MEETING

HEALTH & WELL-BEING BOARD

DATE AND TIME

THURSDAY 12TH MARCH, 2015

AT 10.00 AM

VENUE

HENDON TOWN HALL, THE BURROUGHS, LONDON NW4 4BQ

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

Chairman: Councillor Helena Hart (Chairman),
Vice Chairman: Dr Debbie Frost (Vice-Chairman)

Dr Charlotte Benjamin	Regina Shakespeare	Dawn Wakeling
Paul Bennett	Selina Rodrigues	Cllr Sachin Rajput
Dr Andrew Howe	Dr Clare Stephens	Chris Miller
Kate Kennally	Cllr Reuben Thompstone	

Substitute Members

Cllr David Longstaff	Nicola Francis	Maria O'Dwyer
Mathew Kendall	Dr Jeffrey Lake	Julie Pal
David Riddle	Cllr Wendy Prentice	

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

Andrew Charlwood – Head of Governance (Acting)

Governance Services contact: Salar Rida 020 8359 7113, salar.rida@barnet.gov.uk

Media Relations contact: Sue Cocker 020 8359 7039

ASSURANCE GROUP

ORDER OF BUSINESS

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Minutes of the Health & Well-Being Board

29 January 2015

AGENDA ITEM 1

Board Members:

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

* Dr Charlotte Benjamin	* Regina Shakespeare	Dawn Wakeling
Paul Bennett	* Selina Rodrigues	Cllr Sachin Rajput
Dr Andrew Howe	* Dr Clare Stephens	* Chris Miller
* Kate Kennally	* Cllr Reuben Thompstone	

* denotes Member Present

Substitute Members:
Cllr David Longstaff
Maria O'Dwyer
Dr Jeff Lake
Mathew Kendall

Also in attendance:
Lanna Childs (HB Public Law)

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

The Chairman of the Health & Well-Being Board Councillor Helena Hart, welcomed the attendees to the meeting. The Chairman also welcomed Zoë Garbett Policy and Commissioning Advisor (for Public Health and Wellbeing) who has replaced Claire Mundle. The Chairman also welcomed Regina Shakespeare Interim Director of Commissioning and Chief Operating Officer (Barnet Clinical Commissioning Group).

It was noted that following initial publication corrections have been made to the front cover of the Agenda pack to reflect the current membership of the Board.

Members of the Board were provided with a verbal update on the progress of actions taken forward from the previous minutes of the Health & Well-Being Board meeting on 13 November 2014.

It was noted that in relation to HWB Strategy Year 2 Report a discussion would follow between Barnet CCG, Primary Care and Public Health regarding an approach to drugs and alcohol and that a paper would be presented to the Board in June. The Board heard that the draft Pharmaceutical Needs Assessment is out for a 60 day period consultation and that the PNA has been added to the work programme for July.

In relation to the Sexual Health strategy- the Board heard that a a local strategy is being developed for supporting victims of sexual assault and FGM.

RESOLVED that the minutes of the Health & Well-Being Board meeting held on 13 November 2014 be agreed as a correct record.

2. ABSENCE OF MEMBERS (Agenda Item 2):

Apologies for absence were received from:

Cllr Sachin Rajput (substituted by Cllr David Longstaff)

Dr Andrew Howe (substituted by Dr Jeff Lake)

Dawn Wakeling (substituted by Matthew Kendall)

Paul Bennett

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

There were none.

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

None.

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

None were submitted.

6. BETTER CARE FUND UPDATE (Agenda Item 6):

The Chairman informed the Board that the Better Care Fund Update report was set out before the Board for ratification.

The BCF Plan had already been reviewed and agreed by the Chairmen of the Board and the Barnet Clinical Commissioning Group together with the Chief Executive of the Council.

It was noted that following submission of the BCF Plan to NHS England in September 2014, and the response received from them, the Plan had been further refined giving additional technical information regarding each of the schemes, their costs and specific contributions to the 3.5% reduction of non-elective admissions.

The Chairman drew attention to the fact that the updated submission did not change the vision or aims of the Better Care Fund in any way.

In answer to questions, Maria O'Dwyer (Barnet CCG) stated that the Rapid Response service had been launched in August 2013 and that the Homes Locally Commissioned Service had been operational since September 2014. Ms O'Dwyer noted that the scheme has helped in reducing unplanned emergency admissions to hospitals and additionally had helped people remain independent.

The Adults and Communities Director Mathew Kendall briefed the Board about the further progression of the BCF Plan and how it will enable the delivery of the schemes of work help realise the outcomes identified for 2014/2015 and beyond.

Mr Kendall further stated that the HWB Finance Planning Group will enable LBB and CCG to monitor budgets from the Business Case for Integration across health and social care.

Kate Kennally Strategic Director for Commissioning noted that the BCF requires Local Areas to deliver integrated health and social care services through a pooled budget for closer partnership working and to take forward integration at scale and pace.

Ms Kennally highlighted the importance of ensuring that appropriate and robust mechanisms are in place to support the governance arrangements to create an HSCI Steering Group (as set out in diagram 1.6.15 of the Agenda report).

RESOLVED that:

1) **The Health & Well-Being Board ratifies the final BCF Plan submitted with the Chairman's agreement, along with the Chair of NHS Barnet CCG and the Council Chief Executive, to NHS England on 9 January 2015.**

2) **The HWBB notes the next steps described in the report following approval of the Plan.**

3) **The HWBB notes and comments on progress on delivering and embedding the 5 Tier Integrated Care Model for older people in Barnet.**

4) **The HWBB comments on work to date to create a pooled Budget for the delivery of services in the BCF Plan and that an update on the pooled Budget will be brought to the Board in March.**

5) **The HWBB notes that final approval for the Pooled Budget will be given by the Council's Policy and Resources Committee and by the Barnet CCG Board.**

7. CCG- IMPLEMENTATION OF CO-COMMISSIONING (Agenda Item 7):

The Chairman welcomed the report and noted the plans for the establishment of a Joint Commissioning proposal to come into existence from April 2015 to formally start operating as a Joint Committee.

The Chairman highlighted the importance of the need for representation of the local perspective in Barnet at NCL level.

Dr Jeffrey Lake Consultant in Public Health noted the importance of effective partnership working and communication between Barnet CCG and Barnet Public Health department in regards to the Joint Commissioning proposal.

The Head of Healthwatch Selina Rodrigues highlighted the importance of patient communication and engagement and queried the status of the terms of reference of the Joint Committee.

The Director of Integrated Commissioning (Barnet CCG) Maria O'Dwyer informed the Board that the terms of reference and membership of the Joint Committee are currently under discussion and that this information would be shared with Healthwatch. **(Action:**

3

Head of Healthwatch to receive an update on the development of terms of reference and membership of the Joint Committee by Barnet CCG)

Ms O'Dwyer noted that the CCG is required to confirm membership support and any necessary changes to the CCG constitution. Dr Jeff Lake informed the Board that changes to the Health and Social Care Act 2012 allow for CCGs to take on joint responsibility with NHS England for the primary care contracts.

RESOLVED that:

1) **The Health & Well-Being is requested to note and support Barnet CCG's decision to develop a proposal to jointly co-commission with the other 4 North Central London CCGs**

2) **Consider and discuss how the Health & Well-Being Board will participate in Joint Co-Commissioning Committee across NCL**

3) **Consider the role of Public Health in Joint Co-Commissioning through the Director of Public Health (Harrow and Barnet) Dr Andrew Howe as the HWBB link member and feed any views/ considerations into NCL on-going discussions**

8. THE ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEATH: FROM THE BEATLES TO BEYONCÉ (Agenda Item 8):

Dr Jeff Lake Consultant in Public Health introduced the Annual Report of the Director of Public Health which sets out broad themes and issues across the health and local government sectors over the past 50 years. Dr Lake informed the Board that the Director of Public Health has a statutory duty to publish an annual report on health in the borough.

The Strategic Director for Commissioning Kate Kennally noted that the issues covered in the report would be considered in the development of the Health and Well-Being Strategy refresh and presented to the Board in Autumn 2015.

Vice-Chair of the HWBB and Chair of Barnet CCG Dr Debbie Frost requested that the report be circulated to GPs and community groups.

Action: Public Health to circulate the Annual Report of the Director of Public Health to GPs and community groups

The Chairman thanked Dr Lake for the presentation and welcomed the report.

RESOLVED that the Health & Well-Being Board notes the Annual Report of the Director of Public Health

9. EARLY YEARS SUB-GROUP - UPDATE ON PROGRESS (Agenda Item 9):

The Chairman welcomed this report, bearing in mind the importance of joint working, given the significance of the transition of the Health Visitor service from NHS England to

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the local authority. Councillor Helena Hart welcomed Val White Interim Commissioning Director Children and Young People to the Board. Ms White introduced the report and the proposed approach towards establishing an Early Years sub-group to improve integration and joint working across early years.

The Board heard that the Early Years Review was informed by an independent review of health visiting, school nursing and family nurse partnership. The sub-group would oversee the approach for closer working and integration between health visitors, midwives, children's centres and other health services.

It was noted that the Early Years sub-group would be accountable to the Health & Well-Being Board and that in order to improve the Early Years provision, the sub-group would focus on four key work streams as set out in the report on p193 of the Agenda.

Ms Kennally welcomed the report and requested that in order to provide support and leadership to the sub-group, the minutes of the Early Years sub-group be circulated to the Board Members with specific responsibilities towards Children's Services.

Action: Minutes of the Early Years sub-group to be circulated to

- **Kate Kennally (Strategic Director for Commissioning)**
- **Councillor Reuben Thompstone (Lead Member for Children's Services)**
- **Dr Clare Stephens (Barnet CCG)**

RESOLVED that:

1) **The Health & Well-Being Board approves the terms of reference, including objectives and high level work plan for the Health and Wellbeing Early Years sub-group.**

2) **The Board makes any comments, amendments or recommendations on the Health and Wellbeing Early Years sub-group proposed approach.**

10. DEMENTIA MANIFESTO (Agenda Item 10):

The Chairman reminded the Board that it had considered the Dementia Manifesto on 13 November 2014 and that the Board had requested additional information about signing up to the Dementia Manifesto for London. She drew the Board's attention to 1.2.4 of the report which stated that no boroughs have signed up to the London Dementia Manifesto and that the Alzheimer's Society had stated that this was not the intention of the Manifesto.
The Chairman welcomed the suggestion of a local alternative which allowed Barnet to create a local vision for dementia care and to develop relevant local actions and measures of impact.

Mathew Kendall introduced the item and updated the Board on the discussion about dementia at the meeting of the Older People's Partnership Board on 22 January 2015.

Mr Kendall confirmed that no London borough has signed up to the Dementia Manifesto for London and that there is currently no mechanism for enabling organisations to sign up to the Manifesto. Additionally he stated that this was not the intention of the Dementia

Manifesto for London. Dr Debbie Frost Chair of Barnet Clinical Commissioning Group expressed support for signing up to a Barnet Dementia Manifesto.

The Head of Healthwatch Barnet Ms Rodrigues noted the necessity for a constructive engagement strategy which also involved local residents and community organisations. Mr Kendall also highlighted the importance of creating awareness of the local offer with all stakeholders and residents.

RESOLVED that:

1) **That the Health and Well-Being Board agrees to the development of a local Barnet Dementia Manifesto, which includes an engagement strategy developed with Barnet Healthwatch and which builds on the progress to date on dementia care in Barnet.**

2) **That, subject to agreeing recommendation 1, the Health and Well-Being Board embeds the actions from the final Barnet Dementia Manifesto, when complete, into the Health and Well-Being Strategy refresh.**

3) **That, subject to agreeing recommendation 1, the Health and Wellbeing Board recommends to NHS Barnet CCG's Governing Body that actions from the final Barnet Dementia Manifesto are embedded into the NHS Barnet CCG Delivery Plan.**

4) **That, subject to agreeing recommendation 1, the Health and Well-Being Board recommends to the Council's Adults and Safeguarding Committee that actions from the final Barnet Dementia Manifesto are embedded into the Adults and Safeguarding Commissioning Plan.**

11. HEALTHWATCH UPDATE REPORT (Agenda Item 11):

The Chairman welcomed the report and commended the thorough inspections that have been carried out around hospital discharge and meals.

Selina Rodrigues Head of Healthwatch Barnet introduced the item which included a status report on how Healthwatch is meeting its contractual targets for engaging with a wide range of local communities.

The Chairman welcomed guests from Jewish Care and Advocacy in Barnet to the Board meeting. She asked for the Board to be updated on whether providers were taking notice of the findings and implementing changes. She requested that Healthwatch report back to future meetings.

It was noted that Healthwatch charity partners, Jewish Care and Advocacy in Barnet had reported difficulties experienced by patients including long waits for medication and hospital transport and lack of communication and care. Reports have been sent to local hospitals to request information on how services will be improved.

Ms Rodrigues briefed the Board about the engagement and awareness project undertaken to reach a wider group of people. The Board noted that approximately 160 people were reached in the last quarter through charity networks, Job Centre Plus, drop-in sessions at local libraries and stalls at all local hospitals.

Dr Frost commended the report and noted that effective review of patient feedback is pertinent to improving services. Councillor Hart thanked Healthwatch for the update report.

Action: Healthwatch to request a response from Adult Social Care to their report
Action: Healthwatch to provide an update on progress made by providers to the Health & Well-Being Board

RESOLVED that the Health & Well-Being Board notes the report and provides comments on their content.

12. MINUTES OF THE HEALTH AND WELL-BEING FINANCIAL PLANNING GROUP (Agenda Item 12):

The Board noted the standing item which presents the minutes of the last two meetings of the Financial Planning Sub-Group on 5 November 2014 and 14 January 2015 respectively.

RESOLVED that the Health & Well-Being Board notes the minutes of the Financial Planning Sub-Groups of 5th November 2014 and 14th January 2015.

13. 12 MONTH FORWARD WORK PROGRAMME (Agenda Item 13):

The Strategic Director for Commissioning Kate Kennally informed the Board that the forward work programme of the Health & Well-Being Board is published online and where necessary updated at the beginning of each calendar month.

RESOLVED that:

1) **The Health and Well-Being Board notes the Forward Work Programme and proposes any necessary additions and amendments to the forward work programme (see Appendix 1).**

2) **The Health and Well-Being Board Members proposes updates to the forward work programme before the first day in each calendar month, so that the work programme can be published on the Council's website more efficiently, with the most up to date information available.**

3) **The Health and Well-Being Board aligns its work programme with the work programmes of the new Council Committees (namely the Adults and Safeguarding Committee, and the Children's, Education, Libraries and Safeguarding Committee), Health Overview and Scrutiny Committee, and Barnet CCG's Board. (see Appendix 2)**

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14. ANY ITEMS THE CHAIRMAN DECIDES ARE URGENT (Agenda Item 14):

The Chairman commended the efforts undertaken and the successful meeting with representatives from the Royal Free, People's Choice and CCG with regards to providing a Changing Places facility at Barnet Hospital. It was noted that approval was received in principle from the Royal Free with regard to the provision of the facility.

The Chairman thanked all Board members and guests for their attendance.

The meeting finished at 12.10pm.

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AGENDA ITEM 6

	Health and Well-Being Board **12 March 2015**
Title	**Public Health Commissioning Plan Consultation feedback**
Report of	Dr Andrew Howe, Director of Public Health
Wards	All
Date added to Forward Plan	September 2014
Status	Public
Enclosures	Appendix 1: Public Health Commissioning Plan Appendix 2: Consultation report Appendix 3: Resident Perception Survey Autumn 2014
Officer Contact Details	Jeff Lake, Consultant in Public Health, jeff.lake@harrow.gov.uk 0208 3593974

Summary

This report summarises the key findings from the strategic plan consultation from across the council as they relate to public health and implications for the Public Health Commissioning Plan (Appendix 1).

Although based on small numbers, responses indicate a very high level of support for the priorities identified in the Public Health Commissioning Plan.

Recommendations

1. **That the Health and Well-Being Board notes the consultation feedback on the draft Public Health Commissioning Plan.**
2. **That the Health and Well-Being Board notes that no changes have been made to the draft Public Health Commissioning Plan 2015 - 2020 as consultation feedback was overwhelmingly supportive of the Plan.**
3. **That the Health and Well-Being Board approves the final Public Health Commissioning Plan 2015 – 2020.**

1. WHY THIS REPORT IS NEEDED

1.1 This report summarises the key findings from the strategic plan consultation (Appendix 2) from across the council as they relate to public health and implications for the Public Health Commissioning Plan (Appendix 1).

1.2 Only 7 responses to the public health commissioning priorities were received.

1.3 Of those who did respond, 6 out of 7 (85%) with all of the priorities identified in the Public Health Commissioning Plan. The remaining respondent disagreed with them all.

1.4 Two of the 7 respondents thought that there were missed priorities indicating that alcohol, exercise and healthy eating/obesity require more robust solutions. Each of these areas is identified as a priority in the commissioning plan and significant new investments have been made since the transition of public health to local authority. They all present significant cultural change challenges nationally and are areas where whilst there are developing evidence bases, there are as yet no clear solutions or political consensus on the willingness to intervene. The 2014 Annual Director of Public Health report focused on physical activity and a Fit and Active Barnet Campaign ran throughout the year. This work is now taken forward by the Sport and Physical Activity Partnership. A paper on our approach to obesity is included on the agenda of this board meeting. A substance misuse strategy, including alcohol, is due to be presented to the board in June.

1.5 The Resident Perception Survey (Appendix 3) highlights that residents are more concerned than the rest of London about quality of health services; services in the borough are considered to be 'good to excellent' by the majority. Respondents were also concerned that there is not enough being done for elderly and young people.

1.6 On 13 November 2014 the Health and Well-Being Board approved the Public Health Commissioning Plan for consultation. Consultation on 'Meeting the challenge: Barnet's strategic plan and budget to 2020' including specific consultation on the priorities, approach and outcomes of the Public Health Commissioning Plan, ran from 17 December 2014 to 11 February 2015. Following the consultation, this paper seeks approval of the final commissioning plan (Appendix 1).

2. REASONS FOR RECOMMENDATIONS

2.1 To ensure that the Public Health Commissioning Plan has the support of members in light of consultation with residents.

2.2 Health and Well-Being Board is asked to note that the consultation feedback was overwhelmingly supportive, although in low numbers. Therefore the Health and Well-Being Board is asked to approve the final Public Health Commissioning Plan 2015 – 2020.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 None

4. POST DECISION IMPLEMENTATION

4.1 The Public Health team will implement the commissioning plan. Commitments for the 2015/16 financial year will be overseen by relevant LBB Delivery Units as set out in the Commissioning Plan (Appendix 1).

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 The Public Health Commissioning Plan reflects the corporate priorities of partners as set out in the Joint Health and Wellbeing Strategy. Performance monitoring is carried out through management agreements through each Delivery Unit and is conducted on a quarterly basis by Council Commissioners.

5.1.2 Performance of partners in addressing the priorities identified in the Joint Health and Wellbeing Strategy is reviewed annually and was last reported to the Board in November 2014.

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

5.2.1 The London Borough of Barnet will receive £14.335 million Public Health grant in 2015/16. The delivery of all the priorities detailed in the Commissioning Plan will be funded by the Public Health grant.

5.3 Legal and Constitutional References

5.3.1 Case law has clarified that consultation needs to meet the following requirement - consultation must be undertaken at a time when proposals are still at a formative stage, the proposer must give sufficient reasons for any proposal to permit of intelligent consideration and response, adequate time must be given for consideration and response and the results of the consultation must be conscientiously taken into account in finalising the decision being consulted upon.

5.3.2 The Council's Constitution (Responsibility for Functions – Appendix A) sets out the Terms of Reference of the Health and Well-Being Board:

(5) To receive assurance from all relevant commissioners and providers on matters relating to the quality and safety of services for users and patients

(6) To directly address health inequalities through its strategies and have a specific responsibility for regeneration and development as they relate to health and care. To champion the commissioning of services and activities across the range of responsibilities of all partners in order to achieve this.

(7) To promote partnership and, as appropriate, integration, across all necessary areas, including the use of joined-up commissioning plans across the NHS, social care and public health.

(9) Specific responsibilities for:

- Overseeing public health
- Developing further health and social care integration

5.4 **Risk Management**

5.4.1 None

5.5 **Equalities and Diversity**

5.5.1 The public sector equality duty under s149 of The Equality Act 2010 requires Public Bodies to have due regard to the need to:

1. eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010
2. advance equality of opportunity between people from different groups
3. foster good relations between people from different groups

5.5.2 The broad purpose of this duty is to integrate considerations of equality into day to day business and keep them under review in decision making, the design of policies and the delivery of services

5.5.3 The majority of public health services are unaffected by the commissioning plans. Equality impact assessments will be conducted ahead of any new service procurements/re-procurements.

5.6 **Consultation and Engagement**

5.6.1 This is the focus of this report as outlined above.

6. BACKGROUND PAPERS

6.1 Public Health Commissioning Plan, Health and Well-Being Board 13th November 2014, item 8: https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=177&MId=7783&Ver=4

Health and Well-Being Board- Public Health Commissioning Plan 2015-20

1. The Context for the development of this plan.

Public services in England during the decade 2010-2020 face an unprecedented challenge as the country deals with the impact of the financial crisis of 2008, alongside the opportunities and challenges that come from our changing and ageing population.

Despite a growing economy, the UK budget deficit is forecast to be £75bn at the 2015 General Election, with cuts set to continue to the end of the decade no matter who is in Government. At the same time, demand on local services continues to increase**,** driven by a growing population, particularly the number of young and older residents. We therefore must plan for the fact that austerity will affect all parts of the public sector to the end of the decade and that we will not be able to meet increasingly levels of demand from simply doing more of what we are currently doing.

The public too, does not expect simply more of the same. Expectations of local services are increasing, advances in customer services and technology provides the ability to interact with services 24/7. Local residents as a result expect better services and more prompt responses from the Council. However satisfaction with the Council and local services remains relatively high in Barnet, and over recent years resident satisfaction with a number of local services has increases, despite these challenges.

In thinking about how the Council lives within its means, the Council needs to recognise that residents are also facing wider financial pressures, from high energy bills, increasing housing costs, continued wage restraint, and benefit reforms, so the ability of many households to absorb the impact of reductions from public sector funding through increased financial contributions is constrained.

We can however expect over the duration of this plan that significant opportunities will flow from Barnet being part of a growing and arguably booming London economy. Unemployment levels have fallen by a third in the last year, the number of 16-18 year old ‘NEETs’ in Barnet is, at 2.3%, the fourth lowest in England and less Barnet residents are claiming out-of-work benefits than the London average. This plan needs to ensure that all residents of Barnet can benefit from the opportunities of growth, whether through new employment opportunities, increased investment in infrastructure such as roads and schools, or enjoying new neighbourhoods and places in which all people can live and age well.

2. Barnet Council’s Overarching Approach to meeting the 2020 Challenge

The Council’s Corporate Plan sets the framework for each of the Commissioning Committees five year Commissioning Plans. Whether the plans are covering

services for vulnerable residents or about universal services such as the environment and waste there are a number of core and shared principles which underpin the commissioning outcomes.

The first is a focus on fairness.

Fairness for the Council is about striking the right balance between fairness towards the more frequent users of services and fairness to the wider taxpayer and making sure all residents from our diverse communities - young, old, disabled, and unemployed benefit from the opportunities of growth.

The Council must 'get the basics right' so people can get on with their lives – disposing of waste, keeping streets clean, allowing people to transact in more convenient ways, resolving issues promptly in the most cost effective way.

We must shift our approach to earlier intervention and demand management …. Managing the rising demand on services requires a step change in the Council's approach to early intervention and prevention. Across the public sector, we need to work with residents to prevent problems rather than treating the symptoms when they materialise.

The second is a focus on responsibility.

Continue to drive out efficiencies to deliver more with less… The Council will drive out efficiencies through a continued focus on workforce productivity; bearing down on contract and procurement costs and using assets more effectively. All parts of the system need to play their part in helping to achieve better outcomes with reduced resources.

Change its relationships with residents, with residents working with the Council to reduce the impact of funding cuts to services ... In certain circumstances, residents will also need to take on more personal and community responsibility for keeping Barnet a great place particularly if there is not a legal requirement for the Council to provide services. In some cases users will be required to pay more for certain services as the Council prioritises the resources it has available.

The third is a focus on opportunity.

Prioritise regeneration, growth and maximising income … Regeneration revitalises communities and provides residents and businesses with places to live and work. Growing the local tax base and generating more income through growth and other sources makes the Council less reliant on government funding; helps offsets the impact of service cuts and allows the Council to invest in the future infrastructure of the Borough.

Redesign service and deliver them differently through a range of models and providers … The Council has no pre-determined view about how services should be

designed and delivered. The Council will work with providers from across the public, private and voluntary sectors to provide services which are more integrated, through a range of models most appropriate to the service and the outcomes that we want to achieve.

Planning ahead is crucial… The Council dealt with the first wave of austerity by planning ahead and focusing in the longer-term, thus avoid short-term cuts - the Council is continuing this approach by extending its plans to 2020.

3. Committee context

Responsibility for many aspects of public health services together with public health teams and budgets was transferred to local authorities in April 2013. The transfer of responsibility for local health improvement to local authorities has been the biggest shift in public health delivery in decades. The Government's approach to improving public health is centred on empowering individuals to make healthy choices, and giving communities the tools and resources to address their own health needs.

The Government has provided local authorities with significant new powers and opportunities to develop effective local solutions to manage public health and improve the lives of their residents. Boroughs are uniquely positioned to understand the specific needs of their communities and to draw on a range of existing knowledge, expertise and resources from within their organisations, and from partners, to improve health outcomes for their residents.

The Corporate Plan identifies the Council's commitment to public health emphasising that prevention is better than cure. It also sets out the need to find new ways to encourage families and individuals to look after their health and stay independent and to build strong local partnerships, including with the local NHS, to deliver this.

This Commissioning Plan sets out the high level outcomes that Barnet's Public Health team believe will make the biggest difference to the health and wellbeing of Barnet's residents, in line with Sir Michael Marmot's policy objectives; based on evidence of the impact on health and wellbeing outcomes for individuals; and, cost-effectiveness and return on investment of public health interventions.

This plan aligns with the public health outcomes/ priority areas for action identified in Barnet's Health and Well-Being Strategy (2012-15), that were identified and developed in consultation with stakeholders and residents, and based on the evidence of population need from Barnet's JSNA, the Barnet health profile, and the NHS, social care and public health outcomes frameworks.

This Commissioning Plan recognises the importance of developing public health programmes that focus on the social determinants of health, developed in partnership with Barnet's communities, and that make use of community assets to support delivery of activities wherever appropriate. As such, the plan makes use of recent research from the King's Fund, NICE and other research bodies who are building an evidence base for the return on investment of public health interventions

in a wider set of Council departments (such as housing, transport, planning) and partner organisations (such as schools).

The Health and Well Being Board will provide strategic leadership for this plan, and will work across the various other Council Committees, strategic partnership arrangements (including those in the voluntary and community sector), and the CCG Board to ensure the broadest opportunities to deliver better health and wellbeing outcomes for Barnet's residents are realised.

4. Public Health Commissioning Outcomes 2015-2020

Priority	Key Outcomes	Outcome measures
Giving children the best start in life	• Support for first time mothers. • Women are encouraged to breastfeed their babies and feel confident to do so. • Every woman is supported to avoid alcohol and stop smoking in pregnancy. • Support is provided for mothers experiencing peri/postnatal depression • Children, young people and their families are supported to be physically, mentally and emotionally healthy	• Improved breastfeeding initiation and continuation rates • Smoking status at time of delivery

Priority	Key Outcomes	Outcome measures
Enable all children, young people and adults to maximise their capabilities and have control over their lives	• People are discouraged from taking up smoking in the first place, and encouraged and supported to quit should they wish to. • Children and adults who are overweight and obese are encouraged and supported to lose weight. • Children and adults are discouraged from misusing alcohol and drugs, and encouraged and supported to quit • Children and young people feel supported to achieve and engage, while developing their identities and resilience. • Working age adults and older people are well-connected to their communities and engage in activities that they are interested in, and which keep them well.	• Smoking prevalence • Excess weight in adults • Excess weight in 4-5 year olds • Excess weight in 10-11 year olds • Substance misuse • Rate of harmful drinking • Percentage of active adults
Create fair employment and good work for all, which helps ensure a healthy standard of living for all	• Those furthest from the labour market are supported to access training and employment opportunities, retain job opportunities, and return to employment. • Employers in Barnet are encouraged to promote healthy workplaces that make it easier for their employees to make healthy lifestyle choices.	• Residents with mental health problems supported to retain/return to employment (monitored by enterprise) • Promoting healthy workplaces: Number of large workplaces signed up to the London Healthy Workplace Charter

Priority	Key Outcomes	Outcome measures
Create and develop healthy and sustainable places and communities	• The built environment is conducive to healthy living choices such as walking and the accessibility of safe open spaces. • The range of green spaces and leisure facilities in the Borough are used more extensively, there is more active travel and levels of physical activity increase. • Social isolation, especially amongst older people, is reduced through schemes that enable the sharing of skills and experience. • Working age adults and older people live a healthy, full and active life and their contribution to society is valued and respected. • Sexual ill health and alcohol/substance misuse are treated early and effectively by robust services delivered in partnership across the voluntary sector, the Council, the NHS and other statutory organisations. • People are given many opportunities for volunteering, which increases inclusion into local communities, overcome language barriers and develop stronger inter-generational support.	• Utilisation of outdoor space for exercise/ health reasons • Increased activities for older people • Physical activity participation • Social isolation: The percentage of adult carers who have as much social contact as they would like according to the Personal Social Services Carers survey • Reducing the proportion of persons presenting with HIV at a late stage of infection • Reducing repeat Sexually Transmitted Infections • Successful completion of drug treatment – opiate users • Successful completion of drug treatment – non-opiate users • Successful completion of treatment – alcohol users • Successful completion of treatment – non-opiate and alcohol users • Promote/ create opportunities for volunteering

Priority	Key Outcomes	Outcome measures
Strengthen the role and impact of ill health prevention	• People aged between 40 and 74 years are offered and take-up health and lifestyle checks in primary care to help reduce risk factors associated with long term conditions. • People with a long term condition are encouraged and supported to self-manage their condition, resulting in a delayed/reduced demand for crisis response. • Older people are supported to stay well during winter months. • All people are supported to identify the warning signs of cancer and are encouraged to adopt behaviours that may help to prevent the onset of cancer.	• Take up of lifestyle management programme • Under 75 mortality rate from cardiovascular diseases • Cumulative percentage of the eligible population aged 40-74 who have received an NHS Health Check • Patients self managing (delayed/ reduced demand for crisis response) • Number of households that have had insulation as part of Winter Well

The commissioning intentions below reflect these priority objectives and outcomes.

It is important to recognise that there are a number of public health statutory services that local authorities have to provide, including:

- Sexual health services - STI testing and treatment, and contraception
- School Nursing and the National Child Measurement Programme
- Health Visiting (from October 2015)
- NHS Health Check programme
- Local authority role in health protection
- Public health advice – support to the CCG; JSNA; PNA; annual public health report; Health and Well-Being Strategy

After funding has been allocated to provide each of these services, local areas have the flexibility to decide where to invest their public health funding, based on local needs and priorities. The diverse range of services that are currently commissioned through the public health ring-fenced grant support delivery of each of the 4 chapters of the Health and Wellbeing Strategy (*Preparing for a Healthy Life*, *Wellbeing in the Community*, *How we Live*, and *Care when needed*), and enable a number of the priorities of the Strategy to be met. The Health and Well-Being Board have endorsed and approved the current allocation of the public health grant, so this Commissioning Plan builds on the work already completed by the public health team and Health and Wellbeing Board in partnership, to allocate the grant in line with local needs and priorities.

Following agreement at Health and Wellbeing Board about how the public health grant should be allocated (last agreed in January 2014), and in response to the local authority's medium-term financial challenge, the public health team have identified opportunities to release efficiency savings of a little over £2.26 million from the current baseline public health budget of £14.423 million, approximately 15.7%. This will allow for resources to be strategically focused elsewhere, to meet public health needs through innovative methods of delivery. These investments are identified in the commissioning intentions that follow. In light of the nature of the public health 'ring fenced' grant allocation the financial models in this paper assume that the current funding continues to remain within the public health allocation until 2020. These proposals are incorporated into the commissioning intentions below. The budget projections within these Commissioning Plans contain indicative figures through to 2020. These budgets will be formally agreed each year, after appropriate consultation and equality impact assessments, as part of Council budget setting, and therefore could be subject to change.

The prioritisation of spending has been informed by the Kings Fund (2014) review of return on public health investments (see table 1 below). The most significant shift in spending is towards early years where the greatest returns on investment are seen but which are realised over longer time scales. These investments are important in moving toward sustainable service models for the future. Where possible robust local monitoring of evaluation will be conducted to determine benefits realisation.

Table 1 Direct impacts of actions on health outcomes

Area	Scale of problem in relation to public health	Strength of evidence of actions	Impact on health	Speed of impact on health	Contribution to reducing inequalities
Best start in life	Highest	Highest	Highest	Longest	Highest
Healthy schools and pupils	Highest	Highest	Highest	Longer	Highest
Jobs and work	Highest	Highest	Highest	Quicker	Highest
Active and safe travel	High	High	High	Quicker	Lower
Warmer and safer homes	Highest	Highest	High	Longer	High
Access to green spaces and leisure services	High	Highest	High	Longer	Highest
Strong communities, wellbeing and resilience	Highest	High	Highest	Longer	High
Public protection	High	High	High	Quicker	High
Health and spatial planning	Highest	High	Highest	Longest	Highest

5. Priority objective: Give every child the best start in life

Marmot argued that returns on investment in early childhood are higher than in adolescence, and that early interventions during pregnancy and on-going support in early years are critical to the long-term health of the child and other long-term outcomes.

In Barnet, it has long been acknowledged that giving a child the best start in life is important not only to the individual child but also to society in general. Parents and

carers impact should not 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.

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 there are significant variations in both across the Borough (with the highest rates in Burnt Oak, Edgware and Woodhouse wards).

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 76.6% of pregnant women in Barnet have an antenatal assessment by the 12th week of pregnancy lower than the London rate (80%) and significantly lower than England average (86%). There is also a urgent need to increase health visitor capacity in the borough to meet demand for these early help services.

Children and young people in Barnet have better health and non-health outcomes than London and England as a whole. The level of children aged under 16 living in poverty in Barnet (19.9%) is below the England average (20.6%), and below the London average (26.5%). There is evidence that childhood poverty leads to premature mortality and poor health outcomes for adults. The level of 4-5 year olds who are overweight and obese is also increasing.

Parents have a vital role in taking responsibility for their children's health, and we need to think about how we work within communities, schools and within families to address some of the challenges set out here to ensure that children and young people in Barnet have the best outcomes possible.

	Commissioning intention	**What needs to happen?**
1	Retain current children's centres investments (Breast feeding programme, Family Nurse Partnership, Early education programme, Targeted parenting, Targeted nutritional information) applying 2.5%/annum efficiency savings. Investment in the family nurse partnership and non mandatory early intervention services in children's centres to improve life chances and manage social care demand.	Ongoing contract monitoring and evaluation, annual service development/commissioning review. Intentions to be clear by end of calendar year for commissioning by new financial year. More effective joint working practices between health visiting services and local authority commissioned early years services are being established now through joint commissioning arrangements with NHS England. This work will inform a decision on the approach to fuller integration by October 2015 when the authority takes responsibility for health visiting commissioning.
2	Maintain childhood obesity and nutrition investment via a tier 2	Ongoing contract monitoring and evaluation, annual service development/commissioning

	Commissioning intention	What needs to happen?
	weight management programme applying 2.5%/annum efficiency savings	review. Intentions to be clear by end of calendar year for commissioning by new financial year.
3	In other areas of the schools programme, after capacity building investments in 13/14 and 14/15, schools to determine future investment.	Schools are aware the programme funding ends this year. Council's future approach to schools needs to be determined (i.e. whether elements of funding will be retained, school funded as delivery unit, or left to determine plans – Spring 2015), clear communication with schools at that point.
4	Review school nursing commissioning arrangements maintaining current level of investment applying 2.5%/annum efficiency savings	Notice has been served on current provider. Tender notice will go out November 2014, and service to commence October 2015.

What this means for residents…

- More coordinated early years provision
- Less fragmentation
- Identification, early intervention and prevention

What this means for providers…

- Possible consolidation of services
- Need to work with collaboratively with other providers
- Attention to wider social impacts

Outcome measures

Measure	Baseline – 14/15	Target - 19/20
Breastfeeding initiation	TBC (requiring agreement between PH and other delivery units)	TBC(requiring agreement between PH and other delivery units)
Breast feeding at 6-8 weeks	TBC	TBC
Oral health	TBC	TBC
Smoking status at time of delivery	4.4% (Q3 2013-4)	Maintain at under 5%

Numbers of parents receiving parenting support	TBC	TBC
Early childhood development: Children defined as having reached a good level of development at the end of the EYFS as a percentage of all eligible children	TBC	TBC
School readiness: the percentage of children achieving a good level of development at the end of reception	TBC	TBC
Prevalence of 4-5 year olds classified as overweight	11.60%	11.10%
Prevalence of 4-5 year olds classified as obese	9.40%	8.90%
Prevalence of 10-11 year olds classified as overweight	15.00%	14.50%
Prevalence of 10-11 year olds classified as obese	19.40%	18.90%

Financial impact

A summary of the change in net revenue budget for this priority area is shown in the table below:

14/15	15/16	16/17	17/18	18/19	19/20
2,033,508	2,244,670	2,101,804	2,439,883	2,778,886	3,118,789

6. Priority objective: Enable all children, young people and adults to maximise their capabilities and have control over their lives

Marmot argued that a focus on improving educational outcomes and developing skills is crucial to addressing health inequalities, and defined ‘capability and control’ in the context of his priority area for action in terms of skills and learning. In Barnet, this priority area has been conceived in a broader context, to include the range of positive health states and behaviours that will enable residents to stay healthy and independent. Enjoying good health is the result of responsibility being shared between health services and individuals. Empowering individuals to take responsibly for their own health is central to addressing the public health challenges described in this section over the coming decade. We need to create a new dialogue with residents as ‘active partners’ in achieving good health.

Physical Activity and Obesity

Nationally and within Barnet, there has been a steady increase in the prevalence of those classified as overweight and obese. In children this is considered a primary predictor of obesity in adulthood. The health outcomes of sustained obesity are numerous and include increased incidence of Type 2 Diabetes, CHD, stroke, depression, some cancers and back pain. Obesity throughout adulthood decreases life expectancy by up to nine years.

About 33.6% of Barnet's Year 6 children and 55.6% of Barnet's adults are classified as overweight or obese. The Barnet Sport and Physical Activity Needs Assessment 2012 found that sport and physical activity rates and the use of outdoor space are below the national average. There are no clear reasons for this given that Barnet has a large number of parks and open spaces and leisure provision is comparable with other London boroughs. Given the benefits to population's health, collective action to improve rates of sport and physical activity participation in the Borough is essential. (See also *Creating Sustainable Communities*)

Smoking Cessation

Tobacco use is the most important preventable risk factor for death from cancer, cardiovascular disease and respiratory disease. Despite significant reductions in smoking rates in Barnet, smoking continues to be a major driver of health inequalities and accounts for over 360 deaths each year in the Borough. In the past 10 years, the success of stop smoking services has led to a reduction in smoking prevalence of around 10% in Barnet as well as a reduction in the number of hospital admissions due to smoking and deaths due to smoking. Face to face smoking cessation programmes have made a significant contribution in supporting quit attempts but alternative approaches are now required because recruitment rates have declined. The Public Health team are looking at a broad range of options to encourage people to stop smoking, including integration within care pathways, and upstream intervention (including Making Every Contact Count), targeted interventions (including focusing on people with mental health problems) and legislative change (tobacco control).

Local and national concerns have also been raised about the growing number of shisha establishments. Nationally there has been an increase of over 210% in the number of shisha bars and cafes in England over the past five years and this is also reflected locally. Public health will need to work with many partners to develop tobacco control plans that address these challenges.

Mental wellbeing

In terms of morbidity, mental health accounts for a great health burden than either CHD or cancers. The promotion of mental wellbeing through life skills and social networks has the potential to make a significant contribution to public health improving health and social outcomes and containing public sector costs. Public health is working with colleagues across the local authority and CCG to ensure that wellbeing is promoted and that awareness of mental health and early intervention provision is expanded. However, there are a number of challenges for Barnet to address, including the fact that hospital admissions for mental health conditions among young people are on the rise, reflecting the lack of early intervention and

assertive outreach services in the community. Between 2009-10 and 2011-12, there were 50 admissions for self harm in young people in under 18 in Barnet (giving a rate of 60.2 per 100,000 people aged 17 and under). This is lower than the London average (64.4/100,000 aged 17 and under) and significantly lower than the national rate (115.5/100,000 aged 17 and under).

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. The availability of safe, healthy housing and inclusive community's impact on people's ability to live independently of health and social care services. Building social capital and reducing social isolation among vulnerable groups of the population is required to ensure that these people are supported to maintain good mental health and wellbeing.

Drugs and alcohol

The abuse of substances such as drugs and alcohol can have a detrimental impact on an individual's health, their families and society, crime and antisocial behaviour and the economy.

Information and advice will be provided children and adults to discouraged misuse of alcohol and drugs, and identify and refer onto treatment service when needed.

In Barnet, the rates of alcohol hospital related admissions have been steadily increasing and alcohol attributed recorded crime levels are also above the London average in Barnet. We will need to work with partners to think about the ways in which people who are drinking at harmful levels can be supported as quickly and early as possible building on the development of brief intervention services in pharmacists.

Making every contact count

Making Every Contact Count is an everyday approach to prevention. All partner organisations should require providers and ensure that they themselves use every opportunity to deliver brief advice to improve health and wellbeing whether in health, social care or other service areas.

What this means for residents…

- Reduced provision of face to face smoking cessation services, except for target groups with relatively high smoking prevalence such as mental health patients, due to declining effectiveness and efficiency
- Consideration of local measures to discourage smoking and excess alcohol consumption
- Greater prioritisation of alcohol dependence
- Community weight management offer
- More information about a range of local services
- More brief intervention/prevention
- Information, support but expectation of personal responsibility

What this means for providers…

- Different ways of addressing smoking – more targeted face to face (particularly Mental Health patients) more tobacco control measures
- Greater prioritisation of alcohol dependence
- Need to collaborate with other providers across the statutory and voluntary sector

	Commissioning intention	**What needs to happen?**
1	Maintain physical activity promotion investment	Continue service as normal
2	Develop weight management offer	Offer developed by April 2015
3	Reduce budget for smoking cessation via service redesign away from face to face support, except for target populations – such as mental health patients, develop telephone based support and introduce alternative tobacco control measures	Notice serviced Options by January 2015 Commission services by April 2015
4	Develop emotional wellbeing programme in the community to compliment CAMHS, adult mental health and community resilience plans.	Options by November 2013 Commission services by April 2015
5	Investment to support the introduction of Making Every Contact Count in the borough	Options by April 2015
6	Build on Alcohol brief intervention in pharmacists to discourage alcohol and substance misuse and ensure early identification of the harm	Strategy due to be presented to HWBB in January Options by April 2015

Outcome measures

Measure	**Baseline – 14/15**	**Target - 19/20**
Percentage of active adults	53.9% (2013)	55.60%
Excess weight in adults	55.6% (2012)	Decrease
Smoking prevalence	13.9%	Decrease

Financial impact

A summary of the change in net revenue budget for this priority area is shown in the table below:

14/15	15/16	16/17	17/18	18/19	19/20
871,641	884,092	654,603	624,932	611,359	598,125

7. Priority objective: Create fair employment and good work for all, which helps ensure a healthy standard of living for all

Marmot argued that unemployment and particularly long-term unemployment has significant impact on physical and mental health, and that being in good work protects health. Further, he argued that a certain minimum level of income is necessary to lead a physically and mentally healthy life. Evidence shows that there is a clear association between an individual's socioeconomic position and their health outcomes.

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. In these areas, a number of health and non-health outcomes are poorer.

The numbers of unemployed (but economically active) people have fallen from 9% of the workforce in September 2012 to 6.6% in April 2013 (a 27% fall). For people claiming JSA, the figures have fallen from 2.9% of the workforce in September 2012 to 1.8% in August 2014 (a 38% fall). Whilst similar declines have been observed in London and England there are fewer people claiming out of work benefits in Barnet in this period when compared to London and England. However, certain cohorts of people are more likely to find themselves out of work, including those with mental health problems and substance misuse issues.

What this means for residents…

- More support to stay in/back to work, particularly where motivation/mental health concerns

What this means for providers…

- Expectation of working with other providers and with NHS
- More holistic view of client needs

	Commissioning intention	What needs to happen?
1	Extending investment in employment support programme, improving local pathway for support for clients with motivational, mental health and alcohol/substance misuse issues.	Ongoing contract monitoring and evaluation, annual service development/commissioning review. Intentions to be clear by end of calendar year for commissioning by new financial year.

Outcome measures

Measure	Baseline – 14/15	Target - 19/20
Residents with mental health problems supported to retain/return to employment	180 + 300	TBC (programme currently funded to 2017

Financial impact

A summary of the change in net revenue budget for this priority area is shown in the table below:

14/15	15/16	16/17	17/18	18/19	19/20
200,000	295,000	290,125	285,372	280,738	276,219

8. Priority objective: Create and develop healthy and sustainable places and communities

Marmot argued that changes can be made to the built environments to make them conducive to health. For example, outdoor gym infrastructure, marked and measured routes, cycling, traffic calming and air quality measures to make walking more attractive.

The social environment is also a significant determinant of health and wellbeing. Programmes that help stimulate, grow, support, networks in communities tackles social isolation and builds resilience at both individual and population level.

In Barnet, Marmot's policy objective has been broadened again to include ensuring effective health services infrastructure, which is another important part of creating and developing healthy and sustainable places and communities. Services that are locally accessible for treatment of STIs and drug/alcohol dependence (see below).

<u>Promoting healthy built environments</u>
The health benefits of physical activity are well established and locally physical activity rates are relatively poor. Beyond sport and leisure activities that can be encouraged through the use of initiatives such as outdoor gyms, active travel presents an important means of increasing physical activity and may more easily be integrated into daily living. The promotion of active travel requires communications, workplace health promotion and environmental investments.

<u>Promoting healthy social environments</u>
The health benefits of building social capital and social connectedness are increasingly being recognised within local community development approaches. There is evidence that national community development models such as the Altogether Better programme support older people to remain healthy and active

participants in their communities. Whilst nearly three quarters of Barnet's residents report a strong sense of belonging to their communities, the national average is slightly higher, and poses a challenge to Barnet about what more can be done to build inclusive, supportive communities that all people feel able to contribute to.

Sexual Health

Sexual health is an important aspect of physical and mental wellbeing. Poor sexual health can have a long-lasting and severe impact on people's lives, for example through unintended pregnancies and abortions causing physical disease and poor educational, social and economic opportunities; sexually transmitted infections (STIs) and HIV/AIDS; ectopic pregnancies leading to infertility; cervical and other genital cancers; and hepatitis, chronic liver disease and liver cancer.

Over the past ten years in England there has been a substantial increase in diagnoses of many STIs. It is likely that increased transmission through unsafe sexual behaviour has contributed to the overall rise in STI diagnoses, though improved testing arrangements will have also contributed to the reported increases. The true incidence of STIs in Barnet is not known, since much data is reported at GUM clinic level, but these clinics see people regardless of their place of residence. This presents significant challenges for all local authorities, who have to provide adequate local services for people from any Borough.

There are fewer teenage pregnancies in Barnet than across London and England as a whole. However teenage pregnancy remains a priority area for attention in sexual health, as it 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 also have an increased risk of living in poverty and poor quality housing and are more likely to have accidents and behavioural problems.

Demand for sexual health services are increasing, and the challenge for sexual health services are to ensure that they diagnose and treat STIs and HIV quickly, and ensure that family planning services are in place to reduce unwanted pregnancies. It is also necessary that service identify and protect individuals from female genital mutilation (FGM) and sexual exploitation.

	Commissioning intention	**What needs to happen?**
1	Maintaining outdoor gym infrastructure, new investment in support of active travel and physical activity	Annual maintenance of outdoor gyms. Options for active travel/physical activity campaigns and environmental improvements by Summer 2015.
2	Maintain investment in Better together programme	Ongoing contract monitoring and evaluation, annual service development/commissioning review. Intentions to be clear by end of calendar year for commissioning by new financial year.
3	Contain otherwise escalating	Barnet Sexual Health strategy & West

	Commissioning intention	What needs to happen?
	costs of sexual health services whilst maintaining/improving outcomes.	London Alliance transformation report to Health and Well-Being Board November 14 Collaborative commissioning already underway and contracts for 2015/16 to be agreed by respective lead commissioners ahead of April 15 A proposal for collaborative commissioning across 20 London Boroughs (led by the Barnet and Harrow public health team) is expected to come to the Health and Well-Being Board in November 2014. Over the following 12 months it is expected that new service specifications will be developed, consultation will occur, followed by re-commissioning of new services for 2017/18
4	Review drug and alcohol service commissioning arrangements to improve treatment outcomes and additional social benefits whilst maintaining current level of investment.	Needs assessments completed Oct 2014 Strategies for HWBB sign off Jan 2015 The service is currently being re-procured with the start date of a new service of 1st October 2015.

What this means for residents…

- Environmental improvements (more conducive to healthy choices)
- Personal responsibility for health
- Support for community networks and workplace health promotion
- Opportunities to be more physically active

What this means for providers…

- Consideration to sustainability concerns in procurement

Outcome measures

Measure	Baseline – 14/15	Target - 19/20
Physical activity participation	53.9%	55.60%
% of people with needs relating to STIs who are offered an HIV test at first attendance (excluding those already diagnosed HIV positive).	97.3% (Q2)	97%
% of people with needs relating to STIs who have a record of having an HIV test at	92.1% (Q2)	80%

first attendance (excluding those already diagnosed HIV positive).		
% of people with needs relating to STIs contacting a service who are offered to be seen or assessed with an appointment or as a 'walk-in' within two working days of first contacting the service.	87% (Q2)	98%
Successful treatment - opiate users	41.8%	Increase
Successful treatment - non-opiate users	10.8%	11%
Successful treatment - alcohol users	27.0%	44%
Successful treatment - non-opiate and alcohol users	31.8%	40%
Re-presentations - opiate users	29.8%	45%
Re-presentations - non-opiate users	TBC	TBC
Re-presentations - alcohol users	TBC	TBC
Re-presentations - non-opiate and alcohol users	10.8%	11%
Promote/ create opportunities for volunteering	TBC	TBC

Financial impact

A summary of the change in net revenue budget for this priority area is shown in the table below:

14/15	15/16	16/17	17/18	18/19	19/20
8,226,827	7,815,654	8,384,784	8,154,980	7,981,003	7,679,150

9. Priority objective: Strengthen the role and impact of ill health prevention

Marmot argued that investment in ill health prevention and health promotion needs to substantially increase over coming years. Whilst Marmot specifically referenced work that should be done to address smoking, alcohol, drugs and obesity under this policy

objective, this Commissioning Plan has referenced further major causes of ill health in Barnet that have not yet been addressed in the plan, to ensure that a wider set of problems are tackled.

This includes focusing on ill-health in later life. 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 disability-free life expectancy, the period that people live with chronic disease and demand 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 and secondary prevention that targets those at increased risk of adverse health outcomes.

Cardiovascular disease

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 less than 75 years old. Emergency admission rates for heart disease in Barnet are significantly lower than the national rates, but for stroke the Barnet rate is significantly higher than national rate. Smoking, high risk drinking and obesity are 3 of the biggest risk factors associated with heart disease and stroke, and identifying these risk factors in individuals, and supporting them to make healthier lifestyle choices, is central to reducing the numbers of people who are affected by cardiovascular disease.

Cancer

Cancer is the most common cause of premature mortality but an estimated 42% of cancer cases each year are linked to lifestyle factors. In the last 5 years, almost 600,000 cancer cases in the UK could have been prevented by people not smoking; maintaining a healthy weight; not drinking excess alcohol; eating plenty of fruit, vegetables and fibre, eating less red meat and cutting down on salt and saturated fat; being physically active; and avoiding excess UV radiation from sunlight and sunbeds. Promoting healthy lifestyles and uptake of national screening programmes for cancer will make a significant contribution to public health.

Long-term conditions

Approximately 15.4 million people in England live with a long-term health condition such as diabetes, dementia, asthma and arthritis, and an increasing number of people are living with more than one long term condition (a phenomenon known as “multi-morbidity”). The likelihood of having more than one LTC increases with age. With increasing life expectancy, Barnet’s population of older people is set to grow so we need to work with our partners to support this expanding group of people. Those with long term conditions, and those who care for them, will need to feel empowered to take more responsibility for looking after themselves, but they will also need to be supported to develop the tools, skills and knowledge to manage these conditions effectively. Developing a new partnership between individuals, their families and carers, and health and social care professionals is key to addressing this significant challenge.

Excess Winter Deaths

Barnet has a higher than average percentage of excess winter deaths at 22.3% compared to 19.1% for London and 16.1% for England as a whole. Addressing cold

housing is a key requirement to reduce this rate. Winter Well programmes that support vulnerable residents to be energy efficient, to insulate their homes and to ensure they are equipped with skills to stay warm through winter will help to tackle this challenge.

	Commissioning intention	**What needs to happen?**
1	Develop self management offer – e.g. health champions and expert patient programmes, maintaining intended investment; develop targeted prevention offer	Implementation of commissioning intentions in the Health and Social Care Integrated Care Business Case from October 2014
2	Develop a more targeted Health checks programme	Continue to encourage Barnet GP practices to offer health checks Identify/assess additional outreach opportunities
3	Maintain Winter Well investment	Ongoing contract monitoring and evaluation, annual service development/commissioning review. Intentions to be clear by end of calendar year for commissioning by new financial year.
4	Investment in a health lifestyles cancer prevention campaign	Options appraisal to be conducted by April 2015

What this means for residents…

- Targeted provision of NHS health checks
- Support for self care
- Personal responsibility for health

What this means for providers…

- Expectation of cooperation with other providers

Outcome measures

Measure	**Baseline – 14/15**	**Target - 19/20**
Percentage of the eligible population aged 40-74 who have received an NHS Health Check	6% (2013-14)	10%
Number of households that have had insulation as part of Winter Well	To be established	Increase

Financial impact

A summary of the change in net revenue budget for this priority area is shown in the table below:

14/15	15/16	16/17	17/18	18/19	19/20
1,007,149	1,199,708	1,052,809	978,958	958,140	937,842

10. Service component: staffing

Workforce efficiency savings of approximately 14% of the public health employee budget have also been included. As government funding for local government services continues to reduce, all Council delivery units will need to review their workforce budgets to ensure that they can improve efficiency by 10% by 2020. Corporate initiatives such as the review of terms and conditions and the unified pay project will support delivery units in achieving this saving. Delivery units will also need to review performance management, use of agency staff, management layers and productivity to ensure that this saving can be achieved.

Commissioning intentions:

	Commissioning intention	What needs to happen?
	Improve the efficiency of workforce spend	Review of the current staffing by April 2015 in line with the review of the wider council commissioning structures.

Financial impact

A summary of the change in net revenue budget for this priority area is shown in the table below:

14/15	15/16	16/17	17/18	18/19	19/20
1,963,265	1,863,265	1,818,265	1,818,265	1,692,265	1,692,265

Appendix 2

Public Health Commissioning Plan

Consultation findings

1. INTRODUCTION

This report summarises the key findings from the Strategic Plan to 2020 consultation from across the council as well as more detail on the findings from the Public health Commissioning Plan.

For more information on the background and method to the consultation you can read the full consultation paper here[1].

2. FULL COUNCIL FINDINGS

STRAND 1: Open Consultation on 2015/16 Budget Savings

In total 61 questionnaires were submitted on the 2015/16 budget. Over two-thirds of respondents (34 of the 56 respondents) disagreed with the council's proposed savings in terms of balance between efficiency savings, income generation and cuts to services, with only 8 of the 56 respondents believing the council had got the right balance.

The key reasons for people disagreeing with the balance of savings were;

- Services cannot be reduced
- Council Tax should be increased
- Library service should not be cut.

In regard to Council Tax for 2015/16, the majority of respondents to the open consultation disagreed with the council's proposal to freeze Council Tax, with residents stating that a small increase could support services, with a particular focus on preservation of the library service.

In regard to comments on the balance of savings for each committee respondents felt;

- The council should increase Council Tax
- Cuts are too heavy, with a particular objection to reductions in the Adults and Safeguarding budget and the Library service.

1 http://barnet.moderngov.co.uk/documents/s21538/Appendix%20B%20Consultation%20Headline%20Findings%20UPDATED.pdf

Both the 2015/16 Budget savings and Strategic Plan to 2020 consultation were open at the same time as other major consultations such as the Library Strategy Consultation. It is reasonable to assume that some residents have responded to the three strands of this consultation programme as well as the individual service specific consultations.

From the comments received as part of the consultation it is evident residents have used the vehicle of these consultations to make clear their feelings on the proposed reduction in funding to the library service.

Strand 2 is not included as it is a service specific consultation for Special Educational Needs Transport.

STAND 3: Workshops for Strategic Plan to 2020

The workshops found that when residents had to prioritise services in the context of the financial restraints the council is under, residents' priorities broadly matched the council's current proposals for savings up to 2020.

It was clear from the workshops that residents prioritised targeted support for vulnerable children and adults over universal services such as waste collection and libraries. In general, residents wanted the council to make less reductions to adults and children's service budgets and slightly more savings for Environment Committee.

The findings of the workshops stand in contrast with both the open consultation and the Residents' Perception Survey, where the larger numbers of users of universal services naturally leads to these services being given greater importance in quantitative surveys.

The greater review and discussion of services in the workshops, and the prioritisation of services and funding that the workshops demanded led residents to accept compromises in universal services in order to protect services for the most vulnerable.

a. Key Themes

Support to the most vulnerable is a priority

Across all workshops there was a strong belief that the council should target support at the most vulnerable, findings which match those from the first round of the Priorities and Spending Review in 2014. The majority of residents' priorities can be summarised by the following comment on emergency temporary housing for the homeless;

"These are the most vulnerable people in our society. If we can't help them what's the point?"

Prevention is a good use of resources

The workshops which focused on services for adults and children saw residents prioritise services that supported the prevention agenda as well as the most vulnerable;

"Prevention is better than cure. I think the more one can support those families to get through the year, the better the outcome, the less will be required from the council."

Prevention proved popular in the context of potential cuts as residents thought that prioritising prevention services could reduce the cost to the council in the long term and improve the outcomes for those supported. This was felt to be both just, and a good use of resources.

The importance of a safe environment

Safety was an underlying theme of why many residents prioritised services. This was especially evident in the learning disability workshop. Safety was an issue in regard to safeguarding of vulnerable adults and children as well as safety for all residents through universal services such as street lighting and street cleansing.

Resident's emphasised the importance of street lighting because: *"If you have lights on you are actually saving lives"*.

b. Theme Committee Priorities

The focus of the workshops was on those services which most impact on residents, these were generally services within the remit of Children, Education, Libraries and Safeguarding; Adults and Safeguarding; and Environment Committees.

Children, Education, Libraries and Safeguarding

As part of the workshop focused on Children, Education, Libraries and Safeguarding Committee, residents prioritised the following services;

- Children's mental health
- Short Breaks
- Support for young adults leaving care.

Those services which attendees felt, within the context of council's reductions, had the most potential for savings were;

- Educational support to schools
- Special Educational Needs transport
- Libraries
- Children's Centres.

In later discussions residents still emphasised the importance of these services, but in context they were seen as more palatable options to reduce costs.

For example, although people in the workshops were supportive of libraries as a service, they were not seen as a priority when compared to targeted services which supported the vulnerable. This was a theme not only when focusing on the Children, Education, Libraries and Safeguarding Committee but also in the context of wider council services.

As each specific proposal within the remit of the CELS committee is bought forward, individual consultations will be conducted. The library proposal is currently under active consideration and the outcomes of the library consultation will be reported to the CELS committee in June.

Resident's preference within the workshops was to make less service reductions in the remit of the Children, Education, Libraries and Safeguarding Committee than the council has proposed.

Adults and Safeguarding

As part of the workshop focused on the Adults and Safeguarding Committee, residents prioritised the following services;

- Support offered to carers
- Preventative work for people with learning disabilities
- Short term and residential care for people with mental health issues
- Support to community/voluntary groups for the elderly
- Direct payments for people with physical disabilities
- Leisure centres.

Those services which attendees felt, within the context of council's reductions, had the most potential for savings were the more expensive services of;

- Supporting older people in their homes
- Residential care for older people.

Again there was an emphasis on prevention, with one resident stating that (in regard to short term mental health support):*"It's much better in cost terms than rehabilitation. Short term they can improve and get better rather than, possibly, being institutionalised".*

Resident's preference was to make less service reduction in the remit of the Adults and Safeguarding Committee than the council has proposed.

Environment Committee

As part of the workshop focused on Environment Committee, residents prioritised the following services;

- Street lighting

Those services which attendees felt, within the context of the council's reductions, had the most potential for savings were the more expensive services of;

- Rubbish and recycling collection
- Town centre cleaning
- Green waste
- Management of the council's bowling greens.

Residents, on balance, prioritised residential street cleaning over town centres, whilst the main reason for prioritising street lighting was to protect safety. Residents saw the commercial benefit of increasing the number of events in parks but would be worried if a lot of access to parks was not available to the general public.

On balance, the view seemed to be that a fortnightly rubbish collection was good idea, but a weekly collection of recyclables should remain. It was felt by many that this policy may encourage more recycling.

Residents preferred was to make slightly more savings from the Environment Committee budget than the council has proposed, with residents preferring to prioritise services which supported vulnerable children and adults.

c. Barnet's 'Commissioning Council' Approach

Participants were asked to give their views on the council's 'Commissioning Council' approach. This means that the council's primary concern is about the quality of local services, whether they achieve stated outcomes and whether they are value for money, rather than how services are delivered and by whom. Generally, as part of the workshop there was an acceptance (rather than endorsement) of the concept, but with a concern about whether the council would have the management capacity or skills to manage a broad and range of contracts .

There was a general agreement with the principle of the Commissioning Council model and the following comments give a good summary of the discussion and opinion;

> *"It's all right by me as long as it's done properly with proper controls and transparency"*
>
> *"I think that's completely unrealistic. In principle, in theory, if it's done to the same quality, yes ….but that's not what happens."*
>
> *"As long as the service remains the same it's not detrimental"*

Key concerns were about accountability, especially in regard to private sector organisations with a level of mistrust about large businesses being involved in the delivery of core council services.

In contrast to the workshops, respondents to the open consultation appear to be more negative about the commissioning approach, with 13 out of 23 respondents being strongly opposed to this approach, with only 6 out of 11 respondents either strongly or tended to support this commissioning model.

d. Council Tax

Within the workshops, the majority of respondents attended from the Citizens' Panel were supportive of increasing Council Tax, compared to only a third of the service users who attended workshops, where the majority of attendees preferred a freeze on Council Tax.

The key reason for choosing an increase in Council Tax was that they felt that it was value for money to pay slightly more per resident but minimise cuts to services. Those that chose to freeze or reduce Council Tax felt that Barnet Council Tax was higher than some neighbouring boroughs and was high enough already.

Residents taking part in the open consultation were heavily in favour of raising Council Tax, with the most common responses to open ended questions for each committee being about increasing Council Tax to protect services.

e. Open Consultation on Strategic plan to 2020

Those who responded online supported the council's four proposed priorities as well as the majority of priorities and outcomes for all the Theme Committees. However, as with the 2015/16 Budget feedback, there was a clear emphasis from residents that service reductions were too large, libraries should be protected and that social housing was a priority.

3. PUBLIC HEALTH COMMISSIONING PLAN FINDINGS

a. Open Consultation

Public Health Priorities

The majority of respondents (6 out of 7) agreed with all of the priorities identified for public health, with 1 respondent disagreeing with each of the priorities.

- Give every child the best start in life
- Enable all children, young people and adults to have control over their lives
- Create fair employment and good work for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention

2 respondents thought that there were missed priorities, stating that alcohol and obesity/unhealthy eating needed a more robust solution, whilst another emphasised the importance of exercise and healthy eating.

Public Health Outcomes

In terms of the proposed outcomes identified by public health, the majority of respondents (6 out of 7) agreed with all of the outcomes, with 1 respondent disagreeing with all the outcomes.

None of the respondents thought that any outcomes had been missed.

Public Health Approach

Respondents were asked how much they agreed with the approach that has been identified for public health. 'Maintain investments in public health programmes' was the most popular with support from 6 out of 7 (85 per cent) respondents in agreement and the remaining elements of the approach got agreement from 4 out of 7 respondents (57 per cent).

The only suggestion in regard to public health was around responsible eating and healthy home cooking.

Balance of savings

3 out of 5 respondents agreed that public health had identified the right areas for further investment. The same proportion did not have a view while the remaining respondent strongly disagreed.

No comments were made in response to 'If you disagree with any of these, please tell us below why and where you think we could make investment

b. Relevant Feedback from workshops

Although there was no workshop focused on public health, as the remit of public health covers a range of council services, the following comments and feedback are relevant to the Commissioning Plan

Prevention

Prevention and early intervention were a key theme throughout were themes throughout the workshops, being seen as beneficial to residents and cost effective for the council. The following comments were made as part of various discussions;

"Prevention is better than cure. I think the more one can support those families to get through the year, the better the outcome, the less will be required from the Council."

"It's one of those things that for very little cost really you can give people a much more positive; much better, start in life if you are looking after their mental health and wellbeing. That's something as well that needs to be a joined up issue – looking at what the NHS is providing as well as the council. It is something that with money thrown at it the end result is a better Borough for everybody – a better place to live"

"I just think if we don't deal with children now then we are going to have a bigger problem in the future. By the time they are adults they are going to have that problem 10-fold, probably. So, if we can do something younger …. And try to get to the bottom of the problem – why they've got these issues - as opposed to letting it develop and waiting until they are ostracized from society, can't get a job and all sorts of things like that" (Childrens mental health)

"Prevention can be important. My experience is all my working life is that mangers are very happy to pay a lot to put things right but not happy to spend money to prevent it in the first place."

Early years

There was a positive discussion on Children's Centres and the importance of giving children the best start in life;

"The early years are very important for young mothers….it's not only the children but the mothers who need support"

"Again it's preventative. Get to the problems early – stop them developing"

“I think again it comes down to early prevention. If you catch them from an early age and you invest when they are younger, that investment will pay off in the long term.”

“I moved to the area two weeks before I had my son and I didn’t know anybody and I started accessing one of the Children Centres. I don’t know what I would have done without it to be honest.”

Strengthen the impact of ill health prevention

When discussing the issue of troubled families’ residents saw alcohol and substance misuse as key issues as demonstrated by the comments below;

“I think substance abuse – both drugs and alcohol. It’s interesting the health person when he was giving his speech he didn’t mention anything about drugs or drug policy whatsoever and the burden on the NHS must be massive”

“Education and culture change with regard to alcohol that’s becoming a major drain on the NHS but I don’t know how effective that could be because that would take quite a bit of effort I would think.”

Public health and parks

The role of parks in keeping people healthy was raised by a number of residents, who stated;

“I think they are super – it’s healthy, it’s free, it’s social, it’s all good. Without parks there are fewer places to go that you don’t have to pay for”

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APPENDIX 3

Public Health and Health and Wellbeing

Residents' Perception Survey Autumn 2014

1. Introduction

2.1 This report provides a summary of key findings from the Autumn 2014 Residents' Perception Survey (RPS) which are pertinent to Public Health Commissioning Plan.

2.2 The council runs a Resident's Perception Survey every six months to regularly monitor resident satisfaction and longer term trends in order to improve how we respond to the needs of residents. The Residents' Perception Survey captures residents' general views and perceptions towards the Council, the services it provides and the local area and is used to explore changes in these opinions over time on a number of topics

2.3 The council commissions ORS, an independent social research company, to conduct the surveys. Quota controls are used to ensure a representative sample, with 1,600 responses achieved overall. Responses are weighted to ensure that the survey is representative of the make-up of the borough. It is accurate to within +/- 3 per cent so findings are only viewed as statically important of they are greater than plus or minus 3 per cent.

2.4 The data from the autumn 2014 Resident's Perception Survey was collected between 23 September and 28 November 2014.

2.5 The full results will be published at http://engage.barnet.gov.uk

2. Summary

Residents' concerns

2.6 The top three areas of personal concern for residents in Barnet are Conditions of roads and pavements (31 per cent); A lack of affordable housing (29 per cent); and Crime (29 per cent).

2.7 Concern for Not enough being doing for elderly people (19 per cent), quality of health services (19 per cent), and standard of education (15 per cent) are all in line with results in Spring 2014. Previously Barnet results have been in-line with the London average, however, in the latest results Barnet residents are now more concerned about these issues compared to the rest of London.

2.8 Only 16 per cent of Barnet residents indicated that Not enough being done for young people is one of their top three concerns, in-line with the Spring 2014 and Autumn 2013 results. Barnet residents are slightly more likely to be concerned

about Not enough being done for young people compared to the rest of London (plus two percentage points but not significant).

Strengthen the role and impact of ill health prevention

Local health services

2.9 In terms of general perception three fifths (61 per cent) of Barnet residents rate local health services as 'good to excellent ',in-line with Spring 2014 results, and a two percentage point increase since Autumn 2013. Compared to the rest of London Barnet residents are less likely to rate local health services as 'Good to Excellent' (minus three per cent).

Social services for adults

2.10 In terms of overall perception, just over a quarter of Barnet residents (28 per cent) rate Social service for adults as 'good to excellent', a decrease of four percentage points since the Spring 2014 results. However, results remain one percentage point above Autumn 2013. Compared to London, Barnet residents are more likely to rate Social service for adults as 'good to excellent' (plus nine percentage points).

2.11 **Users** of the service are much more likely to rate Social service for adults as 'good to excellent. Just under three fifths (55%) of users rated the service as 'good to excellent, a 12 percentage point increase since Spring 2014 and a 6 percentage point increase since the Autumn 2013 results. London has also experienced an even larger increase in user satisfaction, with a 23 percentage point increase since Autumn 2013. Barnet is six percentage points below the London average.

Council Owned Leisure Facilities

2.12 Two fifths (40 per cent) of Barnet residents rated Council owned leisure facilities as 'good to excellent', this is in line with Spring 2014 results and significantly higher (plus ten percentage points) than results in Spring 2012. Compared to the rest of London, Barnet residents are less likely to rate Council owned Leisure facilities as 'good to excellent' (minus six percentage points below London).

2.13 Again **users** of the service are much more likely to rate the service as 'good to excellent'. Nearly three fifths (57 per cent) of users rate the service as 'good to excellent ', three percentage points higher compared to both Spring 2014 and Autumn 2013 results but three percentage points below the London average.

Give every child the best start in life

Social services for children and families summary

2.14 In terms of overall perception 29 per cent of Barnet residents rate Social services for children and families as 'good to excellent'. This represents a significant

decline of five per cent since Spring 2014 but remains in line with results in Autumn 2013. This is also eight per cent above the London average.

2.15 Over half of **users (**53 per cent) rated the service as 'good to excellent', a three per cent decrease since Spring 2014 but eight per cent above the London average.

Activities for teenagers/young people summary

2.16 In terms of overall perception 16 per cent of the residents rate the service as 'good to excellent' which is a three per cent decrease from Spring 2014 and in line with results in Autumn 2013. Results remain in line with the London average.

2.17 Residents who have used the service are more likely (30 per cent) to rate the service as 'good to excellent'. However this is a decline (minus five percentage points) since results in Spring 2014.

Under 5's Early Years Education summary

2.18 In terms of overall perception, just under two fifths of Barnet residents (44 per cent) rate Under 5's Early Years Education as 'good to excellent', a decline of four per cent since Spring 2014. However, this remains two per cent above Autumn 2013 results and five per cent above results in Autumn 2012. Compared to the rest of London, Barnet residents are significantly more likely to rate Under 5's Early Years Education as 'good to excellent' (plus 17 per cent).

2.19 Residents who have used the Under 5's Early Education Services are much more likely to rate the service as 'good to excellent (65 per cent). However, user rating for this service shows a decline of eight per cent since the Spring 2014 results. This decline is broadly in line with the London-wide trend, which has also experienced a decline in user rating (68 per cent) of five per cent since Spring 2014. The London average remains three per cent above Barnet, although this is not a significant variation.

Primary Education summary

2.20 Nearly three fifths (57 per cent) of Barnet residents rate Primary Education as 'good to excellent', which is in line with Spring 2014 but remains three per cent below Autumn 2013 results. Compared to the rest of London Barnet residents are significantly more likely to rate Primary Education as 'Good to Excellent' (plus 18 per cent).

2.21 Again **users** of the service are much more likely to rate the service as good to excellent. Three quarters (76 per cent) of residents who have used the service rate it as 'good to excellent' which is in line with Spring 2014 results and the London average.

Secondary Education summary

2.22 Half (50 per cent) of Barnet residents rate Secondary Education as ‘good to excellent,’ a decrease of three per cent since Spring 2014 but in line with the Autumn 2013 results. As with primary education, compared to the rest of London, Barnet residents are significantly more likely to rate Secondary Education as ‘Good to Excellent’ (plus 16 per cent above London).

2.23 Again **users** of the service are much more likely to rate the service as good to excellent. Around seven out of ten users (69 per cent) rated the service ‘good to excellent’ which in line with Autumn 2013, but is one per cent below the London average, not a significant variation.

AGENDA ITEM 7

	Health and Well-Being Board **12 March 15**
Title	**Developing a strategic approach to obesity in Barnet for adults and children**
Report of	Andrew Howe Director of Public Health
Wards	All
Date added to Forward Plan	September 2014
Status	Public
Enclosures	Appendix 1: NCMP Briefing Barnet Appendix 2: Service Specification for Children's Tier 2 weight management service Appendix 3: Adult Tier 2 Weight management service business case
Officer Contact Details	Rachel Wells, Public Health Rachel.wells@harrow.gov.uk Laura Fabunmi, Public Health Laura.fabunmi@harrow.gov.uk

Summary

The Government's call to action Healthy Lives, Healthy People sets out the overarching vision and framework for improving public health outcomes in England. There were two national ambitions for obesity:

- a sustained downward trend in the level of excess weight in children by 2020
- a downward trend in the level of excess weight averaged across all adults by 2020.

To tackle these issues, a life course approach is required that includes agreed actions from all partners in a co-ordinated strategy. The impact of obesity extends well beyond the NHS and impacts on local authorities. Healthy Lives, Healthy people identifies that local authorities are best placed to drive the response to the root causes of obesity, beyond

behaviour change.

In Barnet, some progress has been made to commence the development of a response to obesity but partnership response has been slow; what is required now is an agreed systematic approach.

This paper aims to advise the Board on the steps which Health and Well-Being boards and partners would be expected to be taking and to agree these.

Recommendations
1. The Board agree that tackling obesity is a priority and ensures partners engage with the system-wide approach recommended for both children and adults, in particular that the obesity care pathway is developed with partners and that the CCG attend and engage with the steering groups and review their tier 3 provision.
2. To agree to the development of a strategic statement and action plan, based on the needs assessment and stakeholder events, which all partners should sign up to facilitating system wide action.
3. The Board supports the commissioning of a tier 2 adult weight management service as set out in the Public Health Commissioning Plan (2015 – 2020); develop the weight management offer.

1. WHY THIS REPORT IS NEEDED

1.1 Obesity, diet and lack of physical activity are, after smoking, the most important causes of ill health and premature death. Obesity substantially contributes to the risks of hypertension, diabetes and heart disease, respiratory problems, several cancers, dementia and renal failure. Morbid obesity is associated with 9 years loss of life – equivalent to life-long smoking. If trends continued at the current rate it is estimated that 60 per cent of men, 50 per cent of women and 25 per cent of under-20- year-olds could be obese by 2050.

1.2 There is particular concern about the rise of childhood obesity and the implications of obesity persisting into adulthood. Obese children may also suffer psychological problems such as social isolation, low self-esteem, teasing and bullying. Obesity among children and young people is closely linked with socioeconomic status. Children from more deprived backgrounds have higher levels of obesity.

1.3 The Government's call to action Healthy Lives, Healthy People (Public Health Outcomes Framework, 2012) sets out the overarching vision and framework for improving public health outcomes in England. There were two national ambitions for obesity:

- A sustained downward trend in the level of excess weight in children by 2020
- A downward trend in the level of excess weight1 averaged across all adults by 2020.

1.4 Healthy Lives, Healthy People (2012) recognised that managing weight was an individual's responsibility but also identified that local authorities are uniquely placed to lead the drive to tackle some of the root causes of obesity through planning, transport, education, social care, environmental health as each community had different characteristics and problems that were best addressed at a local level.

1.5 This was to become especially important in 2013 when public health moved into local government, when the responsibility for commissioning tier 1 and tier 2 services for weight management would also fall to local authorities. The responsibility for tier 3 services and onward were to remain with the NHS, but with an overall arching strategic view for planning with local government, in particular health and well being boards. This built upon the life course approach supported in previous reports such as the Foresight report in 2007 and the Marmot Review in 2010 which advocated making the messages and support to maintain a healthy weight consistent from 'cradle to grave'. The emphasis has been to promote individual empowerment, give all partners the opportunity to reduce obesity and transfer the responsibility for prevention to local government.

1.6 The different tiers of services for excess weight together form a coherent weight management care pathway for adults and children as follows:

Tiers	**Description**	**Commissioning responsibility**
Tier 1	Universal interventions – prevention and reinforcement of healthy eating and physical activity, including public health campaigns and brief advice	Local Authority
Tier 2	Lifestyle weight management services – usually time limited	Local Authority
Tier 3	Clinician-led multi-disciplinary team supporting morbidly obese patients or those who are overweight or obese and have significant comorbidities or complex needs (for example, learning disabilities or other additional support needs.	Clinical Commissioning Group

[1] The target for obesity and overweight was combined in Healthy Lives, Healthy People and renamed excess weight. Therefore when excess weight is referred to this means overweight and obese, these are no longer measured separately.

	In addition, referral to tier 3 could be considered for patients: • the underlying causes of being overweight or obese need to be assessed • the person has complex disease states and/or needs that cannot be managed adequately in tier 2 • conventional treatment has been unsuccessful • drug treatment is being considered for a person with a BMI more than 50 kg/m^2 • specialist interventions (such as a very low-calorie diet) may be needed or • surgery is being considered.	
Tier 4	Bariatric surgery supported by multi-disciplinary team, pre and post operation	NHS England[2]

1.7 Adult excess weight (overweight and obesity) is identified as an indicator for the Public Health Outcomes Framework 2013-16 for England.

2. OBESITY IN ADULTS AND CHILDREN – BARNET

2.1 Assessment of need - adults

2.1.1 There has been a marked national increase in the proportion of people who have been categorised as obese (BMI 30kg/m2 or over). 13% of men were categorised as obese in 1993 compared with 25% in 2011 and 16% of women were obese in 1993 to 26% in 2011 in the Health Survey for England. Over both sexes the increase has been from 15% in 1993-5 to just below 25% in 2011.

2.1.2 Obesity prevalence is challenging to report accurately as BMI is not routinely collected by all GP practices. It is assumed that the upward trend observed on a national level is reflected in Barnet. Previously obesity has been estimated using the Health Survey for England sample modelled estimate. This data has been succeeded by the Active People Survey (Sport England 2012) which has a self reported weight measure for adults, with the latest data released in February 2014. It reported that Barnet has lower prevalence of excess weight (obese and overweight together) 55.60% compared to England (63.8%) London (57.3%) and neighbouring boroughs. However, this is a self reported measure and may be subject to some under-reporting.

[2] Note that the transfer of Morbid Obesity Surgery Services will transfer from NHS-E to CCG's in April 2016. It was due to happen April 2015 but due to concerns raised during the consultation process, it has been delayed 1-year. For further details and to read to consultation paper, go to: https://www.gov.uk/government/consultations/transferring-services-from-nhs-england-to-ccgs

2.2 Assessment of need – children

2.2.1 Categorising weight for children is more complex than for adults. The child's height and weight is plotted on a growth reference chart (the UK 1990 BMI charts are used for the NCMP – National Child Measurement Programme), to give age- and gender-specific category.

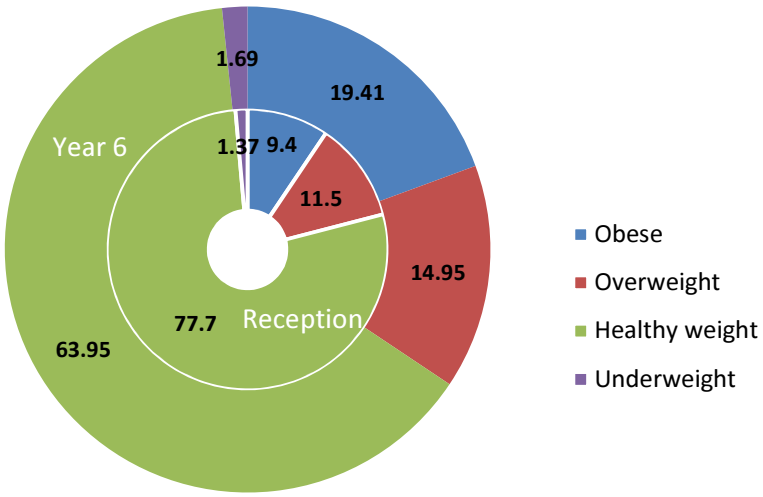
2.2.2 Levels of overweight and obesity remain lower than the National and London average in Barnet for reception children attending school in the borough, while the picture for year 6 children is mixed.

2.2.3 The most recent NCMP (2013/14) data shows that 11.5% of reception age children were overweight in Barnet and 9.4% of reception children were obese. Over the last 8 years, overweight and obesity levels in this group have fluctuated - overweight prevalence is currently at the same level as 8 years ago whereas obesity levels are slightly higher which is in contrast to the London and national trend which has been downward.

2.2.4 For year 6 children, the latest data shows that 19.4% are obese and 14.6 %(higher than the national average) are overweight. In the last 8 years there has been a marked increase in obesity in Year 6 children of 2% for Barnet; from 17.4% to 19.4%. This is similar to the upward trend seen nationally and in London. See Appendix 2 for further information.

2.2.5 Figure 1 shows that in 2013/14, prevalence of obesity in year 6 children was double that of reception children.

Figure 1: Percentage of children by weight category, Barnet, 2013/14



3. COST OF OBESITY

3.1 Nationally, treating the effects of obesity cost the NHS £5 billion a year. The wider cost to the economy is estimated at closer to £20 billion a year when factors such as lost of productivity and sick days are taken into account.

3.2 Although Barnet's excess weight is lower than the London and England average, there are approximately 160,000 adults (16+) within the Borough who are overweight or obese. This poses a significant challenge to the local economy. The total cost of overweight and obesity nationally is estimated to be £94.4 million by 2015.

3.3 In terms of social care and health, in England more than 15 million people have a long-term condition and the care for people with long-term conditions accounts for 70% of total health and social care spend. There are resource implications for the cost of social care for adults with severe obesity, for example, housing adaptations, care arrangements for those who are housebound and transport.

4. EVIDENCE AND NEEDS ASSESSMENT

4.1 Weight gain results from energy imbalance: people are eating too much for the amount of physical activity they undertake. A balanced diet and physical activity are both essential for maintaining health. However, over the last 10 years, average adult energy expenditure has decreased by as much as 30%, suggesting that declining levels of physical activity are of particular importance in rising obesity levels. Obesity can also be linked to factors such as, environmental, genetic, psychological and social/cultural.

4.2 The effective approach to preventing and treating obesity is provided by NICE (National Institute for Health and Care Excellence), which offers guidance on how clinicians should assess obesity, what they should do to treat obesity, how people can remain at a healthy weight and how to make healthy food choices easier for everyone.

4.3 The public health team conducted a needs assessment on obesity in 2014 and the details of this are being updated to reflect changes in guidance. The purpose of this needs assessment was to create an accurate picture and identify need relating to obesity in the London Borough of Barnet for both adults and children. The needs assessment presents available national, regional and local data to establish the current and the projected future prevalence of obesity. Methodologically, this report includes a review of quantitative data to assess levels of obesity in Barnet and model current need and demand. It also notes that there has been no strategic approach to managing overweight and obesity and that this needs to be rectified to improve wellbeing, and help reduce future health and social care costs.

4.4 Examining the latest Census results for the Barnet population with higher risk groups in mind allows more understanding of the obesity picture in the borough. Barnet has slightly higher proportion of children living in poverty (21.2%) when compared to the England average (21.1%) although this is a not statistically significant difference in proportion. This child poverty measure is determined by the level of children in families who are receiving means tested benefits and low income.

4.5 Asian and some other ethnic populations are at greater risk of obesity and Barnet has a high level of residents who are Asian (32%) when compared to the England average (12%) and also Black, Black African, Caribbean or Black British (8%) compared with England as a whole (3%). Barnet has only 5% of its population living in an area which is ranked as in the most deprived 20% of the country which is considerably less than the England average of 20.3%.

5. OPPORTUNITIES TO ADDRESS OBESITY IN BARNET: PHYSICAL ACTVITIY IN ADULTS AND CHILDREN IN BARNET

5.1 The benefits of physical activity are clear in terms of promoting health and preventing disease and staying active is an important factor in maintaining a healthy weight and a helpful method of reducing weight. Beginning at a young age, physical activity is an essential component for energy balance and weight control. Men and women who are more physically active tend to have lower BMIs and smaller waist circumferences.

5.2 The Chief Medical Officer's (CMO's) current minimum recommendation states that over a week activity should add up to at least 150 minutes (2 ½ hours) of moderate intensity activity in bouts of 10 minutes or more. One way to approach this is to do 30 minutes on at least 5 days a week. Alternatively, comparable benefits can be achieved through 75 minutes of vigorous intensity activity spread across the week or combinations of moderate and vigorous intensity activity.

5.3 The CMO guidelines state that children of pre-school age who are capable of walking unaided should be physically active daily for at least 180 minutes (3 hours), spread throughout the day. Most UK pre-school children currently spend 120–150 minutes a day in physical activity, so achieving this guideline would mean adding another 30–60 minutes per day.

5.4 Children aged 5-18 years should engage in moderate to vigorous intensity physical activity for at least 60 minutes and up to several hours every day. Vigorous intensity activities, including those that strengthen muscle and bone, should be incorporated at least three days a week. All children and young people should minimise the amount of time spent being sedentary (sitting) for extended periods.

5.5 The British Heart Foundation, Physical Activity Statistics 2015, used accelerometers as a direct measure of physical activity in a cohort of children. This direct assessment found that showed that none of the 11- to 15-year-old girls and only 7% of boys they measured actually did enough exercise.

5.6 The percentage of adults in Barnet achieving the Chief Medical Officers minimum level of physical activity of 150 or more minutes per week is 56% which is same as the national average. Just over a quarter of Barnet adult residents (26%) get less than 30 minutes of physical activity each week.

5.7 Physical activity data for children is limited, however, sedentary time is at least as important as moderate physical activity as a disease factor. Sedentary behaviour is not merely the absence of physical activity; rather it is a class of behaviours that involve low levels of energy expenditure. The HSE 2012 (Health Survey for England, 2012) asked children about the amount of time spent in sedentary pursuits including time spent watching television, other screen time, reading and other sedentary pursuits.

5.8 The HSE found:

- Average total sedentary time (excluding time at school) was similar for boys and girls on weekdays (3.3 hours and 3.2 hours respectively) and weekend days (4.2 hours and 4.0 hours respectively).
- For both boys and girls, the average number of hours spent watching TV on both weekdays and weekend days increased as equivalised household income decreased.
- The Barnet Sport and Physical Activity Needs Assessment conducted in 2012 included market segmentation of the Barnet population describing the different characteristics, motivations and behaviours of the population including the most significant barriers to participation for different groups. It suggests for example that young mothers often find sport and leisure opportunities inconvenient, particularly with regard to childcare provision. Middle aged adults tend to have busy lifestyles, mostly due to work commitments, which impacts on the time they can make available for physical activity. For older adults, health, injury and disability are the most common barrier to exercise.

5.9 There has been detailed work on the motivations for physical activity as part of the work of the SPA board and the leisure procurement work and this can provided in further detail if the board requires this.

6. APPROACH

6.1 The approach recommended by this paper is that an obesity strategy and action plan is developed to take account of the responsibilities of the Board and the opportunities for integrating this into council business with key partners. The key themes of the strategy may be expressed in terms of:

6.1.1 Developing a strategic steering group to support the development of a shared action plan for adults and children.

6.1.2 Service planning – ensuring that services for children and adults are in place from tiers 1 to 4 and that there is a clear pathway for referral into and between all tiers.

6.1.3 Developing a strategic approach to obesity through planning, built and green environments

6.1.4 Developing a strategic response to tackling environments that are not supportive for obesity prevention

7. PROGRESS TO DATE

7.1 Developing a strategic steering group to support the development of a shared action plan for adults and children

7.1.1 In June 2014 a stakeholder event took place which looked at the steps required to begin looking at a whole systems approach to obesity in Barnet. This was well attended by LLB officers, the voluntary sector, tertiary NHS services and others but there was a low attendance from primary care. Following this event it was the intention to form a strategy group with two sub groups – one on adults and one on children. The strategy group was not successful in gaining commitment from all partners essential for taking the work forward and did not meet. However, the Children's Obesity Pathway subgroup was formed and has met three times. It is well attended but currently lacking GP clinical input. The group has been refining the pathway for children and young people and has contributed to the planning and development of a Children's Tier 2 Weight Management Programme.

7.2 Service planning – ensuring that services for children and adults are in place.

7.2.1 Tier 1 services at prevention level are well represented. There are several services that support people to be physically active in the borough such as health walks, outdoor gyms and the activator programme and various physical activity provisions for older adults. Interventions aimed at enabling children to be more active and improving healthy eating habits are available in children's centres and schools.

7.2.2 A tier 2 family based weight management programme for children has been commissioned by Public Health and the service will commence in April 2015 (Appendix 2). A business case for an Adult Tier 2 weight management service has been developed (Appendix 3), for consideration by the board. It outlines the evidence base for the intervention planned.

7.2.3 It is recommended that £49,999 over two years be allocated from the Commissioning Intentions Budget (Weight management) to fund an Adult Tier 2 weight management service.

7.2.4 The Adult Tier 2 weight management services will be multi-component in line with the NICE guidelines to achieve weight loss or to prevent weight gain as single strategy approaches are less effective on their own. These will include behaviour change strategies to increase physical activity levels or to reduce sedentary behaviour, improve eating behaviour and reduce energy intake. The aim of the service is to prevent further weight gain, promote modest

reductions in body weight and minimise weight regain amongst adults who are overweight or obese to improve associated co-morbidities, risk factors and quality of life.

7.2.5 The services will be free of charge to participants and long-term ongoing support will be provided. Services will be available locality wide and during the day, evening and weekends. Key stakeholders will be engaged in the ongoing development and governance of the programme.

7.2.6 Tier 3 services are commissioned by CCG and tier 4 services by NHSE. Current tier 3 services are not in line with NICE recommendations i.e. they are not multi-component and presently only consist of specialist dieticians whose remit is wider than just obesity. Preliminary scoping conducted through the Children's Obesity Pathway Group found that services are not multi-disciplinary, referral pathways can be convoluted and that the paediatric dieticians are over-stretched and, therefore, many high-risk children are not receiving a NICE compliant service

7.2.7 The implementation of tier 1 and 2 services will support NHS commissioners to plan for Tier 3 services and beyond. The steering group and action plan can also assist in supporting NHS partners in defining and planning these services.

7.3 Developing a strategic approach to obesity through planning, built and green environments

7.3.1 Creating environments that are conducive to preventing obesity and maintaining weight has become high profile since public health moved in to local authorities with the use of public spaces, the ways in which built environments are developed and how open spaces are used central to this. With this in mind public health has begun discussions with planning with regards to how regeneration and redevelopment can be influenced to encourage physical activity and promote schemes that reduce obesity – such as shared spaces, cycling and walking schemes, through the Parks and Open Spaces Strategy. A recent paper from the Town and Country Panning Association, published in December 2014 identified that there are common elements that a collaborative approach to a healthy-weight environment will need to consider. These have been the starting point for our discussions, and it is intended to map activity against these and incorporate these into the strategy and action plan, if agreed.

7.4 Developing a strategic response to tackling environments that are not supportive for obesity prevention

7.4.1 In addition there are programmes in place such as the Healthier Catering Commitment which aims to look at existing food provision in order to encourage healthier options. In Barnet we have revised the scheme and introduced three levels of achievement – bronze, silver and gold and these were launched last year. Local businesses are supported to change menus and offer additional choices and receive an award once they have completed

the changes. Where new developments or contracts are awarded (for example leisure provider) it is intended to attempt to ensure that the HCC award becomes a requirement. Both catering facilities within NLBP have achieved the award. Mapping of fast food outlets has also been undertaken and this will be used to inform the strategy and action plan. Public Health is looking to review other initiatives already being undertaken by the London Healthier high Streets Group to incorporate the broad approach recommended by the TCPA Paper3.

7.5 **Promoting Physical Activity**

7.5.1 Physical Activity in Barnet there is a need to ensure that the population is given the best chance to reduce weight and prevent excess weight where possible. We have begun to tackle this through the development of physical activity initiatives to encourage people to become more active and now need to look more closely at assisting people with excess weight to manage their weight more effectively themselves and prevent obesity in others. In addition, we need to ensure that front line health and social care staff are enabled to raise the subject with clients effectively and signpost them to appropriate services.

7.5.2 The council is already working to address inactivity through the Sport and Physical Activity Strategy statement and the four objectives of SPA have been incorporated into the work on physical activity, the Fit and Active Barnet Partnership Board, and the leisure services re-procurement process.

7.5.3 These have been incorporated into the re-procurement of the leisure services and an innovative approach has been developed to ensure that wider public health outcomes are incorporated into the approach to leisure. The values of the SPA objectives are also incorporated.

8. NEXT STEPS REQUIRED TO FURTHER PROGRESS

8.1 Commitment of partners to a strategic perspective and whole systems approach and develop a strategic partnership group to support the development of an action plan.

8.2 Adult tier 2 weight management programme which is an identified gap is commissioned in line with childrens pathway.

8.3 There is an urgent need to review CCG commissioning of Tier 3 services for both children and adults in line with NICE guidance.

8.4 There is a need to ensure a clear pathway exists, which clarifies the referral pathways and the ongoing care pathways for both children and adults. This should include clarification of how people can be referred between tiers as a step-up or step-down.

[3] ibid

9. REASONS FOR RECOMMENDATIONS

9.1 Obesity requires a systematic approach with all stakeholders working together. This approach is being recommended in order to ensure that Barnet has a response to obesity in place which covers all aspects of weight management which are relevant to our population and has a strong focus on prevention – both in terms of services and an environmental approach in addition to dealing with the current issues.

10. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

10.1 An alternative approach is to do nothing about obesity in Barnet. This is not recommended since the health and social care costs of obesity are significant and will impact on council budgets as well as those of key partners.

11. POST DECISION IMPLEMENTATION

11.1 Convene an Obesity strategy group with aim of developing an action plan for approval supported by an adult pathway sub group and the existing childrens pathway subgroup.

11.2 Work on the built environment and planning to continue.

11.3 If approved, the commissioning of the Adult Tier 2 service will be commissioned in late spring 2015.

11.4 Children's Tier 2 weight management service will commence April 2015.

12. IMPLICATIONS OF DECISION

12.1 **Corporate Priorities and Performance**

12.1.1 The Barnet Health and Wellbeing Strategy recognises the problems of obesity and outlines commitments to reduce rates in Barnet and to improve matters through supporting the most disadvantaged groups.

12.1.2 Adult excess weight (overweight and obesity) is identified as an indicator for the Public Health Outcomes Framework 2013-16 for England.

12.1.3 The Barnet Sports and Physical Activity Strategy recognises the contribution of physical activity in reducing obesity and it aims to increase physical activity of residents of all ages by providing the facilities, open spaces, and community and transport infrastructure.

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

12.2.1 The approval of the approach will have no direct resource implications with exception of Adult Tier 2 weight management service. The Public Health ring-fenced grant will be used to fund this service.

12.2.2 It is critical that a variety of staff and wider strategic partners are involved and contribute to the process as part of their daily business.

12.3 **Legal and Constitutional References**

12.3.1 The responsibility for public health transferred to local authorities in April 2013 under the reforms set out in the Health and Social Care Act 2012. Health and Wellbeing Boards are given statutory effects by s194 of this Act.

12.3.2 The Council's Constitution sets out the Terms of Reference for the Health and Well-Being Board. The responsibilities include:

- To jointly assess the health and social care needs of the population with NHS commissioners, and apply the findings of a Barnet joint strategic needs assessment (JSNA) to all relevant strategies and policies.
- To agree a Health and Well-Being Strategy for Barnet taking into account the findings of the JSNA and performance managing its implementation to ensure that improved outcomes are being delivered.
- To work together to ensure the best fit between available resources to meet the health and social care needs of the population of Barnet (including children), by both improving services for health and social care and helping people to move as close as possible to a state of complete physical, mental and social well-being. Specific resources to be overseen include money for social care being allocated through the NHS; dedicated public health budgets; and Section 75 partnership agreements between the NHS and the Council.

12.4 **Risk Management**

12.4.1 There is a risk that without a shared and systematic approach to obesity across the Borough obesity will continue to become burden to individuals and families and to the health and social care system.

12.5 **Equalities and Diversity**

12.5.1 The 2010 Equality Act outlines the provisions of the Public Sector Equalities Duty which requires Public Bodies to have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010
- advance equality of opportunity between people from different groups
- foster good relations between people from different groups

12.5.2 Having a system-wide approach to obesity will have a positive effect on those who are identified as overweight and obese in the Borough and also those who are 'at risk' of developing obesity or its complications and should be considered as priorities for targeting preventive initiatives. These include the following:

- Children from low-income families (there is a correlation between low income and a greater risk of obesity in childhood as well as adulthood)
- Children from families where at least one parent is obese (the increased risk may be due to genetic and/or environmental reasons)
- Individuals of Asian origin, particularly those of South Asian origin, for whom obesity carries a greater risk of metabolic syndrome and its consequences.
- Ethnic groups with a higher than average prevalence of obesity.
- Adults in semi-routine and routine occupations (using the National Statistics Socio-Economic Classification [NS-SEC])
- People who have a physical disability, particularly in terms of mobility, which makes exercise difficult.
- People with learning difficulties.
- Older people (increasing age is associated with increasing prevalence of obesity up to the age of 64 years, and then a decline in the prevalence begins)

12.6 **Consultation and Engagement**

12.6.1 Stakeholder event held in June 2014 with a broad cross section of organisations plus individuals who would be likely to use and refer to services. Members of the public were also present and the feedback and views were collected during the event. There was support for working towards a co-ordinated response. Further engagement of stakeholders and partners who constitute part of the action plan.

13. BACKGROUND PAPERS

13.1 Public Health Outcomes Framework (2012); http://www.phoutcomes.info/

13.2 Foresight Report: Tackling obesities: future choices. Government Office for Science and Department of Health (2007); https://www.gov.uk/government/publications/reducing-obesity-future-choices

13.3 Strategic Review of health inequalities. Institute of Health Equity (2010); http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

13.4 Active People Survey. Sport England (2012). http://archive.sportengland.org/research/active_people_survey/active_people_survey_7.aspx

13.5 Obesity: identification, assessment and management of overweight and obesity in children, young people and adults. NICE guideline CG189 (2014); http://www.nice.org.uk/guidance/CG189

13.6 Healthy Weight, Healthy Lives: A toolkit for developing local strategies – Estimating the local cost of obesity. Faculty of Public Health (2013); http://www.fph.org.uk/healthy_weight,_healthy_lives%3A_a_toolkit_for_developing_local_strategies%20

13.7 Planning Healthy-Weight Environments. Ross and Chang. (2014). http://www.tcpa.org.uk/pages/planning-out-obesity-2014.html

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National Child Measurement Programme (NCMP) data for 2013/14.

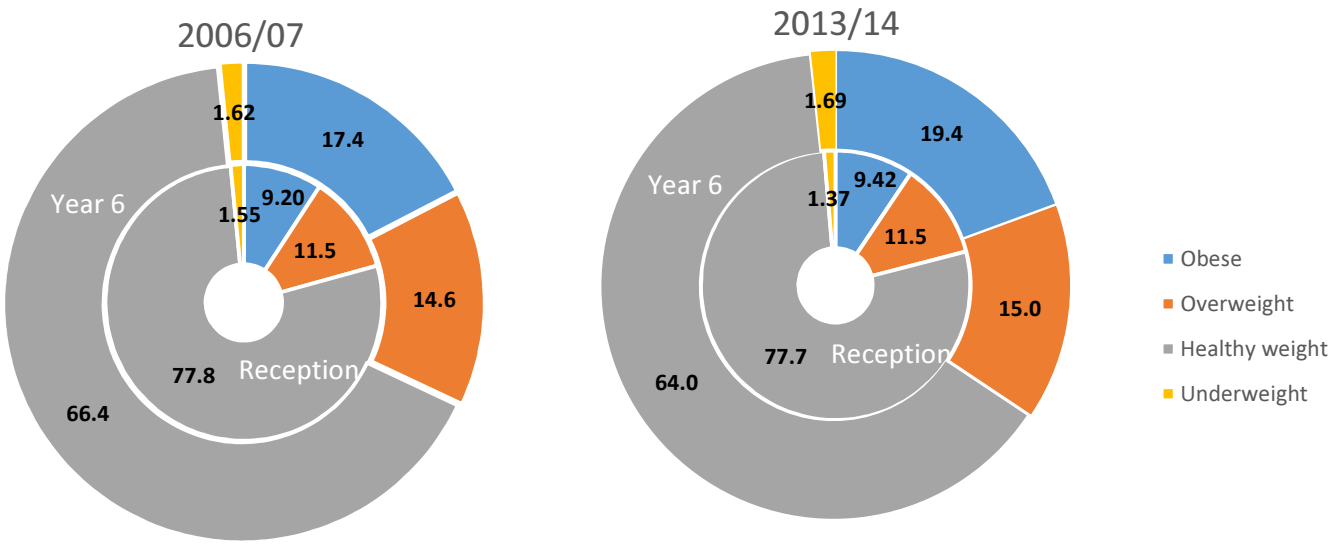
The national child measurement programme (NCMP) collects information on body mass index of children in reception and year 6. The programme was established in 2006 and now has 8 years of robust trend data. Participation rates are high and in 2013/14 the overall participation rate in England was 94% and 93% in Barnet.

Key messages:

Levels of overweight and obesity remain lower than the National and London average in Barnet for reception children attending schools there and have remained fairly stable over the last 8 years.

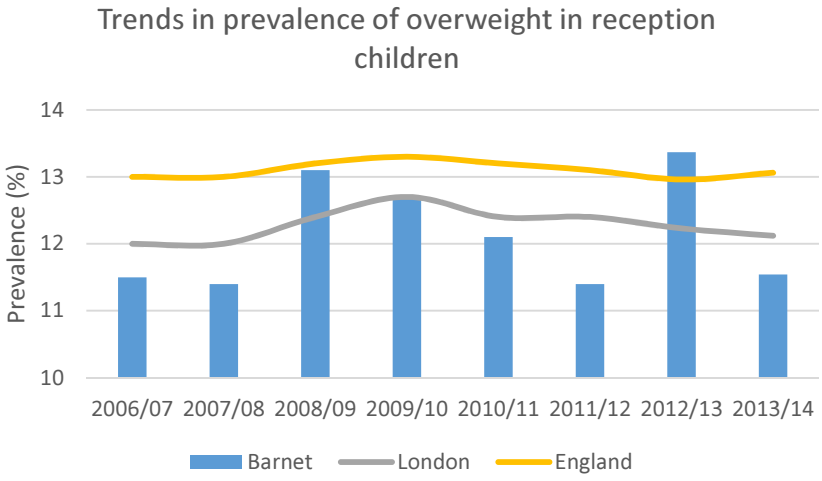
Despite relatively low levels of obesity, prevalence in reception age children has been increasing in Barnet. This is in contrast to trends nationally and in London which are showing decreases.

The biggest increase in prevalence has been obesity in year 6 children; there has been a 2% increase in the last 8 years. However this is equal to the national and London increase, and levels in Barnet in 2013/14 remain 3% lower than the London average (statistically significant).

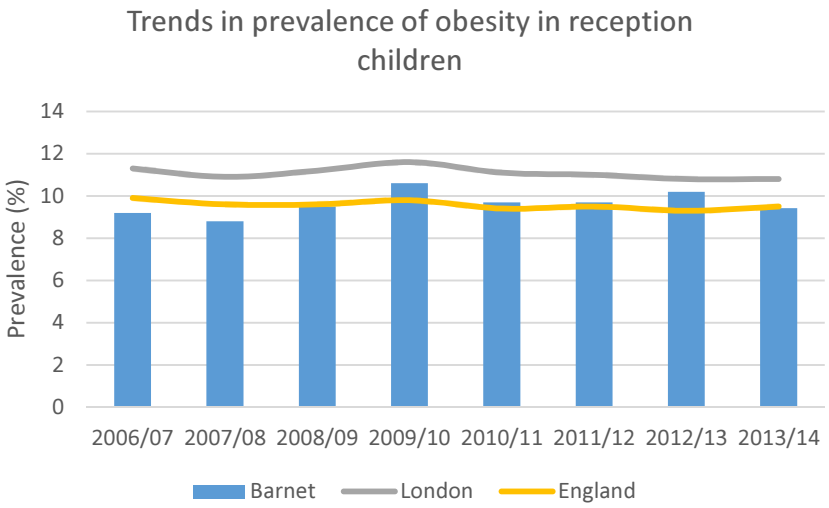


Overweight and obesity trends:

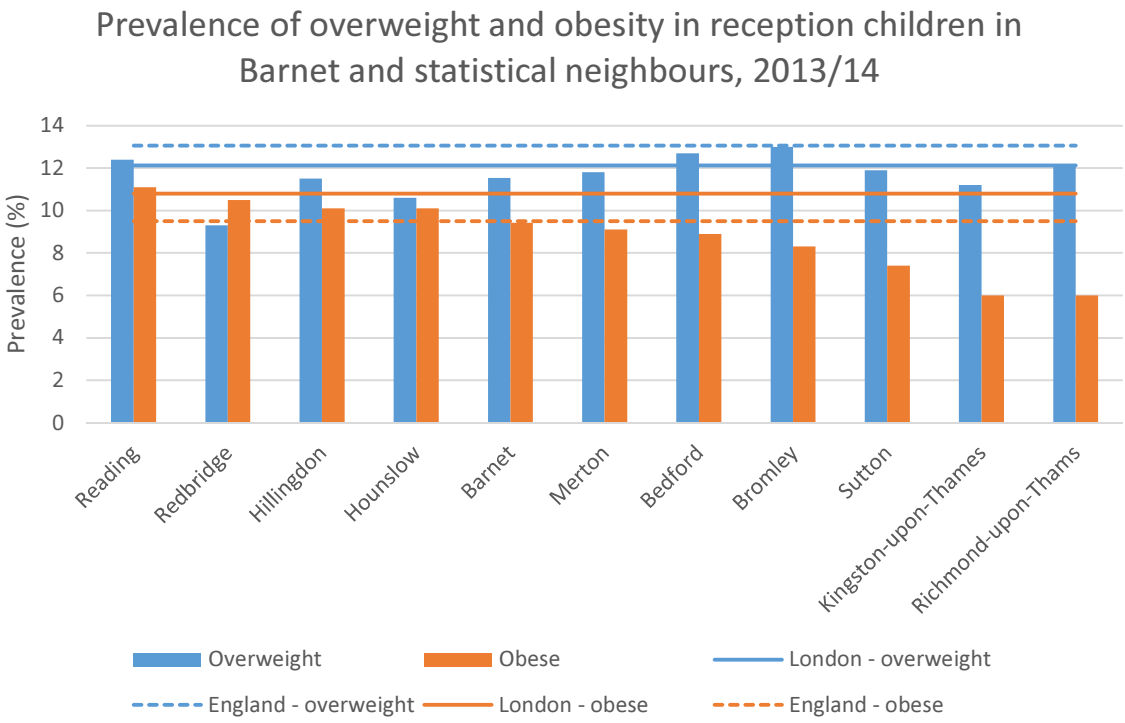
The most recent data show that 11.5% of reception age children were overweight in Barnet. This is lower than the national (13.1%) and London (12.1%) average and is equal to the prevalence 8 years ago.



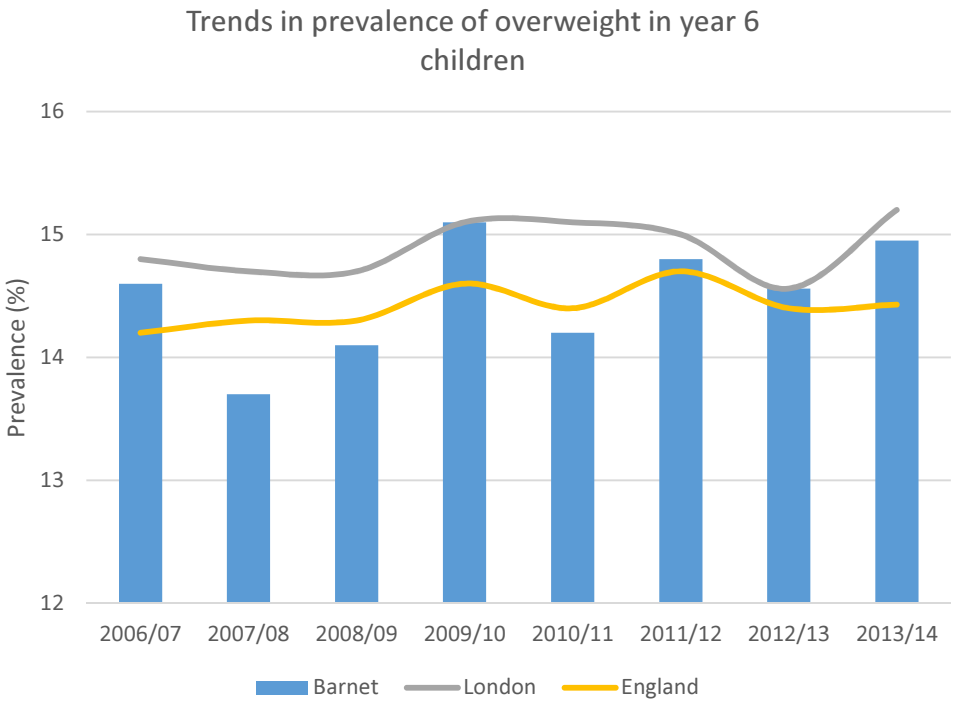
Obesity levels have seen some fluctuation since the programme began, but overall the increase in obesity for reception children in Barnet has been very small; 9.4% in 2013/14 compared with 9.2% in 2006/07. However this is in contrast to prevalence in London and England overall; trend data has shown a decrease in obesity prevalence over the last 8 years from 11.3% to 10.8% and 9.9% to 9.5% respectively.



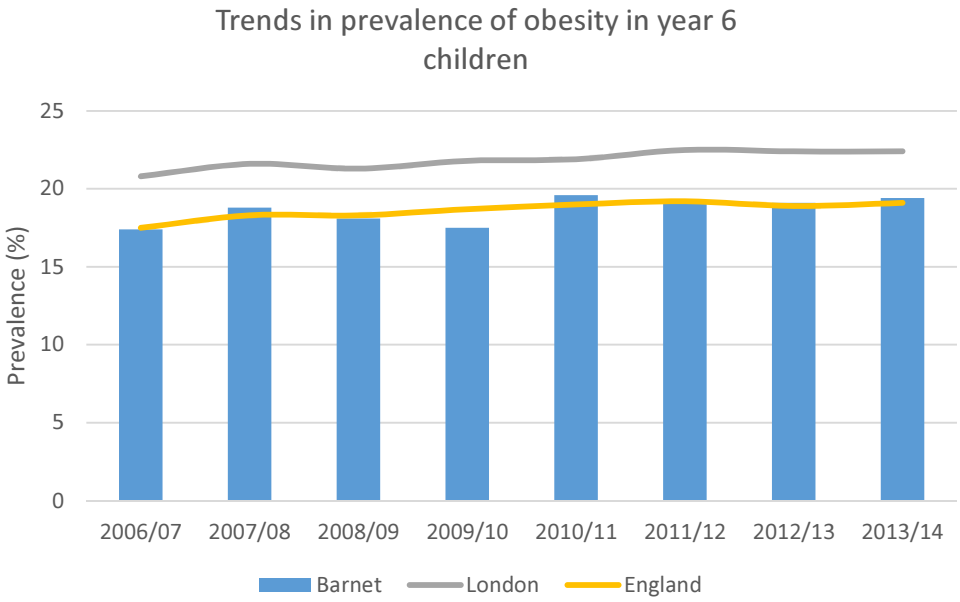
Compared with statistical neighbours, Brent ranks slightly better than the median value for overweight prevalence and slightly worse for obesity prevalence in reception children.



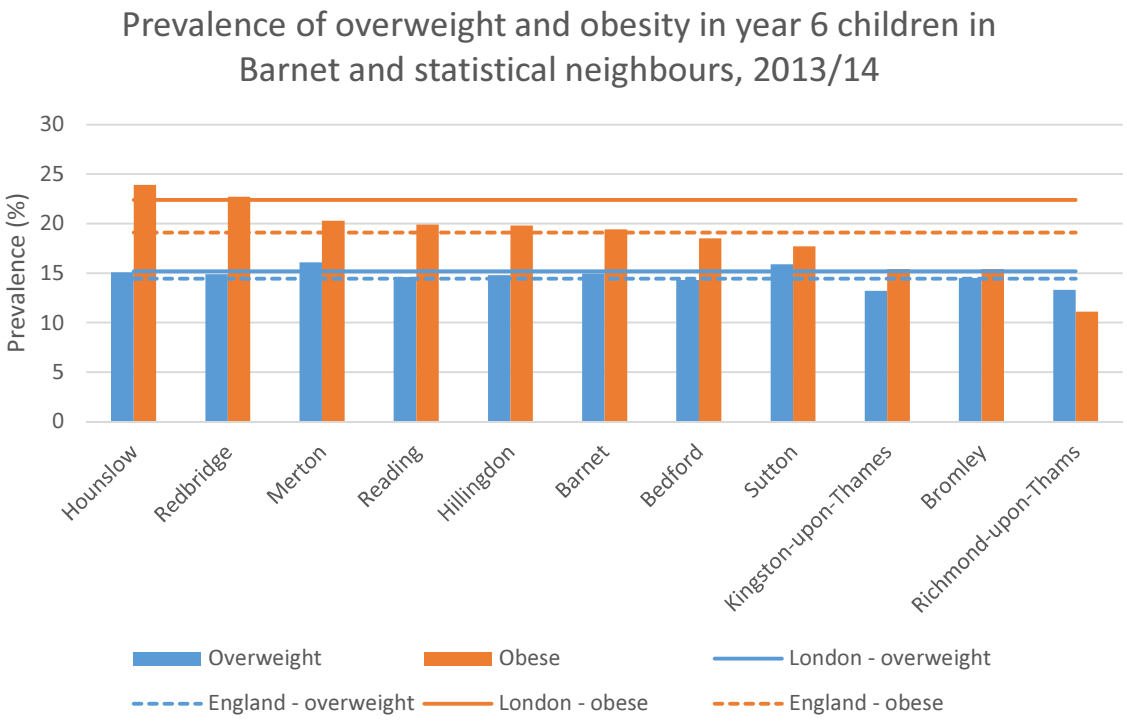
For year 6 children prevalence of overweight is higher than the England (14.4%) average but lower than London (15.2%). Overall, there has been a small increase in overweight prevalence when looking at the long term trend; 14.6% in 2006/07 compared to 15.0% in 2013/14. However there has been a considerable amount of fluctuation throughout that time period.



In the last 8 years the increase in obesity has been 2% for Barnet. This is similar to the upward trend seen nationally and in London, which has also been approximately 2%. Just like levels of overweight; obesity in year 6 children has shown considerable fluctuation over the time period but the data for 2013/14 show an increase since last year from 19.1% to 19.4%.



In Barnet, compared with statistical neighbours the borough ranks 4th worse for levels of overweight and as the median value for prevalence of obesity.



Tackling increasing overweight and obesity levels in year 6 children remains the priority.

Note: All data shown here are grouped by postcode of school therefore not all borough residents will be captured in these data. Pupil level data is now available for 2013/14. Further analysis to examine factors such as deprivation and ethnicity will be conducted on these data soon.

SERVICE SPECIFICATION

Barnet Child Weight Management Programme.

Barnet Council are seeking to commission a service provider to design and deliver an accessible tier 2 lifestyle weight management service, which supports overweight and obese children to reach and maintain a healthier BMI, the service will form an integrated part of the local weight management care pathway.

The service will need to be NICE compliant and therefore offer physical activity, healthy eating and behaviour change. The service will target children who are obese (98th centile or above), or overweight (91st centile or above), but without complicating co-morbidities. In line with the NICE PH47 guidance[1], only the UK90 growth reference charts (boys and girls) will be used.

1. Introduction

The Public Health Team wish to implement a child weight management programme in order to improve children's obesity levels in Barnet. Children and Young people under the age of 20 years make up 25.5% of the population of Barnet, and 25,700 children are educated within Barnet's primary schools. Commissioned lifestyle weight management services need to meet the needs of local children and young people, including those of different ages, different stages of development and from different cultural backgrounds.

Public Health England compared National Child Measurement Programme (NCMP) obesity data to the 'benchmark' for England and rated Local Authorities as better, similar or worse. Barnet has similar obesity prevalence to England for both Reception (9.3% England, 10.2% Barnet), and Year 6 (18.9% England, 19.1% Barnet). In terms of excess weight (obese and overweight) Barnet also has a similar prevalence to England for Year 6 (England 33.3%, Barnet 33.6%) and Reception (England 22.2%, Barnet 23.6%)[2]. Although similar to the national prevalence the trend in Barnet has not been improving and there is much we can do within the borough to help reduce these levels.

The Public Health Team have identified a need, gauged stakeholder preferences and mapped existing provision, and this information gathered has been essential to informing the content of this service specification. This specification outlines the

[1] NICE PH47, (October 2012) Managing overweight and obesity among children and young people: lifestyle weight management services

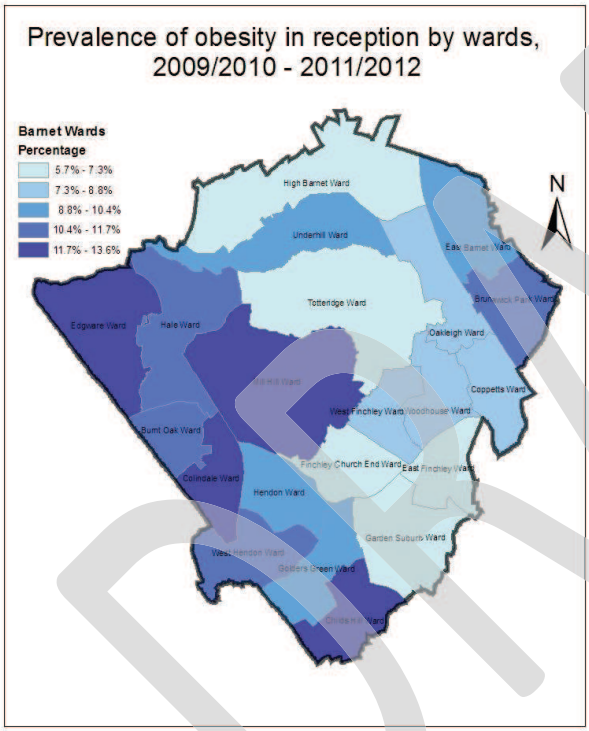
[2] Public Health England NCMP Local Authority Profile 2012/13 http://fingertips.phe.org.uk accessed online 10/02/14

commissioning requirements which focus on outcomes that can successfully assess and compare the effectiveness of weight management services.

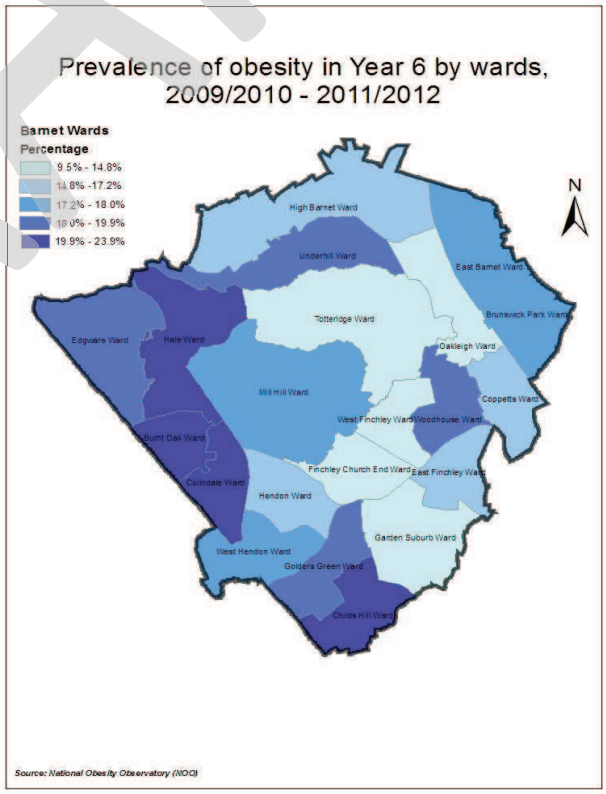
2. Background

Overweight and obesity presents a major challenge to the current and future health of the local population. In children, a BMI greater than or equal to 91st centile is associated with health and psychosocial problems within childhood itself and may put individuals at greater future health risk of type 2 diabetes, coronary heart disease, hypertension and some forms of cancer. It also contributes to increased social care costs.

Looking at NCMP data for 4 and 5 year-olds (Reception) by the wards in Barnet there is an 8% difference in the prevalence between the wards with the lowest rate (Finchley Church End 5.7%) and that with the highest (Colindale 13.6%). Colindale, Edgware, Childs Hill, Mill Hill, Hale and Burt Oak all have obesity rates higher than the London average (10.8%) at this age.



In Year 6 this gap widens and there is a 14.4% difference between the ward with the lowest rate (Garden Suburb 9.5%)) and that with the highest (Hale 23.9%). Hale, Burnt Oak, Colindale and Childs Hill have obesity rates higher than the London average for this age group (22.4%).



Barnet is a very diverse population and as the table below shows Barnet has a higher percentage of children from black/ethnic minority groups compared to England but slightly lower percentage compared to London. Weight management programmes

should meet the needs of the population and be culturally specific as well as NICE compliant.

Table 1: School children in Barnet from black/ethnic minority groups

	Local	London	England
School children from black/ethnic minority groups % of school population (5-16 years)	29,869 (67.9%)	679,515 (69.3%)	1,740,820 (26.7%)

3. Scope

3.1 Aims of the service

To design and deliver an evidence based and accessible tier 2 lifestyle child weight management service that will assist children between the ages of 4-11 years of age who are above the 91st BMI centile to reach and maintain a healthier BMI.The overall aim of this service is to provide a weight management programme that overweight and obese children, accompanied by their parents/guardians, can be referred on too. The service resulting from this commission will form the basis of our new tier 2 service offer to children and will form a key component of the obesity care pathway.

The provider of this service will need to:

- **Ensure the programme is family based, and multi component focusing on healthy eating habits and physical activity and using behaviours change techniques**
- **Be a multi agency approach to promoting healthy weight and preventing obesity, with the input from a multi-disciplinary team**
- **Consist of a team of professionals who specialise in children, young people and weight management including input from a registered dietitian and a qualified physical activity instructor**
- **Encourage adherence to lifestyle weight management programmes**
- **Ensure there is a clear communications strategy in place to advertise the programme**
- **Ensure those involved in referring to, or delivering lifestyle weight management programmes have the skills and confidence to discuss weight management, if not they should be offered support and training**
- **Offer clear referral routes for professionals to signpost to the weight management programme**

3.2 Inclusion/exclusion criteria and thresholds

This tier 2 service will sit within our obesity pathway for children and link to tier 1 interventions aimed to prevent unhealthy weight and tier 3 interventions to support those with greater needs. As such, individuals eligible to access this service must be aged between 4-11 years, in the locality (either live within Barnet or attend a school within the borough)and have a BMI equal to or greater than the 91st centile. The service should be offered to all those children as identified through the NCMP as overweight or obese but without complicating co-morbidities.

Individuals not complying with these criteria will not be eligible to access the service but may be eligible to access alternative provision in the care pathway. Furthermore individuals meeting the following criteria should be excluded from this service:

- Have an eating disorder (as diagnosed by the appropriate medical professional)
- Individuals with an underlying medical cause for obesity and would benefit from more intensive clinical management than a tier 2 service
- Children with more complex needs such as learning difficulties and mental health issues should be considered on a case by case basis, and not part of the tender specification

3.3 Referral Route

- The service provider will:
- Accept referrals from primary care, all healthcare professionals and relevant stakeholders
- Accept self referrals from eligible local families (child would be assessed at first visit and BMI taken)
- Make onward referrals to other relevant health and social care services where appropriate

It should also be noted that a specific school nurse role has been identified. This role will focus on follow up of families where children have been identified through NCMP as overweight or obese. Further clarification of this role is still being determined, and can be made available to the provider when complete.

3.4 Applicable service standards

Providers are expected to demonstrate in their response, and will be evaluated against, how their intervention complies with the following:

- CQC Compliance if applicable
- The relevant aspects of NICE (2013) guidance on Managing overweight and obesity among children and young people: lifestyle weight management services
- Any evidence of previous success delivering interventions that meet this service specification criteria
- Service meets statutory health and safety requirements
- Service meets local and national safeguarding requirements and staff working with children and vulnerable people- e.g. DBS checks and hold valid registration as appropriate on the Register of Exercise Professionals (Level 2, Physical Activity for Children).
- Staff recruitment, training and development policies and practices ensure that staff have the appropriate competencies to deliver the intervention
- The Provider will ensure that staff are trained and up to date on information governance and handling data,
- The Provider must also comply with the London Borough Harrow's information governance policy
- The Provider must ensure that any incidents and/or complaints in relation to the provision of the service will be reported in a written format to the Commissioner within 7 working days of the incident
- Implementation plan shows how the service will be delivered to timescales, and that risks are mitigated
- Ability to meet demand and ability to increase capacity if demand rises

3.5 Service Delivery

The provider will be responsible for co-ordinating and meeting the suitable budget available for the cost of securing the equipment, facilities and materials necessary to deliver the intervention. The commissioner may be able to assist with brokering relationships with key local partners to facilitate the identification of appropriate venues.

3.6 Intellectual property and copyright

The Council will retain ownership of all data and information collected by the Provider. Any data, information or research pertaining to the service may not be transferred, disseminated or used by the Provider without explicit permission from the Commissioner.

3.7 Exit/ handover arrangements at end of contract

- The Provider will produce end of project evaluation report.
- The Provider will pass a copy of electronic records to the Commissioner.
- The Provider will produce a list of key contacts collated

3.8 Finance and Monitoring

Payment will be made as per the terms of the contract.

3.9 Monitoring

The provider will be required to attend quarterly contract meetings with the commissioner and to produce quarterly update reports, which include information on:

- The KPI's set out below
- Programme expenditure

The Provider shall produce an implementation plan demonstrating how it will deliver, monitor and evaluate the service which will meet the requirements of this service specification.

The Provider shall agree and produce appropriate methods for collecting, monitoring and reporting required data. Validated tools must be used to collect data as agreed with the Commissioner.

Throughout the contract the Provider shall submit monitoring reports which will be used to assess performance against the key performance indicators. The monitoring reports will be submitted before the contract monitoring meetings to inform the meetings.

The Provider will also be required to produce an end of project evaluation report summarising the activity and results.

4.0 Evaluation Criteria

Responses to this tender response to deliver to this service specification will be evaluated against their demonstration of the following:

A. Service design and delivery

1. The tender response demonstrates:
2. The service delivery model and the patient journey through the service
3. That the service is designed on the basis of current evidence and meets all NICE (2013) best practice standards for a multi component weight management programme
4. That appropriate monitoring and project management systems are included within the service design and evidence of appropriate governance arrangement has been provided
5. Evidence that the service will be accessible and free to users at the point of contact
6. Evidence of how the service will comply with quality assurance requirements, including statutory requirements as set out in section 3.4
7. How the KPIs will be achieved

B. Previous experience

1. The service provider's previous experience in delivering multi-component lifestyle weight management services to children and their families/carers
2. Evidence of the proposed intervention effectiveness to deliver objectives

C. Finance

1. The service present value for money
2. The overall cost of the service

5.0 Key Performance Indicators

To be agreed with the provider.

6.0 Timescales/ Implementation timetable

Key Milestones	By dates
Invitation to Quote	11th September 2014
Deadline for Questions from Providers	10th October 2014
Deadline for receipt of quotations	17th October 2014
Contract Award	1st December 2014
Programme commencement/launch	26th January 2015
Service delivery phase ends	TBC
End of project report and evaluation	January 2016

Public Health Business Case: Obesity

Adult Weight Management Services

Executive Summary

Obesity is now a major contributory factor in ill health and premature death in the UK. Obesity is a major causal factor in many diseases and, on average, obesity deprives an individual of an extra nine years of life, preventing many individuals from reaching retirement age[1]. Obesity is linked to a number of health risks including type 2 diabetes, high blood pressure, coronary heart disease, certain cancers, mental ill health and musculoskeletal problems. Increasing obesity prevalence along with the growing needs of ageing population, the rise in non-communicable diseases associated with obesity, and rising public expectations for service intervention and treatment[2] present significant challenges and cost implications to both health and social care systems.

Obesity prevalence varies by socio-economic and ethnic group. Rising obesity rates can result in increased ill-health among disadvantaged communities particularly among black and minority ethnic groups[3]. This can lead to widening inequalities in health and social care. Overall the risk of obesity in women tends to increase with deprivation, and for men, manual occupations and lower educational attainment are associated with the highest risk of obesity[4]. Obesity may also result in adverse social impacts such as discrimination, social exclusion and reduced earnings[5,6]

The Government is concerned about the rising levels of overweight and obesity in England and has set an ambition to achieve a downward trend in the level of excess weight averaged. A coherent, community-wide, multi-agency approach to address obesity prevention and management is vital. Guidance on obesity advises that primary care organisations and local authorities should recommend or endorse weight management programmes but only if these follow best practice.

The Barnet Health and Wellbeing Strategy recognises the problems of obesity and makes a commitment to reduce rates and to improve matters through supporting the most disadvantaged groups.

A working group was established by NHS England and Public Health England to examine issues that have arisen in the commissioning of and access to elements of the integrated obesity care pathway for adults and children[7]. The group

[1] National Obesity Forum 2006, Impact of Obesity. Website www.nationalobeistyforum.org.uk accessed online 10/9/13
[2] Kings Fund (2012) Transforming the delivery of health and social care.
[3] Gatineau M, Mathrani S (2011) Obesity and Ethnicity: Oxford: National Obesity Observatiry
[4] The National Obesity Observatory accessed online 05/12/13
[5] Puhl R, Brownell KD (2011) Bias, discrimination and Obesity. Obesity Research. 9(12): 788-805.
[6] McCormick B, Stone I and Corporate Analytical Team (2007) Economic cost of obesity and the case for government interventions. Obesity Reviews. 8:161-164.
[7] Report of working group (2014) Joined up clinical pathways for obesity obesitycarepathway@phe.gov.uk

concluded that the commissioning responsibilities within the current system should be as follows:

Tiers	Description	Commissioning responsibility
Tier 1	Universal interventions – prevention and reinforcement of healthy eating and physical activity, including public health campaigns and brief advice	Local Authority
Tier 2	Lifestyle weight management services – usually time limited	Local Authority
Tier 3	Clinician-led multi-disciplinary team supporting morbidly obese patients	Clinical Commissioning Group
Tier 4	Bariatric surgery supported by multi-disciplinary team, pre and post operation	NHS England

In Barnet there is a need to co-ordinate our response to obesity to ensure that the population is given the best chance to reduce weight and prevent excess weight where possible. We have begun to tackle this through the development of physical activity initiatives to encourage people to become more active and now need to look more closely at assisting people with excess weight to manage their weight more effectively themselves and prevent obesity in others. In addition, we need to ensure that front line health and social care staff are enabled to raise the subject with clients effectively and signpost them to appropriate services.

To support overweight and obese adults to lose weight and learn how to maintain a healthier weight, this business case proposes weight management services in the community. The focus of the service is to achieve changes in behaviour and to achieve long-term changes in eating habits and lifestyle. The service will form part of the Tier 2 element of a local obesity care pathway

Tier 3 obesity service is for obese individuals usually with Body Mass Index (BMI) ≥35 with co-morbidities or BMI ≥40 with or without co-morbidities who have not responded to previous tier interventions. A Tier 3 service comprise a multi-disciplinary team of specialist led by a clinician and typically including a specialist nurse, specialist dietitian, a clinical psychologist, a specialist physiotherapist and a medical consultant or a GP with special interest[8].

It is recommended that £49,999 over two years be allocated from the Commissioning Intentions Budget (Weight management) to fund Tier 2 weight management services.

1. The Case for Change

[8] Given the high rates of obesity in Barnet this service would cost £300K - £500K per annum if Barnet choose to fund such service.

1.1 National Context

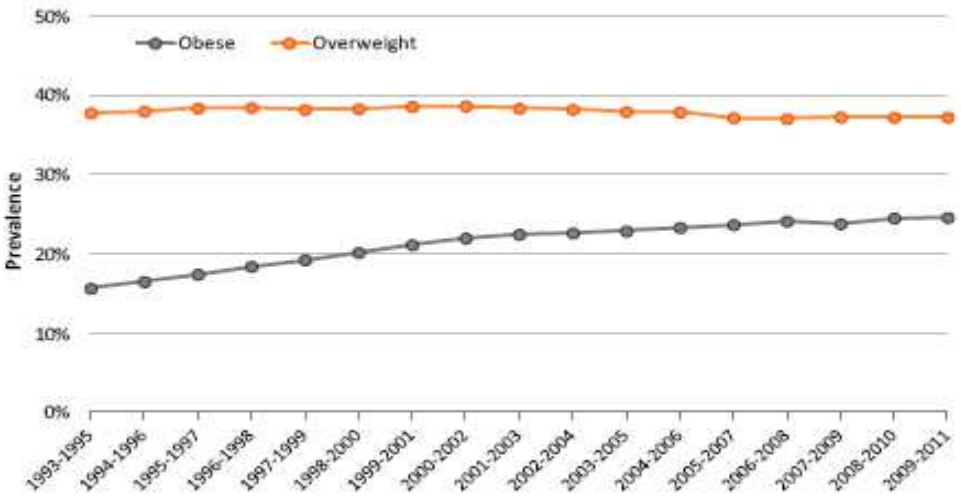
The government's national strategy on obesity 'Healthy Lives Healthy People: a call to action on obesity in England 2011' laid out a clear way forward for dealing with obesity. This built upon the life course approach supported in previous reports such as the Foresight report in 2007[9] and the Marmot Review in 2010 which advocated making the messages and support to maintain a healthy weight consistent from 'cradle to grave'. The emphasis has been to promote individual empowerment, give all partners the opportunity to reduce obesity and transfer the responsibility for prevention to local government[10].

Adult excess weight (overweight and obesity) is identified as an indicator for the Public Health Outcomes Framework 2013-16 for England[11].

1.2 Assessment of need

There has been a marked increase in the proportion of people who have been categorised as obese (BMI 30kg/m2 or over). 13% of men were categorised as obese in 1993 compared with 25% in 2011 and 16% of women were obese in 1993 to 26% in 2011 in the Health Survey for England. Over both sexes the increase has been from 15% in 1993-5 to just below 25% in 2011.

Figure 1 Prevalence of overweight and obese adults (over 16s) 1993-2011 (3 year rolling averages) England



Source: Health Survey for England

Obesity prevalence is challenging to report accurately as BMI is not routinely collected by all GP practices. It is assumed that the upward trend observed on a

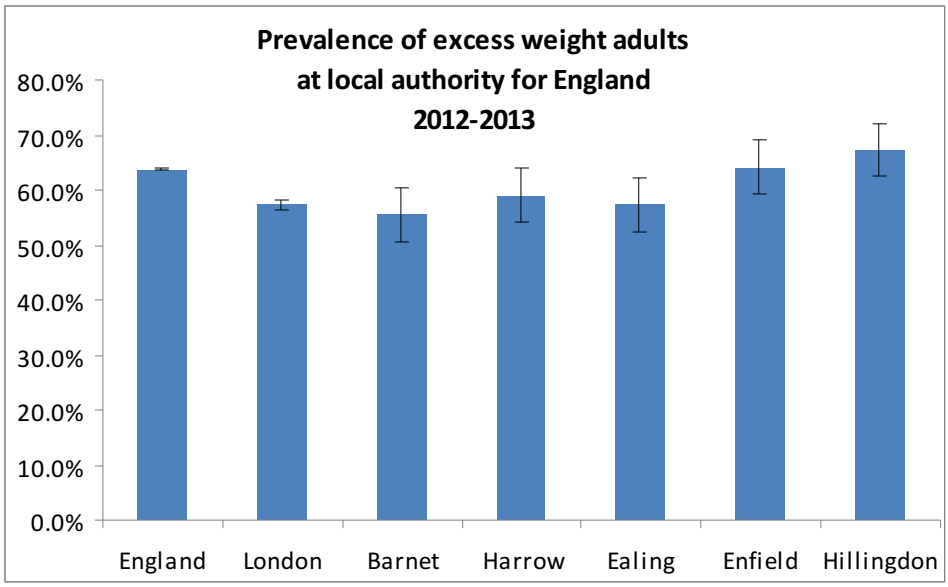
[9] Foresight 2007, Tackling obesities: future choices. Project Report

[10] Healthy Lives Healthy People: a call to action on obesity in England 2011. accessed online www.gov.uk last accessed 20/03/14

[11] http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000042/pat/6/ati/102/page/0/par/E12000004/are/E06000015 last accessed 20/03/14

national level is reflected in Barnet. Previously obesity has been estimated using the Health Survey for England sample modelled estimate. This data has been succeeded by the Active People Survey (Sport England 2012) which has a self reported weight measure for adults and reported in February 2014. It reported that Barnet has lower prevalence of excess weight (obese and overweight together) 55.60% compared to England (63.8%) London (57.3%) and neighbouring boroughs (Figure 2). However this is a self reported measure and may be subject to some under-reporting.

Figure 2. Prevalence of excess weight adults



1.3 Cost of obesity

Nationally, treating the effects of obesity cost to the NHS £5 billion a year. The wider cost to the economy is estimated at closer to £20 billion a year when factors such as lost of productivity and sick days are taken into account.

Although Barnet's excess weight is lower than the London and England average, there are approximately 160,000 adults (16+) within the Borough who are overweight or obese. This poses a significant challenge to the local economy. The total cost of overweight and obesity nationally is estimated to be £94.4 million by 2015[12].

[12] Healthy Weight, Healthy Lives: A toolkit for developing local strategies – Estimating the local cost of obesity accessed online at www.fph.org.uk 10/9/13

Table 2. The estimated annual cost in Barnet to the NHS related to overweight and obesity

overweight and obesity £ million			Estimated annual cost to NHS of diseases in Barnet related to obesity £ million		
2007	2010	2015	2007	2010	2015
85.1	88.3	94.4	44.1	47.8	54.0

In terms of social care and health, in England more than 15 million people have a long-term condition and the care for people with long-term conditions accounts for 70% of total health and social care spend. There are resource implications for the cost of social care for adults with severe obesity, for example, housing adaptations, care arrangements for those who are housebound and transport.

1.4 Evidence base for preventing and treating adult obesity

Weight gain results from energy imbalance: people are eating too much for the amount of physical activity they undertake. A balanced diet and physical activity are both essential for maintaining health. However, over the last 10 years, average adult energy expenditure has decreased by as much as 30%[13], suggesting that declining levels of physical activity are of particular importance in rising obesity levels. Obesity can also be linked to factors such as, environmental, genetic, psychological and social/cultural.

For adults, overweight and obesity are assessed by body mass index (BMI). Obese adults are defined as having a BMI ≥30 and overweight is a BMI ≥25[14]. (Please see appendix 1 for further information on BMI.) The Foresight report predicted that by 2050 60% of men and 50% of women could be clinically obese in England[15].

The effective approach to preventing and treating obesity is provided by NICE (National Institute for Health and Care Excellence), which offers guidance on how clinicians should assess obesity, what they should do to treat obesity, how people can remain at a healthy weight and how to make healthy food choices easier for everyone[16].

Evidence base for brief interventions

Evidence suggests that brief interventions lasting up to 30 mins are as effective as more intensive interventions and more effective than no intervention[17],[18]. Brief

[13] Foresight 2007, Tackling obesities: future choices. Project Report
[14] National Institute of Clinical Excellence (2006) CG 43 Obesity - Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children 2006.
[15] Foresight 2007, Tackling obesities: future choices. Project Report
[16] National Institute of Clinical Excellence (2006) CG 43 Obesity - Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children 2006.
[17] Shaw K, O'Rourke P, Del Mar C, Kenardy J. Psychological interventions for overweight or obesity. Cochrane Database Syst Rev. 2005(2):CD003818.

interventions range from a single session providing information and advice to a number of sessions of motivational interviewing or behaviour change counselling.

One of the most widely used evidence-based strategies for behavioural counselling is motivational interviewing (MI). This is a collaborative, person-centred form of guiding to elicit and strengthen motivation for change[19]. Motivational interviewing is often delivered over an extended time period[20], and does tend to take longer than giving direct advice[21],[22]. While there is evidence that a total of at least 60 minutes MI counselling is optimal, it has also been shown to be effective in brief interventions of only 15 minutes[23]. As far as possible the approach to brief interventions should be planned and consistent and follow an agreed 'care pathway' which includes a periodic follow up[24].

Evidence base for commercial weight management

There is a large body of evidence supporting commercial weight loss intervention programmes[25],[26],[27].

From an eight arm randomised controlled trial (RCT)[28] done in a primary care trust in Birmingham to assess the effectiveness of a range of weight management programmes in terms of weight loss, it was found that commercially provided weight management services are more effective and cheaper than primary care based services led by specially trained staff, such as obesity clinics, which are ineffective.

Examples of programmes used in Birmingham study are:

- Weight Watchers
- Slimming World
- Rosemary Conley

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[18] Greaves CJ, Sheppard KE, Abraham C, Hardeman W, Roden M, Evans PH, et al. Systematic review of reviews of intervention components associated with increased effectiveness in dietary and physical activity interventions. BMC Public Health. 2011 Feb;11(1):119.

[19] Stange KC, Woolf SH, Gjeltema K. One minute for prevention: the power of leveraging to fulfil the promise of health behaviour counselling. Am J Prev Med. 2002 May;22(4):320–3.

[20] Rubak S,.Sandbaek A, Lauritzen T, Christensen B. Motivational interviewing: a systematic review and meta-analysis. Br J Gen Pract. 2005 Apr;55(513):305–12.

[21] Emmons KM, Rollnick S. Motivational interviewing in health care settings. Opportunities and limitations. Am J Prev Med. 2001 Jan;20(1):68–74

[22] Bedard J. Initiate a behaviour change in 3 minutes. June 2010. http://www.lemieuxbedard.com/emc/

[23] Department of Health. Obesity Care Pathway and Your Weight, Your Health. London; 2006.

[24] Department of Health. Let's Get Moving. Commissioning Guidance. London; 2009.

[25] Truby H. et.al. (2006) Randomised controlled trial of four commercial weight loss programmes in the UK: initial findings from the BBC diet trials. BMJ May 2006.

[26] Dansinger ML et.al. (2005) Comparison of the Atkins, Ornish, Weight Watchers and Zone Diets for Weight Loss and Heart Disease Risk Reduction. JAMA 2005, 293:43-53.

[27] Heshka S. et. al. (2003) Weight loss with self-help compared with a structured programme. JAMA 2003, Vol 289:1792-1798.

[28] Jolly K et. al. (2011) Comparison of range of commercial or primary care led weight reduction programmes with minimal intervention control for weight loss in obesity: Lighten Up randomised controlled trial BMJ 2011;343:d6500 (Published 3 November 2011)

- Group based, dietetics led programme
- General practice one to one counselling
- Pharmacy led one to one counselling
- Or providing the participants with 12 vouchers enabling free entrance to a local authority run leisure centre (comparator group).

The cost of interventions below include the cost of the provider's service and the cost of the searches in general practice, invitation letters, and provision of call centre support.

Interventions	**Provider's costs (£)**
Weight Watchers	55.00
Slimming world	49.50
Rosemary Conley	55.00
NHS Size Down	70.00
General Practice	90.86
Pharmacy	90.43

The findings from this study suggest that a 12 week group based programme of weight management can result in clinically useful amounts of weight loss that are sustained at one year in unselected primary care population with obesity. The only programme to achieve statistically significantly greater weight loss than the comparator group was Weight Watchers.

Another study compared weight loss with standard treatment in primary care with that achieved after referral by the primary care team to a commercial provider in the community[29]. In this parallel group, non-blinded, randomised controlled trial, 772 overweight and obese adults were recruited by primary care practices in Australia, Germany, and the UK. Participants were randomly assigned to receive either 12 months of standard care as defined by national treatment guidelines, or 12 months of free membership to a commercial programme (Weight Watchers), and followed up for 12 months. In all analyses, participants in the commercial programme group lost twice as much weight as did those in the standard care group. Referral by a primary health-care professional to a commercial weight loss programme that provides regular weighing, advice about diet and physical activity, motivation, and group support can offer a clinically useful early intervention for weight management in overweight and obese people that can be delivered at large scale.

Commercial weight management providers are increasingly building referral schemes within the NHS yielding successful long-term outcomes. A recent RCT

[29] Jebb SA et.al (2011) Primary care referral to a commercial provider for weight loss treatment versus standard care: a randomised controlled trial The Lancet, Volume 378, Issue 9801, Pages 1485 - 1492, 22 October 2011
08 September 2011

showed that following a 12-week referral period participants maintain 4-5% of weight loss over a 12-month follow-up[30].

The most recent study examined the effectiveness of commercial weight loss programmes against Weight Watchers[31]. The programmes included Slimming World, Rosemary Conley and an NHS group programme. The study concluded that in the short-term all commercial programmes appeared to result in similar weight loss but the NHS alternative appears to produce less weight loss. At 12 months Slimming World led to greater weight loss but the differences between programmes was small and of minor clinical importance.

Moreover a study carried out by Lloyd and Khan (2011)[32] implied that commercial weight programmes produced successful weight loss between providers and deprivation quintiles. The results of the study showed that 44% of all participants achieved a weight loss of more than five per cent at twelve weeks. Conclusions can be drawn from this research that people who attended more than 10 sessions were more likely to be successful at losing more than 5% body weight. Numerous factors can influence the amount of sessions a person may attend the weight loss programme, however deprivation was not found to be a predictive factor as no significant difference was found between the deprivation quintiles. Findings proved positive within the aforementioned study, highlighting that commercial weight loss programmes can result in successful short term weight loss for overweight and obese adults.

There is some evidence suggesting that commercial weight management programmes are efficient use of resources.

An economic modelling study concluded that Weight Watchers is a cost-effective means of providing weight management services for NHS patients[33]. Another study compared standard care vs. a commercial provider (Weight Watchers) in a year long RCT[34] indicated that that it is cost effective for general practitioners (GPs) to refer overweight and obese patients to a CP, which may be better value than expending public funds on GP visits to manage this problem.

2 Summary of Options

Option 1

Do nothing

[30] Stubbs RJ et. al. (2011) Weight outcomes for 34,271 participants in a commercial/primary care weight management partnership scheme. Obesity Facts (4):113-120.
[31] Madigan et al. (2014) Which weight-loss programmes are as effective as Weight Watchers? Non-inferiority analysis. *BJGP*, 64, 620 e128-e136)
[32] Llyod A, Khan R (2011) Evaluation of Health Choices: A commercial weight loss programme commissioned by the NHS. Perspectives in Public Health 4 (131): 177-183.
[33] Trueman and Flack (2007) Economic evaluation of Weight Watchers in the prevention and management of obesity. York Health Economics Consortium, University of York.
[34] Fuller NR et. al. (2013) A within-trial cost-effectiveness analysis of primary care referral to a commercial provider for weight loss treatment, relative to standard care—an international randomised controlled trial. International Journal of Obesity (2013) 37, 828–834.

Positives:

- No cost option (retained budget may be used to fund other, higher priority works if necessary)

Challenges:

- There is a danger of widening health inequalities by not addressing obesity
- Increased risk of diabetes and other diseases
- Increased health and social care cost

Option 2

Structured and brief weight management interventions in primary care

Structured brief weight management interventions will include the following stages:

- Assessing the patient's weight status and readiness to change,
- Providing information and advice and increasing motivation to change,
- Teaching behaviour change techniques such as goal setting, self-monitoring and reinforcement[35]
- Making referrals to more intensive treatment for those at high risk
- Signposting to physical activity provisions and diet advice
- Periodic follow-up – up to 12 months - to help patients to track progress and 'problem-solve' about barriers which have arisen and how to overcome them

By using structured brief interventions health care professionals, dieticians, leisure professionals and other lay care workers can address issues associated with lifestyle or behaviour[36],[37],[38].

In many cases, referral to more intensive services may be the best option to effect long- term behaviour change. However, even in these cases, brief intervention can be crucial in motivating the patient to attend more intensive interventions and to start to seriously contemplate making a behaviour change.

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[35] Miller WR, Rollnick S. Ten things that motivational interviewing is not. Behav Cogn Psychother. 2009 Mar;37(2):129–40.

[36] Kushner RF. Barriers to providing nutrition counseling by physicians: a survey of primary care practitioners. Prev Med. United States1995. p. 546–52.

[37] Bull FC, Milton KE. A process evaluation of a "physical activity pathway" in the primary care setting. BMC Public Health. England2010. p. 463.

[38] McKenna J, Naylor PJ, McDowell N. Barriers to physical activity promotion by general practitioners and practice nurses. Br J Sports Med. 1998 Sep;32(3):242–7.

Positives

- Encourages partnership working between health and social care providers.
- Enables integration of people with existing physical activity opportunities

Challenges

- Expensive
- Maybe less effective than other interventions
- Training for primary care staff –time and opportunity

Option 3

Setting up referral systems between local GP surgeries and community-based commercial weight management services currently operates in Barnet.

Patients will be referred by health professionals based on the eligibility criteria defined by Public Health. The standards of the service will comply with the NICE obesity guidelines as follows:

- Encourage people to aim for a realistic target weight
- Aiming for a maximum weekly weight loss of 0.5-1kg.
- Focus on long-term lifestyle changes
- Multi-component addressing both diet and activity and offering a variety of approaches
- Use a balanced, healthy-eating approach
- Offer safe advice about being more active
- Include some behaviour change techniques[39]
- Providing ongoing support

Positives:

- Supported by evidence of what works
- The most effective in long-term outcomes
- Uses existing structures
- Opportunity to focus on areas of high need
- Enables integration of people with existing physical activity opportunities

[39] NICE Clinical Guidance PH43

Challenges:

- Engagement of primary care
- Unit costs based on areas where there is existing provision

Our preferred option is Option 3. The remainder of the business case focuses on this option.

The weight management services will be multi-component in line with the NICE guidelines to achieve weight loss or to prevent weight gain as single strategy approaches are less effective on their own. These will include behaviour change strategies to increase physical activity levels or to reduce sedentary behaviour, improve eating behaviour and reduce energy intake. The aim of the service is to prevent further weight gain, promote modest reductions in body weight and minimise weight regain amongst adults who are overweight or obese to improve associated co-morbidities, risk factors and quality of life.

The services will be free of charge to participants and long-term ongoing support will be provided. Services will be available locality wide and during the day, evening and weekends. Key stakeholders will be engaged in the ongoing development and governance of the programme.

3 Stakeholder Engagement

The public health team is undertaking stakeholder engagement with the development of our response to tackling obesity on a much broader basis and will incorporate this initiative within this to ensure there is cohesion with providers, the CCG and other key partners. The ways in which we intend to engage with them will vary but will include direct contact, a stakeholder event and an opportunity for service users to be involved with the development of initiatives.

4 Market Appraisal and Procurement Approach

We have engaged with commercial providers who both currently operate within the Borough and are keen to work with the Council. This proposal can be funded from the Obesity Clinic line of the Barnet Commissioning Intentions.

The cost of the proposed service is below £50,000 and so the service can be procured through obtaining a minimum of three quotations.

5 Financial Appraisal

Activity	2015/16	2015/17	Description
Target number of service users	750	0	Target number of service users benefiting from service development

Costs:	£	£	
Activity based Costs (excluding vat)	49,999		Based on unit cost of £65.00 (excluding vat) per 12 week course
Set up costs	0	0	
Net Financial Position	**£49,999**		

Anticipated service start date: 1st August 2015

Year one Part Year effect? 8 months

6 Project Plan

Key milestones - Weight Management Service	By dates
Service Specification	May 2015
Procurement	June 2015
Contract Award	August 2015

7 Conclusion

This business case sets out both the scale of obesity nationally and locally together with its effect on the health of the population and on social care and health costs. The proposed investment will build on existing commercial weight management provision across the Borough and replicate similar local authority investment across London. The proposal will also enable us to monitor and evaluate the effect of this investment and inform future investment proposals and the proposed development of the obesity care pathway.

Name of author and title

Rachel Wells – Consultant Public Health

Seher Kayikci – Senior Health Improvement Specialist

Date

24 Feb 2015

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AGENDA ITEM 8

	Health and Well-Being Board **12 March 2015**
Title	**Development of the Better Care Fund Pooled Fund**
Report of	Adults and Health Commissioning Director CCG Director of Integrated Commissioning
Wards	All
Date added to Forward Plan	January 2015
Status	Public
Enclosures	Appendix 1 - NHS Barnet BCF Plan Wave 3 Approval Letter 15-02-06
Officer Contact Details	Karen Spooner, Rodney D'Costa karen.spooner@barnetccg.nhs.uk / 0203 688 1836 rodney.dcosta@barnet.gov.uk / 0208 359 4304

Summary

NHS England approved the Barnet Better Care Fund (BCF) Plan on 6 February 2015. From April 2015, the Department of Health requires London Borough of Barnet (LBB) and NHS Barnet Clinical Commissioning Group (CCG) to pool budgets allocated for the delivery of the schemes of work stated in the BCF Plan. This will also enable LBB, the CCG and the Health and Well-Being Board (HWBB) to realise the target benefits and outcomes identified.

The amount agreed for the Barnet BCF Pooled fund for 2015/16 and detailed in the BCF Plan is £23.4m. It should be noted that this budget is not new or additional resources, but the reallocation of existing service budgets for services to a pooled fund structure.

This report updates the HWBB on progress to establish the pooled fund and the detailed principles and arrangements agreed regarding its scope and operation.

Recommendations

1) **That the Health and Well-Being Board notes the proposed approach to the BCF pooled fund for the delivery of services in the BCF Plan, prior to final approval by the Council's Policy & Resources Committee and NHS Barnet CCG Board, as noted at the HWBB Meeting on 29 January 2015.**

1. WHY THIS REPORT IS NEEDED

1.1 This report updates the Health and Well-Being Board (HWBB) on progress to establish a pooled fund for services to deliver the vision for integrated care in Barnet, as described in the Final Barnet BCF Plan (presented to HWBB on 29 January 2015) and the Business Case for Integration (presented to HWBB on 18 September 2014).

1.2 From April 2015, for BCF the Department of Health requires London Borough of Barnet (LBB) and NHS Barnet Clinical Commissioning Group (CCG) to pool their budgets allocated for the delivery of the schemes of work in the Plan. This will enable LBB, the CCG and the HWBB to determine investment and work to realise the target benefits and outcomes identified.

1.3 NHS England approved the BCF Plan on 6 February 2015. They commented that it was "strong and robust" and they had "every confidence" Barnet HWBB would ensure its successful delivery because the Plan places Barnet in a "strong position to deliver the changes described". The full approval letter is attached as Appendix 1.

1.4 Local areas are only able, under the BCF regulations, to enter into a formal pooled fund for the BCF once their BCF plans are fully approved. LBB and the CCG are now in a position to formalise the detailed principles and operational and governance arrangements for the first year of the fund.

Scope

1.5 The pooled fund for 2015/16 as described in the Plan is £23.4m (rounded). This is not new or additional resources, but the reallocation of existing service budgets for services to a pooled fund structure.

1.6 Table 1 overleaf breaks down this funding by contribution from LBB or the CCG and by type. £4.20m (rounded) of the £23.4m is allocated for protecting social care, one of the national conditions. Existing s256 spending plans for 2014/15 (£6.634m) as previously agreed by HWBB will continue in 2015/16.

1.7 As the BCF plan moves to full implementation, LBB and the CCG will also where appropriate align other budgets and report them alongside the core BCF fund, in order to review the impact of integrated care delivery against planned benefits (both financial and performance). This will include an agreed Public Heath contribution to deliver Tier 1 and elements of Tier 2 of the 5 Tier Model plus other elements still to be determined.

Table 1 – 2015 /16 BCF

	Source	Type	£000
1	LBB	Adult Social Care Capital Grant	806
2	LBB	s256 Funding	6,634
3	BCCG	Carers Breaks	806
4	BCCG	Enablement	1,860
5	LBB	Disabled Facilities Grant (DFG)	1,066
6	BCCG	NHS Funding *(Note - Includes £846K for Care Act Implementation)*	12,240
		Total	**23,412**

Pay For Performance

1.8 An important element of the pooled fund is the Pay for Performance (P4P) mechanism applied to reducing non-elective admissions (NEL) by our agreed BCF target of 1,205 patients by 31 March 2016. This equates to an estimated benefit/risk of £2.054m and is the amount of the fund at risk depending on our performance on this target.

1.9 This portion of the fund is reflected in line 6 (NHS Funding) in Table 1 above. The CCG will receive the full amount of the BCF P4P element (£2.054M) in April 2015, in the core CCG funding allocation from NHS England. However, this funding can only be released into the fund by the CCG if Barnet achieves its target reduction in NEL.

1.10 LBB and the CCG will need to monitor and report to NHSE on performance in achieving this target quarterly. If Barnet does not fully meet the target, the CCG may only release into the fund a directly proportionate amount of the P4P funding. It must use the rest of the funding in line with NHSE requirements, as detailed in the published BCF Technical Guidance or any other future guidance. It should be noted that this does not specify an alternative usage for this money.

1.11 This means the fund will need an appropriate amount of contingency funding that reflects the likelihood of this risk occurring and does not prevent either organisation from providing the services in the BCF plan. Quarterly reviews of performance will enable LBB and the CCG to determine the amount of P4P funding to be released and to revise contingency funds accordingly.

1.12 We are currently working to define the required amount and source of contingency funds required, as detailed below.

Approach

1.13 Barnet will review and evaluate the operation of the fund during the course of 2015/16. This will enable us to consider increasing the scope where beneficial and to refine operational and governance arrangements further, based on the first year's lessons learned and evolving guidance from NHSE.

1.14 Officers have established a Task & Finish Group to develop the pooled fund arrangements. The Group includes senior officers from LBB and the CCG, including finance, supported by Legal advice.

1.15 The BCF pooled fund will be established through the addition of a new Service Schedule for the services covered by the fund to the existing section 75 agreement for health and social care integration. This will be added to the S75 agreement through a Deed of Variation.

Operational arrangements

a. The HWBB Finance Group will be the pooled fund Executive, with decisions being ratified by the full HWBB as required. The fund will consist of £23.4m of funding and LBB will host it for reporting and accounting purposes.
b. The HWBB Finance Group will be responsible for monitoring progress in delivering the target benefits and outcomes in the BCF Plan and Business Case, with ongoing oversight and sign off of work and spend.
c. The HSCI Steering Group will deliver the HSCI work programme and report progress to HWBB Finance Group and HSCI Board.
d. In the first year (2015/16) there is no joint risk share. LBB and the CCG will bear their own risk as determined by their contribution to the fund.
e. In the first year there is also no joint benefit share. LBB and the CCG will instead take their benefits attributed to them as described in the BCF Plan and Business Case. The first benefits taken will be agreed QIPP Plans for the CCG and Commissioning Plan targets for LBB.
f. In the first year LBB and the CCG will be responsible for their own under or over spend against target benefits or outcomes. Both will consider any such event on a case by case basis and reach an equitable solution to rectify any issues that arise as a result.
g. In the first year budgets in scope will be aligned but effectively pooled for the purposes of progressing the delivery of planned schemes of work and for performance monitoring and reporting. During the year we will look to align more funds to increase the integration and development and impact of services to meeting target benefits and outcomes.
h. We will review performance in achieving the targeted reduction in NEL quarterly and revise P4P funding and contingency funds as a result. We will also agree immediate actions to rectify underperformance and reduce further risks to pooled funds or activities.
i. S75 Agreements for other services, e.g. for Learning Disabilities will carry on in parallel in 2015/16 but we will aim to simplify their number to bring them under the S75 Agreement for Integrated Care. This will enable us to develop the integration of all health and social care services by considering integration between the CCG and LBB in the round.

j. LBB and the CCG will review the status and performance of the fund every six months (first review September 2015) to determine if there is a case to change its scope or operations, e.g. contributions, risk and reward sharing for the following year, to be decided by the following March.

k. In principle LBB and the CCG will monitor all budgets for integrated care from the Business Case for Integration across health and social care through the HWBB Finance Group, in order to track benefits realisation. It should be noted that more work is needed to identify precisely which budgets will be monitored in this way.

Current work

1.16 Prior to the pooled fund coming into operation the following will be completed:

- Confirm the scope of services to include in the Service Schedule for the S75 Agreement, taken from the schemes in the BCF Plan.
- Finalise financial contingency arrangements.

1.17 In the first year of operation, officers will:

- Implement a process for tracking benefits and carrying out internal and external reporting as required.
- Continue to investigate longer-term options for sharing benefits.
- Investigate options to vary the amount and/or the proportion of annual contributions based on policy direction and changes

1.18 We are therefore investigating the likely size of any contingency fund required for 2015/16 and in particular the first quarter until we have a clear view of our performance in achieving our target reduction in NEL, based on:

- Our latest view of performance on NEL for 2014/15, to help understand the profile and level of risk and so contingency funds required.
- Identifying s256 and other sources of funding for 2014/15 that could be carried over or moved into to the fund.
- Forecasting committed spend for 2015/16 against uncommitted funds to date to determine if some of it could act as temporary contingency.

1.19 We will present the final draft pooled fund arrangements for 2015/16 to the Council Policy and Resources Committee and the CCG Board in March. To set up the pooled fund we will:

- Develop the Service Schedule for the S75 Agreement and request legal advisors to execute the necessary Deed of Variation.
- Work with Council Legal Advisors to extend the S75 Agreement beyond the current expiry date of August 2016 until we decide to end it or NHSE or the government change or stop BCF.
- Start work to set up the necessary performance monitoring and progress, financial and operational reporting arrangements.

2. REASONS FOR RECOMMENDATIONS

2.1 The BCF Plan underlines our ambitious plans for transforming and integrating health and social care in Barnet. It presents a clear, analytically driven case for transforming care that has been thoroughly quality assured.

2.2 BCF remains a key delivery vehicle for realising CCG QIPP plans and savings and Council Commissioning Plan priorities and savings. The Plan explains:

- How schemes contribute to achieving target benefits and outcomes and expected change in activity and financial benefit derived.
- The work done/planned to maximise the chances of meeting these aims.

2.3 All key stakeholders in the Barnet health and social care economy have been consulted on the Plan and agree with it. It demonstrates how we will use s256, CCG and LBB adult social care funding to invest in new models of care.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 All areas are required to establish a BCF Plan with a pooled fund for the delivery of greater integration of health and social care services.

4. POST DECISION IMPLEMENTATION

4.1 Work will continue to establish the pooled fund and benefits management arrangements to evidence successful delivery of target benefits and outcomes, as outlined earlier in this report.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 The BCF Plan and Business Case align with the twin overarching aims of Barnet's Health and Well-Being Strategy 2012 to 2015 (published in October 2012), Keeping Well; and Keeping Independent. There are also clear links with the Barnet Council Corporate Plan, the Priorities and Spending Review, the outline aims of Council 5 year commissioning intentions for adult social care and Barnet CCG 2 and 5 year Strategic Plans. LBB and Barnet CCG will lead delivery of the plan through the Joint Commissioning Unit (JCU) and with Public Health and partner service providers.

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

5.2.1 The BCF Plan and Business Case set out the overall investment required to implement the 5 Tier Model for integrated care and the links between it and published CCG QIPP schemes and Council commissioning plan proposals.

5.2.2 The BCF Plan details the financial contributions proposed from LBB and the CCG that will comprise the pool fund used to integrate health and social care services. Table 1 in paragraph 1.9 above details this funding for 2015/16.

5.3 **Legal and Constitutional References**

5.3.1 In 2015/16 BCF (the fund) will be allocated to local areas, placed into pooled funds under joint governance arrangements detailed in s75 Agreements for Integrated Care between CCGs and councils. Section 75 of the NHS Act 2006, provides for CCGs and local authorities to pool budgets.

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

5.3.3 The Department of Health (DH) will use the Mandate for 2015/16 to instruct NHS England to ring-fence its contribution to BCF and ensure it is deployed in specified amounts locally for CCGs and councils to use in pooled budgets.

5.3.4 The DFG is included to incorporate the provision of adaptations into strategic considerations and planning of investment to improve outcomes for service users. DFG will be paid to upper-tier local authorities in 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 DFG funding to their respective housing authorities (district councils in two-tier areas) from the pooled budget so they can continue to meet their statutory duty to adapt the homes of disabled people, including for young people aged up to 17.

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

5.3.6 DH and the Department for Communities and Local Government (DCLG) will also use Section 31 of the Local Government Act 2003 to ensure DoH 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.

5.3.7 Under the Council's Constitution (Responsibility for Functions Annex A) the Health and Well-Being Board has the following responsibility within its Terms of Reference:

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

(9); Specific responsibility for:

- *Overseeing public health*
- *Developing further health and social care integration*

5.4 **Risk Management**

5.4.1 The delivery of the schemes of work funded through the pooled fund will be delivered by LBB / CCG using recognised commissioning and programme and project management methodologies and governance arrangements.

5.4.2 This includes clear processes to identify and report on and manage individual and aggregated risks through LBB and CCG Programme Management Offices and senior management teams in the CCG and LBB Adults & Communities.

5.4.3 Specific risks relating to BCF are included in the BCF Plan and Business Case with detailed mitigating actions. These are monitored regularly in accordance with said governance arrangements and processes.

5.5 **Equalities and Diversity**

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

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

5.5.3 The specific duty set out in S149 of the Equality Act is to have due regard to need to:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

5.5.4 Relevant protected characteristics are – age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

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

5.6 **Consultation and Engagement**

5.6.1 The approved BCF Plan details all public engagement with patients or service users as well as with providers to define the schemes of work to be managed through a pooled budget arrangement.

6. BACKGROUND PAPERS

6.1 Part 1 of the Final Barnet BCF Plan approved by NHSE on 6 February 2015 was presented to the HWBB on 29 January 2015 prior to submission to NHS England on 9 January 2015. Part 2 of the Plan is available for inspection on request from the officers listed on the front page of this report.

6.2 BCF Guidance and Planning was provided in a letter dated 25 July 2014, *NHS England Publications Gateway Ref No. 01977*.

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Publications Gateway Ref. No. 02396

NHS England
Leeds
LS2 7UE

E-mail: england.coo@nhs.net

To:
Barnet Health and Wellbeing Board
NHS Barnet CCG

Copy to:
Barnet London Borough Council

6th February 2015

Dear colleague,

Thank you for submitting further evidence to clear the conditions on your Better Care Fund (BCF) plan. We know that the BCF is an ambitious programme and preparing the plans at pace has proved an immensely challenging task. However, your plan is now part of an ongoing process to transform local services and improve the lives of people in your community.

It is clear that your team and partners have worked very hard over the last few months, making valuable changes to your plan in order to improve people's care.

NHS England is now able to approve plans following the publication of the 2015/16 Mandate. As a result I am delighted to let you know that, following the recent assurance process, your resubmitted plan has been classified as **'Approved'**. Appended to this letter is your NCAR Outcome Report for your information. Essentially, your plan is strong and robust and we have every confidence that you will be able to deliver against it. This puts you in a strong position for delivering the change outlined above.

Your BCF funding will be made available to you subject to the following standard conditions which apply to all BCF plans:

- The Fund being used in accordance with your final approved plan and through a section 75 agreement;
- The full value of the element of the Fund linked to non-elective admissions reduction target will be paid over to CCGs at the start of the financial year. However, CCGs may only release the full value of this funding into the pool if the admissions reduction target is met as detailed in the BCF Technical Guidance[1]. If the target is not met, the CCG(s) may only release into the pool a part of that funding proportionate to the partial achievement of the target. Any part of this funding that is not released into the pool due to the target not being met must be dealt with in accordance with NHS England requirements. Full details are set out in the BCF Technical Guidance

The conditions are being imposed through NHS England's powers under sections

223G and 223GA of the NHS Act 2006 (as amended by the Care Act 2014). These allow NHS England to make payment of the BCF allocation subject to conditions. If the conditions are not complied with, NHS England is able to withhold or recover funding, or direct the CCG that it be spent in a particular way.

We are confident that there are no areas of high risk in your plan and as such you should progress with your plans for implementation.

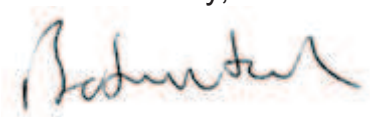
Any ongoing oversight of your BCF plan will be led by your NHS England Regional/Area Team along with your Local Government Regional peer rather than the BCF Taskforce from this point onwards.

Non-elective (general and acute) admissions reductions ambition

We recognise that some areas may want to revisit their ambitions for the level of reduction of non-elective admissions, in light of their experience of actual performance over the winter, and as they become more confident of the 2014/15 outturn, and firm-up their plans to inform the 2015/16 contracting round. Any such review should include appropriate involvement from local authorities and be approved by HWBs. NHS England will assess the extent to which any proposed change has been locally agreed in line with BCF requirements, as well as the risk to delivery of the ambition, as part of its assurance of CCGs' operational plans.

Once again, thank you for your work and we look forward to the next stage.

Yours sincerely,



Dame Barbara Hakin
National Director: Commissioning Operations
NHS England

[1] http://www.england.nhs.uk/wp-content/uploads/2014/08/bcf-technical-guidance-v2.pdf

AGENDA ITEM 9

	Health and Well-Being Board **12 March 2015**
Title	**Domestic Violence and Violence against Women and Girls Report**
Report of	Strategic Director for Commissioning
Wards	All
Date added to Forward Plan	September 2014
Status	Public
Enclosures	Appendix 1: Domestic Violence and Violence against Women and Girls Action Plan 2013-2016
Officer Contact Details	Manju Lukhman – Domestic Violence Coordinator 0208359 5625 Manju.lukhman@barnet.gov.uk

Summary

The Domestic Violence and Violence against Women and Girls Strategy and Action Plan for 2013-2016 addresses the following issues: Domestic Violence and abuse, Rape and Sexual Violence, Forced Marriage, Honour Based Violence, Gangs and Peer on Peer abuse, Trafficking, Prostitution, Female Genital Mutilation and Sexual Exploitation.

This kind of violence has a serious detrimental impact on the health and well-being of the wider local community. This affects men, women and children, not only in relation to the significant costs of the services needed but also the issues of health inequalities that develop as a result of the violence. Exposure to violence as a child has particularly negative impacts, not only increasing the risks of involvement in future violence but of substance misuse, poor mental health and chronic illness in later life.

This report provides the six monthly update requested by the last Health and Well-Being Board in September 2014.

Recommendations

1. **That the Health and Well-Being Board notes the recommendations of the completed Domestic Homicide Review (DHR A) recommendations pertinent to health organisations as set out under section 2 of this report.**

2. **That the Health and Well-Being Board members consider the way forward for the IRIS project in Barnet following the rejection by NHS England to fund this initiative.**

1. WHY THIS REPORT IS NEEDED

1.1 This report provides a six monthly update requested at the Health and Well-Being Board (HWBB) in September 2014. It is important that the HWBB is aware of the progress.

1.2 It was agreed that the Health and Well-Being Board would write to NHS England to request funding for the Identification and Referral to Improve Safety (IRIS) project. This happened and NHS England have responded stating that they are unable to provide local funding for the IRIS project but are looking into other initiatives and training opportunities. We would welcome funding suggestions from the HWBB. The need for the IRIS project was evidenced in the previous report for the September board. Barnet has very low referral rates for domestic abuses from GPs and the IRIS project has been evidenced to be extremely effective in increasing the number of referrals and improving the practice of GPs and their staff in responding to domestic abuse.

1.3 The Domestic Violence and Violence against Women and Girls Action Plan 2013-2016 has progressed (see Appendix 1). More information is contained in the report.

1.4 Following the completion of the last Domestic Homicide Review (DHR A), there were a number of recommendations for Health partners; these are included below for your information.

2. REASONS FOR RECOMMENDATIONS

2.1 The Safer Communities Partnership Board holds overall responsibility to ensure that all the Domestic Homicide Reviews and all of its recommendations are completed in a timely manner. The agencies named in the report/recommendations are responsible for delivery and feeding back on the progress made. It is vital that the HWBB is aware of any recommendations pertinent to NHS organisations arising from Domestic Homicide Reviews to ensure visibility of the issues.

2.2 **Domestic Homicide Review (DHR A)** - The Domestic Homicide Review that was completed and approved by the Home Office In June 2014 and published in December 2014 included recommendations that relate to Health. The

recommendations that follow have been taken from the Review pertinent to NHS organisations.

Recommendations

2.2.1 All Health Partners to develop a policy on domestic violence that includes a requirement that all health staff have training on domestic violence in line with their responsibilities. This should equip staff to be able to recognise when someone may be experiencing domestic violence, to enquire sensitively, recognise risk and refer where appropriate.

2.2.2 The Family General Practice to incorporate the Royal College of General Practitioners' (RCGP) guidance on responding to domestic violence into their own policy. They need to understand the role of the practice management in Domestic Violence

2.2.3 To be assured that primary care are adopting the RCGP guidance on domestic violence across all settings.

2.2.4 To commission the IRIS model to improve the early identification of domestic violence in primary health care.

2.2.5 In conjunction with the Barnet Safeguarding Adults Board and the Barnet Public Health lead, ensure that materials are available in all primary care settings promoting services for domestic violence victims and perpetrators.

2.2.6 To ensure that there is adequate guidance available for health care staff on the use of interpreters and specifically when it is not appropriate for a family member to act as an interpreter during medical consultations.

Consider a "tag and flag" system for medical records of those at risk of domestic violence. Where such notes are archived, to ensure that such tag and flag notifications are transferred along with the notes

2.3 **Domestic Violence and Violence against Women and Girls Action Plan Progress Report – There has been progress since the last Health and Wellbeing Board meeting in September 2014. This includes;**

2.3.1 Discussions are currently taking place to incorporate Domestic Violence and Violence against Women and Girls within the Joint Strategic Needs Assessment.

2.3.2 The CCG and Public Health are currently developing their FGM policy and procedures as outlined in the Domestic Violence and Violence against Women and Girls Action Plan and have organised a training session for partners

2.3.3 A Young Person's Domestic Violence Advocate has been appointed at Solace Women's Aid to support young boys and girls around their issues of being victims of domestic violence. More cases are being reported to this age group.

2.3.4 As it is recognised that the earlier the intervention could break the cycle of having continuous unhealthy relationships; hence a long term saving on the health services.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 At this time there are no other viable options available that have been explored.

4. POST DECISION IMPLEMENTATION

4.1 Work will begin immediately to implement the recommendations if approved.

5. IMPLICATIONS OF DECISION

5.1 **Corporate Priorities and Performance**

5.1.1 The Domestic Violence and Violence against Women and Girls Strategy and Action Plan for 2013-2016 addresses these issues and the new JSNA will incorporate the DV and VAWG agenda, this will also be reflected in the 2015 refresh of the Health and Wellbeing Strategy.

5.1.2 In order to aid our profile and understanding of DV we need more data from our health partners and the police. We will be addressing this through the Safer Communities Partnership Board. This would include data on:

- Violent crime, including age standardised rate of emergency hospital admissions for violence
- Rate of violence against the person offences
- Sexual violence

5.1.3 There is also a new Domestic Violence and abuse best-practice guidance 2014, established by the National Institute for Health and Care Excellence (NICE). This is not mandatory but a good practice toolkit that would be good to adopt.

5.2 **Resources**

5.2.1 The Children's Services currently commission three distinct Domestic Violence and abuse Services; providing Refuge provision, an Advocacy and Support service and a Perpetrator service. This amounts to a total of £673,217.68 in year one and thereafter £650,806.02 annually which are full funded.

5.2.2 North London Rape Crisis Service is commissioned with Barnet and 6 other North London Boroughs. Barnet were previously contributing £20,000 per year towards this. However, in 2014 no payment was required from Barnet towards this contract because this service is currently being funded by the Mayor's Office of Policing and Crime (MOPAC).

5.2.3 The key resource issue for this board is the proposal that funding be identified to support the introduction of the IRIS project.

5.3 **Legal and Constitutional References**

5.3.1 The Council's Constitution sets out the Terms of Reference for the Health and Well-Being Board. The responsibilities include partnership working across health and social care agencies to ensure that resources are directed to meet the needs of Barnet's population.

5.3.2 There are no duties imposed upon local authorities to provide specific services in respect of Domestic Violence against women and girls, but there are overarching duties to provide relevant community care services and to address safeguarding concerns as well as specific child protection duties. The Board is subject to the Public Sector Equality duty in s149 of the Equality Act 2010 when exercising its functions and must have due regard to the need to eliminate discrimination and advance equality of opportunities as required by that duty.

5.4 **Risk Management**

5.4.1 It is important that the Health and Wellbeing Board support the work as the Domestic Violence and Violence against Women and Girls agenda needs the highest possible strategic profile and effective partnership working as there is major health, economic and social consequences of violence. A significant risk is that there is currently under reporting of domestic violence and abuse particularly from health colleagues and agencies. This is evidenced by the multi-agency risk assessment conference (MARAC): within Barnet that deals with high risk Domestic Violence cases. In the last financial year they only received 7 referrals from the health sector out of a total of 234 cases, suggesting significant under-reporting. According to CAADA this is low, considering the size of the health sector.

5.4.2 In the same financial year 2013-2014, the health generated referrals received by our Domestic Violence commissioned services through Solace Women's Aid were very low as well. Out of a total of 1012 referrals only 16 were referred by the Health sector which is low. This risk could be mitigated somewhat by the introduction of the IRIS project.

5.5 **Equalities and Diversity**

5.5.1 Domestic violence and abuse and violence against women and girls disproportionately affect women, although some men are affected as well. It is claimed that 1 in 4 women experience some form of domestic violence and abuse; this cuts across all classes, faiths, ages and ethnic communities.

5.5.2 Recent work has highlighted that there are certain communities, such as Black minority ethnic and refugee (BMER), Lesbian gay, bi-sexual and transgendered (LGBT) and people with disabilities that experience additional barriers to reporting incidents and barriers to accessing services. It is with these concerns that the equalities and diversity issues need to be addressed.

5.5.3 The Domestic violence and abuse definition has lowered the age to 16 years from 18 years so younger teenagers can be supported appropriately. Within

the Children's services the Safer Families Team provides support for women who have children under the age of 11 years old around domestic violence. Also Solace Women's Aid provides support for women and children over the age of 11 years old. However, there are no specialist DV support services for victims under the age of 16 years old who currently need to be dealt with by MASH and family services. There is a Young Person's Advocate that has taken on the role to support 16 – 18 year olds who are experiencing domestic violence.

5.5.4 The latest domestic homicide review in Barnet highlighted the difficulties for older people in accessing support services for Domestic Violence and mental health issues and this must be considered in future service delivery.

5.6 **Consultation and Engagement**

5.6.1 There is a Domestic Violence and Violence against Women and Girls Forum in Barnet, with an independent Chairperson. The members are diverse and include a range of agencies and people who live, work or study in the borough. They have been widely consulted and have approved the transitioned approach from addressing Domestic Violence only to expanding the agenda to include Violence against Women and Girls more generally.

6. BACKGROUND PAPERS

6.1 Domestic, Health and Wellbeing Board 18 September 2014 item 11; https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=177&MId=7782&Ver=4

6.2 Domestic Violence and Violence against Women and Girls Strategy 2013-2016; http://www.barnet.gov.uk/downloads/download/381/barnet_domestic_violence_strategy

6.3 IRIS Commissioning Pack Information; http://www.irisdomesticviolence.org.uk/iris/uploads/documents/IRIS_CommissioningPack.pdf

6.4 Domestic Homicide Review Report (DHR A); https://services-for-schools.barnet.gov.uk/citizen-home/housing-and-community/domestic-homicide-review-dvhr.html

London Borough of Barnet Domestic Violence and Violence Against Women and Girls Action Plan

(2013 – 2016) Progress Report for March 2015

Strategic objective **1. Partnership –** Ensuring that the coordinated community response model to Domestic Violence and Violence Against Women and Girls (DV & VAWG) is developed and implemented locally						
	Activities to fulfil objective	**Actions and Updates**		**RAG Rating**	**Comments**	**Lead Officer's Names**
1.1	**Review and revise DV strategic framework and governance** to **reflect DV & VAWG changes.**	• Confirm DV & VAWG governance arrangements The DVOPS Board and the DVSB Board have merged into the; 'DV and VAWG Delivery Board'. A new Draft Terms of Reference have been produced and agreed. • Confirm arrangement with Safer Communities Partnership Board (SCPB) and Barnet Safeguarding Children's Board (BSCB) and Adults Board (BSAB) KV presented a paper to the BSCB on 26.11.14, outlining the strategic alignment of these boards. A structure chart has been produced and key managers provide the links by sitting on the boards. Agreed more discussion needs to take place to ensure that the boards work alongside each other. • broaden membership (including Health and Well Being Board (HWBB) A report outlining this was presented at the HWWB meeting on 18th September 2014. The recommendations were approved and the HWWB also wrote to NHS England requesting resources for the IRIS project (still awaiting response). An update report on the DV and VAWG work is going to be presented at the next HWWB on 12th March 2015. • Secure strategic engagement with public health and Barnet Clinical Commissioning Group (CCG) To be discussed • CCG is supported to identify a DV & VAWG strategic lead This is Heather Wilson CCG		AMBER		
1.2	**Ensure DV & VAWG is included in reviews of**	• The borough has a comprehensive outline of DV & VAWG as a health and wellbeing priority This still needs to be discussed with the various partners, to decide who leads on this		AMBER		

	JSNA, HWWB, and CYPP.	• DV & VAWG is included in strategic planning This still needs to be discussed with the various partners, to decide who leads on this • Understanding and acknowledgement that DV & VAWG is a health priority This work needs to be aligned as a priority as the new health commissioning contracts started in March 2014. • ML to send the JSNA document to the board members ML sent the JSNA to the Delivery Board members. A meeting took place on 12th September 2014 to discuss this with LBB and Public Health partners. The JSNA is a rolling assessment and topics can be added alongside. Agreed to scope the addition of DV and VAWG if possible. • The JSNA should inform the board of the DV & VAWG priorities; to develop this strategy going forward. To align the work across the boards. The DV & VAWG Delivery Board will identify issues that arise out of the JSNA. Still to do • To establish the commissioning intentions of the CCG and Public Health The Royal Free Hospital have introduced DV health screening as a KPI. To discuss if this can happen in Barnet • To get a copy of the HWWB Plan. Here is a link to the Health and Well-Being Strategy: http://www.barnet.gov.uk/downloads/download/1056/barnet_health_and_wellbeing_strategy http://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=177&MId=7570&Ver=4			
1.3	**Review and audit all multi agency data for DV & VAWG**;	• A local picture of DV & VAWG is established • The borough has a better understanding of DV & VAWG issues, such as knowing the level of sexual exploitation, FGM, forced marriage or trafficking in Barnet. To be informed by local and accurate data that the Partners supply regularly. To agree with partners data set priority areas; the outcomes and Key performance indicators for three years and embed in action planning.	AMBER	To consider other data as all victims do not report to the police. To include	Peter Clifton, LBB.

		• Include police performance on DV and all aspects of VAWG to be available for the partnership to analyse • Improved understanding and knowledge of the issue of DV & VAWG locally • To conduct a multi-agency intelligence gathering and audit of the nature and prevalence of DV & VAWG in the borough The Strategic Crime Needs Assessment (SCNA) has started. To map out DV hotspots and provide police evidence to DV. KV to discuss what relevant data can be used. Peter Clifton set up a Task and Finish Group meeting on 11th July 2014 to start benchmarking the data. This needs to be followed up with another meeting by PC.		partner agencies data. To organise a launch event	
1.4	**Domestic Homicide Review processes and arrangements are effective and in line with the Home Office guidance** **Completion of action plans arising from Domestic Homicide Reviews and learning events.**	• To reduce the risk of DV homicides. The domestic homicide review process works effectively and all the processes are in place. Local arrangements are in place for chairing and coordinating reviews. LBB has decided that the funding is decided individually based on the homicide review case and which agencies are involved. There are current issues around the completion of IMRs from GP practices and how this is funded; this is a gap at present that needs to be addressed. MOPAC have agreed that if a Community Safety Partnership (CSP) identifies that a domestic homicide has taken place, the lead can email VAWG@mopac.london.gov.uk to notify MOPAC and request up to £2,000 towards conducting the review. HW and ML will set up a meeting with Public Health to resolve this issue around GPs. Learning sessions or events are held when necessary, with reviewed action plan • Findings are to be shared across the SCPB • The borough is able to learn the lessons of any review in order to deliver changes to improve services and the multi agency response to DV • Home Office have produced a 'lessons learned' paper. The DV & VAWG Strategy Board to consider this. To establish if there are national learning events taking place. ML sent this to all board members The Current completed DHR is being monitored via this delivery board around its actions and a report went to the SCPB on 31st October 2014; KV to provide an	GREEN	There are issues of delays from the Home Office on the quality assurance feedback. Agreed that the Chair of the SCPB will write to the Home Office re these delays; to include which agencies agree to this.	Kiran Vagarwal and Manju Lukhman, LBB

		update. All the DHR processes are in place for Barnet and functioning well.			
1.5	**Produce and implement an employee DV policy for the local authority and partner agencies and commissioning bodies. Include DV in council HR policies. To ensure that there is staff training available every year and include information in staff induction packs.**	• LBB and all partner agencies to explore the introduction of a DV policy for staff, or check by May 2014, if they have a policy in place. • LBB to Link with LADO procedures. http://www.barnetscb.org/lado LADO Info sheet personal life FV LS.do • To arrange staff briefings, induction and awareness campaign for staff to know about and understand the policy • Feedback from staff affected and supported by the policy (including perpetrators) • Staff and managers supported and equipped in responding to DV concerns in the work place • For increased victim safety • Perpetrators within the workplace to be held accountable for their behaviour • Corporate response which highlights DV as an organisational priority • Improved productivity and reduced absenteeism as a result of DV ML spoke to LBB HR and they advised that no separate policies can be introduced and a 'Keeping Safe' policy will be introduced; possibly reference to DV could be made within this? ML has tried to get an update from Capita, but has had no response. DV Policy in place for the Metropolitan Police Service, under the Directorate of Professional Standards. The Police are named and shamed if dismissed for being a DV perp. The London Fire Brigade, Solace Women's Aid and MT to share a copy of their Policy with CommUnity Barnet, who also have a DV Policy. The Substance Misuse Commissioning Team are looking at implementing one for staff. There are gaps with other partners including Health. Probation are going to check and feedback. To explore what the Voluntary sector have in place. CommUnity Barnet to do this. CB already did a mapping of DV in the Vol. Sector, to provide a copy of the results.	RED	Agreed that JP, as the Chair would send a letter to the health partners and Capita to explore their proposals to introduce a DV Policy.	

Strategic objective **2. Prevention –** changing attitudes and preventing violence, awareness raising campaigns, safeguarding and educating children and young people, early identification/training and training				
	Activities to fulfil objective	**Actions and Updates**	**RAG Rating**	**Comments**
2.1	**Plan, highlight and promote information about the multi agency DV & VAWG work (Communication)**	Year 2 (Safeguarding Month group and CCG and Public Health) • Prioritise new elements of DV & VAWG e.g. young people, stalking, forced marriage. • Ensure DV & VAWG are incorporated in corporate information and publicity including website and the Community Engagement Plan. • Review information available for health • Deliver community engagement events: White Ribbon campaign; Safeguarding month, International Women's Day. Some events took place at Brent Cross shopping centre with JWA, DVIP and SWA for White Ribbon. ML is reviewing the Multi agency training programme for professionals and is hoping to commission in 2015/2016; Domestic violence level 1 and 2, to explore including sexual violence; the MARAC training. Forced Marriage and Honour Based violence training, level 1 and level 2. Promotion through International Women's Day and White Ribbon events • To deliver education campaigns, promote 'This is Abuse' website, to raise awareness borough wide and monitor progress. There are talks to plan an event aimed at the public (women only) for international women's day on 6th March 2015. • Partners will tailor this through their own channels • Joint budgets to be agreed for campaigns with different agencies	AMBER	

		• Practitioners' referrals increase and an increase in reporting levels and residents know what help is available and feel confident to disclose/report, to increase awareness and community confidence. • Ensure community engagement work and hard to reach groups is captured. • Feedback from service users on where they found out about the services. • Barnet achieves white ribbon town status • To contact Middlesex University re student experience for design. ML contacted Middlesex University and a range of applicants applied for this role. ML is preparing a shortlist was going to interview the interns in October 2014, but they cancelled this, to be arranged again. ML has contacted them and has no response at all. KV will propose to the SCPB that a small working group is set up to promote this in the community, alongside their community engagement plan.		
2.2.	**Secure DV expertise in MASH**	• To monitor the number of Police MERLNS where DV is identified and advice given/referral made Police MERLINS are counted in the overall referral source. EF does not know if they can be matched to the reason for referral, in this case DV, EF to check • Effective safeguarding processes for children and young people affected by DV are operating within MASH so that interventions are timely and appropriate to manage risks The MASH operational process is a multi-agency safeguarding process, with partner agencies sharing information including information regarding DV to ensure thresholds are correctly applied and the appropriate service is triggered, e.g. DAT / Safer Families • To track and audit the level of DV cases coming through to the MASH by April 2014. DV is being recorded as the main referral reason, or as one of the risk factors in the family during the MASH process. In cases passed to CSC the Factors tab is also updated by DAT at the end of their single assessment so if DV was not known at the referral stage and it is picked up during the assessment it will also be recorded. EF will ask if we can have a report on this.	AMBER	

		• To monitor the number of cases with the MASH and MARAC MASH monitoring is as described above. MASH also record on a Contact for information only, if there are adults with children on the MARAC list. Discussions have taken place around the MARAC and MASH process; this is in the protocol, but needs to be explored further. The MASH remains the single point of entry for all new referrals, including MARAC, MASE and MAPPA. The internal protocol below;  MARAC and MASH Protocol Information 2 It had been agreed that Solace Women's Aid (DV Commissioned providers) would be co-located every three weeks on the morning of the MARAC meetings, within the MASH team, to advise on DV within the MASH. The SASS Barnet Service Coordinator was attending the MASH every three weeks; but have now decided that this is not the most efficient way, so this arrangement has now ceased. JM and JP are going to have a meeting in January 2015 to resolve this issue.		
2.3.	**Work with the Family Nurse Partnership (FNP)** programme to ensure they are engaged through training on DV risk assessment, recording of domestic violence on case system and referral of appropriate cases	• To monitor the number of referrals made from: - Family Nurse partnership to DV services - Family Nurse Partnership to MARAC • Completion of DV training and training evaluations. • Number clients identified as experiencing DV through completion of CAADA DASH risk assessment tool. • Young women who have experienced domestic violence who are pregnant/recently given birth are appropriately supported and risks managed. • The MARAC Coordinator to deliver training to the FNP staff and work to increase referrals to the MARAC. MYC did a briefing/training session for the FNP staff on 12th June 2014 at Edgware	RED	To capture data to seek out health and vulnerability needs. To see what the cohort is.

	to MARAC	Hospital. ML to meet with the FNP and confirm the age group they work with? They work with all under 20 year olds. • To make contact with the Young Person's Outreach nurse at Barnet and Chase Farm Hospital Alice Milman is now progressing this as the YPVA from SASS Barnet and provides us with all the agencies that she covers. Postcards have been produced for the young boys and girls to access the service too. FNP Barnet work with all first time pregnant young girls under 20 years of age, living in Barnet. They use the Power and Control materials to identify DV and other materials. All clients identified at risk or experiencing DV are referred where necessary to MASH/ MARAC and safer families. Identify clients with FGM and ensure appropriate support and signposting All staff undergoes level 3 safeguarding training annually and other relevant training, the supervisor is level 4 trained. Also all staff have weekly supervision with team supervisor and also quarterly supervision with named nurse. Need to consider how FNP share data with LA regarding DV as presently use Open Exeter database; however any referrals should be identified form referrer. Mee Cheuk to update team in 2015- DT to forward dates of meetings Data from FNP= 33% of clients reported physical or sexual abuse in last 12 months (active clients = 91)- these clients will have been referred by Social care or FNP- where necessary In November 2013 the Sexual Health Nurse jointly delivered MARAC training session to 9 medical staff. In June and October 2014, 3 MARAC briefing sessions were delivered to 35 community Health practitioner's including19 Health Visitors. A meeting is rescheduled for 23rd January with FNP Leader to increase staff awareness around the MARAC. SM raised her concerns about those within a broader remit, i.e. may have a 2nd baby but be under 20 years. The Health visitors are strictly licensed to refer?		

		Do FNP look at CSE issues? On the initial assessment, on a new birth visit, what DV questions are being asked and explored, on subsequent visits as well?		
2.4	**Maternity** Work with health services to scope what is in place, and gaps, for maternity services & midwives relating to DV	(Year 2) Barnet and Royal Free Hospital Trust, Barnet Children's Services, Designated Nurse, CLCH and the MARAC Coordinator • To map provision and the gaps identified. • To liaise with ante-natal and Midwives and to progress with all of the Safeguarding Leads at all of the hospitals and the IDSVA at Royal Free Hospital • The MARAC Coordinator can provide 'information briefing sessions and training' within a hospital setting. The MARAC Coordinator and the Domestic Violence Coordinator have delivered over 20 training sessions for midwives and GPs. ML and MT (SWA) met with the IDSVA and the Safeguarding lead on 3rd September 2014 to discuss their services. There has been a 100% increase of DV referrals since the co-location of this role. (Data will be provided once received). To see if this model can be replicated in Barnet.	AMBER	
2.5.	**Training Programme (i) Children's Service practitioners encouraged to attend DV & VAWG training** with focus on new Home Office definition of DV including 16 – 17 year olds and extending definition to include coercive	(Partnership contribution will need to be agreed) • Map out forums and communication opportunities for schools, youth services, and Children's Social Care. • Monitor the number of Children's Service practitioners that attend DV & VAWG training • To develop an Action plan established for engaging with children's and youth services • Investment/resources secured for school DV & VAWG prevention programme Tender, a training organisation have delivered workshops to 4 secondary schools; Whitefield, Compton, Childs Hill and Woodhouse College; on healthy relationships and the	. AMBER	

	control and implications for practice Year 2 **Training Programme (ii)** Strategic Groups and partner agencies to jointly commission a comprehensive DV & VAWG training programme for the borough	 LC Consortium Letter for Primary Schools.pc violence prevention project. Face Front Theatre delivered a session to some students from Martin Primary, Manor side and Oak Lodge schools • Proposal paper drafted and presented to relevant boards • Partnership agreement secured to jointly commission training programme • Training programme delivered ML has commissioned the following providers to deliver workshops around healthy relationships in schools for 2014/2015/2016; Face Front Theatre to deliver two workshops on SexFM in schools Youth Shield to do four schools, which is Hendon, London Academy, Wren Academy, Totteridge Academy Tender to do one workshop Just Enough UK to do ten workshops on anti-slavery JWA also deliver on-going training in Barnet, which includes GPs. LBB have organised and commissioned Level 1 and 2 DV training for multi-agency staff • Number of sessions and delivered and staff trained • Increase in referrals and reporting across the partnership • Children's Social Care, school support staff and youth workers understand DV & VAWG as it relates to children and young people and clear of safeguarding responsibilities • Staff understand the dynamic of "dating" violence and know how to respond to concerns and disclosures • Improved understanding of domestic violence • Increased safety of people and young people experiencing DV • Increase in referrals from Children's Service for children and young people		

		affected by DV & VAWG • Develop specification for work with 16/17 year olds. A presentation was organised and Information was delivered to the DV and VAWG Forum by AVA in 2013, on the 16 years old definition changes. • Timely safeguarding interventions • Barnet has a skilled and knowledgeable workforce which is equipped to respond appropriately to DV & VAWG • To contact national VAWG organisations such as Ascent, to explore if they can deliver training for multi-agency staff. Ascent Project Partners attended LBB's DV & VAWG Forum in March 2014, to provide information to the members. The June meeting had an update from the Eaves project on Exiting Prostitution and Trafficking. The October meeting had an update on Forced Marriage and Honour Based violence. The January 2015 meeting had a presentation on Trafficking from the Central Govt. commissioned providers, the Salvation Army. • Tender to deliver a further programme to a primary school • Agreed to set up a communications and training Task and Finish sub Group. Radlamah from Barnet Homes to Coordinate this. Radlamah has advised that she is not in a position to coordinate this piece of work. ML met with the Safeguarding Adults and Childrens Board Learning and Development Sub Group on 11th September 2014 to discuss the new DV definition and training for staff.		
2.6	**Men and boys** Map how men and boys are affected by the same issues impacting upon DV & VAWG	• Needs analysis established through the re tendering process • Men and boys receive a safe and appropriate response from services working on DV & VAWG The DV Advocacy and Support Service provide services for men through a male IDVA service.	AMBER	
Year 2				

2.7.	**Work with Public Health** to raise awareness of, and develop appropriate response to the issue of DV and VAWG issues including, Female Genital Mutilation (FGM). Health to devise and implement a FGM Strategy sub group.	• To monitor the number of women supported around FGM concerns Formal data collection on FGM procedures was not available until September 2014. All acute trusts are now reporting numbers to NHSE of women identified as having been subjected to FGM. • To monitor and increase the number of Safeguarding referrals for advice on the issue of FGM • Women who have experience FGM to receive sensitive care from a knowledgeable workforce Barnet SCB has now agreed that women who have had FGM performed historically and who have female children to be referred to the MASH. Working group is currently being set up to take this forward. • Timely safeguarding advice and referrals made for girls who are identified as being at risk of FGM Babies born to mothers with a history of FGM or at risk in BCH are sometimes referred to MASH and this is very inconsistent. There is currently, inconsistent approach across Royal Free Hospital and the Barnet and Camden sites. Public Health are currently organising FGM training for multi agencies and the BCSB are monitoring this piece of work. At present girls considered to be at risk of FGM i.e. those that the mother states that she may consider FGM in the future or may be under pressure to have procedure on her child are referred to MASH. • Increased awareness and understanding of health implications of FGM and that it is a criminal offence Conversations currently take place are held with woman who has had FGM performed and she is made aware about the legal status of the procedure by health professional usually a midwife dealing with her care. • To map out and share information on referral pathways. • To establish a lead in health to lead on this action, CLCH, CCG or Public Health? • To explore how to do prevention work. • To propose adding this to commissioning contracts	AMBER	

		Public Health's role will be of a facilitator capacity. Appropriate commissioners to take leadership of the agenda. Various options are being considered with public health colleagues to promote awareness of FGM in Barnet. • To contact all the ante natal clinics, hospitals and midwives, GP practices and schools in order to raise awareness. Issue of FGM is raised in GP safe guarding training and is discussed in CCG provider safeguarding meeting where provider updates are discussed. Further training to teachers, Mosque leaders etc. are also being explored. • To contact Comfort Momoh, specialist in FGM clinic at Guys Hospital. • Police to explore why there have been no criminal convictions? FGM • ML to coordinate a meeting with Health reps, to clarify if a health strategy is needed or not? (Donna Thornley to provide contact details to ML) This is Celia Jeffrey's at Barnet and Jude Bayly at Royal Free Data systems do not consistently record information on FGM to make the identification of girls at risk of FGM easier; nor is information on FGM shared formally and systematically between professionals and organisations best placed to protect at risk girls, when they are least able to ask for help. It is considered to be good practice to share information regarding mother's FGM status between health professionals. Work is currently being carried out at NHSE regarding recording of information on mother's FGM status on birth notification to GP and health visitor. CLCH are developing a website for school nursing which includes FGM, DV and supports staff and children to increase awareness It is being proposed that any new mother who has undergone FGM should receive a consultation with an appropriate health professional at hospital before discharge and their conversation gets noted in her GP records. To refer all new mothers who have undergone FGM to Multi Agency Safeguarding Hub (MASH) who is then supported by an outreach worker.		

		The above two points has been proposed and is currently under discussion. NHS England are due to be publishing updated guidance on FGM which is due by end of December 2014, until then the advice from NHSE is to have local arrangements. SM advised that MASH referrals will be made on children. They are arranging a FGM conference, date TBC. Celia Jefferies is delivering training on referral pathways. There is a Task & Finish Group on the FGM Policy. To explore why there is a lack of police convictions.		
2.8	**To address and consider all the equalities aspects of supporting DV & VAWG, including;** **Work with lesbian, gay, bisexual and transgender and disability organisations to raise awareness of DV & VAWG and the local MARAC to help increase referrals from these groups and reporting from vulnerable**	• To do work with schools and young people. • To develop equalities data sets and guidance will be issued to the partners following this. • To increase LGBT referrals into the MARAC • Increase in referrals to DV services for these victim/perpetrator groups • Increase the number of individuals, practitioners who are trained and briefed, with feedback from sessions ML has met with; Stonewall, ELOP, Community Barnet, the Police Borough LGBT Liaison Officer, the LGBT centre in Enfield, GALOP and Broken Rainbow. This was to identify and work with this specific community. ML has been advised that there are no organised groups, centres, buildings, social spaces, pubs, clubs etc. in Barnet. Therefore, the community are difficult to identify and work with. I spoke to Pan London agencies to see if they had reports from anyone in Barnet and there are none. This action is difficult to progress and needs some discussion. Solace and Community Barnet are going to arrange an event. There was a health watch and LGBT meeting event organised for 19.2.2015 to discuss setting up a reference group to consult on all issues. Community Independent Living Manager about the MARAC and sent MARAC training information to CIL for circulation to their contacts for interest. Community Barnet was not able to provide a list of member agencies in the voluntary sector but they were happy to publish MARAC information about MARAC	AMBER	Monica Tuohy and Julie Pal to lead on the LGBT event. JP to provide a list of Disability groups and the Learning Disability Network to ML to contact. ML to visit BCIL with CC.

	groups	briefing and training sessions available to agencies that are interested, in their newsletter. Information was sent to Community Barnet in January 2015. ML has set up a complex sub group to address the needs of mental health, substance misuse and DV. The issue of disability is also being discussed within this; as there are gaps in services for victims and perps.		
2.9	**Scope Forced Marriage, Trafficking and Prostitution as an issue locally with a focus on the children, young people and supporting people**	• Identification of individuals at risk of forced marriage, trafficking and prostitution • Increase the number of referrals to specialist support services and MARAC on FM, trafficking and prostitution cases • Increase the number of staff trained on forced marriage and safeguarding responsibilities with feedback from sessions • Number of disclosures and referrals made concerning forced marriage and honour based violence, in increased referrals to specialist support services • To understand gaps and increased safety of victims identified in their groups through timely and effective support being provided. ML met with Eaves to discuss if there were any cases reported to them as the specialists and there were none identified. This needs to be progressed. We invited Imkaan a specialist project in FM/HBV to address the DV and VAWG forum and they are going to be commissioned to deliver training on this topic.	AMBER	HW to provide info on Brothels and sexual health info to ML. Paula Light and Kiran Vagarwal to provide info on call outs to Trafficked women.
2.10	**Ensuring staff who work with people with learning disabilities understand the dynamic and risk factors of forced marriage**	• Improved diversity of cases discussed at the MARAC • Early intervention for these particular victim groups • Effective and timely safeguarding action • Increased safety of persons at risk of forced marriage • Multi-agency response to forced marriage in place • Skilled and competent workforce equipped at dealing with disclosures and concerns of forced marriage, an increased awareness of staff of these issues through training, so they can identify and can correctly respond to any concerns of forced marriage and “honour” based violence “on the very first occasion”	AMBER	

		ML met with Imkaan a specialist agency around this issue on 14th October 2014. Discussed Health and Social Care commissioners to address the gaps in these DV services. To see if this can be incorporated into the contracts. If so, decide how it can be monitored.		
2.11	**Support the Domestic Violence & VAWG Forum to engage with under represented groups such as local faith communities**	• To organise a training session or organise an event • To incorporate the Faith forum into the local response to DV & VAWG and deliver the AVA Project praying for peace toolkit (to check costs for toolkit). It is £10.00 • Link with Faith & Culture sub group BSCB Engagement with faith forum and work on the toolkit agreed. Discussed the difficulties of trying to engage them. NB is going to invite them to the FGM conference.	RED	To present to the SCPB that this is a gap.

Strategic objective **3. Provision –** helping women and girls to continue with their lives (effective provision of services, specialist services and support; emergency and acute services; refuges and safe accommodation)					
	Activities to fulfil objective	**Actions and Updates**	**Timescale for completion Resources required Measurement Expected outcomes**	**RAG Rating**	**Comments**
3.1.	**Secure funding for Rape Crisis service for 2013/14 and re-tendering for 2014/15**	• Borough contribution 20K agreed for 2013/2014 and this has been paid. No payment required from Boroughs in 2014/2015. The tendering has completed and been awarded to Solace Women's Aid for two years until 2016. (This is in conjunction with MOPAC and the MOJ; in consortium with 6 North London Boroughs)		GREEN	

3.2.	**Re-commissioning** Review service provision and capacity for re-commissioning of borough's work on domestic violence and VAWG services within VAWG agreed priorities. Including a local community DV perpetrators programme Map proposal for an Independent Domestic and Sexual Violence Advocacy Service provision available in both a community and court based settings	• To review the existing service provisions and agree to protect and secure the existing DV services • To carry out a Needs gaps analysis to help inform service commissioning process and review the need to expand services to incorporate all the VAWG areas when commissioning. • To increase the number of men who are referred and complete the perpetrator programme • To monitor the repeat victimisation rate • To develop services for victims of DV & VAWG so they are able to access specialist services for help and support when they need them • To explore funds through the Children's Service Domestic Violence commissioning budget plus additional contribution to be agreed from the partnership members? There are 3 DV Services; Advocacy and Support, the refuges and the perpetrator service There are 3 commissioned IDVAS, one of them PT working alongside the Specialist DV Court (SDVC) It has been agreed to extend the current contract with Solace Women's Aid until 2016; when the contract will be re-commissioned. The only variation has been is that Jewish Women's Aid have given up their refuge space, but this has been taken over by Solace Women's Aid. JWA will have their own self-funded refuge space. A Service review is due to take place on all of the three services between October –March 2015. A gaps analysis will take place next year 2015. MOPAC are also commissioning a pan London DV service to make up the shortfall in IDVA posts in boroughs. More information will be available after April 2015, when the contract will be awarded. Barnet Homes alongside LBB and Solace completed a funding bid to DCLG for funds for an additional refuge. We bid for 6 spaces and will be notified by end of February 2015.	GREEN	

3.3.	**Review the CAADA MARAC quality assurance findings** and audit the current workings and effectiveness of the MARAC and develop an Action Plan	• To develop regular MARAC training sessions and resources There are free multi agency training sessions set for 2014/2015. The MC can also deliver external briefings or training sessions to any partner agency. There is a particular focus on health and youth at the moment; to encompass the change to include 16 year olds. • To increase in safety for high risk victims of DV • The MARAC steering group to oversee delivery of the plan and ensure that the MARAC is operating to the required standards as set out by CAADA CAADA carried out their review and a MARAC Action Plan is in place. This is currently being monitored and progressed to increase safety. MARAC members had agreed. CAADA's report on our Barnet MARAC self-assessment. The recommendations are included in the MARAC Action Plan (2015-16).	AMBER	
3.4.	**Independent Sexual violence advocacy service** Map our proposal for an Independent Sexual Violence Advocacy Service provision available in a community settings	To scope this alongside the Rape Crisis service data and police data via the Sapphire Team. To develop evidence and see if can apply for MOPAC funding? MOPAC are developing some funding bids, not sure if the posts can go towards an IDSVA, yet, but TBC.	AMBER	
3.5.	**Housing**	Barnet Homes • Barnet Homes representative to be invited to DV & VAWG Forum. Input from the revised DV & VAWG Delivery Board and the DV & VAWG Forum has been completed. • Work with Barnet homes on development of DV policy; revision of tenancy support and eviction action for perpetrators • To develop feedback from service users/tenants	AMBER	

		• To ensure the staff workforce is trained and able to respond to concerns of domestic violence raised by tenants in a timely and appropriate manner Staff across The Barnet Group have been consulted re. The refresh of The Barnet Group's DV Policy & Procedure. LBB Safeguarding events were well promoted to and attended by TBG staff, including regular blogs on the staff intranet about DV and learning from events. • To monitor the range of actions and the number of evictions action taken against perpetrator • To increase the DV incidences reported • Perpetrators are held accountable for their behaviour through tenancy action • Improved understanding of the issue of domestic violence through the analysis of data that is collected from these services • Sanctuary officer in post. • To review housing services provisions and provide housing DV data. • Housing are going to provide additional actions to be included. • Review and revise the service wide response to all aspects of DV & VAWG All the actions above have been completed apart from addressing the issues around actions towards perpetrators **Housing's new objectives;** • Ensure staff are trained & equipped to respond effectively to customers affected by DV & VAWG • Complete DV & VAWG housing gap analysis and/or benchmarking exercise A good practice visit to Haringey Hearthstone (DV service for those in housing need) took place in November • New Code of Guidance for Domestic Abuse and Homelessness (issued by DCLG November 2014) reviewed • R. Canakiah recently attended a Women & Homelessness event where good practice was shared & potential new initiatives identified		

		• Staff have begun to use a pan-London 'Safe & Secure' reciprocal arrangement for DV survivors • Potential funding has been identified for other DV initiatives • Ensure the provision of Sanctuary effectively meets the needs of the Borough. Not started, (due February 2015) • Ensure DV & VAWG is covered within early intervention & prevention services • Funding has been cut for relevant initiatives so it is unlikely that there will be any further progress in this area • Review the need to reinstate a panel for complex cases e.g. single, non-priority customers • Improve awareness of DV & VAWG services • Increase referrals to DV & VAWG services, including MARAC Not started, (due March 2015) • Improve support provided to TBG employees affected by DV & VAWG The Respect Toolkit for employers has been reviewed and its example DV policy for employees is currently being amended so that it can be utilised by Barnet Homes • Review and refine DV & VAWG data capture, monitoring & utilisation, including user feedback • New Code of Guidance for Domestic Abuse and Homelessness reviewed & relevant recommendations considered • DV information has been refreshed on the LBB website • Need identified for a 'helpful no' leaflet through which DV advice information will be given to those that we do not assist further. • Changes needed to new housing system have been identified (including MARAC referrals, refuge placements, and DV & VAWG categories). Barnet are currently consulting on their Housing Allocations Scheme. Consultation ends on Sept 30th 2014 and the committee is February 2015.		
3.6.	**Mental health services** (Adults both community and	• To ensure that the Enquiry and risk assessments are conducted • To increase the number of DV & VAWG safeguarding alerts/referrals made • To monitor the number of staff trained	AMBER	There are gaps in these

	acute) and CAMHS - review and revise their service wide response to all aspects of DV & VAWG	• DV & VAWG data is regularly collected and shared • To develop an improved response to victims and perpetrators of DV & VAWG who are accessing mental health services • To ensure that there is a skilled and competent workforce able to provide a safe, sensitive and appropriate response to victims and perpetrators • Service Managers should be engaged in the coordinated response to DV & VAWG • To increase the identification and referrals of victims and perpetrators to MARAC and other DV & VAWG services CAMHS have reviewed their DV Policy. There is a mini action plan for the individual services. Staff have attended LBB DV Training and DV has been incorporated within the general assessment DV data is included in the risk assessment		actions, this needs to be progressed.
3.7.	**Substance Misuse Services** review and revise their service wide response to all aspects of DV & VAWG	• All Service managers to be engaged in the coordinated response to DV & VAWG On-going discussion at Complex Sub-Group • DV & VAWG policy and procedures to be reviewed and implemented Via Contract Performance meeting. HAGA has a Domestic Violence Policy. • Enquiry and risk assessments to be conducted Included in Detox/Rehab. Assessment tool (CCA) & Common Assessment Tool • To increase the number of DV & VAWG safeguarding alerts/referrals being made On-going discussion at Complex Sub-Group. SMS currently refer DV/VAWG to Solace who undertake full assessment. • To increase the number of staff trained and develop a skilled and competent workforce able to provide a safe, sensitive and appropriate response to victims and perpetrator Contract Variations 14/15 signed by SMS: all staff to undertake DV/VAWG training in line with L.A. Barnet guidance	AMBER	

		SMS to submit confirmation of sign-up to Complex Sub-Group • DV & VAWG data is regularly collected and share On-going discussion at Complex Sub-Group • To develop an improved response to victims of DV & VAWG who are accessing substance misuse services • To screen clients and manage complex cases. • Increase in identification and referrals of victims and perpetrators to MARAC and other DV & VAWG services SMS to submit confirmation of representation to Complex Sub-Group • The Commissioning team will look at commissioning DV and VAWG services as service variations can be shown on contracts. • There is no specific policy at present. A scoping needs assessment is starting and the reviewer will meet with ML. The reviewer met with ML • ML to arrange a meeting with the providers and commissioners and mental health services This happened on 3rd June 2014 ML attended Barnet SMS Provider Managers' meeting – 07/14. Complex Sub Group commenced and attended by SMS Providers/PH Commissioner • Bridget will send a list of providers to ML and information material for the Police. SMS Provider list forwarded to ML and incorporated into DV/VAWG circulation list. Barnet Service User Group (BSUG) booklet forwarded to Colindale Arrest & Referral Worker and Helen Williams – Met. Police		
	Year 3			
3.8.	**Maternity**	• Work with health services to scope what is in place, and gaps, for maternity services & midwives relating to DV	RED	

		• To establish the right level of representation at the board and to take this forward. The health representative to contact the CCG. Celia to provide an update. To see if DV is disclosed and screened and explore if an IDSVA can be resourced and feedback on frontline services being trained.		

Strategic objective **4. Protection –** delivering an effective criminal justice system (investigation, prosecution, victim support and protection and perpetrator programmes)					
	Activities to fulfil objective	**Actions and Updates**	**Timescale for completion Resources required Measurement Expected outcomes**	**RAG Rating**	**Comments**
4.1.	**Review and extend the MARAC's operation to include 16/17 year olds** affected by DV in line with the new definition of DV	• To increase the number of young people discussed at MARAC The MARAC Paperwork has been amended to include the age changes. • All multi-agency staff to be trained on completion of CAADA DASH risk assessment tool MARAC Training dates have been set for 2014/2015, this is free to all agencies and individual agency's briefings can be arranged • To increase the number of referrals from children services, health, youth services and other agencies to the MARAC and DV services The MC and the DVC have been doing regular briefing sessions to these targeted agencies to increase referrals. • To improve the safeguarding arrangements and responses for young people affected by DV Four awareness raising sessions on young people violence and the support available were delivered 30 practitioners in Youth services. -an information Stall was held in Woodhouse College Lunch time event for students.		AMBER	

		The MARAC Co-ordinator and the YPVA are actively promoting briefings to agencies working with Young People and Education institutions. The MC has written to all schools and has invited them to be briefed around the MARAC and DV.		
4.2.	**Specialist DV Court operating with IDVAS**	• To provide support at both bail/remand trials and court hearings for victims with London Borough of Brent and Harrow. • To increase the safety of victims and witness of domestic violence who are accessing the criminal justice system. • Data collection issues needs to be resolved by partners • Barnet need to explore the funding of a FT court based IDVA for the SDVC. A part time IDVA post is currently allocated to the work of the SDVC for Barnet. The LB Brent and Harrow have commissioned a FT IDVA service each. Barnet met with Brent and Harrow to explore the funding of the additional post of a SDVC Coordinator Post - funding to be confirmed but approximately £40K. LBH do not have funds and LB Brent have re-commissioned their services have included this in there (possible outcome July 2014). The SDVC Court Protocol has been updated and signed by the CEO, Andrew Travers and is currently being implemented. This is due to be revised again in September 2014. This has been signed and completed. There is a SDVC Steering Group in place that ML attends for Barnet. The Steering group has discussed what they will and will not collect around data. ML has raised this but the group are not in agreement with her proposals. So may find it difficult to get.	AMBER	
4.3.	**Agree links to integrated offender management group and Multi Agency Public Protection Arrangements with the MARAC**	• To strengthen the local response to DV & VAWG in order to develop a 'top 10 victims and Offenders List' Operation Dauntless produces top offenders each month. This list is given to the MARAC coordinator who distributes to all agencies • To establish an operational and strategic link • To monitor the number of domestic violence perpetrators known to MARAC which are identified as gang nominal's and prolific offenders • To monitor the Criminal justice sanctions for this cohort • To monitor the Repeat victimisation rate for this cohort • Timely information sharing enable the multi agency partnership to hold perpetrators accountable should be done	GREEN	

		The Chair of MAPPA is the Vice-chair of the MARAC. Therefore all the DV cases are considered. A top 10 list of victims and perpetrators are compiled and shared at the MARAC Probation - The probation service is being part privatised, the public side (National Probation Service) will continue to have an active role in the local MARAC with David Williams SPO in the NPS taking the lead and chairing when required. The Probation Service is due to be privatised in March 2014 and this might impact on this arrangement. From, approximately, October 2014 offenders assessed as low and medium risk will be supervised by the Community Rehabilitation Company - they will still be required to be active in local partnerships to reduce re-offending and MARAC is a key example of this		
4.4.	**Link MARAC to local strategic work on gangs and sexual exploitation**	• To develop the MARAC processes to work effectively with other safeguarding systems • Training on MARAC processes to be delivered to teams and services working on the issue of gangs and sexual exploitation • Seminar to be organised with relevant services and action plan produced to pull learning together of systems and linking responses • To improve multi-agency working arrangements • To develop effective and timely safeguarding interventions • Early intervention approaches should be supported • Combined expertise is mobilised to respond to these inter linked areas There is a Gangs 'multi-agency' Strategic Group in Barnet. To explore work on; Peer on peer abuse, MASE, Serious cases, Girls and Gangs, Youth Violence. This will be linked to the work of the MARAC. Some Members of the MARAC are also members of the MASE. MsUnderstood are supporting this work for 7 North London Boroughs, including Barnet. MARAC and MASE are linked up with the YPVA attending MASE monthly meetings.		

4.5	**Review borough DV & VAWG referral/care pathways** linking to national work.	• To develop DV & VAWG care pathways, to be reviewed and implemented • Launch of pathways at local event and publicity of pathways • Increase of referrals (particularly of under represented groups) • Increase in reporting (particularly of under represented groups) All DV Referral pathways are developed and put on LBB's website. Including national DV Agencies details. Additional VAWG information to be added to the website. Information about the commissioned rape and sexual violence is also provided.	GREEN	
	Year 3			
4.6.	**Borough action plan implemented to support women who wish to exit prostitution safely, locally**	• A Plan to be agreed and implemented • To ensure that Elected members are engaged • To develop a Coordinated response to prostitution and Exit strategies to be put in place • Toolkit of responses to prostitution implemented • To monitor if there is a reduction in related ASB reports and concerns	RED	
4.7	**Clare's Law**	Police • The disclosure of information for women entering relationships, about potential new partners; if they are known to the police re DV offences. • To help women who may be able to avoid getting into new DV relationships. This is being piloted and will be rolled out nationally. This has been rolled out across the borough with presentation being sent to all police officers on Barnet borough and agencies attending MARAC and MASE. FNP use specific material to work with young mums on new relationships and risk to address. Police are already using Clare's Law as appropriate when it is established that victims discussed at the MARAC are at risk of further domestic abuse from perpetrators known for abuse against previous partners. Paula Light is exploring obtaining some data on this.	RED	

4.8	**Police to decrease DV Attrition Rates and to scope Police Intelligence**	Police • To ensure that there is a quality assurance framework to include victim's perspectives. Police to work alongside the CPS to reduce repeat victimisation and improve CJS responses and outcomes. Repeat victims are considered for referral to MARAC. CPS are made aware of the repeat incidents of Domestic Abuse for consideration as part of the case disposal decision. Barnet Borough Police are working with IDVAs (SOLACE) regarding gold service questionnaire.	AMBER	

Meeting abbreviations:

SCPB - Safer Communities Partnership Board

HWBB - Health and Wellbeing Board

DV & VAWG DB – Domestic Violence and Violence against Women and Girls Delivery Board

DV & VAWGF - Domestic Violence and Violence against Women and Girls Forum

BSCB - Barnet Safeguarding Children's Board

BSAB - Barnet Safeguarding Adults Board

MARAC – Multi Agency Risk Assessment Conference

JSNA – Joint Strategic Needs Assessment (sets out health and social care needs of Barnet's residents)

CYPP – Children and Young People's Plan

CCG – Clinical Commissioning Group

CLCH – Central London Community Healthcare

CPS – Crown Prosecution Service

CJS – Criminal Justice System

Training Programme to include:

- Forced marriage as a criminal offence
- Forced marriage and learning disabilities
- Vulnerable adults and domestic violence
- Dynamics of domestic violence and best practice
- Risk assessment and safety planning
- Identification and enquiry
- Female Genital Mutilation identification, enquiry and safeguarding
- DV & VAWG concerns within child protection supervision)
- Stalking and harassment – best practice and legislation
- Risk factors and identification of sexual exploitation

Other Issues:

GPs to provide a uniform response to DV & VAWG across borough practices

Patients and staff receive consistent messages about DV & VAWG

Responsibility for challenging the social tolerance of DV & VAWG is mainstreamed into the service/organisation

Staff and patients know where they can access help and support

Creative opportunities are utilised to cascade information to victims about DV & VAWG services

Potential for early intervention and support through provision of information via health services improved

Women who have experience FGM receive sensitive care from a knowledgeable workforce

Improved maternal care for women who have experience FGM

Timely safeguarding advice and referrals made for girls who are identified as being at risk of FGM

Prevention of FGM

Increased awareness and understanding of health implications of FGM and that it is a criminal offence

Opportunities for FGM enquiry are utilised

Organisational/service response to DV & VAWG

Patients and staff receive consistent messages about DV & VAWG

Responsibility for challenging the social tolerance of DV & VAWG is mainstreamed into the service/organisation

AGENDA ITEM 10

	Health and Well-Being Board **12 March 2015**
Title	**Minutes of the Health and Social Care Integration (HSCI) Board**
Report of	Chair, NHS Barnet CCG Commissioning Director – Adults and Health
Wards	All
Date added to Forward Plan	November 2014
Status	Public
Enclosures	Appendix 1 - Minutes of the Health and Social Care Integration Board – 17th February 2015
Officer Contact Details	Karen Spooner karen.spooner@barnetccg.nhs.uk / 0203 688 1836 Zoë Garbett zoe.garbett@barnet.gov.uk / 0208 359 3478

Summary

This report is a standing item which presents the minutes of the Health and Social Care Integration (HSCI) Board and updates the Health and Well-Being Board on the progress made to deliver the vision for integration in Barnet with substantially improved outcomes for patients, service users and their carers through the successful implementation of a health and social care integration programme.

Recommendations

1. **That the Health and Well-Being Board notes the minutes of the Health and Social Care Integration Board of 17th February 2015.**

1. WHY THIS REPORT IS NEEDED

1.1 HWBB has a clear vision for the integration of health and social care for frail elderly people and people with long-term conditions in Barnet and has set up an ongoing programme of work to deliver it. Commissioners, providers and partner organisations work together to join up care and deliver the very best outcomes for patients and people who use care in Barnet.

1.2 At the Barnet Health and Social Care Integration Summit meeting on 27 July 2012 leaders of the main health and social care commissioners and providers agreed to set up a single Health and Social Care Integration (HSCI) Board.

1.3 The HSCI Board will:

a) *Lead work to realise the Concordat Vision for integrated care in Barnet, as agreed by all members.*

b) *Lead work to design, develop and deliver the vision for integrated health and social care in Barnet in line with the 5 Tier Model for Integrated Care and Barnet Better Care Fund (BCF) Plan.*

c) *Achieve significantly improved outcomes for patients, service users and their carers as detailed in the BCF Plan approved by NHS England in February 2015 and Business Case for Integration approved by the Barnet Clinical Commissioning Group (CCG) Board and Council in October and November 2014.*

d) *Continuously identify greater opportunities for more health and social care integration and innovation across the whole local care system in Barnet.*

1.4 It gives final approval to projects/work proposed by the HSCI Steering Group and promotes the delivery of these initiatives and the realisation of benefits, delegating specific commissioning and delivery decisions to commissioners and providers accordingly.

1.5 The HSCI Board is therefore plays a significant role in driving forward health and social care integration. It oversees and provides strategic direction for the development of integrated health and social care services, proportionate to the level of investment that is required and the complexity of the work programme delivered.

1.6 The Barnet HWBB on 13th November 2014 agreed to receive the minutes of the HSCI Board as a standard item on the agenda to ensure that adequate attention is given at Board level to the work that providers are doing to support delivery of Barnet's integrated care proposals.

1.7 The HSCI Board held its first meeting of 2015 on the 17th February, to review progress and take stock of the current position. Appendix 1 contains minutes of this meeting.

1.8 Highlighted decisions or actions points from the meeting are:

- Membership should include two representatives from each organisation, one of whom should be a director who will be able to make decisions at that meeting.
- The Board noted the work done and progress to develop the Final BCF Plan and Business Case for integration and to implement services for the 5 Tier integrated care model, as detailed in the comprehensive BCF update report presented to HWBB on 29 January 2015 and the Business Case for Integration presented to HWBB on 18 September 2014.
- The Board noted positive indicative performance data for the impact on hospital admissions of the Older People Integrated Care (OPIC) and Rapid Care projects.
- The Board discussed and accepted the early experiences, lessons learned and case studies of the Barnet Integrated Locality Teams Design Pilot.
- The Board approved the priority projects or work planned for 2015/16 and suggested further initiatives for the HSCI Steering Group and Programme to consider for 2015/16 work plan, e.g. opportunities for more focus on falls and mobility services, workforce development and cross member public communications.
- The Board approved the work plan to develop detailed proposals for the scope of work for Tier 2 of the 5 Tier Model. Public Health will lead on this work, holding workshops and engaging with stakeholders to assess gaps in provision and report progress/proposals to the next HSCI Board.

2. REASONS FOR RECOMMENDATIONS

2.1 The HSCI Board is responsible for defining the outcomes, content and projects of the integration programme (the programme plan) and for overall programme delivery, accountable to HWBB.

2.2 By reviewing the minutes of the HSCI Board, HWBB can assure itself that the necessary resources and skills required to deliver the programme are defined and the necessary resources and investment within member organisations are secured.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Not applicable.

4. POST DECISION IMPLEMENTATION

4.1 Provided HWBB is satisfied by the progress being made by the HSCI Board to deliver the programme of work on its behalf, the HSCI Board will progress work as planned.

4.2 If HWBB is not satisfied it can propose future agenda items for forthcoming Board meetings it would like to see prioritised.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 Integrating care to achieve better outcomes for vulnerable population groups, including older people, those with mental health issues, and children and young people with special needs and disabilities, is a key ambition of Barnet's Health and Well-Being Strategy.

5.1.2 Integrating health and social care offers opportunities to deliver the Council's Medium Term Financial Strategy (MTFS) and Priorities and Spending Review (PSR), and the CCG's Quality, Innovation, Productivity and Prevention Plan (QIPP) and Financial Recovery Plan.

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

5.2.1 The HSCI Board has the following functions that impact on and relate to the management of local resources for the delivery of integrated health and social care services in Barnet:

a) Make decisions relating to changes to the strategy for integrated care, the Concordat and the aims and objectives of the work programme.

b) Give final approval for business cases for new projects or work and lead the delivery of work and realisation of benefits, ensuring they are realised and optimised across the whole local care system.

c) Manage significant strategic issues or risks that may affect the vision and long-term direction of the work programme and its successful delivery and impact and decide on changes to the scope, structure and the quality of the work programme and significant deliverables (i.e. adding or removing new, existing projects).

d) Make decisions relating to changes to the planned completion of agreed milestones or 'critical path' work plans or overall timeline for the delivery of the work programme.

5.2.2 The HSCI Board also works closely with other relevant Boards or governance arrangements to support the setting of resources and achieving target benefits and outcomes.

5.2.3 The HSCI Steering Group, comprising director level representation from the LBB and the CCG, will make specific commissioning decisions relating to:

- Setting or changes to the overall budget and financial resources allocated to the work programme and spend on projects, work or services delivering integrated care.
- Individual changes to the design and delivery of projects, work or services agreed for the work programme to manage risks and issues and realise benefits/outcomes.

- Defining and securing, in consultation with the HSCI Board as appropriate the resources, investment and skills required to deliver the programme.

5.2.4 The HWBB Finance Group will:

- Review and scrutinise and challenge the target benefits and outcomes and the budgets and financial resources allocated to the work programme.
- Recommend to the HWBB whether to accept the work programme, target benefits and outcomes and resources proposed.

5.2.5 The HWBB will give final approval to the scope of the work programme, target benefits and outcomes and the proposed budgets and financial resources accordingly.

5.2.6 LBB and CCG will approve the scope of the work programme and allocation of financial and other resources to it through its own governance arrangements as required.

5.3 Legal and Constitutional References

5.3.1 Under the Council's Constitution (Responsibility for Functions – Annex A) the Health and Well-Being Board has the following responsibility within its Terms of Reference:

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

Specific responsibility for:

- *Overseeing public health*
- *Developing further health and social care integration*

5.3.2 Under Section 75 of the NHS Act 2006 and NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (as amended) the Council and NHS partners have the power to enter into integrated arrangements in relation to prescribed NHS functions and health-related functions of local authorities for the commissioning, planning and provision of staff, goods or services. The Council and CCG now have two overarching section 75 agreements in place.

5.3.3 Under the Health and Social Care Act 2012, a new s2B has been inserted into the NHS 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.

5.3.4 The 2012 Act also amends the Local Government and Public Involvement in Health Act 2007 and requires Local Authorities together with partner CCGs to prepare a strategy to meet the needs of their local population.

5.3.5 This strategy must consider the extent to which local needs can be met more effectively through partnership arrangements between local authorities and CCGs and s195 of the Health and Social Care Act 2012 contains a new duty – a duty to encourage integrated working:

s195 (1) A Health and Wellbeing Board must, for the purpose of advancing the health and wellbeing of the people in its area, encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner.

s195 (2) A Health and Wellbeing Board must, in particular, provide such advice, assistance or other support as it thinks appropriate for the purpose of encouraging the making of arrangements under section 75 of the National Health Service Act 2006 in connection with the provision of such services.

5.3.6 These provisions lay the foundations for the vision for integrated health and social care in Barnet and the corresponding work programme and governance arrangements to deliver on it. This includes the HSCI Board.

5.4 Risk Management

5.4.1 The work programme the HSCI Board oversees is delivered using programme and project management methodologies and governance arrangements. This includes clear processes to identify, report and manage individual or aggregate risks through senior management teams in the CCG and in LBB Adults and Communities and LBB/CCG Programme Management Offices.

5.4.2 Specific risks relating to BCF, which covers the majority of work overseen by the HSCI Board are included in the Final BCF Plan and the Business Case for Integration with mitigating actions. These are monitored regularly in accordance with the aforementioned governance process.

5.4.3 Strategically work has begun to assess over-arching governance arrangements for BCF in the context of a pooled fund and shared risk. This is essential to ensure robust management of the fund especially as the size and scope of the BCF and true pooled fund will increase (subject to necessary due diligence).

5.5 Equalities and Diversity

5.5.1 All public sector organisations and their partners are required under s149 of the Equality Act 2010 to have due regard to the need to:

e) Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

f) Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

g) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

5.5.2 Relevant protected characteristics are – age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

5.6 **Consultation and Engagement**

5.6.1 The HSCI Board has engaged and continues to engage fully with users and stakeholders to shape the strategic direction and decision-making it provides in support of the delivery of the BCF Plan and Business Case for Integration. The BCF Plan details the public engagement with patients and service users as well as with providers.

6. BACKGROUND PAPERS

6.1 Part 1 of the Final Barnet BCF Plan approved by NHSE on 6 February 2015 was presented to the HWBB on 29 January 2015 prior to submission to NHS England on 9 January 2015. Part 2 of the Plan is available for inspection on request from the officers listed on the front page of this report.

6.2 The draft Business Case for Integration for approval by the CCG Board and Council was presented to HWBB on 18 September 2014.

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Adult and Communities

MINUTES
HSCI Board

Date: Tuesday 17th February 2015
Time: 10:00-12:00
Venue: Conference Room 2, Ground Floor, Building 2, NLBP

Attendees: Dr Debbie Frost (DF), Dawn Wakeling (DW), Julie Pal (JP), Selina Rodrigues (SR), Pam McClinton (PMC), C Baxter (CB), Leanne Hicks (LH), Muyi Adekoya (MA), Jeff Lake (JL), Dominic Battiston (DB), Maria O'Dwyer (MOD), Fiona Jackson (FJ), Karen Spooner (KS), James Benson (JB), Mathew Kendall (MK), Dr Peter Dutton (PD)
Apologies:
Guest:
Chair: Dr Debbie Frost
Minutes: James Hallifax (JH)

No	Item	Lead
1	Membership and TOR for 2015	
	DW explained that the Board is meant to have a wide membership with two senior staff/directors from each organisation to attend. JB suggested that attendees requested should be a director and a senior manager instead. DW agreed, she added that attendees need only to be able to make decisions. DF confirmed the mood of the meeting that each organisation need to send at least 1 person who can make the necessary decisions AT THE MEETING. SR mentioned that the voluntary sector and residents of Barnet would be represented by the attendance of Community Barnet and Healthwatch Barnet. **Action:** JP offered to provide an updated logo for Community Barnet. **Action:** All to review the membership list and confirm members to JH, who will chase up list.	JH/DB
2	Progress and Success in 2014/15	
	KS presented on the progress and success of Health & Social Care Integration in 2014/15. JL asked if the positive results of the OPIC project presented were certain not to be a regression to the mean as is often the case with PH initiatives. KS replied that the indicators will continue to be monitored to clarify this.	

	PD advised that the RAID implementation took place in the same period and may mean that the results were also related to RAID. MA agreed that the results showed the various schemes in place were having positive effects.	
3	Barnet Integrated Locality Teams Design Pilot	
	MA presented on the BILT pilot. MA informed that through the pilot they discovered that voluntary organisations were being brought too late into the process and that their early involvement will go on to form a bigger part of the strategy going forward. LH presented two case studies of service users whose outcomes (in terms of service involvement) improved after BILT worked with them. PMC asked if any work had taken place on advance care planning. LH replied that it had not yet. DW highlighted the importance of shared care records and advanced care planning, which she suggested should start with close work with the relatives of the service user. MOD proposed further learning and thought around End of Life care. **Action:** MA to build EoL into planning/development for BILT	
4	Priority Projects and Services for 2015/16	
	DB presented on the priority projects and services for 2015/16. DB informed that RW will run a project to mobilise tier 2 organisations and services. DF asked if there was a date set for workshops around tier 2. DB replied that the date had not yet been set and that he was waiting for a response from RW on this. **Action:** DB to propose workshop date by w/c 23rd February. DW suggested that services don't need to be recreated, just used more effectively and asked for a progress report on tier 2 mobilisation for the next meeting. **Action: RW/** DB to report on tier 2 mobilisation – progress to date and forward plan - at next meeting. FJ advised on the importance of workforce development and gave the example using more trusted assessors.	DB RW/DB

CB asked how the BILT differs from or links to the MDT.
MA replied that complex cases go to the MDT, but also that BILT is a pilot at present in just a few GP practices.
DW identified a need for more clarity in these differences and links.

JB suggested that:

- The BILT pathway should be simplified.
- Further thought could be had around the speed of implementation.
- The wider impact on other services should be monitored to ensure that other services can be dropped for that person.

MOD advised that she would like to see a BILT in each locality.

DF asked if pharmacists were involved in the BILT.
MOD replied that they were.

JP advised that the voluntary organisations needed to discuss how best to input their specialist knowledge.

MA informed that the BILT will be sending out two case studies a month for comment.

FJ asked if more telecare development was in the pipeline.
JB replied that it is being looked at but it needs to be scaled up further in order to bring unit costs down.

SR suggested greater promotion of the BILT success on the internet.
DF suggested using videos including patients, with their consent.
MK emphasised the importance of consistency and collaboration in producing this web content across the different sites.

DW informed that the aim of the BILT is to focus on prevention over discharge and that the top risk categories are falls and mobility.

DW advised focus on the falls and mobility categories.

JB informed that his systems are being geared up to analyse the mobility categories.
MOD suggested the use of London Ambulance Service data as the data is rich and falls can be picked up early.
MOD added that there is a need to understand to whether falls are occurring more in personal homes or care homes.

Action: A report to be presented at the next meeting on the FALLS referrals to Rapid Care by CLCH. Purpose is to consider required further development of the 5 tier model and BILT **-JB**

5	Next Steps and Timescales	
	DW informed that the project team will produce a BCF next stage work plan for the next meeting, along with highlight reports on all projects . DF requested that in additional to falls, an item on action required re: advanced care planning development for the 5 tier model be included for the next meeting.	DB
6	Next meeting	
	19th May 1-3pm	

AGENDA ITEM 11

	Health and Well-Being Board **12 March 2015**
Title	**Forward work programme**
Report of	Strategic Director for Commissioning
Wards	All
Date added to Forward Plan	January 2014
Status	Public
Enclosures	Appendix 1- Forward work programme of the Health and Well-Being Board Appendix 2- Forward work programme of Council Committees and Barnet CCG's Board
Officer Contact Details	Zoë Garbett Commissioning and Policy Advisor (Public Health and Wellbeing) zoe.garbett@barnet.gov.uk 0208 3593478

Summary

This report introduces forward work programme for the Health and Well-Being Board and outlines a series of considerations that will support the Board to manage and update its forward work programme effectively. These considerations are:

- The statutory responsibilities and key priorities of the Health and Well-Being Board
- The work programmes of other Strategic Boards in the Borough
- The significant programmes of work being delivered in Barnet in 2015/16 that the Board should be aware of
- The nature of agenda items that are discussed at the Board

Recommendations

1. **That the Health and Well-Being Board notes the Forward Work Programme and proposes any necessary additions and amendments to the forward work programme (see Appendix 1).**
2. **That Health and Well-Being Board Members proposes updates to the forward**

work programme before the first day in each calendar month, so that the work programme can be published on the Council's website more efficiently, with the most up to date information available.
3. That the Health and Well-Being Board aligns its work programme with the work programmes of the new Council Committees (namely the Adults and Safeguarding Committee, and the Children's, Education, Libraries and Safeguarding Committee), Health Overview and Scrutiny Committee, and Barnet CCG's Board. (see Appendix 2)

1. WHY THIS REPORT IS NEEDED

1.1 At the Health and Well-being Board meeting on 13th November 2014 the Board committed to monthly updates of the forward work programme in alignment with other council committees.

1.2 The current forward work programme has been designed to cover both the statutory responsibilities of the Health and Well-Being Board and the key projects that have been identified as priorities by the Board at its various meetings and development sessions. The current work programme covers a 12 month period until the end of February 2016.

1.3 The forward work programme attached to this report at Appendix 1 supersedes the previous work programme presented on the 29 January 2015 to the Board, and suggests a refreshed schedule of reports and items for the following 12 months, reflecting the Board's statutory requirements, new responsibilities as the Commissioning Committee for public health (see below), agreed priorities, and objectives set out in the Health and Well-Being Strategy. Key items to note include the Joint Strategic Needs Assessment and Health and Well-Being Strategy revised timescales and a number of papers from Public Health.

1.4 In June 2014, the Council moved to a Committee Structure of governance. In the Committee system, decisions will be taken by all-party, decision-making Committees, themed around the key areas of Council business. The new themed Council Committees are: Policy and Resources; Housing; Adults and Safeguarding; Assets; Regeneration and Growth; Environment; Community Leadership; and Children's, Education, Libraries and Safeguarding. The Health and Well-Being Board has been designated responsibility to approving the commissioning plans for public health. The principles of these committees are as follows:

- Only one Committee can make a decision; the decision cannot be taken by more than one Committee
- If it is not clear whose responsibility an issue comes under, it will be taken by Policy and Resources Committee
- Broadly, Policy and Resources will be supported by the Council's Strategic Commissioning Board; Performance and Contract Management by Delivery Board; and the Themed Committees by the Commissioning Board
- The number and themes of each Committee has been Member led.

1.5 The Health and Well-Being Board must ensure that it's forward work programme is compatible with the forward work programmes of the new Adults and Safeguarding and Children's, Education, Libraries and Safeguarding Committees. The Board also needs to seek alignment with the work programmes of the Council's Health Overview and Scrutiny Committee, and Barnet CCG's Board, to ensure that these work programmes are discussed within the correct forums, with information shared across other Board's as appropriate. Updated forward work programmes for each of these Boards are attached at Appendix 2 to support the Board plan its work programme effectively.

1.6 There are a number of work programmes being delivered in 2015/16 that will be of interest to the Health and Well-Being Board, and should be reflected in the Board's forward plan. These work programmes include, but are not limited to, the health visiting and school nursing review, delivery of the Children and Families Act and the Care Act, the acquisition of Barnet and Chase Farm NHS Trust by the Royal Free NHS Foundation Trust and commissioning plans.

1.7 The Health and Well-Being Board has a varied and demanding programme of work to cover over the next 12 months. At the Health and Well-Being Board meeting on the 21st November 2013, the Board discussed the high number of agenda items and papers regularly 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. The Chairman 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 and Members will wish to ensure that agendas do not contain more reports than the Board has time to properly consider.

2. REASONS FOR RECOMMENDATIONS

2.1 To maintain a programme of agenda items that will aid the Board in fulfilling its remit.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Not applicable.

4. POST DECISION IMPLEMENTATION

4.1 Following approval of the recommendations in this report, Board Members will be asked to update the forward work programme.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 The Health and Well-Being Board needs a robust forward work programme to ensure it can deliver on the key objectives of the Health and Well-Being Strategy, including the annual priorities within the Strategy that were agreed at the November 2014 Board meeting.

5.1.2 Successful forward planning will enable the Board to meet strategic local and national deadlines for each organisation represented at the Board and transformational changes required to meet the savings targets for both the

Council and the CCG.

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

5.2.1 Currently, all items on the forward work programme of the Health and Well-Being Board will be managed within existing budgets.

5.3 **Legal and Constitutional References**

5.3.1 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.

5.3.2 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.

5.3.3 The work programme should ensure that the Health and Well-Being Board is able to deliver on its terms of reference as set out in the Council's Constitution Responsibility for Functions- Annex A, which are set out below:

*(1) To jointly **assess the health and social care needs of the population** with NHS commissioners, and apply the findings of a Barnet joint strategic needs assessment (JSNA) to all relevant strategies and policies.*

*(2) To **agree a Health and Well-Being Strategy** for Barnet taking into account the findings of the JSNA and performance manage its implementation to ensure that improved outcomes are being delivered.*

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

*(4) To **consider all relevant commissioning strategies from the CCG and the NHS Commissioning Board and its regional structures** to ensure that they are in accordance with the JSNA and the HWBS and refer them back for reconsideration.*

*(5) To **receive assurance from all relevant commissioners and providers on matters relating to the quality and safety of services** for users and patients.*

*(6) To **directly address health inequalities** through its strategies and have a **specific responsibility for regeneration and development as they relate to health and care**. To champion the commissioning of services and activities across the range of responsibilities of all partners in order to achieve this.*

*(7) To **promote partnership and, as appropriate, integration, across all necessary areas**, including the use of joined-up commissioning plans across the NHS, social care and public health.*

*(8) **Receive the Annual Report of the Director of Public Health** and commission and oversee further work that will improve public health outcomes.*

(9) Specific responsibilities for:
- ***Overseeing public health***
- ***Developing further health and social care integration.***

5.4 **Risk Management**

5.4.1 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.

5.5 **Equalities and Diversity**

5.5.1 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.

5.6 **Consultation and Engagement**

5.6.1 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.

5.6.2 The twice yearly Partnership Board Summits, and the meetings of the Partnership Board co-chairs, will provide opportunity for the Board to engage with each of the Partnership Boards on the forward work programme.

6. BACKGROUND PAPERS

6.1 None.

Health and Well-Being Board Work Programme

March 2015 – January 2015

Contact: Zoë Garbett
Commissioning and Policy Advisor (Public Health and Wellbeing)
zoe.garbett@barnet.gov.uk

Subject	Decision requested	Report Of	Contributing Officer(s)
12 March 2015			
Feedback from consultation on Public Health Commissioning Plan	**The Board is asked to discuss the report and approve the recommendations contained within**	Director of Public Health	**Consultant in Public Health Commissioning and Policy Advisor- Health & Wellbeing, LBB**
Strategic approach to obesity	**The Board is asked to discuss the report and approve the recommendations contained within**	Director of Public Health	**Consultant in Public Health**
Better Care Fund – Pooled Budget progress	**The Board is asked to review and comment on the progress of the Better Care Fund pooled budget arrangements**	Commissioning Director – Adults and Health	**CCG Director of Integrated Commissioning**
6 month update- Domestic Violence and Violence Against Women and Girls Action Plan	**The Board is asked to discuss the report and approve the recommendations contained within**	Strategic Director for Commissioning	**Domestic Violence Coordinator**
Minutes of the Health and Well-Being financial planning group (meeting 18th March)	**The Board is asked to approve the minutes of the Health and Well-Being financial planning group**	Strategic Director for Commissioning	**Commissioning and Policy Advisor- Health & Wellbeing, LBB**
Minutes of the Health and Social Care Integration Programme Board	**The Board is asked to approve the minutes from the Health and Social Care Intergration Programme Board**	Commissioning Director – Adults and Health	**TBC**
12 month Forward Work Programme	**The Board is asked to review and update the Forward Work Programme and to contribute items**	Strategic Director for Commissioning	**Commissioning and Policy Advisor- Health & Wellbeing, LBB**
4 June 2015			
Draft substance misuse strategy	**The Board is asked to comment on the draft substance misuse strategy**	Director of Public Health	**Consultant in Public Health**

Subject	Decision requested	Report Of	Contributing Officer(s)
Opportunities to align the Public Health and Planning teams – progress report	**The Board is asked to note the progress that has been made locally to align the work of the public health and planning teams**	Director of Public Health	**Consultant in Public Health**
Barnet's Health Protection Profile – Public Health England report	**The Board is asked to comment on Barnet's Health Protection profile.**	Consultant in Communicable Disease Control (Public Health England)	**Director of Public Health CCG**
Better Care Fund – Pooled Budget progress	**The Board is asked to review and comment on the progress of the Better Care Fund pooled budget arrangements**	Commissioning Director – Adults and Health	**CCG Director of Integrated Commissioning**
CCG Delivery Plan	**The Board is asked to review the plan ahead of submission to NHS England**	CCG Chair	**Interim Director of Commissioning and Chief Operating Officer**
Minutes of the Health and Well-Being financial planning group	**The Board is asked to approve the minutes of the Health and Well-Being financial planning group**	Strategic Director for Commissioning	**Commissioning and Policy Advisor- Health & Wellbeing, LBB**
Minutes of the Health and Social Care Integration Programme Board	**The Board is asked to approve the minutes from the Health and Social Care Intergration Programme Board**	Commissioing Director – Adults and Health	**TBC**
12 month Forward Work Programme	**The Board is asked to review and update the Forward Work Programme**	Strategic Director for Commissioning	**Commissioning and Policy Advisor- Health & Wellbeing, LBB**
30 July 2015			
Report on the Partnership Boards/ Health and Well-Being Board catch up	**The Board is asked to comment on the report and take forward any delegated actions that arise out of the report**	Commissioing Director – Adults and Health	**Customer Care Service Manager, LBB**
Healtwatch update report	**The Board is asked to comment on the progress made by Healthwatch Barnet**	Healthwatch Barnet	**Head of Healthwatch**

Subject	Decision requested	Report Of	Contributing Officer(s)
Draft JSNA refresh and emerging priorities for the Health and Well-Being Strategy	**The Board is asked to comment on the draft JSNA and the implications for the Health and Well-Being Strategy refresh**	Director of Public Health	**Consultant in Public Health Commissioning and Policy Advisory (Economist), LBB**
Update- implementing recommendations from the TB situational report	**The Board is asked to comment on the progress made**	Director of Public Health	**Consultant in Public Health**
Pharmaceutical Needs Assessment	**The Board is asked to comment on the completed Pharmaceutical Needs Assessment (PNA)**	Director of Public Health	**Consultant in Public Health**
CCG Co-commissioning update	**The Board is asked to note the progress that has been made locally towards co-commissioning with NHS England**	CCG Chair	**Director of Commissioning and Chief Operating Officer**
Minutes of the Health and Well-Being financial planning group	**The Board is asked to approve the minutes of the Health and Well-Being financial planning group**	Strategic Director for Commissioning	**Commissioning and Policy Advisor- Health & Wellbeing, LBB**
Minutes of the Health and Social Care Integration Programme Board	**The Board is asked to approve the minutes**	Commissioing Director – Adults and Health	**TBC**
12 month Forward Work Programme	**The Board is asked to review and update the Forward Work Programme**	Strategic Director for Commissioning	**Commissioning and Policy Advisor- Health & Wellbeing, LBB**
September 2015			
Minutes of the Health and Well-Being financial planning group	**The Board is asked to approve the minutes of the Health and Well-Being financial planning group**	Strategic Director for Commissioning	**Commissioning and Policy Advisor- Health & Wellbeing, LBB**
JSNA refresh	**The Board is asked to approve the refresh of the JSNA**	Director of Public Health	**Consultant in Public Health Commissioning and Policy Advisory (Economist), LBB**

Subject	Decision requested	Report Of	Contributing Officer(s)
Draft Health and Wellbeing Strategy refresh	**The Board is asked to comment on the draft Health and Well-Being Strategy**	Commissioning Director – Adults and Health	**Consultant in Public Health Commissioning and Policy Advisor- Health & Wellbeing, LBB**
Report of the Tobacco Control Alliance	**The Board is asked to comment on the progress made by the Alliance**	Director of Public Health	**Consultant in Public Health**
Minutes of the Health and Well-Being financial planning group	**The Board is asked to approve the minutes of the Health and Well-Being financial planning group**	Strategic Director for Commissioning	**Commissioning and Policy Advisor- Health & Wellbeing, LBB**
Minutes of the Health and Social Care Integration Programme Board	**The Board is asked to approve the minutes**	Commissioing Director – Adults and Health	**TBC**
12 month Forward Work Programme	**The Board is asked to review and update the Forward Work Programme**	Strategic Director for Commissioning	**Commissioning and Policy Advisor- Health & Wellbeing, LBB**
November 2015			
Health and Wellbeing Strategy (2015-20)	**The Board is asked to approve the Health and Well-Being Strategy**	Commissioing Director – Adults and Health	**Consultant in Public Health Commissioning and Policy Advisor- Health & Wellbeing, LBB**
Minutes of the Health and Well-Being financial planning group	**The Board is asked to approve the minutes of the Health and Well-Being financial planning group**	Strategic Director for Commissioning	**Commissioning and Policy Advisor- Health & Wellbeing, LBB**
Minutes of the Health and Social Care Integration Programme Board	**The Board is asked to approve the minutes from the Health and Social Care Intergration Programme Board**	Commissioning Director – Adults and Health	**TBC**
12 month Forward Work Programme	**The Board is asked to review and update the Forward Work Programme**	Strategic Director for Commissioning	**Commissioning and Policy Advisor- Health & Wellbeing, LBB**
Janaury 2016			

Subject	Decision requested	Report Of	Contributing Officer(s)
Minutes of the Health and Well-Being financial planning group	**The Board is asked to approve the minutes of the Health and Well-Being financial planning group**	Strategic Director for Commissioning	**Commissioning and Policy Advisor- Health & Wellbeing, LBB**
Minutes of the Health and Social Care Integration Programme Board	**The Board is asked to approve the minutes from the Health and Social Care Intergration Programme Board**	Commissioning Director – Adults and Health	**TBC**
12 month Forward Work Programme	**The Board is asked to review and update the Forward Work Programme**	Strategic Director for Commissioning	**Commissioning and Policy Advisor- Health & Wellbeing, LBB**

Appendix 2 - Forward Work Programmes of Strategic Boards (February 2015 - June 2015)					
Calendar month	Strategic Board	Agenda Item	Nature of item (if known)	Report of	Contributing Officers(s)
February 2015	Health Overview and Scrutiny Committee (9 February 2015)	Annual report of the Director of Public Health	To consider the 2014 Annual Report of the Director of Public Health; and to consider an update on the 2013 Annual Report (to include update on Call to Action on Physical Activity)	Director of Public Health (Barnet and Harrow)	
		North London Hospice: Working with Hospitals	Committee to receive a report from the North London Hospice on the work that they are undertaking with five North London Hospitals in relation to end of life care		
		Central London Community Healthcare: Progress to Becoming an NHS Foundation Trust	Committee to receive a report on Trust's strategy for the next five years and to the progress being made towards becoming an NHS Foundation trust		
		Options for unscheduled care services at Cricklewood GP Health Centre	Barnet Clinical Commissioning Group (CCG) and NHS England are currently considering options for the continuation of services at Cricklewood GP Health Centre, following the expiration of the current service contract in June 2015. Committee to receive an update on this issue.		
		Member's Item - East Barnet Health Centre	Committee to consider a Member's Item on East Barnet Health Centre.		
		Update Report: Royal Free London NHS Foundation Trust	Committee to receive an update report from the Royal Free London NHS Foundation Trust to cover: Response to the removal of the Liverpool Care Pathway Winter Pressures: to report on winter pressures, including Accident and Emergency and bed Capacity. Parking at Barnet Hospital		
	CCG Board (26th February) - Listing special business items only	Finance report month 10			
		Information Governance Tool Kit Submission Report			
		Clinical Quality and Risk Report			
		NCL CCG Proposal for Joint Primary Care Co-Commissioning			
		Recovery Plan			
		2015/16 Budget - Delegated Approval Authority			
		Performance Exception including Progress Report on remdial action plan on Cancer Waiting Times	Major performance issues for each of NHS Barnet's CCG's main providers		
March 2015	Children, Education, Libraries & Safeguarding Committee (9 March 2015)	Preparing to Meet Future Need for Children with Special Educational Needs	To agree a commissioning strategy for services to support children with special educational needs.	Education and Skills Director	Education and Skills Director
		Business Planning	To approve five year commissioning priorities, proposals for meeting financial targets set out in the MTFS	Strategic Director for Communities	Commissioning Director (Children and Young People)
		Barnet Schools Forum	Committee to receive a report which describes the structure of the Schools Forum and its decision-making and advisory powers.	Education and Skills Director	
		Independent schools seeking maintained status	To approve a framework for decision making for applications from individual faith schools to join the maintained sector	Commissioning Director (Children and Young People)	Commissioning Director (Children and Young People), Education and Skills Director
	Adults and Safeguarding Committee (19 March 2015)	Your Choice Barnet Task & Finish Group	To consider a six-month update report from Officers on the approved recommendations of your Choice Barnet Task and Finish Group.	Housing and environment lead Commissioner, Later Life Lead Commissioner	

		Commissioning priorities	To agree commissioning priorities for 2015/16	Family and community Wellbeing Lead Commissioner, Later Life Lead Commissioner	
		Implementation of the Care Act	To receive an update on progress with the implentation of the Care Act	Adults and Communities Director, Later Life Lead Commissioner.	
		Implementation of the care Act- Remodelling Adult Social Care	To agree changes to the ASC process that will enable it to comply with the Care Act 2014. To agree a new a policy arising from the Care Act 2014 formalising the new duties of the council where a care provider falls. To agree an approach to how councils can develop a sustainable social care market place to meet the new duties of the Care Act 2014	Adults and Communities Director, Later Life Lead Commissioner.	
		Implementation of the care Act- Prevention, Information & Advice Policy	To agree an approach to Information & Advice and Advocacy services in relation to the requirements of the Care Act 2014	Adults and Communities Director, Later Life Lead Commissioner.	
		Implementation of the Care Act- Prevention policy	To agree new policies in line with the requirements fo the care act.	Adults and Communities Director, Later Life Lead Commissioner.	
		Implementation of the Care Act - Eligibility and Contributions	To agree new policies in line with the requirements fo the care act.	Adults and Communities Director, Later Life Lead Commissioner.	
		Management Agreements	To review management agreements for the commissioning and delivery of Adult Social Care services	Adults and Communities Director, Later Life Lead Commissioner.	
	Health Overview and Scrutiny Committee (30 March 2015)	Update Report from NHS England: Immunisations Task and Finish Group	Committee to receive an update report from NHS England on the work of the Task and Finish Group undertaken in relation to immunisations		
		Healthwatch Barnet Enter and View Visits- Update Report	Committee to receive an update on the visits to Barnet Hospital as reported to committee at their meeting in December 2014		
		Royal Free London NHS Foundation Trust Acquisition- Update Report (to Include Ambulances)	Committee to receive an update report from the Royal Free London NHS Foundation Trust provide an update report on the topic of Ambulances.		
		Barnet, Enfield and Haringey Mental Health Trust: Quality and Performance			
		GP/ Primary Care Services at Finchley Memorial Hospital- Update report	Committee to receive an update from NHS England and Barnet Clinical Commissioning Group on GP/ Primary Care Services at the Finchley Memorial Hospital Site.		
April 2015	Adults and Safeguarding Committee (23 April 2015)	Your Choice Barnet Task & Finish Group	To consider a 12-month update report from Officers on the approved recommendations of the Your Choice Barnet Task and Finish Group	Adults and Communities Director.	
		Implementation of the Care Act	To review progress made against the implementation plan	Adults and Communities Director, Later Life Lead Commissioner.	
		Healthwatch Barnet Enter & View Reports	To receive Enter & View reports from Healthwatch Barnet which relate to the provision of the adult social care services	Adults and communities Director	
	Children, Education, Libraries & Safeguarding Committee (20 April 2015)	Naom conversion to Voluntary Aided Sector	To approve the granting of voluntary aided status to Noam primary School	Education and Skills Director	Education and Skills Director, Schools, Skills and Learning Lead Commissioner
		Looked after children	To note progress made in developing services for looked after children and agree priorities for 15/16	Commissioning Director (Children and Young People), Family Services Director	Commissioning Director (Children and Young People), Family services Director

		Health Visiting Transfer	To agree the transition plan and commissioning priorities for 15/16	Director of Public Health (Barnet and Harrow), Commissioning Director (Children and Young People)	Director of Public Health (Barnet and Harrow), Commissioning Director (Children and Young People)
	CCG Board	Working on forward plan			
May 2015	Health Overview and Scrutiny Committee (11 May 2015)	NHS Trust Quality Accounts (11th May)			
June 2015	CCG Board	Working on forward plan			
Unallocated item	Health Overview and Scrutiny Committee	Public Health Commissioning Intentions	Decision required before 29 May 2015		

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