MEETING
HEALTH & WELLBEING BOARD
DATE AND TIME
THURSDAY 21ST JANUARY, 2016
AT 9.00 AM
VENUE
HENDON TOWN HALL, THE BURROUGHS, NW4 4BG

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

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

Dr Charlotte Benjamin
Dr Andrew Howe
Chris Munday
Councillor Sachin Rajput
Elizabeth James
Dr Clare Stephens
Councillor Reuben Thompstone
Dawn Wakeling
Michael Rich
Chris Miller
John Atherton

Substitute Members

Julie Pal
Councillor Wendy Prentice
Councillor David Longstaff
Bernadette Conroy
Dr Ahmer Farooqui
Dr Barry Subel
Maria O'Dwyer
Nicola Francis
Mathew Kendall
Dr Jeffrey Lake

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

Andrew Charlwood – Head of Governance

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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3.	Declaration of Members' Interests	
4.	Report of the Monitoring Officer (if any)	
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Decisions of the Health & Wellbeing Board

12 November 2015

Board Members:-

AGENDA ITEM 1

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

* Dr Charlotte Benjamin	* Cllr Sachin Rajput	* Dawn Wakeling
* Dr Andrew Howe	Cllr Reuben Thompstone	* Chris Miller
* Chris Munday	* Regina Shakespeare	Michael Rich
	* Dr Clare Stephens	John Atherton

Substitutes
* Cllr David Longstaff

* denotes (substitute) Member Present

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

The Chairman of the Health and Wellbeing Board, Councillor Helena Hart welcomed all attendants to the meeting. An update was received on the actions from the previous meeting:

Following comments from the Board, the JSNA executive summary has been updated to include reference to the positive achievements which have been delivered. The micro webpage for the JSNA 2015-2020 is being developed and is due to be launched in December.

2. ABSENCE OF MEMBERS (Agenda Item 2):

Apologies for absence were received from:

- Councillor Reuben Thompstone who was substituted by Councillor David Longstaff
- Michael Rich
- John Atherton

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

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 received.

6. JOINT HEALTH AND WELLBEING STRATEGY (2015-20) INCLUDING PUBLIC

HEALTH REPORT ON ACTIVITY 2014/15 AND THE DEMENTIA MANIFESTO (Agenda Item 6):

The Chairman introduced the item which sets out the final version of the Joint Health and Wellbeing Strategy (JHWB Strategy) (2015-2020), the production of which was one of the most important responsibilities of the HWB Board. The Chairman highlighted that the JHWB Strategy provides the framework and direction for local commissioning and service planning. She further drew attention to the Joint Foreword included in the Strategy - co-authored by the Vice-Chairman Dr Debbie Frost and herself - which reflected not only the truly joint nature of the Strategy but also the dedication of all partners on the HWB Board to its implementation.

It was noted that the Strategy has been informed by virtue of the feedback received during the public consultation period which took place from 17 September 2015 to 25 October 2015.

Both the Chairman and Vice-Chairman commended the contributions that all partners together with the voluntary and community sector groups and local residents have made towards the development of the JHWB Strategy which has been informed by the JSNA, in order to achieve the best possible outcomes for residents in Barnet.

Dr Andrew Howe was welcomed by the Chairman to make comments. Dr Howe thanked Zoë Garbett and Dawn Wakeling for their work on the Strategy. Dr Howe highlighted the continuity with the previous version of the Strategy and the focus on prevention and mental health being a thread throughout the Strategy. Dr Howe also noted that the Annual Report from Public Health (2014/15) is included as an appendix to the report.

The Board heard about the prevention and early intervention to slow the progress of further development of diseases as well as increasing individual responsibility and building resilience to improve health and wellbeing. Dawn Wakeling, Commissioning Director for Adults and Health informed the Board that a further update report will be brought to the Board in January with details of the implementation plan.

Following an enquiry from the Board, the Chairman welcomed Judy Mace, Head of Joint Children's Commissioning for Barnet CCG and LBB, who explained how data is being shared between health and early intervention settings. The Board heard about the data sharing difficulties encountered, particularly in relation to outreach work for vulnerable adults and children.

Ms Mace emphasised the importance of formalising the process towards data sharing. Chris Munday, Commissioning Director for Children and Young People, informed the Board that the discussion around data sharing will be taken forward outside of the meeting with partners.

Having highlighted the commitment in the Strategy to improve mental health across all age groups from pregnancy to later life, the Chairman introduced the Dementia Manifesto for Barnet, the first such manifesto to be developed by a London Borough. The Board noted Barnet's Dementia Manifesto and Public Health's Annual Report as appendices to the report. The Dementia Manifesto for Barnet has been developed as a result of increasing concerns about the number of people living with dementia in Barnet and across the Country and the devastating effects this can have both on sufferers and their families.

Ms Wakeling explained that the Manifesto has been produced by the Joint Commissioning team and reflects the good progress that has made, particularly in diagnosing dementia and in the development of the pathway. Ms Wakeling mentioned the clear commitment from the CCG to increase diagnosis rates and noted the vision set out in the Dementia Manifesto for the people of Barnet.

The Chairman noted that following approval of the Board, Barnet's Dementia Manifesto will be developed and published as an online tool and that a further implementation plan will be developed with partners and stakeholders.

RESOLVED:

1. **That the Health and Wellbeing Board approves the Joint Health and Wellbeing Strategy (2015-2020, appendix 1) for wider circulation including publication on the websites of partner organisations.**

2. **That the Health and Wellbeing Board notes that the Finance Planning Sub-Group will develop an implementation plan for the Joint Health and Wellbeing Strategy and this will be presented to the Board in January 2016.**

3. **That the Health and Wellbeing Board notes the progress made by Public Health during 2014/15 (appendix 4).**

4. **That the Health and Wellbeing Board approves the Dementia Manifesto for Barnet (appendix 3).**

7. BARNET CLINICAL COMMISSIONING GROUP PRIMARY CARE STRATEGY PROPOSAL (Agenda Item 7):

Elizabeth James, Director of Clinical Commissioning, Barnet CCG, joined the meeting and briefed the Committee about the development of the local Barnet CCG Primary Care Strategy. Ms James noted that the Primary Care Strategy will be used to inform future joint and delegated primary care commissioning from NHS England.

Councillor Hart raised the issue of residents encountering difficulties with the processes for making complaints or changing their GP; these processes are often raised by residents as being hard to understand and navigate. Councillor Hart asked for this to be looked as the Strategy develops this will become an important local issue to address when responsibility becomes shared with NHS England.

Following a query from the Board about future consultation with patients and the Local Authority, Ms Shakespeare informed the Board that the proposed actions will be reported to the relevant Overview and Scrutiny committees.

Mr Munday welcomed the proposal to engage with Members outside of the Board and also noted the importance of effective engagement with young people.

Dr Howe also noted the importance for consultation with Council teams as well as Care Homes.

Furthermore, the Board heard that following approval by the Board, consultation will be undertaken with service users, providers, Public Health, the Local Authority, Healthwatch

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and other stakeholders which will then be presented at the next meeting of the Health and Wellbeing Board.

RESOLVED:

1. **That the Health and Wellbeing Board notes and comments on the process to be adopted to develop the local Barnet Primary Care Strategy.**

2. **That the Health and Wellbeing Board notes that the final Barnet CCG Primary Care Strategy will be brought to the Board in January 2016 for information.**

8. ADULT SOCIAL CARE COMMISSIONING PRIORITIES (Agenda Item 8):

The Commissioning Director for Adults and Health, Dawn Wakeling introduced the item which provides an overview of the Adult Social Care Commissioning Priorities and highlights the opportunities and challenges for adult social care.

Ms Wakeling highlighted the challenge faced in respect of an increasing elderly population, a higher demand for services and the resources available. The Board also heard about the importance of closer working between local NHS partners and the Council to achieve the changes required.

The Adults and Health Commissioning Director also briefed the Committee about the increase in the number of referrals to adult and social care via accident and emergency.

Following a query from the Board, Ms Wakeling noted that as part of the Adults Transformation Programme, a work programme has been developed to meet the challenges for the provision of adult social care.

Dr Charlotte Benjamin queried when the consultation around the new mental health enablement model would start. Ms Wakeling stated that consultations had taken place through the Mental Health Partnership Board and with social workers themselves.

Councillor Sachin Rajput, Chairman of the Adults and Safeguarding Committee welcomed the report and noted the scale of the challenges in developing a more sustainable health and social care economy and the need for adequate funding to meet increasing demand as set out in table 1 on page 134 of the agenda.

Ms Shakespeare welcomed the discussion and highlighted the need for partnership working to develop plans towards future sustainability in context of the health and social care economy and in light of lessons learnt from previous years. Ms Shakespeare also highlighted that plans need to be developed over more than one year and that more will be known following the Comprehensive Spending Review.

Following an enquiry from the Board, Ms Wakeling explained that emerging technologies are being explored as part of a consortium of 19 boroughs.

Following discussion and proposals for amendment of recommendation 2,

That the Health and Wellbeing Board notes the financial context for the provision of Adult Social Services in Barnet and, ~~in line with national guidance, the need for the Better Care Fund to provide funding for the protection of adult social care in~~

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***~~2016/17.~~ the necessity for negotiations between Barnet CCG and LB of Barnet which take this into account, when determining the arrangements for the Better Care Fund and the protection of adult social care in 2016/17 for agreement by* HWBB.**

The Board:

RESOLVED

1. **That the Health and Wellbeing Board notes the Adult Social Care Commissioning Priorities set out in paragraphs 1.4 and 1.5.**

2. **That the Health and Wellbeing Board notes the financial context for the provision of Adult Social Services in Barnet and the necessity for negotiations between Barnet CCG and LB of Barnet which take this into account, when determining the arrangements for the Better Care Fund and the protection of adult social care in 2016/17 for agreement by HWBB.**

3. **That the Health and Wellbeing Board notes the need for financial sustainability across the health and social care economy in Barnet and endorses the areas highlighted for future joint work as set out in Appendix A of the report.**

9. BARNET CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS) TRANSFORMATION PLAN (Agenda Item 9):

The Chairman introduced the Barnet CAMHS Transformation Plan report and noted that the Transformation Plan had been submitted to NHS England on 16 October 2015. It was coming to the HWB Board for formal sign off

Ms Mace was invited to the table and provided the Board with an overview of the Transformation Plan for Child Adolescent Mental Health Services (CAMHS) over the next five year period, in order to improve outcomes for children and young people in the borough. Following the clear national line the document details plans to improve support for children and young people with eating disorders which is a major issue for families in Barnet. The plans also include details on prenatal and crisis care. There is also a national drive to improve national and local data collection. Ms Mace highlighted that the key challenge is turning things around quickly in Quarter 4.

The Commissioning Director for Children and Young People, Chris Munday, noted that the Transformation Plan has been developed to improve both life chances for individuals and reduce the reliance (and cost) on public services later in life.

The Chief Operating Officer (Interim) Barnet CCG, Regina Shakespeare, emphasised the proposed planned spend which includes additional funding from the CCG as set out in table 1 on page 156 of the report.

Following a query form the Board in relation to CAMHS services and budgets, Mr Munday suggested that the Children's Services Priorities and Commissioning Intentions should be brought to a future meeting of the Health and Wellbeing Board. (**Action**)

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The Board agreed that a lifespan approach needed to be taken to support residents effectively. The Board also noted that supporting people with mental health problems is important for other service areas such as housing, regeneration and employment.

RESOLVED

1. **That the Board notes and confirms the approval of the Transformation Plan.**

2. **That the Health and Wellbeing Board notes the ongoing development of the five year plan.**

3. **That the Board approves the plan for publication on the LBB and CCG websites**

10. BARNET SAFEGUARDING CHILDREN BOARD AND SAFEGUARDING ADULTS BOARD ANNUAL REPORTS (Agenda Item 10):

The Chairman welcomed the Barnet Safeguarding Children Board and Safeguarding Adults Board Annual Reports, which had already been reported to the Children, Education, Libraries and Safeguarding Committee as well as the Adults and Safeguarding Committee respectively.

Chris Miller, Independent Chair of BSCB and SAB introduced the item which notes the performance as well as the work to be delivered to address areas of concern. Mr Miller referenced the committed partnership working of both Boards in delivering their priorities.

Ms Wakeling noted the challenge for staff around their understanding of what it means to have 'capacity' to make decisions, an issue that was highlighted by the 'Cheshire West case' which sets out a new threshold for professionals in assessing the concept of liberty and the need to safeguard clients from harm.

Further to the query from Dr Debbie Frost, Mr Miller noted the need for recruiting more independent lay members to join the safeguarding boards.

RESOLVED

1. **That the Health and Wellbeing Board notes and comments on the Annual Reports of the Barnet Safeguarding Children Board (BSCB) and Safeguarding Adults Board (SAB) attached at Appendix 1 and 2.**

11. HEALTH AND SOCIAL CARE INTEGRATION PROGRESS REPORT INCORPORATING BETTER CARE FUND PERFORMANCE (Agenda Item 11):

The Chairman welcomed the report on the progress in relation to the Better Care Fund (BCF) targets as well as the delivery of the health and social care integration work which is a key piece of work for the Board.

Ms Wakeling briefed the Board about the dashboard set out on pages 321-322 of the agenda which provides a summary of the performance against each of the BCF metrics. Ms Wakeling drew attention the non-elective admissions (NEL) which relates to the pay for performance element of the BCF. Ms Wakeling requested the Board to note that, as shown by the BCF metrics in the report, the groups impact on performance are outside of

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the BCF plans and that these focus on people over 55 with long term conditions and the frail elderly.

The Chairman invited Maria O'Dwyer, Director for Integrated Commissioning, Barnet CCG to join the meeting, Ms O'Dwyer explained that Non-Elective Admissions are the key indicator on which Barnet's success with the BCF is assessed.

Action: Ms O'Dwyer to share the BCF paper from a recent Finance, Performance and QUIPP (FPQ) Group with the HWBB

Following a query from the Board, Ms O'Dwyer informed the Board that deeper analysis and clinical work will be undertaken to look at the 0-4 age group for viral infections which will inform the paediatric urgent care work currently being scoped.

The Director for Public Health, Dr Andrew Howe welcomed the analysis work and noted the partnership work required towards prevention measures and early intervention.

The Chairman welcomed the discussion and the Board requested an update on the three key areas which require deeper analysis work (**Action**) :

- Admissions in the 50-59 age group with particular emphasis on chest pain
- Admissions in the over 85 age group linked to falls and fractures from falls
- The 0-4 age group for viral infections which will inform the paediatric urgent care work currently being scoped.

RESOLVED

1. **That the Health and Wellbeing Board notes and makes comments as appropriate on the progress on current work to integrate health and social care.**

2. **That the Health and Wellbeing Board notes and makes comments as appropriate on the performance for Quarter 1 2015/16 of the Better Care Fund.**

3. **That the Health and Wellbeing Board approves the proposed performance report of Quarter 2 2015/2016 Better Care Fund that will be reported to NHS England in the November submission.**

4. **That the Health and Wellbeing Board notes the minutes of the Health and Social Care Integration Board of 9 September 2015.**

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

The Board noted the standing item on the agenda, minutes of the Health and Wellbeing financial planning group meeting of 16 September 2015. It was noted that in September the Group agreed the plan for the transfer of Public Health Commissioning Responsibilities for 0- 19 Healthy Child Programme which novate from NHS England to the Council on the 1st October 2015.

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RESOLVED

1. **That the Health and Well-Being Board notes the Minutes of the Financial Planning Sub-Group meeting of 16 September 2015.**

13. FORWARD WORK PROGRAMME (Agenda Item 13):

The Board received the standing item on the agenda and noted the contents and items on the Forward Work Programme for the Health and Wellbeing Board.

RESOLVED

1. **That the Health and Wellbeing 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 Wellbeing Board Members agree to propose 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 Wellbeing Board agrees to align its work programme with the work programmes of the 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).**

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

The next meeting of the Health and Wellbeing Board will commence at 10am on 21 January 2016.

The meeting finished at 11.40 am

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AGENDA ITEM 6

	Health and Wellbeing Board **21 January 2016**
Title	**Motion from Full Council, Tackling the Growing Problem of Shisha**
Report of	Head of Governance
Wards	All
Status	Public
Urgent	No
Key	No
Enclosures	None
Officer Contact Details	Salar Rida – Governance Officer salar.rida@barnet.gov.uk 0208 359 7113

Summary

The report informs the Health and Wellbeing Board of a Motion which was reported to Full Council on 8 December 2015. In accordance with Council Procedure Rule 23.5, if a Member's Motion is not deal with by the end of a Full Council meeting, it will be referred to the appropriate committee for consideration and any necessary action.

Recommendations

1. **That the Health and Wellbeing Board instructions are required in relation to this item.**

1. WHY THIS REPORT IS NEEDED

1.1 On Tuesday 8 December 2015 Councillor Helena Hart submitted an Administration Motion to Full Council as follows:

1.2 Tackling the Growing Problem of Shisha

1.2.1 Council notes that the popularity and consumption of Shisha has steadily increased in the UK over recent years and that the number of premises offering the substance in London has expanded by over 600% in the last six years.

Locally, there are twenty known Shisha businesses in the borough – an increase of over 50% compared to January 2014. Council notes that young people are more likely to be drawn into Shisha smoking if there are outlets operating near their homes or schools.

1.2.2 Council is very concerned about this trend given the serious impact Shisha smoking can have on people's health. The average Shisha smoking session lasts about an hour, during which time the smoker can inhale up to 200 times more smoke than from a cigarette. Council notes that the health effects are similar to those of other tobacco products, including increased risk of cancer, heart disease, respiratory disease and complications during pregnancy. In addition, Council notes that by users sharing the same mouthpiece there is the further risk of transmitting infectious diseases such as Tuberculosis.

1.2.3 Council believes that many people are unaware of the dangers of Shisha smoking and that current regulations are not stringent enough. Council was shocked that of thirteen premises inspected by Environmental Health in the last two months, ten were found not to be compliant, but notes that previous prosecutions proved costly, time-consuming and resulted in insufficient penalties to constitute an effective deterrent.

1.2.4 Whilst Council is clear that it does not wish to impose a total ban on the provision of Shisha in the Borough, in view of the overriding health considerations associated with its use, Council requests the appropriate officers to urgently investigate how local residents, especially young children, can best be educated about - and protected from - the harmful effects of Shisha. Council requests these investigations centre on Borough-wide educational campaigns led by Public Health, adherence to existing and possibly additional Planning and Licencing laws and, above all, far tougher enforcement and penalties for contravention of existing legislation.

1.3 Council's Constitution, Full Council Procedure Rule 23.5 states that:

If the Member's Motion is not dealt with by the end of the meeting, it will be referred to the appropriate Council Committee or sub-Committee for consideration and any necessary action. (However, if the proposer has specifically asked in his or her notice for the Motion to be voted on at that Council meeting it will be voted on without discussion).

1.5 The motion was not discussed or voted on at the Full Council meeting. Therefore the Health and Wellbeing Board are requested to consider the contents of the motion as set out in section 1.2 of this report and give instruction.

2. REASONS FOR RECOMMENDATIONS

2.1 No recommendations have been made. The Health and Wellbeing Board are therefore requested to give consideration to the motion and provide instruction.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Not applicable.

4. POST DECISION IMPLEMENTATION

4.1 Post decision implementation will depend on the decision agreed by the Board.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 If the committee propose to action in relation to this motion, any actions arising will need to be evaluated against the Corporate Plan and other relevant policies such as the Health and Wellbeing Strategy.

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

5.2.1 None in the context of this report.

5.3 Social Value

5.3.1 None in the context of this report.

5.4 Legal and Constitutional References

5.4.1 Council Constitution, Full Council Procedure Rules (section 23.5) states if the Member's Motion is not dealt with by the end of the meeting, it will be referred to the appropriate Council Committee.

5.4.2 The Council's Constitution, Responsibility for Functions (Annex A) sets out the terms of reference for the Health and Wellbeing Board which includes:

- To receive assurance from all relevant commissioners and providers on matters relating to the quality and safety of service for users and patients.

- Specific responsibilities for:
    - Overseeing public health
    - Developing further health and social care integration.

5.4.3 There are no legal references in the context of this report.

5.5 **Risk Management**

5.5.1 None in the context of this report.

5.6 **Equalities and Diversity**

5.6.1 None in the context of this report.

5.7 **Consultation and Engagement**

5.7.1 All of these issues must be considered for their equalities and diversity implications.

5.8 **Insight**

5.8.1 None in the context of this report.

6. BACKGROUND PAPERS

6.1 Motion to Full Council, 8 December 2015:

http://barnet.moderngov.co.uk/documents/s27832/Cllr%20H%20Hart%20-%20Tackling%20the%20Growing%20Problem%20of%20Shisha.pdf

AGENDA ITEM 7

	Health and Wellbeing Board **21 January 2016**
Title	**Joint Health and Wellbeing Strategy Implementation plan (2015 – 2020)**
Report of	Commissioning Director – Adults and Health Director of Public Health
Wards	All
Date added to Forward Plan	September 2015
Status	Public
Urgent	No
Key	Yes
Enclosures	Appendix 1: Joint Health and Wellbeing Strategy Implementation Plan (2015 – 2020)
Officer Contact Details	Zoë Garbett, Commissioning Lead, Health and Wellbeing Email: zoe.garbett@barnet.gov.uk, Tel: 020 8359 3478

Summary

Following the approval of the final Joint Health and Wellbeing (JHWB) Strategy 2015 – 2020 by the Health and Wellbeing Board (HWBB) in November 2015, this paper presents the JHWB Strategy implementation plan for approval. The plan has been developed with partners, overseen by the HWBB Financial Planning Group. A progress report, covering the implementation of the JHWB Strategy, will be brought to each meeting of the HWBB with a focus of certain elements, with a full report on progress annually each November.

Recommendations

1. **That the Health and Wellbeing Board approves the Joint Health and Wellbeing Strategy implementation plan (2015-2020, appendix 1).**
2. **That the Health and Wellbeing Board agrees to receive progress reports, covering the implementation of the JHWB Strategy, at each meeting.**

1. WHY IS THE REPORT NEEDED

1.1 Background

1.1.1 At its meeting in November 2014 the Health and Wellbeing Board (HWBB) requested work to commence on refreshing the current Barnet Joint Strategic Needs Assessment (JSNA) and on producing a new Joint Health and Wellbeing (JHWB) Strategy.

1.1.2 On 17 September 2015 Barnet's Health and Wellbeing Board approved the updated JSNA (2015 - 2020). The JHWB Strategy has been developed following the refresh of the JSNA, using it as the evidence base to determine priority areas for action. The JSNA is now available online at www.barnet.gov.uk/jsna and there are plans for the JSNA to have its own microsite which will be kept up-to-date.

1.1.3 On 12 November 2015, the Health and Wellbeing Board approved a new Joint Health and Wellbeing (JHWB) Strategy (2015 – 2020)[1] for Barnet. The JHWB Strategy has four themes – Preparing for a healthy life; Wellbeing in the communities; How we live and Care when needed. JHWB Strategy has a section on each theme which describes progress to date (since the last strategy), key data from the updated JSNA, and most importantly the planned activity to meet our objectives as well as specific targets.

1.2 Developing the implementation plan

1.2.1 Barnet Council and Barnet CCG held a workshop with local organisations (Healthwatch, CommUNITY Barnet, Groundwork) attended a workshop on 9 December to reviewed and developed the draft implementation plan the actions contained in the JHWB Strategy and confirmed that they remained relevant and that leadership was in place to secure delivery.

1.2.2 The meeting also provided an opportunity to consider the development of further system enablers for achieving the outcomes of the JHWB Strategy. The following areas were identified as key areas that would benefit the partnership and most importantly the residents of Barnet:

- Joining up our knowledge and contact with service users, residents and patients to reduce duplication and ensure that hard to reach communities are involved in shaping services
- Health and social care support outside of traditional settings; social prescribing, pharmacy and supporting people with long term conditions through peer support
- The role of the workforce; communication of key messages, building relationships and improving the health and wellbeing of the workforce itself. Supporting all public agencies to achieve the Workplace Wellbeing Charter and provide employment opportunities to adults with health conditions/ disabilities

[1] The final Joint Health and Wellbeing Strategy (2015 – 2020) can be found here: https://barnet.gov.uk/citizen-home/public-health/Joint-Health-and-Wellbeing-Strategy-2015-2020.html

- Better use of technology to improve working between organisations and resident use and experience of service users.

1.2.3 The development of the implementation plan has been overseen by the HWBB Financial Planning Group. On the 15 December, the Financial Planning Group agreed this version of the plan.

1.2.4 As much detail as possible is included in the current version of the plan (at appendix 1), it is envisaged that the plan will be a living document which can be updated and refined (presented at each meeting of the Board). The current plan contains a number of areas where targets and action details needs to be confirmed such as primary care initiatives to reduce long term conditions and details about health pathways which was not available at the time of publication. These areas will be clarified in the first progress report to be Board.

2. REASONS FOR RECOMMENDATIONS

2.1 The production of a Joint Health and Wellbeing Strategy is a legal requirement of the Local Government and Public Involvement in Health Act (2007). Local Authorities and Clinical Commissioning Groups (CCGs) have equal and joint duties to prepare a JHWB Strategy, through the Health and Wellbeing Board. To ensure that we deliver the JHWB Strategy and meet its targets, an implementation plan, developed with and agreed across the partnership, is essential.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 There is a legal requirement to draft a Health and Wellbeing Strategy. Not producing a JHWB Strategy implementation plan would create a risk of non-alignment across the Health and Wellbeing Board membership, could result in decisions being made either in silos or based on sub-optimal evidence and intelligence, and increase the likelihood of unnecessary duplication and overlap of public sector spend.

4. POST DECISION IMPLEMENTATION

4.1.1 The Board will be kept up to date with progress being made in implementing the HWBB Strategy through regular performance reports.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 The JHWB Strategy supports evidence-based decision making across the Health and Wellbeing Board and its partners. The JHWB Strategy has been developed to align and bring together national and local strategies and priorities including Barnet Council's Corporate Plan 2015-2020 and BCCG's strategic plans.

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

5.2.1 The JHWB Strategy directs the Health and Wellbeing Board priorities for the period 2015 – 2020, building on current strategies and focusing on areas of joint impact within current resources. The priorities highlighted in the JWHB Strategy will be considered by all the relevant organisations when developing

activities. The JHWB Strategy will support the work of all partners to focus on improving the health and wellbeing of the population. It emphasises on effective and evidence-based distribution of resources for efficient demand management. Each project will be individually funded however, using the existing resources of the participating organisations.

5.3 **Social Value**

5.3.1 The JHWB Strategy focuses on the health and social care related factors that influence people's health and wellbeing, with clear recognition of the importance of addressing wider factors such as education, employment, income and welfare. These wider factors can both impact on and be impacted by the health and wellbeing of an individual or population, and need to be considered in order to make sustainable improvements to health and wellbeing. The JHWB Strategy will inform commissioning.

5.3.2 The Public Services (Social Value) Act 2013 requires those who commission public services to think about how they can also secure wider social, economic and environmental benefits. Before commencing a procurement process, commissioners should think about whether the services they are going to buy, or the way they are going to buy them, could secure these benefits for their area or stakeholders.

5.4 **Legal and Constitutional References**

5.4.1 Producing a JHWB Strategy is a legal requirement of the Local Government and Public Involvement in Health Act (2007). Local authorities and CCGs have equal and joint duties to prepare JSNAs and JHWSs, through the Health and Wellbeing Board. The Board must have regard to the relevant statutory guidance – Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies - when preparing the JSNA and JHWS.

5.4.2 The Council's Constitution (Responsibility for Functions – Annex A) sets out the Terms of Reference of the Health and Wellbeing Board which 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 manage its implementation to ensure that improved outcomes are being delivered.
- 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 JHWBS and refer them back for reconsideration.
- 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.

- To promote partnership and, as appropriate, integration, across all necessary areas, including the joined-up commissioning plans across the NHS, social care and public health.
- Specific responsibilities include overseeing public health and developing further health and social care integration.

5.5 **Risk Management**

5.5.1 There is a risk that if the JSNA and JHWB Strategy are not used to inform decision making in Barnet that work to reduce demand for services, prevent ill health, and improve the health and wellbeing and outcomes of people in the Borough will be sub optimal, resulting in poorly targeted services and an increase in avoidable demand pressures across the health and social care system in the years ahead.

5.6 **Equalities and Diversity**

5.6.1 The JHWB Strategy has used evidence presented in the JSNA to produce an evidence based resource which has equalities embedded at its core, explicitly covering the current and future needs of people in Barnet from each equalities group.

5.6.2 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 and foster good relations between people from different groups. Both the Local Authority and the CCG are public bodies. The relevant protected characteristics are age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

5.7 **Consultation and Engagement**

5.7.1 A number of partners have been involved in the development of the JHWB Strategy including a public consultation which ran from 17 September – 25 October 2015 which included an online survey and workshops.

5.7.2 Feedback from the consultation has informed the final JHWB Strategy 2015-2020. Overall there was support for our vision, themes and areas of priority focus. A full consultation report was presented to the HWBB in November 2015.

5.7.3 The implementation plan has been developed with a number of partners to ensure the plan is universally agreed and embedded across the public sector.

5.8 **Insight**

5.8.1 The JSNA is an insight document and pulls together data from a number of sources including Public Health Outcomes Framework, GLA population

projections, Adults Social Care Outcomes Framework and local analysis. The Joint HWB Strategy has used the JSNA as an evidence base from which to develop priorities.

6. BACKGROUND PAPERS

6.1 Joint Health and Wellbeing Strategy (2015 – 2020) including Public Health report on activity 2014/15 and the Dementia Manifesto, Health and Wellbeing Board, 12 November 2015, item 6:
https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=177&MId=8387&Ver=4

6.2 Joint Strategic Needs Assessment 2015 - 2020, Health and Wellbeing Board, 17 September 2015, item 7:
https://barnet.moderngov.co.uk/documents/s25805/Joint%20Strategic%20Needs%20Assessment%202015-2020%20HWBB%20Sept%202015.pdf

6.3 Draft Joint Health and Wellbeing Strategy (2016 - 2020), Health and Wellbeing Board, 17 September 2015, item 8:
https://barnet.moderngov.co.uk/documents/s25837/Draft%20Joint%20Health%20and%20Wellbeing%20Strategy%20HWBB%20September%202015.pdf

6.4 Draft Joint Strategic Needs Assessment (JSNA) and emerging priorities for the Health and Wellbeing Strategy, Health and Wellbeing Board, 30 July 2015, item 6:
https://barnet.moderngov.co.uk/documents/s24989/Draft%20Joint%20Strategic%20Needs%20Assessment%20JSNA%20HWBB%20July%202015.pdf

6.5 Dementia Manifesto, Health and Wellbeing Board, 29 January 2015, item 10:
https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=177&MId=7784&Ver=4

6.6 Health and Wellbeing Priorities for 2015 – 2020, Health and Wellbeing Board, 13 November 2014, item 7:
https://barnet.moderngov.co.uk/documents/s19164/Health%20and%20Well-Being%20Priorities%20for%202015-20.pdf

healthwatch Barnet | BARNET LONDON BOROUGH | NHS England | NHS Barnet Clinical Commissioning Group

Barnet's Joint Health and Wellbeing Strategy: Keeping Well, Promoting Independence

Implementation Plan 2015 – 2020

The Joint Health and Wellbeing (JHWB) Strategy is the borough's overarching strategy which aspires to improve health outcomes for local people and aims to keep our residents well and to promote independence. The JHWB Strategy focuses on health and social care related factors that influence people's health and wellbeing, with clear recognition of the importance of prevention, early intervention and supporting individuals to take responsibility for themselves and their families. The JHWB Strategy also addresses wider factors such as education, employment, income and welfare. These wider factors can both impact on and be impacted by the health and wellbeing of an individual or population, and need to be considered in order to make sustainable improvements to health and wellbeing.

It is intended that the implementation plan is read alongside the JHWB Strategy which can be found at: https://barnet.gov.uk/citizen-home/public-health/Joint-Health-and-Wellbeing-Strategy-2015-2020.html

Actions in the JHWB Strategy have and will be included in other key strategies and action plans such as the Housing Strategy, Primary Care Strategy, Early Intervention and Prevention Strategy, Better Care Fund plans and Entrepreneurial Barnet to ensure delivery across the health and social care system in Barnet. The actions detailed in this implementation plan focus on the priorities that require a partnership approach. The Plan indicates where an action or target is aspirational. The plan has no new financial resources to support its implementation but provides a framework and direction for focus of existing resources to have a significant impact on the health and wellbeing of the borough.

The Implementation Plan is structured around the four theme areas of the JHWB Strategy: Preparing for a healthy life; Wellbeing in the community; How we live and Care when needed. For each theme area, the priorities are highlighted. Outcomes and targets are shown with the agreed action, timescale and organisational lead (for delivering the outcome and reporting).

The Implementation Plan enables the Health and Wellbeing Board to monitor progress and success in the short, medium and long terms. The Health and Wellbeing Board will receive regular progress reports which will allow the Health and Wellbeing Board to continue to develop its work programme.

Overarching outcome measures

Below is a list of the key overarching measures that we will monitor to ascertain whether we are on track to achieve our vision to help everyone to keep well and to promote independence. The outcome measures listed in the implementation plan contribute to these overarching indicators. The overarching indicators will be monitored; no specific targets are set but our intentions are clear.

Outcome	Baseline	Reducing inequalities gap
Increase life expectancy	Most recent data (2013) shows that, in Barnet, women have a higher average life expectancy (85 years) than men (81.9 years) (2013). The life expectancy of men has increased at a higher rate than that of women, reducing the life expectancy gap between genders from 5.1 years (1991/93) to 3.1 years.	The life expectancy of individuals living in the most deprived areas of the borough are on average 7.6 years less for men and 4.7 years less for women than those in the most affluent areas.
Increase healthy life expectancy	Gains in life expectancy have outstripped gains in healthy life expectancy. This indicates that although women are living (on average) longer than men, a larger proportion of women's lives is spent in poor health; 19.1% (16.2 years) for women and 17.0% (13.9 years) for men.	Aiming to reduce the gap between life expectancy and healthy life expectancy.
Reduce premature mortality due to cardiovascular disease (including coronary heart disease, hypertension, stroke and congenital heart disease)	Coronary Heart Disease is the number one cause of death amongst men and women. Data for 2011-2013 show that the Barnet death rate due to preventable cardiovascular disease (CVD) in those aged less than 75 years was 39.7 per 100,000 and was higher in males (58.3) compared to females (23.3). CVD mortality rate in age under 75 years was also higher in males than in females i.e. 89.6 vs. 39.4 respectively. Barnet's rates were lower than the average rates for the London region (males = 113.5, females = 49.6) and England (males =109.5, females = 48.6).	Reducing the gap between the most and least deprived wards in Barnet (through measuring the life expectancy gap between wards in top and bottom deciles of deprivation in Barnet).
Reduce premature mortality due to	Cancer is the second most common cause of death in Barnet. The incidence rate for all cancers in Barnet (356.7 per	Reducing the gap between the most and least deprived wards in Barnet (through

cancers	100,000) is lower than the average for England (398.1 per 100,000). The incidence rates (per 100,000) of breast cancer (126.6), prostate cancer (99.8 per 100,000), cervical cancer (6.7), ovarian cancer (14.9) and stomach cancer (8.1) are similar to the national average rates of these cancers (i.e. 125.7, 105.8, 8.8, 16.7 and 8.4 per 100,000, respectively). The incidence rate of lung cancer (35.6 per 100,000) and bowel cancer (403 per 100,000) in Barnet are lower than the average rates of these cancers in England (47.7 and 46.5 per 1000,000 respectively).	measuring the life expectancy gap between wards in top and bottom deciles of deprivation in Barnet).
Reduce tooth decay in children under 5	In 2011/12, 0.86 was the meant severity of tooth decay for children under 5 in Barnet which is below the England average (0.94)[1]. Reduce the prevalence of early childhood dental caries from 6.1% (2013) to the national average (3.8%) by 2020.	Tooth decay is a predominantly preventable disease. Significant levels remain, resulting in pain, sleep loss, time off school and, in some cases, treatment under general anaesthetic. Dental neglect is considered a good proxy for wider health and wellbeing issues for children, therefore measuring this will allow assessment of the borough's early intervention strategy (closely linked to the borough's efforts to reduce childhood deprivation).

[1] As measured by the mean severity of tooth decay in children aged five years based on the mean number of teeth per child sampled which were either actively decayed or had been filled or extracted decayed/missing/filled teeth: http://www.phoutcomes.info/public-health-outcomes-framework#page/6/gid/1000044/pat/6/par/E12000007/ati/102/are/E09000003/iid/90359/age/34/sex/4

Preparing for a healthy life: Improving outcomes for babies, young children and their families

- Focus on early years settings and providing additional support for parents who need it

Outcome / target	Action	Year (start / end)						Strategic Lead	Operational Lead
		2015	2016	2017	2018	2019	2020		
Increase the percentage of children Barnet foster care[2] as a percentage of all children in care from 35% (2014/15) to 39% (2015/16) and 53% (2019/20)	Develop a Corporate Parenting Pledge							Commissioning Director Children and Young People	Voice of the Child Coordinator
	Recruit more local foster carers								Head of Placements
Improve outcomes for children and young people and lower costs throughout the partnership • Increase number of mothers who initiating and maintaining breastfeeding (14/15 85.1% to increase to 92% by 2020) • Contribute to an increase smoking cessation (smoking rates reduced from 15% to 13.5% by 2020); specifically reducing the number of women smoking during pregnancy (local target TBC).	Five centres for children to be accredited Healthy Children's Centres (by 2016)							Commissioning Director Children and Young People	Head of Early Years and Early Help
	Remainder for children to be accredited Healthy Children's Centres (by 2020)								
	Deliver an integrated multi-agency partnership early help offer which delivers on the principles of the Early Intervention strategy (Intervening as early as possible, Whole family approach, Using evidence based interventions), specifically developing an agreed pathway and menu of interventions for all partners of Children's services.								
	Integration of health visiting: • Implement the Healthy							Commissioning Director Children	Head of Joint Children's

[2] Defined as a child in a foster placement in Barnet rather than outside of the borough

	Child Programme Integrate provision of service in readiness to undertake a competitive procurement							and Young People	Commissioning
Remain above the national average for good level of development at the end of reception; in 2015 68.2% achieved in Barnet compared to 66.3% average Increase the percentage of free entitlement early years places taken up by parents/carers (where eligible) from 41% (2014/15) to 50% (2015/16) and 85% (2019/20) Reduction in hospital admissions caused by unintentional and deliberate injuries to children 0 – 14 years old (2013/14 64.4 per 10,000, remain below the national rate)	Improve early years' service offer: Increase the supply and demand for the two year old (free childcare) offer • Promote the service offer to eligible parents (2015 / 16) • Improve application process for eligible parents (2015/16) • Support existing businesses to increase their offer and support new businesses to apply to become members of the scheme (2016/17).							Commissioning Director Children and Young People	Head of Early Years and Early Help
Have 85% (65% from vulnerable groups) of families with child/ren under 5 registered and accessing services at centres for children by 2015/16 and 96% (65% vulnerable groups) by 2019/20	Continue to develop the early years service including the locality model							Commissioning Director Children and Young People	Head of Early Years and Early Help
Increase satisfaction of children and parents with services for children and young people (aged 0 – 25 years old). Baseline to be set by the service. Satisfaction to be determined through annual surveys (TBC) then increase by 5% each year	Create an improved service user experience through implementation of 0 – 25 disability service designed to support a journey to adulthood, involving service users in the choices and decisions that affect their lives							Commissioning Director Adults and Health Commissioning Director Children and Young People	0 – 25 Head of Service 0 – 25 Programme Consultant

Enable young adults to live as independently and healthy as possible and engage in purposeful employment and social activity in their local community	Introduction of new ways of working designed to maximise independence Developing a personalised approach to all aspects of support using person centred practices, personal budgets and building strong communities								
Increase the frequency of occurrences whereby children and young people are engaged and involved in the design, planning and review of services and commissioning processes (measured via the Voice of the Child Strategy[3])	Refresh and deliver the Children and Young People's (CYP) Plan (2016 – 2020)							Head of Service Workforce Development, Libraries & Community Engagement	Commissioning Strategy & Policy Advisor-Children & Young People
	Develop a Children's Charter reflecting priorities identified by children and young people in Barnet (across the partnership) overseen by Children, Education, Libraries and Safeguarding (CELS) Committee							Commissioning Director Children and Young People	Voice of the Child Coordinator
	Continue engagement with children and young people through: • Existing groups including the Role Model Army, Youth Board and Young Commissioners							Head of Service Workforce Development, Libraries & Community Engagement	Voice of the Child Coordinator

[3] Voice of the Child Strategy (follow link at the bottom of the page) - https://www.barnet.gov.uk/citizen-home/children-young-people-and-families/key-strategic-documents-and-plans.html

	• Develop new Youth Voice Forums • One mystery shopper experience per quarter to allow the children in care council to review current level of provision on offer to CIC and Care Leavers • CYP involved in 4 interview panels and major service reviews (e.g. CAMHS, 0 – 25, Family Court).								
Increase social action and voluntary and community sector activity (local targets)	Work in areas highest need to increase voluntary and community sector provision • Five social action projects a year in areas of high need, resulting in increased volunteering • Seven start-up organisation supported each year							Commissioning Director Adults and Health	Local Infrastructure Organisations
Safeguard children and young people Prevent number of children and young people becoming victims to child sexual exploitation (CSE) and Female Genital Mutilation (FGM) and appropriately support victims	Deliver domestic violence (DV) and Violence Against Women and Girls (VAWG) strategy 2013 - 2016[4]: • Deliver community engagement events • Secure DV expertise in MASH • Ensure that all relevant staff (e.g. Family Nurse							Head of Community Safety	Domestic Violence and Violence against Women and Girl's Co-ordinator Designated

[4] Barnet Domestic Violence and Violence Against Women and Girls Strategy pages: https://www.barnet.gov.uk/citizen-home/children-young-people-and-families/parental-support/domestic-violence-and-violence-against-women-and-girls.html

	Partnership, GPs, schools) are appropriately trained to ensure timely safeguarding advice and referrals made for girls who are identified as being at risk of FGM • Monitor and increase the number of Safeguarding referrals for advice on the issue of FGM .								Safeguarding Children Nurse
	Review, update and deliver Barnet's DV and VAWG Strategy								
	Support the delivery of the Barnet Safeguarding Children's Board Business plan[5]							Commissioning Director Children and Young People Barnet Safeguarding Childrens Board Chair	CSE Co-ordinator Designated Safeguarding Children Nurse
Increase uptake of childhood immunisations (six vaccinations) to be at or above the England average. Currently below England average for each vaccination[6].								NHS England – London Regional Lead	Public Health / Childrens JCU
Stretch targets									
Reduce the prevalence of early childhood dental caries from 6.1% (2013) to the national average (3.8%) by 2020	Review access to dentistry for children and young people							Head of Healthwatch	Healthwatch / Childrens JCU
	Increase the reach and organisational involvement in the							Commissioning Director Children	Public Health / Head of Joint

[5] Barnet's Safeguarding Children's Board: https://www.barnet.gov.uk/bscb/

[6] Please see Public Health Outcome Framework for details: http://www.phoutcomes.info/public-health-outcomes-framework#page/0/gid/1000043/pat/6/par/E12000007/ati/102/are/E09000002

	work of Oral Health Champions							and Young People	Childrens Commissioning

Wellbeing in the community: Creating circumstances that enable people to have greater life opportunities									
Outcome / target	**Action**	**Year (start / end)**						**Strategic Lead**	**Operational Lead**
		2015	**2016**	**2017**	**2018**	**2019**	**2020**		
Focus on improving mental health and wellbeing for all – year one priority									
Baseline and targets to be confirmed: • More people will have good mental health • More people with mental health problems will recover • More people with mental health problems will have good physical health • More people will have a positive experience of care and support • Fewer people will suffer avoidable harm • Fewer people will experience stigma and discrimination.	Work with Enfield and Haringey CCGs to review Psychiatric Liaison Service provision							Barnet CCG	
	Continue to work with Enfield and Haringey CCGs on the Crisis Concordat implementation plan							Barnet CCG	
	Review local pathways for antenatal and postnatal depression							Barnet CCG	
	Reimagining mental health (including implementation of hubs, exploring peer support, social prescribing) • Co-design groups established (2015) • Co-design groups proposals are developed and delivered (2015/16).							Barnet CCG	Joint Commissioning Manager, Mental Health
For people eligible for services under the Care Act with mental health problems increase: • Health-related quality of life (0.508 14/15, target TBC) • Independent living (with or without support) from 5.2% (2014/15) to be in the top 25% of comparable boroughs by 2019/20.	Development of new model for mental health social work. Focusing on recovery, social inclusion and enablement. • Implement an enablement care planning approach delivering a recovery focussed six week offer • Establish Local							Adults and Communities Director	Joint Commissioning Manager

	Enablement Teams that will reach into family services, primary care and a range of other community services • Establish, with BEHMHT, a Local Enablement Hub ensuring that enablement opportunities with partners are maximised and extending the range of services whilst reducing dependency on secondary care • Deliver cultural change through building on local best practice and service user feedback to embed enablement approaches throughout the pathway.								
Local targets and baseline to be confirmed: • Reduce the waiting time for eating disorder services • Reduce self-harm admissions and A&E presentations • Every young person presenting with self-harm or crisis to be seen within two hours regardless of setting; improve parent and teacher reported Strength and Difficulties Questionnaire (SDQ) to below threshold for referral.	Undertake, collaboratively across North Central London, an end-to-end pathway redesign of existing Child and Adolescent Mental Health Services (CAMHS) as our response to the national CAMHS Transformation agenda (working with schools)							Head of Joint Childrens Commissioning	Childrens Joint Commissioning Unit (JCU)
	Develop school traded approach								
	Work with schools to support children and young people experiencing mental health problems							Healthwatch	Youth Healthwatch / Childrens Services

Increase proportion of people who are feeling supported to manage their condition from 57.1% (2014/15) to above the England performance, 66.5% (2014/15) Service outcomes for people involved in the practice • Increased involvement with social activities and social groups • Increase knowledge and skills related to health and social care • Increased satisfaction with GP services • A shift towards a community-centred practice.	Recruit 50 Health Champions in 2016 with further roll out to 2020 (Link to Making Every Contact Count Training below)							Director of Public Health Commissioning Director of Adults and Health Director of Adults and Communities	Public Health
Remain below the national average (20%) for people self-reporting high anxiety (Barnet; 14.5%) (2013/14) Increase the number of Adults and Children with mental health conditions who feel able to manage their condition (TBC).	Procure digital mental health service (as part of pan-London programme)								
	Wellbeing Campaign (TBC)								
Increase the percentage of adult social care users who have as much social contact as they would like from 41.4% in 2014/15 to being in the top 25% in England by 2019/20	Develop and promote opportunities for increased social contact (Better Care Fund) • Deliver the neighbourhood services model • Implement the new adult social care operating model which includes community based hubs and increased working with the voluntary sector							Commissioning Director Adults and Health	Commissioning Lead Health and Wellbeing / Adults Delivery Unit

	and asset based social work practice.								
Support people to gain and retain employment and promote healthy workplaces									
Increase the proportion of adults in contact with secondary mental health services in paid employment from 5.7% (2013/14) to 7% (2015/16) and continue to increase (2019/20)	Implement WLA Mental Health Continue Employment Trailblazer and Public Health Employment Support initiatives								
Support 240 people into work via BOOST in 2015/16 and 2016/17	Continue to deliver and replicate BOOST approach to community based support							Commissioning Director Growth and Development	Commissioning Lead
Maintain or reduce the percentage of employees who have had at least one day off in the previous week (1.3% in 2010 – 2012) Increase employee satisfaction (local measures TBC)	Barnet Council to achieve (by 2016) and maintain London Healthy Workplace Charter							HR (LBB)	Public Health
Wellbeing at home									
Increase percentage of adults with additional needs in appropriate accommodation: • Percentage of adults with learning disabilities who live in stable accommodation; from 58.1% in 2013/14 to above the England average (74.9%) by 2019/20 • Percentage of older people remaining at home 91 days after discharge; from 71.9% (2013/14) to the top 25% of comparable	Implement the borough's Housing Strategy (2015 – 2020)[7]							Commissioning Director Growth and Development	Barnet Homes

[7] Housing Strategy (2015 – 2020) - https://www.barnet.gov.uk/citizen-home/housing-and-community/housing-strategy-and-policies.html

boroughs by 2019/20. Increase the standard of private sector housing (local measure) Decrease statutory homelessness from 4.7 per 1000 in 2013/14									
Reduction in excess winter deaths[8]; 17.6 August 2010 – July 2013 (three years) in Barnet (England average was 17.4 for the same period) Reduction in numbers of vulnerable people living in fuel poverty	Continue to deliver winter wellness programme • Run a Winter Well helpline • Provide emergency supplies and services • Energy switches.							Director of Public Health (LBB)	Re

[8] Excess Winter Deaths Index (EWD Index) is the excess winter deaths measured as the ratio of extra deaths from all causes that occur in the winter months compared with the expected number of deaths, based on the average of the number of non-winter deaths.

How we live: Encouraging healthier lifestyles

Outcome / target	Action	Year (start / end)						Strategic Lead	Operational Lead
		2015	2016	2017	2018	2019	2020		
Focus on reducing obesity and preventing long term conditions through promoting physical activity									
Increase the total number of leisure centre members (all categories) from 26,400 in 2014 to 30,000 in 2020 Increase total leisure centre attendances (1,149,290) by 2% by 2020 Increase participation (as measured by Sport England active people survey) by 1% for the following groups by 2020: • Females 16 years and over • Older adults (55 and over) • People with disabilities, currently. Reduce excess weight in adults (55.7% in 2014/15)	New leisure contract, with an increased focus on public health outcomes, in place by 1 January 2018. Improve and enhance Barnet leisure facilities, ensuring that opportunities are accessible for all residents. • Two new leisure centres open in 2018/19 Refresh and relaunch strategic "Fit and Active Barnet" network.							Commissioning Director Adults and Health	Strategic Lead – Sports and Physical Activity
	Develop Obesity Strategy (mid-2016)							Director of Public Health	Consultant in Public Health
Reduce the prevalence of children classified as overweight and obese by 0.5% for each group (4 – 5 year olds overweight, 4 – 5 year olds obese, 10 – 11 year olds overweight, 10 – 11 year olds obese) by 2020	Commission child weight management service (impact not on a population level) Following the Obesity Strategy, develop a Childhood Obesity plan which will be taken forward by the Childhood Obesity group (end-2016).							Director of Public Health	Consultant in Public Health

Assure promotion and uptake of all screening including cancer screening and the early identification of disease									
Improve early identification of long term conditions.	Primary care initiatives (TBC)							Barnet CCG	
	Target NHS Health Check uptake: high risk groups to be identified							Director of Public Health	Public Health
Increase screening uptake (data April 2015) • Cervical Cancer (25 – 29) – 63.2% • Cervical Cancer (50 – 64) – 74.8% • Breast Cancer (50 – 70) – 68.1% • Bowel Cancer (60 – 69) – 49.3%	Improve promotion and work with underserved communities to improve the take up of screening							NHS England: London Regional Lead	
Wider healthy lifestyle support									
Broad outcomes: Increased support for residents Aspirational: Increased signposting and uptake of services (including smoking cessation, sports and physical activity) therefore improved physical and mental wellbeing	Develop a training resource to upskill staff (300 in first) who interact with residents to maximise opportunities to promote good health (Making Every Contact Count Training)							Director of Public Health	Commissioning Lead Health and Wellbeing
Remain below the England average (645 per 100,000) for hospital admission episodes for alcohol related conditions (Barnet, 470 per 100,000 in 2013/14) Increase successful completion of drug treatment: • Completion of drug treatment - opiate users (2014); Barnet 10.7, England Average 14.9 • Completion of drug treatment - non-	Increase quality of and access to substance misuse and smoking cessation services							Director of Public Health	Public Health

opiate users (2014); Barnet 30, England 58.5. Increase smoking cessation (smoking rates reduced from 15% to 13.5% by 2020).									
Remain below England average for late HIV diagnosis (40.6% for Barnet, 42.2% for England) Reduce under 18 conceptions (10.2 per 1000 for Barnet, 24.3 per 1000 for England)	Commission pan- London sexual health services							Director of Public Health	Public Health
Decreased social isolation (local measure for areas of regeneration) Increase the percentage of residents who are satisfied with Barnet as a place to live from 88% (quarter 1 2015/16) to 90% (2015/16) Long term - increased incidental physical activity, decreased obesity (see above indicators)	Build health and social care into planning, including developing healthy high streets model							Commissioning Director Growth and Development	Public Health / Regeneration

Care when needed									
Outcome / target	**Action**	**Year (start / end)**						**Strategic Lead**	**Operational Lead**
		2015	**2016**	**2017**	**2018**	**2019**	**2020**		
Focus on identifying unknown carers and improving the health of carers (especially young carers)									
Increase the identification of unknown carers by 10% by 2015/16 and continue to increase to 2019/20: • In 2014/15 there were 5951 registered carers (including 596 young carers) with the commissioned lead provide for carers and young carers support services.	Agree and deliver the Barnet's Carers Strategy (2015 – 2020) Recommission of carers support services (both adult and young carers) to start April 2016 including targeted campaigns to identify carers, improving the respite offer for carers as well as high quality general support Raise awareness of employment rights of carers with local businesses and with carers and young carers							Adults and Communities Director / Family Services Director	Prevention and Wellbeing / Family Services
Improve support to carers • Reduce the number of carers requiring additional support as a result of carers breakdown in 2014/15 there were no carers aged 18 – 64 requiring additional support and 13 over 65 who did • Increase the proportion of carers who reported that they had as much social contact as they would like from 32.5% (2014/15) to being in the top 25% of comparable boroughs.									
Increase the proportion of carers satisfied with social services from 33.3% (2014/15) aiming for the top 25% of comparable	Carers are involved in service development							Adults and Communities Director	Prevention and Wellbeing

boroughs by 2019/20.	Training to support the needs of young carers							Family Services Director	Family services
Work to integrate health and social care services									
Maintain the diagnosis rate of 77.1% and continue to meet the 12 week referral to diagnosis target for dementia Reduction in stigma and increase local understanding of dementia (local measure TBC)	Implement Barnet's Dementia Manifesto							Commissioning Director Adults and Health / Director of Integrated Commissioning	Joint Commissioning Manager, Older People
Increase choice and control through take up of Personal Health Budgets (local target to be confirmed) monitored by Markers of Progress scorecard[9]	Roll out personal health budgets							Director of Integrated Commissioning	Continuing Health Care / Adults and Childrens Joint Commissioning
Increase the proportion of older people still at home 91 days after discharged from hospital from 73.8% (2014/15) to 81.5% (2015/16) with the aim of being in the top	Continue to implement the Health and Social Care Integration Model:							Commissioning Director Adults and Health / Director of	Head of Service, Joint Commissioning / Public Health /

[9] Markers of Progress: http://www.personalhealthbudgets.england.nhs.uk/_library/Resources/Personalhealthbudgets/DeliveryProgramme/Making_progress_PHB_national_delivery_programme.pdf

10% in the country by 2019/20	• Roll out BILT • Embed the use of the risk stratification tool • Improve care home services; exploring the development of primary care services to reduce use of urgent care • Develop programmes to support self-management • Develop the Healthy Living Pharmacy model.							Integrated Commissioning	Commissioning Lead Health and Wellbeing
Reduce permanent admissions to residential and nursing care homes of 622.5 per 100,000 population (65+ year olds) in 2014/15 to be in the upper quartile in our comparator group by 2019/20									
Increase the proportion of people who feel in control of their own lives from 73.3% (2014/15) to the top 25% in England by 2019/20									
Working with NHS England and partner organisations to reduce the proportion of people reporting a very poor GP experience (monitored locally).	Jointly commission primary care with NHS England; support continued development of networks Coordinate care around the needs of the patient Recruit and retain the best staff Provide high quality and safe premises and practice							Barnet CCG / NHS England	Barnet CCG / NHS England
Reduced rate of emergency hospital admissions due to stroke: • During 2013/14, the rate of emergency hospital admissions for stroke in Barnet (235.4 per 100,000) was higher than the national rate (174.3 per 100,000)	Improve stroke pathway • Improve identification of atrial fibrillation • Review provision to ensure quality • Review appropriateness of referrals.							Director of Integrated Commissioning	Head of Service, Joint Commissioning
Reduce injuries due to falls in people over 65 (1,980 per 100,000 in 2013/14), to	Improve falls prevention (including in care homes)								

exceed the performance of our comparable boroughs	• Become NICE compliant[10] • Ensure the use of best practice in commissioning at a community level.								
Increase number of people dying in a place of their choice (measure TBC).	Improve end of life care • Work with the voluntary and community sector to improve information and raise awareness of the importance of talking about dying and death as well as getting your affairs in order • Continue to ensure timely identification of the end of life phase, this will involve linking the palliative care register with other long-term condition registers • Further develop local processes for access to rapid response end of life care in the community.							Director of Integrated Commissioning	Head of Service, Joint Commissioning
Tuberculosis (TB)									
Increase the detection of TB (targets TBC); reduce risk to vulnerable children / adults	Develop latent TB screening programme to be delivered in primary care.							Barnet CCG	

[10] Falls NICE Guidelines: http://www.nice.org.uk/guidance/cg161/chapter/1-recommendations

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AGENDA ITEM 8

	Health and Wellbeing Board **21 January 2016**
Title	**The Five Ways to Mental Wellbeing in Barnet: The Annual Report of the Director of Public Health (2015)**
Report of	Director of Public Health
Wards	All
Status	Public
Urgent	No
Key	No
Enclosures	Appendix 1: Annual Director of Public Health Report 2015
Officer Contact Details	Rachel Wells (rachel.wells@harrow.gov.uk) Consultant in Public Health Robert Reed (robert.reed@harrow.gov.uk) Public Health Analyst Joanna Boutros (joanna.boutros@harrow.gov.uk) GP Trainee

Summary

The report is a call to action on the issue of mental ill health in Barnet from the Director of Public Health. It looks at the levels of mental ill health in the population and a range of physical, social and environmental factors which influence mental health. It then gives an introduction to the 'five ways to mental wellbeing' as a method to improve the response to mental ill health.

The five ways to wellbeing, detailed in the report, are:

- Connect
- Get active
- Take notice
- Learn
- Give

A general overview of Barnet's current response to mental health is also provided, with specific case studies of relevant programmes. A recommendations section points to ways

in which the five ways to wellbeing can be used to improve Barnet's efforts to prevent and intervene early where mental ill health is concerned.

Recommendations
1. That the Health and Wellbeing Board considers the Annual Report of the Director of Public Health 2015 – The Five Ways to Wellbeing in Barnet (Appendix 1), and the proposed actions outlined in the report, and supports the responses to the mental health challenge.
2. That the Health and Wellbeing Board considers and comments on the recommendations of the activities / actions outlined under sections 2.1 of the report and in Appendix 1 (on page 47).
3. That the Health and Wellbeing Board notes the verbal accounts, presented in the meeting, from residents who have been supported by the borough's employment support services.

1. WHY THIS REPORT IS NEEDED

1.1 High levels of mental as well as physical wellbeing are essential for healthy families, communities and societies. Good mental health is a dynamic state which allows someone to develop their potential, work productively, build strong and positive relationships, and contribute to their community. A person's mental wellbeing greatly influences their path through life. It is vital for us to promote and develop good mental health throughout our population, so that everyone can reach their potential.

1.2 Mental illness is common and disabling. The risk of experiencing mental illness at some point in life varies from one in four to as high as one in two, and it is the cause of 70 million lost work days every year. In Barnet over 80,000 people between the ages of 16 and 74 have a common mental health disorder. The annual cost of mental health problems to the UK economy is around £70 billion; in Barnet this equates to about £685 million.

1.3 The government's 'No Health without Mental Health' strategy, published in 2011, highlighted several areas for action. For example: reducing the stigma and discrimination faced by people with mental illness; promoting mental health across all our lives; ensuring mental health has equal status with physical health; and identifying mental health problems and intervening early at all ages. Putting these principles into action in Barnet will improve everyone's mental wellbeing.

1.4 This Annual Director of Public Health Report 2015 (Appendix 1) highlights the importance of mental health and wellbeing as an issue in Barnet. Promoting good mental health and raising awareness of mental health issues will improve interventions and reduce the impact of mental illness upon individuals and communities. There is a lot of evidence that improvements in mental health can bring a range of health, social, educational and economic benefits to individuals and communities.

1.5 This report also introduces the five ways to wellbeing and offers recommendations as to how these can be used to improve Barnet's mental wellbeing and response to mental ill health.

2. REASONS FOR RECOMMENDATIONS

2.1 This Annual Director of Public Health Report 2015 contains three recommendations to improve Barnet's response to mental ill health and wellbeing:

1. Add a 'Five ways to Mental Wellbeing' page to the Public Health section of the Barnet Council website

   - Provide a page introducing the five ways and list of programmes available in Barnet that utilise the five ways
   - This will help to:
     - raise awareness of the value of the five ways amongst the general public whilst also making programmes more accessible
     - increase levels of self-referral and increase independence of people with mental ill health

2. Identify ways to incorporate the five ways into more council and Clinical Commissioning Group led programmes

   - Continue to work with commissioners to support people with eating disorders in Barnet
   - Use the Public Health team to promote and encourage greater use of 'be active' and 'take notice' components of the five ways in council programmes
   - This should focus on programmes that target the elderly or people living in care homes
   - The following examples of ways to take notice indicate the ease with which this component could be added to programmes. Ways to take notice include asking others about themselves, noticing how friends or colleagues are feeling, taking a different route to work or the shops, and taking pleasure in the little things.

3. Incorporate promotion of mental wellbeing and the five ways into healthy workplace schemes

   - The five ways will offer a structured and easily understood method for employers in Barnet to promote mental wellbeing and healthy lifestyle choices

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 The alternative option is to do nothing. This was not considered as the Annual Director of Public Health Report is a statutory requirement of the Director of Public Health.

4. POST DECISION IMPLEMENTATION

4.1 The implementation of the recommendations will take place through the integration of the five ways to wellbeing into existing programmes and future planned work.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 The report supports Barnet's Corporate Plan 2015 – 2020 and Barnet's vision for 2020, the latter of which includes a commitment for Health and Social Care services to be personalised and integrated, with more people supported to live longer in their own homes. By 2020, social care services for adults will be remodelled to focus on managing demand and promoting independence, with a greater emphasis on early intervention. People with mental health issues will receive support in the community to help them stay well, get a job and remain active, with support focused on helping people with their whole life, not simply providing a diagnosis.

5.1.2 In addition there is a commitment to meeting the Public Sector Equality Duty with by focusing on housing and employment for vulnerable groups such as people with learning disabilities and people with mental health issues.

5.1.3 The report also supports the Joint Health and Wellbeing Strategy (2015 – 2020). The strategy identifies that both physical and mental wellbeing depend on a broad range of characteristics including facilities for active travel, public transport and green spaces. Simply put, feeling good about where you live is a key factor in feeling good about yourself. Feeling good about yourself is key to making lifestyle changes which will bring about improvements in health.

5.1.4 In 2014, Barnet Clinical Commissioning Group (BCCG) and Barnet Council signed up to the national Crisis Care Concordat, which emphasises the importance of achieving parity of esteem between physical and mental health; valuing mental health equally with physical health. Examples of actions already taking place include:

- Barnet Council's Network Enablement Service
- BCCG and the council working with Barnet, Enfield and Haringey Mental Health Trust to improve secondary care services towards a community based model
- BCCG implementing a locally enhanced service to improve access to primary care for people with mental health problems who are homeless
- Public Health has developed a Suicide Prevention Strategy, Working Group and action plan, and self-harm and suicide prevention workshops
- Public Health has commissioned employment support services – Motivational and Psychological Support, and an Individual Placement and Support scheme
- Befriending schemes run by the Alzheimer's Society (supporting people with dementia and their carers) and Homestart (supporting families)

- A Barnet Schools Health and Wellbeing programme has been in place since 2013

5.1.5 The Barnet Joint Strategic Needs Assessment (JSNA) also identifies that the number of people with mental health conditions is predicted to increase as the population grows. In November 2014, the Health and Wellbeing Board (HWBB) identified prevention of and early intervention in mental health problems as a priority. Mental health is the HWBB's key priority in year one of the strategy. Feelings of social isolation and loneliness can be detrimental to a person's health and wellbeing. The aim is to improve the identification of people (children, young people, adults and older people) at risk of or experiencing social isolation through Healthy Living Pharmacies, hospital discharge teams and substance misuse treatment services.

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

5.2.1 There are no specific financial implications arising from the recommendations of the ADPH report.

5.2.2 Implementation / delivery will be contained within the annual public health grant envelope. Prioritisation of resources will be considered as part of the annual approval of commissioning intentions.

5.3 **Social Value**

5.3.1 The Public Services (Social Value) Act 2013 requires those who commission public services to think about how they can also secure wider social, economic and environmental benefits. Before commencing a procurement process, commissioners should think about whether the services they are going to buy, or the way they are going to buy them, could secure these benefits for their area or stakeholders.

5.4 **Legal and Constitutional References**

5.4.1 The Health and Social Care Act 2012 (s30) added in a new s.73A to the National Health Service Act 2006 requiring the appointment of a Director of Public Health. Under subsection s.73B (5), the Director is required to prepare an annual report on the health of the people in the area of the Local Authority and the Local Authority is required to publish this report.

5.4.2 Under the NHS Act 2006 as amended by the Health and Social Care Act 2012, Local Authorities are required to take particular steps in exercising public heath functions and the regulations cover commissioning of services.

5.4.3 The terms of reference (Responsibility for Functions – Annex A) of the Health and Wellbeing Board are set out in the Council's Constitution and include:

- To jointly assess the health and social care needs of the population with NHS commissioners, and to apply the findings of the Barnet JSNA to all relevant strategies and policies.

- To receive assurance from all relevant commissioners and providers on matters relating to the quality and safety of services for users and patients.
- 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.
- Receive the Annual Report of the Director of Public Health (ADPH) and commission and oversee further work that will improve public health outcomes.
- Specific responsibilities for overseeing public health and developing further health and social care integration.

5.5 **Risk Management**

5.5.1 None identified

5.6 **Equalities and Diversity**

5.6.1 The ADPH report is split into chapters focused on different types of mental ill health and risk factors. It also has sections considering the significance of physical activity for those with mental health problems and disabilities. The report highlights that there are inequalities in relation to a number of determinants of mental health and wellbeing between wards in Barnet

5.6.2 The report highlights inequalities between wards in the borough in relation to:

- Low educational attainment
- Material disadvantage
- Poor physical health
- Social isolation
- Working conditions and unemployment

5.6.3 For example it highlights the impact of dementia upon the elderly and eating disorders amongst children and young people. It also highlights that social isolation is a problem in elderly people in Barnet.

5.6.4 The report contains steps which can be taken to increase the use of the five ways to wellbeing as a method to improving mental wellbeing in the population. When public bodies are making relevant decisions on policies, programme planning, funding of services, and contractual arrangements with third party providers, the information contained in the ADPH report should be used to identify any impact of these decisions on specific protected groups under the Equality Act 2010.

5.7 **Consultation and Engagement**

5.7.1 Not applicable. None taken as this report is a call to action.

5.8 **Insight**

5.8.1 Public health intelligence data is the primary source for the report alongside the JSNA. Intelligence data presented in the report is the most up to date available at the time of writing.

6. BACKGROUND PAPERS

6.1 New Economics Foundation. (2013). The Five Ways to Wellbeing: The Evidence. Available: http://b.3cdn.net/nefoundation/8984c5089d5c2285ee_t4m6bhqq5.pdf. [Accessed 04/11/2015].

6.2 New Economics Foundation (2013). The Five Ways to Wellbeing: New applications and new ways of thinking. Available: http://www.neweconomics.org/publications/entry/five-ways-to-well-being-new-applications-new-ways-of-thinking. [Accessed 10/12/15].

6.3 Mental Health Foundation. (2015). Fundamental Facts about Mental Health. Available:http://www.mentalhealth.org.uk/content/assets/PDF/publications/fundamental-facts-15.pdf?view=Standard. [Accessed 10/12/15].

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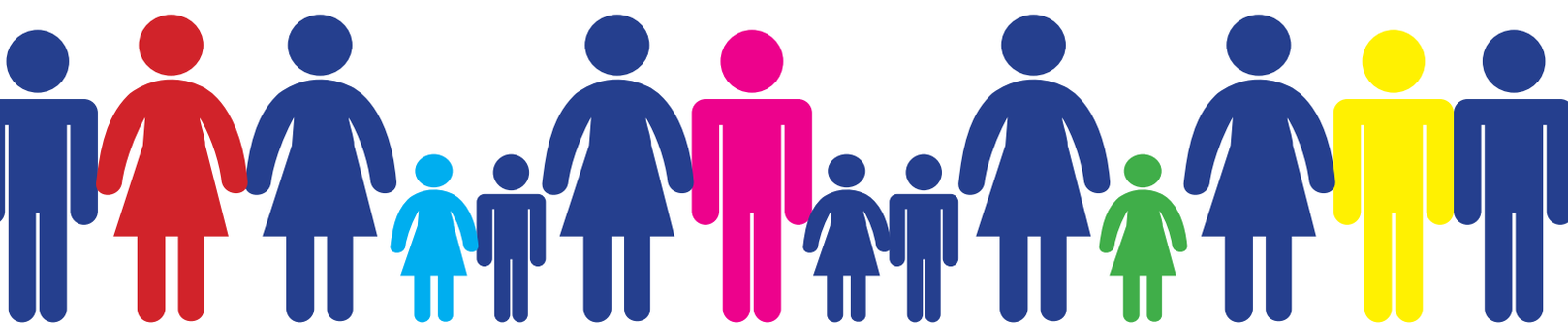
Director of Public Health
Report for Barnet
2015



The Five Ways to Mental Wellbeing in Barnet

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1 Foreword from the Director of Public Health

We all want to be healthy. We all want our families to be healthy, and to live in a healthy society. Good mental health plays a key role in this.

High levels of mental as well as physical wellbeing are essential for healthy families, communities and societies. Good mental health is a dynamic state which allows someone to develop their potential, work productively, build strong and positive relationships, and contribute to their community. A person's mental wellbeing greatly influences their path through life. In short, I believe it is vital for us to promote and develop good mental health throughout our population, so that everyone can reach their potential.

The government's 'No Health Without Mental Health' strategy published in 2011 highlighted several areas for action, for example: reducing the stigma and discrimination faced by people with mental illnesses; promoting mental health across all of our lives; ensuring mental health has equal status with physical health; and identifying mental health problems and intervening early across all ages. We are looking to put these principles into action in Barnet to improve everyone's mental wellbeing.

One in four people will develop a mental health problem at some point in their lives, and one in six people suffer with a mental health problem at any one time. An effective response to mental health requires all stakeholders and partners to acknowledge the problems and work together.

This report will highlight the importance of mental health and wellbeing as a public health issue in Barnet.

By promoting good mental health and raising awareness of mental health issues we can improve interventions and reduce the impact of mental illness upon individuals and communities. There is a lot of evidence that demonstrates improvements in mental health can bring a range of health, social, educational and economic benefits to individuals and communities.

We start from the standpoint that mental illnesses are preventable. Prevention of mental illness should form the core of any strategy for improving wellbeing. Providing information, guidance and support to people throughout their lives can greatly reduce the chances of developing a mental illness.

This report will introduce the idea of mental health and wellbeing and summarise the state of mental health in Barnet and some of the services that are currently available. We will also suggest recommendations to improve our response to the mental health challenges we face. Our aims are to promote mental wellbeing in Barnet, improve understanding of the factors that influence mental wellbeing, and promote the use of the 'five ways to mental wellbeing' as a method to improve mental wellbeing.

The five ways to wellbeing emerged from the Government Office for Science report 'Mental Capital and Wellbeing' which looked at how to improve mental wellbeing throughout life. Following on from this the New Economics Foundation set out five ways to improve wellbeing. These will be considered later in the report but they include: helping people to connect with others in their community; maintaining an active lifestyle; taking notice of the small pleasures and experiences in life; learning throughout life; and giving time to volunteering and community work.

The five ways model offers an excellent opportunity to address mental wellbeing consistently and proactively throughout all of our lives. I believe early intervention and prevention guided by the five ways can help improve mental wellbeing and reduce the occurrence and severity of mental health issues in Barnet.

My thanks go to my team and all those who contributed to the production of this report. I look forward to building upon our work so far and implementing the recommendations in this report to make Barnet a healthier place to live, work and grow.

Dr Andrew Howe
Director of Public Health

2 Key Messages

There are ten key messages that this report highlights:

- Mental health is a state of wellbeing where the individual can cope with stress, enjoys life satisfaction, has the ability to contribute to society, and can realise their full potential
- Mental illness affects people throughout their lives, including new mothers, children and adolescents, adults and older aged people
- Mental illness is common and disabling: the risk of experiencing mental illness at some point in life varies from one in four to as high as one in two[1], and it is the cause of 70 million lost work days every year[2]
- Education, housing, working conditions and unemployment, physical health, and social isolation all affect mental health
- Mental illness costs: the overall cost of mental health problems to the UK economy is £70-£100 billion every year; in Barnet this means about £685m[3]
- The five ways to wellbeing – connect, be active, take notice, keep learning and give – are evidence based actions that improve mental wellbeing[4]
- In Barnet over 80,000 people between the ages of 16 and 74 have a common mental health disorder[5]
- There is projected to be a rise in the coming years in the number of people in Barnet with common mental disorders, psychosis, drug and alcohol addictions, and dementia. The number of child admissions for mental health has also been increasing
- There is substantial inequality in levels of personal wellbeing between wards in Barnet: for example, personal wellbeing is higher in Garden Suburb than in Burnt Oak
- These facts require serious attention. The five ways to wellbeing offer an excellent opportunity to reduce the burden of mental ill health by using a range of methods thoughout someone's life. Although a lot is being done already in Barnet, there is still much room for improvement and progress in this area

3 Introduction

The Foresight report (2008) and the Chief Medical Officer's report (2013) led to increased interest in mental health and wellbeing nationally. Both reports focused on mental health, which remains one of the more neglected aspects of health and wellbeing, and receives less focus than physical health. The reasons for this lack of attention are not completely clear, but it may be due in part to:

- a more limited understanding of mental health, and some limitations in current treatments, when compared to significant advancements in physical health;
- an underestimation of the personal, social and economic impact of mental health; and
- the stigma which remains associated with mental illness.

What is clear is that mental illness is common, disabling and costly, and the benefits of good mental health numerable.

There is now a focus on good mental health as a positive state, rather than just the absence of illness. This has led to a shift in focus from simply treating illness, to expanding efforts to increase people's capacity for mental wellbeing, in particular through the five ways to wellbeing.

This report will first lay the foundation of what mental health and mental illness are, and what are the things that influence them. The report will also explain and examine the 'five ways to wellbeing' as a way to improve and promote mental wellbeing, both for those with mental illness, as well as those without. It will then focus on the specific mental health problems residents in Barnet experience, and consider some of the programmes in the borough and the extent to which they already use the five ways to improve mental wellbeing. Finally, the report will recommend areas for improvement.

The aim is that this report will robustly present the case for the need to increase the focus on mental health in Barnet. It will also promote the five ways to wellbeing as an effective way for individuals, organisations and policy makers to improve their own wellbeing and that of their friends and family.

If you have any further comments, questions or suggestions these would be very welcome, and can be sent to: robert.reed@harrow.gov.uk.

4 What is Mental Health?

Mental health is commonly used as a term to denote mental illness. In fact, the term is wider than this as it comprises both the positive and negative aspects of mental health and wellbeing.

The World Health Organisation (WHO) defines mental health as "***a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community***"[6].

Mental health and wellbeing can be broken down into three aspects:

- ***psychological wellbeing***, which includes self-acceptance, personal growth and development, a belief that life is purposeful, and a sense of self-determination.
- ***emotional wellbeing***, which encompasses happiness and life satisfaction.
- ***social wellbeing***, a term to describe social integration, acceptance, contribution and coherence.

As such, mental wellbeing is much more than just the absence of mental illness. As a result those with mental disorders can still achieve good levels of mental wellbeing.

This understanding of mental wellbeing was reinforced by the Government's Foresight report (2008). This report emphasized the importance of good mental capital, which it defines as "the totality of an individual's cognitive and emotional resources, including their cognitive capability, flexibility and efficiency of learning, emotional intelligence (for example, empathy and social cognition), and resilience in the face of stress"[7]. The report put forward five ways to wellbeing to help people improve their mental capital and wellbeing. This perspective on mental health highlights the need to not simply focus on the prevention and treatment of mental illness, but also the active promotion of good mental health.

4.1 Types of mental ill health

Mental disorders are wide ranging. They can include anxiety, depression, schizophrenia, and alcohol and drug dependency.

4.1.1 A summary of the types of mental ill health

Some of the most common forms of mental ill health are conditions such as generalised anxiety disorder, depression, phobias, obsessive compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and panic disorders[8].

There is considerable variation in both the prevalence and severity (see box below) of common mental health disorders (CMDs). A 2001 national survey estimated the prevalence rate of CMDs to be 16%[9]. It is important to note that "common" does not mean that these disorders are not serious; all of them can be associated with significant long-term disability in some cases.

Depression, for example, is associated with high levels of morbidity. It is the second greatest contributor to Disability-Adjusted Life Years (see box below) in the developed world, and is the most common disorder contributing to suicide[10]. Common mental disorders have

Prevalence: a measure of how common a disease is in a population.
Incidence: the rate of occurrence of a disease

Disability-Adjusted Life Years (DALYs): measure of overall disease burden, expressed as the number of years lost due to ill-health, disability or early death

a considerable social impact on families and the workplace. Half last longer than a year, and some reoccur throughout someone's life.

Up to 90% of depressive and anxiety disorders are diagnosed and treated by GPs. The most common treatment for these conditions in primary care is medication. This is largely due to the limited availability of psychological interventions such as talking therapies. It is estimated that around half of those affected by CMDs are not diagnosed[11]. This is partly due to the difficulties in recognising these disorders, but also because patients can be worried about the stigma associated with mental health disorders. There are also many people who experience poor mental health that does not reach the threshold of clinical diagnosis.

Depression is a broad diagnosis encompassing a range of symptoms. These can include: a depressed mood and / or a loss of pleasure in doing things; feelings of guilt or low self-worth; disturbed sleep or appetite; low energy; and poor concentration. The number and severity of the symptoms, combined with the level of practical and functional impairment, are used to diagnose the severity of the disorder. Fifty per cent of people who have depression will only have a single episode, but the other half will have further episodes and their depression may take a remitting and relapsing course that returns throughout their life. Recovery time varies, but is often around six months to a year or more[12].

Anxiety disorders, as their name suggests, have anxiety symptoms at their core and include generalised anxiety disorders, panic disorders and obsessive-compulsive disorders. In all disorders the symptoms may be severe and persistent enough to have a significant impact on the person's daily life. Generalised anxiety disorder is the most common anxiety disorder and is characterised by excessive worry with heightened tension. Other symptoms include irritability and physical symptoms such as restlessness, tense muscles and tiredness, as well as trouble concentrating or sleeping. A person is not diagnosed with an anxiety disorder unless their symptoms have been present for at least six months and are causing significant distress or impairment of functioning. Social anxiety disorder involves a persistent fear or anxiety about one or more social situations that is disproportionate to the actual threat posed by the situation[13].

Panic disorder is a condition in which someone experiences recurring, unforeseen panic attacks, with persistent worry about a further attack, and concern about the consequences of an attack or a change of behaviour.

Obsessive-compulsive disorder may comprise obsessions or compulsions or both. Obsessions are repeated, unwanted, intrusive thoughts, images or urges. Compulsions are when someone feels compelled to carry out repetitive behaviours or mental acts.

Post-traumatic stress disorder (PTSD) develops after events or situations that are particularly stressful, threatening or catastrophic, such as severe accidents, disasters or military action. People with PTSD often relive the traumatic event through nightmares and flashbacks. They may also experience irritability, guilt and feelings of isolation and have symptoms such as insomnia and difficulty concentrating.

4.1.2 A summary of the types of mental ill health with psychotic symptoms

The phrase mental ill health with psychotic symptoms is used to refer to those disorders that result in someone losing touch with reality or experiencing delusions, or those that require high levels of care, which may include hospital treatment. The most common of these severe mental disorders are schizophrenia, bipolar disorder and schizoaffective disorder.

Although less widespread than common mental disorders, severe mental disorders are more persistent and affect more of a person's life. As such, they frequently cause more significant impairment and a higher rate of premature mortality (see box below)[14]. It has been estimated that people with these types of mental illness die 10 years younger than other people because of their associated poor physical health. For example, those affected by schizophrenia and bipolar disease are at a higher risk of experiencing physical conditions including diabetes, HIV, hepatitis C and some cardiovascular diseases and respiratory diseases. There may be a number of reasons for this: a difficulty in accessing services; a lack of empowerment; increased likelihood of engaging in risky lifestyle behaviours; and social factors which disproportionately affect people with severe mental ill health[15].

Bipolar disorder

Bipolar disorder is characterised by episodes of mania or hypomania (abnormally elevated mood or irritability) and episodes of depression. The peak age of onset is 15-19 years, but there is often a significant delay before people access mental health services. Those with bipolar disorder often have other mental disorders, such as anxiety disorders and personality disorders.

Premature mortality: death which occurs prior to the average life expectancy for a specific population

Psychosis

Psychosis is a term often used to refer to a group of psychotic disorders, including schizophrenia, schizoaffective disorder and delusional disorder. They are disorders in which one's thoughts, mood, perceptions and behaviour are significantly altered. There are positive symptoms, such as hallucination and delusions, and negative symptoms such as apathy, self-neglect and social withdrawal. Those affected may first have what is called a prodromal period (a period of early symptoms indicating the onset of the disease), followed by an acute episode, which may be recurrent. Treatment often leads to a reduction in the positive symptoms, while some negative symptoms remain. Although evidence suggests that most will recover, many have persisting difficulties and are vulnerable to further episodes.

The risk of developing psychosis and schizophrenia at some point in life is about 1%. The first symptoms usually begin in young adulthood, but can occur at any age. There is considerable stigma associated with this diagnosis, and the symptoms and behaviours associated with the disorder often have a distressing impact on the individual affected as well as on their family and friends. Following acute episodes, those affected often face social exclusion and difficulties returning to work or study.[16] It is estimated that the costs to society of schizophrenia alone are £6.7 billion per year[17]. Although the number of people living with schizophrenia is currently low, it is expected to rise with increases in rates of marital separation and divorce, difficulties in home ownership, urbanisation, drug abuse (including cannabis), and immigration.

4.1.3 Other mental health issues

Personality disorders

Personality disorders (PDs), which include disordered patterns of thought, feelings and behaviours, are less well understood compared to other disorders. It has been estimated that the prevalence in the UK is 4%[18].Those affected by PDs are at an increased risk of other serious mental health problems. Two of the most significant PDs are borderline personality disorder (BPD) and antisocial personality disorder (ASPD). Persistent personal and emotional instability characterises BPD, and individuals can then struggle to maintain relationships, and are at higher risk of self-harm and suicide. Antisocial personality disorder is characterised by a disregard for the rights of others, and the disorder is believed to contribute to a disproportionately high percentage of crimes and violence[19].

Addictions

Drug and alcohol addictions are common, but are sometimes not taken as seriously as other mental health problems and often ineffectively treated. There are substantial consequences associated with addictions, as they affect physical health, families, communities, society and the economy. There is also believed to be an association with other mental disorders[20].

Suicide and self-harm

Suicide and self-harm are not mental health problems themselves, but are linked with mental health disorders. Nearly 6% of adults reported that they had made a suicide attempt at some point in their life (according to the Adult Psychiatric Morbidity Survey[21]), and suicide is the largest cause of death for men aged 20-49 years in England and Wales[22]. The incidence of self-harm and suicide is higher amongst those with mental health disorders.

4.2 Mental disorders at key points in life

Disorders relating to pregnancy

During pregnancy and in the first year after birth, mothers can be affected by a range of mental disorders. Collectively, these issues are termed perinatal mental disorders. Depression and anxiety are the most common mental health problems during pregnancy, and affect 15-20% of women in the first year after childbirth. Postpartum psychosis affects between one and two in every 1000 women who have given birth; those with bipolar disorder are at particular risk. Mental illnesses that are already present can also be exacerbated during this period. For example those with bipolar disorder can see an increased rate of relapse postnatally.

Although the response to treatment for perinatal mental health problems is often good, they frequently go unrecognised and untreated. These disorders are particularly significant as they may affect the development of mother-child attachment and the care-giving relationship, resulting in long-term negative effects on the child's development - emotionally, socially and cognitively[23]. Furthermore, mental health disorders can increase the risk of maternal death, and were responsible for 1.27 deaths per 100,000 maternal deliveries in the UK in 2006-2008[24].

Child and adolescent mental health

Most mental ill health begins relatively early in life. A study in the US found that approximately half of mental health problems were established by age 14, and 10% of school-age children had a mental health problem[25]. Childhood mental disorders include conduct disorders, emotional disturbances such as anxiety and depression, and attention deficit hyperactivity disorder (ADHD). Self-harm is relatively common

among young people, with the average age of onset being 12[26]. Although the initial onset of most mental disorders occurs in childhood or adolescence, diagnosis and treatment are often delayed to later in life, which can make disorders more difficult to treat.

Older people

Older people experience many of the same difficulties and disorders as the rest of the population, however depression and dementia are particular problems for this age group. Depression is estimated to affect 10-16% of over 65s, and this rises to up to 40% in those living alone or in residential care and those with physical illnesses or disabilities[27]. Older people have a similar risk of suicide to younger adults, but attempts in this group are more likely to be successful.

Dementia is mainly, but not exclusively, a disease that affects older people. Incidence almost doubles with every 6 year increase in age, from 3.9 per 1,000 person-years at age 60-64 to 104.8 per 1,000 person-years at age 90+[28]. A report from Alzheimer's Disease International estimated that around 44 million people are living with dementia worldwide, with this figure expected to double by 2030[29]. Research indicates that in the UK in 2015 there are 850,000 people with dementia and this number is set to rise to 1 million by 2021[30]. People with dementia frequently use NHS services – up to a quarter of hospital beds are occupied by people with dementia at any one time[31]. Dementia costs the UK economy £26.3 billion a year. According to The King's Fund[32] annual spending on dementia will reach £35 billion by 2026.

5 Why Focus On Mental Health?

Poor mental health is highly prevalent, hugely disabling and very costly[33]. Furthermore, treatment for mental health problems is still only partially effective. Historically there has always been a greater focus on physical health rather than mental health. However a recent change in NHS focus reflects a growing consensus than, in light of the great burden of poor mental health, there needs to be more parity[34].

Highly prevalent

According to the World Health Organisation (WHO), the largest burden of disease globally is attributable to mental ill health[35]. It has been estimated that at any given time one in six adults experiences mental ill health, and during the course of a year over a third of adults are affected[36]. The lifetime risk of mental ill health varies from one in four to as high as one in two, depending on the setting[37]. People of all ages are affected: 10% of children aged 5 to 16 years old have a mental health problem; 10% of new mothers are affected by postnatal depression; and 22% of men and 28% of women aged over 65 are affected by depression[38].

The burden of mental ill health in the UK is growing and the statistics paint a clear and worrying picture. Up to 12% of the population will experience depression in any year[39]. Mixed anxiety and depression is the most common mental disorder in Britain, with almost 9% of people meeting criteria for diagnosis. Common mental health disorders disproportionately affect poorer people, the long-term sick and the unemployed[40]. Depression is also an issue among older people with one in five experiencing depression[41]. People living in care homes are also vulnerable to mental health problems, with two in five residents suffering from depression. Dementia affects 5% of people over the age of 65 and 20% of those over 80[42]. Ten per cent of children between the ages of 1 and 15 have a mental health disorder and rates of mental health problems in children rise as they enter adolescence[43].

Hugely disabling

Mental health conditions are the most common single cause of Disability-Adjusted Life Years (see box on page 7) in the Western World. This is greater than cardiovascular disease and cancer. Mental ill health is also believed to increase the risk of poor physical health, with 46% of those with mental health problems suffering from a long term physical health condition[44]. This association may be partly due to the greater likelihood of people with mental disorders engaging in risky behaviour, and the fact that they can be less able to care for themselves. Strikingly, those affected are two to four times more likely to die prematurely[45].

Very costly

In light of this, it is unsurprising that mental health problems inflict a huge cost. They represent the largest single cost to the NHS, at 11% of spending[46]. There is also a significant cost to the economy through loss of work: 35-40% of work-related health problems, sickness absence, long-term incapacity and early retirement in the UK are accounted for by mental health problems.[47] This means that 70 million days each year are lost due to mental ill health[48]. There is also a strong connection between mental health problems and crime, violence and homelessness: personality disorders affect 60% of adults living in hostels[49], and it is estimated that up to 90% of prisoners have a diagnosable mental health problem or substance misuse problem. As such, it is estimated that the overall cost to the economy of mental health problems in the UK is £70-£100 billion every year, or about 4.5% of Gross Domestic Product[50].

Impact on family members and carers
Mental ill health has a huge impact on family members and carers. Informal care for people with mental health problems is provided by around 88,000 people in London[51]; these informal carers often experience negative effects on their health and wellbeing. Furthermore, children of those with mental health problems may suffer long term detrimental consequences.[52]

Stigma and discrimination
Stigma is defined as 'an attribute that is deeply discrediting and that reduces the bearer from a whole and usual person to a tainted, discounted one'. People with mental ill health are continually stigmatised and this has an impact upon public health and inequality.

Research has found that around nine in ten people with mental health issues experience stigma and discrimination. This can negatively impact work, education, friendships, social participation and people's willingness to talk about mental health issues. Those with a mental illness experience more stigma and discrimination than those with physical health conditions (apart from HIV/AIDS), and 70% of mental health service users say they feel the need to conceal their illness[53].

Stigmatisation affects the lives of those with mental health problems in a number of ways. For example, a 2009 'Time to Change' survey found that 56% of UK adults wouldn't hire someone who'd previously had depression, even if they were the most suitable candidate for the job.

Benefits of good mental health
The converse is also true. Those with higher levels of good mental health and wellbeing have better educational outcomes, higher productivity at work and higher incomes[54]. They also have better general health, longer life expectancy and a higher likelihood of enjoying a healthy lifestyle[55]. Furthermore, people with good mental health are more sociable and have stronger social relationships[56].

Addressing inequality
There are significant inequalities in mental health across society. Those who are poorer or more disadvantaged are disproportionately affected by common mental health problems[57]. The Marmot Review declared that trying to put right these inequalities is a matter of social justice, and necessary to make a fairer society[58].

Limitations of treatment - need for prevention and promotion of good mental wellbeing
As we have seen, mental ill health in the UK is under-diagnosed and under-treated. Only 25% of those with mental health problems receive services, and even when they do, they wait too long for therapy.[59] It is thought that, most of the time, the majority of those with mental health problems try to manage it themselves, or are helped by people who care about them.[60] In addition, current treatment is only partially effective. It has been estimated that even if all those affected by mental ill health were treated with the best currently available treatments, the burden of mental ill health would only be reduced by 28%. Given this, protection against mental illness by reducing risk factors and increasing protective factors is imperative and likely to be more effective and efficient. This includes a need for a focus on public mental health and the dissemination of practical tools to help people "better understand how their minds work, to recognise when problems are developing and to take early action"[61].

6 Mental Health Profile for Barnet

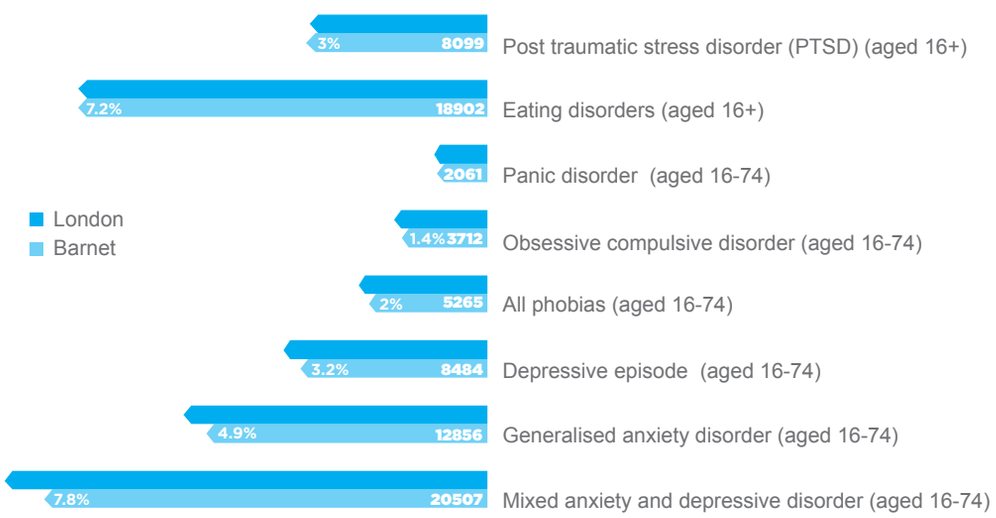
The information set out in this section shines a light on the burden of mental ill health in Barnet. In summary, the population of Barnet is affected by a diverse range of mental health issues which touch people of all areas, ages and socioeconomic groups.

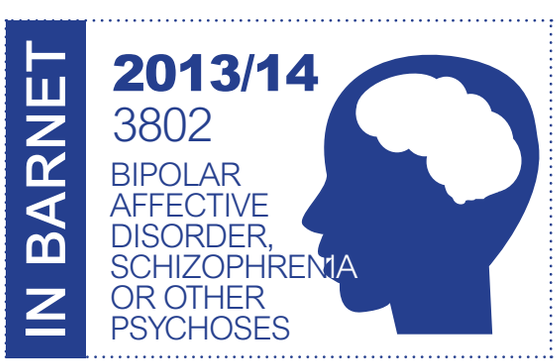
6.1 Mental health issues

In Barnet in 2012 almost 80,000 people between the ages of 16 and 74 had a common mental health disorder. The most common illness in the 16-74 age group was mixed anxiety and depressive disorder with a prevalence of almost 8% (over 20,000 people). We also know that there are high levels of eating disorders in the borough, with just over 7% of those over 16 being directly affected. Eating disorders generally begin in childhood or adolescence and include anorexia nervosa, bulimia nervosa and related conditions. As well as physical consequences, eating disorders often result in acute psychological distress. There is a greater incidence of both eating disorders and PTSD in Barnet when compared to London as a whole. The prevalence of other common mental illnesses in Barnet and London is shown in Figure 1.

Figure 1. Estimated prevalence of common mental illness in Barnet and London (% and number of population) (2012)

Sources: Public Health England, Office for National Statistics.





6.2 Mental health issues with psychotic symptoms

In Barnet in 2012 there were 71 cases of psychosis in people aged 16-64. In 2013/14 there were 3,802 people registered with GP practices in the borough who were recorded as having schizophrenia, bipolar affective disorder or other psychoses.

The number of people living with a common mental health disorder in Barnet is projected to rise over the next four years. Projections for a range of mental disorders are shown in Figure 2.

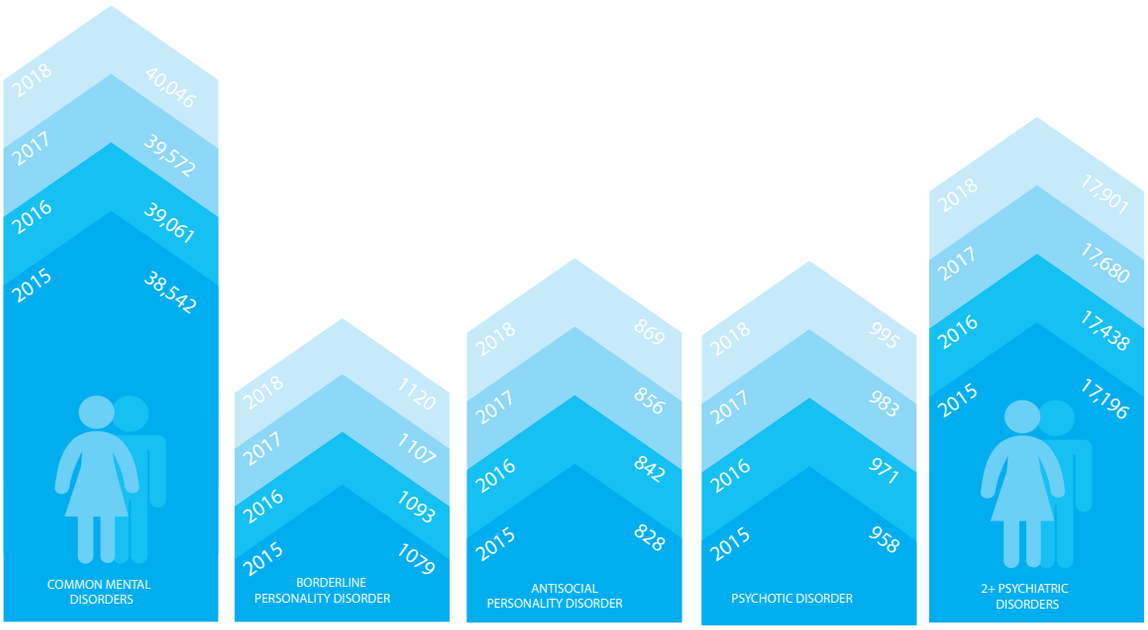
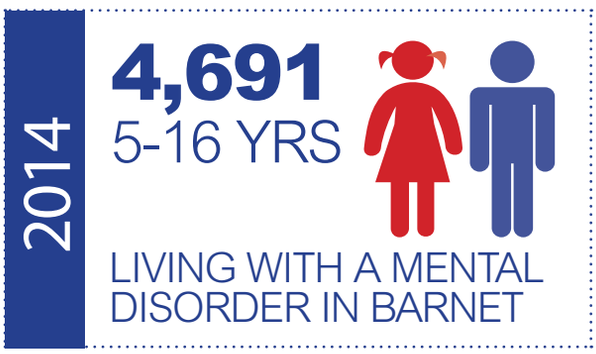


Figure 2. Projected increase in the number of Barnet residents experiencing four types of mental disorder, and two or more psychiatric disorders, 2015 to 2018. Source: Projecting Adult Needs and Services System



6.3 Child mental health issues

According to the Office for National Statistics (ONS) an estimated 4,691 children aged between 5-16 were living with a mental health disorder in Barnet in 2014[62]. Between 2010/11 and 2013/14 the number of mental health admissions in 0-17 year olds increased from 124 to 184. Figure 3 shows this as a rate per 100,000 population. It is understood that child mental health is more difficult to define and diagnose and so the figures are likely to be significant underestimates.

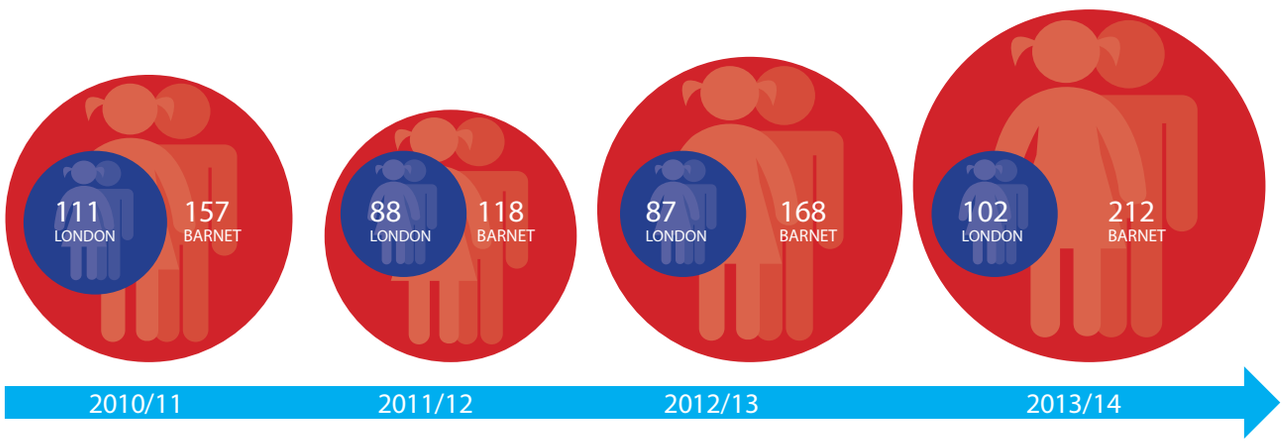


Figure 3. Child admissions for mental health in Barnet and London, 2010/11 to 2013/14: rate per 100,000 aged 0 -17 years

Source: Health & Social Care Information Centre

6.4 Dementia

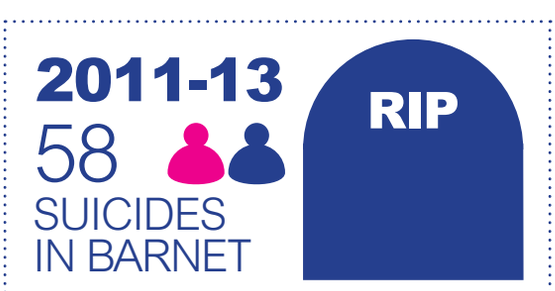
The number of people living with dementia in Barnet increased from 2,101 in 2010/11 to 2,275 in 2012/13. This increase is driven largely by an ageing population and improvements in diagnosis. Despite this, current estimates from the Health and Social Care Information Centre (HSCIC) indicate that only 52% of those living with dementia actually receive a diagnosis. This suggests that more people have dementia than we are currently aware of.

Projections show that the proportion of people in Barnet aged over 65 and living with dementia will decline from 7.7% in 2015 to 5.7% in 2018. Despite this, the actual number of people over the age of 65 living with dementia is projected to increase from 4,044 in 2015 to 4,404 in 2018 (Figure 4).

6.5 Suicide

There was a decline in the number of suicides in Barnet between 2001-03 and 2011-13 (See Figure 6). Between 2011 and 2013 there were 5.7 suicides per 100,000 people per year (58 suicide deaths over the 3-year period), down from more than 7 per 100,000 in 2001-03. Suicide is a major issue for society and a significant cause of years of life lost through premature death. In Barnet for example in 2011-13 for every 100,000 people aged 15-74 there were 52 years of life lost as a result of suicide.

Projections suggest the number of suicides in Barnet will remain relatively consistent over the next four years, increasing by one death by 2018 (see Figure 5).



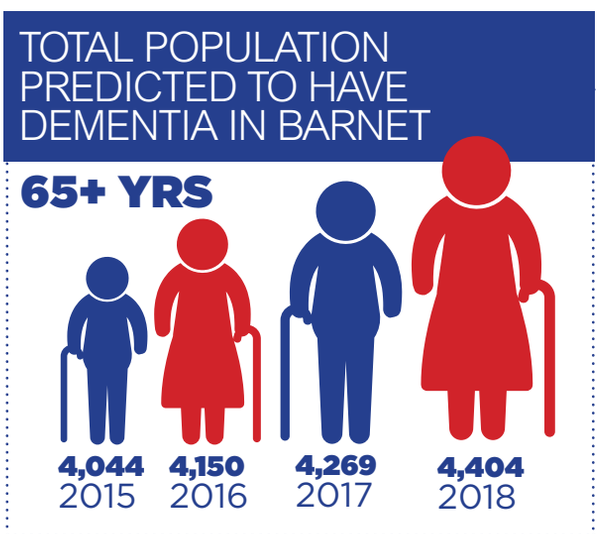


Figure 4. Projected dementia prevalence in Barnet, 2015 to 2018

Source: Projecting Older People Population Information System

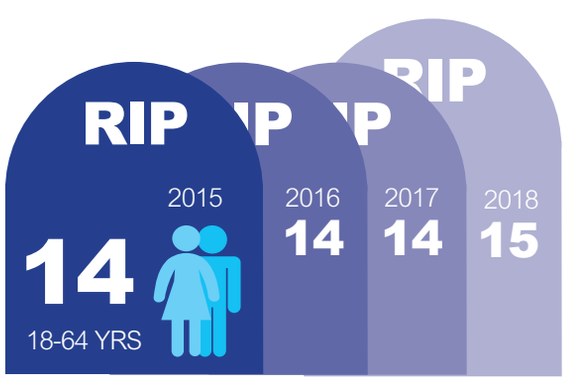
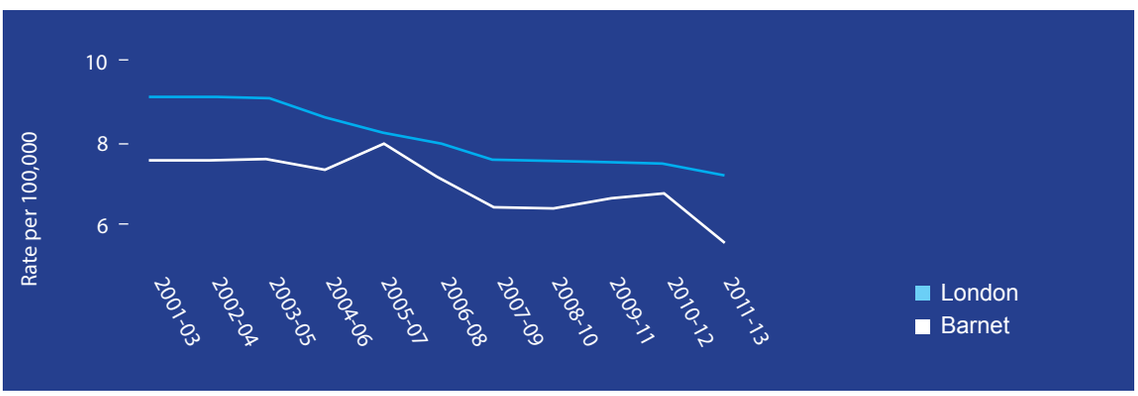


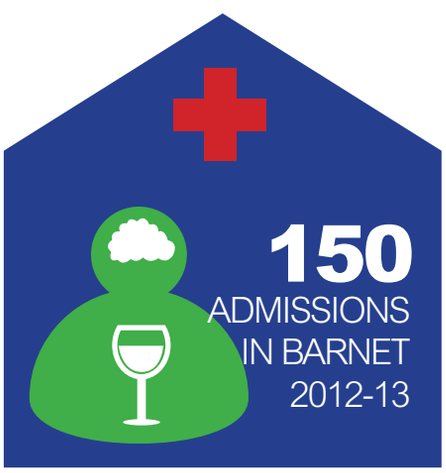
Figure 5. Four year projections of mortality from suicide for all people aged 18-64 in Barnet

Source: Projecting Adult Needs and Service Information System

Figure 6. Suicide age-standardised rate in Barnet and London, 2001-03 to 2011-13: rate per 100,000 persons (three year average)

Sources: Public Health England, Office for National Statistics





6.6 Alcohol and substance misuse

In Barnet in 2012/13 there were 150 admissions to hospital for mental and behavioural disorders due to alcohol, a rate of 43 admissions per 100,000 people. This is significantly lower than the London rate of 90.9. Predictions indicate that there will be an increase in the number of alcohol dependent and drug dependent people in Barnet over the next four years (see Figure 7).

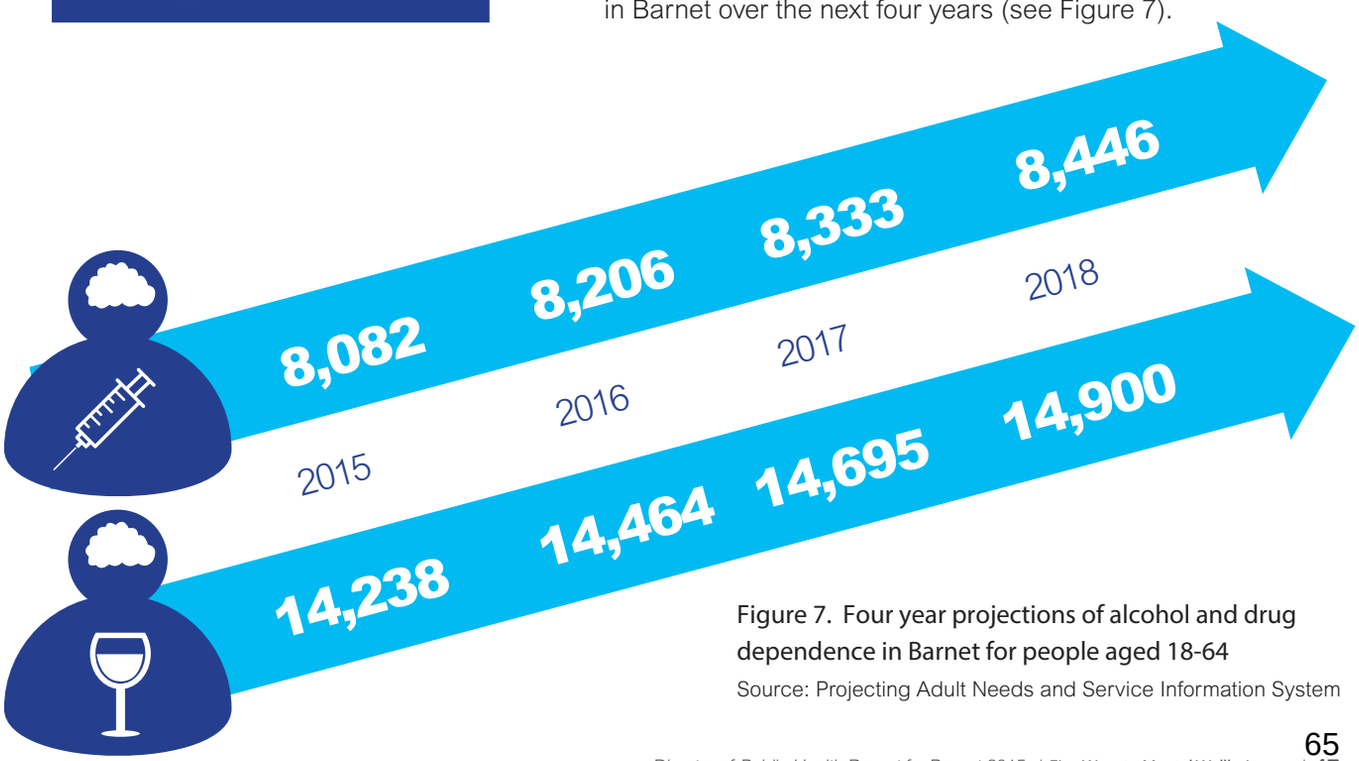


Figure 7. Four year projections of alcohol and drug dependence in Barnet for people aged 18-64

Source: Projecting Adult Needs and Service Information System

The prevalence of opiate and/or crack cocaine use in Barnet remained the same between 2010/11 and 2011/12. The crude rate in Barnet (6.2 opiate and/or crack users per 1,000 people) is below that of London (9.6 opiate and/or crack users per 1,000 people) (see Figure 8).

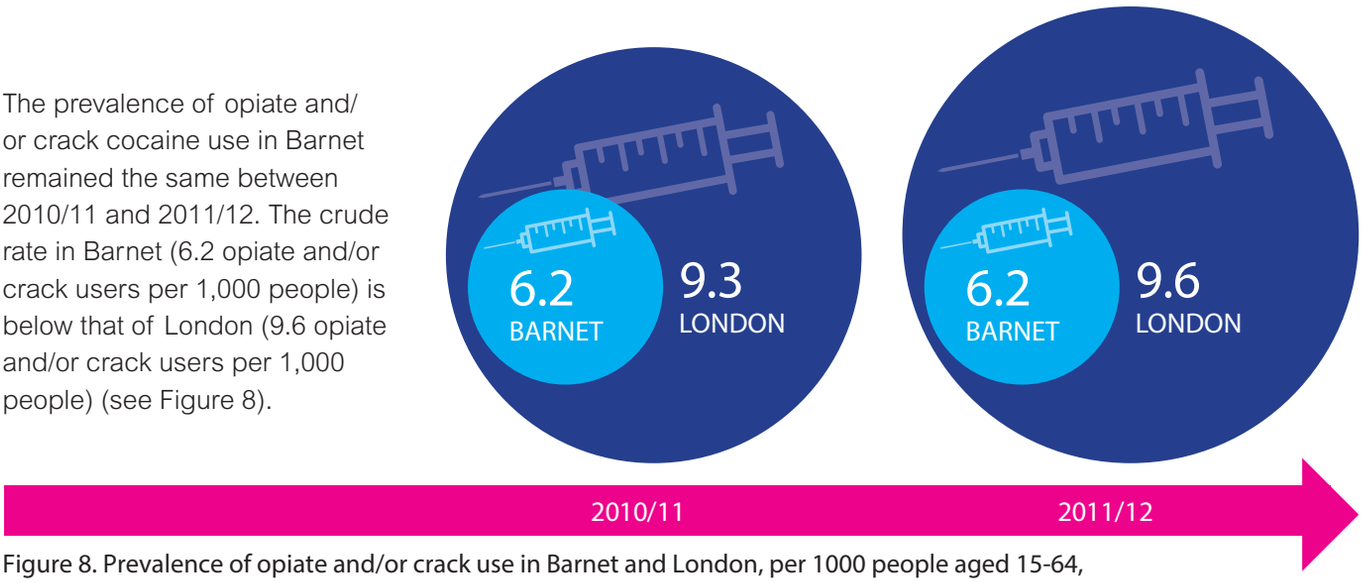


Figure 8. Prevalence of opiate and/or crack use in Barnet and London, per 1000 people aged 15-64, in 2010/11 and 2011/12

Source: Public Health England

6.7 Happiness and anxiety in Barnet

The Office for National Statistics (ONS) measured mental wellbeing as part of the Annual Population Survey in 2014/15. People taking the survey were asked to rate whether they:

- felt happy yesterday
- felt anxious yesterday

The results are shown in Figures 9 and 10. The average happiness rating in Barnet was 7.46 ('high' happiness levels).The average anxiety rating in Barnet was 2.31 (very low anxiety levels). Both these ratings were better than the average for outer London boroughs. Despite the average happiness rating in Barnet being high there remained a substantial percentage of people (8.53%) who rated their happiness as low, and 13% of residents rated their anxiety levels as high.

Figure 9. Happiness levels for Barnet and Outer London residents in 2014/15 (% of residents)

Source: Office for National Statistics

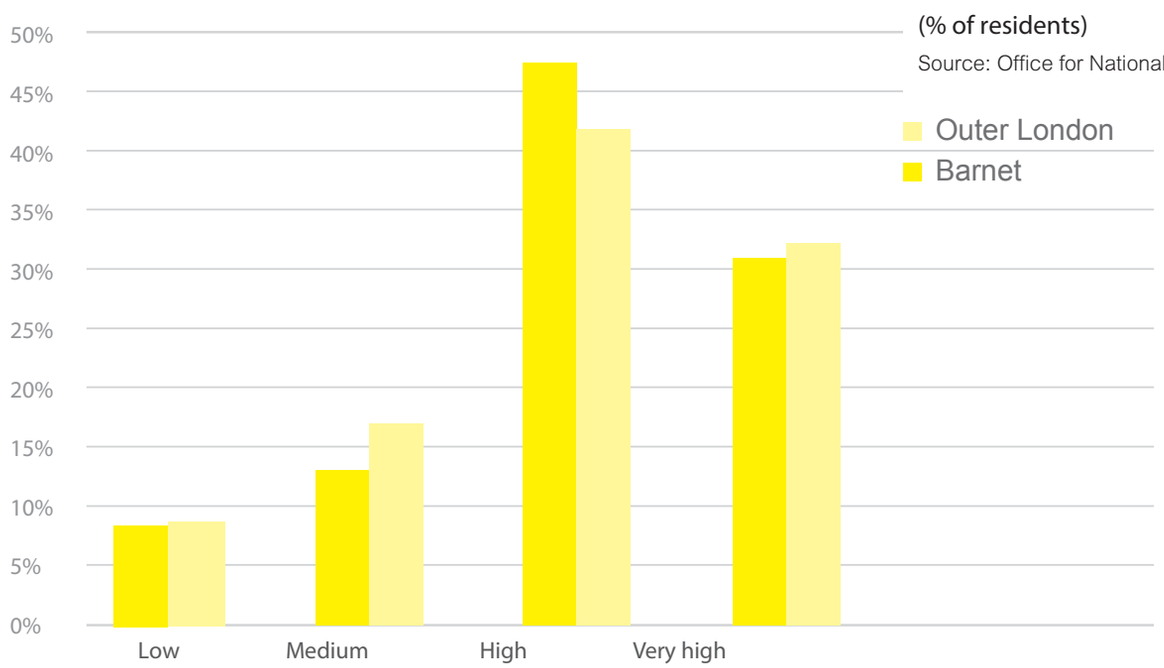


Figure 10. Anxiety levels for Barnet and Outer London residents in 2014/15 (% of residents)

Source: Office for National Statistics

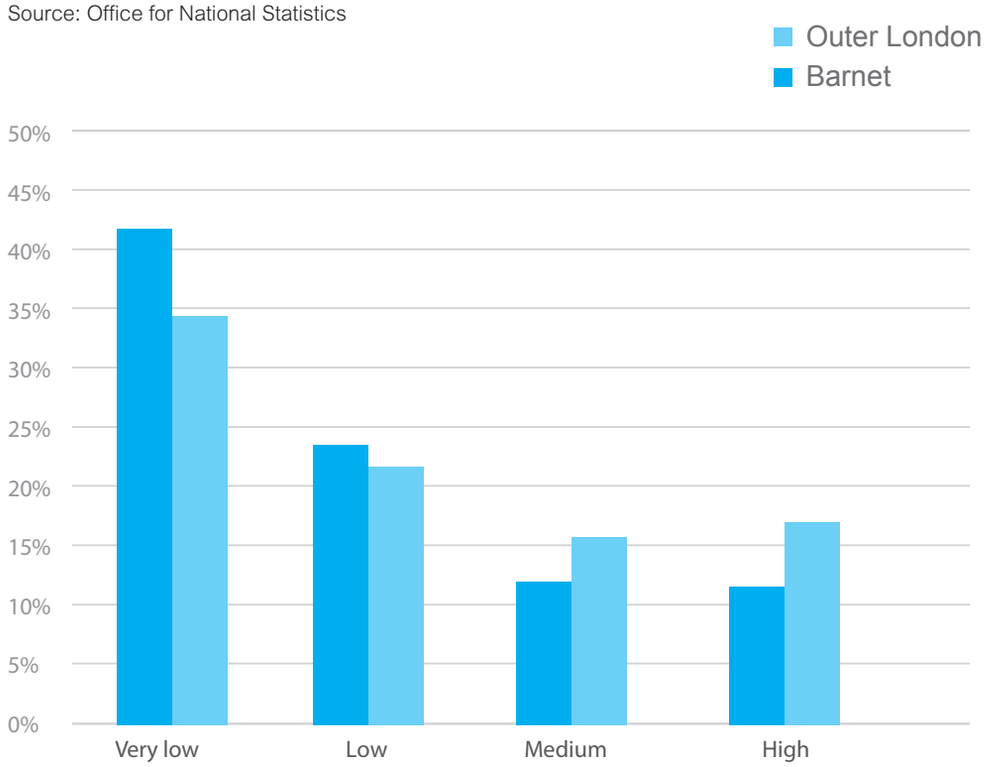
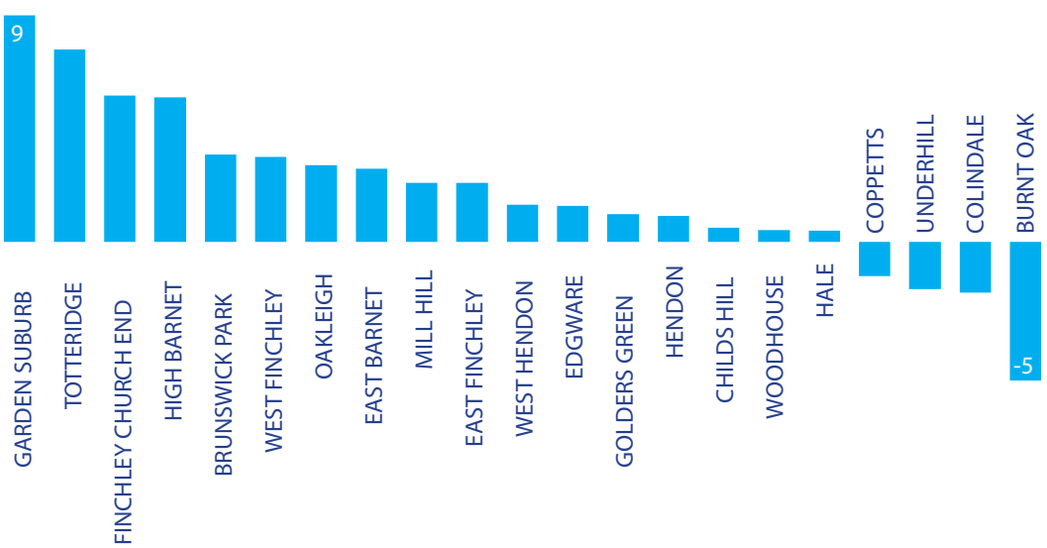


Figure 11. Subjective wellbeing score for each ward in Barnet (2012) (scores over 0 indicate a higher probability that the population on average experiences positive wellbeing

Source: Metropolitan Police Service

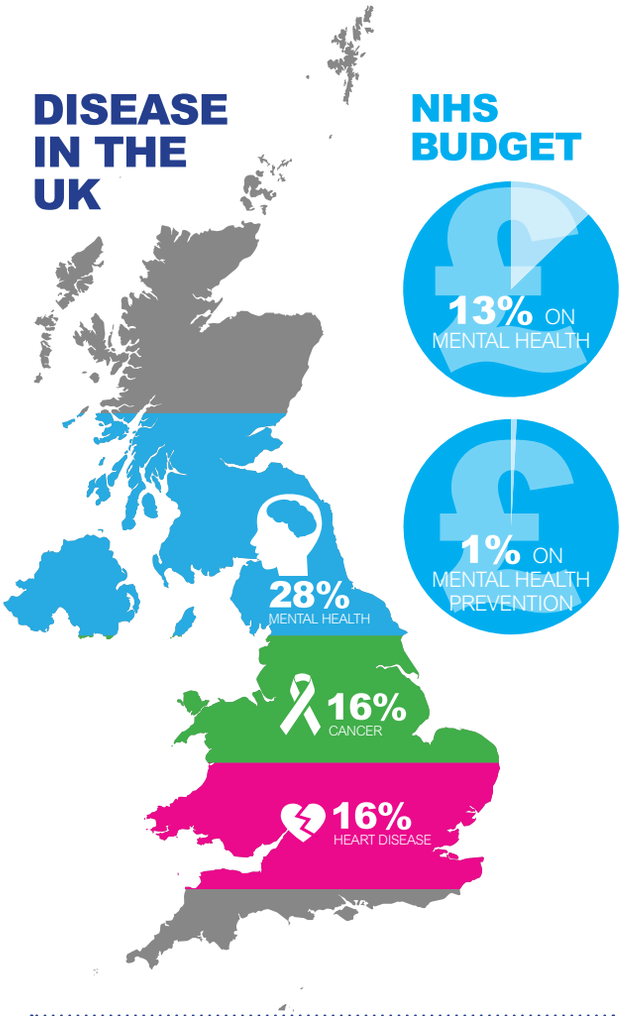


7 The Costs of Mental Ill Health

7.1 Costs to health and social care

Mental ill health has large but often underestimated economic consequences. The costs are such that it is easy to make a case for increased investment in mental health services and prevention. In exactly the same way as physical health conditions, there are direct and indirect costs associated with mental ill health. Focussed and sustained investment in mental health interventions and prevention has the potential to produce large savings for local authority and NHS budgets.

Mental ill health makes up 28% of the total burden of disease in the UK. This is larger than either cancer (16%) or heart disease (16%)[63]. Despite this just 13% of the NHS budget is spent on mental health services[64]. In addition, promotion and prevention work receives very little investment[65], with less than 1% of all NHS and local authority expenditure on mental health services in England being spent on mental health prevention. To put this into context London boroughs spend £550 million a year on social care to treat mental disorders and £960 million on benefits to support people with mental health issues. NHS spending on mental health in Barnet is the 12th lowest in London, and Barnet also has much lower expenditure on prevention and health promotion.



£105 BILLION[66]

MENTAL HEALTH COST TO ENGLISH ECONOMY EACH YEAR

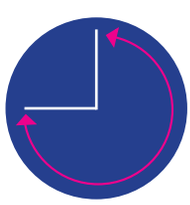
1 IN 6 PEOPLE EXPERIENCE STRESS IN THE WORKPLACE[67]

£26 BILLION

ECONOMIC & SOCIAL COST OF MENTAL ILL HEALTH IN LONDON YEARLY

70M

UK WORK DAYS LOST YEARLY[68]



2013-2014

11.3M WORK DAYS LOST

DUE TO STRESS, DEPRESSION AND ANXIETY

7.2 Cost to employers and productivity

Mental ill health also has an economic dimension. It is estimated that mental ill health costs the English economy £105 billion each year[66]. The annual economic and social cost of mental ill health in London is £26 billion. One in six people in the workplace are experiencing some form of distress, depression or stress problem at any one time[67] and mental health issues are the leading cause of sickness absence, with 70 million working days being lost each year[68]. In 2013/2014, stress, depression and anxiety alone accounted for 11.3 million work days lost, which is 39% of all work related illnesses[69].

7.3 Human costs

Of course as well as the financial cost, mental health issues are associated with an immense human cost. For example depression alone is projected to reach second place in the ranking of diseases responsible for Disability Adjusted Life Years (DALYs, see page 7) calculated for all ages by 2020. The WHO has reported a continuing trend of increasing burden of depression[70].

Depressive disorders are the third leading cause of DALYs (3.8% of all DALYs); alcohol use disorders are the sixth leading cause (2.9%); and Alzheimer's disease and other dementias are the 15th leading cause (1.9%)[71]

Premature mortality is also more common amongst people with severe mental ill health. In England the mortality rate among mental health patients aged 19 and over is 4,008 per 100,000, compared to 1,122 per 100,000 in the general population[72].

7.4 Potential savings

Investment in the prevention of mental ill health could result in huge cost savings. In England, early intervention for first-episode psychosis results in savings of over £2,000 per person over three years as a result of improved employment and education[73]. Programmes aimed at promoting mental health in the workplace have also been associated with saving £10 for every pound spent[74]. The London School of Economics (LSE) estimates that for every pound spent on early intervention psychosis teams dealing with first episode schizophrenia or bipolar disorder there is a consequent £18 of savings. The LSE has also claimed that "the economic returns from school-based programmes to deal with bullying and other behavioural problems are even larger"[75].

7.5 Barnet perspective regarding the costs of mental ill health

7.5.1 Economic costs of mental ill health in Barnet

Figure 12 highlights the large financial implications associated with mental wellbeing in the borough.

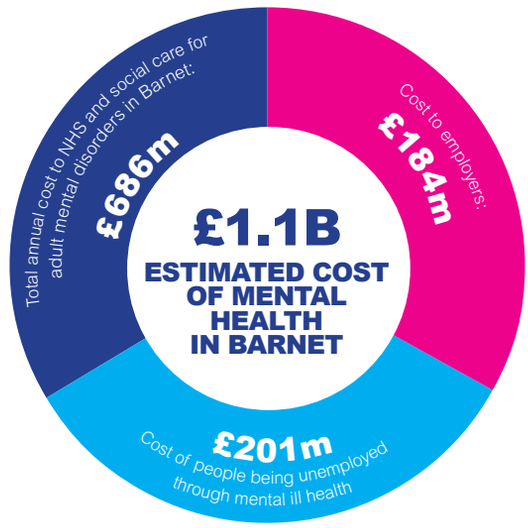


Figure 12. Annual Barnet mental health costs

Source: University College London Partners

7.5.2 Potential savings in Barnet

In Barnet there are a number of estimated economic savings that could be generated by interventions to prevent and treat mental disorders[76]. For example:

- If all people estimated to develop first episode psychosis each year received care via the early intervention psychosis services: £1.9m
- If all people estimated to develop a Clinical High Risk State (CHRS) each year received care from early detection services: £3.4m
- If all increasing risk adult drinkers in Barnet received screening and brief interventions in primary care: £11m
- Estimated savings to NHS over three years if all people in Barnet who are on the Severe Mental Illness (SMI) register received family therapy: £15.5m
- Estimated savings to NHS over three years if all people in Barnet who are on the SMI register received cognitive behavioural therapy (CBT): £3.6m
- Net savings after ten years if each one year cohort of 10 year olds in Barnet received school based social and emotional programmes to prevent conduct disorder[77]: £40.6m
- Net savings after one year if all employed adults in Barnet received mental health promotion: £121.6m

8 Determinants of Health and Wellbeing

Mental wellbeing is influenced and shaped by the social, economic and physical environment. For example, many forms of inequality and poverty are associated with an increased risk of mental ill health[78].

A review of population surveys in European countries[79] found that higher rates of mental disorders such as depression and anxiety were associated with the factors shown in Figure 13.

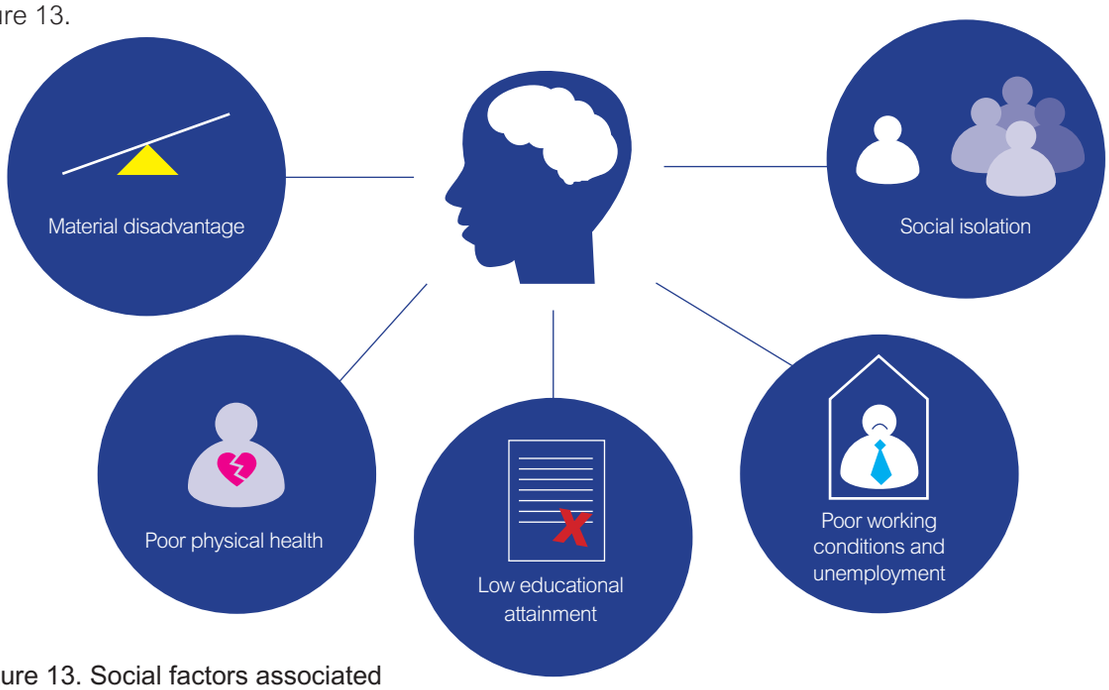


Figure 13. Social factors associated with mental disorders

Source: Fryers et al., 2005[79]

These factors can influence a person's mental wellbeing throughout their life. Thus, efforts to substantially reduce the burden of mental ill health necessitate a life-course approach: an approach that looks at the whole of someone's life rather than just one aspect or period. The need for decision makers to adopt a life-course approach when tackling mental health problems has been supported by a range of large, evidence based reviews including the Marmot Review[80] and WHO European Review[81]. This approach requires a focus upon social and community factors as well as the individual determinants of mental ill health. These are shown in Figure 14.

Figure 14. Individual, family, social and community determinants of mental health

Sources: Marmot Review Team, 2010[80]; Kieling et al., 2011[81]

8.1 Social and Community Determinants

8.1.1 Education

Education and learning play an essential role in the mental and social development of children and adults. Poor mental health is associated with low educational achievement, and individuals with no or few qualifications are at an increased risk of developing mental ill health[82]. Exposure to good quality and sustained education can greatly improve self-esteem and encourage social interaction[83]. Gaining qualifications in secondary education has been associated with a 7% reduced risk of adult depression. This risk falls even further with the highest levels of education and is 50% lower for those with highest qualifications[84]. The Marmot Review (2010) argued that a child's school readiness and attainment is closely linked to physical, social and mental wellbeing. The review found that higher school attainment is associated with a reduced risk of mental ill health, including lower rates of depression[85].

A range of observational and experimental studies have found that formal learning throughout life improves wellbeing particularly when learning objectives are self-generated and suit the aspirations of individuals[86]. Adult learning is also linked with improved wellbeing, greater life satisfaction and better social integration[87]. Not being in education, employment or training (NEET) is also associated with mental ill health and social isolation in young people[88]. Educational activities have also proved useful in reducing depression in the elderly.

Free school meals are a reliable guide to the socioeconomic position (SEP) of children and adolescents attending school. Socioeconomic position plays an important role in mental health due to the influence of family circumstances upon children[89]. Many characteristics related to SEP can be a source of chronic stress. For example, social conditions, housing conditions, parental health promoting behaviours[90] and chronic stress[91].These all play a role in mental wellbeing.

Research into the incidence of mental health in people with special educational needs (SEN) indicates that higher than normal rates of mental ill health are experienced by this group[92]. Emerson and Hatton's (2007) analysis of ONS data identified that children and adolescents with learning disabilities are six times more likely to have a diagnosable psychiatric disorder than non-disabled pupils[93]. It is agreed that identifying mental health problems among pupils with complex needs is challenging for teaching professionals. For example, the boundaries between autism spectrum disorder (ASD) and mental health issues are often unclear as there is overlap between the symptoms[94]. This can lead to children not receiving the help they need early enough.

8.1.1.1 Barnet perspective regarding education

Primary education in Barnet

Demand for primary school places is projected to increase in Barnet with school rolls expected to rise by up to nine forms of entry between 2015 and 2021. Barnet has a higher proportion of special educational needs pupils in primary schools compared to the proportion for London, and nationally.

Secondary education in Barnet

Between 2010 and 2014, the number of children on roll in mainstream secondary schools increased by 6.1% to 22,853 pupils. Barnet has a higher proportion of pupils on roll with a statement of special educational needs compared to London and statistical

neighbours. There is an 11% difference in attainment between disadvantaged pupils (those who have been eligible for free school meals in the past six years or are in local authority care) and non-disadvantaged pupils.

In 2013/14 74.4% of pupils achieved at least five GCSEs at grades A* – C, which is above the London average of 70%. Rates including English and maths were 66.3% which was again above the London average of 60.6%[95]. In Barnet, the performance of disadvantaged children is significantly below that of non-disadvantaged children. In 2014, performance was 28% lower in disadvantaged children compared to non-disadvantaged pupils at Key Stage 4. The percentage of young people in Barnet progressing to higher education is 58%, greater than the London average. However the percentage of children in receipt of free school meals who progress is lower, at 43%, below the average for London. Black pupils perform relatively poorly compared to other ethnic groups in Barnet across all key stages. Whilst disadvantaged children in Barnet perform better than disadvantaged children nationally, they continue to perform significantly worse than their non-disadvantaged counterparts. The proportion of adults with no qualifications is lower in Barnet (15.5%) compared to London (17.6%) and the England average (22.5%).[96]

Barnet performs well at ensuring all young people engage in education, employment or training up until age 19. The proportion of 16 to 18 year olds not in education, employment or training (NEET) is the fourth lowest nationally. This low rate is also seen in pupils with learning difficulties or disabilities. In Barnet the most recent figures (June 2015) show that 93.1% (9,602) are non-NEET, and just 2.6% (266) are NEET.

8.1.2 Housing, overcrowding and access to open space

A wide range of evidence suggests that the use of green spaces improves mental, social and physical wellbeing[97]. Increased exposure to green space (particularly in disadvantaged areas) has been shown to increase physical activity, reduce obesity and also reduce levels of mental ill health[98]. Grahn and Stigsdotter (2003) found that using parks resulted in reduced stress-related illness and improved mental wellbeing[99]. Green spaces also have a positive role in moderating the negative influence of stressful life events[100] whilst increasing the capacity of residents to cope with the effects of poverty[101]. The positive impact of green space usage in reducing stress and anxiety applies across all age groups[102].

Lower levels of mental distress have been found in people living in greener areas[103]. A UK study found a trend of reduced admissions for mental illness associated with increasing levels of greenness[104]. Scandinavian studies have also found that those living in close proximity to or frequently visiting green spaces experience a reduction in stress related illnesses[105].

Poor housing and deprivation are associated with mental ill health. Poor quality living conditions can greatly increase stress, anxiety and social isolation. Mental ill health is often a reason for tenancy breakdown, and housing problems are a common cause of a person being admitted to inpatient mental health care[106].

Living in poor quality housing is linked to poorer educational attainment and mental wellbeing among children[107]. Individuals living in local authority housing have poorer mental health than those who live in privately owned homes. One possible explanation for this is that local authority housing stock is generally of a lower quality than privately owned housing. For example a Scottish study based in Glasgow found dampness was significantly associated with poorer

mental health[108]. A study in North-West England found overcrowding was significantly associated with poor mental health[109]. The study concluded that extreme deprivation (including overcrowding) may be related to higher rates of psychiatric morbidity. Living in a damp, mouldy or cold home is associated with anxiety and depression[110]. A study of a council estate in Glasgow[111] also identified that dampness (rather than overcrowding) was significantly and independently associated with mental ill health. Despite this a London study also found that overcrowding was associated with psychological distress in women between the ages of 25-45[112].

8.1.2.1 Barnet perspective regarding housing, overcrowding and access to green space

Overcrowding

According to the Integrated Household Survey from the ONS (2010) 6.7% of households in Barnet were overcrowded, which is less than the London average of 7.5%. Like all London boroughs Barnet has a lack of appropriately sized homes. As a consequence the problem of overcrowding in the borough cannot be fully addressed through so called 'trade down' rehousing (rehousing people from under-occupied homes to increase the number of larger homes available).

The lack of appropriately sized homes is an obvious concern when we consider the negative mental health consequences of overcrowding. This situation is all the more concerning when we consider that negative consequences can be seen at relatively low levels of overcrowding. For example Booth and Cowell[113] in Toronto found overcrowding of greater than one person per room had an effect on mental health.

Green spaces

In Barnet, parks and green spaces are the most popular location for exercising, accounting for over 50% of exercise in the borough[114].

Figure 15 below shows the location of parks and green spaces in Barnet, and Figure 16 shows satisfaction with parks and green spaces by ward. Although not directly

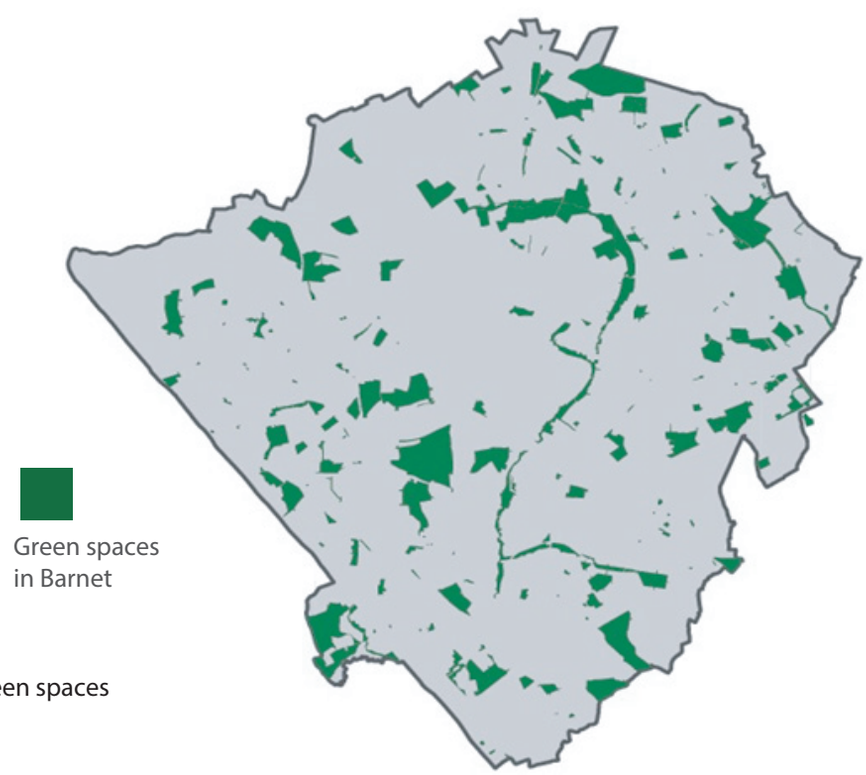


Figure 15. Barnet's parks and green spaces

Source: Capita Insight

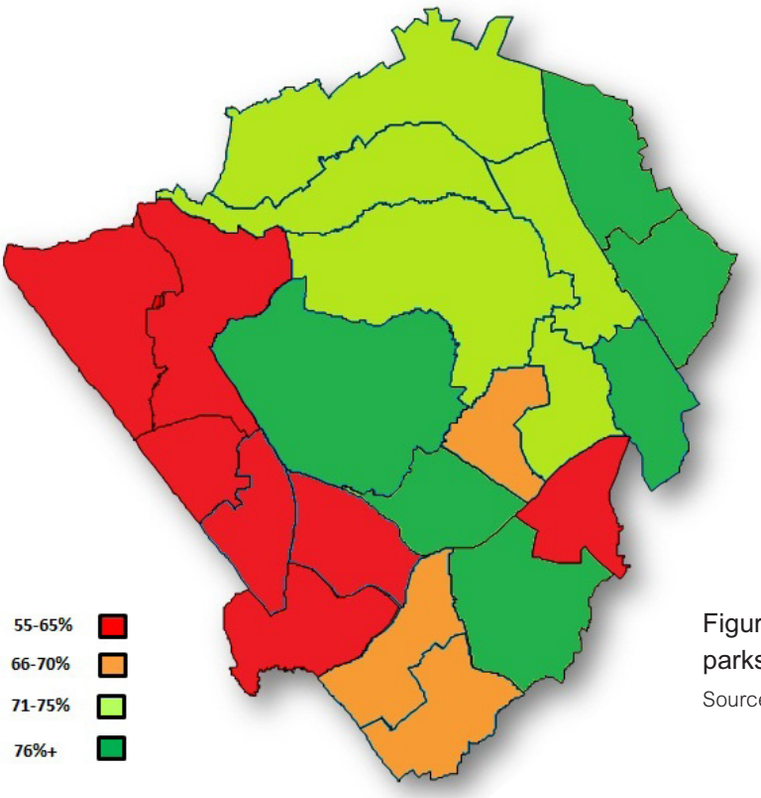


Figure 16. Barnet residents' satisfaction with parks and green spaces, by ward, 2014

Source: London Borough of Barnet

applicable, the level of satisfaction may give an indication of the provision and usage of green spaces. In 2014, the average satisfaction rate for parks and green spaces in Barnet was 70%. Burnt Oak residents had the lowest level of satisfaction (55%) whereas Garden Suburb residents had the highest (86%)[115]. Generally speaking, the west of the borough had lower satisfaction with parks than the east. With the exception of East Finchley, the wards with the lowest satisfaction were all in the Hendon constituency. It is important to note that, given the higher proportion of flats in the west of the borough, there is a greater need for public open space within this area. Levels of engagement with parks are lowest in the wards of Burnt Oak, West Hendon and Underhill.

A council assessment and service survey in 2013 found:

- wards with higher rates of crime have the lowest level of satisfaction with parks
- park use could be increased if facilities and safety were improved

8.1.3 Social isolation and participation in meaningful activities

Both isolation and loneliness are intimately linked with mental wellbeing. Older people are particularly vulnerable to the effects[116]. Socially isolated people are more likely to experience significant stress and have lower self-esteem when compared to those with strong social support networks[117]. Adults with chronic mental illness often experience social exclusion and struggle to participate in meaningful activities such as employment, volunteering, education, hobbies and exercise.

A British study conducted in 2002 found that poor levels of social engagement were an accurate marker for later ill health[118]. Participation in meaningful activities can greatly reduce levels of social isolation and loneliness. Participation also helps people feel engaged and stimulated, particularly into their old age[119]. A study by the Mental Health Foundation in 2014 found people with early stage dementia who participated in groups experienced increased mental and social wellbeing and developed practical coping strategies[120].

Two-thirds of people with mental ill health conditions live alone, four times more than the general population. Over 50% of people with mental ill health experience poor social contact compared with 6% of the general population[121]. Levels of loneliness tend to be higher amongst the elderly. The 2013 English Longitudinal Study of Ageing (ELSA) found 46% of people aged 80 and over reported being lonely compared to 34% of people aged 52 and over[122]. More recently, a 2014 Age UK survey of people aged 65 plus found almost 3 million people felt they had 'no social support' with 40% of respondents reporting that they were 'feeling lonely'[123].

8.1.3.1 Barnet perspective regarding social isolation

Social isolation

According to the Projecting Older People Population Information System (POPPI) the population aged 65 and over in Barnet is projected to increase from 32,500 in 2015 to 78,000 by 2030. At present a majority of older people in Barnet own their own home and the number of older people living alone is also expected to increase. As a result, the number of people requiring care and support to remain physically and socially active will increase, particularly amongst those aged 85 and over.

Living alone

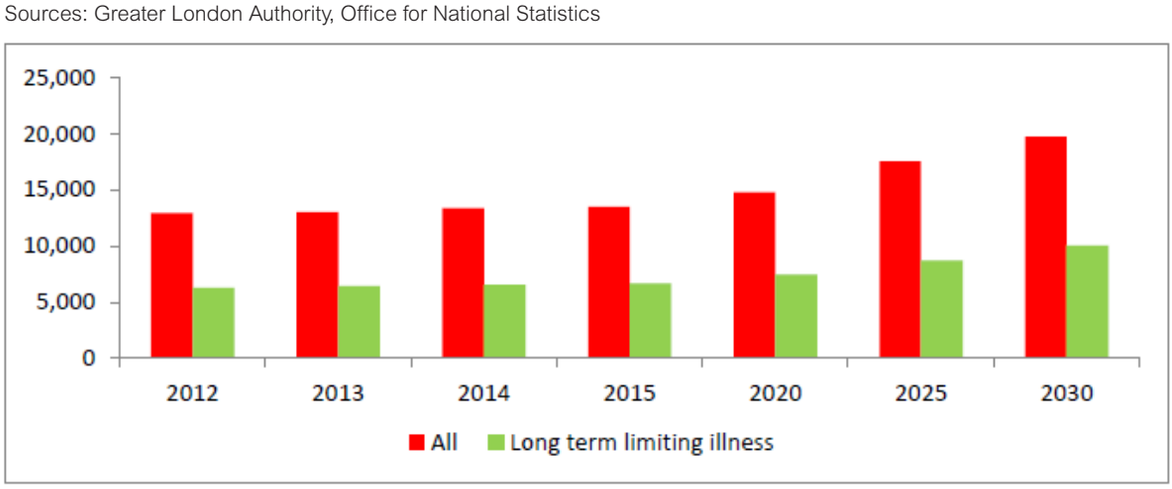
The 2006 Barnet Housing Needs Survey estimated that 38,000 households are under-occupied by older people living in larger homes. Figure 17 shows that the number of people over the age of 75 living alone in Barnet will increase over the coming decades. This emphasises that there is a need to ensure that the 'trade down' scheme is effective and those affected by the under-occupancy charge have an option to move into smaller homes.

8.1.4 Unemployment

There is a clear link between unemployment and mental ill health. Being unemployed can greatly diminish a person's social networks and reduce motivation. Those living with a mental health problem are especially vulnerable to the negative impact of unemployment. Unemployed people are more likely to suffer from high levels of all psychiatric disorders[125]. Unemployment is also associated with almost a 3-fold increased risk of common mental disorder and 4-fold increase in the risk of disabling mental disorder[126].

Figure 17. Number of people aged over 75 projected to be living alone in Barnet, by long term illness status, 2012-2013

Sources: Greater London Authority, Office for National Statistics



8.1.4.1 Barnet perspective regarding unemployment

Whilst employment in Barnet is increasing, areas in the west of the borough still have significant unemployment levels. For example in 2011 there was 8.4% unemployment in Colindale and 8.1% in Burnt Oak. The lowest rates of unemployment in 2011 were in Garden Suburb (3.6%), Totteridge (4.1%) and High Barnet (4.5%). Economically inactive (retired people, those in full time education, etc.) rates are slightly higher in Barnet than in either London or England. There is also a higher benefit claimant rate in Barnet than London or England.

8.2 Family and individual determinants

8.2.1 Physical activity, health and lifestyle

People living with chronic physical illness tend to have a greater rate of mental ill health. According to the National Institute of Health & Care Excellence (NICE) (2009) people living with a long term physical condition have a three-fold increased risk of depression. A World Mental Health survey carried out in 2007 found the risk of depression was seven times greater in those with a chronic physical illness[127]. As people age they are more likely to suffer with long term ill health. Research has found that 69% of people aged 75+ had a chronic illness compared to just 15% of people aged 16-24[128].

It is also worth noting that physical activity has a beneficial impact on people living with mental health issues. Physical activity can reduce anxiety and depression and improve mood more generally. Research suggests that exercise reduces a person's sensitivity to psychosocial stressors[129].

There is also evidence of a close relationship between obesity and mental health. Obese people can often experience low self-esteem, stigma, dieting and weight cycling, medication, and hormonal and functional impairment, which can lead to mental ill health. In turn people with mental health problems can have unhealthy lifestyles, issues with medication and reduced support, which could exacerbate obesity[130].

The Health Survey for England (2013) found that adults who completed 150 minutes of physical activity per week (as per government guidelines) reported the highest levels of wellbeing. Those with the lowest levels of activity displayed the lowest levels of wellbeing. Research into social isolation has found that people who exercised regularly felt more socially integrated when compared to those exercising rarely or not at all[131]. Clearly the benefits of being physically active don't simply include gains in physical fitness but also increased social cohesion and self-esteem.

8.2.1.1 Barnet perspective regarding physical activity, health and lifestyle

The association between age and ill health poses a significant mental health challenge particularly in ageing populations like Barnet. In London the number of people 65 and over is projected to rise by 300,000 to 1.17 million by 2031. The population of people over 90 is expected to almost double to 96,000. Whilst some ward populations in Barnet are projected to get younger (Golders Green, Colindale and Mill Hill), the population in the borough as a whole is ageing. The rise in the population aged 65 and above over the next decade will almost certainly result in increases in mental illnesses that are associated with chronic illness. Currently in Barnet there are 24,162 people aged over 65 living with a limiting long term illness. The size of this population is projected to increase by over 12% by 2020[132]. The highest rates of child obesity are seen in the wards of Colindale, Burnt Oak and Underhill. Unsurprisingly these are also the wards with some of the lowest levels of:

- participation in sport
- park use
- rates of volunteering

In Barnet, 42.1% of the adult population is of a healthy weight. The majority (55.7%) of the adult population has excess weight, with 35.2% being overweight and 20.5% being obese. Public Health England (2012)[133] estimates that the wards with the highest levels of adult obesity are Burnt Oak, Colindale and Underhill. Wards with the lowest levels of adult obesity are Garden Suburb, Finchley Church End and West Finchley (see Figure 18). There are similar levels of this stark inequality between wards in estimates for obesity amongst reception children (see Figure 19).

Barnet has 55.1% physically active adults, which is just below the average rate in the London region (56.2%). Forty per cent of

Figure 18. Estimated prevalence of adult obesity in Barnet wards (2012)

Source: Public Health England

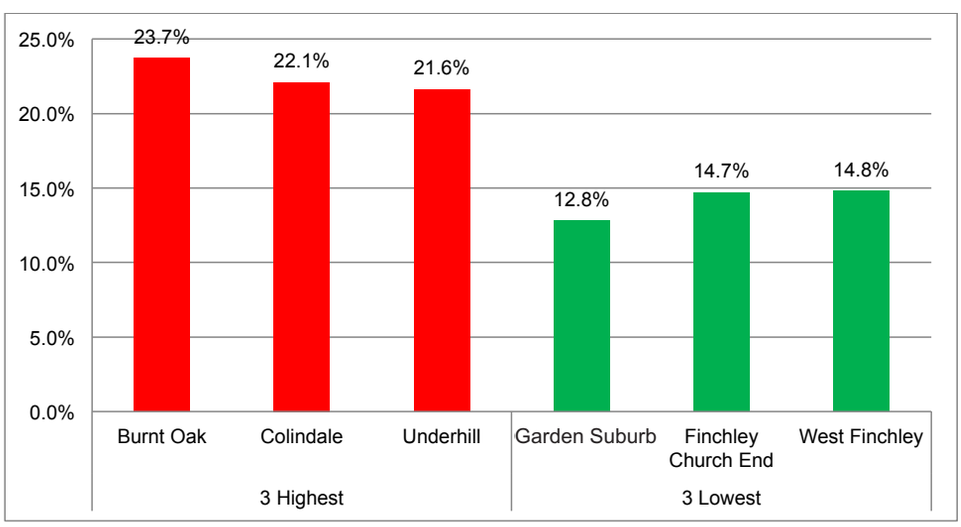
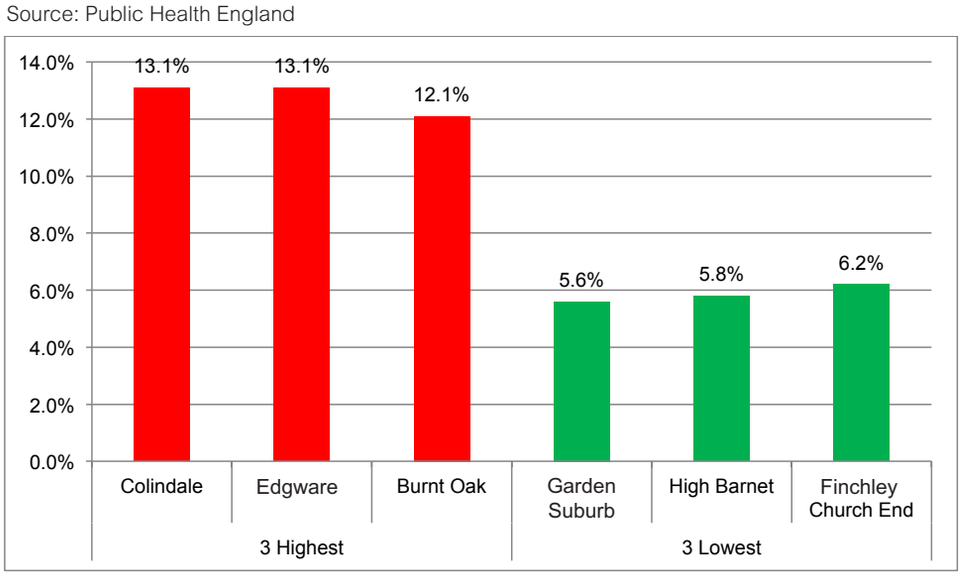


Figure 19. Estimated prevalence of obesity in Reception children in Barnet wards (2012)

Source: Public Health England



Barnet's residents aged 14 and above are involved in sports once a week. Participation in sports is higher in white British residents than those of black and minority ethnic (BME) origin. There are also inequalities in participation in sports between different localities in Barnet. Sport England's Active People Survey (APS6, 2011-12) shows once weekly sports participation at the Middle super output area (MSOA) level in Barnet was lowest in two MSOAs in Burnt Oak (36.5%, 38.7%) and one in Underhill (40.9%)[134].

Whilst the rate of physically inactive Barnet adults (26.1%) is similar to the London average, there is still a large group of the population not benefiting from the physical and mental health benefits associated with exercise. The Active People Survey revealed a substantial unmet demand for physical activity, with 68% of Barnet's 16 and over population reporting that they would like to do more sports.

8.2.2 Substance misuse

Heavy drinking is associated with mental illness, and almost all drinkers seeking help report symptoms of anxiety or depression[135]. Mental illness can exacerbate an alcohol problem but alcohol misuse can also make it more likely that drinkers will suffer from mental ill health[136]. Children brought up in families where parents or carers are abusing drink or drugs have the greatest risk of mental illness in later life[137]. The national mental health strategy ('No Health Without Mental Health')[138] acknowledges the association between drug and alcohol misuse and mental ill health. The misuse of illicit or prescription drugs also affects mental health[139]. Drugs can make mental ill health worse whilst also increasing the chances of developing illness such as schizophrenia. People simultaneously misusing drugs and living with mental health issues are particularly complex cases and often face additional challenges including poor physical health, unemployment and homelessness.

Smoking also shows a link to mental ill health. Forty-two per cent of all tobacco consumption in England is by those with mental health problems. Parental smoking is also associated with an increased risk of mental disorders in children[140]. Contrary to the perception that smoking relieves stress, a recent study found that smokers have a 70% increased risk of depression and anxiety when compared to non-smokers[141]. The study, of over 6,500 people over the age of 40, found that 18% of smokers said they suffered depression and anxiety compared with 10% of non-smokers and 11% of ex-smokers.

8.2.2.1 Barnet perspective regarding substance misuse

The number of people in treatment for alcohol dependence has risen by 53% in the last five years. The level of successful completions for alcohol treatment (28.1%) is below the national average (37.5%) for 2013/14.

In Barnet, numbers of people using opiates and crack cocaine, and people injecting drugs, have increased. However, the estimated rates (per 10,000 population) of opiate and crack cocaine use, and of people injecting drugs, are lower in Barnet than in London and England[142].

The wards with the highest prevalence of smoking in Barnet are Hendon, Mill Hill and Underhill. Whilst smoking in Barnet is below the national average the borough faces two major issues. Firstly, smoking cessation programmes in Barnet are significantly less effective than the national average. Second, women in Barnet are much less likely to quit smoking in pregnancy compared to the average for London.

Smoking prevalence in adults over 18 years in Barnet is 15%, which is below the national average of 18.4%. Estimated smoking prevalence amongst children aged 15 is 5.5% and prevalence amongst pregnant women is 4.4%[143].

It is estimated that smoking related illnesses in Barnet costs about £8m annually to the local NHS. Given the association between smoking and mental ill health, smoking cessation interventions could go some way to reducing the mental health burden in Barnet[144].

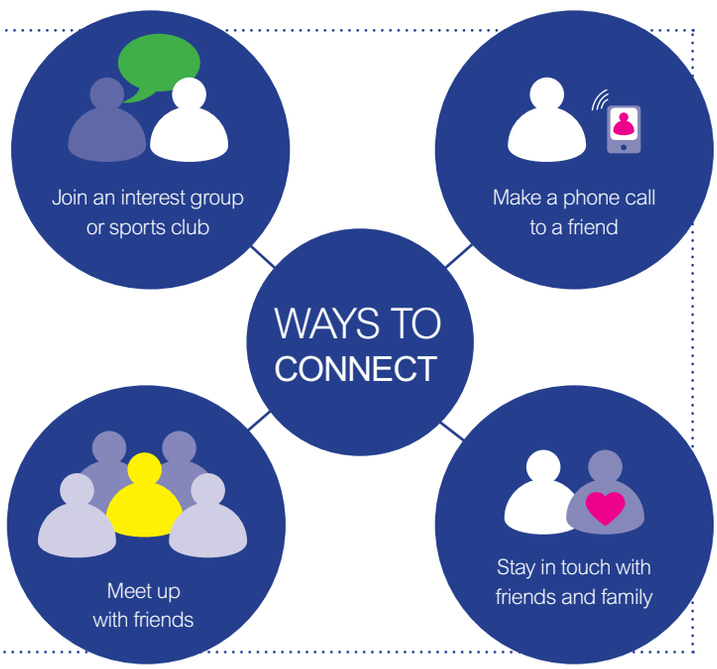
9 What are the Five Ways?

9.1 How were the five ways to wellbeing developed?

The concept of the 'five ways to mental wellbeing' emerged from the UK government's Foresight programme. The objective of the programme was to develop policy to manage major issues facing UK society over the next two decades. The 2008 Mental Capital and Wellbeing Project emerged from this and looked at ways of maximising mental wellbeing. Finally the Centre for Wellbeing at the New Economics Foundation (NEF) was commissioned to develop a set of evidence based actions to improve mental wellbeing. These actions came to be known as the five ways to wellbeing. The five ways are explained below.

CONNECT

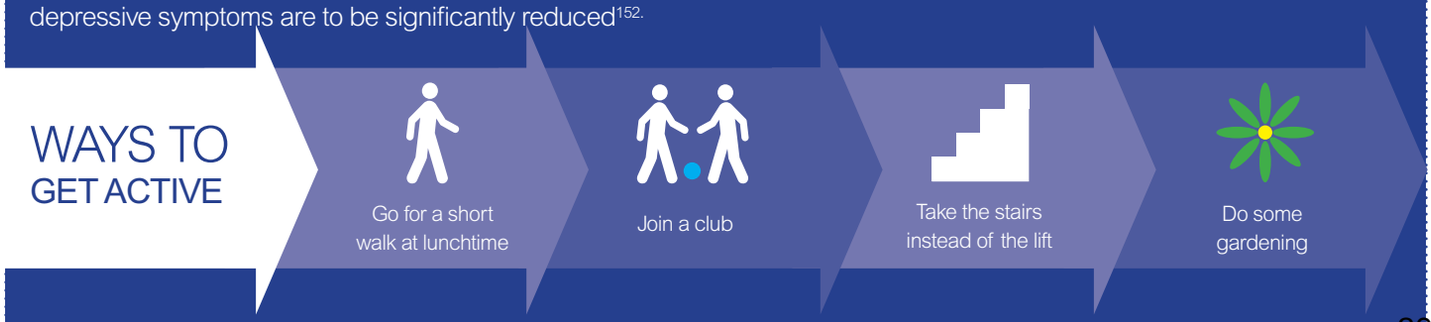
Surveys show that the most significant difference between those who do and do not experience mental ill health is levels of social isolation[145]. One study for example found that someone with a main social network of three or fewer close relatives and friends had an increased risk of developing common mental health disorders[146]. This is understandable as research suggests that social networks promote a sense of belonging and wellbeing in individuals[147].



GET ACTIVE

Physical activity is associated with improved feelings of wellbeing and reduced rates of depression and anxiety for all age groups[148]. Long term studies show that if you are physically active you are better protected against the onset of depression and anxiety and cognitive decline in your later years[149]. Participation in physical activity has also been found to increase self-confidence and perceived ability to cope with adversity[150].

Even minor increases in activity among people who are inactive or elderly can significantly benefit wellbeing. For example, if you take single bouts of exercise for less than **10 minutes** this can improve mood[151]. Despite this, current evidence suggests that recent guidelines - advising bouts of moderate physical activity three to five times a week - must be followed if depressive symptoms are to be significantly reduced[152].



TAKE NOTICE

Mindfulness is a simple and very popular skill that takes between 8 – 12 weeks to learn. It helps you be very aware of your surroundings and feelings. Being trained to be aware of mood, thoughts and feelings like this can improve your feelings of wellbeing for several years[153]. For example being in a state of mindfulness ('being attentive to and aware of what is taking place in the present') has been found to bring about positive mental states[154]. It is thought that taking notice of your feelings can allow you to make more appropriate life choices that are consistent with your values and interests[155]. Taking notice means 'being in the moment' and focussing on present activities rather than dwelling on the past or worrying about the future.

LEARN

Learning plays an essential role in our social and cognitive development[156]. Lifelong learning also increases self-esteem, encourages social interaction, and leads to a more active and fulfilling life. Adult learning is associated with improvements in wellbeing and self-confidence[158]. So-called 'goal directed learning' also has a beneficial impact upon levels of life satisfaction as it allows learning to be self-directed and appropriate to an individual's values. Finally, lifelong learning also improves people's ability to plan for unexpected circumstances, thus reducing the impact of stressful events[159].

GIVE

An active social life and participation in the community is known to increase happiness and life satisfaction[160]. For example, volunteering can help develop optimism and give more meaning to life, particularly for the elderly[161]. People displaying a greater interest in helping others are more likely to define themselves as happy. Performing an act of kindness once a week has also been associated with increased wellbeing [162].

10 Mental Health Strategy and Services in Barnet

Improving mental health and wellbeing is a key priority in Barnet. Both the council and the Clinical Commissioning Group (CCG) know how important it is to achieve equal status between physical and mental health and also between prevention and early intervention.

So to help with this, the council and the CCG have introduced a range of initiatives and programs. An overview of mental health strategy and services in Barnet is detailed below and illustrated in the case studies in section 11 ('How is Barnet using the Five Ways to Address Mental Wellbeing?')

The Council and CCG have reviewed services and developed five key elements of the vision to transform mental health services in Barnet:

1. A focus on prevention – working with families to support parenting, and de-stigmatising mental health
2. Services focused on children and young people and their families/ carers
3. A focus on outcomes and evidence based support – using interventions that have been proved to work
4. A focus on developing seamless services from pregnancy to adulthood
5. A flexible service accessible to young people and their families/ carers, to access how and when they want, using communication technology

The council and CCG are committed to a range of initiatives:

- Working with Barnet, Enfield and Haringey Mental Health Trust to improve secondary care (hospital) services and move towards a community based model of care.
- Enhancing local services to improve access to primary care for people with mental health problems who are homeless and to reduce the waiting list and encourage referral to the Improving Access to Psychological Therapies (IAPT) service.
- Public Health team mental health initiatives:
    - A suicide prevention strategy
    - Two linked Employment support services: Motivational and Psychological Support for job seekers based in local Job Centres; and an Individual Placement and Support scheme for people with enduring mental ill health
- A Barnet Schools health and wellbeing programme has been in place since 2013. This offers support to develop programmes, a directory for signposting, and training to build capacity within schools.
- Barnet's wellbeing campaign focuses on improving mental wellbeing and reducing stigma. The campaign will:
    - Celebrate World Mental Health Day
    - Develop a health champion programme in primary care focused on improving mental health and wellbeing
    - Review local pathways for antenatal and postnatal depression, including promoting peer support
    - Be part of the pan-London digital mental health support service
    - Maximise the potential of improvements to and changes in the management of open spaces, where this could support improved mental wellbeing

- The Children and Adolescents Mental Health Service (CAMHS) in Barnet provides care to over 2,000 young people per year. Priorities for the services include improving access to services for young people with mental health issues and reducing the number of children and young people requiring CAMHS services.

There are currently three key providers of CAMHS services in Barnet:

1. Barnet, Enfield and Haringey Mental Health Trust, which provides: generic 'tier 3' services; primary/secondary projects in schools; services for looked-after children; the Service for Children and Adolescents with Neuro Developmental Difficulties (SCAN); the Barnet Adolescent Service (BAS); and paediatric liaison
2. Royal Free Hospital, which provides out of hours, paediatric liaison and eating disorder services and general CAMHS
3. Tavistock and Portman, which provide brief therapy, family services, refugee services, an autism team and fostering, adoption, kinship care, and trauma services

- The Reimagining Mental Health project, set up and run by Barnet CCG, aims to deliver more targeted health services by using a more community–based approach. Barnet CCG will use its commissioning power to:
  - Work with Enfield and Haringey CCGs to review the Psychiatric Liaison Service provision
  - Review each 2015/16 contract for services for older people that relates to multidisciplinary care offered in people's own homes. These link closely with primary, secondary, social, and voluntary and community sectors
  - Undertake (in partnership with others) a comprehensive redesign of existing CAMHS. This is in response to the CAMHS Transformation agenda and will have a particular focus on the most vulnerable.
  - Produce CAMHS out of hours service, working with North Central London partners

In summary, it is extremely positive that the importance of prevention of and early intervention for mental ill health are being highlighted in Barnet. It is important to recognise that the five ways empower people to improve their mental wellbeing, allowing them to make small but effective changes to everyday activities throughout their lives. As such the five ways can make a great contribution to preventing and reducing mental ill health in Barnet.

11 How is Barnet Using the Five Ways to Address Mental Wellbeing?

Barnet is trying to introduce projects and create opportunities so that people can adopt the five ways. A range of programmes and interventions are available which use some of the five ways to improve the mental wellbeing of residents. Twelve examples are given below. Each 'way' is highlighted in a relevant colour when a given programme directly or indirectly uses any of the five ways in its methodology.

CONNECT

BE ACTIVE

TAKE NOTICE

KEEP LEARNING

GIVE

Altogether Better Coffee and Chat group

- Weekly social meeting place
- Meet and chat with others over tea and coffee
- Two 'helpers' attend each week to welcome newcomers
- Helpers also assist visitors to sign up for other activities in the area
- Sessions enable otherwise lonely or isolated individuals to CONNECT and BECOME INVOLVED in their local community.

Testimony

- Many comment that they are pleased to have the opportunity to BECOME PART OF A GROUP. Ester lost her husband two years ago and has attended 'Coffee and Chat' mornings since they began;

"I never realised how lonely I would be when my husband died. The meetings on Mondays have been a lifesaver, with lots of cheerful exchanges and people from all walks of life. I have MADE NEW FRIENDS and TRIED NEW ACTIVITIES through this group"

Altogether Better Table Tennis

- Free-to-attend service
- Aims to bring people of all ages and fitness levels TOGETHER to engage in SPORTING ACTIVITIES
- The group helps people to CONNECT WITH OTHERS through participation in sport
- Allows people to BUILD A FRIENDSHIP network

Testimony

- A gentleman in his 70s who has been attending the group had previously been looking for an activity to suit him;

"I am a keen tennis and table tennis player but my back problems prevent me from playing tennis and I have never been able to find a club or players to play table-tennis before now"

"There is always friendly banter and so a great afternoon's activity is enjoyed by all"

"It has helped my fitness enormously and I think my standard of play has increased greatly"

Dementia Support Services

How it works

- Provided by the Alzheimer's Society Barnet office
- Advisors make DIRECT CONTACT with people diagnosed with dementia and their carers
- Provides people suffering from dementia a named individual to offer ADVICE AND SUPPORT and signposting to local care or support services.
- Offers referral to services such as dementia cafés and supports people in getting the help and care they need
- Offers resource packs for people with dementia and their carers
- Offers support and advice to front line care staff whilst promoting wider awareness of dementia
- Advisors also act as an initial contact point for GPs, community nurses, and social workers seeking assistance for patients with dementia.

Benefits of the service

- Helps people with dementia make informed decisions
- Offers a service that is practical and personalised, at a place and time convenient to users
- Allows people to EXPRESS CONCERNS and discuss unique care and support needs
- Allows people to receive up-to-date information, tailored to their individual needs
- Signposting to other services allows people to access a diverse range of support services.

Testimony:

"I am very grateful because my dementia advisor has helped me and my wife tremendously and provided so much support to access the help I required. I have been able to get help from social services. I am very very grateful".

Dementia Café

How it works

- The Alzheimer's Society runs three cafés in New Barnet, Mill Hill and Golders Green and another separately funded café at Finchley Memorial Hospital
- They offer an informal environment for people with dementia and carers, to SOCIALISE and receive information, advice and activities
- People affected by dementia can drop in
- Each session offers a range of cultural, craft and other ACTIVITIES
- Advice from dementia advisors and carer support is available at all sessions
- They offer a chance to meet people newly diagnosed with dementia to develop social support networks and receive INFORMATION REGARDING DEMENTIA

Benefits of the service

- Reduced social isolation
- Increased choice and self determination
- INCREASED AWARENESS and understanding of dementia
- Support for people and carers living with dementia
- Easy access to care, support and advice following diagnosis.

Testimony:

"An enjoyable session. We always enjoy coming here. There is always something interesting to keep us engaged."

Health Champions

- Aims to support people to DEVELOP LIFE EXPERIENCE AND SKILLS
- HEALTH CHAMPIONS HELP FRIENDS, families and community members to lead healthier lives
- Health Champions are; *"individuals who possess the experience, enthusiasm and skills to encourage and support other individuals and communities to engage in health promotion activities"*

Health Champions in Barnet

- The new programme in Barnet will:
  - improve access to health and social care services
  - foster an integrated community-based approach to health and wellbeing.

How it works

- GPs will invite people on their list to receive training as 'Health Champions'
- Once trained, champions will be supported to work with practice staff to develop groups and activities to meet the challenges faced by the practice.
- Champions will be incentivised through the possibility of employment and personal development.
- Health Champions will:
  - help patients make better use of the practice services and clinical consultations
  - help practices have STRONGER LINKS WITH THE COMMUNITY
  - provide resources to practices for health promotion, promoting behaviour change/self-care
  - address social and emotional needs by:
    - providing PEER SUPPORT and BEFRIENDING
    - engaging people in MEANINGFUL ACTIVITIES and community life (singing, crafting, walking or cycling).

Benefits of the service

- 'Health Champions' will be rolled out in Barnet next year. The scheme has been provided elsewhere with good results. A rapid review of the evidence found that 'Health Champions' resulted in:
  - positive impact on volunteer health, including better mental health
  - positive behaviour changes (increased PHYSICAL ACTIVITY), particularly when working with disadvantaged, low-income or minority ethnic communities
  - increased KNOWLEDGE AND AWARENESS of health issues
  - increased uptake of preventive measures such as immunisation
  - improved disease management for long term conditions
  - more appropriate use of health care services, including reducing barriers to access and decreasing hospital admissions

  The programme benefits health champions themselves, to learn and GIVE, and reap the benefits of the volunteering for their own wellbeing.

  The programme can lead to increased opportunities to be ACTIVE, CONNECT and KEEP LEARNING through activities, groups and peer support.

Mental Health & Employment

- Aims to PROVIDE EMPLOYMENT SUPPORT to people with mental health difficulties
- Employment coaches provide motivational support and signposting
- Started in Barnet in November 2014
- The programme has two branches:
  1. Motivational and Psychological Support (MaPS)
     - combines psychological and employment support within 'Job Centre Plus' for people with mild to moderate mental health issues.
  2. Individual Placement and Support (IPS)
     - for people who are unemployed with severe mental illness and supported by specialist mental health services.

How MaPS works

- PSYCHO-EDUCATION:
  - combination of both psychology and education
  - holistic competence-based approach stressing health, collaboration, and empowerment
  - helps to change behaviour patterns, values, and interpretation of events
- MaPS service uses:
  - cognitive techniques like role play and problem-solving in a safe setting
  - support to INCREASE WORK READINESS (increase confidence and assertiveness)
  - individual action plans for users to stabilise their living situation and monitor progress
  - signposting for people with higher level needs to appropriate care services.

How IPS works

- Delivered by employment teams operating in community mental health centres with clinical staff
- Individuals who express interest in working are referred to employment specialist in IPS team
- IDENTIFYING A USER'S GOALS AND PREFERENCES and providing information about IPS
- Individual and employment specialist work together to make a plan for job hunting locally
- Employment specialists also provide CV development, interview training and on-the-job support.
- A service user's preferences are at the heart of IPS, service users decide:
  - what information potential employers know about their mental illness
  - whether the specialist contacts an employer on their behalf
  - which jobs to apply for and how much he or she wants to work.

Outcomes

- The main outcomes to be achieved by this service are to:
  - SUPPORT PEOPLE INTO FULL-TIME PAID WORK
  - enable people to achieve paid work that reflects their aspirations
  - improve the mental health of service users.
- The August 2015 interim report indicated that the programme has been successful in:
  - increasing the number of people with mental health issues securing paid work
  - clients have expressed high levels of appreciation for the personally tailored support: "it helped me decide what to do and I explored different avenues I might enjoy"
  - users reported increased confidence, self-belief, motivation and sense of purpose.
- Overall, this programme can improve mental health and wellbeing by:
  - allowing users to BECOME MORE AWARE OF THEMSELVES and their goals
  - allowing clients to GAIN NEW SKILLS by becoming work ready and gaining employment.

Schools Wellbeing Programme

- The Barnet Schools Wellbeing Programme (BSWP) was set up in October 2013 to equip schools to improve the health and wellbeing of their pupils and staff

How it works

- The programme was rolled out in primary schools and extended to secondary schools
- The programme focused on five public health work streams:
    1. HEALTHY EATING
    2. PHYSICAL ACTIVITY
    3. EMOTIONAL WELLBEING
    4. substance misuse prevention
    5. SEXUAL HEALTH EDUCATION
- Also supported schools to achieve the Healthy Schools London (HSL) awards
- Providers delivered training, consultancy and resource packages to support schools implementing sustainable health and wellbeing measures.

Benefits of the service

- Between October 2013 and August 2015 the majority of targets were exceeded
- Numerous outcomes contribute to improved mental health and wellbeing:
    - an increased number of children learning new skills such as:
        - LEARNING TO COOK through "let's get cooking" clubs for example at Parkfield Primary School.
        - LEARNING TO GROW FOOD for example at the food allotments at Wessex Gardens Primary School.
- INCREASED AMOUNT OF PHYSICAL ACTIVITY in schools with:
    - 35 primary schools providing two hours of PE per week
    - at St Catherine's RC Primary School there was a:
        - 200% increase in the percentage of pupils playing/running/skipping
        - 47% increase in the percentage of pupils playing games.
- An increase in the number of schools (45) providing more opportunities to build pupils' confidence, wellbeing and self-esteem
- Mathilda Marks Kennedy Park School worked on peer mediation:
    - children received training in how to sort out problems such as bullying, disagreements and arguments, giving the children a chance to GIVE to others as well as LEARN NEW SKILLS
- The substance misuse stream empowered children to make better decisions
- The BSWP encouraged a holistic approach towards improving health and wellbeing in schools - benefiting teachers, parents and children and tackling many aspects of health and wellbeing
- It allowed children and teachers to learn new skills, increase levels of activity and CONNECT WITH DIFFERENT GROUPS.

Self-harm & Suicide Prevention Training

- The aim of this programme is to PROVIDE TRAINING WORKSHOPS on self-harm and suicide prevention for frontline staff who work with children and young people (up to age 25) in Barnet.
- Frontline staff include:
    - social workers
    - youth and community workers
    - welfare staff and housing officers
    - police, prison and probation officers
    - GPs
    - faith leaders
    - domestic abuse workers
    - teachers and support staff in educational institutions
    - railway staff
    - refugee and asylum seeker service staff.

How it works

1. Half Day AWARENESS TRAINING:
    - for a minimum of 300 frontline staff who come into contact with children and young people on self-harm and suicide awareness
    - recognising signs and symptoms and signposting to appropriate help.
2. One Day training:
    - SKILL-BASED TRAINING for at least 100 staff who undertake 1:1 work with children and young people
    - equipping them to intervene, manage and prevent self-harm and suicide.

Benefits of the service

- The training aims to enable frontline staff to:
    - increase their ability to RECOGNISE SIGNS of self-harm and suicidal thoughts
    - ensure a better response to those self-harming or having suicidal thoughts
    - develop a non-judgmental approach and a 'ready to help' attitude
    - increase knowledge of where to go for advice and support
    - encourage help seeking behaviour amongst adults, children and families.

- The programme ended in November 2015, and will now be evaluated
- The programme should enable the front line staff to:
    - TAKE NOTICE of those around them
    - GAIN NEW SKILLS needed to support those they identify as being at risk.
- Increased awareness of others may also help them to be more aware of their own feelings, thereby contributing to their own mental wellbeing.

Silver Service Scheme

- For those over 60 and their guests (carer, friend, relative of any age)
- Diners have a choice of restaurants in East Finchley and Edgware
- Offers a £5 restaurant lunch deal on Tuesdays
- Gives older people the opportunity and incentive to GET OUT OF THE HOUSE, eat well and SOCIALISE with people of their choice for a reasonable price.

Testimony

- One user has been able to try new restaurants which she would not otherwise have been able to try:

"I do enjoy going to a new restaurant, especially as I have lived in the area for 16 years"

"It is always fun to go and MEET NEW PEOPLE in a nice environment"

"We all enjoy going to NEW RESTAURANTS together in the area that we would not have gone to without the scheme"

"I'm enjoying meeting new people in the area and it's nice to meet locally but somewhere you have never been before"

Substance Misuse Service

- A new Substance Misuse Service will operate from two hubs.
- Both will provide treatment and recovery to reduce the number of clients not attending treatment.
- The pathway will aim to increase the rate of successful completions by adopting a more holistic approach to patient care.
- Patients will receive an initial assessment to identify individual need:
  - Information from this assessment will inform referral to an appropriate care coordinator.
  - Patients will then be offered a range of PROGRESS TO RECOVERY INTERVENTIONS with additional support offered in complex cases.
  - Patients will also receive support in COMMUNITY RE-INTEGRATION.
  - Regular patient reviews will be carried out every 5 weeks or when circumstances change
  - Reviews will be supplemented with weekly client program and review meetings to discuss client progression and concerns.

Visbuzz

- New initiative designed to help KEEP PEOPLE CONNECTED through technology
- Targets those at particular risk of mental health problems (elderly, isolated and disabled).

How it works

- Visbuzz is a simple video calling system, which enables users to video CALL FRIENDS, family, carers or health care professionals with just one touch
- Application is used on a tablet device (either provided by the service or the user's own) and displays photographs of people the user might want to call.
- Touching a photograph connects the user to face-to-face chat.
- If the desired person is unavailable, that person will receive a text message saying that the user has tried to call them.
- Software is provided through a cloud and users can connect to the service through different devices in different places.

Visbuzz in Barnet

- 'Visbuzz' is currently being run as an exploratory pilot, funded by London councils as part of 'Capital Ambition'
- The pilot aims to reach 100 people in each borough.
- Tablets will be provided to residents in Barnet from December 2015.

Benefits of the service

- Anticipated benefits of the project include:
    - REDUCED LONELINESS and increased wellbeing through increased contact
    - reduced anxiety for family and friends of users
    - INCREASED SOCIAL INCLUSION
    - INCREASED DIGITAL INCLUSION and confidence with technology
    - enablement of health and social care appointments without leaving the house
    - reduced wasted emergency call outs and loneliness call outs.

Volunteering in Barnet

- According to the Spring 2015 Barnet Residents' Perception Survey:
  - 26% VOLUNTEER at least once a month
  - 13% volunteer, but less than once a month.
- The London Borough of Barnet Charter with the voluntary and community sector commits the council to support volunteering.

Groundwork

- Groundwork London has been providing volunteering services for Barnet since April 1, 2015.
- Groundwork offers cost-effective, non-clinical solutions that can INCREASE PHYSICAL and SOCIAL ACTIVITY and improve mental wellbeing.
- Groundwork brings a holistic approach to improving health and wellbeing:
  - community based services that embed health improvement into PERSONAL DEVELOPMENT, social mobility and green space development programmes
  - based around community development in accessible community locations

12 Summary and Recommendations

This report has highlighted the substantial burden of mental ill health in Barnet. The challenge presented by mental ill health will grow over the commings years. For example the number of people living with common mental disorders and two or more psychiatric disorders is projected to rise over the next four years. The rate of child admissions for mental health in Barnet is significantly above that for London and increased sharply between 2011/12 and 2013/14. The prevalence of dementia in Barnet is also above the London average and the number of people with dementia is also projected to rise.

Though levels of happiness are generally high in the borough a substantial proportion of residents report low levels of happiness (8.5%) and high levels of anxiety (13.1%). There is also substantial inequality in levels of personal wellbeing between wards in Barnet.

The projected increases in mental ill health and inequalities in personal wellbeing in Barnet require serious attention. The five ways to mental wellbeing offer an excellent opportunity to reduce the burden of mental ill health using a diverse range of methods that can be aplied at different points throughout a person's life.

In light of Barnet's mental health profile, future projections, and current programmes and interventions, the following actions and recommendations are proposed. If implemented these will allow Barnet to address mental ill health through improved use of the five ways to mental wellbeing.

Recommendations:

1. Add a 'Five ways to Mental Wellbeing' page to the public health section of the Barnet Council website
    - Provide a page introducing the five ways and list of programmes available in Barnet that utilise the five ways.
    - This will help to:
        - Raise awareness of the value of the five ways among the general public whilst also making programmes more accessible
        - Increase levels of self-referral and increase independence of people with mental ill health.
2. Identify ways to incorporate the 'five ways' into more council and CCG led programmes
    - Continue to work with commissioners to support people with eating disorders in Barnet.
    - Use the public health team to promote and encourage greater use of 'be active' and 'take notice' components of the five ways in council programmes.
    - This should focus on programmes that target the elderly or people living in care homes.
    - Examples of ways to take notice indicate the ease with which this component could be added to programmes. Ways to take notice include asking others about themselves, noticing how friends or colleagues are feeling, taking a different route to work or the shops and taking pleasure in the little things.
3. Incorporate promotion of mental wellbeing and the 'five ways' into healthy workplace schemes
    - The five ways will offer a structured and easily understood method for employers in Barnet to promote mental wellbeing and healthy lifestyle choices.

If you have any questions or comments about this report, or would like more information about any of the programmes, projects or research mentioned, please contact: robert.reed@harrow.gov.uk

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AGENDA ITEM 9

	Health and Wellbeing Board **21 January 2016**
Title	**Children and young people commissioning priorities to 2019/20**
Report of	Commissioning Director – Children and Young People
Wards	All
Date added to Forward Plan	November 2015
Status	Public
Urgent	No
Key	No
Enclosures	Appendix 1: Revenue Planning Template Appendix 2: Capital Planning Template
Officer Contact Details	Chris Munday – Commissioning Director Children and Young people chris.munday@barnet.gov.uk / 0208 359 7099

Summary

The Children, Education, Libraries and Safeguarding Committee, on the 18 November 2015, considered the proposals to achieve the financial envelope for the Children, Education, Libraries and Safeguarding Committee. This reports sets out the strategic priorities, indicative budget and capital programme up to 2019/20 as agreed by the Children, Education, Libraries and Safeguarding Committee.

The following report sets out a revised savings programme that will inform the consideration of the Council's Medium Term Financial Strategy which will be agreed by Policy and Resources Committee on 16 December 2015. In terms of the Children, Education, Libraries and Safeguarding Committee there is a saving required of £14.5m (by 2020) rising from £9.9m previously; from a total budget of £55.6m. The Council's budget has already reduced by 25% from 2010 in real terms. Additional proposals have been developed to meet this target which accord with the Children, Education, Libraries and Safeguarding Commissioning plan (2015 – 2020) which provides the outcomes framework

by which progress will be measured. The budget projections through to 2020 are indicative figures. The budget 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.

Recommendations
1. That the Health and Wellbeing Board notes the commissioning priorities for children and young people within the budget context being faced by local government.
2. That the Health and Wellbeing Board will consider the children and young people commissioning priorities when making commissioning and policy decisions.

1. WHY THIS REPORT IS NEEDED

1.1 Following the General Election in May, the Finance and Business Planning report presented to Policy and Resources (P&R) Committee in July 2015, updated the assumptions in the Medium Term Financial Strategy (MTFS). It noted a revised budget gap for 2016-20, estimated at £29.4m beyond the proposals previously set out in the MTFS. This represents an increase of £7.5m on the assumptions presented to Council in March. This is mainly a result of an anticipated reduction in funding that Barnet will receive from Government.

1.2 In terms of the Children, Education, Libraries and Safeguarding (CELS) Committee there is a saving required of £14.5m (by 2020) rising from £9.9m previously; from a total budget of £55.6m. The Council's budget has already reduced by 25% from 2010 in real terms.

1.3 As a result of the scale of the challenge facing Local Government from public spending reductions and increasing demand, Barnet's response to the financial challenge is predicated around:

- Maximising the revenues we generate locally through growth and investment
- Targeted help to those that need it – a focus on employment
- Investing in the future
- Managing demand on services

1.4 **Capital Programme**

1.4.1 The current Council capital programme totals £168m up to 2020, funded from a combination of capital receipts, borrowing, revenue and external grant contributions.

1.4.2 Additions to the capital programme are required in order to:

- Fulfil statutory requirements;
- Secure investment to generate future capital value; and

- Secure investment to realise MTFS revenue savings

1.4.3 For the CELS Committee, Appendix 2, sets out the proposed changes to the existing capital programme. The following are critical capital requirements:

School places (including alternative provision):

1.4.4 At its meeting on the 15th September 2015, the Children, Education, Libraries and Safeguarding Committee considered a report setting out the estimated future need for school places in Barnet to 2019/20. The capital requirements set out in the report were estimated using Barnet's experience to date in delivering school places. They reflected the recent cost increases experienced by the Council within its school construction programme as a result of rising building cost inflation due to a construction boom, an issue being experienced across London and elsewhere.

1.4.5 The report set out that the total estimated capital cost of providing new school places (not yet commissioned) is estimated to be £207.9m between 2016/17 and 2019/20. However, the full cost of the building programme is unlikely to fall solely on the Council. Central government funding makes a contribution to the cost of providing new school places through three main avenues; an annual capital basic need grant, specific grant funding schemes such as the Priority School Building Programme and the funding of free schools. Taking into account assumptions on free school delivery and levels of future grant, the report identified a funding gap of £16m for school places over and above the current capital programme.

Libraries:

1.4.6 The council is currently undertaking further consultation on a proposal to reshape Barnet's Library service in order to realise revenue savings of £2.277m. At its meeting on the 12th October 2015, the Children, Education, Libraries and Safeguarding Committee received a report that included an assessment of the estimated capital investment to implement this proposal should it be approved following the consultation. This report was referred to full Council and agreed. The report estimated that £4.41m would be required to reconfigure library sites and invest in new equipment to enable technology enabled opening arrangements at ten library sites.

Youth Zone:

1.4.7 As agreed by the Assets, Regeneration and Growth (ARG) Committee on the 7th September 2015, proposals are progressing to develop a Youth Zone in Barnet. The capital contribution agreed by ARG is for the council to contribute up to £4.2 million towards the £6million capital build.

1.5 **Strategic direction of service**

1.5.1 Barnet has one of the largest populations of children and young people in London and in general, according to the detailed Joint Strategic Needs Assessment, they do well. Children in Barnet generally have:

- Good health outcomes overall
- Access to good and outstanding schools
- Good education performance and achieve well across all key stages

- Low rates of offending

1.5.2 Despite this there is a need to ensure that all children thrive and achieve their potential. To ensure this happens we need, either directly or through partnerships, to deliver effective, safe and high quality services that continue to meet the needs of children and young people within the borough.

1.5.3 The challenging financial climate in which we are operating requires a focus on ensuring that all resources are deployed effectively to deliver the key outcomes and priority for CELS Committee.

1.5.4 CELS Committee agreed in October 2014 that the critical outcomes for Barnet's Children and Young People are as set out in the following table:

Priority	Key Outcomes
Safeguarding	- Children and young people are safe in their homes, schools and around the borough, with an ability to develop healthy relationships with others. - When children are at risk, by intervening early the Council will improve outcomes for children, young people and families, enabling them to thrive.
Education	Excellent school standards result in all children achieving their best, being safe and happy and able to progress to become successful adults. ● Every child attends a good or outstanding school, as judged by Ofsted. ● The attainment and progress of children in Barnet schools is within the top 10% nationally. ● The progress of the most disadvantaged and vulnerable pupils is accelerated in order to close the gap between them and their peers.
Health & emotional well-being	- Children and young people are physically, mentally and emotionally healthy. - Every child in Barnet has a great start in life, with the security and safety to grow in a nurturing environment. - Childhood in Barnet is safe and fun, with lots of opportunities to grow and develop through education, leisure and play. - Children and young people feel supported to achieve and engage, while developing their identities and resilience.
Preparation for adulthood	- Young people are ambitious for their futures, ready for employment and contribute positively to society. - Young people with special educational needs or disabilities and their families are able to plan for their future and enable growth.

Parenting	- All parents and carers are able to develop high quality relationships with their children, establishing effective boundaries and support physical and emotional well-being.
Libraries	- Children benefit from reading, literacy and learning opportunities. - Adults benefit from reading, learning opportunities and easy access to the wider world of knowledge and information. - A range of outcomes are achieved by community groups through community spaces, access and resources.

1.5.5 To deliver these priorities within the new financial envelope there is a need to consider and refocus our priorities. Over the Business Planning period it is proposed to focus on:

- Further reshaping of early intervention and prevention services to provide effective, targeted interventions which reduce the need for higher cost interventions
- Developing new models of social work practice and intervention which reduce the need for higher cost placements and the number of adolescents in our care, especially in residential provision
- Integrating health, social care and education services and resources to improve the experience of receiving care and support for disabled children and their families and reduce duplication
- Increasing the productivity of education and children's services through developing new ways of working to meet the needs of a growing population within available resources
- Utilising new technologies and community capacity to create a sustainable library offer for Barnet.

2016/17 Proposals

Priorities	**Changes**
To further reshape early intervention and prevention services to provide effective, targeted interventions which reduce the need for higher cost interventions	Contract Management and Third Party Spend Early Years Review
To develop new models of social work practice and intervention which reduce the need for higher cost placements and the number of adolescents in our care, especially in residential provision	Placement Commissioning
To integrate health, social care and education	0-25 Year Service Development

services and resources to improve the experience of receiving care and support for disabled children and their families and reduce duplication	
To increase the productivity of education and children's services through developing new ways of working to meet the needs of a growing population within available resources.	Education and Skills Alternative Delivery Model
To utilise new technologies and community capacity to create a sustainable library offer for Barnet	Libraries

1.6 **Education and Skills Alternative Delivery Model**

1.6.1 This proposal is for the procurement of a partner organisation to deliver the Council's Education and Skills service. Procurement is well advanced and a decision to consider the award of a contract is scheduled for December 2015, with implementation on the 1st April 2016. The arrangement would see the partner organisation contracted to deliver core education services (including Special Educational Need transport commissioning and brokerage) as well as a range of traded services to schools. The savings would be generated through efficiencies and by growing the traded service business.

1.7 **Contract Management**

1.7.1 Each year the Council provides monies to address inflationary pressures in commissioned services. This saving consists of containing inflation on contracts and improved contract management and negotiation of better rates across a range of contracts. It is an efficiency saving, not a change in the way services are delivered and so it is not anticipated to have an impact on service delivery, customer satisfaction or equalities. In light of the living wage, it is recognised that it will not be possible to completely contain inflation, and so some monies have been kept aside to help mitigate the impact of this. A risk remains that it will not be possible to contain inflation to the extent envisaged, but the risk to the delivery of this saving is not considered high.

1.8 **Third Party Spend**

1.8.1 This involves making efficiencies in and reconfiguring commissioned services' contracts, including by commissioning different models of service delivery, ceasing contracts, improved contract management and negotiation of better rates. The contracts include Independent Reviewing Officers, early intervention commissioned services and recently concluded procurements. Over half of these savings have already been made and will be released in 2016/17. Delivery of these savings is not considered high risk. A small number of individuals may be impacted and consultation will take place with them, and an Equalities Impact Assessment will be undertaken.

1.9 **0-25 Service**

1.9.1 Alongside partners the Council is developing an integrated approach to disabled children and young adults. Through this approach it is anticipated that SEND and Continuing Care needs will be identified and funded appropriately by those partners.

1.10 **Placement Commissioning**

1.10.1 This involves reducing the cost of placements for looked after children by growing and strengthening the in-house foster care service; intervening early to prevent placement breakdown, stepping-down placements from residential to foster care, and ensuring provision of high quality, competitively priced residential placements in appropriate locations. This proposal has the potential to significantly improve outcomes, and keep children local. The placements commissioning strategy went to CELS Committee in April 2015 and consultation has taken place with looked after children and young people, foster carers and staff who have fed into development of the strategy.

1.10.2 This proposal is ambitious as it means that by 2019 Barnet will have one of the largest proportions of looked after children placed with in-house foster carers in the country. The foster carer recruitment strategy is resulting in more foster carers, and consequently reducing cost. It does however need to be seen in the context of an overspending social care placements budget

1.11 **Early Years Review**

1.11.1 This involves savings through implementation of Early Years Review aimed at ensuring early years services are best configured within limited resources, including use of the public health grant to fund service levels in addition to the statutory minimum to embed an early intervention approach in early years. Consultation has taken place and a new locality model was implemented in September 2015. These savings are considered deliverable for 2016/17 and the impact on customers and equalities will continue to be measured.

1.12 **Libraries**

1.12.1 The Council is currently undertaking a further round of public consultation on a proposal to reshape Barnet's Library service to deliver savings through to 2019/20.

Future year transformation savings

1.13 All of the savings proposals that will be recommended to Policy & Resources Committee and then subject to public consultation are set out at Appendix 1.

1.14 The key proposed changes are set out in the table below:

Priorities	**Additional changes**
To develop new models of social work	• Signs of Safety

practice and intervention which reduce the need for higher cost placements and the number of adolescents in our care, especially in residential provision	• PAUSE • No Wrong Door
To increase the productivity of education and children's services through developing new ways of working to meet the needs of a growing population within available resources.	• Professionally led, not for profit Children's Services delivery vehicles • Adoption Regionalisation
To further reshape early intervention and prevention services to provide effective, targeted interventions which reduce the need for higher cost interventions	• Youth Services • Early Years • CAMHS

1.15 The effective safeguarding of the borough's vulnerable children and young people is and always will be at the heart of what the Council does. As the Council changes and local services evolve, this commitment will not change.

1.16 Barnet's social workers, youth workers and other members of the children and families workforce remain central to ensuring the Council is able to manage the needs of our population and the demands that places on children's service, which will result from our changing demographic profile.

1.17 To successfully manage the needs of our communities and improve outcomes for our children we need to intervene both early and effectively. There is a need for even more purposeful, early intervention and social work practice by professionals with the skills, the practice models and the autonomy to achieve the best for our children.

1.18 Building on the existing strength of the workforce, the Council will work with social workers and other children's services professional to develop, in Barnet, national models of good practice like Signs of Safety, PAUSE and No Wrong Door. These are practice frameworks and approaches used to implement targeted intervention to prevent escalation of the needs of children and young people. This in turn impacts on the levels of demand into the service and seeks to result in cost efficiencies.

1.19 The Council will also consider the future strategies for the delivery of Early Years, Youth Services and CAMHS to ensure that they are focussed to deliver critical targeted services that prevent further escalation of need. The further Early Years' Review will consider the changing landscape in early years with the development of additional 2 year old provision and proposed increased hours in provision available to parents of 3 and 4 year olds.

1.20 The Council will work closely with its staff and explore the opportunities for and support required for the development of a children's services led, non-

for-profit organisation (like a charitable trust, mutual, care trust or Community Interest Company) to provide our services for children and young people as an alternative to maintaining the service in-house. This will include all our early years, youth, preventative and social care services.

1.21 We will consider working with neighbouring authorities and across London to drive good practice and efficiencies through social work practice improvements. At the core of this proposal is the need to explore with our staff the best ways to enable them to do their jobs effectively, considering, with them, an organisational form that places outstanding practice in children's service at the centre, and that appropriately integrates provision around the needs of the child. This is not about outsourcing services to a private sector company which would be illegal rather; it is about putting greater emphasis on a way we work to drive improved outcomes.

2. REASONS FOR RECOMMENDATIONS

2.1 This report updates the Health and Wellbeing Board on the current children and young people commissioning priorities in the context of the Children, Education, Libraries and Safeguarding Committee savings which, for 2016-20, is now £14.5m raising from £9.9m previously.

3. POST DECISION IMPLEMENTATION

3.1 These proposals will be considered by the Policy and Resources committee on 16 December 2015 and will form part of the delivery of the Council's Medium Term Financial Strategy.

4. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

4.1 Not applicable

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 The Council's Corporate Plan for 2015-20 sets the vision and strategy for the next five years based on the core principles of fairness, responsibility and opportunity, to make sure Barnet is a place:

- Of opportunity, where people can further their quality of life
- Where people are helped to help themselves, recognising that prevention is better than cure
- Where responsibility is shared, fairly
- Where services are delivered efficiently to get value for money for the taxpayer.

5.1.2 The Corporate Plan priorities and the Health and Wellbeing Strategy have been considered in the development of the proposals as outlined in Appendix 1, linked to the principles identified in the Corporate Plan. Work will be undertaken over the coming months to set the performance targets for 2016-17 which will be bought back to CELS Committee on the 3rd March 2016.

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

5.2.1 The present budget for CELS is projecting an overspend of £1.2m as at the

end of quarter 2, mainly due to pressures in children's social care placements and staffing. A recovery plan is in place to address this issue.

5.2.2 The future savings proposals are significantly challenging and dependent on a range of factors often outside of the control of the service and with longer lead in times. The achievement of savings predicated on reducing demand through improved preventative work and social work practice should led to better outcomes for children and young people. However the relationship between early intervention/prevention and reduced demand on social care is not always linear and is subject to a range of both controllable and uncontrollable variables. There is therefore a risk that the savings set out may not able be deliverable as the Council must always ensure that safeguarding of children and young people remains paramount.

5.2.3 Appendix 1 sets out the revenue proposals. Appendix 1 shows the total of the CELS Committee Savings proposals which total £14.5m, in line with the Committee's saving target. Each line represents a savings idea and the negative value the saving amount per annum. The totals at the bottom relate to the total savings per annum.

5.2.4 Appendix 2 sets out the capital proposals. Appendix 2 shows the additional capital funding required, for the period to 2020 this is £55.8m. The sheet also details the funding stream for project / additional amount for an existing project. The majority of the additional amounts in the period relate to funding school place planning, due to increasing demographics in the borough.

5.3 **Social Value**

5.3.1 In taking forward the proposals due regard will be paid to the Social Value Act. The Social Value Act will be a useful tool in ensuring that our activities are embedded in prevention and early intervention. We will seek to look for added value providers can bring in delivering our services such as where apprenticeships are provided.

5.3.2 The Public Services (Social Value) Act 2013 requires people who commission public services to think about how they can also secure wider social, economic and environmental benefits. Before commencing a procurement process, commissioners should think about whether the services they are going to buy, or the way they are going to buy them, could secure these benefits for their area or stakeholders.

5.4 **Legal and Constitutional References**

5.4.1 All proposals emerging from the business planning process will need to be considered in terms of the Council's legal powers and obligations (including, specifically, the public sector equality duty under the Equality Act 2010) and, where appropriate, mechanisms put into place to ensure compliance with legal obligations and duties and to mitigate any other legal risks as far as possible. The proposals are already or will be subject to separate detailed project plans and reports to committee. The detailed legal implications of these proposals are included in these reports.

5.4.2 Terms of Reference of the Health and Wellbeing Committee are set out in the Council's Constitution, Part 15, and Responsibility for Functions, including. The responsibilities of the Health and Wellbeing Committee:

- 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 wellbeing. Specific resources to be overseen include money for social care being allocated through the NHS; dedicated public health budgets; the Better Care Fund; and Section 75 partnership agreements between the NHS and the Council
- To receive assurance from all relevant commissioners and providers on matters relating to the quality and safety of services for users and patients
- 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. To explore partnership work across North Central London where appropriate.

5.5 **Risk Management**

5.5.1 The Council has taken steps to improve its risk management processes by integrating the management of financial and other risks facing the organisation. Risk management information is reported quarterly to the council's internal officer Delivery Board and to the relevant Committees and is reflected, as appropriate, throughout the annual business planning process.

5.5.2 Risks associated with each individual savings proposal will be outlined within the individual Committee report as each proposal is bought forward for the CELS Committee to consider.

5.6 **Equalities and Diversity**

5.6.1 Equality and diversity issues are a mandatory consideration in the decision-making of the council. This requires elected Members to satisfy themselves that equality considerations are integrated into day to day business and that all proposals emerging from the finance and business planning process have properly taken into consideration what impact, if any, there is on any protected group and what mitigating factors can be put in train.

5.6.2 As individual proposals are brought forward for consideration by the Children, Education, Libraries and Safeguarding Committee, each will be accompanied by an assessment of the equalities considerations, setting out any potential impact of the proposal and mitigating action. The equalities impact of all other proposals will be reviewed as proposals develop and will inform the final consideration of the savings proposals by the Policy and Resources Committee on 16th February 2016. The relevant protected characteristics are age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

5.6.3 Where there are changes, it is inevitable that there is likely to be an impact

on individuals in different ways. However at each stage of the process, the council will conduct full EIA to ensure that where some current and future clients are impacted, proper measures are considered to minimise the effect as far as possible. Those affected by any changes resulting from any of the proposals will be fully engaged.

5.6.4 The revenue savings sheet shown as Appendix 1 currently indicates an initial assessment of a likely negative impact for proposals. As the full impact of these changes is understood, each initiative will undertake to work with those affected and consider options available to them to help mitigate any adverse impact

5.6.5 All human resources implications will be managed in accordance with the Council's Managing Organisational Change policy that supports the Council's Human Resources Strategy and meets statutory equalities duties and current employment legislation.

5.7 **Consultation and Engagement**

5.7.1 As a matter of public law the duty to consult with regards to proposals to vary, reduce or withdraw services will arise in 4 circumstances:

- where there is a statutory requirement in the relevant legislative framework;
- where the practice has been to consult or where a policy document states the council will consult then the council must comply with its own practice or policy;
- exceptionally, where the matter is so important that there is a legitimate expectation of consultation and
- where consultation is required to complete an equalities impact assessment

5.7.2 Regardless of whether the council has a duty to consult, if it chooses to consult, such consultation must be carried out fairly. In general, a consultation can only be considered as proper consultation if:

- Comments are genuinely invited at the formative stage;
- the consultation documents include sufficient reasons for the proposal to allow those being consulted to be properly informed and to give an informed response;
- there is adequate time given to the consultees to consider the proposals;
- there is a mechanism for feeding back the comments and those comments are conscientiously taken into account by the decision maker / decision making body when making a final decision.
- the degree of specificity with which, in fairness, the public authority should conduct its consultation exercise may be influenced by the identity of those whom it is consulting and
- the consultation is clear on the reasons why, and the extent to which alternatives and discarded options have been considered.

5.7.3 Public consultation on the overall budget 16/17 will commence following

Policy and Resources Committee on 16th December 2015 before the final savings are agreed by Policy and Resources Committee on 16th February 2016 and recommended to Full Council on the 3rd March 2016.

5.7.4 The public consultation will give residents an opportunity to comment on the 16/17 overall budget and Children, Education, Libraries and Safeguarding Committee individual proposals to deliver the 16/17 savings identified in this report, before final decisions are taken by CELS committee and savings plans are formalised in the council's annual budget.

5.7.5 In terms of service specific consultations, the council has a duty to consult with residents and service users in a number of different situations including where proposals to significantly vary, reduce or withdraw services. Consultation is also needed in other circumstances, for example to identify the impact of proposals or to assist with complying with the council's equality duties.

5.7.6 Where appropriate separate service specific consultations have already taken place for the 16/17 savings. The council is currently consulting on the proposal to reshape Barnet's Library service to deliver savings from 2016/17 through to 2019/20. The consultation is will be completed by the 6th January 2016 and a final decision will be taken by the Children; Education, Libraries and Safeguarding Committee on the 3rd March 2016.

5.8 **Insight**

5.8.1 The proposals have been developing using the Joint Strategic Needs Assessment (JSNA) which outlines the current and projected needs of the boroughs population. The proposals have also used evidence of best practice and guidance to develop our initiatives.

6. BACKGROUND PAPERS

6.1 Business Planning 2015/16 – 2019/20, Policy and Resources, 9 July 2015, item 10:
https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=692&MId=8346&Ver=4

6.2 Business Planning (Appendix A: Commissioning Plan), Children Education Libraries and Safeguarding Committee, 9 March 2015, item 7:
https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=697&MId=7927&Ver=4

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Appendix 1: Appendix 1 shows the total of the CELS Committee Savings proposals which total £14.5m, in line with the Committee's saving target. Each line represents a savings idea and the negative value the saving amount per annum.
The totals at the bottom relate to the total savings per annum.

Children's, Libraries, Education and Safeguarding Committee

Line ref	Opportunity Area	Corporate Plan Priority: Fairness, Responsibility or Opportunity	Responsibility (Commissioning Director or Delivery Unit)	Description of saving	Consultation (How are we consulting on this proposal)	Impact Assessment			Budget	Saving								Variance Analysis
									2015/16	2016/17		2017/18		2018/19		2019/20		
						Impact on Service Delivery	Impact on Customer Satisfaction	Equalities Impact	£000	£000	FTE	£000	FTE	£000	FTE	£000	FTE	
Efficiency																		
E1	Contract management, including keeping costs down	Responsibility	Family Services Delivery Unit	Budget proposals for 2016-20 include efficiency savings on third party contracts. The overall budget has extra built in to allow for increases in the prices charged by suppliers. This savings would be acheived by improving contract management and negotiating better rates across a range of services.	Service specific consultation will be undertaken if required.	This proposal increases the efficiency of third party contract spending. It is not expected to impact on service delivery	This proposal increases the efficiency of third party contract spending. It is not expected to have a negative impact on customer satisfaction.	Initial analysis indicates that no staff and/or service user Equalities Impact Assessment is required because the proposal does not impact on service delivery or staff. This will kept under review as the specific proposals develop and any changes reported back at the next Committee decision within the business planning process.	17,860	(381)		(135)		(134)		(188)		(4.69)%
E2	3rd Party Spend	Responsibility	Family Services Delivery Unit	Proposal to save money by commissionoing different models of service delivery and ceasing contracts, improved contract management and negotiating better rates. The contracts include Independent Reviewing Officers, early intervention commissioned services and recently concluded procurements.	One to one engagement with service users on a case by case basis.	This proposal may result in services being provided differently but should not impact on levels of service available.	This proposal is not expected to have a negative impact on customer satisfaction.	There may be an equalities impact related to this proposal and an Equalities Impact Assessment will be undertaken to ascertain whethere there is an impact. This will kept under review as the specific proposals develop and any changes reported back at the next Committee decision within the business planning process.	17,860	(285)								(1.60)%
E3	Workforce-related spend	Responsibility	Family Services Delivery Unit	Proposal to reduce spending on work related travel and on agency staff. This includes a small reconfiguration of some back office functions. The recruitment and retention approach being implemented in Family Services will support the reduction in agency spend; there are opportunities to save money on travel through purchasing arrangements and better planning of required travel. The savings are in the context of significant reductions in the workfroce in the past year.	One to one engagement with service users on a case by case basis.	This proposal may result in services being provided differently and will include some reconfiguration, but should not impact on levels of service available.	This proposal is not expected to have a negative impact on customer satisfaction.	There may be an equalities impact related to this proposal and an Equalities Impact Assessment will be undertaken to ascertain whethere there is an impact. This will kept under review as the specific proposals develop and any changes reported back at the next Committee decision within the business planning process.	16,816			(180)		(231)		(146)		(3.31)%
Total										**(666)**	**0**	**(315)**	**0**	**(365)**	**0**	**(334)**	**0**	
Income Generation																		
I1	Education and Skills revenue share	Opportunity	Education & Skills Delivery Unit	Through the development of a proposed new Delivery model for Education and Skills services in Barnet there will be a contractual requirement for a gainshare of profits from the trading of services externally.The council's share of any surplus that is available through Gainshare will be allocated as savings acheived as a result of the growth in services. This is over and above the agreed contractual savings.	Specific consultation with schools, residents and groups of parents during 2014/15. On going consultation with schools throughout the procurement process.	This saving is not expected to impact on service delivery	There is likely to be a positive impact on schools as services are protected and potentially enhanced.	Initial equalities analysis has been undertaken and indicates that there is a potential impact on staff and/or service users. An initial Equalities Impact Assessment formed part of the draft outline business case considered by CELS on the 15th September 2014. This will be kept under review as proposals develop and reported in the February 2016 Budget paper.	7,149							(300)		(4.20)%
I2	SEN placements	Fairness	Education & Skills Delivery Unit	Through the development of the 0-25 integrated service savings through appropriate allocation of education costs for joint placements for children under the age of 18.	No service specific consultation required	This proposal is not expected to impact on service delivery	None	Initial analysis indicates that no staff and or service user Equalities Impact Assessment is required because the proposal does not impact on service delivery or staff. This will kept under review as the specific proposals develop and any changes reported back at the next Committee decision within the business planning process.	5,047	(250)		(250)		(250)		(250)		(19.81)%
I3	Child and Adolescent Mental Health Services traded service	Fairness	Commissioning Group	At present the council funds support for Child and Adolescent Mental Health provision in Primary and Secondary schools. It is proposed to remove that investment and develop a more bespoke traded service enabling schools to access required support where neccessary.	Service specific consultation will be undertaken if required.	The proposal may impact on service delivery.	This proposal may impact on customer satisfaction	There may be an equalities impact related to this proposal and an Equalities Impact Assessment will be undertaken to determine whether there is an impact. This will kept under review as the specific proposals develop and any changes reported back at the next Committee decision within the business planning process.	970			(430)						(44.33)%

Line ref	Opportunity Area	Corporate Plan Priority: Fairness, Responsibility or Opportunity	Responsibility (Commissioning Director or Delivery Unit)	Description of saving	Consultation (How are we consulting on this proposal)	Impact Assessment			Budget	Saving								Variance Analysis
									2015/16	2016/17		2017/18		2018/19		2019/20		
						Impact on Service Delivery	Impact on Customer Satisfaction	Equalities Impact	£000	£000	FTE	£000	FTE	£000	FTE	£000	FTE	
I4	Partnership funding of substance misuse services	Fairness	Family Services Delivery Unit	It is proposed to fund children's substance misuse services with the public health grant to support joined up delivery with wider public health services.	No service specific consultation required	This proposal is not expected to impact on service delivery	None	Initial analysis indicates that no staff and or service user Equalities Impact Assessment is required because the proposal does not impact on service delivery or staff. This will kept under review as the specific proposals develop and any changes reported back at the next Committee decision within the business planning process.	45	(45)								(100.00)%
I5	No Recourse to Public Funds	Opportunity	Commissioning Group	Government is, at present, consulting on a range of proposals to change the approach for people with No Recourse to Public funds. In light of these proposals there will be an opportunity to reduce spending in this area. Proposals to reduce spending on No Recourse to Public Funds will not affect any new asylum seeking families who are likely to receive support from the Government.	Service specific consultation will be undertaken if required.	The proposal may impact on service delivery.	This proposal may impact on customer satisfaction	There may be an equalities impact related to this proposal and an Equalities Impact Assessment will be undertaken to determine whether there is an impact. This will kept under review as the specific proposals develop and any changes reported back at the next Committee decision within the business planning process.	177					(227)				(128.25)%
I6	Continuing Care	Fairness	Commissioning Group	As part of the on-going work to develop an integrated 0-25 year service, the council will ensure that all eligible children with disabilities and other limiting conditions are receiving continuing care funding from the NHS to better meet their health and care needs.	No service specific consultation required	This proposal is not expected to impact on service delivery	None	Initial analysis indicates that no staff and or service user Equalities Impact Assessment is required because the proposal does not impact on service delivery or staff. This will kept under review as the specific proposals develop and any changes reported back at the next Committee decision within the business planning process.	2,201	(150)		(150)		(200)				(22.72)%
Total										**(445)**	**0**	**(830)**	**0**	**(677)**	**0**	**(550)**	**0**	
Reducing demand, promoting independence																		
R1	LAC Placement commissioning strategy	Responsibility	Family Services Delivery Unit	Reduce cost of placements for children in care by growing and strengthening the in-house foster care service; intervening early to prevent placement breakdown, transitioning placements from residential to foster care, and ensuring provision of high quality, competitively priced residential placements in appropriate locations. By 2019 Barnet will have one of the largest proportions of children in care placed with in-house foster carers in the country.	Service specific consultation has taken place with looked after children and young people, foster carers and staff and fed into development of the strategy.	This proposal has the potential to significantly improve outcomes, and keep children local. Placements commissioning strategy went to CELS Committee in April 2015.	This proposal is likely to lead to better outcomes for looked after children	A full Equalities Impact Assessment has been completed. This/these will be kept under review as proposals develop and reported at February 2016 Budget paper.	18,001	(131)		(144)		(149)		(69)		(2.74)%
R2	Social care demand management	Responsibility	Family Services Delivery Unit	Additional social care demand management. This will focus on considering new models for social care practice. These approaches include a focus on preventing periods of accommodation for children and preventing escalation of needs.	Service specific consultation will be undertaken if required.	Likely to impact on service delivery	May impact on customer satisfaction	There may be an equalities impact related to this proposal and an Equalities Impact Assessment will be undertaken to determine whether there is an impact. This will kept under review as the specific proposals develop and any changes reported back at the next Committee decision within the business planning process.	11,574					(440)		(1,267)		(14.75)%
Total										**(131)**	**0**	**(144)**	**0**	**(589)**	**0**	**(1,336)**	**0**	
Service reform																		
S1	Early Years	Responsibility	Family Services Delivery Unit	Savings through implementing an Early Years Review aimed at ensuring early years services function effectively in the face of limited resources. Use of public health grant to fund service levels above the statutory minimum (£1.5m), intervening early before needs escalate.	Service specific consultation took place (24/06/2014 - 12/09/2014)	Consultation has taken place and implementation of new model is underway.	Improved service model should increase satisfaction in the medium term but short term changes will mean some customers are less satisfied in the meantime.	A full Equalities Impact Assessment has been completed as part of the Early Years business case considered by the Children, Education, Libraries & Safeguarding Committee on the 29th October 2014. This will be kept under review as proposals develop and reported at February 2016 Budget paper.	3,864	(550)		(506)		(535)		(74)		(43.09)%

Line ref	Opportunity Area	Corporate Plan Priority: Fairness, Responsibility or Opportunity	Responsibility (Commissioning Director or Delivery Unit)	Description of saving	Consultation (How are we consulting on this proposal)	Impact Assessment			Budget	Saving								Variance Analysis
									2015/16	2016/17		2017/18		2018/19		2019/20		
						Impact on Service Delivery	Impact on Customer Satisfaction	Equalities Impact	£000	£000	FTE	£000	FTE	£000	FTE	£000	FTE	
S2	Early Years further service reform	Opportunity	Family Services Delivery Unit	Proposal to reconfigure Early Years, building on the locality model and further integrating services. The integration of services will include looking at different ways of delivering some elements of the Healthy Child Programme through Children's Centres.	Service specific consultation will be undertaken if required.	Likely to impact on service delivery	Likely to impact on customer satisfaction	There may be an equalities impact related to this proposal and an Equalities Impact Assessment will be undertaken to determine whether there is an impact. This will kept under review as the specific proposals develop and any changes reported back at the next Committee decision within the business planning process.	3,864							(850)		(22.00)%
S3	Alternative Libraries	Opportunity	Commissioning Group	Developing an alternative approach to providing library services by maintaining the size of the libraries network and increasing opening hours through the use of technology. £546k of this is income generated for Family Services through Estates Services.	Service specific consultation currently taking place (28th October 2015 - 6th January 2016)	Impact on service delivery will depend on option agreed by CELS Committee in 2015	Impact on customer satisfaction will depend on option agreed by CELS Committee in 2015.	Initial equalities analysis has been undertaken and indicates there is a potential impact on staff and/or service users. A full Equalities Impact Assessment is set out in the appendix to the libraries strategy paper considered by the Children, Education, Libraries & Safeguarding Committee on the 28th October 2014. This will be kept under review as proposals develop and reported at February 2016 Budget paper.	4,602	(194)		(1,907)		(25)		(151)		(49.48)%
S4	Libraries service reform	Opportunity	Commissioning Group	Following the implementation of the libraries review the implementation will be monitored to see if additional income over and above the present model is being delivered. If not alternative savings will need to be found	Service specific consultation will be undertaken if required.	Likely to impact on service delivery	Likely to impact on customer satisfaction	There may be an equalities impact related to this proposal and an Equalities Impact Assessment will be undertaken to determine whether there is an impact. This will kept under review as the specific proposals develop and any changes reported back at the next Committee decision within the business planning process.	4,602							(573)		(12.45)%
S5	Child and Adolescent Mental Health Services recommissioning	Opportunity	Commissioning Group	Developing joined up Child and Adolescent Mental Health provision with neighbouring boroughs enabling a saving through re-commissioning the externally commissioned service.	Service specific consultation will be undertaken if required.	May impact on service delivery	May impact on customer satisfaction	There may be an equalities impact related to this proposal and an Equalities Impact Assessment will be undertaken to determine whether there is an impact. This will kept under review as the specific proposals develop and any changes reported back at the next Committee decision within the business planning process.	1,198			(200)						(16.69)%
S6	Youth service	Opportunity	Family Services Delivery Unit	Proposal to remodel the Council's existing youth service, alongside the development of a youth zone, to secure economies of scale and to realise opportuntities to generate income.	Service specific consultation will be undertaken if required.	Likely to impact on service delivery	Likely to impact on customer satisfaction	There may be an equalities impact related to this proposal and an Equalities Impact Assessment will be undertaken to ascertain whethere there is an impact. This will kept under review as the specific proposals develop and any changes reported back at the next Committee decision within the business planning process.	2,434							(800)		(32.87)%
Total										**(744)**	**0**	**(2,613)**	**0**	**(560)**	**0**	**(2,448)**	**0**	
Shared services models																		
S7	Education and Skills-New Delivery model	Opportunity	Commissioning Director	Create an alternative way to deliver the Education and Skills service that currently provides school improvement support, school admissions, support for children with special educational needs, post-16 support and school catering. By developing a new service delivery model in partnership with schools, there is an opportunity to grow and develop services rather than reduce them.	Specific consultation with schools, residents and groups of parents during 2014/15. On going consultation with schools throughout the procurement process.	This saving is not expected to impact on service delivery	There is likely to be a positive impact on schools as customers.	Initial equalities analysis has been undertaken and indicates there is a potential impact on staff and/or service users. An initial Equalities Impact Assessment formed part of the draft outline business case considered by the Children, Education, Libraries & Safeguarding Committee on the 15th September 2014. This will be kept under review as proposals develop and reported at February 2016 Budget paper.	7,149	(85)		(160)		(255)		(350)		(11.89)%

Line ref	Opportunity Area	Corporate Plan Priority: Fairness, Responsibility or Opportunity	Responsibility (Commissioning Director or Delivery Unit)	Description of saving	Consultation (How are we consulting on this proposal)	Impact Assessment			Budget	Saving								Variance Analysis
									2015/16	2016/17		2017/18		2018/19		2019/20		
						Impact on Service Delivery	Impact on Customer Satisfaction	Equalities Impact	£000	£000	FTE	£000	FTE	£000	FTE	£000	FTE	
S8	Shared services/ models	Opportunity	Commissioning Group	The Council will look at emerging best practice across the country to ensure the highest quality of purposeful social work and wider children's service, with a focus on targeted early intervention and prevention. Professionally lead by children's workers, the approach may include established practice models such as a not for profit charitable trust or a Community Interest Company. Early evidence suggests that these models, by focussing on effective practice, have achieved greater productivity and delivered efficiencies. The integration of the delivery of services with other local London Boroughs will also be considered.	Service specific consultation will be undertaken if required.	Likely to impact on service delivery	Likely to impact on customer satisfaction	There may be an equalities impact related to this proposal and an Equalities Impact Assessment will be undertaken to determine whether there is an impact. This will kept under review as the specific proposals develop and any changes reported back at the next Committee decision within the business planning process.	29,687							(800)		(2.69)%
S9	Adoption regionalisation	Opportunity	Family Services Delivery Unit	Government is proposing for all adoption agencies to move to a regional model of provision. Savings would come from regionalisation of adoption and integrating services across London.	Service specific consultation will be undertaken if required.	May impact on service delivery	May impact on customer satisfaction	There may be an equalities impact related to this proposal and an Equalities Impact Assessment will be undertaken to determine whether there is an impact. This will kept under review as the specific proposals develop and any changes reported back at the next Committee decision within the business planning process.	1,447					(150)				(10.37)%
Total										**(85)**	**0**	**(160)**	**0**	**(405)**	**0**	**(1,150)**	**0**	
Overall Savings										**(2,071)**	**0**	**(4,062)**	**0**	**(2,596)**	**0**	**(5,818)**	**0**	

Appendix 2: Appendix 2 shows the additional capital funding required, for the period to 2020 this is £55.8m. The sheet also details the funding stream for project / additional amount for an existing project. The majority of the additional amounts in the period relate to funding school place planning, due to increasing demographics in the borough

Childrens, Education, Libraries and Safeguarding - capital additions, reductions and re-profiling

		Expenditure						Funding						
Committee	Project	2015-16	2016-17	2017-18	2018-19	2019-20	Total	Grants / External Funding	RCCO / MRA	Other (incl. S106 and CIL)	Capital Reserve	Capital Receipts	Borrowing	Total
		£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Childrens, Education, Libraries and Safeguarding	Libraries capital programme	(120)	120				0							0
Childrens, Education, Libraries and Safeguarding	Early education provision	1,754	(2,254)	500			0							0
Childrens, Education, Libraries and Safeguarding	Meadow Close Childerns home	200	2,150	150			2,500						2,500	2,500
Childrens, Education, Libraries and Safeguarding	Family services -Information Management system	(100)	100				0							0
Childrens, Education, Libraries and Safeguarding	Early years review - IT and Estates	(140)	70	70			0							0
Childrens, Education, Libraries and Safeguarding	Youth Zone	200	2,400	1,200	400		4,200			4,200				4,200
Childrens, Education, Libraries and Safeguarding	Loft conversion and extension policy for Foster Carers	130	240	220	180	130	900						900	900
Childrens, Education, Libraries and Safeguarding	New Park House Childrens home		80				80						80	80
Childrens, Education, Libraries and Safeguarding	Libraries service capital works		3,940				3,940						3,940	3,940
Childrens, Education, Libraries and Safeguarding	School place planning and alternative provision		8,000	12,347	17,482	6,345	44,174	13,038		14,309			16,827	44,174
Total		**1,924**	**14,846**	**14,487**	**18,062**	**6,475**	**55,794**	**13,038**	**0**	**18,509**	**0**	**0**	**24,247**	**55,794**

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AGENDA ITEM 10

	Health and Wellbeing Board **21 January 2016**
Title	**Review of Adults Health and Wellbeing Engagement Structures**
Report of	Adults and Communities Director
Wards	All
Status	Public
Urgent	No
Key	No
Enclosures	None
Officer Contact Details	Hannah Ufland – Engagement Officer, Adults & Communities Hannah.ufland@barnet.gov.uk 020 8359 4712 James Mass – Community and Wellbeing, Assistant Director James.Mass@barnet.gov.uk 020 8359 4610

Summary

The Council and Barnet Clinical Commissioning Group both recognise the immense value of effectively engaging with people who use services and their carers to provide challenge, identify improvements, co-design and ensure that the focus remains on improving outcomes for local people.

Following a six month period of work with people who use the current engagement structure, this report sets out some of the perceived deficiencies with the current approach to engagement and a series of proposals and principles to address these. It is anticipated that these changes will increase the impact of engagement activities and lead to even more tangible improvements to services.

If approved, there will be a final phase of co-design to develop the finer details of the approach and then a transition period before implementation in April 2016.

Recommendations
1. **That the Health and Wellbeing Board agree in principle the proposed changes to the engagement approach for adult social care and health and note that the details of how they will be implemented will be co-produced between January and March 2016.**
2. **That the Health and Wellbeing Board agree to the development of a reporting line between the updated engagement structure and the Health and Wellbeing Board.**

1. WHY THIS REPORT IS NEEDED

1.1 Background

1.1.1 The current engagement structure is run collaboratively by the London Borough of Barnet and Barnet Clinical Commissioning Group. It centres around five Partnership Boards that cover specific user groups, namely Learning Disabilities, Older Adults, Carers, Mental Health and Physical and Sensory Impairment. It also includes an 'experts by experience' reference group.

1.1.2 The current Partnership Boards aim to:

- undertake strategic partnership working between the key public, voluntary and community organisations
- include service users, carers and the wider public to secure better health and wellbeing outcomes for the whole population
- support the delivery of the Health and Wellbeing Strategy through their delegated responsibility

1.1.3 A review of the Partnership Board structure was last completed in 2012 and this delivered a number of recommendations to support the delivery of early engagement and co-production. It also focused on developing an improved relationship between the Health and Wellbeing Board and the Partnership Boards including the introduction of the twice yearly summits.

1.1.4 These changes have led to positive improvements in engagement but there was regular feedback from those involved that there were further improvements and developments that could be made.

1.2 Purpose of Engagement

1.2.1 Good engagement is vital to service improvement.

- People who use public services are experts in the services they use.
- During times of increased financial challenges it is vital that the decisions that are made include the people they effect
- Successful engagement with the right partners can be powerful in shaping services that are effective for all the partners

1.2.2 The aim of the changes in this paper are not to devalue the engagement work undertaken by the current Partnership Boards but to build on the strong foundations they provide and ensure that the structure is appropriate for the current environment. Engagement opportunities need to enable residents to have a powerful impact on the delivery of high quality services in Barnet within a flexible and timely fashion

1.2.3 Engagement opportunities for people who use social care services, their carers and the third sector need to fulfil a range of purposes including:

- Providing information regarding work that is taking place around Health and Social Care.
- Consulting on plans that will impact on the people who use Health and Social Care Services.
- Providing opportunities to become involved in the decision making process around the delivery of Health and Social Care Services.
- Providing co-production opportunities to design work from the start of projects.

1.3 Work to Date

1.3.1 At the Health and Wellbeing Summit in July 2015 a review of the engagement approach and current structure was started. There has been engagement throughout the process with the people who are involved in the current Partnership Boards. This has included workshops, a survey and a working group of the non-statutory co-chairs.

1.3.1 The feedback received included:

Positive:

- The current Partnership Board structure works well to bring together a range of organisations to give a variety of views.
- Partnership Boards provide an opportunity to discuss the issues that affect people who use services.
- Board meetings enable people to feel part of the community.
- There is a good opportunity to have your voice heard.

Negative:

- Limited feedback on the impact of the work.
- Members don't feel their voice gets heard or can make an impact.
- Work not joined up across boards.
- Limited ownership of the work of the boards.
- No effective reporting system to the Health and Wellbeing Board.
- Not the most effective use of time or the current budget.

1.3.3 The findings from this work have led to the development of the proposed changes in this paper. At this stage the proposals provide a framework for how engagement will work. We will work with people who engage within the

current structure to design the details of how the proposal will work in practice. This work will ensure that we create a shared approach to the new structure.

1.4 Proposed engagement principles

1.4.1 A series of focused working groups will deliver direct engagement on pressing issues, significant projects and areas for improvement. They will deliver recommendations for improvement having carefully considered the pertinent issues. These groups will have clear terms of reference including their expected impact, will have the right people representing the Council and CCG and will be given clear feedback on any recommendations made. It is anticipated that around ten working groups will be established each year, depending on the scale of their work and the number of meetings that each would require.

1.4.2 A structure will be developed between the Health and Wellbeing Board and the working groups that will take ownership of setting priorities, agreeing the work plan, monitoring progress and ensuring there are effective responses to recommendations.

1.4.3 The membership of this will be agreed through a co-production approach but it is suggested that there will be resident representatives and other VCS stakeholders along with senior managers from both Adults and Communities Delivery Unit and Barnet CCG.

1.4.4 It is proposed that there will be a regular reporting function between the updated engagement structure and the Health and Wellbeing Board to ensure that there is a clear flow of information.

1.4.5 An annual event will provide an opportunity for the members of the Health and Wellbeing Board and the engagement structure to meet and discuss the priorities for the next 12 months.

1.4.6 There will continue to be opportunities for people who use services and carers to be involved in tender panels and interview opportunities. We will continue to develop how we work with representative groups in the community such as the Learning Disabilities Parliament, Carers Forum and Barnet Seniors Assembly.

1.4.7 To ensure that there are wide opportunities for participation and support for hard-to-reach groups to engage, it is proposed that there is a sustained focus on developing the database of individuals keen and willing to participate in engagement opportunities.

1.4.8 The database will hold the details of everyone in the community who has identified that they wish to be involved in engaging and what areas are of particular interest to them. This will enable us to share information and opportunities with a wide range of people in a convenient and timely manner.

1.4.9 There will continue to be support to ensure individuals have the right skills / training for the roles that they take on. In addition, there will continue to be an important role for representative groups across the Borough. Over recent

years these relationships and mechanisms have been developed and have been proven able to have an impact.

1.4.10 It is proposed to develop more community and outreach engagement to ensure that the diversity of the people we engage with is representative of the population of the borough who currently use our services. Initial ideas around this include identifying and attending a diverse range of community events around the borough, to establish drop in listening sessions and to develop an engagement conference.

2 REASONS FOR RECOMMENDATIONS

2.1 This approach is being recommended following engagement with people who use our services, their carers and a range of other stakeholders. It is designed to address the identified shortfalls with the current approach, whilst also building on its strengths and will allow people to engage with as many or few projects as they wish to.

2.2 This approach is believed to be able to respond flexibly to the needs of all partners whilst also allowing the opportunity for residents to be involved in work from the earliest opportunity.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Continue with the current engagement Partnership Board structure. This option is not being recommended as the challenges that have been identified through the engagement process would not be effectively managed within the current structure.

3.2 Remove the engagement function altogether. This option is not being recommended as engagement is a valuable opportunity to develop services that provide the best possible outcomes for those who use them through involving them in the key decisions that are made. There is a statutory duty on local authorities to consult with residents who use services.

4. POST DECISION IMPLEMENTATION

4.1 There will continue to be engagement workshops with people who use our services, carers, voluntary sector representatives and other stakeholders to design the details of the approach. There will then be a transition process from an old to new approach. The new approach will be implemented from April 2016 and will replace the existing Partnership Board structure.

4.2 It is proposed that the approach is refined over time to improve the effectiveness of the engagement. There will be also be a co-produced reviewing mechanism in place to assess the new model and make changes where necessary.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 The council has set out in its Corporate Plan 2015-2020 that “greater community participation, engagement and involvement will be an essential part of the change the council will achieve over the next five years.” The proposals in this paper aim to address this whilst also ensuring “that services

are of good quality, represent value for money and achieve the outcomes residents want".

5.1.2 The current structure of Partnership Boards holds the responsibility to support the delivery of the Joint Health and Wellbeing Strategy (2015-2020). The new structure will continue to ensure that there is support to engage on the delivery of the strategy and there are strong links between the engagement structure and the Health and Wellbeing Board

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

5.2.1 All of the proposals within this paper are expected to be delivered within the existing budget for engagement set out by the Delivery Unit.

5.3 Social Value

5.3.1 The proposals outlined in this report will ensure that a strong engagement structure is in place that supports, the Public Services (Social Value) Act 2012. This will be achieved through ensuring that a diverse group of people using adult social care services, the voluntary sector and key stakeholders are consulted with and able to inform decisions regarding the future development, implementation and delivery of services.

5.3.2 The Public Services (Social Value) Act 2013 requires people who commission public services to think about how they can also secure wider social, economic and environmental benefits. Before commencing a procurement process, commissioners should think about whether the services they are going to buy, or the way they are going to buy them, could secure these benefits for their area or stakeholders.

5.4 Legal and Constitutional References

5.4.1 The best value statutory guidance (Department for communities and local government 2012) states that **"**before deciding how to fulfil their Best Value Duty – authorities are under a duty to consult representatives of a wide range of local persons; this is not optional. Authorities must consult representatives of council tax payers, those who use or are likely to use services provided by the authority, and those appearing to the authority to have an interest in any area within which the authority carries out functions. Authorities should include local voluntary and community organisations and small businesses in such consultation. This should apply at all stages of the commissioning cycle, including when considering the decommissioning of services."

5.4.2 The care and support statutory guidance that is issued under the Care Act 2014 states in section 4.50 that "Local authorities should pursue the principle that market shaping and commissioning should be shared endeavours, with commissioners working alongside people with care and support needs, carers, family members, care providers, representatives of care workers, relevant voluntary, user and other support organisations and the public to find shared and agreed solutions."

5.4.3 Under the Council's Constitution, Responsibility for Functions (Annex) the terms of the reference of the Health and Wellbeing Board includes:

- 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
- To receive assurance from all relevant commissioners and providers on matters relating to the quality and safety of services for users and patients
- 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. To explore partnership work across North Central London where appropriate.

5.5 Risk Management

5.5.1 There is a risk that people who engage with us under the current structure may feel isolated from the new approach as it is not user group specific and could then disengage from the process. This will be mitigated through co-producing solutions with people who currently engage with us. We will also work to develop improved links with existing community groups to ensure that groups of individuals are able to engage in an environment they are comfortable with.

5.6 Equalities and Diversity

5.6.1 The engagement structure aims to promote equality and diversity through ensuring as many people as possible are able to be engaged in a way that is convenient for them. Through the redevelopment of the database of individuals involved in engagement analysis of the current diversity of engagement can be completed in proportion to those who use social care services. Targeted outreach and community engagement will be able to work with those groups who have been identified as seldom heard to ensure engagement is representative of the population of Barnet.

5.6.2 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.

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

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

5.7 Consultation and Engagement

5.7.1 There has been extensive engagement work with a number of key

stakeholders and people who use social care services and their carers. Engagement work has included:

- Individual discussions with key stakeholders including CCG and Public Health and Healthwatch
- Engagement workshop session at the Health and Wellbeing board and Partnership Board Summit in July 2015
- Engagement Workshop with members of the Partnership Boards
- Independent meeting of service user and carer co-chairs of 5 existing Partnership Boards
- Further presentation at the Health and Wellbeing Board and Partnership Board Autumn Catch Up
- Further engagement workshop with members of the current Partnership Boards

5.7.2 There is a continued commitment to engage to develop the details of the engagement structure and also to develop a mechanism for regular review and change sessions as necessary throughout the implementation phase.

5.8 Insight

5.8.1 Insight has been gained through the engagement and co-production described above.

6 BACKGROUND PAPERS

6.1 There are no background papers relevant to this paper

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AGENDA ITEM 11

	Health and Wellbeing Board **21 January 2015**
Title	**Barnet Clinical Commissioning Group Primary Care Strategy Proposal**
Report of	Chair – Barnet Clinical Commissioning Group Director of Operations and Delivery– Barnet Clinical Commissioning Group
Wards	All
Status	Public
Urgent	No
Key	No
Enclosures	Appendix 1 – Roadmap and Proposed Content of the Primary Care Strategy for May 2016
Officer Contact Details	William Redlin, Director of Operations and Delivery, Barnet Clinical Commissioning Group William.Redlin@barnetccg.nhs.uk

Summary

As outlined to the Health and Wellbeing Board (HWBB) in November 2015, CCGs are increasing their role in the commissioning of primary care services through a process of Joint Commissioning with NHS England – this joint arrangement became fully functional from 1st October 2015 with two formal meetings since the last HWBB summary was presented. In addition we continue to work as part of the North Central London (NCL) transforming primary care collaborative developing primary care commissioning across London with several planning meetings being held during November/December. Barnet CCG are aligning our own local primary care strategy to these national and regional initiatives. In preparation for delivery of the published strategy we have created a local route map which will inform HWBB on our process – building on the previous information provided in November.

A draft primary care strategy document has been produced but this is in the process of being socialised with our GP constituent membership practices, patient participation groups (through our working collaboration with Healthwatch Barnet) – a process which we will complete by May 2016 at which time the final document will be presented to Health and Wellbeing Board colleagues and the wider public.

The purpose of this paper is to update the Health and Wellbeing Board on the route map for completion, to share a summary of the evolving content and demonstrate how this has been aligned with the ambitions of our joint NCL primary care commissioning partners, local authority in

terms of integration across both Adult and Children's service and community and secondary care providers to date.

The CCG Governing Body met for a primary care strategy focus session on 17 December when it was agreed that a full engagement afternoon would be planned for our constituent GP members prior to sending out the draft and final documents into the public domain – we require all practices and primary care service providers to have full ownership of the CCG strategy prior to wider circulation. Information will also be included from our practice nursing development day being held on 28 January 2016.

The Governing Body unanimously agreed on 17 December that the final primary care strategic document would be shared for information at the May Health and Wellbeing Board.

Recommendations
1. That the Health and Wellbeing Board notes and comments on the updated route map and evolving content for developing and delivering the Barnet Primary Care Strategy.
2. That the Health and Wellbeing Board notes that the final Barnet CCG Primary Care Strategy will be brought to the Board in May 2016 for information, following full engagement with the Constituent GP Membership.

1. WHY THIS REPORT IS NEEDED

1.1 As outlined in November the local Primary Care Strategy for Barnet will be developed to realise the ambitions set out in the Five Year Forward View and the delivery of the Transforming Primary Care – A Strategic Commissioning Framework for London. In addition it will also:

- Provide a local focus on primary care transformation and development;
- support the North Central London collaborative of CCGs' (Barnet, Enfield, Haringey, Camden and Islington) approach to primary care commissioning and delivery;
- provide clarity for the roles and responsibilities between the CCGs for primary care commissioning and those of NHS England now that we are actively operating as joint commissioners of primary care;
- establish a local process for identifying primary care commissioning priorities, such as primary, urgent and social care collaboration – ensuring there are strong links to need identified in the JSNA;
- inform and influence the development of primary and community care estate whilst addressing limited resources and demonstrating value for the public purse;
- inform how primary care providers in Barnet can deliver at scale including providing appropriate support for the development of the new Pan Barnet GP Federation and locality networks;
- support the strengthening and development of the GP and practice team workforce at a time when morale is low and demand on practices is increasing including working in collaboration with education providers such as CEPN and Health Education England;
- inform technological investment plans – already Barnet primary care providers have access to shared patient care records with signed data sharing agreements – and are actively seeking patient consent to enable information sharing for seven day services. Already community services, secondary care and local authority are part of the data sharing agreement process.

- address conflicts of interest, effectively addressing and managing governance issues when commissioning primary care services;
- outline the procurement processes that are to be applied when commissioning primary care enabling transparency and fairness whilst addressing patient choice. This will enable robust market testing whilst ensuring quality and value for money.

1.2 The Health and Wellbeing Board are requested to note the work undertaken since November to inform the primary care strategy - an updated route map and summary of the drafted content to date is included at Appendix 1.

1.3 Barnet CCG and NHS England are now actively engaged in joint commissioning – since the last Health and Wellbeing Board joint work has already commenced on Personal Medical Service (PMS) reviews, supporting practice development and performance including approving priorities for NHS Estate development with bimonthly joint committee meetings. It is anticipated that all NCL CCGs will be applying for delegated commissioning status in 2016/17.

1.4 The Personal Medical Services (PMS) review process is being actively undertaken to reduce variation of investment across primary care, ensure value for money and create consistency of care across Barnet. NHS England are continuing to lead the process with NHS Barnet producing financial models of how future PMS investment will be delivered. Commissioning intentions for PMS will be signposted in the final strategy in May 2016.

1.5 Barnet CCG is actively working with NCL to further strengthen the primary care vision at scale across all five CCGs within the context of the delivery of the Strategic Commissioning Framework. The benefits of collaboration will ensure that resources can be strengthened, best practice shared and SPG (strategic partnership group) learning developed jointly to ensure equity of development. It will also allow us to develop more innovative models of care as outlined in the Five Year Forward View with a particular focus on the development of new models of care which will transform health outcomes.

1.6 As previously outlined it is our intention to widen the strategy in the near future to include integrated plans for community pharmacy, NHS dentistry and NHS eye care services. Core contract management and service development for these groups continues to lie currently with NHS England. The CCG commissions eye care services currently being delivered as local enhanced services through the NHS Standard Contract to enable more robust review of key performance indicators and create eye care pathways that create seamless referral into secondary care. The Local Pharmaceutical Committee has met with the GP networks to share their work and begin to explore how they can collaborate with the Pan Barnet Network (Barnet GP Federation Ltd) as this evolves.

1.7 The GP practices in Barnet (all five existing GP locality networks) have worked together to legally form a new Pan Barnet GP Federation – Barnet GP Federation Ltd which came into being on 5 December 2015. The CCG will work closely with this new provider to explore how primary care services can be delivered at scale, starting with a pilot for additional primary care access which commenced on 11 December 2015. This pilot will be evaluated with specific feedback from patients and the public being captured to help design a substantive service going forward in collaboration with Barnet Healthwatch.

2. REASONS FOR RECOMMENDATIONS

2.1 The previous paper outlined the rationale for introducing the primary care strategy. This paper builds on those recommendations, signposting the HWBB to the process now being undertaken and updating on timescales for delivery (May 2016). The Board are asked to note that a full engagement process is underway with our CCG Board members and constituent GP practices and service providers to ensure ownership of the strategy by primary care and service users – with additional feedback from recent and planned sessions being fed into the content of the final document.

2.2 It became apparent when positively working with Local Authority leads (eg Children's Services Director, Public Health team, Estates Planning) that the strategy content will benefit from further local authority engagement and information prior to publication of the final document. Meetings continued during November and December with more engagement planned in early January which will feed into the document narrative.

2.3 In addition to the priorities outlined in the November HWBB paper, NCL collaboration is continuing to evolve for primary care and we wish to include further information from the December primary care workshop which will inform our local approach. This information is due in early January and includes detail of NCL financial modelling which will inform how the CCG commissions services locally ensuring value for money.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 The CCG could have opted to release the draft document as it currently stands, but the Governing Body opted not to publish draft information until this was fully socialised with patient participation groups and the CCG GP constituent members. We are working to publish the final document once all key stakeholders have had chance to input into the content by May 2016.

4. POST DECISION IMPLEMENTATION

4.1 As previously outlined, the CCG will deliver the milestones outlined in the route map (see Appendix 1) with a deadline for delivery of the final document in May once all stakeholders have had adequate opportunity to feed into the document. The Governing Body have agreed to establish a strategic working group who will oversee delivery for May which will be led by the newly appointed Director of Operations and Delivery.

5. POST DECISION IMPLEMENTATIONIMPLICATIONS OF DECISION

5.1 **Corporate Priorities and Performance**

5.1.1 The primary care strategy, on completion, will inform decision making across Barnet CCG and its partners including delivery plans for the local authority, NHS England (London), Healthwatch Barnet and the third sector. Detail and references of these interdependencies will be contained within the primary care strategic document.

5.1.2 Key components from the London Borough of Barnet JSNA and Joint Health and Wellbeing Strategy are already included in the draft and will continue to be referenced as the primary care strategy document evolves.

5.1.3 As previously outlined, the Primary Care Strategy will feed into the Barnet CCG operating framework and annual commissioning intentions process.

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

5.2.1 The Primary Care Strategy informs Barnet CCGs primary care commissioning

priorities for primary care and the wider health system for 2016/17 and beyond.

5.2.2 Barnet CCG will use the strategy to support the sustainability of integrated care including multidisciplinary team working, GP network development, establishment of the single health care record, dynamic information technology (including shared care agreements and patient consent) to enable seamless out of hospital services for patients.

5.2.3 At a time when recruitment, retention and engagement of GPs and practice nurses is challenged, we will look to strengthen GP/CCG relationships, prioritise education and strengthen clinical and business capabilities of all practices and federative networks. We will work with NHS England to ensure that practices are sustainable and able to respond to change – whilst still maintaining high quality services for their patient lists.

5.2.4 NHS England and the NCL collaborative are working to develop a practice quality and performance framework which can be used to measure and demonstrate success as well as outlining challenges which can be actively supported. The CCG will collaborate with this approach.

5.2.5 The CCG is working closely with the Local Authority and NHS England to develop a strategic estates plan with a focus on regeneration and targeting the most effective areas for investment. Areas such as Colindale where we are seeing urgent regeneration impact are prioritised in terms of shaping the services in readiness for population expansion. These priorities are being fed into the strategy together with identifying which premises are not fit for purpose and opportunities for improving leases and inviting discussion re mergers where this would be appropriate. In terms of financial implications for the council, the key area remains around estate – and as a response we have been working very closely with the local authority planning team to ensure council priorities are aligned with those of the CCG and financial risk sharing opportunities identified.

5.2.6 Since November the process for evaluating locally commissioned services commissioned for primary care has been developed with a current review process underway, including self-reporting questionnaires and a percentage of random review meetings by the CCG.

5.3 **Social Value**

5.3.1 Ensuring patients, carers and the voluntary sector are at the heart of decision making for their own care remains central to our primary care strategic approach, supporting policies that promote improved quality of clinical outcomes and compassionate care.

5.3.2 The Public Services (Social Value) Act 2013 requires people who commission public services to think about how they can also secure wider social, economic and environmental benefits. Before commencing a procurement process, commissioners should think about whether the services they are going to buy, or the way they are going to buy them, could secure these benefits for their area or stakeholders.

5.4 **Legal and Constitutional References**

5.4.1 Joint commissioning primary care arrangements enable shared responsibility with NHS England for the adherence to the legal and constitutional obligations set for the strategic direction of services commissioned through GMS, PMS and APMS contracts. The CCG is actively working with GP practices to ensure that these contractual obligations and nationally negotiated Directions are followed with financial

reference to the Standard Fees and Entitlements documentation where applicable – this can be most clearly seen in the work currently being undertaken with our PMS review process.

5.4.2 The CCG are committed to working closely with the Local Medical Committee (LMC) to ensure contractual considerations are met as appropriate for primary medical care services and the Local Optometric Committee (LOC for optometry services commissioned).

5.4.3 As outlined for non-GMS, PMS, APMS services, the CCG is committed to using the NHS Standard contractual framework which has been commissioned during November for locally commissioned primary care services and our optometry services (glaucoma and cataract services) and our additional access pilot. These processes are being actively audited. As before all financial investment in primary care is scrutinized through our primary care procurement committee addressing all potential conflicts of interest. No GPs sit on this committee.

5.4.4 In respect of procuring primary care services outside the nationally agreed contractual specifications, the CCG will follow the Public Contract Regulations 2015 (the "Regulations") to ensure patient choice and full engagement of the wider health provider market. In any event procurement of contracts falling into the primary care services category are subject to the overriding EU Treaty principles of equal treatment, fairness and transparency in the award of contracts.

5.4.5 Under the Council's Constitution (Responsibility for Functions – Annex A) the responsibilities of the Health and Wellbeing Board includes:

- To consider all relevant commissioning strategies from the CCG and the NHS England and its regional structures to ensure that they are in accordance with the JSNA and the HWBS and refer them back for reconsideration.
- To receive assurance from all relevant commissioners and providers on matters relating to the quality and safety of services for users and patients.
- 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.
- 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. To explore partnership work across North Central London where appropriate.

5.5 **Risk Management**

5.5.1 If we do not have a local primary care strategy the CCG will be unable to influence the development of primary care services across the NCL strategic partnership group (SPB) and access transformational funding. We need to target investment appropriately while addressing significant conflicts of interest avoiding inequity of service provision and increasing access.

5.6 **Equalities and Diversity**

5.6.1 Equity of access to primary care service provision and quality of care, seven days a week, is a priority for the CCG. As a result we will ensure that reinvestment of PMS premium funding is managed equitably across all Barnet practices (whether GMS or PMS).

5.6.2 The primary care strategy will include a full assessment of need (referencing

information from the JSNA and the Joint Health and Wellbeing strategy) via qualitative and quantitative review from patients and carers which will inform primary care commissioning intentions.

5.6.3 The Equality Act 2010 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 and foster good relations between people from different groups. The relevant protected characteristics are age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

5.7 **Consultation and Engagement**

5.7.1 The updated route map which includes further plans for consultation and engagement during January/February 2016 is included in Appendix 1. The CCG has already undertaken several engagement exercises, details of which are included in the summary, but further consultation and engagement is required with constituent GP member practices and other key groups prior to publication in May 2016, including patient participation groups and service user groups.

5.8 **Insight**

5.8.1 The refreshed October Joint Strategic Needs Assessment has been used to inform the content of the strategy to date together with a wider literature review relevant to primary care commissioning, NHS England joint primary care commissioning and NCL collaboration and references to best practice.

6. BACKGROUND PAPERS

6.1 Barnet Clinical Commissioning Group Primary Care Strategy Proposal, Health and Wellbeing Board, 12 November 2015, item 7:
https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=177&MId=8387&Ver=4

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Appendix – Primary Care Strategy Development Route Map and Deliverables

The following table outlines the content developed to date for the primary care strategy, work already developed and status of pending work including detail of ongoing engagement. The timescale is working to deliver a completed strategy which has achieved full engagement with all Barnet CCG Constituent GP Practices by the end of April 2016 for presentation to the Health and Wellbeing Board in May. The work builds on the actions identified by the Health and Wellbeing Board in November 2015.

Chapter detail	Summary of content	Status of development	Timescale for delivery
Executive Summary	Scene setting for the purpose of the strategy	**Initial content drafted** For completion following engagement with all Barnet CCG constituent member GPs	Delivery: Half day event planned with constituent GPs. **Mid-February 2016**
Introduction	Setting the context • Outline of the significance of the primary care strategy and how it will be used. • Definition of primary care • Alignments to national policy and other strategic priorities (eg Five Year Forward View, Transforming Primary Care in London: A strategic commissioning framework;, JSNA; Health and Wellbeing Strategy, NHS England joint and delegated commissioning	**Initial content drafted** Confirmation of how the strategy will be used with GP constituent members still to fully socialise	Delivery: Half event planned with constituent GPs for midFebruary to engage fully with the strategy - with subsequent write up of outcomes **Mid-February 2016**

	and Barnet CCGs operating plan)		
Establishing a primary care vision for Barnet	What does good primary care look like now and in the future • The vision of the CCG leadership • The vision of service users • The vision of service providers • The vision for service transformation and new models of care	**Initial content drafted** Governing Body and members of the clinical cabinet met on 29 October and 17 December to shape leadership vision. November session held with the Barnet Health Watch Primary Care Committee – information from the session included in chapter narrative Narrative included from Barnet Youth Council engagement session – "what primary care good looks like for young people" The vision for service transformation is being further developed by the Governing Body – more information will come from a facilitated workshop at the end of January 2016.	Delivery: Vision being socialised with the wider service provider network –at January PM forum to socialise vision with practice managers – Facilitated session planned for early February for constituent GP members. **January – February 2016** Wider stakeholder vision and engagement being sought from PPG groups – this has already begun via Barnet Health Watch primary care committee and CCG communications **7th January – CCG Communications working group** **11th January – Barnet Healthwatch** Service transformation and new models of care session with GP members **2 February GB development session**
Delivering primary care transformation through joint commissioning	• Highlights of the benefits of joint commissioning with primary care , how this is supported through the NCL vision "Transforming Primary	**Initial content drafted** This chapter is continuing to evolve as the strategic commissioning framework ambitions are developed locally.	Delivery: NCL 8th December workshop held to establish next steps – a full report is awaited from NCL - highlights from which will feed into the document

and NCL wide collaboration	Care for London" • The strategic commissioning framework (SCF) and how this can be delivered locally – our regional priorities for the next five years • Section also includes the implications for moving to delegated commissioning in 2016/17 and the implications for Barnet locally with challenges and opportunities that delegated responsibility brings including implications for service providers	Governing Body 17th December reviewed SCF priorities – outcomes from that session informed chapter content.	**Information received 22/12 to be included in the document**
Understanding the Barnet Health Population Profile and how it relates to primary care	JSNA highlights for primary care • An ageing population • Supporting diversity • Understanding the needs of our children and young people • Addressing mental health needs • Supporting patients with disabilities • Providing care for the entrenched and transient homeless • Providing care for care homes	**Content completed** Information from the refreshed October JSNA and commissioning for value	**Delivery: Further meetings with public health team to identify any other key areas for inclusion – mid-January meetings scheduled**
Understanding the clinical priorities for	• Capturing clinical priorities from the Governing Body and	**Initial content drafted**	Discussion with GB on 17th December

primary care commissioning	JSNA • Urgent care review • Priorities for clinical integration • Importance of managing demand and keeping patients out of hospital • Applying risk stratification to determine individual clinical need • Approach to diagnosing mental health priorities	Clinical priorities to be further developed by GB clinical leads and clinical cabinet. Facilitated session with Governing Body Risk stratification summary included at the request of the November H&WB Board. More information to be included from mental health commissioners and service providers	**Delivery** – Further GB session to agree local clinical priorities Session to determine priorities of GP constituent members and CCG clinical leadership team. **Engagement meeting scheduled for 2 February 2016** **Delivery** – additional information being provided from mental health commissioners and unscheduled care. **Section to complete end January 2016**
The value of patient and public engagement in shaping primary care in Barnet	• Working with Barnet Health Watch to establish service user priorities • Working with patient participation groups to shape primary care services • Engaging children and young people in shaping primary care need • Improving information flows to support patients to both challenge and compliment services they receive and how this is used by the CCG and service users to improve care	**Initial content drafted** Compliments and complaints process included at the request of November H&WBB	**Delivery:** further content to be included from active engagement with PPGs via January Health Watch Primary Care Committee **11th January 2016 to complete section once all PPGs have had the opportunity to comment end February/early March**

Supporting and developing the primary care workforce	• Effective engagement with primary care teams • Assessing the current workforce challenges and opportunities • Delivering primary care at scale - supporting practice federative network development • Exploring new models of care between primary care and wider service providers • Multidisciplinary team working – the value of integrated care • GP and practice nurse recruitment and retention and the importance of capacity planning • Primary care workforce education and the role of CEPN (Clinical Education Professional Network)	**Initial content completed**	**Delivery**: More information and feedback required from constituent GP practices in respect of recruitment and retention and educational priorities. **Practice Nurse feedback from event on 28 January 2016 to add to section content** **GP membership session planned for end February 2016.**
Developing the primary care infrastructure to enable change	• Primary care estate • Information technology – developing the digital roadmap • Delivering shared patient records and systems to enable seamless care between service providers	**Content completed** Content evolving	**Delivery** - Working with the GP IT team to ensure the ambitions of the digital roadmap and development of the shared care record is captured **Meeting first week January 2016 for final drafting end January 2016 to ensure new legislative**

			timescales are included.
Governance priorities for primary care	• Demonstrating how conflicts of interest will be managed when investing in primary care • Developing market testing and robust procurement processes to enable patient choice	Content completed	
Conclusion	• Final summary • Mobilising the strategy • Next steps	**Initial content drafted** – content continues to evolve as new information is captured	**Delivery** - End February 2016
Appendices	• Contributors to the strategy • Definition of Terms	**List of contributors drafted** - with additions as the engagement work continues Definition of terms and acronyms to support navigation of the document	**Delivery** – End February 2016

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AGENDA ITEM 12

	Health and Wellbeing Board 21 January 2016
Title	**London Sexual Health Transformation Project**
Report of	Director of Public Health
Wards	All
Status	Public
Urgent	No
Key	No
Enclosures	Appendix 1: Definitions, Commissioning responsibility, Glossary of Terms
Officer Contact Details	Audrey Salmon, Head of Public Health Commissioning – Audrey.salmon@harrow.gov.uk

Summary

This report provides an update on the procurement of sexual health services for Barnet through the collaboration between London boroughs on Genitourinary Medicine (GUM) services. It sets out the main findings of the market engagement developed by the pan London Sexual Health Transformation Project. It also sets out the next steps of the project consisting of a collaborative procurement plan for GUM services and Contraception and Sexual Health Service (CaSH) Services. This fulfils a key commissioning intention from the Council's Public Health Commissioning Plan, agreed at the Health and Wellbeing Board in March 2015.

Recommendations

1. **That the Health and Wellbeing Board endorses the program made to procure sexual health services in Barnet through:**
   a. **a pan-London procurement for a web-based system to include a 'front-end' portal, joined up partner notification and home/self-sampling**
   b. **North Central London (NCL) sub-regional arrangements, with the London Boroughs of Camden, Islington, Haringey, Enfield, Hackney and City of London for the procurement of Genitourinary Medicine (GUM) and Contraception and Sexual Health Service (CaSH) Services (including primary care sexual health services, outreach and prevention).**

1 WHY THIS REPORT IS NEEDED

1.1 Background

1.1.1 This report sets out how the Council will fulfil its obligation to commission Genitourinary Medicine Services (GUM) and Contraception and Sexual Health services (CaSH) and details the steps that will be undertaken to re-model services in collaboration with other London boroughs. It will also provide an update on progress undertaken to date to ensure that a new service model will be in place by April 2017.

1.1.2 Commissioning responsibilities for HIV, sexual and reproductive health have undergone major changes since April 2013 and are now shared between NHS England, Local Authorities and Clinical Commisioning Groups (CCGs).

1.1.3 Local authorities are responsible for commissioning 'open access' services (including free STI testing and treatment, notification of sexual partners of infected persons and free provision of contraception). They are also responsible for the provision of specialist services, which includes young people's sexual health, teenage pregnancy services, outreach, HIV prevention, sexual health promotion, services in schools, colleges and pharmacies.

1.1.4 Public Health England records (GUMCAD) show that in 2013 there were 21,091 attendances at GUM Services from Barnet residents across England. Most of these services were accessed through the Royal Free Hospital Trust either through the Marlborough Clinic (at the main site in Camden) or Claire Simpson Clinic. The Clare Simpson Clinic offers two sexual health clinics at Barnet General Hospital and Edgware Community Hospital. A Young Person's Sexual Health Outreach Service also offers testing, contraception, advice and support.

1.1.5 In addition, the main Contraception and Sexual Health (CASH) service is delivered by Central London Health Care Community Trust in Barnet. This service, which is comprised of contraception and STI screening and testing, is delivered at 4 locations: Edgware Community Hospital, Vale Drive Primary Care Centre, Grahame Park Health Care Centre and Torrington Park Health Centre. In 2014/15 Barnet residents attended 10031 appointments at this service.

1.1.6 The main CASH service is complemented with a primary care offer which is accessible through General Practitioners (GPs) and Pharmacies. In 2014/15 GPs delivered 937 appointments relating to contraceptive implants and Intrauterine Contraceptive Device (IUCD, also known as the Coil). GPs were also commissioned to carry out chlamydia screening, of which 227 were carried in 2014. . Pharmacies are commissioned to provide Emergency Hormonal Contraception (EHC); 105 EHC were dispensed in 2013/14.

1.1.7 It should be noted that as part of the Inter Authority Agreement between Barnet and Harrow Council, is monitoring and procurement of Public Health contracts for both boroughs is undertaken by the Harrow & Barnet Joint Public Health Service (H&BJPHS) through Harrow Council's procurement process.

1.1.8 In line with Harrow Council's Corporate Procurement Rules (CPRs), H&BJPHS sought approval from Harrow's Cabinet (November 2014) to:

- extend the Contraception and Sexual Health Service (CaSH) contracts until March 2017
- participate in collaborative procurements, where appropriate, and repeat the negotiation and direct award of Genitourinary Medicine contracts for 2015/2016 and 2016/2017.

1.1.9 As these contracts are due to expire in March 2017, Harrow &Barnet JPHS acquired permission from Harrow Council on 10 December 2015, as the host authority, to procure new services and to enter any collaborative arrangements with other London boroughs, for both boroughs.

1.2 Proposed changes

1.2.1 Local Authorities (LAs) are facing unprecedented challenges in providing improved quality of service provision whilst at the same time dealing with increased demand and a backdrop of reduced funding. Members will be that an in-year grant reduction of approximately 6.2% (£1.048m) on the public health grant reduction was confirmed at the end of November and the Comprehensive Spending Review announced average real time savings of 3.9% to 2020/21.

1.2.2 GUM services are provided on an 'open access' basis which means that residents are entitled to visit sexual health facilities available, in any part of the country, without the need for a referral from GP or other health professionals. This open access requirement service puts the Council under financial uncertainty as the level of activity is unpredictable.

1.2.3 H&BJPHS are currently leading the pan London Sexual Transformation project, which aims to deliver a new collaborative commissioning model for GUM services across the capital. The key outcomes are to improve patient experience, improve sexual health outcomes and provide successful cost effective delivery of excellent services across the capital. The aim is to commission the services so that the system is operating under new contracts by April 2017.

1.2.4 The pan London Sexual Health Transformation project was initiated in June 2014. The project evolved from work that had been undertaken by the West London Alliance (WLA) and Tri-borough councils in 2013/14 to agree prices and terms and conditions for GUM services with the major NHS providers in North West London. In 14/15 the work expanded to include Camden, Islington and Haringey. The 12 councils working together were successful in negotiating acceptable tariff prices for GUM and in implementing standard service specifications and common Key Performance Indicators (KPIs). By taking this joint approach to discussions with GUM providers, participating councils achieved an avoided cost of £2.6m (9.1%) in 13/14 and avoided cost of £2.5m (6.5%) in 14/15.

1.2.5 The 12 councils agreed to jointly review the need for and provision of GUM services and, recognising the interdependencies across borough boundaries, invited all other councils in London to be involved. The final group of councils who engaged in this review and contributed to project costs are: Barnet, Brent, Camden, City of London, Ealing, Enfield, Hackney, Hammersmith and Fulham, Haringey, Harrow, Islington, Kensington and Chelsea, Lambeth, Lewisham, Merton, Newham, Redbridge, Southwark, Tower Hamlets, Waltham Forest, Wandsworth and Westminster. London Boroughs spent approximately £101.7m on GUM services in 13/14. The 22 councils involved in this project account for 83% of this spend and clinics operating in the areas covered by those 20 councils were responsible for delivering approximately 79.1% of all the GU activity for London in 2013/14. There are now 29 councils participating in this project.

1.2.6 To assess the current state of GUM services in London, the project team has undertaken a GUM needs assessment, an analysis of GUM patient flow data, interviews with commissioning and public health leads in each council involved, a review of the legal and policy environment and some exploration of the possible alternatives to the traditional service models.

1.2.7 From this work, the project team developed case for change which is based on five elements:

- London has the highest rates of Sexually Transmitted Infections (STI's) in England. Rates vary significantly throughout London but even the London boroughs with the lowest rates of STIs are close to or exceed the England average. Men who have sex with men (MSM) and Black Caribbean communities have significantly higher rates of STI's than other groups
- Access to services is highly variable across London and significant numbers of residents from every London borough are accessing services in central London
- There is a significant imbalance in the commissioner/provider relationship. Service development has typically been provider-led. With several services in the London area, no single council has sufficient leverage to deliver significant system-level change

- The systems for clinical governance need improvement. Patient flows and the lack of a 'helicopter view' of what is taking place within individual services make it difficult for councils to have sufficient assurance over quality and safety
- Growth in demand for these services and costs of healthcare are likely to significantly outpace growth in the Public Health Grant. In addition the open access nature of the services means that it is difficult to control or predict demand. Participating councils have identified the need to develop models that will allow them to meet increasing need with decreasing resources and reduced funds. It is estimated that a cost saving of at least 20% to 25% is required to ensure the services are sustainable.

1.2.8 **The proposal is to develop a networked system of services either on a pan-London or sub-regional basis.** An integral component of this networked system will be a Pan-London Sexual Health On-Line portal. The front door into services will be through a web-based single platform; providing patients with information about sexual health, on-line triage, signposting to the most appropriate service for their needs and the ability to order self-sampling tests. A single database will be developed with the highest levels of confidentiality and security enabling greater understanding of the patient flows and with a focus on prevention and specialist services for those most in need. This web based platform is expected to commence by January 2017.

1.2.9 The **Pan-London Online Portal** will incorporate the following elements (see figure 1 below for graphic representation):

- Triage and Information ("Front of house");
- Self-Testing/Self Sampling;
- Partner Notification; and
- Signposting/ Patient Direction and where possible Appointments (Booking system) (dependent on ability to interface with existing clinic systems).

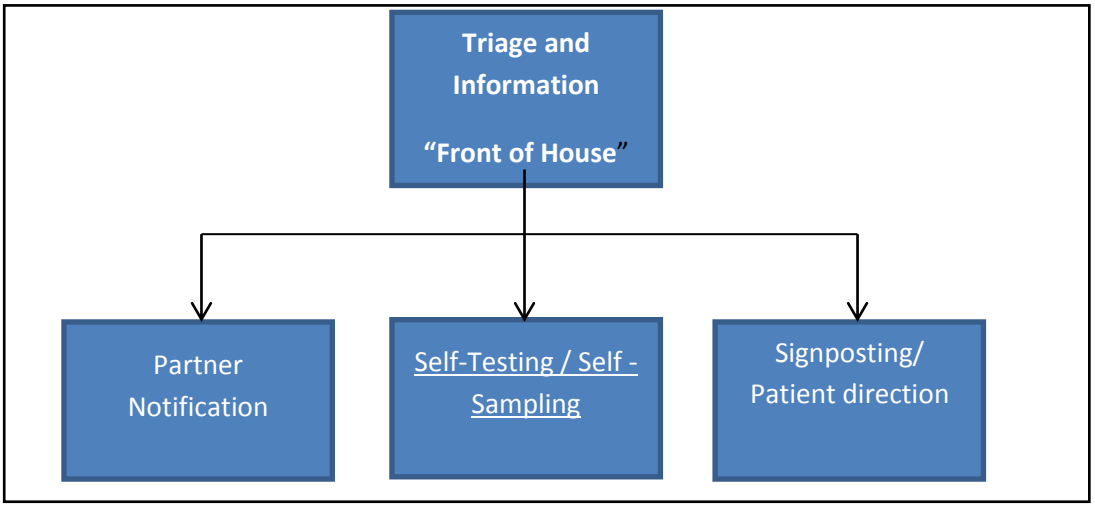


Figure 1: Scope of Pan-London Online Procurement Project

1.2.10 There is an expectation that all major clinics will offer patients the opportunity to triage and self-sample on site, in addition all services will be required to ensure that results are available electronically to patients within 72 hours. Patients who are diagnosed with an STI will be offered an appointment within 48 working hours or will be fast tracked if they present to a walk in service. Improved systems for identifying and notifying contacts of patients with an STI will ensure that resources are targeted at the highest need groups.

1.2.11 Alternatives to clinic-based services should be part of the future service model; new technologies including online services continue to inform and expand options for sexual health service delivery.

1.2.12 Centralisation of partner notification data along with the use of a single patient identifier system / technology to ascertain attendance at clinic of those notified of infection would support the reduction of rates of re-infection and repeat attendance.

1.2.13 The primary aim of this system will be to ensure that high volume, low risk and predominantly asymptomatic activity is controlled and managed where appropriate outside of higher cost clinic environments. By shifting testing of asymptomatic patients away from costly clinical environments through this model; it is estimated that considerable savings will be released. The evidence review and discussions with providers suggests that anything from 15% to 30% of activity could be redirected to lower cost service options in a staged manner. The results of the waiting room survey undertaken as part of LSHTP indicate that up to 50% of attendees do not have symptoms.

1.2.14 Locally, the vision is to develop and coordinate an integrated system of sexual health provision linked to a network of pan London and regional services. This will enable each Council to achieve the objectives set out in the Sexual Health Strategy and improve sexual health outcomes. A lead provider model is proposed to coordinate and manage all elements of the system including clinical, primary care, and the third sector. The whole system will be designed to ensure that evidence based practice drives changes, and resources are focused on groups with the highest risk. It is important that the new system is flexible and responsive to changes in demography and local need.

1.2.15 The next phase for the project is for the collaborating boroughs to proceed to the re-procurement of these services, with new contracts by April 2017.

1.2.16 Following the procurement outcome and in recognition of the boroughs' interdependencies and the existence of similar interdependencies with all major GUM providers, the collaborating councils will consider the development of a single commissioning unit either hosted by a LA or commissioned from a specialist commissioning organisation. This service will provide oversight of the system to ensure it works and delivers optimally.

1.2.17 It is envisaged that each element (excluding appointments, which will form part of the provision of Triage and Information) will constitute a separate lot, to be procured concurrently. This assumption is predicated on prior engagement with online testing providers, which supports the belief in discrete areas of capability, i.e. capability in self-testing does not confer equivalent aptitude in design and build of the Triage and Information module (or ability to select the optimum sources of provision via a lead/sub-contract mechanism).

1.2.18 Prior engagement with providers noted that delivering clinically effective, cost effective partner notification is one of the key challenges to sexual health service providers. The use of technology has meant individuals can access their results in 'real time' and pass on information to partners via instant messaging however ascertaining and monitoring whether partners access testing and treatment is problematic.

1.2.19 The joined up PN should allow current services to release further efficiencies. In discussions, providers have indicated that the current system for partner notification is a major draw on staff time. By having a shared database/system for partner notification the staff time taken to validate that patients have been seen and treated will be significantly reduced.

1.2.20 It is proposed therefore to carry out a concurrent and coterminous Pan-London Online Procurement and award contracts for a minimum term of 5 years aligning with the GUM procurement which will ensure that providers can focus on the clinical aspects of the service requirement necessary to deliver transformed services.

1.2.21 The proposed initial contract term of the Pan-London Online Procurement is envisaged to slightly precede the Sexual Health Service procurement. The aim however is for the outcome to be available for the main stage of SH procurement (i.e. the detailed stage of the CPN estimated to take place around April – June 2016). Also the actual time that the 'front end portal' will go live is likely to vary in each borough and it should be noted that the self-testing element will only be switched on as each borough determines it is ready i.e. has procured local services. An estimate of the Pan-London Online contract(s) term will be in the region of 6 years, allowing for the 'front end' to commence first estimated October 2016 to 31 March 2022; with an option to extend for up to a maximum of 4 further years (up to March 2026), subject to performance and funding availability. This is realigned with the SH procurement contract term stated in paragraph 3.4.9.

1.3 Indicative SH On-Line Procurement Timescales:

Market Engagement, Procurement Process Preparation	December 2015 – January 2016
Procurement Process Contract Award	January - September 2016

Mobilisation & Staged Contract Start	October 2016 onwards – April 2017

1.4 Sub regional procurement

1.4.1 GUM and CaSH services are to be procured on a geographical 'lots' basis across London. There are 2 primary reasons for this – firstly, it was identified through the market engagement exercise that no one bidder has the capability or capacity to be able to provide all sexual health services across London. It is proposed therefore to divide the London region into sub regions for the procurement of GUM and CaSH services.

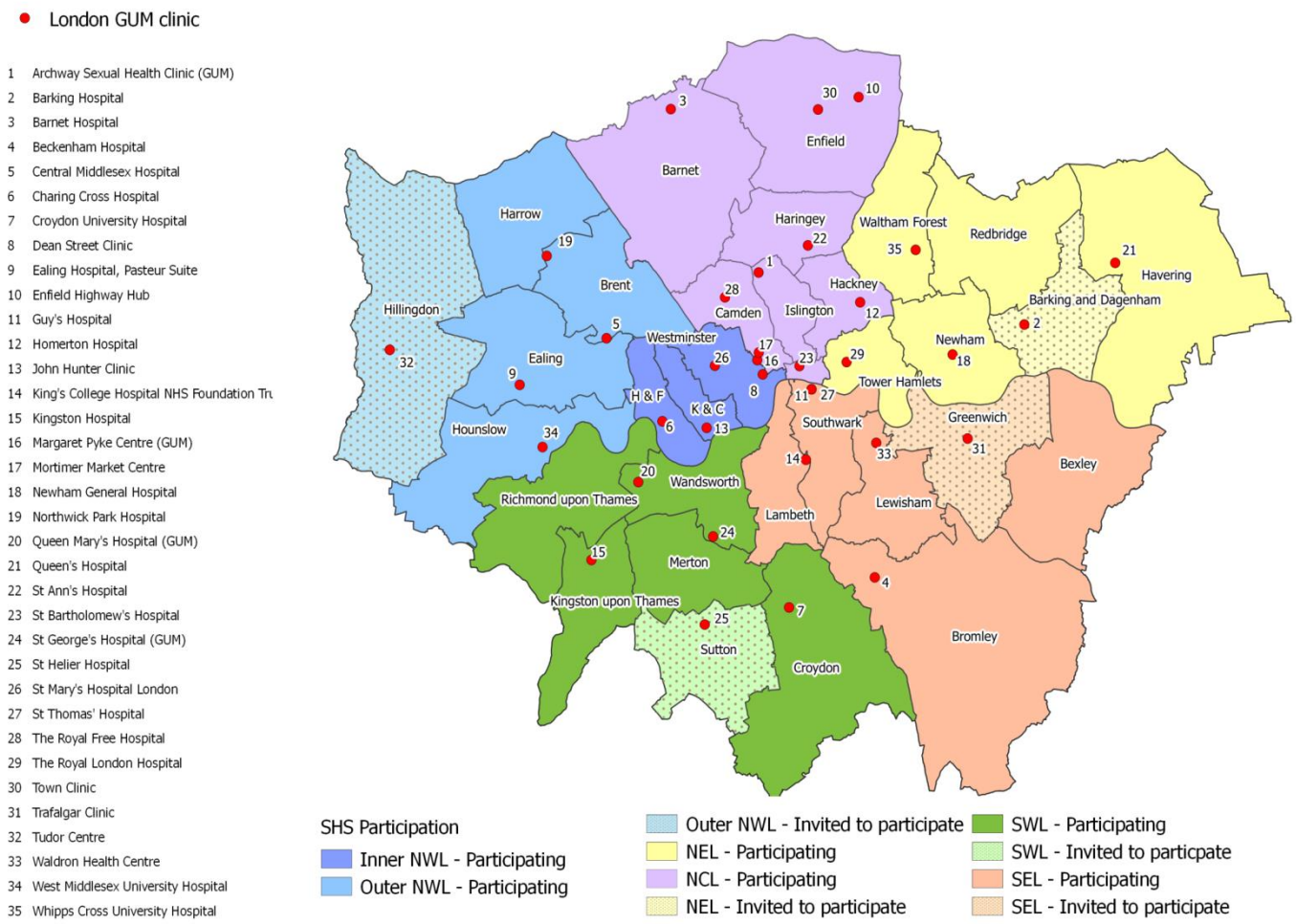
1.4.2 Secondly considerable work has been done to map and understand how patients currently move around the system. While all boroughs will have residents who attend at almost every London service the majority of people attend services either in their borough of residence or in boroughs immediately adjacent.

1.4.3 This intelligence has informed the regional proposals detailed below. LB Barnet will be part of the North Central London sub-regional procurement, which will include the following Council: Camden, Islington, Haringey, Enfield, Hackney and City of London. The sub regions are as follows:

North West London – NWL split into two sub regions NWL inner and NWL outer	
NWL outer Brent, Harrow, Ealing, NWL inner H&F, K&C, Westminster.	Hounslow, participating on the online procurement only. Hillingdon invited to participate
North Central London – NCL	
Barnet, Camden, Enfield, Haringey, Islington, Hackney and City of London.	
North East London – NEL	
Redbridge, Newham, Tower Hamlets, Waltham Forest and Havering participating on the online procurement only. B&D, invited to participate.	
South West London – SWL	
Merton, Richmond and Wandsworth. Kingston and Croydon participating on the online procurement only. Sutton invited to participate. Hounslow could opt to work in this sub region	
South East London – SEL	

Lambeth, Southwark, Lewisham, Bromley and Bexley
Greenwich, invited to participate.

London GUM Clinics & Local Authorities participation in the Sexual Health Services review 2015



1.4.4 Barnet will collaborate with boroughs in the North Central Region for the procurement of a new integrated Sexual Health Service consisting of both GUM and CaSH service and other nonclinical sexual health services including primary care, outreach, HIV prevention for both boroughs.

1.5 Procurement Timetable

1.5.1 It is intended that the sub-regional procurement will be undertaken using the Competitive Procedure with Negotiation (CPN) under the Public Contract Regulations 2015. Most procurements are undertaken using the open or restricted (invitation to tender) routes. Under these the procuring organisation sets out what services are required in the form of a detailed specification and seeks submissions from bidders; with a successful bidder appointed on the basis of price, quality and other appropriate considerations.

1.5.2 CPN allows the organisation to work with interested parties to design/establish with sufficient precision the specification. This approach is more flexible and allows for more tailored and innovative specifications and solutions to be developed. Given the wider transformational change and phasing this enables greater flexibility and potentially greater benefits, both financial and non-financial in terms of greater, integrated and improved access service improvements to residents. It should be noted that the grounds for using CPN are harmonised with the grounds permitting use of the competitive dialogue procedure.

1.5.3 There are several advantages to this. The opening up of the development/finalising of the specification with potential bidders will allow bidders to draw on their experience and knowledge to ensure that a bespoke solution is created for London. Many bidders will have experience of delivering such services elsewhere and will be well placed to work with clinical commissioners to design a high quality service model.

1.5.4 At this stage, it is not possible to articulate the detailed configuration of the new services, as the CPN process itself will help in the design of this. However, the following considerations are pertinent:

- Patients with complex needs/high risk groups may need to receive their treatment within a clinic setting. In developing the final specifications, clinical specialists will be engaged to ensure the proposed model is clinically safe and appropriate.
- The dialogue phase will assist in clarifying the percentage of current activity that will be diverted out of a clinical setting and in particular diagnostics out of acute settings.
- The service may be provided by someone other than the current provider. As a result of market sounding that has been undertaken the project team has determined that nearly all the existing NHS Trusts have expressed an interest. In addition a number of private and not for profit organisations have expressed an interest in providing some or all of the required services.
- Most of the services will be provided within a clinic setting possibly complemented by community settings. We will work with the bidders to

identify economies of scale for delivery. That is, some elements of the services may need to be delivered in one location, whereas others could be delivered at several locations within each sub region or even by alternative service means like on-line testing and/or primary care providers such as, pharmacies and GPs (especially when the service is high volume and less complex/risk – asymptomatic–).

1.5.5 The project will deliver a new model of clinical service delivery. The aims of the new model are to ensure that:

i. Good quality services are accessible to all London residents and visitors;
ii. Level 3[1] GUM services are designed in a way that ensures they operate as part of a wider sexual health system that can meet future needs and provide excellent value for money. This will include measurably improved performance on key PH outcomes in particular prevention and early diagnosis of HIV, prevention and reductions in the incidence of STIs and unwanted teenage pregnancy.
iii. London councils are commissioning effectively including seeking cost effective benefits from lower transaction and operating costs for boroughs;
iv. London councils have excellent oversight of service quality; and
v. Service costs are reduced and that optimum quality services can be maintained in light of significant pressures on budgets

1.5.6 The Sexual Health indicative procurement project timetable is as follows:

Competitive Procedure with Negotiation using PIN as a call for competition	PLANNED START DATE	PLANNED FINISH DATE
Issue Prior Indicative Notice(PIN) as a call for competition	22-Jan-16	22-Feb-16
Send Invitation to confirm interest to economic operators	23-Feb-16	04-Apr-16
Allow 30 days	24-Feb-16	04-Apr-16
Closing date of receipt of confirmation of interest	04-Apr-16	04-Apr-16
Despatch of invitation to submit initial tender	05-Apr-16	05-May-16
Time for return by mutual agreement or min 10 days if not agreed	05-Apr-16	05-May-16
Initial tender deadline	05-May-16	05-May-16
Evaluate initial tender submissions	06-May-16	31-May-16
Despatch of invitation to negotiate tender	01-Jun-16	03-Jun-16
Negotiation phase 3 weeks	06-Jun-16	24-Jun-16
Issue Call for Final Tenders (CFT)	27-Jun-16	27-Jun-16
No minimum period common deadline to be set for all tenderers	28-Jun-16	18-Jul-16
FT deadline	18-Jul-16	18-Jul-16
FT Tender evaluation	19-Jul-16	02-Sep-16
FT Tender moderation evaluation if required	05-Sep-16	09-Sep-16
Draft Award recommendation report	12-Sep-16	16-Sep-16
DPH Briefing & Officer Clearance	19-Sep-16	23-Sep-16
Portfolio Holder and stakeholder consultation	26-Sep-16	30-Sep-16
Draft Award Notification Letters	26-Sep-16	30-Sep-16

[1] See Appendix 1 for definition of Levels

Notification & Voluntary** Standstill Period	03-Oct-16	14-Oct-16
Successful Supplier Notified	17-Oct-16	21-Oct-16
Contract Award	24-Oct-16	28-Oct-16
Contract Transition Period (allowing for possible TUPE)	31-Oct-16	31-Mar-17
Contract Handover	01-Mar-17	31-Mar-17
Contract Start	01-Apr-17	01-Apr-17

2 REASONS FOR RECOMMENDATIONS

2.1 H&BJPHS are currently leading the pan London Sexual Transformation project, which aims to deliver a new collaborative commissioning model for GUM services across the capital. The key outcomes are to improve patient experience, improve sexual health outcomes and provide successful cost effective delivery of excellent services across the capital.

2.2 To engage the services to continue to be provided within a reducing financial envelope, the case for change leads to two key conclusions:

1. Significant change is required to the traditional models of service delivery
2. Collaboration on a wide scale across London councils is needed to deliver the level of change required and to commission these services more effectively to ensure robust quality and financial monitoring

2.3 It is therefore recommended for H&BJPHS to be involved in, and lead, the pan London and sub-regional developments.

2.4 Officers have considered a range of options to get the best price and quality for residents. Overall, the Council wants to maintain quality but with the current financial pressures, price is also critical. To achieve this, Barnet as agreed as part of the North Central Sub-region procurement at 50% quality and 50% price.

2.5 The project team is in the process of developing the sub criteria and evaluation methodology.

3 ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Alternative Option 1: Do nothing. Current system remains unchanged.

3.1.1 London has the highest rates of Sexually Transmitted Infections (STI's) in England. Rates vary significantly throughout London but even the London boroughs with the lowest rates of STIs are close to or exceed the England average. Men who have sex with men (MSM) and Black Caribbean communities have significantly higher rates of STI's than other groups. See Barnet's Sexual Health Strategy for the local epidemiology.

3.1.2 Access to good quality GUM services is highly variable across London. Due to the nature of 'open access' GUM services, significant numbers of residents from every London borough are accessing services in central London. A Cross-charging arrangement requires local authorities to pick up the costs when local residents access GUM services elsewhere.

3.1.3 Costs of the services to commissioners have been managed to date by

collaborative negotiations to maintain the prices at the tariff levels applied in 2012/13. In addition, the collaborating councils have achieved further containment of cost pressures by:

- Ceasing the payment of the 2.5% CQUIN that applied in the NHS
- Negotiating efficiencies of up to 5% of tariff price
- Agreeing marginal rates for activity above agreed thresholds.

3.1.4 However, the process involved in achieving the above has been very intensive and has absorbed a significant amount of commissioners' time; thus reducing the time available for wider commissioning activities, such as contract and performance management and longer term service planning. There is a consensus that the current model is not financially sustainable and will not deliver the efficiencies and improved outcomes required.

3.2 **Alternative Option 2: To focus on the development of a local sexual health service model that includes Level 3, reducing dependence on central London services.**

3.2.1 This localised service model would be developed on the basis that local residents could only access sexual health services within their respective boroughs. Similar to the preferred option, the local vision is to develop and coordinate an integrated system of sexual health services. However, the difference is that in this option, local services would be independent of the Pan-London on-line portal and the wider network of services provided across London.

3.2.2 As an open access service, there is an established arrangement across the Country for cross-charging, with most of the activity for both Barnet and Harrow seen in London. Due to the confidential and sensitive nature of this service, many residents choose to access GUM services outside their borough of residence; for convenience they opt for services closer to work or where they socialise. For example, in 2013, Barnet residents attended 18,231 appointments in GUM services in 2014/15; only 24% of this activity was seen at Barnet Hospital whereas 36% was seen at the Royal Free Hospital in Camden. The rest of this activity was in Islington (15%), Westminster (12%), Brent (4%), Southwark (2%), City of London (2%), Enfield (1%), Hammersmith (1%) and rest of London (4%).

3.2.3 For this model to be successful, more local residents would need to be attracted to the local service. Although we intend to encourage more residents to access sexual health services locally, we will need to accept that some residents will continue to use out of borough provision for convenience. There is evidence to show that some of the central London clinics are much more accessible and appropriate for the needs of high risk groups (particularly for men who have sex with men) and it may not be cost-effective to replicate this provision locally, particularly if residents prefer to access these services in a central location. It is worth noting that there are interdependencies between each London borough's sexual health provisions and therefore a local model would not be able to sufficiently meet the needs of all local residents.

4 POST DECISION IMPLEMENTATION

4.1 The comments from the Board will be considered and incorporated into the plans. The procurement activity will be carried out as detailed in section 1.

5 IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 The proposed new model will improve sexual health related outcomes for local residents, particularly vulnerable and high risk groups, such as Black African communities and men who have sex with men (MSM). The proposed new service model will support the core principles of the Council's Corporate Plan, of "fairness, responsibility and opportunity".

5.1.2 The new service will enable residents to 'further their quality of life' by improving access to high quality sexual and reproductive health services through community and primary care. The London Pan-Online portal will 'help' residents to maintain their sexual and reproductive health by preventing and protecting themselves and others from sexually transmitted diseases and unwanted pregnancies. Residents will be encouraged 'to help themselves' by using the on-line portal to: (1) access information about local sexual health service, (2) request STI self-sampling and (3) support the partner notification service.

5.1.3 As demonstrated through this report, the proposed new service model of sexual health services across London will deliver improved outcomes and better value for money for residents.

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

5.2.1 In economic terms alone, sexual health and reproductive services take up around one third of the current public health budget.

5.2.2 The Public Health Grant is currently ring fenced, however the Comprehensive Spending Review noted the Government intention to consult on options to fully fund local authorities' public health spending from their retained business rates receipts, as part of the move towards 100 per cent business rate retention. The ring-fenced on public health spending will be maintained in 2016/17 and 2017/18 with average real time savings of 3.9% per annum until 2020/21.

5.2.3 Across London, councils currently spend approx. £115m per annum on GU services excluding contraception and this is predicted to increase to £124.5m by 2022 if LA's do not take action to redesign the system now. The financial prediction is estimated on the basis of projected population growth(which varies from Council to Council) however this may be a conservative estimate as changes in behaviour are driving demand also

5.2.4 The starting point for the grant for 2015/16 for Barnet totals £14.335m, excluding the in-year allocation for Health Visiting and the in-year grant

reduction changes to the ACRA formula.

5.2.5 In Barnet, the sexual Health spend proportion of the non-HV element of the grant is 36%. The grant is a ring-fenced allocation for the provision of both mandatory and discretionary public health services. In this respect, the impact of changes in expenditure arising from the procurement exercises will need to be contained within the annual grant amount.

5.2.6 Whilst the ring-fence is maintained, any efficiencies achieved on public health expenditure (including that delivered through procurement programmes) deliver capacity in the grant. This grant capacity then enables mitigation of demand led service growth in areas such as sexual health, with any residual capacity being available to grant fund expenditure appropriately incurred across the council delivering the wider determinants of health.

5.2.7 As GUM and primary care activity are funded on an activity basis, the projected spend for 2015/16 is based on the previous year's spend. Barnet expenditure for all sexual health services for 2014/15 was £4.6m.

5.2.8 The current system of contracting for services where tariffs are renegotiated annually and frequently not agreed until well into the financial year is time consuming and does not allow for proper financial planning on the part of either commissioners or providers. In this current year, most Trusts did not reach agreement with commissioners until autumn 2015. The proposal is to award contracts for a minimum term of 5 years which will ensure that the current annual cycle of tariff negotiation is avoided and that providers can invest in any systems or premises necessary to deliver transformed services.

5.2.9 The current contracts for GUM and CaSH Services were previously extended and they will expire on 31st March 2017. Procurement will include both services.

5.2.10 The proposed initial contract term of the Sexual Health Service procurement will be 5 years, commencing 1 April 2017 to 31 March 2022; with an option to extend for up to a maximum of 4 further years (up to March 2026), subject to performance and funding availability.

5.2.11 Based on current spend the LSHTP estimated aggregate value across participating London Authorities of the proposed GUM contract for 5 years is in the region of (£498.5 million) plus 4 years (£404.7 million.) = £903.2 million. All the above figures are subject to funding.

5.2.12 The above estimates are based on:

- Calendar year 2014 total attendance (first and follow activity) taken from GUMCAD2 reporting system
- The tariff agreed by commissioners for 13-14 tariff which was £133 for a first appointment and £82 for a follow up appointment and NHS Market Forces factor (MFF). The calculations do not include any deflators or application of marginal rates as these varied per Trust. The calculations do include projected change in the population of each London borough.
- The estimates include, GU activity only, they does not include block

contracts for Contraception and Sexual Health (CaSH)

5.2.13 For Barnet, based on current spend the estimated aggregate value of the proposed GUM contract for 5 years is in the region of £33.9 million. All the above figures are subject to funding.

5.2.14 The current annual CaSH contract value is £930k; £65k for Primary Care and £38k HIV testing (Home Sampling).

5.2.15 It should be noted that the above estimates are based on current spend based on separate contracts and therefore are only indicative. The actual contract value will be defined following the procurement and providers are already informed that LSHTP seeks to reduce capacity within a clinic setting and integrate services with the view to improve the service offer to residents.

5.2.16 This procurement, which is part of a wider sexual health transformation project, is expected to deliver savings. The following areas are ways in way the efficiencies are expected to be achieved:

- Single web based front door to services ie; online triage which will enable self-sampling and potentially increased use of GP's and pharmacies
- Single partner notification (PN) system
- Redirection of asymptomatic patients
- Consolidation of numbers of Level 3 GUM clinics
- Economies of scale
- Use of an integrated tariff

5.2.17 The anticipated 2016-17 budget for GUM services for Barnet total £4.480m and the five year plan assumes a reduction of 10% in the costs of GUM services will be delivered from the procurement exercise and that future growth will be contained within the reduced budget.

5.2.18 It is difficult at this stage to quantify further the level of savings which may be delivered through an integrated service, however these are expected to be in the region of 10%- 25% although these could potentially increase over time as the new system is embedded and the desired behavioural changes are achieved. Further potential savings from the wider transformation project will be included in future budget proposals as these become more robust following the progress around the wider procurement exercise.

5.2.19 The award of any contracts will result in contractual obligations with the provider for services which are funded by external grant and which cannot be guaranteed in the longer term, however these are mandatory services.

5.3 Social Value

5.3.1 The Public Services (Social Value) Act 2013 requires people who commission public services to think about how they can also secure wider social, economic and environmental benefits. The North Central London Sub regional group have assigned 5% of the award criteria to Social Values to ensure that social, environmental and economic benefits will be delivered as part of the contract.

5.4 Legal and Constitutional References

5.4.1 Local authorities have a duty under The *Health and Social Care Act 2012* ("the Act") to take appropriate action to improve the health of the local community. In general terms, the Act confers on local authorities the function of improving public health and gives local authorities considerable scope to determine what actions it will take in pursuit of that general function. Under in this Act, local authorities have a statutory responsibility to commission Genitourinary Medicine Services (GUM) and Contraception and Sexual Health services (CaSH).

5.4.2 It should be noted that as part of the Inter Authority Agreement between Barnet and Harrow Council, the monitoring and procurement of Public Health contracts for both boroughs are undertaken by the Harrow & Barnet Joint Public Health Service (H&BJPHS) with the support of Harrow Council. As the host authority, Harrow Council's Corporate Procurement Rules (CPRs) will be followed.

5.4.3 The procurement exercise for the pan-London Sexual Health Transformation will be subject to the Public Contract Regulations 2015 (the "Regulations") and the Council's Contract Procedure Rules. The overall value of the contract for this service will exceed the applicable threshold and so it will be necessary for the tender exercise to adhere to the strict application of the Regulations.

5.4.4 It is proposed to use one of the new processes introduced by the Regulations that allows for negotiation throughout the tendering exercise which will ensure good quality services are procured at a competitive price.

5.4.5 The procurement of public health contracts are subject to the overriding EU Treaty principles of equal treatment, fairness and transparency in the award of contracts.

5.5 Risk Management

5.5.1 The key risk to achievement of outcomes within timescales is the complexity of partnership working. Some changes or waivers to individual council's policies or procedures may be required due to the nature of arrangements where significant numbers of different organisations are involved. For some inner London services, up to 8 councils will need to be involved to effectively commission the services.

5.5.2 It is important to note that service transformation and behaviour change may require clinic redirection and alternative suitable clinical premises located at "hotspots" which may not be feasible within the procurement timescales. In addition the premises need to meet all legal and planning regulations in order to deliver core services. An example where delay may occur and affect the procurement timetable may be the need of a D1 planning status for the treatment services. Whilst the provider(s) develop their own property strategy to

locate within the regions we will work with the outgoing and incoming providers to ensure that services aren't disrupted.

5.5.3 Due to the nature of the service, possible re-location of the new service may meet local opposition. LAs will need to work with residents, stakeholders, the local press and politicians to ensure the establishment of the new service is managed effectively. There is a project communication strategy addressing key messages and key audiences ensuring consistency of communication.

5.5.4 It is important that councils work closely together, any LA doing different things in their area or not delivering their part within the collaborative project will negatively impact on each other and the collaboration project.

5.5.5 On the basis of a collaboration across 26 councils (potentially 28) London boroughs, it is estimated that a pan-London procurement would be for services of a value between £0.5 billion for an initial 5 year contract and £1billion for the 9 year contract which included 4 years (2+2) extension. Whilst sexual health services fall under the 'light touch' regime in the Public Contract Regulations 2015 the anticipated value of the procurement sum is considerably in excess of the threshold of €750k (approximately £625k). Given also the attention that this procurement will be given it is recommended that the full OJEU process be followed to ensure that proper processes are followed throughout each stage of the procurement.

5.5.6 There is no established practice of consultation on the design of sexual health services provision. Commissioners have carried out provider and service user engagement via surveys, questionnaires, focus groups, stakeholder events and one to one sessions. On individual local level, each borough needs to assure itself that they have satisfied their consultation duties in this regard. There are specific statutory duties in s. 221 of the Local Government and Public Involvement in Health Act 2007 to ensure that members of the public are involved in decisions regarding (inter alia) commissioning of health services, which may involve public consultation but need not do so.

5.5.7 In any collaborative procurement, it is essential that clear and effective inter-borough arrangements are put in place, not only in connection with the procurement process but also in relation to the subsequent operation of the contract. An interim collaborative governance structure with representatives from all participant LAs has been agreed pending Cabinet approval. Officers will need to establish more detailed governance arrangements. Officers will need to ensure appropriate legal, financial and other relevant advice is obtained in establishing suitable governance and professional project resources meeting procurement start of February 2016. Governance arrangements will ensure there is clear accountability and liability between the councils and appropriate binding inter authority agreements. Professional services arrangements will ensure that there is consistency of approach, legal, procurement, financial and communications advice and appropriate programme and project management. This will be particularly important for carrying out a compliant CPN procedure

whilst ensuring that any risk of challenge is eliminated.

5.6 Equalities and Diversity

5.6.1 The Council has a duty under s149 of the Equality Act 2010 to have due regard to the needs of those with relevant protected characteristics such as: age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; sexual orientation, in the provision of Public Health Services. An Equality Needs Assessment has been undertaken to assess the impact of this procurement on local residents. In conclusion, it was recognised that there was a disproportionate prevalence of sexually transmitted diseases amongst certain groups resulting in poor outcomes for these groups. It is intended that the proposed procurement will deliver better value for money whilst achieving improved outcomes for high risk and vulnerable and the whole community.

5.7 Consultation and Engagement

5.7.1 The following information illustrates the consultation and engagement that has been undertaken locally as part of this project; however it should be noted that this is for information only as a decision is not being sought.

5.7.2 A service review was also undertaken in the London Borough of Barnet during the same period. Key stakeholders and local residents were invited to participate in the service review, which comprised of focus groups, interviews and surveys. To date, a series of surveys have been completed by a variety of stakeholders: service user staff (20), GPs (21), pharmacies (6), service users (147) and young people (135). Focus groups are currently been undertaken with young people, Black and Ethnic Minority males and females and Lesbian, Gay, Bisexual and Transgender (LGBT).

5.7.3 The service review set out to capture information on the following themes and highlights elements of the current sexual health provision that needs improvement developments. These findings along with the needs assessment will inform the new service model. The initial findings are set out below:

- **Knowledge of sexual health services**
  Service users were asked to identify the various ways they accessed information about sexual health services; 56% of respondents found information about local services from their GP; other popular responses included friends (41%) and family (40%).

  Initial findings from the stakeholder surveys are as follows: 47% agreed with the statement that ‘I understand the Barnet sexual health referral pathway” and 59% believed that the “quality of Barnet sexual health service provision is high”. Stakeholders felt that prevention was not high enough on the agenda with only 44% agreeing with the statement that “there is sufficient positive sexual health promotion taking place in Barnet”.

  81% of service users believed that “lack of awareness of services was a barrier to accessing services”. In contrast, 48% said that the sexual

health information “they had seen was good” and 40% felt that there is adequate sexual health information in the right places. When asked where they found information about sexual and reproductive health: 56% stated the internet, followed by their GP (41%) and friends and family (40%).

Service users felt that education and awareness of sexual health is vital; 54% expressing a need for more information through schools and colleges; with 30% stating that they had received sex education when they were at school.

The majority of stakeholders agreed that education and early intervention were contributing factors to reducing teenage pregnancies and sexually transmitted infections.

- **Attitudes, motivators and barriers to accessing services**
  Service users stated the key reasons for accessing sexual health services were as follows: for contraception (86%), sexual health check-up (77%) and due to previous experience of the service (53%)

  The key barriers identified by service users included: embarrassment (83%), unaware of services available (81%), opening times not convenient (73%), believe their behaviour will be judged (64%).

- **Needs and priority target groups**
  Service users were asked if services should be targeted at any particular groups: 30% stated that more work should be targeted at those at risk, with 29% identifying young people as a particular target group.

  Over 50% of stakeholders identified the need to target service provision at the following groups: vulnerable adults (particularly those with mental health issues and learning disabilities) and those from the following communities LGBT, BME and men who have sex with men.

- **Experience of services**
  Over 80% of service users stated that they had a positive experience of existing sexual health services.

5.7.4 The local service review and need assessment highlighted the importance of health education and awareness raising with regards to the local service provision. It also identified the lack of coordination and the fragmented nature of the current service pathway. It also highlighted the need for improved access to services for vulnerable and high risk groups, particularly young people.

5.7.5 The London Sexual Health Transformation project, the Local Sexual Health Strategy and the initial findings from the service review highlight the need for a change in the way that local services are delivered in Barnet and Harrow. The next step is to re-model the service and to develop a service specification which reflects the needs and demands of the local residents, whilst considering the interdependences which exist between local provision and regional and pan-

London network of services.

5.7.6 The commissioning and provision of an integrated service model is supported by professional guidance from FSRH, BASHH, BHIVA, MEDFASH, RCOG and NICE[2]. It is also supported by Department of Health and Public Health England.

5.8 Insight

5.8.1 The JSNA is an insight document which pulls together data from a number of sources including Public Health Outcomes Framework, GLA population projections and local analysis. The Joint HWB Strategy has used the JSNA as an evidence base to develop priorities.

5.8.2 The sexual health procurement will enable the Board to deliver its commitment to improve local sexual health priorities as set out in the JSNA and the Sexual Health Strategy 2015-2020. Sexual Health Strategy 2015 -2020 accepted by Health and Wellbeing Board on 13 November 2014.

6 BACKGROUND PAPERS

6.1 Barnet Sexual Health Strategy 2015-2020, Health and Wellbeing Board, Thursday 13 November 2014, item 9: https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=177&MId=7783&Ver=4

[2] See Appendix A for Glossary of Terms

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Appendix A - Project definitions for elements of STI management at Levels 1, 2 and 3

The following lists comprise elements of STI management that are appropriate at various levels of service provision. They are drawn from the three Levels (1, 2 and 3) defined in the National strategy for sexual health and HIV, published by the DH in 2001, and have been updated by this project to take account of modern service provision in 2009. They look specifically at STIs and related conditions and do not include elements of contraceptive and reproductive healthcare that may also be provided at these levels.

The elements of care listed below are not to be considered as minimum requirements, but rather as maximum specifications, for each service level. Care pathways should be in place for onward referral if the clinical condition is beyond the scope or competence of the original service. To ensure optimum care for service users, it is recommended that there should be formal links between services providing STI management at Levels 1 or 2 and those at Level 3 as set out in Standard 7.

Level 1

Sexual history-taking and risk assessment
including assessment of need for emergency contraception and HIV post-exposure prophylaxis following sexual exposure (PEPSE)

Signposting to appropriate sexual health services

Chlamydia screening
Opportunistic screening for genital chlamydia in asymptomatic males and females under the age of 25

Asymptomatic STI screening and treatment of asymptomatic infections (except treatment for syphilis) in men (excluding MSM)* and women

Partner notification of STIs or onward referral for partner notification

HIV testing
including appropriate pre-test discussion and giving results

Point of care HIV testing
Rapid result HIV testing using a validated test (with confirmation of positive results or referral for confirmation)

Screening and vaccination for hepatitis B
Appropriate screening and vaccination for hepatitis B in at-risk groups

Sexual health promotion
Provision of verbal and written sexual health promotion information

Condom distribution
Provision of condoms for safer sex

Psychosexual problems
Assessment and referral for psychosexual problems

Level 2

Incorporates Level 1 plus:

STI testing and treatment of symptomatic but uncomplicated infections in men (except MSM)* and women excluding:

• men with dysuria and/or genital discharge**

• symptoms at extra-genital sites, eg rectal or pharyngeal
• pregnant women
• genital ulceration other than uncomplicated genital herpes

Level 3

Incorporates Levels 1 and 2 plus:

STI testing and treatment of MSM*

STI testing and treatment of men with dysuria and genital discharge**

Testing and treatment of STIs at extra-genital sites

STIs with complications, with or without symptoms

STIs in pregnant women

Recurrent conditions
Recurrent or recalcitrant STIs and related conditions

Management of syphilis and blood borne viruses
including the management of syphilis at all stages of infection

Tropical STIs

Specialist HIV treatment and care

Provision and follow up of HIV post exposure prophylaxis (PEP)***
both sexual and occupational

Appendix B – Summary of commissioning responsibility

Local authorities' commission

Comprehensive sexual health services. These include:

1. *Contraception (including the costs of LARC devices and prescription or supply of other methods including condoms) and advice on preventing unintended pregnancy, in specialist services and those commissioned from primary care (GP and community pharmacy) under local public health contracts (such as arrangements formerly covered by LESs and NESs)*

2. *Sexually transmitted infection (STI) testing and treatment in specialist services and those commissioned from primary care under local public health contracts, chlamydia screening as part of the National Chlamydia Screening Programme (NCSP), HIV testing including population screening in primary care and general medical settings, partner notification for STIs and HIV*

3. *Sexual health aspects of psychosexual counselling*

4. *Any sexual health specialist services, including young people's sexual health services, outreach, HIV prevention and sexual health promotion, service publicity, services in schools, colleges and pharmacies*

Social care services (for which funding sits outside the Public Health ringfenced grant and responsibility did not change as a result of the Health and Social Care Act 2012), including:

1. *HIV social care*
2. *Wider support for teenage parents*

Clinical commissioning groups commission

1. *Abortion services, including STI and HIV testing and contraception provided as part of the abortion pathway (except abortion for fetal anomaly by specialist fetal medicine services – see "NHS England commissions")*
2. *Female sterilisation*
3. *Vasectomy (male sterilisation)*
4. *Non-sexual health elements of psychosexual health services*
5. *Contraception primarily for gynaecological (non-contraceptive) purposes*
6. *HIV testing when clinically indicated in CCG-commissioned services (including A&E and other hospital departments)*

NHS England commissions

1. *Contraceptive services provided as an "additional service" under the GP contract*
2. *HIV treatment and care services for adults and children, and cost of all antiretroviral treatment*
3. *Testing and treatment for STIs (including HIV testing) in general practice when clinically indicated or requested by individual patients, where provided as part of "essential services" under the GP contract (ie not part of public health commissioned services, but relating to the individual's care)*
4. *HIV testing when clinically indicated in other NHS England-commissioned services*
5. *All sexual health elements of healthcare in secure and detained settings*
6. *Sexual assault referral centres*
7. *Cervical screening in a range of settings*

8. *HPV immunisation programme*
9. *Specialist fetal medicine services, including late surgical termination of pregnancy for fetal anomaly between 13 and 24 gestational weeks*
10. *NHS Infectious Diseases in Pregnancy Screening Programme including antenatal screening for HIV, syphilis, hepatitis B*

Reference:

Public Health England, Making it Work, September 2014

Appendix C - Glossary of Terms

A&E	Accident & Emergency
BASHH	British Association for Sexual Health and HIV
BHIVA	British HIV Association
CaSH	Contraception and Sexual Health Service
CCG	Clinical Commissioning Group
DH	Department of Health
FSRH	Faculty of Sexual and Reproductive Healthcare
GP	General Practitioner
GUM	Genitourinary Medicine
HIV	Human Immunodeficiency Virus
LA	Local Authority
LARC	Long Acting Reversible Contraception
MEDFASH	Medical Foundation for HIV & Sexual Health
MSM	Men who have Sex with Men
NCSP	National Chlamydia Screening Programme
NICE	National Institute for Health and Care Excellence
OJEU	Official Journal of European Union
PEP	Post Exposure Prophylaxis
PEPSE	Post Exposure Prophylaxis following Sexual Exposure
PH	Public Health

PHE	Public Health England
PIN	Prior Information Notice
RCOG	Royal College of Obstetricians and Gynaecologists
SH	Sexual Health
STI	Sexually Transmitted infection

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AGENDA ITEM 13

	Health and Wellbeing Board **21 January 2016**
Title	**Minutes of the Joint Commissioning Executive Group**
Report of	Commissioning Director – Adults and Health Director of Clinical Commissioning
Wards	All
Date added to Forward Plan	November 2014
Status	Public
Urgent	No
Key	Yes
Enclosures	Appendix 1- Terms of Reference Appendix 2 - Minutes of the Financial Planning Group – 21 October 2015 Appendix 3 – Minutes of the Financial Planning Group – 15 December 2015
Officer Contact Details	Zoë Garbett Commissioning Lead – Health and Wellbeing zoe.garbett@barnet.gov.uk 0208 3593478

Summary

This report is a standing item which presents the minutes of the Joint Commissioning Executive Group (formerly known as the Financial Planning Group) and updates the Board on the joint planning of health and social care funding in accordance with the Council's Medium Term Financial Strategy (MTFS) and Priorities and Spending Review (PSR), and Barnet CCG's Quality Improvement and Productivity Plan (QIPP) and financial recovery plan. The Groups key areas of work include the Better Care Fund and Section 75 agreements.

Recommendations

1. **That the Health and Wellbeing Board notes and comments on the minutes of the Financial Planning Sub-Group meeting of 21 October 2015 and 15 December 2015.**

1. **That the Health and Wellbeing Board notes the revised Terms of Reference (Appendix 1) for the Joint Commissioning Executive Group.**

1. WHY THIS REPORT IS NEEDED

1.1 The Barnet Health and Wellbeing Board on the 26th May 2011 agreed to establish a Financial Planning sub-group to co-ordinate financial planning and resource deployment across health and social care in Barnet. The financial planning sub-group meets bi-monthly and is required to report back to the Health and Wellbeing Board (HWBB).

1.2 In 2015/16, the section 256 allocation for Barnet Council is £6,634,000 to deliver the main social care services which also have a health benefit. In 15/16, this funding is no longer received from NHS England but included within CCG allocations as part of the total Better Care Fund allocation of £23.4M for Barnet, which includes the NHS Barnet CCG minimum contribution to the Better Care Fund of £14,060,000. The Health and Wellbeing Board Financial Planning Sub-Group has in its terms of reference the approval of plans for S256/BCF funds on behalf of the HWBB.

1.3 The budgets will be used to continue to support the delivery of existing initiatives, as well as any such new initiatives identified to support the delivery of Better Care Fund (BCF) outcomes and the appropriate protection of social care services.

1.4 In March the Financial Planning sub-group reviewed the operating context for the CCG and LBB given the changes that both organisations have experienced over the past nine months and therefore the relevance of the Financial Planning Sub-group. It was agreed that the group should:

- Focus on areas of strategic joint work between the CCG and LBB which includes the section 75 agreements, the operation of the Joint Commissioning Unit and the Better Care Fund (BCF)
- Change its name to the Joint Commissioning Executive Group in line with the national guidance of the BCF
- Review the Terms of Reference to reflect this new strategic emphasis and update the membership given personnel changes in both organisations
- Shape the Health and Wellbeing Board work programme with the Health and Well-Being Board Chairman and Vice Chairman
- Support the development of the Health and Wellbeing Strategy

1.5 Given the above, in December 2015 the Group agreed the revised Terms of Reference for the Joint Commissioning Executive Group. The revised Terms of Reference can be found at Appendix 1.

1.6 Minutes of the meeting of the Financial Planning sub-group held on the 21 October 2015 are presented in appendix 2 and minutes from the sub-group held on the 15 December 2015 are presented in appendix 3.

1.7 In October the Group:

- Continued work to review our current Section 75 agreements
- Reviewed non-elective hospital admissions performance and agreed action to target areas to reduce admissions
- Considered the cost pressures across the health and social care system and recognised that the NHS and local government experience cost pressures due to an increase use of non-urgent care and delays in treatment
- Reviewed and developed the implementation plan for the Joint Health and Wellbeing Strategy

1.8 In December the Group –

- Agreed the updated Terms of Reference for the group (Appendix 1)
- Agreed to the protection of adult social care element of the Better Care Fund (BCF) for 2016/17
- Further shaped the Joint Health and Wellbeing Strategy (2015 – 2020) Implementation Plan
- Discussed primary care
- Discussed the development of an overarching Section 75 agreement for adults and childrens between LBB and BCCG
- Reviewed BCF performance (quarter 2)
- Confirmed and programmed plans to sign the BCF Schedule and Deed of Variation for 2015/16 before 24 December 2015, as agreed at the BCCG Governing Body on 23 November 2015

2. REASONS FOR RECOMMENDATIONS

2.1 The Health and Wellbeing Board established the Health and Wellbeing Financial Planning Sub-Group (now the Joint Commissioning Executive Group) to support it to deliver on its Terms of Reference; namely that the Health and Wellbeing Board is required:

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.

2.2 Through review of the minutes of the Joint Commissioning Executive Group, the Health and Wellbeing Board can assure itself that the work taking place to ensure that resources are used to best meet the health and social care needs of the population of Barnet is fair, transparent, stretching and timely.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Not applicable.

4. POST DECISION IMPLEMENTATION

4.1 Provided the Health and Wellbeing Board is satisfied by the progress being made by the Joint Commissioning Executive Group to take forward its programme of work, the group will progress its work as scheduled in the areas of the Better Care Fund, Section 75 agreements and financial reporting.

4.2 The Health and Wellbeing Board is able to propose future agenda items for forthcoming group meetings that 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 and children and young people with special needs and disabilities, is a key ambition of Barnet's Joint Health and Wellbeing 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 Joint Commissioning Executive Group acts as the senior joint commissioning group for integrated health and social care in Barnet. The Groups functions relate to the management of local resources, as outlined in appendix 1.

5.3 Social Value

5.3.1 Not applicable.

5.4 Legal and Constitutional References

5.4.1 The Health and Wellbeing 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.

5.4.2 The Council and NHS partners have the power to enter into integrated arrangements in relation to prescribed functions of the NHS and health-related functions of local authorities for the commissioning, planning and provision of staff, goods or services under Section 75 of the National Health Service Act 2006 and the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (as amended). This legislative framework for partnership working allows for funds to be pooled into a single budget by two or more local authorities and NHS bodies in order to meet local needs and priorities in a more efficient and seamless manner. Funds pooled by the participating bodies into single budget can be utilised flexibly to support the implementation of commissioning strategies and improved service delivery. Arrangements made

pursuant to Section 75 do not affect the liability of NHS bodies and local authorities for the exercise of their respective functions. The Council and CCG now have two overarching section 75 agreements in place.

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

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

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

5.5 **Risk Management**

5.5.1 There is a risk, without aligned financial strategies across health and social care, of financial and service improvements not being realised or costs being shunted across the health and social care boundary. The Financial Planning sub-group has identified this as a key priority risk to mitigate, and the group works to align timescales and leadership of relevant work plans which affect both health and social care.

5.6 **Equalities and Diversity**

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

a) *eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;*

b) *advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;*
c) *foster good relations between persons who share a relevant protected characteristic and persons who do not share it.*

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

5.6.3 The MTFS has been subject to an equality impact assessment considered by Cabinet, as have the specific plans within the Priorities and Spending Review. The QIPP plan has been subject to an equality impact assessment considered.

5.7 **Consultation and Engagement**

5.7.1 The Joint Commissioning Executive Group will factor in engagement with users and stakeholders to shape its decision-making.

5.7.2 The Joint Commissioning Executive Group will also seek assurance from group members that there is adequate and timely consultation and engagement planned with providers as integrated care is implemented.

5.8 **Insight**

5.8.1 N/A

6. BACKGROUND PAPERS

6.1 None.

BARNET LONDON BOROUGH

NHS Barnet Clinical Commissioning Group

Joint Commissioning Executive Group
Terms of Reference

The Joint Commissioning Executive Group (JCEG) will monitor existing joint arrangements between NHS Barnet Clinical Commissioning Group (CCG) and the London Borough of Barnet and make recommendations to the relevant decision making bodies or officers for future joint arrangements. The London Borough of Barnet and NHS Barnet CCG have agreed that the JCEG will have the terms of reference as set out below:

Purpose

To oversee the delivery of Section 75 agreements between NHS Barnet CCG and London Borough of Barnet and refer matters for decision to the Health & Well-being Board and/or relevant NHS Barnet CCG and/or London Borough of Barnet officers.

To develop proposals for integrated health and social care systems and make recommendations to the Health & Wellbeing Board and/or NHS Barnet CCG and London Borough of Barnet as appropriate.

Declaration of Interests

The Chairman will ask at the beginning of each meeting whether any member has an interest about any item on the meeting agenda. If a member has a direct or indirect conflict with an issue on the agenda which may impact on his or her ability to objective, it should be declared at the meeting and recorded in the minutes. On the basis of the interest declared, the Group will make a decision as to whether it is appropriate or not for this member to remain involved in considering the agenda item in question.

Functions

1. To oversee the development and implementation of plans for an improved and integrated health and social care system (including Education where relevant) for children and young people, adults with disabilities, older people, those with long term conditions, and people experiencing mental health problems.

Date Agreed: December 2015
Date of next review: April 2016

2. To oversee the delivery of the Better Care Fund including:

   a) Overseeing the Integrated Care Model by holding the Joint Commissioning Unit and partners to account for its delivery.

   b) The Group is responsible for making recommendations on the governance and legal functions required to develop and implement the Better Care Fund Pooled budget and manage risk.

   c) Monitoring expenditure for budgets for the Better Care Fund and for wider work to integrate care services.

   d) Monitor progress in delivering Better Care Fund services and tracking benefits realisation against these budgets.

   e) Overseeing the financial risk of the Better Care Fund and, where necessary, making recommendations on recovery plans.

3. To oversee all Section 75 agreements held between the London Borough of Barnet and NHS Barnet CCG to ensure that they are operating effectively and to bring them in line with overarching Section 75 agreements. Having oversight of the extension and renewal process for Section 75 agreements and referring matters for decision to the relevant Committee of NHS Barnet CCG and/or London Borough of Barnet which has the appropriate level of delegated authority to take decisions. Receiving performance reports on Better Care Fund, Section 75 agreements and other relevant services/projects. Refer to the contracts which sit underneath each Section 75 agreement and state that the group will receive performance and contract monitoring reports on these contracts. Progress for each agreement will be reported at least 6 monthly to JCEG. Section 75 agreements are:–

   For adults -

   a. Community Equipment;
   b. Prevention / Voluntary Sector;
   c. Learning Disability;
   d. Campus Re-provision; and
   e. Health and social care integration

   The Group will monitor the Mental Health Section 75 agreement (between the Council and Barnet, Enfield and Haringey Mental Health Trust).

   For children –

   a. Speech and Language Therapy;
   b. Looked After Children; and
   c. Occupational Therapy.

4. To review all annual budget, additional budget, budget virement and all new expenditure commitment proposals relating to the Better Care Fund, or to other joint budget arrangements prior to these being taken through the approval processes required under each partner's own scheme of delegation.

5. To approve the work programmes of the Joint Commissioning Units (adults and children).

6. To develop and review the work programme for the Health and Wellbeing Board and make recommendations for amendments or additions.

7. To review reports being considered by the Health and Wellbeing Board which have financial or resource implications.

8. To receive financial reports (Better Care Fund and Section 75 reports).

9. To recommend to the Health and Wellbeing Board, Council Committees and Barnet CCG's Finance Performance and QIPP Committee how budgets should be spent to further integrate health and social care.

10. To ensure appropriate governance arrangements and management of additional budgets delegated to the Health and Wellbeing Board.

11. To agree business cases arising from the Joint Commissioning Units for adults and children's, subject to both the Council and Barnet CCG's governance framework or Scheme of Reservation and Delegation

12. To support the refresh of the Joint Strategic Needs Assessment and oversee the refresh and implementation of the Joint Health and Wellbeing Strategy.

13. To develop and maintain a forward work programme to ensure strategic and operational alignment between the Council and Barnet CCG. All members will contribute to the work programme.

14. Each organisation should ensure that the risks relating to BCF and section 75 agreements are clearly reflected on each organisation's respective Risk Registers and that these risks are reviewed regularly at each meetings and escalated to the Health and Wellbeing Board and the FPQ Committee as required.

Date Agreed: December 2015
Date of next review: April 2016

Membership

Organisation	Post
London Borough of Barnet (LBB)	Commissioning Director for Adults and Health
	Commissioning Director for Children and Young People
	Director of Public Health
	Director of Resources
NHS Barnet Clinical Commissioning Group (CCG)	Director of Integrated Care
	Director of Quality
	Director of Clinical Commissioning
	Chief Finance Officer

Members are able to appoint a substitute to attend in their place if they are unavailable to attend a meeting.

Administration and Secretariat Support

The Council and CCG will provide support to the Board which will include taking and circulating minutes, organising meetings (dates; rooms), circulating papers and supporting agenda setting and developing a work programme. The following roles will support the Board and referring matters for decision to the relevant Council or CCG committee:

- Associate Director of Governance & Corporate Affairs (CCG)
- Commissioning Lead Health and Wellbeing (LBB)

Quoracy

For the Group to be quorate, two members from each organisation (CCG and LBB) need to be present.

Chairmanship

There will be alternate chairing arrangements, shared between the Commissioning Director for Adults and Health (LBB) and the Director of Integrated Care (CCG).

Reporting and Referrals

The minutes of all the JCEG meetings (including an attendance record) shall be formally recorded and submitted to the Health & Wellbeing Board for noting and comment, and to NHS Barnet CCG's Finance, Performance and QIPP Committee for noting.

The JCEG will refer matters for decision to the Health & Wellbeing Board and/or relevant NHS Barnet CCG and/or London Borough of Barnet officers as appropriate.

Frequency and Notice of Meetings

Meetings shall be held at the same frequency as, and at least two weeks before, the Health & Wellbeing Board, unless otherwise agreed.

Items of business to be transacted for inclusion on the agenda of the meeting should be approved via the work programme and agreed with the chair at least 15 working days before the meeting takes place (chairs are able to add items to the agenda as they arise). Any supporting papers should be sent to the members at least 5 working days before the meeting.

The Chair reserves the right to call for an urgent or extraordinary meeting of the Group through a virtual distribution of paper(s) with clear specific instructions to the members.

Review

These terms of reference will be reviewed on an annual basis and the work of this group is subject to both organisation's internal audit work plan and programme to review its effectiveness.

Date Agreed: December 2015
Date of next review: April 2016

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BARNET LONDON BOROUGH

NHS Barnet Clinical Commissioning Group

Minutes from the Health and Well-Being Board – Financial Planning Group
Wednesday 21 October 2015
North London Business Park, Boardroom
11am – 1pm

Present:
(AD) Anisa Darr, Deputy Finance Director, LBB
(CM) Chris Munday, Commissioning Director Children and Young People, LBB
(DW) Dawn Wakeling, Commissioning Director – Adults and Health, LBB
(HMG) Hugh McGarel-Groves, Chief Finance Officer, Barnet CCG
(KH) Kirstie Haines, Adults Wellbeing Strategic Lead, LBB
(MB) Melanie Brooks, Programme Director Health and Social Care Integration, Barnet CCG/LBB
(MOD) Maria O'Dwyer, Director for Integrated Commissioning, Barnet CCG (Chair)

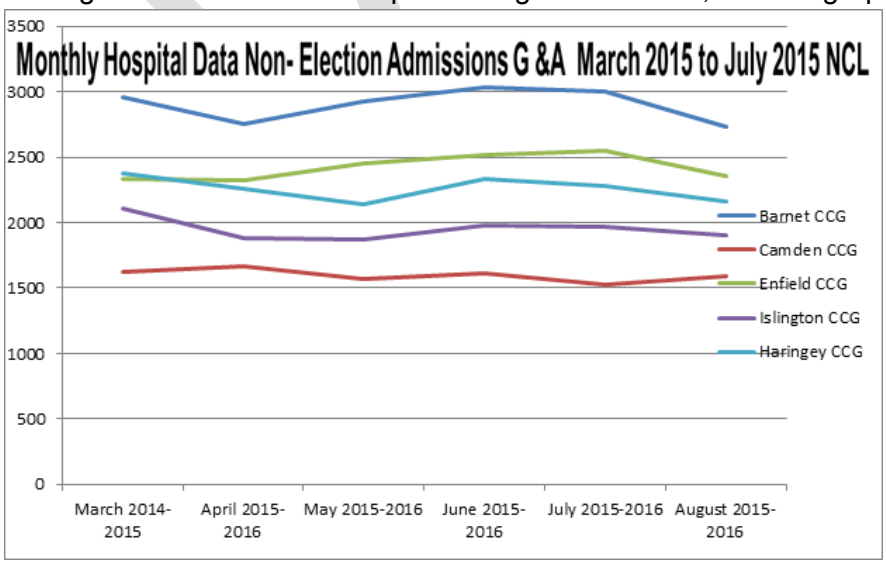
(ZG) Zoë Garbett, Commissioning Lead Health and Wellbeing, LBB (minutes)

Apologies:
(AH) Andrew Howe, Director of Public Health, Barnet and Harrow Public Health Team

	ITEM	ACTION
1.	**Welcome / Apologies** As Chair MOD welcomed the attendees to the meeting. Apologies were received from Andrew Howe.	

2.	**Minutes of the last meeting**
	
	The Group noted that the new ToR are still under development and therefore not agreed. LBB governance and working with BCCG governance to finalise the ToR.
	
	To be circulated with track changes -
	• **ToR (ZG)**
	• **BCF (MB)**
	  ○ **S75**
	  ○ **Deed of Variation**
	  ○ **MOU**
	To ensure that changes from LBB and BCCG have been incorporated.
	
	Corrections were made to the minutes:
	• Transfer of Public Health Commissioning Responsibilities for 0- 19 Healthy Child Programme – decision agreed and minutes to be updated to reflect the recommendation in the paper
	• CAMHS transformation plan – to include the date this went to SCB (13 October)
	
	The minutes will be taken to a future HWBB.
		
		ZG
		
		MB

3.	**Action log** The action log was reviewed and updated.	
4.	**Section 75s Q2:** **4.1 Status report (appendix 1&2)** The Group reviewed an overview document of all the section 75s (appendix 1). This document was considered to be helpful but needs more detail and clearly show which agreements are already schedules to the adults and children's overarching S75 agreements. The Group also reviewed the quarter 2 S75 performance report. This was considered a useful document but needs to include more performance and outcome information. The Group decided the following approaches – • Adults – one overarching S75 with schedules • Children – single agreement, with ability to expand and contract • Legal have agreed to the approach with a new overarching agreement in August 2016 • DW and CM have delegated authority to sign off the updated agreements for the council • CCG authority still to be determined and needs to be aligned with work on CCG schedules of delegation **The Group requested a critical path clearly showing when each agreement ends and the action required to bring each agreement in line with the overarching agreement as schedules. KH and ZG to work with JCU (Rodney D'Costa, Muyi Adekoya, Sue Tomlin, Caroline Glover, Ian Hutchison, Paula Arnell), governance (Andrew Charlwood, Andy Nuckcheddee) and legal to take forward.** The section 75 agreement between LBB and Barnet Enfield and Haringey Mental Health Trust is to be included in the work going forward. **4.2 Q2 Finance report (appendix 3)** The Group noted that underspends are shown as positives (in line with CCG conventions) and that it was a draft document. By the next meeting quarter 2 figures will be cleared internally with respective organisations and discussed at finance group. A working group has looked at what information is required. **HMG (BCCG Finance) and AD (LBB Finance) to bring Q2 figures for discussion to the next meeting**	**KH/ZG** **HMG/AD** **HMG/AD**

	HMG and AD to bring a clear timetable to show when reports are cleared and by who.	
5.	**BCF:** **5.1 Performance report – NEL** The Group noted that the Adult Social Care Delivery Unit quarter 2 performance data was not received yet. The Group heard that hospital admissions had increased and had not achieved the BCF target reduction but that August was similar to last year. DW stated that the report was interesting as the areas of high admissions are not those targeted through our BCF (which targets over 65s with LTCs): 50 - 59 chest pain / heart failure non MI, then 0 – 4s and only then falls in 85+. The Group noted that the BCF metric covers all ages whilst our plans focus on people over 65. The Group also noted that our plans cover the boroughs population not the GP register, unlike the metric. MOD stated that that the cardiology pathway needed to be reviewed and this work was underway (plans going to FPQ 22 October). Admissions for 0 – 4 year olds are being looked at by Children's service leads. **The Group agreed that best practice needs to be implemented in regards to falls including NICE guidance and examples from other boroughs.** Achieving the reduction in NEL targets has also been a challenge for neighbouring boroughs. However Barnet is performing well in terms, see the graph below:  	**MOD/KH**

5.2 Finance report

The Group agreed that implications of performance on the financial position needs to be clear to the HWBB and partners. MOD to feedback from FPQ.

Currently CCG are showing data at a commissioner level and LBB at a provider level (the latter is more detailed). Also need to be clear what is a LBB budget and what is BCF. CCG to include non-BCF budgets as well to give a broader picture. **Agreed that the level of financial information is to be the same for LBB and BCCG.** **HMG/AD**

The Group noted the financial risks and pressures to social care of the national living wage and care law on time taken to travel from home. **HMG/AD/MB**
The Group requested a risk and mitigation schedule.

5.3 BCF allocation 16/17
Following previous discussions at the Finance Group, AD presented a further report, giving an overview of the current position for adult social care noting population, demand and system pressures. AD acknowledged cost pressures across the health and social care system. The paper showed the cost pressures to social care from growth in health referrals:

Referrals	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	% increase since 2009/10
Primary Health	1,635	1,460	1,800	1,585	1,660	1,702	4%
Secondary Health	2,565	2,650	2,780	2,985	3,425	3,814	49%
Other	5,575	5,535	5,170	4,090	4,055	4,548	-18%
Total	9,775	9,645	9,750	8,660	9,140	10,064	3%

The paper set out the financial challenges for adult social care.

MOD stated that the discussion is broader than the BCF. Whilst MOD noted the financial pressures to social care, she noted that there needs to be a broader discussion between the CCG and LBB to resolve this.

HMG described the review (NCL level) that will provide a financial framework by December (NHS England deadline). This will then need to be discussed and worked through.

AD stated that the report set out options for 2016/17, on the 16 December a report will be going to LBB's Policy and Resources committee to give an overview of the budget to 2020 with a focus on 2016/17 and how the budget pressure in Adults will be bridged.

HMG stated that this would need to be looked at to explore the options to resolve

	issues together. HMG described that the CCG are in transition to a point where they may be able to put in new money to the BCF at a future date, however it was too soon in their planning cycle to confirm. It was agreed that a resolution needed to be found and the council would struggle to continue to fund its contribution to integrated care without more funding from the BCF. **MOD agreed to set up a specific discussion including finance leads from LBB/CCG, GS, DW and KK.** The discussions are to include childrens services as well as adults. DW left the meeting.	**MOD**
6.	**Review of joint priorities** The Group reviewed the joint priorities which were agreed in March 2015. The group noted that there are a number of areas which should be reflected in this document such as childrens safeguarding. The document also needs to include timelines. **ZG to update and review with Debbie Frost and Councillor Hart.**	**ZG**
7.	**Joint Health and Wellbeing Strategy delivery plan** The JHWB Strategy is out to public consultation until 25 October. The final strategy will be presented to the HWBB on 12 November 2015. The Group reviewed the JHWB Strategy delivery plan (first draft) and made amendments. **ZG to develop delivery plan with all JHWB Strategy actions and other critical activity.**	**ZG**
8.	**HWBB work programme** The Group are to send comments to ZG.	
9.	**Finance Group Work Programme** ZG to update in light of discussions at this meeting and the joint priorities.	
10.	**AOB** None	

Next meeting – Tuesday 15th December 1pm – 3pm (F13, Building 2, NLBP)

BARNET LONDON BOROUGH

NHS Barnet Clinical Commissioning Group

Minutes from the Health and Well-Being Board – Financial Planning Group
Tuesday 15 December
North London Business Park, F13
1pm – 3pm

Present:
(AC) Andrew Charlwood, Head of Governance, LBB
(AD) Anisa Darr, Resources Director, LBB
(AH) Andrew Howe, Director of Public Health, Barnet and Harrow Public Health Team
(AN) Andy Nuckcheddee, Interim Associate Director of Governance & Corporate Affairs, BCCG
(BR) William (Bill) Redlin, Director of Operations and Delivery, Barnet CCG
(CM) Chris Munday, Commissioning Director Children and Young People, LBB
(DW) Dawn Wakeling, Commissioning Director Adults and Health, LBB (Joint Chair)
(LJ) Liz James, Interim Joint Chief Operating Officer/Director of Clinical Commissioning, BCCG
(MB) Melanie Brooks, Programme Director Health and Social Care Integration, BCCG/LBB
(PL) Peter Large, Deputy Monitoring Officer, LBB
(RH) Roger Hammond, Deputy Chief Finance Officer, BCCG
(ZG) Zoë Garbett, Commissioning Lead Health and Wellbeing, LBB (minutes)

Apologies:
(HMG) Hugh McGarel-Groves, Chief Finance Officer, BCCG
(MOD) Maria O'Dwyer, Director for Integrated Commissioning, BCCG (Joint Chair)

	ITEM	ACTION
1.	**Welcome / Apologies** As Chair DW welcomed the attendees to the meeting. Apologies were received from MOD and HMG. LJ, BR and RH represented Barnet CCG. AN, AC and PL attended for item 4.	
2.	**Minutes of the last meeting** Action from last meeting – • BCF Risk Register - To be drawn from LBB and CCG corporate risk register and presented as a standing item at each meeting. Minutes agreed as accurate.	
3.	**Action log** The action log was updated.	

4.	**JCEG Terms of Reference (ToR)** DW explained that, over the last few months, the Finance Group, with support from LBB governance (AC and PL) and CCG Governance (AN) had been reviewing its Terms of Reference. The Finance Group was asked to sign off the ToR and report these to the Health and Wellbeing Board with the Group's minutes in January 2016. The Group resolved: • To have equal membership (four members from the CCG and four from LBB) • For the Group to be quorate there needs to be two members from each organisation present at the meeting • LBB and the CCG will provide Board Support from the Associate Director of Governance & Corporate Affairs (CCG) and Commissioning Lead Health and Wellbeing (LBB). Both roles will not be formal members of the Group • That the HWBB Finance Group minutes report will go to the CCG's FPQ meetings. The CCG will coordinate this • That a forward work plan will be maintained and reviewed at each meeting but the co-chairs have the discretion to add items to the agenda as they arise. **AN and ZG to review and populate work programme.** • To review the ToR in April 2016 (and then annually) **The ToR to be updated as above.** The Group formally adopted the updated ToR. The Group would be titled the Joint Commissioning Executive Group in future. PL and AC left the meeting	**AN/ZG** **AC/ZG**
5.	**BCF Planning 16/17** Due to new members attending the Group, AD updated the group on discussions to date of the BCF and LBB budget setting. AD explained that at the last meeting of the Finance Group, HMG had stated that the CCG may be in a position to invest in priorities as appropriate which could address the challenges outlined at previous meetings. AD went on to explain that LBB were expecting their financial settlement on the 17 December 2015 and would like to engage with the CCG to conclude the discussion that had taken place at the previous meeting concerning increasing the protection of the social care element of the BCF by £2.4m. RH agreed that starting conversations prior to the CCG settlement was reasonable and explained that the first version of the CCG's finances and activity plan would be submitted in mid-February. Following negotiations with providers, the CCG will be in a position to explore other priorities (one of which will be BCF). DW asked if the CCG would know their position with regards to BCF by the end of January, to be able to inform the budget paper going to LBB's Policy and	

	Resources (P&R) Committee on 16 February. RH said that this was too soon to know the final financial settlement but principles can be included in the paper. It was agreed that two meetings would take place in January to discuss the matters with the aim of reaching an agreed position on the BCF for 16/17 including the protection of adult social care. **LBB and CCG agreed to inform each other of what additional information is required to inform these discussions.** **LJ, BW, RH, DW and AD to meet twice in January to discuss BCF 16/17. ZG to arrange.**	**RH/AD** **ZG**
6.	**JHWB Strategy Implementation Plan** ZG introduced the item. Following the agreement by the HWBB of the final Joint Health and Wellbeing Strategy (2015 – 2020) in November 2015, a working group had met to explore enablers to delivering the strategy as well as identifying leads and timescales for the agreed actions. Further meetings are being held with the CCG to ensure that the actions included are appropriate. The group made the following comments – • NHS England lead to be specified • Clearer links to be made back to JHWB Strategy / our vision • Needs to link to targets • Clearer start and end dates • Presentation to be amended, with actions presented by year as well as theme • SMART actions for all areas **ZG to update the plan ahead of review by the HWBB (21 January 2016).**	**ZG**
7.	**Primary Care** LJ updated the group with the CCG's progress in co-commissioning primary care. The CCG anticipates moving to greater delegation soon. LJ confirmed that budget and quality control remains with NHS England. LJ explained that the CCG are reviewing PMS practices to ensure that outcomes are being delivered for the funding these practices are receiving, discussions will take place in February / March with new contracts in place from 1 July 2016. A programme is currently underway to improve access over the winter, increasing opening hours on Friday / Monday evening and weekends. All residents are able to access these practices (rather than just the practice they are registered with). The programme is operating through one contract with the network. AH asked about the ambition and long term plan for primary care in Barnet given the changing context (e.g. devolution). LJ welcomed the question and is keen to develop our local model of primary care for the future. A primary care strategy will	

	be bought to the HWBB in January. DW asked if Health, Overview and Scrutiny Committee (HOSC) would be sighted on the discussions, as the Committee is interested in access to primary care. LJ expected that they would be and stressed the importance of communication on primary care availability (e.g. the improved access over winter programme) to residents. DW asked about improving the links with primary care as part of our Better Care Fund, such as use of risk stratification, hospital discharge and anticipatory care for high risk individuals. CM stressed the importance of there being a Children and Young People (CYP) section in the primary care strategy, which will include feedback from Barnet's Youth Convention (such as the importance for CYP to be able to get appointments outside of school hours).	
8.	**Adult Health and Social Care Section 75s including Section 75 finance report** DW gave an overview of the report which describes the intention to agree an overarching S75 agreement with schedules, for adults and childrens, for S75s between LBB and BCCG. ZG explained that MOD had been involved in previous discussion at the Finance Group as well as in separate meetings outside of the Group. **ZG to send LJ previous minutes of the Finance Group that include discussions on S75s.** LJ agreed the proposal in principle but it was agreed that LJ and colleagues would engage with CCG colleagues before giving a final decision, having not been directly involved before. LJ also outlined that the CCG needed to obtain a legal opinion on the proposal before giving a final decision. The CCG would not be able to confirm finances by the 31 January 2016 (as detailed in the paper). The paper asked – (i) Provide comments and amendments to the proposed approach to administering our integrated commissioning and service delivery arrangements under one high level s75 agreement. (ii) To agree to the use of deeds of variation to change historical s75 agreements into schedules of the open ended high level s75 agreement. (iii) To agree to recommend to the LBB HWWB that a new open ended s75 agreement be established between LBB Adult Social Care and BCCG. This agreement will replace the current overarching s75 agreement between LB B Adult Social Care and Barnet CCG (subject to legal advice) (iv) To provide advice and guidance on the appropriate governance routes to secure the legal agreements required to make these changes in each of the partner organisations. (v) To agree changes in the monitoring and review of s75 agreements and schedules as detailed in the report. **The CCG to seek advice on the s75 paper and confirm their agreement.**	**ZG** **LJ/RH**

	DW to send LJ and BR S75 Audit Report. <u>S75 Finance</u> The group reviewed the section 75 finances up to month 7 and would like to see more narrative linked to outcomes.	**DW**
9.	**BCF - Q2 Performance report (to NHSE 27 November) , Finance Report** DW explained that the report had been submitted to NHS England on the 27 November 2015. The non-elective admissions data shows increased admissions for: • Admissions in the 50-59 age group with particular emphasis on chest pain • Admissions in the over 85 age group linked to falls and fractures from falls • The 0-4 age group for viral infections which will inform the paediatric urgent care work currently being scoped. A performance report will be taken to a future HWBB to explain our current NEL performance; the report will focus on falls as well as the audits and work in the other areas. Quarter 3 data and finance will come to the next meeting of the Group.	
10.	**HWWB – Forward Plan** The group reviewed the forward work plan for the HWBB and heard that there will be work over the next few weeks to move the work plan to drive forward the JHWB Strategy 2015 – 2020.	
11.	**Finance Group / JCEG –n Forward work programme** Items to be added to the February agenda – • Public health commissioning intentions • CYP Plan • Corporate Parenting Pledge Health visiting to be added to a future agenda.	
12.	**AOB** <u>Towards a sustainable health and social care economy</u> DW updated the group about a piece of work that has started to review which aims to explore areas of opportunity around how to shape and influence a new type of health and social care offer that reflects our local aspirations for wellbeing, independence, and economic growth.	**ZG**

	ZG to circulate review overview. <u>BCF 15 / 16 Schedule and Deed of Variation</u> DW explained that the Deed of Variation documents are ready to be signed by both organisations. DW has the authority to sign this off on behalf of the Council. The documents have been sent to the CCG Audit Chair and it was agreed at the last CCG Governing Body that the CCG would secure sign off under Chairs action (Audit Committee Chair) before Christmas. **LJ to confirm by 17 December when the CCG will be able to sign the documents before 24 December 2015.**	**LJ**
Next meeting – Wednesday 17 February 17 2016, 1pm – 3pm (Boardroom, NLBP)		

AGENDA ITEM 14

	Health and Wellbeing Board **21 January 2016**
Title	**Forward Work Programme**
Report of	Commissioning Director Adults and Health
Wards	All
Date added to Forward Plan	January 2014
Status	Public
Urgent	No
Key	No
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
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Summary

This report introduces the forward work programme for the Health and Wellbeing 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 Wellbeing Board
- The work programmes of other Strategic Boards in the Borough, thematic Committees and Health Overview and Scrutiny Committee
- 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 Wellbeing 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 Wellbeing Board Members continues to propose 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 Wellbeing Board continues to align its work programme with the work programmes of the 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 Wellbeing 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 Wellbeing 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 seven month period until the end of July 2016.

1.3 The forward work programme attached to this report at Appendix 1 supersedes the previous work programme presented to the Board on 12 November 2015 and suggests a refreshed schedule of reports and items for the following nine months, reflecting the Board's statutory requirements, responsibilities as the Commissioning Committee for public health and agreed priorities set out in the Joint Health and Wellbeing Strategy (2015 – 2020). The work programme will be regularly reviewed and updated.

1.4 Future agendas will be split into two sections. The first section will be decision and discussion items which will explore topical issues; this section will include external speakers (including residents) to speak at the Board to agree joint action. In the second section, the Board will consider and note papers.

1.5 The Health and Wellbeing Board must ensure that its forward work programme is compatible with the forward work programmes of the 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 Governing Body, to ensure that these work programmes are discussed within the correct forums, with information shared across other Board's as appropriate. Items of interest from other committee are also included so that the Board are sighted on relevant items. Updated forward work programmes (September 2015 – May 2016) for each of these Boards

are attached at Appendix 2 to support the Board in planning 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 Wellbeing Board, and should be reflected in the Board's forward plan. These work programmes include, but are not limited to, Adult Social Care Alternative Delivery Model (ADM) project, Early Years ADM and work across North Central London.

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 Wellbeing Board needs a robust forward work programme to ensure it can deliver on the key objectives of the Joint Health and Wellbeing Strategy, including the annual priorities within the Strategy that were agreed at the November 2015 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 Barnet 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 Wellbeing Board will be managed within existing budgets.

5.3 Legal and Constitutional References

5.3.1 Health and Wellbeing 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 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 **Social Value**
5.4.1 N/A

5.5 **Risk Management**
5.5.1 A forward work programme reduces the risks that the Health and Wellbeing 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.

5.6 **Equalities and Diversity**

5.6.1 All items of business listed in the forward programme and presented at the Health and Wellbeing 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 Wellbeing 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.

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

5.6.3 This is essential when addressing 5.3.2. (6) above regarding health inequalities.

5.7 **Consultation and Engagement**

5.7.1 The forward work programme will be set by the Members of the Health and Wellbeing Board but the Health Overview and Scrutiny Committee also has the opportunity to refer matters to the Board.

5.7.2 The bi-annual 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.

5.8 **Insight**

5.8.1 N/A

6. BACKGROUND PAPERS

6.1 None.

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Health and Well-Being Board Work Programme

March 2016 – November 2016

Contact: Zoë Garbett
Commissioning Lead – Health and Wellbeing (LBB)
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Subject	Decision requested	Report Of	Contributing Officer(s)	Key decision*
10 March 2016				
DISCUSSION				
Tackling the Growing Problem of Shisha	**The Board is to discuss the growing problem of shisha and agree appropriate action.**	Director of Public Health	**Consultant in Public Health**	Yes
Public Health Commissioning Plan 2015 – 2020	**The Board is asked to approve the revised PH commissioning intentions (2015-2020) in light of changes to the public health grant. This report will include how PH will contribute to the JHWB Strategy priority to improve mental health and wellbeing.**	Director of Public Health	**Consultant in Public Health**	Yes
NCL Sustainability and Transformation Plan	**The Board is asked to comment on Barnet's roles and contribution to the developments across North Central London (NCL).**	CCG Chief Operating Officer	**TBC**	No
Better Care Fund 2016/17	**The Board is asked to agree the Better Care Fund plans for 2016/17**	Commissioning Director Adults and Health CCG Chief Operating Officer	**Director of Integrated Commissioning**	Yes
NOTE				
Falls	**The Board is asked to review the borough's approach to reducing non-elective hospital admissions due to falls.**	Commissioning Director Adults and Health CCG Chief Operating Officer	**Director of Integrated Commissioning** **Joint Commissioning Manager**	No

***A key decision is one which**: Will result in the Council incurring expenditure which is, or the making of savings which are, significant having regard to the Council's budget for the service or function to which the decision relates; or is significant in terms of its effects on communities living or working in an area comprising two or more wards.*

Subject	Decision requested	Report Of	Contributing Officer(s)	Key decision*
JHWB Strategy Implementation Plan	**The Board to note the progress made to implement the Joint Health and Wellbeing Strategy 2015 – 2020.**	Commissioning Director – Adults and Health	**Commissioning Lead – Health and Wellbeing**	Yes
Opportunities to align the health outcomes and planning – progress report	**The Board is asked to consider and discuss 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**	No
Update on Substance Misuse services for Adult and Young People	**The Board is asked to note the progress made to deliver substance misuse services.**	Director of Public Health	**Head of Public Health Commissioning**	No
Services for people with learning disabilities including Winterbourne View – Assuring Transformation	**The Board is asked to note the contents of the paper, the progress made with regards to the Winterbourne View Concordat and the current position**	Commissioning Director – Adults and Health	**Joint Commissioning Manager**	No
Minutes of the Health and Wellbeing Board Working Groups (where available): • Joint Commissioning Executive Group • Health and Social Care Integration Programme Board	**The Board is asked to approve the minutes of the Health and Well-Being financial planning group and Health and Social Care Integration Programme Board**	Commissioning Director – Adults and Health CCG Chief Operating Officer	**Commissioning Lead – Health and Wellbeing**	No

***A key decision is one which**: Will result in the Council incurring expenditure which is, or the making of savings which are, significant having regard to the Council's budget for the service or function to which the decision relates; or is significant in terms of its effects on communities living or working in an area comprising two or more wards.*

Subject	Decision requested	Report Of	Contributing Officer(s)	Key decision*
Forward Work Programme	**The Board is asked to review and update the Forward Work Programme**	Commissioning Director – Adults and Health	**Commissioning Lead – Health and Wellbeing**	No
May (TBC)				
DISCUSSION				
Family Friendly Barnet	**The Board is asked to approve the action plan underpinning the new Children and Young People's Plan 2016-2020**	Commissioning Director – Children and Young People	**Commissioning Strategy and Policy Advisor – Children and Young People**	Yes
Report of the work of the Barnet ,Enfield and Haringey (BEH) Mental Health Strategic Partnership Board	**The Board is asked to consider Barnet's role and contribution in delivering the work programme for the sustainability of the mental health trust following the Carnall Farrar report.**	CCG Chief Operating Officer	**TBC**	No
NCL Sustainability and Transformation Plan (final)	**The Board are asked to endorse the final plan.**	CCG Chief Operating Officer	**TBC**	No
Primary Care Strategy	**The Board is asked to note the Primary Care Strategy**	CCG Chief Operating Officer	**Director of Operations and Delivery**	No
NOTE				
Health checks	**The Board is asked to note the progress in delivering the local Health Checks programme**	Director of Public Health	**Consultant in Public Health**	No

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Subject	Decision requested	Report Of	Contributing Officer(s)	Key decision*
JHWB Strategy Implementation Plan	**The Board to note the progress made to implement the Joint Health and Wellbeing Strategy 2015 – 2020.**	Commissioning Director – Adults and Health	**Commissioning Lead – Health and Wellbeing**	Yes
Healthwatch update report	**The Board is asked to comment on the progress made by Healthwatch Barnet**	Healthwatch Barnet	**Head of Healthwatch**	No
Minutes of the Health and Wellbeing Board Working Groups (where available): • Joint Commissioning Executive Group • Health and Social Care Integration Programme Board • Engagement Board	**The Board is asked to approve the minutes of the Health and Well-Being financial planning group and Health and Social Care Integration Programme Board**	Commissioning Director – Adults and Health CCG Chief Operating Officer	**Commissioning Lead – Health and Wellbeing**	No
Forward Work Programme	**The Board is asked to review and update the Forward Work Programme**	Commissioning Director – Adults and Health	**Commissioning Lead – Health and Wellbeing**	No
July 2016 (TBC)				
DISCUSSION				
Mental Health services – CAMHS, Reimagining Mental Health and Mental Health Social Work	**The Board is asked to consider and discuss the progress made to improve mental health and wellbeing for all.**	Commissioning Director – Adults and Health CCG Chief Operating Officer	**Joint Commissioning Manager**	No

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Subject	Decision requested	Report Of	Contributing Officer(s)	Key decision*
Devolution – estates	**The Board is asked to comment on Barnet's roles and contribution to the developments across North Central London (NCL).**	Commissioning Director – Adults and Health CCG Chief Operating Officer	**TBC**	No
NOTE				
JHWB Strategy Implementation Plan	**The Board to note the progress made to implement the Joint Health and Wellbeing Strategy 2015 – 2020.**	Commissioning Director – Adults and Health	**Commissioning Lead – Health and Wellbeing**	Yes
Public Health report on activity 2015/16	**The Board is asked to comment on the progress Public Health made in 2015/16**	Director of Public Health	**Consultant in Public Health**	No
Progress report: NCL working	**The Board is asked to comment on Barnet's roles and contribution to the developments across North Central London (NCL).**	CCG Chief Operating Officer Commissioning Director – Adults and Health	**TBC**	No
Minutes of the Health and Wellbeing Board Working Groups (where available): • Joint Commissioning Executive Group • Health and Social Care Integration Programme Board • Engagement Board	**The Board is asked to approve the minutes of the Health and Well-Being financial planning group and Health and Social Care Integration Programme Board**	Commissioning Director – Adults and Health CCG Chief Operating Officer	**Commissioning Lead – Health and Wellbeing**	No

***A key decision is one which**: Will result in the Council incurring expenditure which is, or the making of savings which are, significant having regard to the Council's budget for the service or function to which the decision relates; or is significant in terms of its effects on communities living or working in an area comprising two or more wards.*

Subject	Decision requested	Report Of	Contributing Officer(s)	Key decision*
Forward Work Programme	**The Board is asked to review and update the Forward Work Programme**	Commissioning Director – Adults and Health	**Commissioning Lead – Health and Wellbeing**	No
September 2016 (TBC)				
DISCUSSION				
Primary care co-commissioning	**The Board is asked to review and comment on the CCG progress to co-commission primary care.**	CCG Chief Operating Officer	**Director of Primary Care**	No
Immunisations update	**The Board is asked to review and comment on the progress made to improve immunisation uptake in the borough.**	Director of Public Health	**Consultant in Public Health** **NHS England: London Regional Lead**	No
Screening update	**The Board is asked to review and comment on the progress made to improve screening uptake in the borough.**	Director of Public Health	**Consultant in Public Health** **NHS England: London Regional Lead**	No
NOTE				
JHWB Strategy Implementation Plan	**The Board to note the progress made to implement the Joint Health and Wellbeing Strategy 2015 – 2020.**	Commissioning Director – Adults and Health	**Commissioning Lead – Health and Wellbeing**	Yes
Progress report: NCL working	**The Board is asked to comment on Barnet's roles and contribution to the developments across North Central London (NCL).**	CCG Chief Operating Officer Commissioning Director – Adults and Health	**TBC**	No

***A key decision is one which**: Will result in the Council incurring expenditure which is, or the making of savings which are, significant having regard to the Council's budget for the service or function to which the decision relates; or is significant in terms of its effects on communities living or working in an area comprising two or more wards.*

Subject	Decision requested	Report Of	Contributing Officer(s)	Key decision*
Minutes of the Health and Wellbeing Board Working Groups (where available): • Joint Commissioning Executive Group • Health and Social Care Integration Programme Board • Engagement Board	**The Board is asked to approve the minutes of the Health and Well-Being financial planning group and Health and Social Care Integration Programme Board**	Commissioning Director – Adults and Health CCG Chief Operating Officer	**Commissioning Lead – Health and Wellbeing**	No
Forward Work Programme	**The Board is asked to review and update the Forward Work Programme**	Commissioning Director – Adults and Health	**Commissioning Lead – Health and Wellbeing**	No
November 2016 (TBC)				
DISCUSSION				
Employment and healthy workplaces	**The Board is asked to consider and discuss initiatives supporting people to gain and retain employment.**	Commissioning Director – Adults and Health Commissioning Director – Children and Young People	**TBC**	No
Joint Health and Wellbeing Strategy Implementation plan – performance report	**The Board is asked to consider the progress made to deliver the Joint Health and Wellbeing Strategy.**	Commissioning Director – Adults and Health Commissioning Director – Children and Young People Director of Public Health CCG Chief Operating Officer	**Commissioning Lead – Health and Wellbeing**	Yes
NOTE				

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Subject	Decision requested	Report Of	Contributing Officer(s)	Key decision*
Progress report: NCL working	**The Board is asked to comment on Barnet's roles and contribution to the developments across North Central London (NCL).**	CCG Chief Operating Officer Commissioning Director – Adults and Health	**TBC**	No
Minutes of the Health and Wellbeing Board Working Groups (where available): • Joint Commissioning Executive Group • Health and Social Care Integration Programme Board • Engagement Board	**The Board is asked to approve the minutes of the Health and Well-Being financial planning group and Health and Social Care Integration Programme Board**	Commissioning Director – Adults and Health CCG Chief Operating Officer	**Commissioning Lead – Health and Wellbeing**	No
Forward Work Programme	**The Board is asked to review and update the Forward Work Programme**	Commissioning Director – Adults and Health	**Commissioning Lead – Health and Wellbeing**	No
Unallocated				
Fit and Active Barnet - including leisure services and green spaces	**The Board is asked to consider and discuss the progress made to encourage healthier lifestyles.**	Commissioning Director – Adults and Health	**Strategic Lead – Sports and Physical Activity**	No
Better Care Fund – Non elective hospital admissions	**The Board is asked to consider and comment on the progress made to reduce non-elective hospital admissions.**	Commissioning Director – Adults and Health CCG Chief Operating Officer	**Joint Commissioning Manager** **Director of Integrated Commissioning**	Yes

***A key decision is one which**: Will result in the Council incurring expenditure which is, or the making of savings which are, significant having regard to the Council's budget for the service or function to which the decision relates; or is significant in terms of its effects on communities living or working in an area comprising two or more wards.*

Subject	Decision requested	Report Of	Contributing Officer(s)	Key decision*
Health visiting and integration of health services	**The Board is asked to comment on the progress made in developing the Boroughs health visiting and integration of health services.**	Commissioning Director – Children and Young People	**Head of Joint Children's Commissioning**	No
Children's Continuing Care	**The Board is asked to comment on the progress to develop the model for children's continuing care.**	Commissioning Director – Children and Young People	**TBC**	No
Corporate Parenting	**The Board is asked to comment on the progress made to develop the borough's offer to children looked after.**	Commissioning Director – Children and Young People	**TBC**	No
Implementing Barnet's Carers' Strategy	**The Board is asked to comment on the progress made to implement the Carer's Strategy.**	Commissioning Director – Adults and Health Commissioning Director – Children and Young People	**Carer's Lead**	No

***A key decision is one which**: Will result in the Council incurring expenditure which is, or the making of savings which are, significant having regard to the Council's budget for the service or function to which the decision relates; or is significant in terms of its effects on communities living or working in an area comprising two or more wards.*

Appendix 2 - Forward Work Programmes of Strategic Boards (January 2016 - May 2016)

Calendar month	Strategic Board	Agenda Item	Nature of item (if known)
January			
06 January 2016	Children, Education, Libraries & Safeguarding Committee	Schools Finance	Committee to receive a report on school finance
		Future Delivery of SEND Provision	Committee to receive a paper on the future provision of SEND
		Response to the Annual Safeguaridng Report	
11 January 2016	Environment Committee	Parks & Open Spaces Strategy: Draft for consultation	To approve the draft strategy for stakeholder consultation
28 January 2016	CCG Governing Body	TBC	
February			
8 February 2016	Health Overview & Scrutiny Committee	Update Report: Cricklewood GP Health Centre	At their meeting 6 July 2015, the Committee received a report from Barnet Clinical Commissioning Group which outlined options for the continuation of services at Cricklewood GP Health Centre - update report
		Annual Report of the Director of Public Health	Committee to receive the annual report from the Director of Public Health
		Dentistry in Barnet	
March			
3 March 2016	Children, Education, Libraries & Safeguarding Committee	Commissioning Plan	
7 March 2016	Adults and Safeguarding Committee	Implementing the Care Act: Adult Social Care and Support Contributions Policy	Committee to receive a report on implementing the Care Act: Adult Social Care and Support Contributions Policy
		Independent Living Fund Transfer	Committee to consider a briefing on the management of the Independent Living Fund transfer and outcome of care reviews
9 March 2016	Community Leadership Committee	Review of dedicated Place Order for Street Drinking	To note the legal changes as a result of the ASB 2014 Act. To consider if the Dedicated Place Order for Street Drinking Continues or the new Public Space Protection Order under the 2014 ASB Act (PSPO) is used.
14 March 2016	Assets, Regeneration and Growth Committee	Regeneration Strategy	To approve an updated regeneration strategy for consultation.
		Development pipeline Programme Tranche 2	To receive business cases for the following projects, and authorise next steps. 1. Older People's Housing (Full Business Case) 2. Private Rented Sector development on Council Land (Full Business Case)
31 March 2016	CCG Governing Body	TBC	
May			
11 May 2016	Housing Committee	Review of the " One Offer Only" policy in the Housing Association Scheme	
		Review of the Landlords Incentive Scheme	
		NHS Trust Quality Accounts	Committee to consider and comment upon the Quailty Accounts of NHS Trusts for the year 2015/16.

16 May 2016	Health Overview and Scrutiny Committee	Finchley Memorial Hospital - Update Report	
		North West London, Barnet & Brent Wheelchairs Service Redesign	
18 May 2016	Children, Education, Libraries & Safeguarding Committee	Committee to receive various papers relating to Young People Focus	
26 May 2013	CCG Governing Body	TBC	
Unallocated item			
Unallocated item	Health Overview and Scrutiny Committee	Dehydration in Patients Admitted to Hospitals from Care Homes	
Unallocated item	Children, Education, Libraries & Safeguarding Committee	Noam Conversion to Voluntary Aided Sector	
		Annual Report of Educational Standards	