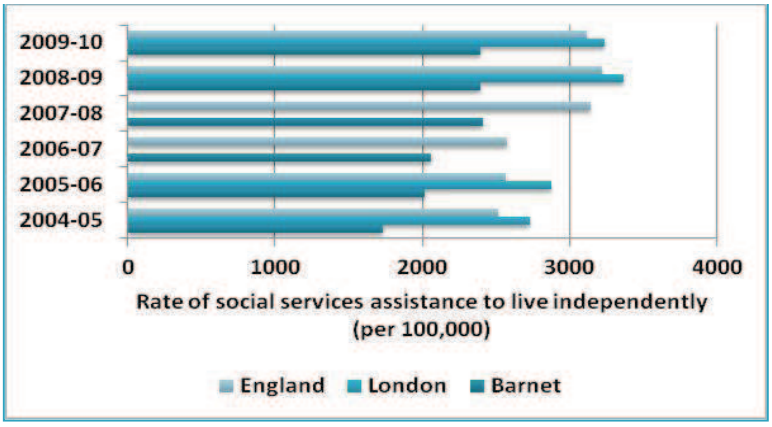

## Crime and mental health

Crime levels are associated with both illness and poverty, increasing the burden of ill health on those communities least able to cope. Violent crime can result directly in psychological distress and subsequent mental health problems. The rate of violent crime is much lower in Barnet than in London and England and this rate has been decreasing since 2007/08.

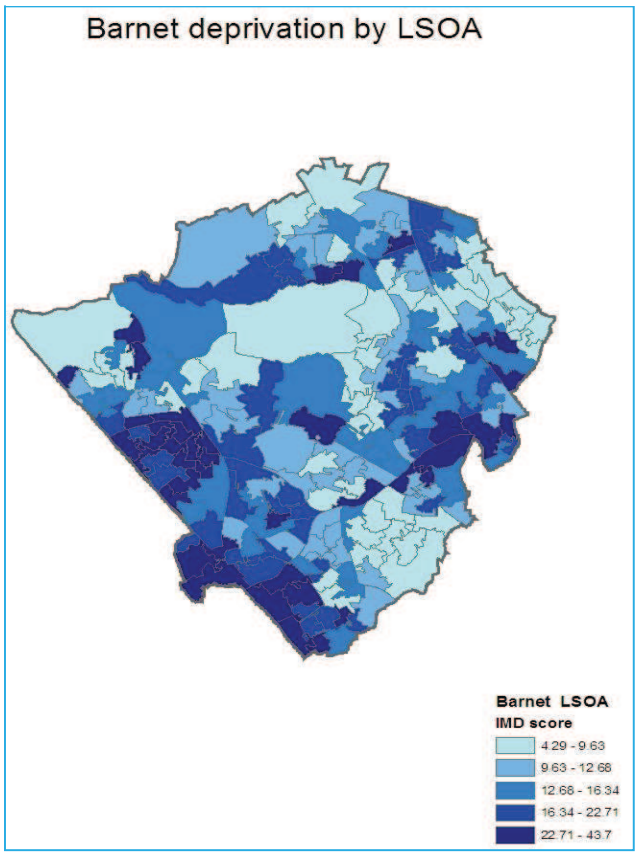
Although the rate of violent crime is low in Barnet, the perception of crime, both violent and non-violent, also has the potential to impact mental health and wellbeing.

## Independence

Being able to live independently is a key factor in good mental health and wellbeing. Since 2004/05 the rate of social service assistance for Barnet residents to live independent lives has steadily increased. However, the rate of assistance in London and England remains higher than in Barnet over this period.




*Data for London is missing for 2006/07 and 2007/08*

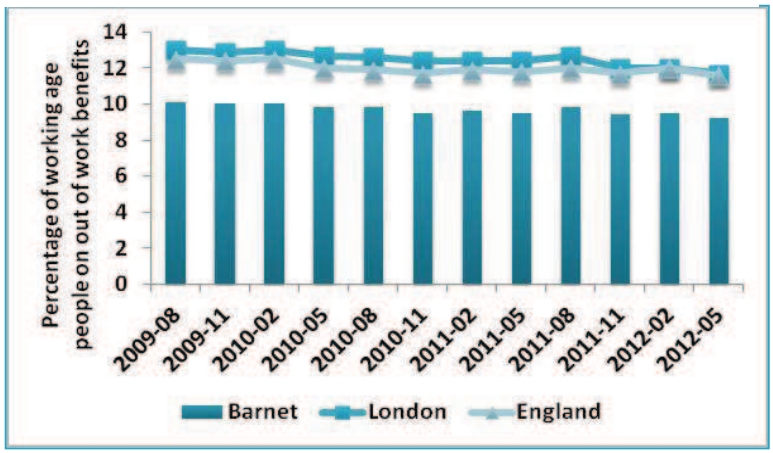



## Deprivation

The index of multiple deprivation (IMD) identifies areas with substantial levels of multiple deprivation which helps to measure and identify health inequalities across the borough. Although in overall terms Barnet is an affluent borough there are pockets of deprivation. These exist along the western edge of the borough and in parts of Coppetts, East Finchley and Brunswick Park wards.

## Work and benefits

The proportion of people claiming out of work benefits in Barnet has declined slightly between August 2009 and May 2012. Similar declines were also observed in London and England although there are fewer people claiming out of work benefits in Barnet in this period when compared to London and England.



## Health & Wellbeing

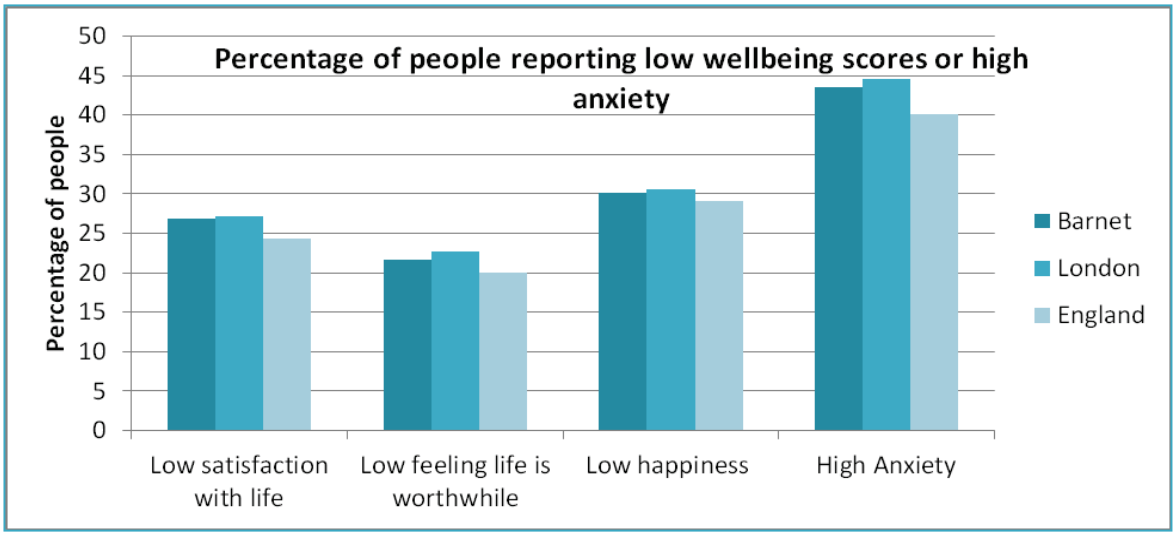
People with higher self-reported well-being have lower rates of illness, recover more quickly and for longer, and generally have better physical and mental health.

Overall health and wellbeing in Barnet is good, with, eight out of 10 residents saying that they have good or very good health and wellbeing. The over 65 age group also appears to be in good health with only two in 10 reporting that they were not in good health. This is lower than the London average and the 5th lowest of all London boroughs


A new national survey asks people four questions:

- Overall, how satisfied are you with your life nowadays?
- Overall, how happy did you feel yesterday?
- Overall, how anxious did you feel yesterday?
- Overall, to what extent do you feel the things you do in your life are worthwhile?

The percentage of people in Barnet reporting low levels of satisfaction, happiness and feeling worthwhile is higher than the England average but slightly lower than the average for London. The percentage of people in Barnet reporting high levels of anxiety is higher than the England average but slightly lower than the average for London.



# Understanding the Spine Chart

The spine chart is a way of demonstrating a lot of information on a single diagram.

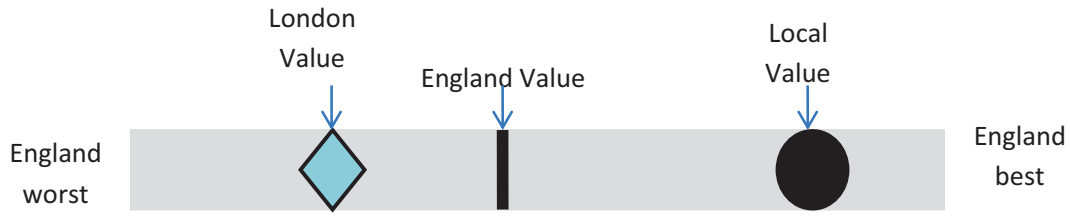
The indicators in the spine chart are generally one of three sorts:

- an indicator of higher or lower need
- an indicator of better or worse performance
- an indicator of better or worse outcomes

The "spine" is the line running down the centre. This is the England average for each indicator. The grey bar shows the range of values in local authorities across England.

Values to the **right** of the England average are better performance or outcomes or of lower need.

Values to the **left** of the England average are worse performance or outcomes or of more need.




**Direction of travel indicator**

⇧ Indicator has improved since last year i.e. Improvement in performance or decrease in need

⇩ Indicator has worsened since last i.e. decrease in performance or increase in need

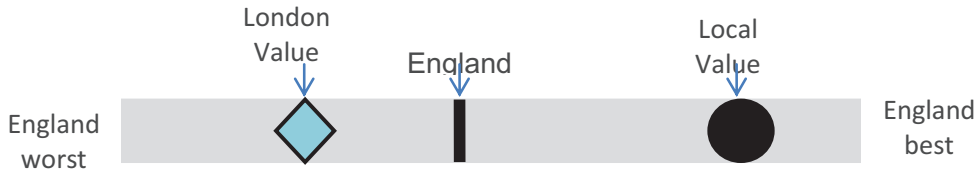
⇔ No change since previous year

**Green** indicates that, according to the latest data, the area is either performing better or has lower need than England average

**Red** indicates that, according to the latest data, the area is performing at least 2% worse or has at least 2% greater need than the England average.

**Amber** indicates that, according to the latest data, the area is performing worse or has greater need but is within 2% of the England average.

# Spine Chart




| | Indicator | Direction of travel | Local Value | Eng Avg | Eng Worst | England Range Worse Higher / OUTCOMES / NEED / Better Lower | Eng Best |
|---|---|---|---|---|---|---|---|
| 1 | Percentage of NEET 16-18 year olds, 2010/11 | ↓ | 4.1 | 6.2 | 11.9 | | 1.9 |
| 2 | Epidsodes of violent crime, 2010/11 | ↑ | 12.7 | 14.6 | 34.5 | | 6.3 |
| 3 | Living in 20% deprived areas in England, 2010 | ↓ | 5.8 | 19.8 | 83.0 | | 0.3 |
| 4 | Working age adults who are unemployed, 2010/11 | ↓ | 64.2 | 59.4 | 106.2 | | 8.3 |
| 5 | Hospital admissions due alcohol conditions, 2010/11 | ↓ | 18.9 | 23.0 | 38.6 | | 11.4 |
| 6 | Adults in drug treatment, 2011/12 | ↑ | 2.8 | 5.2 | 0.8 | | 18.4 |
| 7 | Statutory homeless households, 2010/11 | ↔ | 1.8 | 2.0 | 10.4 | | 0.1 |
| 8 | Percentage with a limiting long term illness, 2001 | ↔ | 13.5 | 16.9 | 24.4 | | 10.2 |
| 9 | First time youth justice system entrants, 2001 - 2011 | N/A | 587.0 | 876.0 | 2436.0 | | 343.0 |
| 10 | Recommended physcial activity (Adults), 2009/10-2011/12 | ↑ | 8.5 | 11.2 | 5.7 | | 17.3 |
| 11 | Percentage of adults (18+) with dementia, 2011/12 | ↓ | 0.6 | 0.5 | 1.0 | | 0.2 |
| 12 | Recorded/expected prevalence of dementia, 2010/11 | N/A | 0.5 | 0.4 | 0.3 | | 0.7 |
| 13 | Percentage of adults (18+) with depression, 2011/12 | ↓ | 8.5 | 11.7 | 20.3 | | 4.8 |
| 14 | Percentage of adults with learning disabilities, 2011/12 | ↑ | 0.4 | 0.5 | 0.2 | | 0.8 |
| 15 | Mental health hospital admissions, 2009/10 to 2011/12 | ↓ | 216.0 | 243.0 | 1257.0 | | 99.0 |
| 16 | Unipolar depressive disorders hospital admissions, 2009/10 to 2011/12 | ↑ | 30.5 | 32.1 | 84.8 | | 4.7 |
| 17 | Alzheimer's & other related dementia admissions, 2009/10 to 2011/12 | ↑ | 53.0 | 80.0 | 226.0 | | 5.0 |
| 18 | Schizophrenia & other delusional disorder admissions, 2009/10 to 2011/12 | ↓ | 96.0 | 57.0 | 233.0 | | 5.0 |
| 19 | Allocated average mental health spend, 2011/12 | ↔ | 179.0 | 183.0 | 147.0 | | 257.0 |
| 20 | Adult & elderly secondary mental health service use,2010/11 | ↕ | 2.5 | 2.5 | 0.0 | | 9.6 |
| 21 | Referrals from Improving Access to Psychological Therapies, 2011/12 | N/A | 35.2 | 60.1 | 28.9 | | 99.7 |
| 22 | Numbers on Care Programme Approach | ↓ | 7.7 | 6.4 | 0.3 | | 17.1 |
| 23 | In-year bed days for mental health,2010/11 | ↔ | 191.0 | 193.0 | 72.0 | | 489.0 |
| 24 | Contacts with Community Psychiatric Nurse, 2010/11 | ↓ | 150.0 | 169.0 | 3.0 | | 584.0 |
| 25 | Total mental health services contacts, 2010/11 | ↔ | 330.0 | 313.0 | 31.0 | | 823.0 |
| 26 | Living in settled accommodation with mental illness/disability , 2011/12 | N/A | 65.9 | 66.8 | 1.3 | | 92.8 |
| 27 | DSR for self harm emergency admissions, 2011/12 | ↓ | 121.0 | 207.0 | 543.0 | | 52.0 |
| 28 | ISR for suicide and undetermined injury, 2010/11 | ↓ | 104.0 | 100.0 | 174.0 | | 29.0 |
| 29 | Unintentional and deliberate injuries in <18s, 2009/10 | N/A | 79.0 | 123.0 | 217.0 | | 68.0 |
| 30 | Improving Access to Psychological Therapies, 2011/12 | N/A | 51.0 | 43.8 | 9.9 | | 65.3 |
| 31 | Excess serious mental illness mortality (<75), 2010/11 | N/A | 596.0 | 921.0 | 1863.0 | | 210.0 |

For indicators 6, 14, 20 and 22-25, there is no perceived polarity, so ”lowest” and “highest” replace “worst” and “best”.

# Spine chart data sources

| | Data description | Year | Other sources of information or data |
|---|---|---|---|
| 1 | Percentage of 16-18 year olds not in employment, education or training (NEET) | 2011 | Local Government Improvement and Development |
| 2 | Episodes of violent crime, rate per 1,000 population | 2010/11 | Neighbourhood Statistics |
| 3 | Percentage of the relevant population living in the 20% most deprived areas in England | 2010 | Department for Communities and Local Government |
| 4 | Working age adults who are unemployed, rate per 1, 000 population | 2010/11 | Department for Communities and Local Government |
| 5 | Rate of hospital admissions for alcohol attributable conditions, per 1,000 population | 2011/12 | Local Alcohol Profiles England |
| 6 | Number of people (aged 18-75) in drug treatment, rate per 1,000 population | 2011/12 | National Treatment Agency for Substance Misuse |
| 7 | Statutory homeless household, rate per 1,000 households, all ages | 2010/11 | Department for Communities and Local Government |
| 8 | Percentage of the population with a limiting long term illness | 2001 | Office for National Statistics |
| 9 | First time entrants into the youth justice system 10 to 17 year olds | 2001 to 2011 | Youth Justice Indicators, Department for Justice |
| 10 | Percentage of adults (16+) participating in recommended level of physical activity | 2009/10 to 2011/12 | Sport England |
| 11 | Percentage of adults (18+) with dementia | 2011/12 | Health and Social Care Information Centre |
| 12 | Ratio of recorded to expected prevalence of dementia | 2010/11 | POPPI & PANSI |
| 13 | Percentage of adults (18+) with depression | 2011/12 | Health & Social Care Information Centre |
| 14 | Percentage of adults (18+) with learning difficulties | 2011/12 | Health & Social Care Information Centre |
| 15 | Directly standardised rate for hospital admissions for mental health | 2009/10 to 2011/12 | Hospital Episode Statistics, Health & Social Care Information Centre and the Office for National Statistics |
| 16 | Directly standardised rate for hospital admissions for unipolar depressive disorders | 2009/10 to 2011/12 | Hospital Episode Statistics, Health & Social Care Information Centre and the Office for National Statistics |
| 17 | Directly standardised rate for hospital admissions for Alzheimer's and other related dementia | 2009/10 to 2011/12 | Hospital Episode Statistics, Health & Social Care Information Centre and the Office for National Statistics |
| 18 | Directly standardised rate for hospital admissions for schizophrenia, schizotypal and delusional disorders | 2009/10 to 2011/12 | Hospital Episode Statistics, Health & Social Care Information Centre and the Office for National Statistics |
| 19 | Allocated average spend for mental health per head | 2011/12 | Department of Health, Exposition book |
| 20 | Numbers of people using adult & elderly NHS secondary mental health services, rate per 1,000 population | 2010/11 | Health & Social Care Information Centre – Mental Health Minimum Dataset |
| 21 | Percentage of referrals entering treatment from Improving Access to Psychological Therapies | 2011/12 | Health & Social Care Information Centre |
| 22 | Numbers of people on a Care Programme Approach, rate per 1,000 population | 2010/11 | Health & Social Care Information Centre – Mental Health Minimum Dataset |
| 23 | In-year bed days for mental health, rate per 1,000 | 2010/11 | Health & Social Care Information Centre – Mental Health Minimum Dataset |
| 24 | Number of contacts with Community Psychiatric Nurse, rate per 1,000 population | 2010/11 | Health & Social Care Information Centre – Mental Health Minimum Dataset |
| 25 | Number of total contacts with mental health services, rate per 1,000 population | 2010/11 | Health & Social Care Information Centre – Mental Health Minimum Dataset |
| 26 | People with mental illness and or disability in settled accommodation | 2011/12 | Health & Social Care Information Centre |
| 27 | Directly standardised rate for emergency hospital admissions for self harm | 2011/12 | Hospital Episode Statistics, Health & Social Care Information Centre and the Office for National Statistics |
| 28 | Indirectly standardised mortality rate for suicide and undetermined injury | 2010/11 | Compendium of population health indicators, Health & Social Care Information Centre and the Office for National Statistics |
| 29 | Hospital admissions caused by unintentional and deliberate injuries in <18s | 2009/10 | Hospital Episode Statistics, Health & Social Care Information Centre and the Office for National Statistics |
| 30 | Improving Access to Psychological Therapies – Recovery Rate | 2011/12 | Health & Social Care Information Centre |
| 31 | Excess under 75 mortality rate in adults with serious mental illness | 2010/11 | Compendium of population health indicators, Health & Social Care Information Centre and the Office for National Statistics |

# Stakeholder views

A discussion of the topic was held at the Autumn Partnership Catch up in November 2013. The following is a summary of comments from the day.

### On improving data on Mental Health and Wellbeing

"We need to take account of wider community data such as crime data. People with MH problems are often victims of crime. We need to acknowledge that people who commit crime may do so because they didn't get the help they needed initially."

The needs to be better "Linking of data i.e. mental health of parents with maternity data so that there is information to support service development."

### On improving Mental Health and Wellbeing Services

"Better communication between services. Navigate through services."

"There are people with mental health issues who get batted around."

"Mental Health services do need to recognise that carers can be of help."

### On improving care in Mental Health and Wellbeing

"Wellbeing in the community – more needs to happen. What community health services are available, where they are – point of entry"

"More support for voluntary organisations. Help each other. Low cost services, integration."

"Better use of venues that are empty – for organisations that are looking for buildings."

"Learning disabilities and mental health services working together in terms of skills and training."

AGENDA ITEM 13

| | |
|---|---|
| Meeting | Health and Well-Being Board |
| Date | 23rd January 2014 |
| **Subject** | CCG strategic and operational planning 2014/15 onwards |
| Report of | Barnet CCG Chief Officer |
| Summary of item and decision being sought | This paper describes the planning processes to be followed by clinical commissioning groups in developing five-year strategic plans and two-year operational plans. The Health and Well-Being Board is asked to support the process. |

| | |
|---|---|
| Officer Contributors | Owen Richards, Commissioning Support Director (Barnet), NEL Commissioning Support Unit<br>John Morton, Chief Officer, Barnet CCG |
| Reason for Report | To inform the Board of the planning processes to be followed by Clinical Commissioning Groups in developing five-year strategic plans and two-year operational plans |
| Partnership flexibility being exercised | None |
| Wards Affected | All |
| Status (public or exempt) | Public |
| Contact for further information | Owen Richards, Commissioning Support Director (Barnet)<br>North and East London Commissioning Support Unit<br>Owen.Richards@nelcsu.nhs.uk |

## 1. RECOMMENDATIONS

**1.1 That the Health and Well-Being Board (HWBB) notes the requirement on Barnet CCG to work with neighbouring CCGs on the development of a five year strategic plan, allied to a two year operational plan for the CCG.**

**1.2 That the Health and Well-Being Board (HWBB) receives and supports the final submissions in line with the national timetable.**

## 2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 Previous meetings of the Health and Well-Being Board will have received reports on the plans being prepared by Barnet CCG. This report updates the process to be followed.

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

3.1 The operational plan will need to align with local partnership strategies. The five year strategic plan covers a wider footprint – the five clinical commissioning groups in North Central London – and hence will be at a very strategic level. Each CCG will ensure that local strategies are aligned in this document. The plans relating to the *Better Care Fund* will complement the strategic and operational plans.

## 4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 The Joint Strategic Needs Assessment will inform the CCGs plans. Proposals will be assessed for their impact on equality and diversity in line with the CCGs Equality Delivery System.

## 5. RISK MANAGEMENT

5.1 The key issue for Barnet CCG is its financial position, which has been previously rehearsed with the Health and Well-Being Board. Alongside growing demand for healthcare and the need to deliver the targets set out in the NHS Constitution, the CCG will need to ensure it can commission a range of service, within its resources, which address these targets. To do so, it must redesign the way in which care is provided to local people.

5.2 Progress on delivering the plans will be monitored by the CCGs senior management team, its Finance, Performance and QIPP committee and the Board itself. These groups will assess risk to delivery and agree remedial action.

## 6. LEGAL POWERS AND IMPLICATIONS

6.1 The Health and Social Care Act 2012 established clinical commissioning groups with the mandate to commission healthcare services for local people. This will include the development of strategic and operational plans.

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

7.1 The plans will set out how the CCG intends to use its commissioning budgets over the planning period. Clearly for Barnet CCG, the financial challenges and the need to achieve financial balance will feature heavily in this work. CCGs are also expected to

project forward in line with the national consultation *A Call to Action*, which highlights the increasing demands on the NHS in the period to 2020/21.

## 8. COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 Local events under the banner of *A Call to Action* have already taken place in Barnet and will inform the plans. The CCG will shortly be undertaking a stakeholder mapping exercise to strengthen its engagement work. CCGs will be expected to demonstrate high levels of engagement when plans are submitted for assurance by NHS England.

## 9. ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 The CCG will use its structure of clinical commissioning programme boards to develop its plans. These include clinical representatives from local providers.

## 10. DETAILS

10.1 Background and objectives

Commissioners of healthcare services are required to prepare (or contribute to) two planning documents for the period commencing 2014/15:

1. A five-year strategic plan, covering a wider planning unit than just the CCG
2. A two-year operational plan for each commissioner

10.2 The NHS Outcomes Framework remains central to the work of commissioners. It sets out five aims:

- Preventing people from dying prematurely, with an increase in life expectancy for all sections of society
- Ensure that those people with long term conditions, including mental health, get the best possible quality of life
- ensure patients are able to recover quickly and successfully from episodes of ill-health or following an injury
- Ensure patients have a great experience of all their care
- Ensure that patients in our care are kept safe and protected from all avoidable harm

10.3 NHS England also recognises that more radical change is required to keep pace with the challenges of rising demand, new technologies, and ageing population and limited finances. The Chief Executive of NHS England set out six ambitions for the commissioners to address in their plans for the coming five-year period:

- Securing additional years of life for people with treatable mental and physical health conditions
- Improving the quality of life of people with one or more long term conditions, including mental health
- Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital
- Increasing the number of people with mental and physical health conditions having a positive experience of hospital care
- Increasing the number of people with mental and physical conditions having a positive experience of care outside hospital, in general practice and in the community
- Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care

10.4 Taken together, these lead to a description of a high quality sustainable health and social care system, based on:

- Citizen participation and empowerment
    - Listening to patients' views
    - Delivering better care through the digital revolution
    - Transparency and data sharing
- Wider primary care, provided at scale
    - Transforming primary care services
- A modern model of integrated care
    - Ensuring tailored care for vulnerable and older people
    - Care integrated around the patient
- Access to the highest quality urgent and emergency care
- A step-change in the productivity of elective care
- Specialised services concentrated in centres of excellence

10.5 Strategic plan

Barnet CCG is working with the other four CCGs in North Central London and NHS England to produce the five year strategic plan.

This will comprise a "plan on a page", setting out a very high level vision, objectives and improvement interventions and delivery mechanisms. This section of the strategic plan will be followed by a more detailed submission relating to individual organisations' strategic plans. These will need to align to the Plan on a Page, but should also include CCG specific content, i.e., around Health and Wellbeing Board collaboration and Better Care Fund arrangements.

The key change in this approach is the need to take a system-wide perspective, recognising that local providers are commissioned by more than one CCG.

10.6 Operational plan

Against the background of the strategic plan, each CCG will prepare a two year operational plan to set out how it will deliver its objectives. This will be supplemented by a set of financial and service improvement templates (including trajectories to reduce the number of avoidable admissions or to improve patient experience, for example), as well as the *Better Care Fund* plan.

Significant work has been undertaken by the CCG and its partners to shape local plans. The objectives and ambitions listed above are entirely in keeping with locally focussed aims and ambitions, so there is no requirement to start again with this work.

10.7 Timetable

CCGs are working to the timetable shown below. In line with the dates below, drafts will need to be brought to the Health and Well-Being Board.

| Activity | Deadline |
|---|---|
| First submission of plans | 14 February 2014 |
| Contracts signed | 28 February 2014 |
| Refresh of plan post contract sign off | 5 March 2014 |
| Reconciliation process with NHS Trust Development Authority and Monitor | From 5 March 2014 |
| Plans approved by boards | 31 March 2014 |
| Submission of final 2 year operational plans and draft 5 year strategic plan | 4 April 2014 |
| Submission of final five year strategic plans<br><br>Years 1&2 of the 5 year plan will be fixed per the final plan submitted on 4 April | 20 June 2014 |

## 11 BACKGROUND PAPERS

11.1 The Planning Guidance from NHS England can be found at Everyone Counts: Planning for Patients 2014/15 to 2018/19

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| | |
|---|---|
| Meeting | Health and Well-Being Board |
| Date | 23rd January 2014 |
| **Subject** | **Barnet Clinical Commissioning Group (CCG) Primary Care Strategy** |
| Report of | Barnet CCG Chief Officer |
| Summary of item and decision being sought | This paper presents to Board members, a summary of the progression of the Barnet CCG Primary Care Strategy and implementation. The Board is asked to note the areas of work being progressed within primary care within the borough of Barnet and comment on the way in which the Board would wish to further support implementation within Barnet. The paper also highlights the implications for strategic implementation of primary care, arising from the NHS England document *'Transforming Primary Care in London: General Practice – A Call to Action'*. Consultation on this document ends on 31st March 2014 and will be the subject of a separate response. |

| | |
|---|---|
| Officer Contributors | Anthony Davis, Emma Hay, Amol Joshi, Jeff Lake (Public Health in respect of s.11.3-11.6) |
| Reason for Report | To share the progression of implementation of the Barnet Primary Care Strategy |
| Partnership flexibility being exercised | Not applicable |
| Wards Affected | All |
| Status (public or exempt) | Public |
| Contact for further information | Anthony Davis, anthony.davis@barnetccg.nhs.uk, 020 3688 1829 |

## 1 RECOMMENDATIONS

**1.1 That the Health and Well-Being Board notes the current update on the implementation of the primary care strategy and comment on the way in which the Board can support implementation in Barnet.**

**1.2 That the Health and Well-Being Board notes issues arising from the NHSE consultation document '*Transforming Primary Care in London: General Practice – A Call to Action'*.**

## 2 RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 The Primary Care Strategy was agreed in July 2013 and the network plans were signed off by the Board in October 2013

2.2 Meetings of the Primary Care Strategy Implementation Group within the CCG on a bi-monthly basis

## 3 LINK AND IMPLICATIONS FOR STRATEGIC PARTNERSHIP-WIDE GOALS

### Link to Commissioning Strategies

3.1 As signed off by the Barnet CCG, the key overarching goals of the strategy that links with partnership goals are:

- **clinical and cost effectiveness**, by supporting a re-profiling of investment in healthcare between acute, and community and primary care to rebalance the health economy;

- **prevention,** by supporting a reduction in the gap between diagnosed long term conditions, and expected prevalence, and by supporting healthy lifestyles; and

- **integrated care,** by supporting closer working between health and social care professionals in a range of settings.

### Link to Health and Well-Being Strategy

3.2 The Health and Well-Being Strategy sets out the aspirations of the Health and Well-Being Board and its member organisations. Particular health outcomes are identified as local priorities for improvement and these will inform the focus of the local Primary Care Strategy implementation plan.

### Link to Sustainable Community Strategy

3.3 The Primary Care Strategy describes a vision for primary care that will support these objectives through greater integration between primary care practices and local health and social care providers; easier transfer, with patient permission, of patient information through web-based systems to ensure providers have timely access to information about the patient's needs; a greater role for primary care in supporting improvements in the health of the population; improvements to access to primary care; and support to patients to take responsibility for their own health.

## 4 NEEDS ASSESSMENT AND EQUALITIES IMPLICATIONS

4.1 As noted above, the focus for implementation of the primary care strategy in Barnet is informed by the Health and Well-Being Strategy, which has in turn been informed by the Joint Strategic Needs Assessment.

4.2 An equality impact analysis was undertaken in January 2012. This indicated that: "the EQIA demonstrates the policy / change is robust and there is no potential for discrimination or adverse impact"[1].

## 5 RISK MANAGEMENT

5.1 Risks to the success of the strategy have been identified as[1]:

5.1.1 that GPs may not engage with the implementation of the strategy, thus preventing anticipated improvements in patient access and safety, clinical effectiveness and the patient experience. This risk has being mitigated through a focus on engagement of GPs in the development and implementation of the strategy and through a mutually beneficial investment in primary care which will support practices to achieve explicit quality standards, which is clinically led and informed by the patient experience of current service provision;

5.1.2 a financial risk that the time-limited investment in primary care does not deliver the required rebalancing of the health system to enable continued investment beyond the initial three year period. This risk is mitigated by embedding within the local implementation, a robust process for allocating the available investment to initiatives with demonstrable potential to support the desired transformational change, based on best practice and patient experience.

5.1.3 General Medical Service contracts within primary care are held and managed by NHS England. The risk is maintenance of a relationship between NHS England and Barnet CCG that is cogniscent of the support needed within the wider system to achieve the local primary care strategy.

## 6 LEGAL POWERS AND IMPLICATIONS

6.1 The passing of the Health and Social Care Bill, resulted from 1 April 2013, in the commissioning functions of NHS North Central London passing to a number of organisations, primarily: Clinical Commissioning Groups (CCG); the NHS Commissioning Board; Local Authorities; and NHS Property Services Ltd. Responsibility for implementation of the primary care strategy is divided between these organisations. Barnet CCG will take responsibility within Barnet for: securing continuous improvements in the quality of services commissioned; reducing inequalities; enabling choice and promoting patient involvement; securing integration; and promoting innovation and research, the NHS Commissioning Board, through NHS England is responsible for managing the contracts and performance of primary care contractors

## 7 USE OF RESOURCES IMPLICATIONS

[1] Cover paper to the North Central London Primary Care Strategy 2012/16, Meeting of the Joint Boards of NHS North Central London, Thursday, 26 January 2012.

7.1 It is expected that time-limited investment in primary care will support reductions in the use of secondary care, thus reducing costs by more than the total initial investment.

## 8 COMMUNICATION AND ENGAGEMENT WITH USERS AND STAKEHOLDERS

8.1 During the original process of development, the primary care strategy was shared with Local Involvement Networks (LINk) and the Joint Health Overview and Scrutiny Committee.

8.2 A Barnet Primary Care Strategy Implementation Group (BPCSIG) has been formed and is chaired by a Barnet CCG Board member to:

- Champion the opportunities provided by the strategy to:
  - Improve the quality of primary care as a major part of the overall health system; and
  - Improve health outcomes for the population of Barnet;
- Support development and delivery of an implementation plan that builds on the particular strengths, and addresses the particular challenges, of primary care in Barnet

## 9 ENGAGEMENT AND INVOLVEMENT WITH PROVIDERS

9.1 The Primary Care Strategy signals a potentially transformational change for practices in Barnet. Building local momentum is vital and therefore it is important to provide opportunities throughout implementation, for practices and local 'champions' to become engaged. This has been achieved through the Primary Care network meetings, the Primary Care Locality meetings, practice visit programme, Local Medical Committee (LMC) Liaison meetings. The Local Medical Committee remains an important partner in engaging practices.

9.2 The primary care strategy, through network development aims to present opportunities for primary care to engage with a range of stakeholders within health and social care, based around improving access to health and social care provision and centred on patient need.

9.3 It is anticipated that the voluntary sector and other provider organisations will have an important role in defining the integrated care networks.

9.4 It will therefore be vital to provide opportunities for the Local Authority, and NHS and voluntary sector providers to support the implementation plan in its early stages; in this way we will gain maximum benefit from the knowledge and wide range of perspectives of our partners.

## 10 DETAILS

10.1 Networks within primary care have developed with the purpose of enabling service development to meet the needs of patients that goes beyond the core service provision within primary care. In doing so, the networks aspire to act as catalysts to enable and promote integrated working across primary care practices and eventually across community, social, primary and secondary care. This development would be supported by strengthening workforce development through targeted investment in multidisciplinary training as funding permits. These changes are necessitated by the need for primary

care to tackle the increasingly complex needs of older patients and patients with long term conditions, and the expectation of delivering healthcare 7 days a week, which is the challenge being proposed by the NHS England document :' Transforming Primary Care in London: General Practice – A Call to Action'

10.2 Barnet Clinical Commissioning Group, while not responsible for commissioning primary care services, is committed to working, with NHS England, to improve the quality of primary care. We recognise this as a key enabler of our four strategic objectives:

- Improve inequalities in health;
- Prepare children and young people for a healthy life;
- Provide the right care at the right time, in the right place; and
- Develop an integrated care system across health and social care.

10.3 The aim of primary care development is therefore to support achievement of these strategic objectives, by supporting primary care to:

1. Be a valued first point of contact for the population, for the majority of healthcare needs;

2. Support patients with more complex needs, so that care for these patients is well planned, proactive, and managed.

Achievement of these objectives will require different ways of working in primary care, with greater collaboration between general practices, other health providers, Barnet Local Authority and third sector organisations, informed by the needs of patients. The aim of this collaboration is to provide an integrated experience of care for the patient, provision of the right care at the right time and in the right place, greater use of technology to support integrated ways of working with the patient at the centre, the achievement of the improved productivity across agencies, and greater empowerment of patients and carers to be active participants in their care and decisions about their care.

**Progress to date**

10.4 Key themes of the Primary Care Strategy are:

**Primary Care Network Development:**

Five network proposals were received from Primary Care in 2013/14.The networks were approved. There has been GP involvement in the Better Care design group and the following is a summary of what the networks have developed:

- West Barnet Network (4 General Practices – total list size 40,700 people)
  Proposed provision of a dedicated Monday – Friday afternoon GP and Nurse Practitioner triage and consultation service (different practice location each day on rotation) to offer urgent triage and consultation across the collective practice population.

- Burnt Oak/Colindale, West Barnet Network (5 General Practices – total list size 46,000 people)
  Proposed provision of a phlebotomy service, a wound dressings service, minor illness service and wellness service to patients of the network practices.

- North Barnet Network (32 General Practices – total list size 168,910 people) Proposed provision of ambulatory 24 hour blood pressure monitoring measurement, to confirm a diagnosis of hypertension and monitoring; spirometry with reversibility testing; provide access for 24 hour ambulatory ECG measurement and therefore reduce the number of people who require care in a hospital setting.

- South Barnet Network (19 General Practices – total list size 101,452 people Proposed pilot service – integrated primary care mental health service model to improve patient recovery and improve independence, and increase capability and capacity in general practice to manage a range of mental health presentations. This proposal for a pilot is about to progress to procurement by the network.

- West 1 Barnet Network (7 General Practices – total list size 26,370 people) This network is currently identifying a proposal for service provision, based on analysis of what would benefit patients within the network.

**Information Technology to support clinical practice:**

Poor use of technology in primary care has been highlighted. The position has been improved in the following ways:

- 57 General Practice sites are 'live' with EMIS web, the web based clinical system within which patient's clinical record is maintained. All practices are on a trajectory to be on EMIS web by April 2014. This will facilitate improved access to patient data from (for example), a domiciliary setting or nursing/residential home setting, with further investment in remote access devices.
- 18 practices are to start piloting a clinical decision support tool DXS, to support clinical decision making in assessment and treatment of patients
- 9 practices have gone live with electronic prescribing, which enables the electronic requesting of repeat prescriptions by patients and electronic transfer to pharmacists. A further 14 practices are committed to further roll out.
- Text messaging by General Practices is widely used across Barnet. These messages are used to promote health campaigns e.g. flu vaccination availability, and also to remind patients of their appointments (with the option of returning the text if they no longer need or cannot make the appointment) – In the period April-November 2013, 293,463 text messages were sent, with some 5,572 appointments subsequently freed up by patients who might otherwise have not attended on the day of the appointment. This recovered appointment capacity was available to other patients requiring an appointment.

**Minor Ailments Scheme:**

Primary Care in addition to General Practice includes a range of other provision, for example pharmacists, which is recognised within the strategy:

- This scheme enables patients to access minor ailment advice and treatment from pharmacies. Eight pharmacies are part of the scheme. Between January-December 2013, some 542 consultations have taken place with the participating community pharmacists across Barnet. The three most common reasons for people attending the

minor ailments scheme in the 8 pharmacies were: Hay Fever, Threadworm and Fever. The pilot is to be extended to the 3 local hospital sites, with the aim of providing a viable alternative for minor ailment advice/treatment to attending the walk-in-centre or Urgent Care Centre.

**Medicines Management:**

The strategy recognises the importance for patients of effective and safe management of medication:

- The CCG has supported the improved optimisation of medication prescribing within General Practice, in respect to choice and monitoring of a range of conditions
- The CCG has implemented a local enhanced scheme aimed at ensuring that there is the appropriate level of monitoring associated with the repeat prescribing of methotrexate, to monitor the impact of this cytotoxic medication.
- The CCG has supported the provision of the National Enhanced Service for anticoagulation within primary care.
- The CCG has implemented a locally enhanced service to improve access to primary care for people who are homeless.

**Looked After Children:**

- General Medical Practitioners perform a medical assessment on children who have become looked after by social care. The CCG has in place a local enhanced service to two general practices in the borough that can perform these assessments. The specification for the provision of this service has been reviewed with the local authority, in line with national guidance and the nature of the tariff, and will be presented as a Local Improvement Scheme (LIS) from April 2014

**Palliative Care:**

- The CCG have in place a local enhanced service associated with provision of end of life care to patients who are nearing the end of life. This is aimed at supporting the choice of patients to die at home (including care homes), through the provision of appropriate medical care within the context of the multidisciplinary team that will provide palliative care. In addition a Palliative Care GP facilitator works with GP practices in Barnet.

**Learning by Peer review and practice development:**

- 49 GP Practice Development Visits have taken place so far and 6 clinical specialities have been reviewed as part of the Learning Through Peer Review programme in 2013/14. The Learning through Peer review programme focuses on a number of clinical conditions that are seen frequently in General Practice. The Peer review meetings are clinically led and facilitate the review by GP's, of the diagnosis, management and appropriate referral criteria before a referral to secondary care. Clinical specialties that have been reviewed through the LPR programme are Urology, Mental Health, Gynaecology, Diagnostics- MRI, and Dermatology. It has led to improvement in the confidence of GP's managing a range of conditions within the specialities reviewed and a reduction in referrals of 7.6%. The LPR programme will help inform patient pathway and service redesign in these areas. The practice

development visits have also been used to promote the national screening programmes.

- All GP practices have also audited their referrals and existing pathways in chronic heart failure, and male-female incontinence pathways as a part of QOF reviews. They have also reviewed existing rapid response pathways, palliative care pathways and urgent care pathways for children and older and frail patients.

10.5 **NHS England Consultation: 'Transforming Primary Care in London: General Practice – A Call to Action':**

10.6 The Transforming Primary Care in London document has been published by NHS England. The commentary in this present update report to the Health and Well-being Board is not intended to represent the formal response that the CCG and Local Authority would wish to make to the document by the closing date of 31st March 2014, but rather to indicate some of the issues that need to be appraised within the context of the Barnet Primary Care Strategy and developing a Barnet Primary Care response to the challenges the document present.

10.7 The document recognises that 'the model of General Practice that has served Londoners well in the past is now under unprecedented strain'. In particular 'population growth' and the 'complexity of serving larger numbers of patients with long term conditions are driving up demand and general practice is struggling to respond effectively'. It is the intention of NHS England to publish a 'service offer' in January 2014 that it believes 'all practices would like to provide and that all Londoners should have access to'. 'The service offer will focus on three aspects of care: accessible care, proactive care and coordinated care'. NHS England intend to 'undergo extensive engagement with practices, patients and other stakeholders.'

10.8 **Aspects of general practice that are highly valued and clinically important to safeguard?**

- Continuity of care provision
- Accessibility
- The opportunity afforded by the longer-term relationship that develops with patients, to provide proactive individualised care for vulnerable and high risk patients, particularly with long term physical and mental health issues
- The opportunity to develop individualised care planning around the patient, based on the more holistic view of the patient developed through better knowledge of the individual patient, their social circumstances and support networks
- The opportunity to promote self-management by patients, based on deeper knowledge and experience of the individual patient and supported and maintained by the opportunity to establish a longer term doctor-patient relationship
- The opportunity arising from patients seeing their GP or Practice Nurse as their 'key contact' in matters relating to their health

10.9 **How the general practice service model should develop in the future to deliver more?**

- Develop network access solutions to respond to fluctuations in on day demand as well as increases in demand and complexity for management of long term conditions

- To support the above, review how community care long term condition and rapid response services can be re-designed and re-specified, to enable development of a primary and community care platform that can provide more of the patient pathway within this setting.
- In respect of the above point, to move to a more integrative and coordinated range of services, through better integration of primary care, community and social care teams, with an emphasis on developing the requisite specialised knowledge and experience within the service to support vulnerable patients and those with long term conditions closer to home
- Support for the role of care coordination within primary care
- Resource reallocation and investment following the patient demand movements within the health and social care system
- Pathway commissioning of services across the range of providers, with the emphasis being on reproducibility and dependability in the way patients are managed clinically and in the way the patient accesses and experiences their care.
- Improved workforce development within primary care, to capitalise on the contribution that the various team members and professional groups make to the quality of the care provided and the quality of the patient experience.
- Consistent with the above point, the support of an educational programme and multidisciplinary training that focuses on, and is measured by, outcomes in patient care and disease management that is achieved as a result, and is focused on the multidisciplinary team.
- Investment in nursing and non-clinical staff training to realise the leadership needed in all parts of the organisation of primary care to meet the challenges currently faced by general practice
- Improved use of information technology in the provision of care. For example the use of telehealth and telecare in respect of higher risk patients, working with the local authority to deliver telecare solutions
- Extended hours of provision on a network basis
- Ensuring availability of primary care to areas of rapidly expanding population growth in regeneration areas.
- Provision of easier access to social care services within primary care
- Investment in IT solutions that support integrated provision of care between primary care, social care, community and hospital service provision

10.10 **Implications for how general practice infrastructure should evolve?**

- Ensuring that premises are suitable for a wider range of service provision, are in the right geographical location within Barnet to ensure ease of access and have ease of access to diagnostic procedures that is required to deliver a wider range and depth of service provision
- Increased use of a network approach to provide a range of specialised services within primary care, with ease of access to consultant specialist input to service provision within primary care
- Having an IT strategy that is matched to and can support the range of service development and support the provision of integrated care and better care coordination and proactive management
- Integration of health and social care provision around the individual

- Improved rapid response service (health and social care) capability and capacity to respond to the need for urgent assessment and care planning for vulnerable individuals, at any time.
- Development of a single point of access to services.
- There is frustration within primary care in Barnet, concerning the change in arrangements surrounding estate and premises development, which hinders the progression of developing primary care and future service provision.

10.11 **What we need to concentrate on to enable general practice to develop?**

- Investment shift
- Workforce development
- Increased workforce capacity and support
- Incentivise solutions that make a real step change in demand management, clinical outcomes, cost effectiveness of care
- IT investment
- Estate development

Within Barnet, the Primary Care Strategy, supported by networks of GP practices is a way to take this forward.

## 11 BACKGROUND PAPERS

11.1 Transforming Primary Care in London: General Practice – A Call to Action (Published by NHS England on 28th November 2013

Links to the document (1st link) and the relevant section of the NHS website (2nd link) are as follows:

http://www.england.nhs.uk/london/wp-content/uploads/sites/8/2013/12/london-call-to-action.pdf

http://www.england.nhs.uk/london/london-2/ldn-call-to-action/gp-cta/

AGENDA ITEM 15

| | |
|---|---|
| Meeting | Health and Well-Being Board |
| Date | 23rd January 2014 |
| **Subject** | **12 month Forward Work Programme** |
| Report of | Strategic Director for Communities |
| Summary of item and decision being sought | To present the current 12 month forward work programme 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. |
| Wards Affected | All |
| Status (public or exempt) | Public |
| Contact for further information | Claire Mundle, Commissioning and Policy Advisor- Public Health / Health and Well-Being,<br>020 8359 3478, Claire.Mundle@Barnet.gov.uk |
| Appendices | Health and Well-Being Board 12 month Forward Work Plan (updated 14th January 2014) |

## 1. RECOMMENDATIONS

**1.1 That the Health and Well-Being Board proposes any necessary additions and amendments to the 12 month forward work programme (attached at Appendix A).**

**1.2 That the Health and Well-Being Board considers the forward work programme in light of the Health and Well-Being Strategy objectives that it prioritised in November 2013, to ensure sufficient focus is being given to each of these areas at Board meetings.**

**1.3 That the Health and Well-Being Board considers the alignment of its work programme with the work programmes of other strategic boards in the Borough, including the Children's Trust Board, Safer Communities Board, Health Overview and Scrutiny Committee, and Barnet CCG's Board.**

**1.4 That the Health and Well-Being Board notes that there will not be a Board meeting in May 2014 owing to local elections in Barnet. The Board is asked to review the scheduling on the forward work programme in light of this.**

## 2. RELEVANT PREVIOUS DISCUSSIONS AND WHERE HELD

2.1 Health & Well-Being Board- forward work programme– 21st November 2013. The Board last discussed the forward work programme at the November 2013 Board meeting. The Board discussed the importance of limiting agenda items so that each item requiring in-depth discussion or strategic decision-making received sufficient attention. It was suggested that items which the Board is only required to note be considered in a different way in future.

## 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 The work programme should reflect the key objectives of the Health and Well-Being Strategy. The Board is asked to consider the work programme in light of the priorities within the Strategy that were agreed at the November Board, and ensure that attention will be given to these priorities at Board meetings over the coming year.

3.3 There are a number of work programmes being delivered in 2014 that will be of interest to the Health and Well-Being Board and other strategic boards in the Borough. These work programmes include, but are not limited to, the health visiting and school nursing review, delivery of the Disabled Children's

Charter, and the potential acquisition of Barnet and Chase Farm NHS Trust by the Royal Free NHS Foundation Trust. The Board must have confidence that it's forward work programme is compatible with the forward work programmes of the Children's Trust Board, Safer Communities Board, Health Overview and Scrutiny Committee, and Barnet CCG's Board, to ensure that these work programmes are discussed within the correct forums, with information shared across other Board's as appropriate.

## 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.

6.2 The Public sector equality duty at s149 of the Equality Act 2010 will apply to CCGs and local authorities who as public authorities must in the exercise of their functions have due regard to the need to eliminate discrimination, harassment, victimisation, and any other conduct that is prohibited by or under the 2010 Act and advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it and foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

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

7.1 Any additions or amendments proposed by the Health and Well-Being Board will be managed within existing budgets.

## 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 and 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 The forward work programme attached to this report supersedes the previous work programme presented on the 21st November to the Board, and suggests a refreshed schedule of reports and items for the following 12 months, reflecting the Board's statutory requirements, agreed priorities, and objectives set out in the Health and Well-Being Strategy.

10.2 At the Health and Well-Being Board meeting on the 21st November, the Board discussed the high number of agenda items and papers being presented at Board meetings and suggested that some of this work could be delegated to other Boards. It was also suggested that items which the Board was only required to note be considered in a different way.

10.3 The Chairman also noted that the Board need to factor in reasonable time for full discussions where agenda items require input from NHS England or other external partners.

10.4 In light of this discussion, it was agreed that Board Members would review the forward work programme and ensure that future agendas contained a sensibly limited number of items, to give the Board more time for strategic discussion and decision-making.

10.5 The forward work programme for 2014 should also be set bearing in mind the Health and Well-Being Strategy objectives that it prioritised in November 2013, to ensure sufficient focus is being given to each of these areas at Board meetings. For reference, these priority areas are as follows:

<u>Preparing for a healthy life</u>

1. That the Health and Well-Being Board works concertedly with NHS England to address the pre-school immunisations data issues they have identified so that the local area can be assured that immunisation rates are being maintained (as the Strategy requires them to be)

2. That the Health and Well-Being Board provides strategic multi-agency leadership to the two forthcoming transformation programmes in response to legislative changes that affect children and young people- namely the

development of a new model for health visiting and school nursing services for 2015-16; and the development of a single, simpler 0-25 assessment process and Education, Health and Care Plans for children with special educational needs and disabilities from 2014.

Well-Being in the community

1. That the Health and Well-Being Board considers what partners collectively should be doing to promote models that limit social isolation, in partnership with Older Adult's Partnership Board and Barnet Older Adults Assembly. This should involve giving specific focus to the solutions that will most effectively reduce level of excess cold hazards in elderly people's homes.

2. That the Health and Well-Being Board considers the multi-agency leadership role it can play to support residents into employment, be they those who have been affected by welfare reform or those who are furthest from the job market, with a view to help them afford stable accommodation.

How we live

1. That the Health and Well-Being Board commissions the Public Health team to lead the development of a plan to address the worryingly high levels of tuberculosis in the Borough.

2. That the Health and Well-Being Board considers in-depth how it can coordinate activities across partners to tackle increasing and higher risk drinking in the Borough, considering the various local levers it has at its disposal to affect change. Healthwatch Barnet could engage with young people and different ethnic communities to further the development and delivery of key messages and services in this area.

Care when needed

1. That the Health and Well-Being Board continues to drive the development of integrated care proposals ahead of the national deadline of March 2014, that will support Barnet's frail elderly residents and those with long-term conditions to maintain independence in their own homes for as long as possible.

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

10.6 The Health and Well-Being Board also agreed to prioritise actions to address mental health needs in the Borough, at the November 2013 Board meeting.

10.7 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.

10.8 Board Members are also asked to make sure that the Health and Well-Being Board forward work programme is compatible with the forward work programmes of the Children's Trust Board, Safer Communities Board, Health Overview and Scrutiny Committee, and Barnet CCG's Board, to ensure that items on the work programmes are discussed within the correct forums, with information shared across other Board's as appropriate.

10.9 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.

10.10 A copy of the draft forward work programme is attached at Appendix A for the Board's comments. The forward work programme also notes the dates of the Health and Well-Being Board Financial Planning Group meetings, and those of the individual Partnership Boards.

10.11 The forward work programme attached in Appendix A also accounts for the dates of significant national and local health and well-being policy changes. This calendar of dates provides the Board with an additional reference point against which to schedule papers for the Health and Well-Being Board.

10.12 The Board is also asked to note that there will not be a meeting in May 2014 owing to local elections in Barnet. The Board is asked to review the scheduling on the forward work programme in light of this.

## 11 BACKGROUND PAPERS

11.1 None

Legal – LC
CFO – JH

**Appendix A: Health and Well-Being Board 12 month Forward Work Plan (updated 14TH January 2014)**

| MONTH | AGENDA ITEMS | PURPOSE | REPORT OF | NATIONAL HWB POLICY IMPLEMENTATION DATES | LOCAL HWB POLICY IMPLEMENTATION DATES | HWBFINANCIAL PLANNING GROUP | PARTNERSHIP BOARDS MEETING |
|---|---|---|---|---|---|---|---|
| **January (Board meeting: 23rd January 2014)** | **Quality & Safety:** Quality & Safety in the NHS update- update on Francis | For discussion | CCG Chief Officer | First Ofsted style inspections of GP surgeries<br><br>Completion of End of Life Care Strategy review | Possible start date: acquisition of Barnet & Chase Farm by the Royal Free<br><br>LBB Cabinet report finalises Council's budget for 14-15 and 15-16<br><br>NHS England Call to Action Strategy published (January-March TBC)<br><br>Public Health led Stop Smoking Campaign | 13th January | Older Adults Partnership Board: 23rd January |
| | **Performance:** | | | | | | |
| | **Strategy:** Report on progress against the Primary Care Strategy | For discussion | CCG Chief Officer | | | | |
| | **Commissioning:** PH commissioning intentions for 2014/15<br><br>Updated JSNA refresh<br><br>Barnet CCG's Strategic and Operational | For decision<br><br>For decision<br><br>For discussion | Director of Public Health<br><br>Director of Public Health<br><br>CCG Chief Officer | | | | |

| MONTH | AGENDA ITEMS | PURPOSE | REPORT OF | NATIONAL HWB POLICY IMPLEMENTATION DATES | LOCAL HWB POLICY IMPLEMENTATION DATES | HWBFINANCIAL PLANNING GROUP | PARTNERSHIP BOARDS MEETING |
|---|---|---|---|---|---|---|---|
| | Plans | | | | | | |
| | **Partnerships:** Update progress reports from Healthwatch Barnet & LBB commissioners | For discussion | Head of Healthwatch Barnet; Adults & Communities Director | | | | |
| | **Integration:** Better Care Fund application (BCF)<br><br>Report from the HWB Financial Planning Group | For decision<br><br>For information | Adults & Communities Director<br><br>Strategic Director for Communities | | | | |
| **February** | | | | | 2 year Better Care Fund application submitted to NHS England and ministers (14th February) | 13th February | Mental Health Partnership Board: date TBC |
| **March (Board meeting: 20th March 2014)** | **Quality & Safety:** Winterbourne View: progress against Concordat | For discussion | Adults & Communities Director | | CCG final operating plan 14/15 and 3-5 year commissioning plan submitted to NHS England<br><br>Completion of Barnet's Health Visiting/ School Nursing Review (31st March) | | Carers' Strategy Partnership Board: 5th March |
| | **Performance:** Barnet, Enfield and Haringey Mental Health Trust: | For discussion | CCG Chief Officer | | | | Physical and Sensory Impairment Partnership Board: 7th March |

| MONTH | AGENDA ITEMS | PURPOSE | REPORT OF | NATIONAL HWB POLICY IMPLEMENTATION DATES | LOCAL HWB POLICY IMPLEMENTATION DATES | HWBFINANCIAL PLANNING GROUP | PARTNERSHIP BOARDS MEETING |
|---|---|---|---|---|---|---|---|
| | implementing the BEH mental health commissioning strategy<br><br>Barnet Mencap report on experiences of access to health and social care services for people with learning disabilities | <br><br>For discussion | <br><br>Healthwatch Barnet | | | | |
| | **Strategy:** Priorities and Spending Review and implications for health and well-being<br><br>Action plan on tobacco control alliance and Shisha | For discussion<br><br>For discussion | Strategic Director for Communities<br><br>Director of Public Health | | | | Learning Disability Partnership Board: 18th March |
| | **Commissioning:** Barnet CCG's final 2 year and draft 5 year Strategic plans | For decision/ discussion | CCG Chief Officer | | | | |

| MONTH | AGENDA ITEMS | PURPOSE | REPORT OF | NATIONAL HWB POLICY IMPLEMENTATION DATES | LOCAL HWB POLICY IMPLEMENTATION DATES | HWBFINANCIAL PLANNING GROUP | PARTNERSHIP BOARDS MEETING |
|---|---|---|---|---|---|---|---|
| | Outline business case for integrated care (frail older people) | For decision | CCG Chief Officer/ Adults & Communities Director | | | | |
| | **Partnerships:** Discussion with CQC on their role and relationship with HWBBs | For discussion | CQC | | | | |
| | **Integration:** | | | | | | |
| **April** | | | | NHS England Palliative care funding pilots completed | Final package of LBB Priorities and Spending Review proposals drafted | | |
| **May** | ***** **NO BOARD MEETING WILL TAKE PLACE IN MAY OWING TO LOCAL ELECTIONS** ***** | | | | | | |
| **June/ July (Board meeting: TBC)** | **Quality & Safety:** | | | Winterbourne View Concordat: 'all individuals receive personalised care and support in appropriate community settings no later than 1 June 2014'<br><br>Department of Health: Winterbourne View follow-up report (after 1 June 2014) | Conclusion of the LBB Priorities and Spending Review | | |

| MONTH | AGENDA ITEMS | PURPOSE | REPORT OF | NATIONAL HWB POLICY IMPLEMENTATION DATES | LOCAL HWB POLICY IMPLEMENTATION DATES | HWBFINANCIAL PLANNING GROUP | PARTNERSHIP BOARDS MEETING |
|---|---|---|---|---|---|---|---|
| | | | | NHS England to publish wider set of clinical indicators to the public | | | |
| | **Performance**: Progress report: Disabled Children's Charter<br><br>Annual report from Healthwatch Barnet | For discussion<br><br>For discussion | Cabinet Member for Education, Children and Families<br><br>Healthwatch Barnet | | | | |
| | **Strategy:** Early Years Review | For discussion | Strategic Director for Communities | | | | |
| | **Commissioning:** Final CCG 5 year Strategic Plan (Submitted 20th June) | For discussion/ decision | CCG Chief Officer | | | | |
| | **Partnerships:** Report on the Partnership Boards/ HWBB summit<br><br>Discussion with PHE on their role and relationship with HWBBs | For discussion<br><br>For discussion | Adult and Communities Director<br><br>PHE | | | | |

| MONTH | AGENDA ITEMS | PURPOSE | REPORT OF | NATIONAL HWB POLICY IMPLEMENTATION DATES | LOCAL HWB POLICY IMPLEMENTATION DATES | HWBFINANCIAL PLANNING GROUP | PARTNERSHIP BOARDS MEETING |
|---|---|---|---|---|---|---|---|
| | **Integration:** | | | | | | |
| **August/ September (Board meeting: TBC)** | **Quality & Safety:** | | | Implementation of Children & Families Bill | | | |
| | **Performance:** | | | | | | |
| | **Strategy:** | | | | | | |
| | **Commissioning:** | | | | | | |
| | **Partnerships:** | | | | | | |
| | **Integration:** | | | | | | |
| **October/ November (Board meeting: TBC)** | **Quality & Safety:** | | | | | | |
| | **Performance:** Second annual performance report: Health and Well-Being Strategy | For decision | Director of Public Health | | | | |
| | **Strategy:** | | | | | | |
| | **Commissioning:** | | | | | | |
| | **Partnerships:** | | | | | | |
| | **Integration:** | | | | | | |
| **December** | | | | | | | |