MEETING

HEALTH & WELLBEING BOARD

DATE AND TIME

THURSDAY 12TH MAY, 2016

AT 9.00 AM

VENUE

HENDON TOWN HALL, THE BURROUGHS, NW4 4BG

TO: MEMBERS OF HEALTH & WELLBEING BOARD (Quorum 3)

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

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

Substitute Members

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

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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Decisions of the Health & Wellbeing Board

10 March 2016

Board Members:-

AGENDA ITEM 1

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

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

Substitute(s) present:

*Councillor David Longstaff

* denotes Member Present

Dr Laura Fabunmi (To present Public Health reports)

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

The Chairman of the Health and Wellbeing Board, Councillor Helena Hart welcomed all attendees to the meeting and noted that the actions outstanding from the previous Minutes have been taken forward, many of which were covered in the agenda for this meeting.

RESOLVED that the Minutes of the previous Meeting of the Health and Wellbeing Board held on 21st January 2016 be agreed as a correct record.

2. ABSENCE OF MEMBERS (Agenda Item 2):

Apologies for absence were received from:

- Councillor Sachin Rajput who was substituted by Councillor David Longstaff
- Dr Andrew Howe – Dr Laura Fabunmi was in attendance to present papers (HB Public Law)
- Dr Charlotte Benjamin (Barnet CCG)
- John Atherton (NHS England)

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

Dr Debbie Frost, (Chairman Barnet Clinical Commissioning Group) on behalf of CCG Board Members declared a non-pecuniary interest in relation to Agenda Item 6 (Public Health & Wellbeing Commissioning Plan 2015 – 2020: 2016-17 addendum & targets) and Agenda Item 9 (Joint Health and Wellbeing Strategy Implementation plan 2015 – 2020 progress update) by virtue of being GPs and CCG Board Members – this was noted in light of CCG's responsibilities towards co-commissioning services in primary care and the recent coverage in the press.

Dr Frost also informed the Board that in the interest of transparency and managing conflicts of interest, training and information will continue to be provided internally by Barnet CCG. Elizabeth James, Barnet CCG (Interim) Joint Chief Operating Officer & Director of Clinical Commissioning noted that GPs are not involved with financial aspects of co-commissioning services in primary care.

There were no other interests declared.

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. PUBLIC HEALTH & WELLBEING COMMISSIONING PLAN 2015 - 2020: 2016-17 ADDENDUM & TARGETS (Agenda Item 6):

The Chairman welcomed the report which sets out the updated Public Health Commissioning Plan targets and detailed Delivery Plan for 2016/17. She stated that the Board had approved the Public Health Commissioning Plan 2015-2020 in March 2015 and that the Board in common with the other Theme Committees was asked to review the targets for the year ahead.

Dr Laura Fabunmi (HB Public Health) presented the paper and noted the priorities for the 2016/17 period:

- Investing in demand management to put all statutory services on a secure footing for the future
- Ensuring that additional investment in non-statutory but priority services are targeted to achieve the best possible health outcome
- Influencing the priorities of internal and external delivery partners to improve the health of Barnet residents
- Helping residents to engage with their own health and wellbeing

Following a query from the Board about the targets set for sexual health services and obesity for 2016/17 and beyond, Dr Fabunmi stated that targets are flat-lined because it has been difficult to provide a trajectory without an established baseline.

In relation to excess weight and obesity it was noted that this issue will be tackled through a multi-model approach and benchmarks can be set and reviewed at a later stage against the achievements delivered.

The Commissioning Director for Children and Young People requested that clarification is provided in respect of the Smoking Prevalence indicator at p24. (**Action**)

In response to a request to expand on the number of indicators for children and young people from the Board, Dr Fabunmi noted that Public Health would review the indicators to cover issues facing children and young people. (**Action**)

Councillor Reuben Thompstone, Chairman of the Children, Education, Libraries and

Safeguarding Committee welcomed the report and the need to invest in demand management towards services such as Health Checks and National Child Measurement Programme.

It was also noted that the review of the Commissioning Plan targets will continue through the Performance and Contract Management Committee and that progress will be monitored against the Council's Corporate Plan, including the performance of both internal and external Delivery Units.

Councillor David Longstaff, Chairman of the Community Leadership Committee requested that a change be made to the wording of the appendix at p23, under the first bullet point, 'Healthy and Sustainable places and communities', to reflect the relevance to all Barnet residents and to read:

The Council is investing £30 million in redeveloping two leisure centres at New Barnet and Copthall, and implementing our Sport and Physical Activity strategy, to ensure that all Barnet residents have access to high quality health and fitness facilities~~, particularly in areas where the local population is projected to grow~~
(**Action**)

RESOLVED:

That the Health and Wellbeing Board reviewed and approved with comments as set out above, the addendum to the Public Health & Wellbeing Commissioning Plan for 2016/17 (Appendix A).

7. THE GROWING ISSUE OF SHISHA SMOKING IN BARNET (Agenda Item 7):

The Chairman welcomed this Report which followed a referral to the Health & Wellbeing Board of her Motion to Full Council on 8th December 2015 and a request from the Board at its last meeting in January for a substantive item for discussion on the Growing Issue of Shisha Smoking in Barnet. She noted that the Report had been informed by local intelligence, research and best practice in other areas to suggest a plan of action to tackle the issue.

Upon invitation from the Chairman, James Gould (Senior Planning Enforcement Officer) Emma Phasey (Group Manager, Development and Regulatory Services) and James Armitage (Service Director, Development and Regulatory Service) joined the meeting for this item.

Dr Laura Fabunmi (Public Health) introduced the report and briefed the Board about the health effects of shisha smoking and noted the evidence which shows that there has been a significant increase in shisha uptake, particularly among young people and university students.

The Board noted that research had shown that enforcement actions towards shisha has been limited and that therefore a multi-pronged partnership approach is required to address the compliance and enforceability issues more effectively. Councillor Reuben Thompstone welcomed the report and noted the need for an effective education campaign.

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In relation to the misconceptions about the health effects of shisha smoking in comparison to cigarette smoking, Dr Fabunmi also highlighted the importance of the health promotion and education campaign.

She also noted the aims of the campaign, particularly to raise awareness of the negative health impacts of shisha among users and young people. To ensure that a wide audience is reached, Elizabeth James, Barnet CCG (Interim) Joint Chief Operating Officer & Director of Clinical Commissioning expressed interest in linking with Public Health to discuss inclusion of further clients groups and patients. (**Action**)

Mr Armitage briefed the Board about the current enforcement issues that regulatory services are faced with when prosecutions are brought under the Health Act 2006. He noted that prosecutions for non-compliance by virtue of the Health Act 2006 are costly and time consuming and that the penalties imposed by courts are usually of a small-scale.

Ms Phasey elaborated on the points raised and informed the Board that warnings issued by Regulatory Services are often only implemented over a long period of time and that this also adds to the delay towards enforcement.

A suggestion was put forward by Mr Armitage that subject to review and approval by the local authority, the possibility of issuing fixed penalty notices could be considered.

Subject to the Board's approval of the recommendations, Dr Fabunmi noted that a Task and Finish Group will be established, which will aim to coordinate visits with partners including HMRC and share intelligence with regulatory services to tackle illegal structures related to shisha and other areas of non-compliance.

Mr Chris Miller welcomed the report and noted that section 2.7 of the report states that the prevalence of shisha smoking may be influenced by the proximity between shisha premises and schools.

In light of this, he queried the penalty options available and possible measures to prevent underage shisha tobacco usage at shisha establishments. In response, Ms Phasey expressed concerns about penalties, which would potentially be higher fines but not significantly higher.

The Chairman thanked the speakers and Board Members for the discussion and noted that a report will be brought to a future meeting of the Health and Wellbeing Board with further findings, including issues that can be lobbied nationally and enforceability options which can be carried out by key partners.

RESOLVED that:

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1. **The Health and Wellbeing Board confirmed its commitment to reducing the use of shisha in the borough on health grounds.**

2. **The Health and Wellbeing Board approved the multi-pronged approach outlined in the report, of health education and promotion, regulation, and exploration of local Planning Policy, with the following actions:**

- **Educate and Engage. A health education and promotion campaign in partnership with the Council's communications department that is aimed at users of shisha, with a particular focus on young people but also including shisha premises.**
- **Regulate Activity. A partnership approach to be taken to non-compliant premises, focusing on agreed hotspots identified through local intelligence, including the Community Safety Team and Partnership, HMRC, the Police and London Fire Brigade.**
- **Explore current Planning and Enforcement Policy. To include health and wellbeing considerations, so that local businesses such as shisha establishments, do not adversely impact on neighbouring residential amenity.**

3. **The Health and Wellbeing Board supported a partnership problem solving approach to non-compliance in shisha premises which actively and fairly applies all relevant legislative powers available to the Council.**

4. **The Health and Wellbeing Board noted and approved a Task and Finish group to develop and implement an action plan for reduction in the use of shisha in Barnet. The remit of this group will include:**

- **Cross council representation from Public Health, Environmental Health, Trading Standards/licensing, Planning, Community Safety and regeneration**
- **Working with key partners such as the police, fire and the CCG**
- **Being jointly chaired by Public Health and Client Commissioning lead for Enforcement services to ensure actions from both the public health and enforcement perspective are driven forward**
- **Reporting back to the Health and Wellbeing Board on how the powers and functions available across the Council, which may lie within the scope of other Council Committees, can be harnessed to reduce shisha use, such as the Safer Communities Partnership, Area Committees, Licensing Committees and Planning Committees.**

8. HEALTH REPORT - CHILDREN IN CARE (Agenda Item 8):

The Council's Corporate Parenting Advisory Board considered this Report on 9 February 2016 (Appendix 1 of the report) and the Chairman noted that this item had been submitted to the Board for consideration following a request from the Lead Member for Children, Councillor Reuben Thompstone. The Chairman stated that the health and wellbeing of children in general but especially of looked after children had always been a primary concern both for all members of the HWB Board as well as of all members and officers of the Council. The Commissioning Director for Children and Young People

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introduced the paper and welcomed comments from the Board in relation to the recommendations.

The Chairman noted that the Board had been asked to consider a number of key issues which were highlighted within the Report as requiring further work to ensure that the best possible service and care is being provided to children in care, as well as measures to improve their health and wellbeing as much as possible. It was also noted that safeguarding of children has always been an important factor of the work of the Council and the CCG.

The Chairman invited Siobhan McGovern (Designated Nurse for Safeguarding Barnet CCG) to join the table.

Following a query from the Board about health assessments, Ms McGovern explained that when children are placed in care both a designated doctor and a designated nurse are appointed and that going forward measures have been put in place to ensure that initial health assessments are carried out within the specified time frame. The Board also noted the role of the designated nurse and designated doctor in assisting commissioners of health services to improve the health of looked after children.

The Chairman thanked the Board for the discussion. The Board requested that officers and report authors implement arrangements to ensure timely escalation of health issues to partner organisations. (**Action**)

RESOLVED:

1. **That the Health and Wellbeing Board noted and commented as above on the Health of Children in Care Annual Report (Appendix 2).**

2. **The Board noted the poor compliance with statutory timescales for initial health assessments for looked after children and recommended that further information is urgently sought from the CCG in terms of the capacity to undertake assessments and that a report on timescales for initial health assessments is brought back to the May meeting of the Corporate Parenting Advisory Board.**

9. JOINT HEALTH AND WELLBEING STRATEGY IMPLEMENTATION PLAN (2015 - 2020) PROGRESS UPDATE (Agenda Item 9):

The Commissioning Director for Adults and Health, Dawn Wakeling introduced the Report which provides the Board with an update on the progress of the Implementation Plan reported to the Board at its meeting in January, following approval of the final Joint Health and Wellbeing Strategy 2015-2020 in November 2015.

Ms Wakeling informed the Board that upon request from the Board, update reports on specific topics and areas of concern can be included on the forward work programme for reporting at a future meeting.

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Both Dr Frost and Mr Munday noted the importance of receiving updates on the issue of childhood immunisation. Following discussion the Board considered two further recommendations which were seconded:

Additional recommendation: *That the Health and Wellbeing Board agrees to include the Health of Looked After Children as an area of focus within the Joint Health and Wellbeing Strategy Implementation Plan and track the progress made in delivering improvements.*

Additional recommendation: *That the Health and Wellbeing Board requests that a joint letter from the Commissioning Director for Children and Young People, Lead Member for Children's Service and Barnet CCG is submitted to NHS England about childhood immunisation, seeking urgent action and clarification on the issue and requests that the Lead NHSE representative attends the HWBB meeting where this item is reported.*

Following approval of the two motions which were carried, it was
RESOLVED:

1. **That the Health and Wellbeing Board noted progress to deliver the Joint Health and Wellbeing Strategy (2015-2020) and agreed further action where necessary.**

2. **That the Health and Wellbeing Board agreed to include the health of Looked After Children as an area of focus within the Joint Health and Wellbeing Strategy Implementation Plan and track the progress made in delivering improvements.**

That the Health and Wellbeing Board requested that a joint letter from the Commissioning Director for Children and Young People, Lead Member for Children's Service and Barnet CCG is submitted to NHS England about childhood immunisation, seeking urgent action and clarification on the issue and requested that the Lead NHSE representative attend the HWBB meeting where this item is reported.

10. MINUTES OF THE JOINT COMMISSIONING EXECUTIVE GROUP (Agenda Item 10):

The Chairman received the standing item on the agenda and the Board considered the minutes of the Joint Commissioning Executive Group meeting held on 22nd January 2016.

RESOLVED:

1. **That the Health and Wellbeing Board noted the minutes of the Joint Commissioning Executive Group meeting of 22 February 2016.**

11. FORWARD WORK PROGRAMME (Agenda Item 11):

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The Commissioning Director for Adults and Health, Ms Wakeling introduced the standing item on the agenda and invited the Board to make suggestions for future items for consideration.

The following changes to the Forward Work Programme were agreed:

- That the item under the May meeting 'Family Friendly Barnet' be reported to the HWBB meeting on July 2016
- To include Commissioning Director for Children and Young People under Report Of, for the 'Mental health services – CAMHS, Reimagining Mental Health and Mental Health Social Work' item
- To change the 'Health checks' report which is currently listed under the May Forward Work Programme to be included in the Public Health report on activity 2015/16 in July 2016.

RESOLVED

1. **That the Health and Wellbeing Board noted the Forward Work Programme and proposed any necessary additions and amendments as set out above to the forward work programme (see Appendix 1).**

2. **That Health and Wellbeing Board Members continue 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).**

12. SERVICES FOR PEOPLE WITH LEARNING DISABILITIES INCLUDING WINTERBOURNE VIEW (Agenda Item 12):

The Chairman welcomed the public report and invited Sue Tomlin Joint Commissioning Manager Learning Disabilities who joined the meeting and presented the paper. The Board received a briefing on the content of the report which provides an overview of the work carried out by NCL Transforming Care Partnership and the alternative services to meet health and support needs outside hospital settings.

Ms Tomlin informed the Board that work will continue in order to ensure that patients receive support services outside hospital settings particularly in light of the partnership's commitment in relation to the Winterbourne View concordat. The HWBB will continue to receive updates on progress every six months.

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RESOLVED:

That the Board noted the contents of the report including the draft plan to deliver the Assuring Transformation programme through the North Central London Transforming Care Partnership, progress made on patient discharges and the update on patients subject to the Winterbourne View Concordat.

13. ANY ITEMS THE CHAIRMAN DECIDES ARE URGENT (Agenda Item 13):

The Chairman noted that a workshop session will be held 9am -10am on 12th May 2016 prior to start of the Health and Wellbeing Board meeting at 10am.

14. MOTION TO EXCLUDE THE PRESS AND PUBLIC (Agenda Item 14):

The Chairman informed the Board and the public gallery that the meeting would now be held in private to hear exempt papers.

RESOLVED - that by virtue of paragraphs 1, 2 of Part 1 of Schedule 12A of the Local Government Act 1972 the public and press be excluded from the meeting for the following items of business on the grounds that they involve the likely disclosure of exempt information as defined in paragraph 1 and 2 of Part 1 of Schedule 12A of the Act (as amended)

15. WINTERBOURNE VIEW COHORT – UPDATE ON PATIENT DISCHARGES AND COURT OF PROTECTION (EXEMPT) (Agenda Item 15):

It was **RESOLVED that the Health and Wellbeing Board noted the contents of the exempt report and the update information contained in the exempt report.**

The meeting finished at 11.20 am

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AGENDA ITEM 6

	Health and Wellbeing Board **12 May 2016**
Title	**Strategic Framework for Primary Care**
Report of	Head of Primary Care, Barnet CCG Director of Operations and Delivery, Barnet CCG
Wards	All
Status	Public
Urgent	No
Key	Yes
Enclosures	Appendix 1: Strategic Framework for Primary Care Appendix 2: Barnet CCG Presentation – Strategic Framework for Primary Care 2016-2020
Officer Contact Details	Sean Barnett, Head of Primary Care, Barnet CCG Sean.barnett@barnetccg.nhs.uk 07982716276

Summary

Barnet Clinical Commissioning Group have produced a draft Strategic Framework for the delivery of Primary Care services. The CCG welcomes dialogue around this framework approach which will then be considered before a final version is approved by the CCG.

This framework incorporates the North Central London vision for primary care, building on the local priorities already established from the Transforming Primary Care in London regional primary care strategy. These priorities developed from regional and local consultation have helped shape the primary care work programme for Barnet for the next three years, namely:

Accessible care - Better access to primary care professionals, at a time and through a method that is convenient and with a professional of choice.

Co-ordinated care - Greater continuity of care between NHS and other health services, named clinicians, and more time with patients who need it.

Proactive Care - More health prevention by working in partnerships to reduce morbidity, premature mortality, health inequalities, and the future burden of disease in the borough. Treating the causes, not just the symptoms.

As an umbrella to these three strands Barnet CCG has signed up to the "Right Care" programme which ensures our focus remains on addressing those areas that provide the greatest opportunities for increased value across the system in Barnet; improving the quality of services to patients as well as reducing waste through improved medicines

optimisation, self-care and quicker access.

In order to achieve the three aims above we will work through five workstreams of:

- New Delivery Models
- Patient and Professional Engagement
- Workforce
- Estates
- Information Management and Technology

This strategic plan will be underpinned by a delivery plan, in partnership with NCL, member practices and the public to ensure we achieve a sustainable transformation programme that provides better outcomes for the resident population. We will ensure our delivery plan uses underpinning data from public health to help the narrow the gap between populations in terms of Quality Adjusted Life Years (QALYs) and life expectancy. Improving the quality of care provided will ensure better clinical outcomes for local residents, and we will work with regulators and commissioners such as the Care Quality Commission and NHS England in identifying areas for improvement and providing tailored support where required.

This plan will be a challenge as we face significant financial pressures across the system. With professional partners we aim to shift specific clinical activity out of acute care with a corresponding flow of resources. Expanding the workforce and improving access to existing workers will release experts to take a more proactive role in managing complex cases. We will also complete the GP contract review to equalise the financial allocation per patient with practices and commission specific local schemes that have a high impact on outcomes. There are some things that we cannot change quickly, and we will continue to work with national policy and within the constraints that the wider system has in place, but wherever possible we will be innovative, open to ideas and criticism on shaping a better local health economy and taking pride in our achievements.

Recommendations

1. **That the Health and Wellbeing Board provide comments on the framework, especially in relation to engagement and supporting the primary care vision on the three themes of Accessible, Proactive and Coordinated Care**
2. **That Barnet CCG develop their implementation plan considering any comments from the Board and feedback on progress to the Board in September 2016.**
3. **That the Strategic Framework for Primary Care is duly noted, and once approved by the CCG, will be shared across members of the Health and Wellbeing Board for inclusion in other workstreams.**

1. WHY THIS REPORT IS NEEDED

1.1 The CCG previously indicated to the HWBB that they would produce a Barnet version of primary care strategy, including the vision shared across all five partners in North Central London. There is increased pressure on primary care, both to ensure people receive immediate health care, advice and treatment as well as longer term planning and management of chronic conditions. Doing more of the same will not keep pace with population expansion, the need to improve access and drive up quality.

The Framework helps the CCG engagement with public, patients and professional to ensure that we deliver a consistent and focused approach around the underpinning element of service design and delivery, namely estates, workforce and information technology.

The document describes some principles and vision, sets the framework within which we will commission and monitor and support service delivery and provides a vehicle for further engagement on service design.

2. REASONS FOR RECOMMENDATIONS

2.1 The CCG recognises the importance of constructive dialogue with all partners. The HWBB is a crucial partner in commissioning services that affect our resident populations. The focus towards more preventative models of care delivery, increased self-care and utilising a wider multi-skilled workforce including the voluntary sector is a significant change. The CCG need to ensure we have described the right visionary approach, continue to engage and act on feedback in this new approach. We welcome feedback and continued commitment to work together on improving sustainable services.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 The current model of service delivery – namely many small practices - will quickly fail either in terms of financial sustainability or with clinical delivery pressures from residents. The Strategic framework puts the clinical delivery model in the driving seat and any operational models will flow out of commissioning the right services first.

4. POST DECISION IMPLEMENTATION

4.1 Feedback from the members of the HWBB will be considered by the CCG before a final version is approved by the CCG Clinical Cabinet and the CCG Board. That final version will be shared with the HWBB as soon as agreed.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 Monitoring reports of service delivery will be available via the CCGs Performance Committee and progress on delivering the framework approaches reported back to HWBB in September 2016.

5.1.2 The Joint Health and Wellbeing Strategy 2015-2020 has been referenced in writing the framework and the two will continue to dovetail together in ensuring approaches are consistent.

5.1.3 The report uses JSNA data to ensure we understand population changes and respond with delivery approaches to provide equitable services for those in need. The plan aims to target those areas in most need in improving access, proactive care and coordinated care locally.

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

5.2.1 This Framework does not ask the HWBB, nor partners for any additional funds. Primary care is currently commissioned in the main by NHS England. A small number of additional services developed through Locally Commissioned Services targeting specific areas of population issues are funded by the CCG.

5.2.2 By acting now, the CCG aim to target any new NHS monies towards primary care. Working with strategic acute partners we will examine where possible and safe to do so the movement of some activity from acute hospitals into community settings, with a corresponding resource allocation.

5.2.3 The NHS have announced a number of funding streams to enhance primary care provision and we will be bidding for those monies to deliver short term improvements that promotes the long term sustainability of services through innovative changes.

5.3 **Social Value**

5.3.1 The framework considers utilising patient self-care, families, carers and voluntary sector in a much more coordinated fashion, developing the skill sets and including social community integration of the services.

5.4 **Legal and Constitutional References**

5.4.1 The CCG 's duties to provide , commission and arrange primary care services are given under the National Health Service Act 2006 as amended by the Health and Social Care Act 2012.

5.4.2 The Health and Wellbeing Board can consider the draft strategic framework as included in its functions found at Annex A of the Constitution, and specifically under paragraph 4:

4) 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.

5.4.3 The terms of reference of the Health and Wellbeing Board is set out in the Council's Constitution Responsibility for Functions (Appendix A) and includes the following responsibilities:

- 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 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.
- Specific responsibilities for overseeing public health and developing further health and social care integration.

5.5 **Risk Management**

5.5.1 The CCG are undertaking a full Risk and Issues log in managing the delivery of this approach alongside a detailed implementation plan over the next 4 years.

5.6 **Equalities and Diversity**

5.6.1 The CCG will be completing its own Equality and Diversity assessment. In order to narrow the gap in Quality Adjusted Life Years and life expectancy we will need to target certain communities, notably in the west of the borough. This will, by its nature, result in some differences of service provision, but will yield an improvement of outcomes for those most affected.

5.7 **Consultation and Engagement**

5.7.1 The Framework describes the engagement that has taken place so far. The CCG welcomes further opportunity to share the framework and its development with key stakeholders, public and patients across the borough.

5.8 **Insight**

5.8.1 Data from the Public Health team has been used in this report.

6. BACKGROUND PAPERS

6.1 None.

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Barnet Clinical Commissioning Group

Strategic Framework for Primary Care

Delivering accessible, proactive and coordinated high quality primary care services for the people of Barnet

April 2016

Document Version Control

Document Title :	Barnet Clinical Commissioning Group Strategic Framework for Primary Care "Delivering accessible, proactive and coordinated high quality primary care services for the people of Barnet"
Ref:	V8.2 – Final Draft for Health and Wellbeing Board
Date:	28th April 2016
Programme:	Primary Care
Authors:	Rebecca Thornley (to 2nd March 2016) Sean Barnett (from 2nd March 2016)
Programme Manager:	Sean Barnett, Head of Primary Care, Barnet CCG
Senior Responsible Owner:	Liz James, Director of Operations and Delivery, Barnet CCG

Contents Page

1. Executive summary

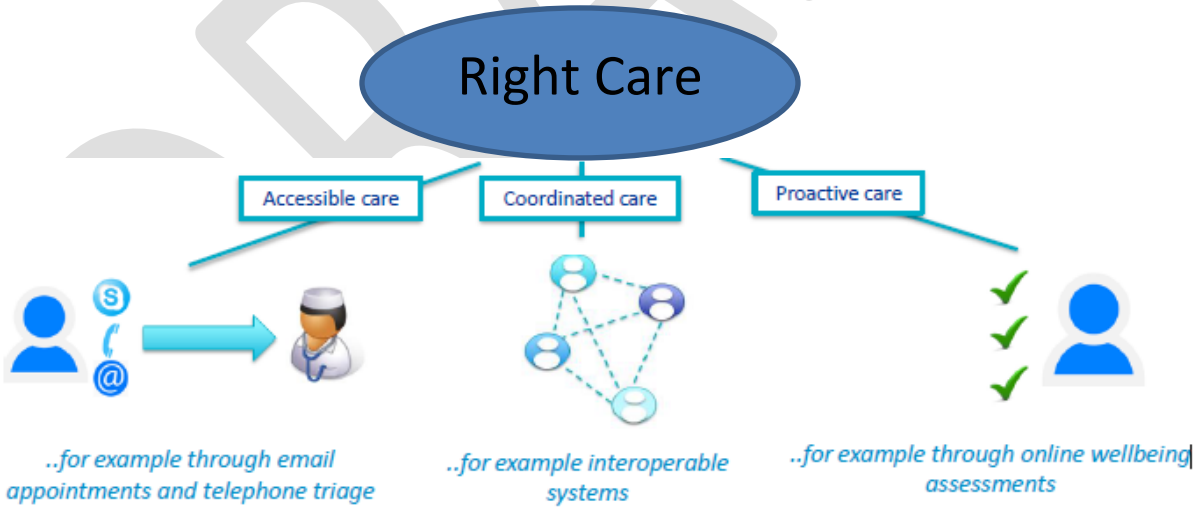
As outlined in the North Central London vision for primary care we wish to build on the local priorities already established from the *Transforming Primary Care in London* regional primary care strategy. These priorities developed from regional and local consultation have helped shape the primary care work programme for Barnet for the next three years, namely:

Accessible care - Better access to primary care professionals, at a time and through a method that is convenient and with a professional of choice.

Co-ordinated care - Greater continuity of care between NHS and other health services, named clinicians, and more time with patients who need it.

Proactive Care - More health prevention by working in partnerships to reduce morbidity, premature mortality, health inequalities, and the future burden of disease in the borough. Treating the causes, not just the symptoms.

As an umbrella to these three strands Barnet CCG has signed up to the *"Right Care"* programme[1] which ensures our focus remains on addressing those areas that provide the greatest opportunities for increased value across the system in Barnet; improving the quality of services to patients as well as reducing waste through improved medicines optimisation, self-care and quicker access.



In order to achieve the three aims above we will work through five workstreams of:

- New Delivery Models
- Patient and Professional Engagement
- Workforce
- Estates

[1] https://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/ and http://www.rightcare.nhs.uk/

- IM&T

This strategic plan will be underpinned by a delivery plan, in partnership with NCL, member practices and the public to ensure we achieve a sustainable transformation programme that provides better outcomes for the resident population. We will ensure our delivery plan uses relevant data from public health to help the narrow the gap between populations in terms of Quality Adjusted Life Years (QALYs) and life expectancy. Improving the quality of care provided will ensure better clinical outcomes for local residents, and we will work with regulators and commissioners such as the Care Quality Commission and NHS England in identifying areas for improvement and providing tailored support where required.

This plan will be a challenge as we face significant financial pressures across the system. With professional partners we aim to shift specific clinical activity out of acute care with a corresponding flow of resources. Expanding the workforce and improving access to existing workers will release experts to take a more proactive role in managing complex cases. We will also complete the GP contract (PMS) review to equalise the financial allocation per patient with practices and commission specific local schemes that have a high impact on outcomes. There are some things that we cannot change quickly, and we will continue to work with national policy and within the constraints that the wider system has in place, but wherever possible we will be innovative, open to ideas and criticism on shaping a better local health economy and taking pride in our achievements.

2. Introduction

A Case for Change

This framework for primary care aims to address a number of underlying issues that affect the effective delivery of services. Many of these issues are present nationally, which we have recognised locally and requires us to develop a robust work programme to secure change for commissioning and developing services fit for the future.

In listening to patients and practices it is clear that current provision does not always meet expectations of both parties. Patients report difficulty in obtaining a suitable appointment to see a health care practitioner, especially where they feel that need is more urgent. They report having to attend a number of appointments before a diagnosis or treatment helps them, and especially those with complex conditions feel holistically their needs are not always met quickly enough. Patients and carers report that if rapid access to services had been available, conditions could have been prevented from worsening. The changing demographics of our local population, both in terms of significant areas of growth as well as an aging population, places pressure on traditional GP delivery models. More patients are wanting to be seen outside standard opening hours and do not mind seeing a different GP for their needs when urgent. But patients with complex needs welcome the continuity of a named GP.

Whilst many practices now have a Patient Participation Group (PPG), some of these meet infrequently and are not always effective in providing a reflective view of the practice and improvements needed – with many patients reporting a lack of awareness of such groups. The annual patient survey has shown a small decrease in satisfaction levels by local patients.

Healthwatch Barnet is very active locally and has engaged very positively with the CCG and organisations that deliver care, but is not fully representative of the whole local population.

GPs report increasing demands by patients to be seen quickly and frequently, when clinically they do not always need to be seen by a doctor. Some patients are reluctant to be seen by a nurse or another health care worker as they place a high degree of trust in their GP. The changes to referral pathways means GPs struggle to always refer appropriately especially where clinical symptoms or conditions may present less frequently.

Pressure on GPs in managing the financial sustainability of a practice is growing and recruiting suitable staff to deliver essential care is difficult. Barnet CCG has a higher than average number of single and double-handed partner practices, with 40% of the GP workforce aged over 50 years – factors that exasperate the challenges around recruitment and sustainability.

Whilst practices have established a common IT system under EMIS Web, frustrations remain at the lack of integration with acute provider data and social care records, so that the bigger picture can be seen for complex patients.

A number of practices have particular challenges in the condition and maintenance of premises and others who need additional clinical space are unable to extend placing pressure on existing space.

The strategic context

The Barnet local health economy has striven to be innovative, benchmarking well against key measures such as prescribing, Quality Outcome Framework (QoF) and non-elective admission rates. Nationally the Five Year Forward View challenges providers to look to new models of care, creating accountable care systems (ACS) where commissioners and providers come together to determine priorities and assess local need.

The Strategic Framework for Primary Care will be constantly evolving – but to shape the current content we have actively engaged with NHS England, our constituent GP members, patient and public representation, CCG lay members, key service providers and colleagues from the wider health and social care system. Contributors to the framework are listed in Appendix 4. This document will also inform the internal resources required to deliver transformational change and priorities for service redesign.

The deliverables identified within the plan will be implemented via a substantive primary care team within the CCG, overseen by the CCG primary care working group, the Joint Primary Care Commissioning Committee[2] (in collaboration with NHS England) and where financial investment is required, the CCG primary care procurement committee or the joint commissioning board to ensure any conflicts of interest are addressed.

A sustainability and transformation plan (STP) will be delivered for primary care both on an individual CCG basis and NCL wide. Ambitions for the plan will be funded through the three year financial allocations some of which will be redirected to primary care. The CCG will undertake both financial modelling and a baseline survey to complete the plan – the Strategic Framework for Primary Care will form a key part of the process as will the detail of how the CCG has responded to the opportunities presented with co-commissioning.

[2] https://www.england.nhs.uk/**commissioning**/pc-co-comms

3. Our population and local health needs

The Joint Strategic Needs Assessment (JSNA) creates a collaborative hub of evidence which informs the case for change for health, social care, public and preventative health, prioritisation for the voluntary sector and provides a platform of information which can enable service providers to identify areas of business development[3]. The latest JSNA[4] states that Barnet is the largest Borough in London and is continuing to grow rapidly with large areas of regeneration especially in the West of the Borough. The population of Barnet is, like most of the UK, ageing with the proportion of people aged over 65 forecast to grow up to three times as fast as the overall Barnet population.

Primary care will continue its work to develop services that meets the specific health challenges of Black, Asian and Minority Ethnic (BAME) backgrounds,

The NCL transformation plan shows that young people across North Central London are the second fastest growing population after the over 65s. Prevention of ill health starts in primary care through effective immunisation programme and education around self-care.

Information from public health colleagues (appendix 8) has provided focus for a range of improvement activities including cardiovascular disease (CVD), diabetes and mental health. Ensuring the most needy groups of residents have access to the right services that prevents ill health and minimises the impact on quality of life is essential if we are to narrow the health gap across the local population.

4. Current primary care provision

We have 244 (204 wte) registered doctors and approximately 110 practice nurses in 62 GP practices. Core contracts require practices to deliver care from 8.00 am until 6.30 pm from Monday to Friday (excluding bank holidays). Some GP practices also deliver additional extended hours meaning they open on Saturday mornings or evenings.

For the most part, patients must book an appointment to see a GP or practice nurse, although the process for managing appointments differs across practices and there is no national requirement to standardise this. However in Barnet all practices are now on the same clinical system and have adopted data sharing agreements to enable clinical records to be shared across the borough and with other service providers such as community services.

All our GP practices are constituent members of the CCG and the CCG is working to strengthen membership engagement whilst addressing any conflicts of interest that may arise. Our GP practices elect GP representatives who sit on the governing body or provide clinical expertise to service redesign and clinical priorities. During 2015 all 62 practices came together to form a federation through which they would be able to formally share best practice, resources such as specialised staff and hold NHS contracts outside their immediate core GP contracts.

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[3] Barnet Joint Strategic Needs Assessment 2015-2020 https://www.barnet.gov.uk/citizen-home/council-and-democracy/council-and-community/maps-statistics-and-census-information/JSNA.html

[4] JSNA summary https://www.barnet.gov.uk/citizen-home/council-and-democracy/council-and-community/maps-statistics-and-census-information/JSNA.htm

The CCG will be working actively with the GP federation in Barnet, our localities, out of hour's provider and urgent care team to fully understand the levels of demand and capacity to inform future commissioning intentions as demand continues to grow. The CCG has commissioned, as a pilot scheme, additional access through the GP federation which sees practices working at scale from locality hubs to increase capacity during the evenings and over the weekend. We will evaluate this pilot before deciding on a longer term view on such additional capacity.

I have 3 children and I work part time. After collecting them from the child minder I noticed that one of them was unwell. I was really pleased that when I rang the practice after 5pm they could still offer me an appointment. It wasn't at my usual practice or with my usual doctor but instead at a practice down the road and at least it was with a professional who was able to prescribe medication. Later in the night she got worse so I called the Out of Hours team who could see my child's record on line. It turned out to be something more serious and arranged for her to be admitted. It took 10 days for her to be well again – so glad that staff acted quickly.

One of the priorities for the CCG in the coming year is to undertake a risk mapping exercise assessing the sustainability of practices and work with them, NHS England and the LMC to identify how we can address identified risks and avoid untoward pressures on practices and the resilience across the network. The CCG will also be supporting the development of the Pan-Barnet GP Federation who will be actively promoting working at scale, facilitating joint back office functions and developing their role to support sustainable primary care.

A number of primary care providers in the west locality have been involved with joint working arrangements with LBB social care and CLCH community providers (BILT). Following positive evaluation showing that through increased coordination, patients felt better supported and accessed secondary care less frequently, the scheme is being expanded to include the whole CCG area with identified patients at risk of hospitalisation being supported in a holistically to prevent their admission to hospital.

5. Patient and public engagement in shaping primary care

"Our primary care vision is to have a high quality, primary care system that provides out of hospital care with clear coordinated care which links

seamlessly to social care, public health and the voluntary sector".

The CCGs engagement with patients, carers and the wider public regarding our primary care plans began with the collaborative CCG NCL engagement events in 2014 which are outlined in detail in the main *Transforming Primary Care in London: A Strategic Commissioning framework*[5] which set the accessible care, proactive intervention and coordinated delivery of services as priorities for the region. We have built on that with a number of sessions and other contributors (appendix 4). Subsequent engagement is being undertaken as part of the CCGs overall communications and engagement strategy including the publication of a patient facing version. We have recognised the value in patient feedback and have built in the key elements from the most recent 2015 GP patient survey findings (appendix 6) into our primary care planning process. Whilst this is a small sample compared to the volume of activity undertaken in primary care, it nevertheless serves as a useful indicator on progress in improving patient satisfaction.

We asked patients, carers and public representatives what building blocks they feel support a high quality primary care service. Those priorities were shared with the quality team at the CCG and will shape the quality framework that the CCG develops in collaboration with NHS England:-

Our vision - (Summary of key themes taken from consultation with Barnet Healthwatch, Barnet Youth Council and service providers)

There should be joined up culture a mutual respect for different skills, strengths and expertise	Primary care will address health prevention not just medical care	Primary care will proactively support patients in managing long term conditions	Access to primary care will be bespoke, based around local needs – at weekends and evenings as well
Primary care will contribute to a health system where the GP together with the wider primary care family plays a central role	We will change from just face to face consultations to using modern technology improving patient choice	Primary care will meet the needs of all patients, carers, service providers, commissioners, and public	Primary care needs to focus on functions rather than professions with a more seamless multidisciplinary team

Building blocks to making a quality primary care service:-

Access to complete patient records	Strong communication	All the services are joined up	Prompt and appropriate treatment	Demonstrate good active listening skills	Welcoming and friendly GP practice team
Provides a wide range of services	Demonstrate kindness, respect and empathy	Responsive to all patients and carers	Good access and excellent clinical skills	Efficient and friendly practice teams	The service sees all tasks through to the end

Our patient and public representatives were asked how they think primary care services will change in the next five to 10 years. We asked this question to help the CCG as it develops a broader vision for primary are in five to ten years' time:-

[5] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

We will see more private entities and private services	There will be more active patient participation	GPs will be providing seven day services	GP teams will be more specialised and case management focused
We may see payment for some appointments, or at least charging for non-attendance	GPs will be starting to merge into larger GP practice hubs with more skill mix	We will see pharmacists working directly from practices	Patient education will be more common with a focus on self-management
There may well be more rationing – with exception treatment panels the norm	GPs will be in A&E departments to prevent non-urgent/non-emergency patients entering hospital	There will be care in the community – with out of hospital services working in collaboration with other agencies (i.e. voluntary sector)	There will be technological improvements – where skype consultations, on line bookings, telephone consultations and on line self-care will be the norm

Building on the key themes outlined above, and our board, constituent GP and wider patient engagement, by 2020 our CCG aims for primary care to be:-

Proactive, co-ordinated and accessible	Using technology to maximum effect	Offering defined levels of care through varying models of care	Providing care from fit for purpose estate
Working actively with public health to deliver the prevention agenda	Providing easy access for patients offering appointments according to need seven days a week	An exciting, rewarding, valued place to work – where people are working in supportive teams	Valued and accessed appropriately by patients who have better information and signposting to services
GPs having time to focus the most complex patients	Cost effective delivering high quality health outcomes	Central, sustainable part of the urgent care system	Supporting patients to manage self-care of long term conditions

Engaging with patients and the public through the GP patient survey

For Barnet CCG, **23,562** questionnaires were sent out, and **7,380** were returned completed. This represents a response rate of **31%**.
Information obtained focusses on the four following domains:-

- Accessing GP services
- Making an appointment
- Opening hours
- Overall experience

The latest outcomes are contained in Appendix 5 and have been summarised in respect of actions the CCG will take. This summary will be used to inform our wider primary care commissioning intentions for 2016/17 – working with any practices who are outliers to support improvement.

Supporting primary care through working towards a community programme

The Community-centred Practice pilot which Barnet CCG is actively supporting is a national and regional programme focusing on finding, developing and supporting Practice Champions to work in primary care and the community. The programme invites groups of champions to work closely with the GP surgeries in Barnet in different ways starting with introducing Practice Champions, recruited and supported as a group to work closely with their practice creating new ways for patients to access non-clinical support

The CCG will actively work with Practice Champions to promote their work in primary care to provide additional active patient and health care champion voices to support the development and transformation of primary care.

After being diagnosed with diabetes I felt alone. The practice organised a local support group and I could see that there were others with the same condition. We now support each other now, with some of us becoming practice champions helping people in our community understand how to look after ourselves better.

6. Understanding the clinical priorities for primary care in Barnet

Implementing key clinical priorities "Transforming Primary Care in London"

The following action plan, themed against the three key areas of the London-wide strategy outlined above will be monitored by the CCGs Primary Care Working Group and shared with our constituent member practices and other key stakeholders. This will feed into our regular review by NHS London against the targets set and form a central part of Barnet's Sustainability Transformation Plan (STP).

Clinical priorities from the 2016 Commissioning for Value Pack

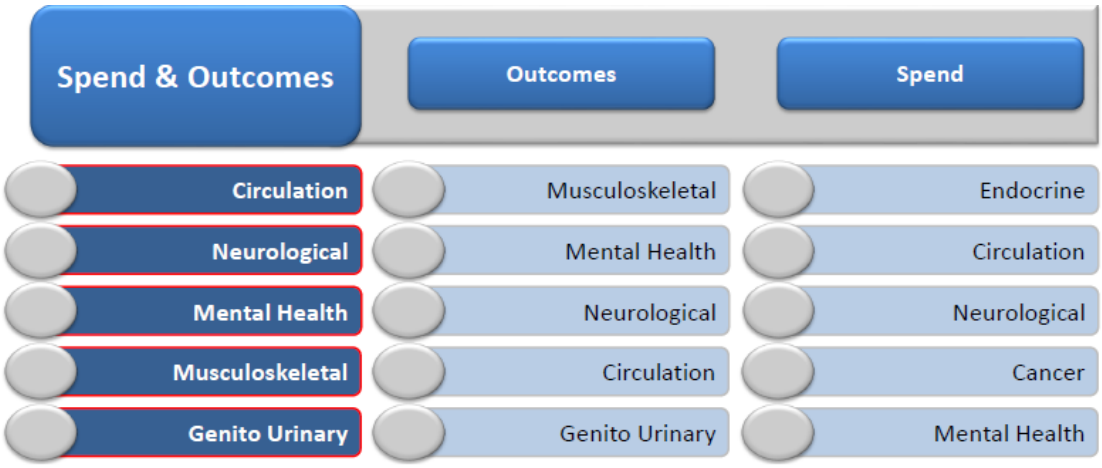
Barnet CCG were successful in becoming a First Wave Right Care Programme together with Enfield and Haringey CCGs in NCL. The Right Care Programme not only supports our 2016/17 QIPP ambitions and quality agenda but also aligns to our transformational work around accessible, proactive and coordinated care working to reduce unwarranted variation, improve health outcomes and realise increased value.

The Commissioning for Value approach begins with a review of indicative data across the 10 highest spending programmes of care to highlight the top priorities (opportunities) for transformation and improvement.

The table below identifies areas of potential focus:

- those areas with relative high spend and poor outcomes are far left,
- clinical areas with poorer outcomes are in the middle,
- high spending areas which may have average or good outcomes are far right.

The CCG focus will target areas on the left with initial specific Primary Care focus across CVD and mental health.



A note on the methodology used to calculate your headline opportunities is available on our website: https://www.england.nhs.uk/comm-for-value/

Cancer opportunities in primary care will be managed through the transformation of cancer in primary care programme at NCL level. A summary of savings opportunities as identified through Commissioning for Value are in appendix 3.

Prescribing

In our Barnet CCG Commissioning Intentions we committed to ensuring that medicines optimisation is both clinically appropriate and cost effective as well as reflecting national and local advice. This is being achieved by ensuring GP Practices are given full information and are supported to make prescribing decisions based on balancing cost efficiency and improving clinical outcomes for patients.

Medicines optimisation can be broadly defined as the approach by which the NHS uses medicines and ensures evidence based medication prescribing protocols based on shared decision making, informed consent, and the principle of 'do no harm.' in all care settings. Self-care must be at the heart of the approach and decisions about medicines should be made jointly with patients and carers.

My dad has COPD and gets very anxious when the weather turns cold and damp. The Barnet Integrated care team are great at offering a direct dial number where he can get reassurance. His named worker knows him well and can tell quickly when his breathing is affected. He has a "steroid rescue pack" in the bathroom which means he can stay safe over the weekend.

Whilst this framework [illegible] general practice, it recognises the need to engage and develop new ways of working with a variety of professionals and providers such as local community pharmacies. Many patients seek advice and reassurance from their GP, when in fact their local pharmacist is equally placed to offer such reassurance and support. This fact about the work that pharmacists do is largely under-

recognised within primary care and the wider public at large[6] and is an intangible asset to the NHS. Improving self-care and proactive care models should further utilise the highly skilled and locally accessible workforce within community pharmacy who have the expertise to participate in medication reviews and Medicine Use Reviews with high-risk patients and provide information and advice for managing complex care through MDT's. Some 22 Healthy Living Pharmacies have been established where pharmacies have taken up a role supporting patients as a first line intervention, signposting and acting as an advice centre. Barnet CCG piloted a Minor Ailments scheme in 2013/14 with a small number of pharmacies and GP practices. The small scale of the pilot meant limited data was available to support further implementation.

How risk stratification will contribute to our primary care clinical objectives

Pro-active care management or risk stratification is a system which supports GPs to help their patients manage their health. In primary care this involves using a secure NHS computer system to look at selected information from the patient care record, reviewing existing health conditions alongside any recent treatments to provide an alert to the likelihood of any possible deterioration in a patient's health. This will inform prompt action or referral expediting care and targeting clinical intervention where it is needed. The Strategic Framework for Primary Care recognises the need to do more engagement with vulnerable patients to explain this shift of care and how a care team operates differently to prevent admissions to hospital.

In order to improve co-ordinated care it is essential that we develop the use of risk stratification as a way of targeting specific patients using a wrapped around package of care that promotes self-care and independence, with a defined care plan for when problems occur using a multi-disciplinary approach. The successes of the BILT scheme is being expanded from the West Locality to serve the whole borough. This will allow us to fully evaluate the initial positive effects seen in the pilot "…fewer anxious calls to the GP from carers and next of kin; relatives and next of kin are able to be more proactive in caring for patients".

Primary care collaboration with our community mental health provider

We recognise that mental health issues affect a significant number of patients, and primary care has significant pressure placed upon it as a result. We will work with local providers to explore the range and breadth of current services and to find new ways of maximising delivery of good mental health support with the creation of a 'Single Strategic Vision' for future service delivery.

The Reimagining Mental Health programme has developed through an iterative approach to programme planning, allowing flexibility for organisations, individuals and the wider community to take part in early co-production of the high level principles governing the approach through workshop-style collaboration. This collaborative style promotes the principles of partnership working in creating a clear strategy and understanding for new ways of working and service delivery.

The expected benefits of this approach will result in cashable and non-cashable elements including closer working partnerships between statutory and non-statutory organisations, agreed care pathways and ease of access to primary care facing mental health services. Future service developments will align with other strategies ensuring services are based on prevention, early detection, enablement and integration, ensuring ease of access and a menu of 'choice' for both

[6] https://www.barnet.gov.uk/citizen-home/public-health/pharmaceutical-needs-assessment.html

clinical and non-clinical interventions. Traditional primary care teams will need to change to encompass these new teams as part and parcel of everyday delivery of care.

I get a text to remind me that I have an appointment with my counsellor. If I can't make it I can send a reply meaning they can offer that slot to someone else. It also means if I'm very anxious they will often have a slot for me quickly. I'm seen at my usual practice rather than the hospital, which is great as that way others don't know why I'm there if I see someone I know.

Transforming care for people with learning disabilities and/or autism

The restructure of LD services away from hospital based assessment and treatment to services within communities is underway. BCCG is part of the North Central London Transforming Care Partnership which has developed a joint transformation plan to deliver this change for people of all ages with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition. The plan will deliver a change of care and culture working towards a life course approach with locals services built around the individual.

Other overarching aims of the plan (which link closely to the Strategic Framework for Primary Care) include:

- Reducing inpatient and specialist commissioning activity by 50% (by March 2019)
- Eliminating out of area placements
- Shifting investment to community services including crises intervention, respite and family support
- Eliminating health inequalities

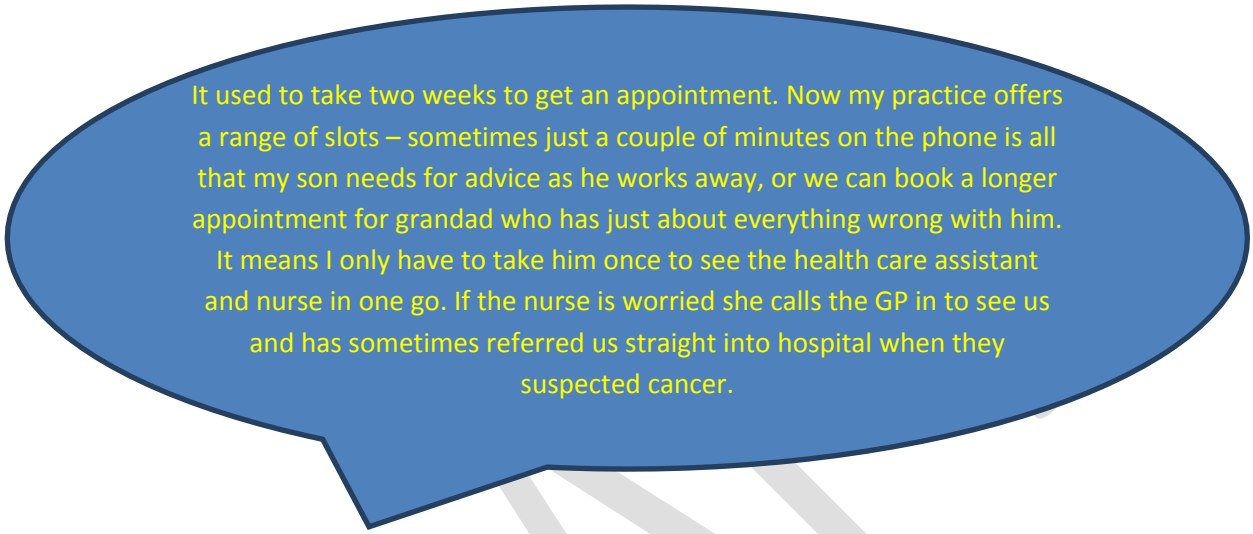
The integrated learning disabilities service will be re-designed by February 2018 to fulfil the plan and the National Model for community learning disabilities services (described in Building the Right Support).[7] The numbers of people with complex and challenging needs being supported by the service will increase, the shift of the resources within the system will enable development of community provision including primary care services for people with learning disability and autism with lower needs.

7. Delivering primary care improvement through collaboration

To help NCL CCGs to navigate the challenges ahead NHS England in London have released a programme of support to enable us to deliver improvements to primary medical care. The *Strategic Commissioning Framework Primary Care Transformation for London*[8] approach is

[7] The National Plan to develop community services and close inpatient facilities (NHSE, LGA, ADASS - 2015)
[8] https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2015/03/lndn-prim-care-doc.pdf

providing a road map for London CCGs to develop primary care strategic plans working to improve the competence of primary care service providers while continuing to realise improved health outcomes and service experience for patients. The strategic framework lists 17 specifications under three key areas (appendix 7) – accessible, proactive and coordinated care and Barnet CCG is working closely with the NCL collaboration to deliver against these key areas, embedding them in our local primary care work programme.

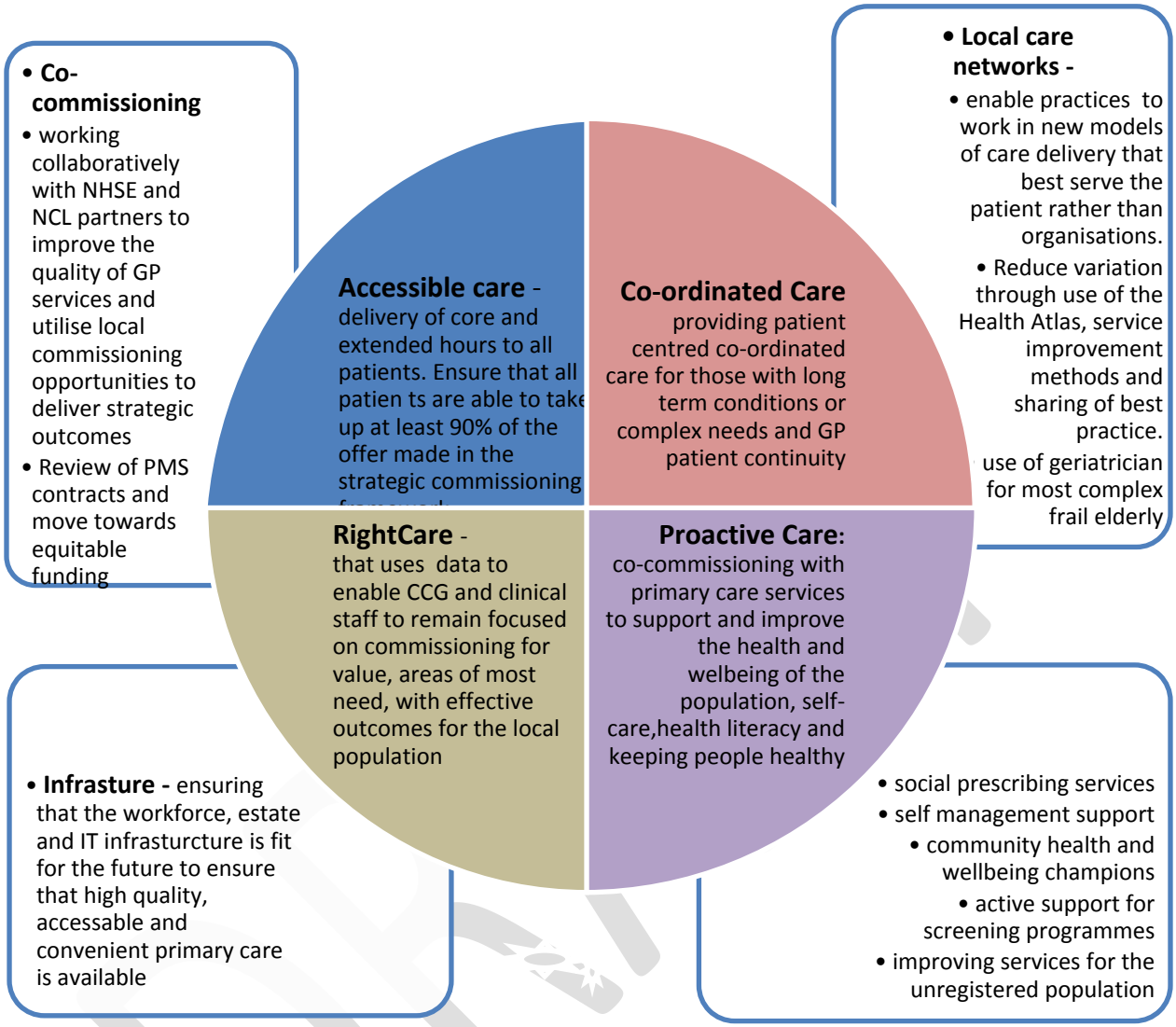


NHS England approved the council and BCCG joint Better Care Fund bid in January 2015 which laid out how we plan to better care for people with complex needs. Barnet's Better Care Fund represented a single pooled budget of £23,312,000 for 2015/16, to support health and social care services to work more closely together. The council and BCCG are working together, within the Health and Social Care Integration model, to deliver a robust programme of work including Healthy Living Pharmacies and Barnet's Integrated Locality Team (BILT).[9]

There are a number of other national, regional and local strategies impacting on primary care and these are summarised in Appendix 2.

Primary Care co-commissioning with NHS England (London) is currently at level 2 and has given Barnet CCG the opportunity to realise objectives in a new way as clinical commissioners of both primary and secondary care. The move towards full delegation during 2016 (level 3) of primary care commissioning, will allow services and contracts to be shaped to reduce variation and promote consistency of care, improve quality, align primary care services to the wider CCG commissioning intentions and ensure value for money.

[9] https://engage.barnet.gov.uk/commissioning-group/joint-hwb-strategy-2016-2020/results/joint-health-and-wellbeing-strategy-2015---2020-booklet.pdf



Our Strategic Framework for Primary Care seeks to place General Practice at the heart of health and social care services by:

- The active integration of multidisciplinary teams ensuring seamless services and strengthening the clinical workforce across all networks.
- Fully integrating clinical pathways of care across primary care, mental health, learning disabilities and autism, social care and the third sector - Referral forms will be developed aligned to pathways ensuring that they are easily followed by GPs, highlighting what diagnostics or previous work up should have been done before a patient is referred.
- GP IT systems will be aligned to these pathways for example “bundles” of diagnostic tests directly related to pathways available through “one click” on the tquest system, and the EMIS web system will also be populated with the library of pathways making them easily accessible. This will support our aim to provide evidence based care, by ensuring that diagnostic bundles reflect best practice.
- Improving access and continuity of care for patients seven days a week across primary, secondary and out of hours services
- Placing a greater focus on prevention and managing self-care.

Supporting the collaborative approach through new models of care

One of the key challenges to primary care in the Five Year Forward View was for local health economies to establish a vision for delivering new models of care for patients, especially those with long term conditions – seeing the division between secondary care, community services, mental health services and primary care reducing – actively encouraging collaboration between service providers in an attempt to deliver personal, coordinated and seamless care. But this vision presents us with challenges, not least the requirement to invest in prevention, facilitate collaboration and invest where needed whilst avoiding conflicts of interest.

The challenges, and potential solutions, of how we approach developing new care models as a CCG are summarised below:-

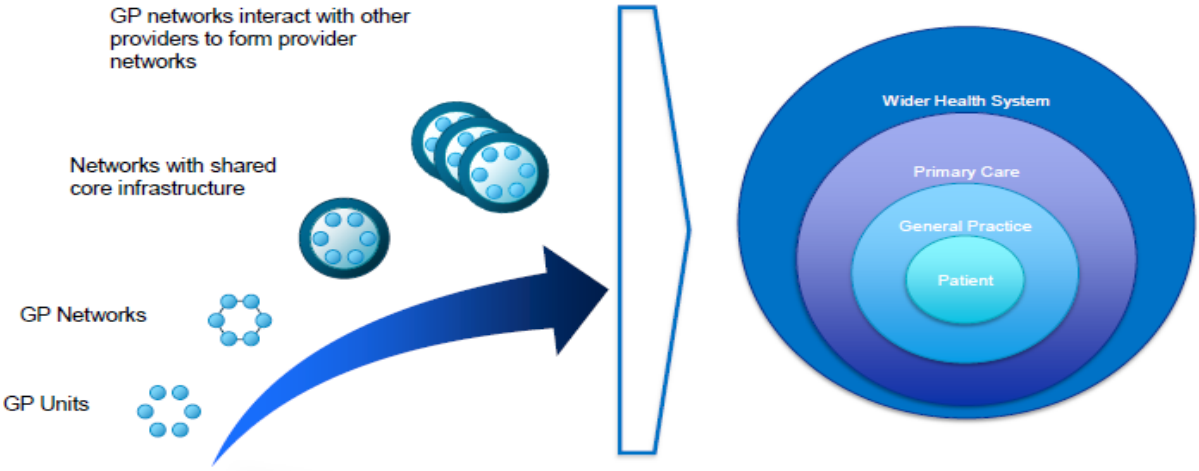
To challenge the health and wellbeing gap	In our Borough we need to see a radical upgrade in prevention – working in collaboration with the Health and Wellbeing Board and Public Health	We need to back national action to combat the major health risks Need to align targeted prevention initiatives (eg diabetes and CVD) Need to develop greater patient control Need to harness the renewable energy of our localities and communities
Need to address the care and quality gap	New models of care can deliver this by working at scale and in collaboration	In Barnet one size doesn't fit all but equally 62 individual units can't demonstrate real value in terms of quality, health outcomes and money Once clinical models agreed, locally can determine the best provider delivery model The health and social care systems need to provide investment and flexibility to support new care models
Need to address the funding gap	Efficiency and investment	Implementation of these care models and other actions could deliver significant efficiency gain There is the need for upfront, pump-priming investment to support providers to develop the vision and infrastructure

The above challenges can be met by:

- Managing systematic networks of care, not just organisations
- Ensuring out of hospital care is a much larger part of NHS commissioning locally
- Integrating services around the needs of the patient – for example patients with mental health conditions need their physical health addressed at the same time. Already in Barnet we have introduced innovative multidisciplinary team pilot *Barnet Integrated Locality Team* programme (BILT) deliver this vision and are developing a primary care mental health strategy to ensure mental health and primary care priorities are aligned.
- Learning from the best examples around us – collaboration at NCL level will help Barnet CCG learn best practice from neighbouring CCGs – we are actively working with our neighbouring CCGs to identify transformation opportunities in primary care
- We need to evaluate which new care models locally, regionally, nationally and internationally deliver the best experience and health outcomes for patients and deliver the best value for money. Already the CCG have networked and reviewed some of the innovations currently developing nationally – but all successful exemplars say that additional investment of time, resource and funding is key

It is crucial that the CCG uses its leverage as a membership organisation to encourage GPs to work innovatively, at scale and in new organisational forms to develop the capacity to deliver primary care services that meet not only the current but future needs of Barnet. The Five Year Forward View reinforces the need to look beyond the single operating model for primary care commissioning.

To realise the above challenges Barnet CCG appreciates that we need to invest in, expand and strengthen the role of primary/out of hospital care. There are 62 practices providing services across Barnet CCG, 3 provider networks and one GP federation as discrete legal entities capable of holding NHS contracts for additional services.



The CCG aim to support and encourage partnerships in order to provide a stable platform to deliver sustained transformation. Due to conflict of interest issues this is unlikely to be via direct funding. There are a number of different models that other CCGs across England have adapted including:

- Super-partnerships
- GP Federations
- Multi-speciality Community Providers
- Primary and Acute Care System

It should be stressed that there is no “one size fits all” model, nor is the CCG dictating in any way the precise model that could be adopted in Barnet. There are a number of options, and it will be important that local providers are given the opportunity to see for themselves what will work best for their patients within our health economy. The CCG will help to facilitate such discussions and support organisational development where appropriate to achieve these goals once the clinical models for services are agreed.

Super-partnerships

Models such as those in Birmingham under the Modality brand appear to have had success in establishing groups of like-minded practices, working together offering as a single partnership a

wide range of services from specific locations. There is one contract holder covering a discrete geographic area, although there are some such groups that are not limited by location.

General Practice federations

There are a small number of GP federations established across the UK, and local GPs across Barnet have formed their own. Individual practices retain their business model and partners, but work together, using individual strengths and expertise in offering a wider range of services, or utilising premises more efficiently at quieter times. They are able to work together to deliver core GP contract services through sharing premises, staff and resources to agreed standards.

Multi-speciality Community Providers (MCPs)

Some areas are moving to establish federative working (the Pan-Barnet GP federation has already been established) which pave the way for multi-specialty community providers (MCPs). This means that in the future we could see a wider range of care being offered within primary care. The table below summarises what a MCP can look like:-

What they are	How they could work
• Greater scale and scope of services that dissolve traditional boundaries between primary and secondary care • Targeted services for registered patients with complex ongoing needs (e.g. the frail elderly or those with chronic conditions) • Expanded primary care leadership and new ways of offering care • Making the most of digital technologies, new skills and roles • Greater convenience for patients	• Larger GP practices bring in a wider range of skills – including hospital consultants, nurses, therapists and community Pharmacy employed or as partners • Shifting outpatient consultations and ambulatory care out of hospital • Potential to own or run community hospitals • Delegated capitated budgets – including for health and social care • By addressing the barriers to change, enabling access to funding and maximising use of technology

Primary and Acute Care Systems (PACS)

Other new models of care include integrated primary and acute systems – joining up general practice, acute hospital, community and mental health services which are already being delivered in more than 12 areas across the country. The CCG will work to raise awareness locally of the outcomes from these pilots and to explore how we can facilitate the development of the range of contracting and organisational forms encouraging the establishment of prime providers and collaborative ventures for Barnet.

The Five Year Forward View does highlight that establishing PAC models will be complicated and challenging to establish and as such NHS England will continue to evaluate early pilots and our CCG will share learning across our own Borough as this becomes available through training sessions and provider engagement.

8. Quality and safety

The quality of primary care provision is generally high with the average Quality Outcome Framework (QoF) achievement exceeding the England average. The CCG is working with NHS England to further develop a quality scorecard which will help identify exemplar practices and provide support to practices with identified areas of weakness. We will continue to work with NHS England to support practices through the Care Quality Commission (CQC) inspection process – to date 18 (28%) of Barnet's practices have been visited with a number being either good or outstanding. Four practices are seen as requiring support and the CCG will be working with NHS England and our development partner, Primary Care Commissioning (PCC), to support them to make the necessary improvements.

Throughout our transformation work across primary care we will remain committed to ensuring commissioned services deliver a high quality and safe service to patients. We will develop monitoring schemes across our services that reflect real time activity and situations and where possible communicate these to patients, for example current waiting times in a local urgent care centre.

We will intervene quickly where a provider appears to be delivering a service of poor quality, but also share the success and learning where providers carry out best practice or go above and beyond what would be expected of them. For practices where indicators show weaker performance a range of interventions may take place, including peer and local team support, education and learning, involvement in regional or national schemes to improve leadership or provide clear organisation or skills or improve partnerships or estates.

9. Supporting and developing the primary care workforce

Barnet has an aging workforce with 75 doctors (30%) over 55 years of age. Practices across Barnet are reporting challenges in recruitment, with the CCG working closely with Community Education Provider Network (CEPN) and the Deanery to provide additional local placements for both GPs and practice nurses to encourage opportunities within the Borough. The CCG recognise and welcome the need to diversify the workforce away form a predominately GP-only model and utilise a range of staff with varied clinical expertise This ambition is outlined in six steps in the Royal College of General Practice paper - "2022 GP – A vision for Primary Care in the future NHS": [10].

Promote a greater understanding of generalist care and demonstrate its value to the health service	Develop new generalist-led integrated services to deliver personalised, cost-effective care
Expand the capacity of the general practice workforce to meet population and service needs	Enhance the skills and flexibility of the general practice workforce to provide complex care
Support the organisational development of community-based practices, teams and networks to support flexible models of care	Increase community-based academic activity to improve effectiveness, research and quality.

[10] http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z-policy/The-2022-GP-A-Vision-for-General-Practice-in-the-Future-NHS.ashx

CEPN will assist with training Emergency Care Practitioners and other staff that will work in primary care. Practices need to recognise the value in continuing CPD across a range of clinical and non-clinical fields that result in improved care and effective and efficient management of services. The CCG will support that process with a series of development days and processes such as utilising community pharmacy workforce and upskilling through independent prescribing qualifications. National evidence indicates that practices that lack leadership or good management show an increased level of concern in terms of service quality delivery. We will target practice managers and leaders to ensure good quality education and development is made available, with sharing of best practice and support that uses the skills and experiences available locally and regionally.

Addressing current challenges	- Addresses key issues for General Practice, such as building the workforce and ensuring investment.
Supporting an attractive profession	- Allowing GPs to be 'expert generalists' that they came into the profession to be. - Modernizes service. - Will help attract more graduates to the profession.
More time for patients who need it	- Those that require more care from clinicians receive this. - Patients assisted to stay well independently, freeing up GP time for patients who need it most.
Empowering better care provision	- By building a team around the GP, patients are able to see the right person at the right time. - GP directs patients to the right person to deliver the care they need. - Expertise is most appropriately used.
'Headspace' to innovate	- Reducing the burden on GPs to allow them time to consider service development and innovation
Supporting patients' care journey	- Better connections to other health providers/ multi-disciplinary teams allows GPs to support patients to transition throughout their health service. - Improves GP satisfaction (they see the outcome of their work) - Enhances patient/doctor relationships.

Clinical leaders within the CCG, GP, practice nurse and management representatives across Barnet have expressed the need to more effectively engage as a CCG with the primary care workforce. Currently there is only limited engagement with our GP practices. Some of the 62 Barnet practices reporting, through 360 degree feedback, state that they feel isolated and excluded from service redesign plans and commissioning intentions although they are constituent members of the CCG. There appears to be a lack of understanding as to what the CCG represents, how we can support GP practices and what we are trying to achieve through our operational plan, commissioning intentions and strategy for the next five to ten years. This is a priority issue and will be addressed through more active engagement, improved communications processes and practice visits by the primary care development team.

The announcement made on 21st April 2016 that the NHS will fund 5,000 additional GPs through an increased budget of £2.4bn is welcome news, and we will be working with education providers locally to ensure Barnet obtains a fair share of that commitment in improving our workforce capacity.

10. Developing the primary care infrastructure – estates

Our NHS Estate in Barnet is currently undertaking a full review and an overarching Estates Strategy is in the process of being completed, incorporating primary care, to enable the delivery of clinical and financial benefits for the CCG. The recently announced Prime Ministers Access Fund (also known as the Primary Care Transformational Fund – PCTF) will be supporting transformational development of primary care estate over the next five years – and the CCG will work alongside groups of practices in submitting appropriate schemes that transform the way in which services are delivered. The CCG, in line with NHS E, will reduce their support for small-scale remedial schemes that have in the past been funded via the Primary Care Improvement Grant (PCIG) funds.

PCTF has been introduced to enable CCGs to realise the priorities set out in the Five Year Forward View. Barnet CCG has developed selection criteria which are overseen by the Primary Care Procurement Committee – making recommendation to the Governing Body about estate. This includes not only new buildings, but improvements to existing primary care premises to enable improved access – with particular focus on access for the increasing frail elderly population, access to general medical services over seven days and in the evening, and improving IT systems to allow for seamless transfer of records.

Whilst on the whole deprivation levels across Barnet are not high, there are specific areas, notably in the west, where we must ensure good access to primary care facilities for those in greatest need. We will complete feasibility studies in three areas – East Finchley, Barnet Town with East Barnet and Hendon/Cricklewood/Golders Green to identify areas of potential collaboration and estate solutions. Such solutions will involve wider group of providers including community and mental health services, social care and the voluntary sector. We are actively involved in the Colindale/Graeme Park redevelopment in perhaps the second largest regeneration scheme in London. Lessons learned from previous projects across London will be incorporated into a truly unique and exciting development of shared primary, community and social care space for local residents.

Finchley Memorial Hospital transformation project

The Finchley Memorial (FMH) project has been designed to make better use of the excellent new building to deliver a range of primary care and community health services targeted at the CCG's areas of greatest commissioning priorities. The CCG's clinical cabinet has identified four priorities for new services to be developed in Finchley Memorial Hospital:

- An Older People's Assessment Service (OPAS) to help keep patients independent in the community for longer and prevent avoidable A & E attendances
- A new GP practice focused on the needs of the frail elderly and care home patients – more closely integrated with the existing Walk in Centre
- Increased inpatient activity (empty 17 bed ward) and reviewing the service model
- Establishing a permanent Breast Screening service

The CCG is currently developing service specifications for each of these services and preparing commissioning business cases to be reviewed by the Clinical Cabinet and then the Primary Care Procurement Committee.

11. Investing in information technology

For the CCG to be effective in delivering its primary care ambitions, we need to embrace the goals of the new national information framework which supports the effective delivery of technology enabled, personalised and seamless care.

The priorities of the digital roadmap for primary care includes the following:

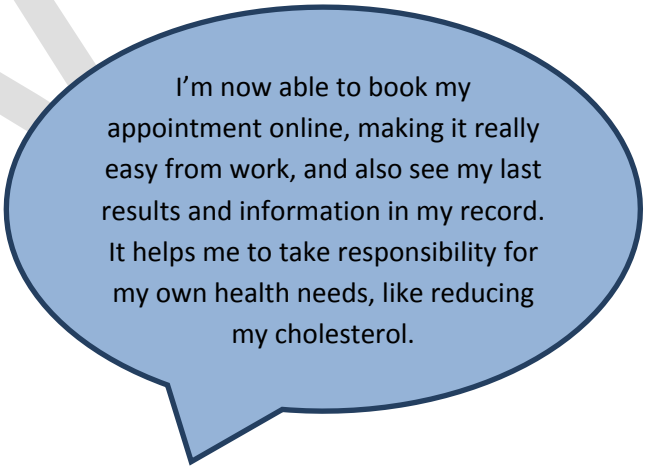
- To enable patients to make the right health and care choices by supporting digital services for patients and the wider public
- To transform general practice and its IT capability
- To support care out of hospital which is fully integrated with community, mental health and social care
- To ensure acute services are aligned to the IT solution
- To develop a paperless healthcare system
- To produce effective data and information which can effectively measure health outcomes and inform local research into establishing best practice

The focus on all of the above is the effective integration of systems and information with the extension of patient records to make them accessible wherever needed, subject to patient consent. We will ensure that there are optimised clinical systems in all the constituent member practices which support the appropriate sharing of information and the development of clinical pathways, allowing patients and their carers to become partners in their own care. We aim to have real time quality information available to all healthcare professionals in all care settings.

Barnet CCG's IMT Strategy focuses on nine themes with a stated vision to position the CCG "to better exploit information and technology both within the CCG and across the whole of Health and social care, to achieve strategic objectives and to work with local people to develop seamless accessible care for a healthier Barnet"

Barnet CCG nine delivery themes are:

- IT management and Governance
- Information Governance and Security
- Digital by 2018
- Information knowledge management
- Service Management
- Infrastructure
- Shared Care Records
- Patient Access and Enablement
- Referral Management



The next 3-5 years will see the increased use of information technology benefiting both patients and practices in BCCG. The emphasis will continue to be on reducing the paper processes within practices and putting in place systems and procedures that will speed up services whilst at the same time improving data quality and data capture.

The IT strategy for primary care seeks to build on the following priority areas:

- Integrated Digital Care Records (IDCR) to enable practices to share their data with each other to support the advent of seven day working, the integrated care agenda and able to securely share and exchange agreed information across the healthcare community.

- Video consulting - to reduce travel time between practices but to also support the opportunity to provide additional methods of communication and access to patients.
- Social prescribing – providing the technology and access to our GPs and voluntary sector providers to support patients in the community within appropriate governance framework.
- Implementation of text messaging offering texting appointment reminders and cancellations integrating directly into practice systems, ensuring that released appointments can be seen in real time as well as reducing their DNA rates.
- Implementation of the text based system for collecting friends and family responses enabling practices to eliminate the administrative burden of collating paper returns.
- Introducing a Patient Held Record (PHR). Allowing patients to view an electronic summary of their basic health and social care record which will include information on appointments, care pathway, medications, allergies and adverse reactions.
- Make effective use of online tools and software integrated into practice systems to help improve practices efficiency. This includes DXS, e-referrals, GP to GP, Admissions, the online appointment booking system and online ordering of repeat prescriptions.
- Introducing flexible IT solutions to support mobile working, enabling full access to EMIS Web for GPs during home/care home visits and case conferencing between multi-agency professionals supporting inter-agency multi-disciplinary team meetings.

12. Governance priorities for primary care

In primary care, not only must the CCG and service providers work collaboratively to improve the quality of the care residents receive but we must be able to show that we are accountable through clinical and corporate governance to demonstrate clear and measurable outcomes. Accountability is not new – clinicians are accountable to their professional regulatory bodies – but confidence in the existing system of peer-led self-regulation has raised concerns about accountability and how as a CCG we manage conflicts of interest.

At the heart of our Strategic Framework for Primary Care is the CCGs commitment to strengthen both clinical and corporate governance in the areas of primary care – to give service users, primary care colleagues and the wider public confidence in the way we commission, provide, assure and measure the impact of primary care services. The value of clinical commissioning is that clinicians are accountable to their clinical colleagues, and working at scale – collaborative and multidisciplinary team working will strengthen this. To ensure transparency and fairness primary care is now assessed and assured by the Care Quality Commission and the CCG will be working both with the CQC and NHS England to support practices – developing a framework of support and improvement where this is required.

The CCGs commitment to clinical governance extends primary health care professionals' accountability beyond current forms of legal and professional accountability. This involves increasing the accountability of primary care professionals to local communities, to the joint commissioners of their services (London Borough of Barnet, BCCG and NHS E) and to their peers (through collaborative and federated working models). As a CCG we appreciate that this will require both clinical and financial investment and as such we have appointed two clinical leads to oversee primary care and aligned primary care to our Quality and Assurance committee who will review areas of concern in collaboration with the primary care development team.

The role of the Health and Wellbeing Committee and the London Borough of Barnet's Overview and Scrutiny Committee further assures the governance process – as does the presence of Lay Members on the Joint Primary Care Committee, Primary Care Working Group and Primary Care Procurement Committee.

Ensuring conflicts of interest are effectively managed with our constituent GP practices and clinical leaders is also a key priority of the CCG and this is regularly reviewed by our lay members, NHS England and patient representatives.

13. Next Steps

Implementation and delivery of the Strategic Framework for Primary Care will be managed by the Joint Primary Care Commissioning Committee for NCL and the Primary Care Working Group for Barnet CCG. The working group will develop a work programme which will identify and work to mitigate risks as appropriate. It will also link with the CCG's other committees and programme boards for specific work streams. The final document will be reviewed and approved by the CCG Executive and Governing Body and published on the CCG website.

Financial investment is key to delivering effective, efficient and accessible primary care. Our 2016/17 CCG investment plan has prioritised the following key areas of spend to support the delivery of our primary care commissioning ambitions:-

Barnet CCG Primary Care Investment Priorities 2016/17
• Roll out of Community Education Provider training programme to support ECPS • Full review of Personal Medical Services contracts (PMS) with plans for reinvestment across all practices to ensure equity of primary care investment • GP Federation workforce development to support targeted clinical training for GPs and practice nurses • EMIS (patient record system) community for integrated care to support effective sharing of patient records • Pan-Barnet GP Federation development • Development of primary care services at scale including extended access leading to seven day working • Review and further development of locally commissioned services using RightCare and Public Health data for high impact • Development of a substantive primary care development team • Roll out of Barnet Integrated Locality Teams with a new Risk Stratification tool

Appendix 1 - Constituent GP Practice Members – Barnet CCG

North locality

Practice and Address	Practice Partners	Practice Manager
Oakleigh Road Health Centre 280 Oakleigh Road North Whetstone N20 0HD 020 8446 0171	Dr Kim Lumley Dr Jane Howells Dr Dan Free Dr Claire Hassan Dr Kiran Nakrani Dr Zvi Morris Dr Anisha Divani	Kate Johnson
Lichfield Grove Surgery 64 Lichfield Grove Finchley N3 2JP 020 8346 3123	Dr Anne Arnold Dr Alena Chong Dr Philomena Dardis	Neelam Christie
Ballards Lane Surgery 209 Ballards Lane Finchley N3 1LY 020 8346 0726	Dr Su Thwe Dr Remin Mathews	Soo Koh
Cornwall House Surgery Cornwall Avenue Finchley N3 1LD 020 8346 1976	Dr Amelia Chan Dr Adam Townley Dr Zareena Cuddis Dr Vicek Sekhawat	Maria Evangelou
Derwent Medical Centre 20 Derwent Crescent Whetstone N20 0QQ 020 8446 0171	Dr Jonathan Lubin Dr Katherine Boodle Dr Irene Liu Dr Laila Abdullah	Tariq Minhas
Dr David Monkman East Barnet Health Centre 149 East Barnet Road New Barnet EN4 8QZ 020 8440 7417	Dr David Monkman	Katherine Herzmark
Drs Peskin & Hussain East Barnet Health Centre 149 East Barnet Road New Barnet EN4 8QZ 020 8440 7417	Dr Colin Peskin Dr S F Hussain	Katherine Herzmark
Drs Weston & Helbitz East Barnet Health Centre 149 East Barnet Road New Barnet EN4 8QZ 020 8440 7417	Dr Penny Weston Dr Tal Helbitz	Katherine Herzmark
East Finchley Medical Practice 39 Baronsmere Road Finchley N2 9QD	Dr Diane Twena Dr Sanchita Sen Dr Sharon Lawrence	Rachel Evans

020 8883 1458		
Friern Barnet Medical Centre 16 St Johns Villas Friern Barnet Road N11 3BH 020 8368 1707	Dr Sneha Patel Dr Hitesh Shah Dr Anjali Bajekal Dr Rasha Gadeirab Dr Kartik Modha Dr Lesley Perkins	Virginia Saldanha
Gloucester Road Surgery 1B Gloucester Road New Barnet EN5 1RS 020 8449 7677	Dr Patrick Laichungfong	Joyce Lai
Holly Park Clinic Holly Park Road Friern Barnet N11 3HB 020 8368 7626	Dr Raju Raithatha Dr Priti Patel	Virginia Saldan
Brunswick Park Health Centre Brunswick Park Road New Southgate N11 1EY 020 8368 1568	Dr Oge Ilozue Dr Nitin Lakhani Dr Stella Okonkwo Dr Keiran Sneath	Jacqui Perfect
Longrove Surgery 70 Union Street Barnet EN5 4HT 020 8370 6660	Dr Steven Livingston Dr R S Naidoo Dr Michelle Amos Dr Carole Solomons Dr Roselyn Aldeman Dr Nufar Wetterhahn Dr Arani Ananda	Claire Shea
Mountfield Surgery 55 Mountfield Road Finchley N3 3NR 020 8346 4271	Dr Patrick Keane Dr Ann C Robinson Dr Carmel T Mond	Lisa Clark
Rosemary Medical Centre 2 Rosemary Avenue Finchley N3 2QN 020 8346 1997	Dr Sudama Prasad Dr Ritu Prasad Dr Nitu Jones Dr Madhvi Shah	Manish Prasad
Squires Lane Medical Centre 2 Squires Lane Finchley N3 2AU 020 8346 1516	Dr Elizabeth Barthes-Wilson Dr Geeta Thawani	Michaela Mydlova
St Andrews Medical Centre 50 Oakleigh Road Whetstone N20 9EX 020 8445 0475	Dr Anita Patel Dr Sandeep Tanna Dr Alex Whiter Dr Wan Nei Ng Dr Latha Reddy Dr Nicole Hutter Dr Heather Ward Dr Nick Mistry Dr Varuna Ayaru Dr Rakhee Shah (GP Reg) Dr Saleh Ahmed (GP Reg)	Michelle Eshmene
Station Road Surgery 33B Station Road		

EN5 1JJ 020 8440 2912	Dr R Moman	Mahmood Dharas
Dr Isaacson & Partners 192 Colney Hatch Lane Muswell Hill N10 1ET 020 8883 5555	Dr H Mulkis Dr Victoria Knock	Malvi Shah
The Addington Medical Centre 46 Station Road New Barnet EN5 1QH 020 8441 4425	Dr Andrew Painter Dr Minoti Patel Dr Gareth Dee Dr Ayodele Awe	Annie Jones
The Old Courthouse Surgery 27 Wood Street New Barnet EN5 1RS 020 8449 2388	Dr Prashant Desai Dr Susan Lowe Dr Ahmer Farooqi Dr Sumi Sukumar	Tracey Rudge
The Speedwell Practice The Health Centre Torrington Park N12 9SS 020 8445 7261	Dr Stephen Corcoran Dr Clare Stephens Dr Uzma Ali Dr Gumek Nagra	Alison Vint
Dr Ranasinghe Vale Drive Medical Practice Vale Drive High Barnet EN5 2ED 020 8447 3566	Dr Nalini Ranasinghe Dr Raju Raithatha	Dr Ranasinghe
The Village Surgery 113 East Barnet Road New Barnet EN4 8RF 020 8449 6443	Dr Jerry McElligott Dr Anna Turner Dr Elissa Musetti	Lynn Armstrong
Torrington Park Group Practice 16 Torrington Park North Finchley N12 9SS 0844 477 8736	Dr Allan Diatz Dr Peter Bezuidenhout Dr Tessa Buckman Dr Nevil Vallayll Dr Simon Kohll Dr Sarah Showman Dr Vivek Sekhawat Dr Hannah Bartlett	Amanda Reilly
Wentworth Medical Centre 38 Wentworth Avenue Finchley Central N3 1YL 020 8346 1242	Dr Surendra Patel Dr Anuj Patel Dr Sam Peston Dr Saumya Jha Dr Giovanna Russo Dr Sabina Kazi	Margaret Scott Jignasha Patel
Woodlands Medical Centre 54 Leopold Road Finchley N2 8BG 020 8442 2339	Dr Paul Dakin Dr Alexis Ingram Dr Natalie Green	Lynn Rafferty

South locality

Drs Adler & Rosenberg The Surgery 682 Finchley Road NW11 7NP 020 8455 9994	Dr Joseph Adler Dr Frazer Rosenberg Dr Walter Ableman Dr Sylvia Abramov Dr Andrew Wilfin	Aviva Adler
Phoenix Practice 7 Brampton Grove Hendon NW4 4AE 020 8202 9030	Dr Anthony Uzoka Dr Cristina Davis Dr Gaby Stein Dr Afshin Kahen	Lhahir Ismail
Cherry Tree Surgery 26 Southern Road N2 9JG 020 8444 7478	Dr Sergio Decesare	Manish Prasad
Greenfield Health Centre 143-145 Cricklewood Lane NW2 1HS 020 8450 5454	Dr K Mehta Dr A Briffa Dr H Dunseath Dr Deepa Kothari Dr Laily Pourghomi	Jacqui Tonge
BARNDOC Healthcare Ltd Britannia Business Suite Cricklewood NW2 1DZ 03000 334 335	Dr Justin Peter Dr Ujjal Sarkar Dr Sant Ghosh Dr Anthony Uzoka	COO – Alan Levett
Heathfielde Medical Centre Lyttelton Road N2 0EQ 020 8458 9262	Dr S Gibeon Dr L Anderson Dr R Mellins Dr J A Goldin Dr L Cullen Dr Jack Menashy	Chamila Perera
Hillview Surgery 114 Finchley Lane NW4 1BG 020 8203 0546	Dr S Samuel	Cara Garney
Pennine Drive Surgery 8 Pennine Drive NW2 1PA 020 8455 9977	Dr Cerian Choi Dr Barbara Frosh Dr Clare Halsted Dr Deborah Bentley Dr Umar Rashid Dr Peter Rudge	Sunita Miles
Ravenscroft Medical Centre 166-168 Golders Green Road NW11 8BB 020 8455 2477 020 8455 9530	Dr Paul Blom Dr Stuart Wolfman Dr Barry Subel Dr Liam Chapman Dr Dina Kaufman Dr Andrew Frankl	Jane Elliott
St Georges Medical Centre 7 Sunningfields Road NW4 4QR 020 8202 6232	Dr J S Schwartz Dr R J Mailoo Dr C R Hoffbrand Dr C A Benjamin Dr R Maria-Shah Dr A Alakakone Dr Belinda Magnus	Riz Husain
Supreme Medical Centre 300 Regents Park Road N3 2JX 020 8346 3291	Dr Judith Cavendish Dr Roma Fernandez	Jaydev Vyas

Temple Fortune Health Centre Temple Fortune Lane NW11 7TE 020 8209 2401	Dr Lawrence Buckman Dr Martin Harris Dr Serena Leader Dr Sherry Taylor Dr Natalie Woodward Dr Rosenfelder Dr J Kapoor	Christina Brown
PHGH Doctors Temple Fortune HC 23 Temple Fortune Lane NW11 7TE 020 8209 2400	Dr Leora Harverd Dr Karen Grossmark Dr Peter Herbert Dr Saul Kaufman Dr Sharon Roback Dr Farzana Vanat Dr Rasha Gadelrab Dr Abirame Sambasivan	Karen Coughlan
The Hodford Rd Surgery 73 Hodford Road NW11 8NH 020 8905 5234	Dr Michael Cavendish Dr David Suppree	Carole Carlton
The Practice @188 118 Golders Green Road NW11 9AY 020 8298 6498	Dr Tina Grimble Dr John Bentley Dr Alka Meta Dr Intkhab Raja	Julia Hynes
Hendon Way Surgery 67 Elliot Rd Hendon NW4 3EB 020 81029830	Dr Sanaria Abdulla Dr Douglas Baldy-Gray Dr Sadoon Fathi Dr Shireen Ismail	Bina Pandya
Dr Azim & Partners 67 Elliot Rd Hendon NW4 3EB 020 8457 3950	Dr Aimal Azim Dr Nayeem Azim Dr Sevim Bozok Dr Natalie Craven Dr Salima Tariq Dr Mansi Gandhi	Sabreen Hanif

West locality

Dr Sirisena & Partners Deans Lane Medical Centre 156 Deans Lane Edgware HA8 9NT 020 8906 3337	Dr Nihal Sirisena	Samadara Wijemanne
The Surgery 1 Wakemans Hill Avenue Colindale NW9 0TA 020 8205 2336	Dr I Ukachukwu Dr O Bamgbose Dr A Dufu	Nazma Ansari
Penshurst Gardens 39 Penshurst Gardens Edgware HA8 9TN 020 8958 3141	Dr Zoe Pinto Dr Joseph Jones Dr Joanna Yong Dr Katherine Breckon	Kyra Rowlatt
Colindale Medical Centre 61 Colindeep Lane Colindale NW9 6DJ 020 8205 6798	Dr Manu Lamba Dr Amrit Lamba Dr Vasantha Param	Pushpa Lamba

Boyne Avenue Surgery 57 Boyne Avenue Hendon NW4 2JL 020 8457 1540	Dr L Miller Dr H Dimson	Frances Coleman
Jai Medical Centre 114 Edgwarebury Lane Edgware HA8 8NB 0300 033 7860 / 1	Dr Vidya Patel Dr Leena Mistry Dr Rosemary Alexander Dr Swati Dholakia Dr Barsha Jabbar Dr Fayaz Hasham Dr Siva Sundar	Suresh Vaghela
Lane End Medical Centre 2 Penshurst Gardens Edgware HA8 9GJ 020 8958 4233	Dr Penny Cox Dr Michelle Ferris Dr Amit Majevadia Dr Michelle Newman Dr Lyndon Wagman Dr Rebecca Chalk Dr Christina Papadopoulos Dr Simone Shelley Dr Vimal Vyas	Barbara Fortune
Millway Medical Practice 2 Hartley Avenue Mill Hill NW7 2HX 020 8959 0888	Dr Debbie Frost Dr Simon Figa Dr Stephanie Hall Dr Justin Peter Dr Daniela Amasanti-DeBono Dr Thivyan Thiruudaian Dr Kavel Patel Associates Dr Franklyn Harris Dr Adowoa Dufu Dr Sarah Shelley Dr Nick Dattani Dr Amanda Grattan Dr Jenny Noimark	Krishna Moorthy
Mulberry Medical Practice 3 Sefton Avenue Mill Hill NW7 3QB 020 8959 1868	Dr M Gomes Dr A Tobias Dr Rao Petite Dr Jeremy Nathan Dr Leonie Miller Dr Devi Moodaley	Angeline Scully (Woodcroft)
Oak Lodge Medical Centre 234 Burnt Oak Broadway Edgware HA8 0AP 020 8951 6303	Dr Lauren Stephenson Dr Narishta Sebastianpillai Dr Kaksha Shah Dr Siva Ramanathan Dr Hayley Dawson Dr Chuin Kee Dr Sheryl Kaplan Dr Jenny Noimark Dr Sherry Taylor Dr Niamh White	Caroline Peters-O'Dwyer
Park View Surgery 36 Cressingham Road Edgware HA8 0RW 020 8906 7980	Dr T Ganesh Dr S Shanmugaratnam	Susan Murphy
The Everglade Medical	Dr Ila Thakkar	

Practice Grahame Park Health Centre The Concourse Colindale NW9 5XT 020 8432 8641	Dr Heather Hills Dr Sukhjit Sangha Dr Aashish Bansal Dr Hina Taylor Dr Kavita Gopaldas Dr Bryony Moore	Faiyaz Bobat
Langstone Way 28 Langstone Way Mill Hill NW7 3QB 020 8343 2401	Dr Yew Tang Dr David Ruben Dr Gillian Frost Dr Maralyn Pampel Dr Joanna Seres Dr Philippa Kaye	Sanda Handerek
The Raleigh Surgery 4 Raleigh Close Hendon NW4 2TA 020 8202 8302	Dr Victoria Aziz	Maureen Dryer
Watford Way Surgery 278 Watford Way Hendon NW4 4UR 020 8203 1166	Dr S L Datoo	Neeta Mathur
Watling Medical Centre 108 Watling Avenue Edgware HA8 0NR 020 8906 1711	Dr Yvette Saldanha Dr Anup Patel Dr Sanjiv Ahluwalia Dr Murtaza Khanbhai Dr Lauren Goldschmidt Dr James Rusius	Kiran Bakhshi
Dr Makanji Woodcroft Medical Centre Gervase Road Edgware HA8 8NB 020 8906 0500	Dr Hazmukh H Makanji	

Appendix 2 – Strategies influencing primary care

Strategy	National/Regional/Local	Implications for primary care in Barnet
Transforming Primary Care in London: A Strategic Commissioning Framework	Regional - London	Framework for primary care commissioning across London – promoting CCG collaboration to identify key opportunities for transformation with a focus on accessible, proactive and co-ordinated primary care
Five Year Forward View	National	National road map for delivering effective, sustainable accessible and high quality healthcare in England – with a focus on avoiding variation and enabling new models of care
Better Care for London	London	Promotes primary care as the enabler for realising transformational change across the regional health system – encouraging GP working at scale through federative models to improve quality and improved health outcomes
The Future of Primary Care – creating teams for tomorrow	National – the Primary Care Workforce Commission	Focus on the workforce issues facing primary care and how these can be effectively managed locally
Barnet Health and Wellbeing Strategy	Barnet (Borough)	Defines the health and social care priorities for Barnet and the local route map for collaboration between health and social care services with a focus on engagement
Barnet Joint Strategic Needs Assessment	Barnet (Borough)	Provides public health intelligence and expert information on the demographic population of Barnet and the health and social care needs this presents.
Pharmaceutical Needs Assessment (PNA).	Barnet (Borough)	Pharmaceutical services provided, together with when and where these are available Details of planned or likely changes which may affect the future provision Any current or future gaps taking into account the needs of the population
Barnet CCG – IM&T Strategy	Barnet (Borough)	CCG strategy setting out the IM&T priorities for Barnet as we seek to adopt the key elements of the digital road map and movement to a single patient health record.
Barnet CCG – Estates Strategy	Barnet (Borough)	CCG strategy aligned to the wider NCL estates vision – highlighting estate investment priorities for Barnet to enable primary care transformation.
Barnet CCG Quality Strategy www.barnetccg.nhs.uk/Downloads/Publications/Strategies/NHS-Barnet-CCG-Quality-Strategy-2015-18-final.pdf	Barnet(Borough)	Strategy outlining the key quality priorities for the CCG and its service providers – linking to primary care and ensuring quality standards are maintained across the whole of the health and social care system.
Developing sustainability plans- Gateway reference: 04820 Feb 2016	National - NHS England	Local health and care systems will come together in STP 'footprints'. The health and care organisations will work together to narrow the gaps in the quality of care, their population's health and wellbeing, and in NHS finances.
The 2022 GP – A vision for general practice in the future NHS	Royal College of General Practice	A view of health care in the next decade and plan to help GP profession evolve to meet the challenges of this new era: an era in which our population will face more complexity, more choice and more uncertainty and will rely on the expertise, skill and compassion of their GP like never before.

Appendix 3 Right Care Improvement and Savings

This table presents opportunities for quality improvement and financial savings for a range of programme areas. These are based on comparing NHS Barnet CCG to the average of the best 5 amongst a peer group of 10. It should be noted that the opportunities highlighted are what Barnet would realize if it achieved the performance of the average of CCG comparators. The potential opportunities to deliver optimal pathways would result in greater value.

Disease area	spend	£000	Quality	Patients
Cancer and tumours	Spend on elective and daycase admissions	722	Females aged 50-70 screened for breast cancer in last 36 months	2,486
			Receiving 1st definitive treatment within 2 months of urgent GP referral	35
			Successful quitters, 16+	87
			Bowel cancer screening	2,268
Circulation problems (CVD)	Spend on non-elective admissions	420	Stroke patients spending 90% of their time on stroke unit	36
			Patients with CHD whose last blood pressure reading is 150/90 or less	135
	Spend on primary care prescribing	1,143	Patients with CHD whose last measured cholesterol is 5mmol/l or less	91
			% hypertension patients whose BP<150/90	756
			% stroke/TIA patients on anti-platelet agent	51
			% AF patients with stroke risk assessment on ASA therapy	34
			Emergency readmissions within 28 days	12
			% patients returning home after treatment	131
Endocrine, nutritional and metabolic problems	Spend on elective and daycase admissions	110	% diabetes patients whose BP <150/90	153
			% patients receiving care processes	181
			Retinal screening	755
	Spend on non-elective admissions	164		
	Spend on primary prescribing	1,702		
Gastrointestinal	Spend on primary care prescribing	627		
Genitourinary	Spend on non-elective admissions	264	Patients on CKD register with a BP of 140/85 or less	237
			Patients on CKD register with an ACE-I or ARB	15
	Spend on primary prescribing	238	Reported to estimated prevalence of CKD	1
Maternity and reproductive health			Live and still births <2500grams	45
			Flu vaccine take-up by pregnant women	217
			Breastfeeding at age 6-8 weeks	6
			% receiving 3 doses of 5-in-1 vaccine by	822

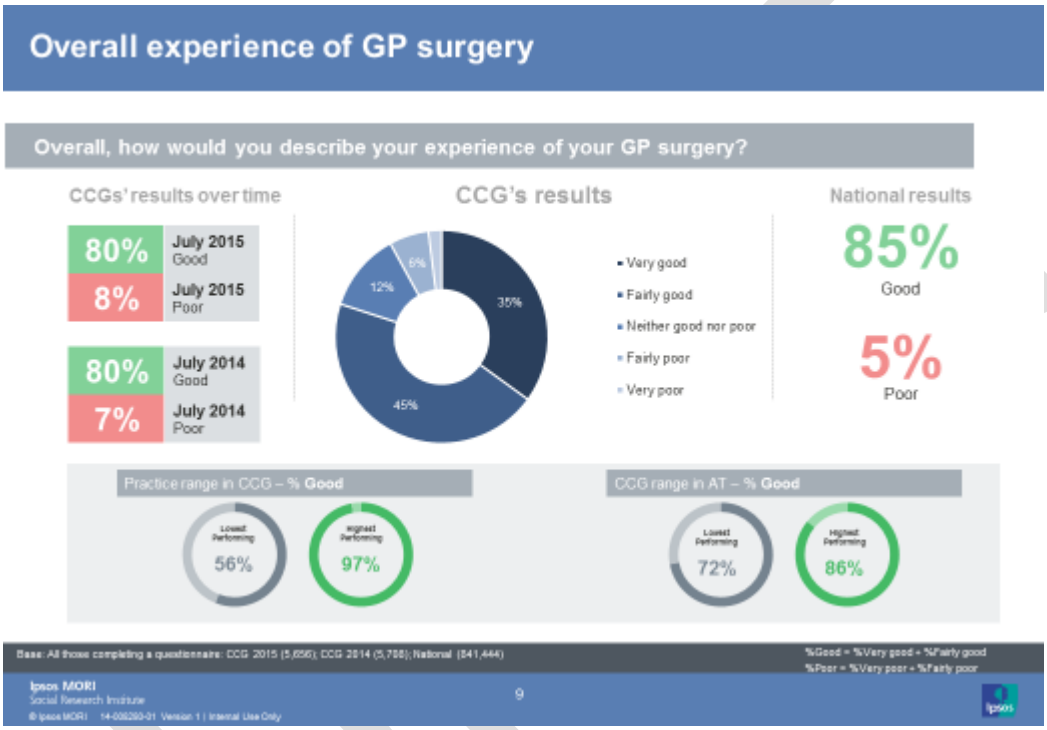
			age 2 % of children aged 4-5 who are overweight or obese % receiving 2 doses of MMR vaccine by age 5 Mean number of decayed, filled or missing teeth in children aged 5 years	 64 976 96
Mental health problems	Spend on primary prescribing	665	People with mental illness and or disability in settled accommodation Assessment of severity of depression at outset Access to IAPT services IAPT referrals with a wait, 28 days Completion of IAPT treatment IAPT % patients receiving treatment IAPT % patients with provisional diagnosis IAPT % referrals with outcome measured IAPT % moving to recovery rate IAPT % achieving reliable improvement Service users on CPA Mental health admissions People subject to mental health act People on CPA in employment	125 205 3,267 645 822 230 934 23 25 57 277 72 66 35
Musculoskeletal System Problems (excluding trauma)	Spend on primary prescribing	40	Knee replacement, EQ-5D index, average health gain % osteoporosis patients 50-74 treated with Bone Sparing Agent % patients 75+ years with fragility fracture treated with BSA Hip replacement emergency readmissions 28 days	6 17 21 4
Neurological system problems	Spend on non-elective admissions Spend on primary prescribing	767 96	Mortality from epilepsy under 75 years	3
Respiratory system problems	Spend on primary prescribing	44		
Trauma and injuries	Spend on elective/daycase admissions Spend on primary prescribing	120 81	Injuries due to falls in people aged 65+ % fractured femur patients returning home within 28 days	138 17
Total saving		7,203	Total patients with improved quality	16,679

Appendix 4 - Contributors to the Strategic Framework for Primary Care

Gerald Alexander	Local Pharmacy Committee
Barnet Youth Council	Working Group
Dr Charlotte Benjamin	Governing Body Member and GP Representative, Barnet CCG
Dr John Bentley	Governing Body Member and GP Representative, Barnet CCG
Sue Blain	Co-chair Healthwatch Barnet Primary Care Group
Stewart Block	Co-chair Healthwatch Barnet Primary Care Group
Sarah Brown	Healthwatch Barnet Primary Care Group
Teresa Callum	Demand and Capacity Lead, Barnet CCG
Christa Caton	Joint Health Commissioner Barnet CCG
Mandy Claret	Barnet CEPN Project Manager
Bernadette Conroy	Governing Body Member and Lay Representative, Barnet CCG
Colin Daff	Senior Pharmacist, Medicines Management Team, Barnet CCG
Dr Swati Dholakia	Governing Body Member and GP Representative, Barnet CCG
Helen Donovan	Governing Body Member and Nurse Representative, Barnet CCG
Michelle Eshmene	Practice Manager, St Andrews Medical Centre
Dr Ahmer Farooqi	Governing Body Member and GP Representative, Barnet CCG
Dr Debbie Frost	Clinical Chair, Barnet CCG
Zoe Garbett	Commissioner, London Borough of Barnet
Melvin Gamp	Healthwatch Barnet Primary Care Group
Alan Gavurin	Estates Project Director FMH, Barnet CCG
Jackie Green	Engagement and Communications lead, Barnet CCG
Dr Tal Helbitz	GP, East Barnet Health Centre, and Primary Care Working Group
Roger Hammond	Director of Finance, Barnet CCG
Valerie Harrison	Governing Body Member and GP Representative, Barnet CCG
Health and Wellbeing Board	London Borough of Barnet
Linda Jackson	Healthwatch Barnet Primary Care Group
Elizabeth James	Joint Chief Operating Officer, Barnet CCG
Seher Kayikci	Senior Health Improvement Specialist, Public Health
Raksha Kukadia	Programme Manager, Primary Care, Barnet CCG
Jeff Lake	Consultant in Public Health, Borough of Barnet
Dr Jonathan Lubin	Governing Body Member and GP Representative, Barnet CCG
Dr Rohan Mailoo	St Georges Medical centre
Chris Munday	Director of Children and Young People's Services, LBB.
Dr Michelle Newman	Governing Body Member, BCCG and Clinical Lead for Primary Care
Mary O'Brien	Delivery Partner, Right Care Programme, NHS England
Maria O'Dwyer	Director of Integrated Commissioning, Barnet CCG
Matthew Powls	Joint Chief Operating Officer, Barnet CCG
Kyra Railata	Practice Manager, Penhurst Gardens Surgery
Robert Reed	Public Health Consultant, LBB
William Redlin	Director of Operations and Delivery, Barnet CCG
Asmina Remtulla	Healthwatch Barnet Primary Care Group
Lisa Robbins	Volunteer and Projects Officer, Healthwatch Barnet
Monica Shackman	Healthwatch Barnet Primary Care Group
Amita Shah	Nurse Development Lead Barnet CCG)
Dr Milen Shah	Watling Medical Centre
Regina Shakespeare	Chief Operating Officer, Barnet CCG (to December 2015)
Margaret Singer	Healthwatch Barnet Primary Care Group
Dr Clare Stephens	Governing Body Member and GP Representative, Barnet CCG
Dr Barry Subel	Governing Body Member, BCCG and Clinical Lead for Urgent Care
Janice Tausig	Healthwatch Barnet Primary Care Group
Sue Tomlin	Joint Commissioning Manager - Learning Disabilities BCCG/LBB
Garrett Turbett	Senior Business Planning & Commissioning Manager Barnet CCG
Beverley Wilding	Head of Primary Care, Barnet CCG

Appendix 5 – Key outcomes from the GP Patient Survey

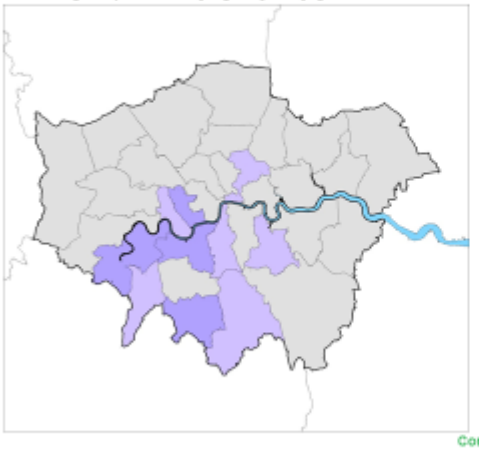
Below are the findings from the 2015 GP patient survey for Barnet – they highlight the CCG specific results and will be used to further inform primary care commissioning intentions moving forwards. The CCG can also review results at practice level and will work with any practices who have identified challenges from the survey with support provided to any particular outliers in terms of performance. This information will also be shared with the CCG quality team and will inform the evolving primary care performance dashboard.



Overall experience: how the CCG's results compare to other CCGs within the Area Team

Overall, how would you describe your experience of your GP surgery?

Percentage of patients saying very/fairly good



Results range from

72%

to

86%

Comparisons are indicative only: differences may not be statistically significant

Base: All those completing a questionnaire: CCG bases range from 2,735 to 6,829 — %Good = %Very good + %Fairly good

Overall experience – how the CCG's practices compare

Overall, how would you describe your experience of your GP surgery?

Percentage of patients saying very/fairly good

Overall Experience of GP Surgery
- 93.0 up to 100.0
- 88.8 up to 93.0
- 84.3 up to 88.8
- 77.9 up to 84.3
- 28.7 up to 77.9

Results range from

56%

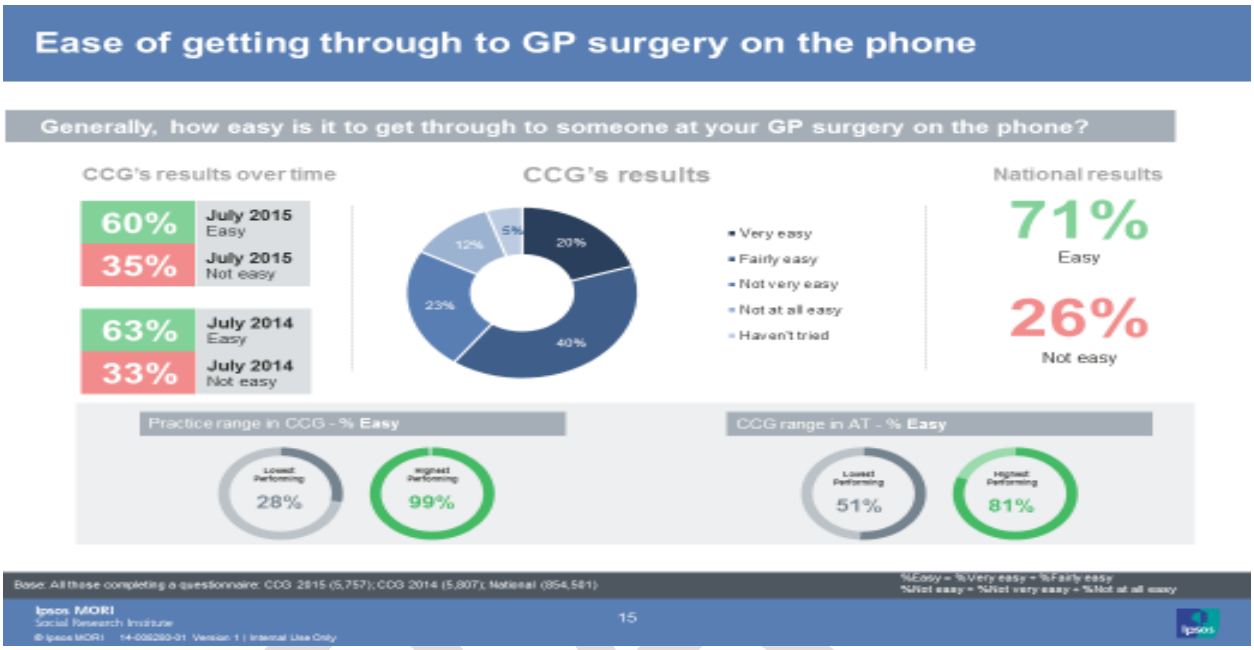
to

97%

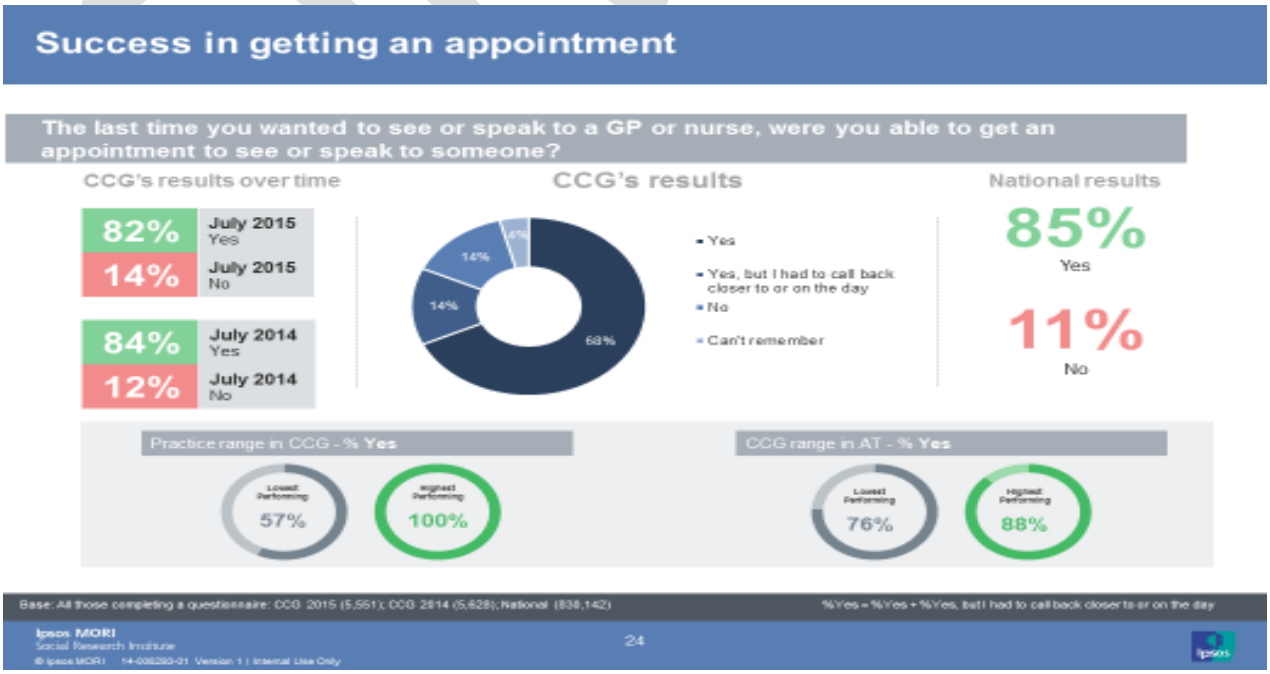
Comparisons are indicative only: differences may not be statistically significant

Base: All those completing a questionnaire: Practice bases range from 16 to 253 — %Good = %Very good + %Fairly good

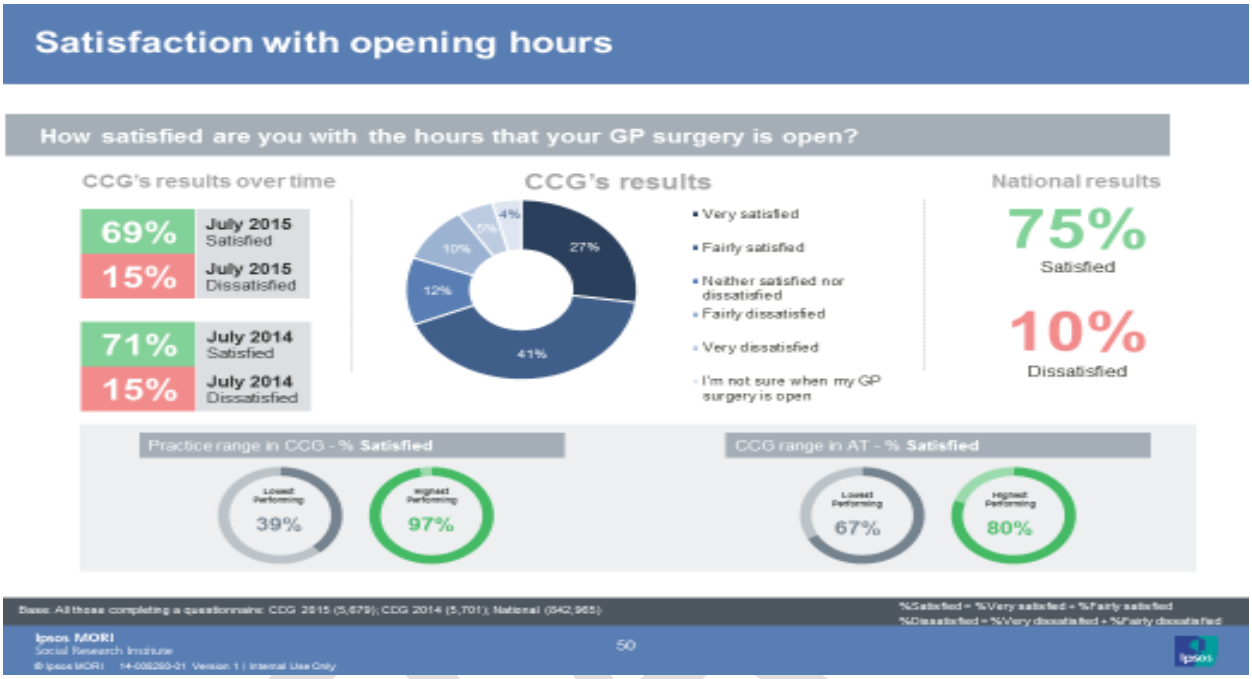
Access - In terms of access, patients appear to be having more difficulty getting through on the telephone with 60% (from 63%) stating easy access. There is concern for the 35% of patients saying it is not easy and here the CCG is below the national average. More discussion with practices on how this can be improved will be undertaken working with exemplar practices achieving 99% to demonstrate how those practices below 30% can be best supported as well as working closely with PPGs and Barnet Healthwatch to realise improvement.



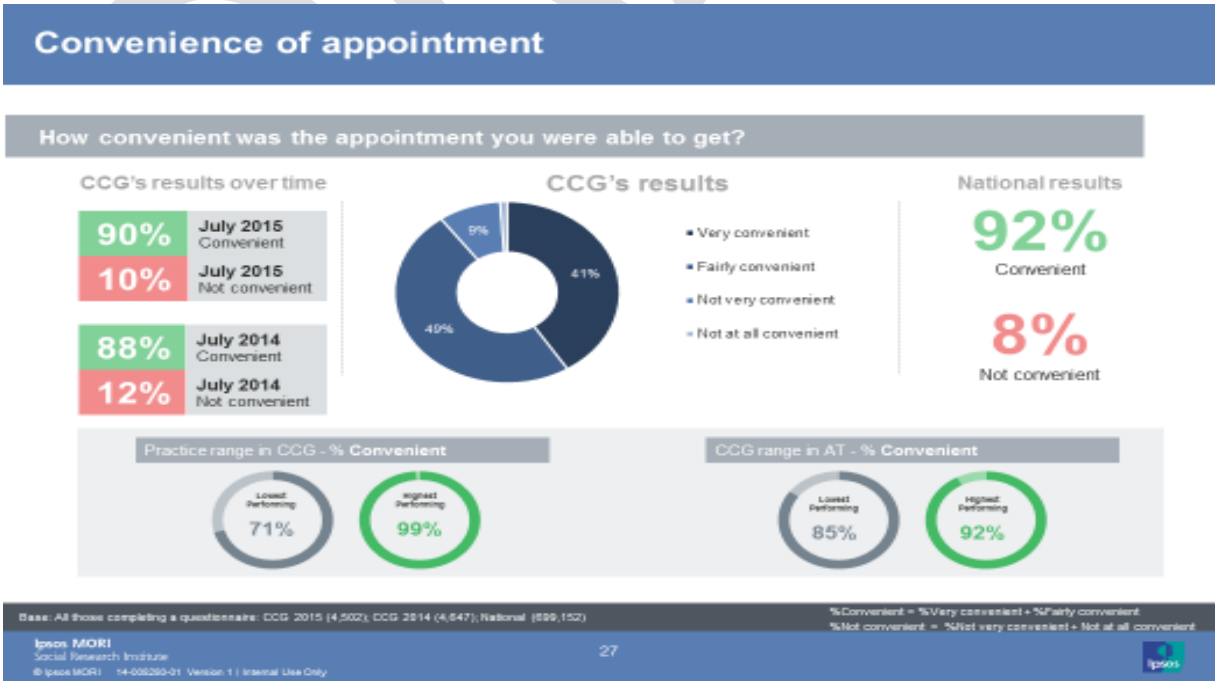
Making an appointment - patients are reporting quite good rates of success in getting an appointment although results are slightly down on rates from 2014. Again some practices have achieved 100% and the CCG will again explore with those high achieving practices how learning can be shared with practices below 60% which give concern.



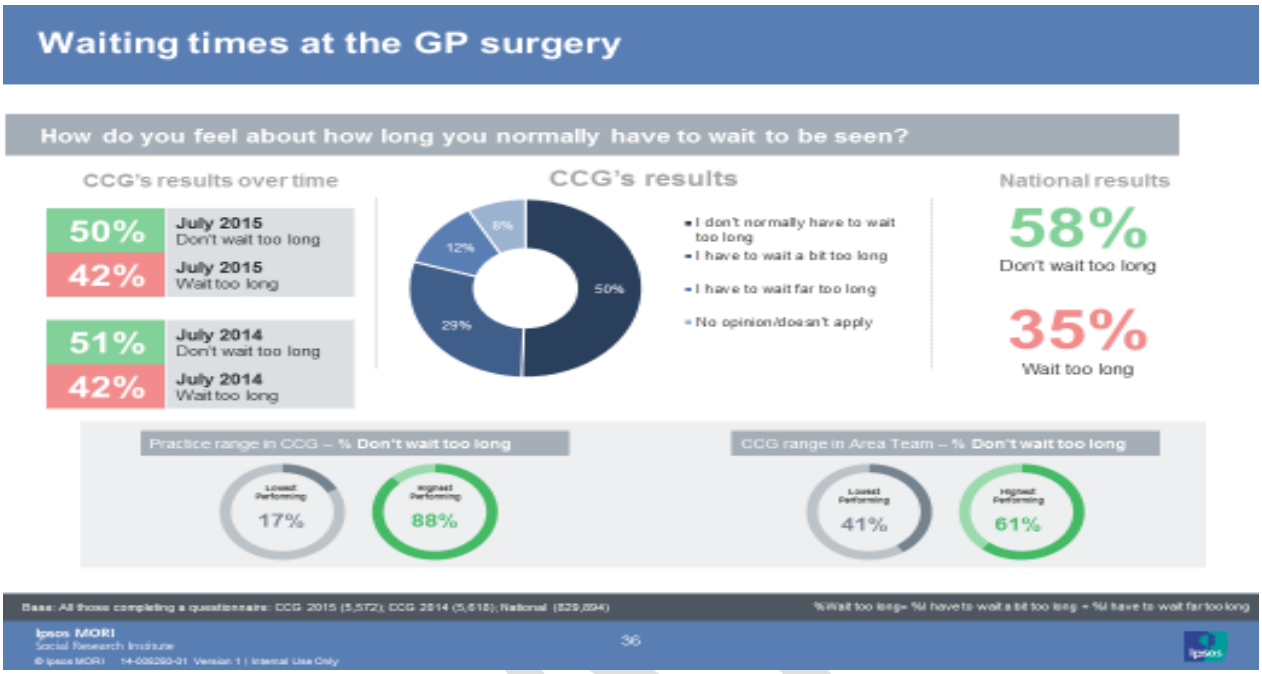
Opening Hours – satisfaction with opening hours has fallen slightly from the previous year. Higher national figures may well be as a result of the PMAF which has seen additional access pilots developed across the country. Barnet have introduced a pilot to provide additional appointments over the weekend which should improve satisfaction rates which are being actively monitored as part of the service specification.



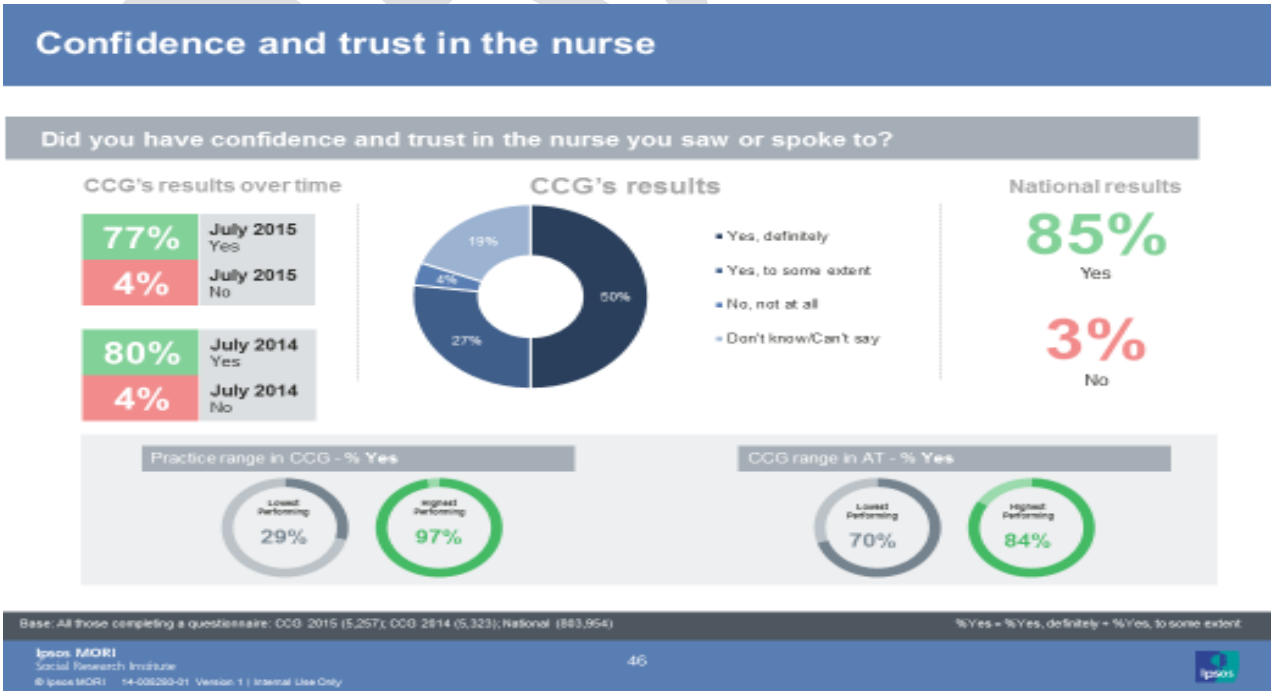
Results have improved from 2014 in terms of convenience of appointment. GP practices and CCG have created more convenient appointments especially through the winter and pilots looking at additional appointment provision at evenings and weekends should improve further.



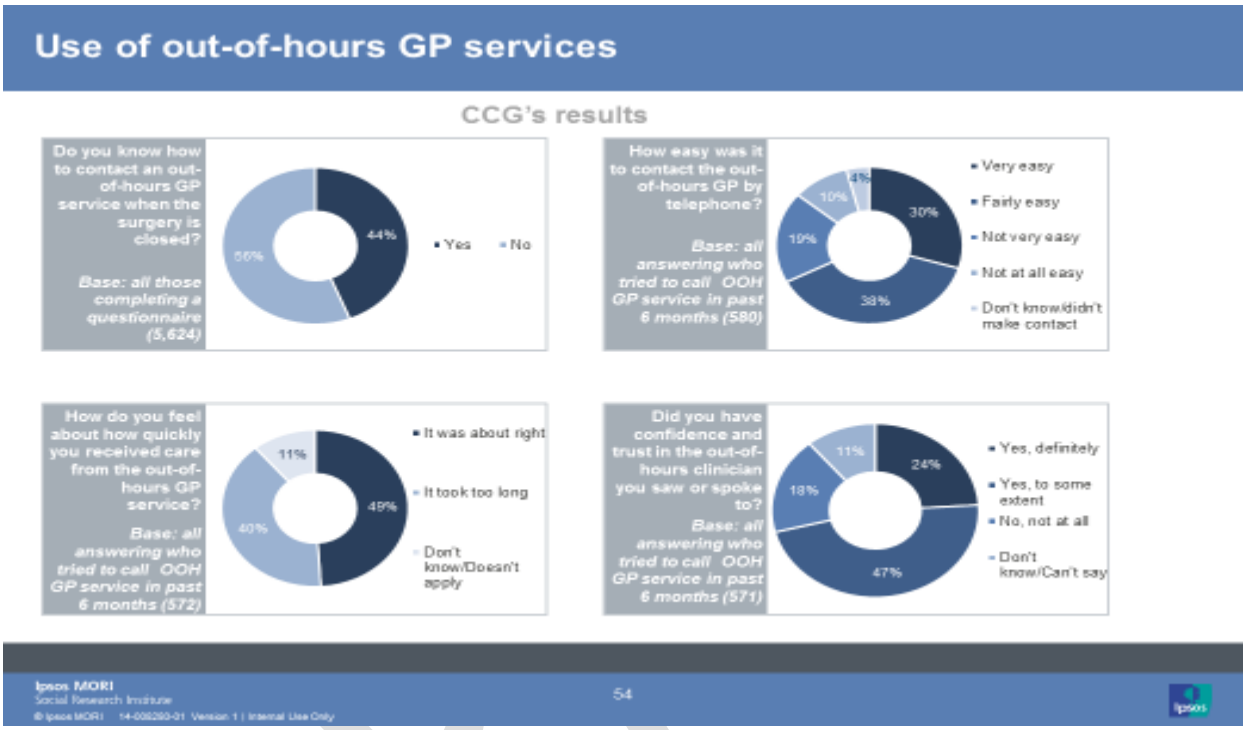
Waiting times would appear to have increased very slightly whilst at the GP surgery – on line booking and telephone consultations moving forward should support improvement.



Patient experience - confidence and trust in practice nurses has fallen slightly since 2014 although the poor experience percentage is unchanged. Pressures on nursing workforce has been challenging but work with CEPN in developing additional nursing capacity and training for new professional entrants should address some of these challenges. The CCG are progressing a practice nurse network where the issue of confidence and trust from patients will be explored.



Experience of GP out of hours is also captured as part of the survey and this shows slightly improved results from the previous year. The emergence of the single patient record and additional primary care appointments created to support access should also have a positive impact on out of hours experience but there is still work to be done with practices and patient representative groups to ensure that out of hour's services meet the needs of all of the Barnet population.



The CCG will continue to work closely with individual practices who have lower percentage survey results to look at ways of supporting improvement whilst working with the GP networks to build on the experience of high achieving practices. Results are also given at practice level which supports this process. In addition the CCG will also work with NHS England, Barnet Healthwatch and individual practice Patient Participation Groups (PPGs) to address areas where there are significant challenges to access, opening hours, making an appointment and overall patient experience. We will also triangulate information to align to individual practice Friends and Family Test (FFT) outcomes and individual practice compliments and complaints procedures.

Appendix 6: Public engagement work and CCG response summary.

Key themes identified through patient and public representation – what do patients and the public want to see from primary care now?	How the CCG is responding to this key theme
Accessible Care As can be seen from the GP survey results and in feedback from discussions, while satisfaction with opening hours is generally good, patients would like to see their GP practice open in the evenings and at weekends – although going to another practice in their locality would be acceptable. Good access during key opening times is also seen as a priority and there is a desire to see their own named GP more easily. Adopting new ways of access – telephone consultations, email and even digital communication (eg skype) would be welcomed but it does not replace a direct face to face consultation and must be with patient consent. This is a particular priority with the Barnet Youth Council representatives. Patients also stated that they would like to see better use of the ten minute appointment – with the introduction of surgery PODs where blood pressure, results and a summary of the problem are all captured prior to seeing the doctor or specialist health care practitioner	Barnet CCG is committed to extending access and has raised contracts for an additional 15,000 appointments during evenings and at the weekends from locality hubs which all Barnet patients can access. We will look to improve access taking lessons from the PMAF. Maintaining and expanding capacity in hours is also a priority together with trialling the capacity needed for Saturday and Sunday working. The CCG has invested in IM&T, introducing one clinical system to all practices and information sharing agreements, meaning records, with patient consent, can be shared. The CCG is also working with the practice managers and GP federation to see how working at scale can help support access with sharing resources. All practices are required to provide a named GP for co-ordinating their care –now applying to all patients. Pre-assessment work prior to the GP consultation is now possible with the introduction of physicians' assistants, Nurse practitioners and more integrated care practitioners. The CCG is working with our localities to look at new health care models allowing GPs to concentrate on the more complex patients, long term conditions and out of hospital services.
Coordinated Care • *Holistic seamless care leading to complete wellness* • *Clear signposting to other services* • *Safe and efficient referrals with clear communication about outcomes* • *Continuity of care for long term conditions – seamless care between the different agencies*	The CCG has invested in one single clinical system to enable communication between practices and other agencies in developing a single patient record. The Barnet Integrated Locality Teams (BILT) ensure seamless transfer of care between primary and community teams which will develop into wider multidisciplinary team

• *Clear signposting to other services* • *Dynamic district nursing service that feels part of the practice team (supporting continuity of care)* • *Need to promote self-care and ensure patients access services appropriately.* • *Patients see the value of out of hours and 111 services* Patient representatives state that they want to see services that are joined up in terms of communication, service pathways and management of care with timely, high quality, accurate referrals and a movement to more care out of hospital.	working based around the locality hubs and community hospitals E-referral is being implemented for all practices with a requirement to oversee referrals made by junior doctors and locums ensuring quality and clear communication. Effective case management and care planning being developed by the CCG in partnership with our community service providers and district nursing teams with a focus on long term conditions and frail elderly care, agreeing joint care pathways which ensure seamless care and improved health outcomes. The CCG will work to deploy new technology to support self-care as a key part of the service for patients with long term conditions. Our communications plan will ensure we provide more information about self-care. The CCG will work with NHS England and other NCL CCGs and the urgent care team to consider the future delivery of NHS 111 and how this works seamlessly with primary care.
Proactive Care *Close working with social care and the voluntary sector (eg supporting patients in sheltered accommodation)* *Active patient participation groups who can in turn lead patient self-help groups* *Patient representatives would like to see more evidence of preventative medicine in areas like smoking, obesity etc* Patient groups state they want to see more preventative medicine in practices, better information, better signposting to the voluntary sector etc. Also the value of self-help needs actively promoting by patient participation groups and Health Champions.	The CCG will be working closely with Health Champions, PPGs and primary care providers to ensure that self-care is actively promoted – linking this with the voluntary sector, promoting the use of care navigation etc. The CCG will work closely with public health and the Health and Wellbeing Board to ensure that prevention is a priority for primary care as well as reactive care. Our patient engagement strategy will work closely with public health to include health promotion alongside service pathway development especially with work being undertaken with children and young people.
Patient Choice • *Choice of practitioner, eg nurses physiotherapists pharmacists not just GPs)* • *Choice of clinics and services in house (eg phlebotomy, blood pressure clinics, physiotherapy,*	The CCG will be working with the GP federation, other service providers and educational leads to look at developing new models of care that enable wider choice of service providers whilst supporting primary care delivery. The workforce section of the strategy

gynaecology, palliative care) Patient representatives report that they would like to see wider choice about the services they can access, the practitioners who provide them, improved access to services out of hospital and the ability to go to other primary care centres for services where their own GP cannot deliver them.	describes how different professionals such as pharmacists, physician's assistants, practice nurses and emergency care practitioners may become increasingly involved in the delivery of primary care services. The CCG will support practices to diversify their teams and work with them to ensure the value of these specialists is communicated to service users. Developing more services out of hospital will be a key part of the CCGs primary care ambitions for the next three years, reducing the number of outpatient clinics in an acute setting, developing more appropriate locally commissioned services and redesigning care pathways so that there are more outreach clinics requiring less acute service access.
Quality *Clean and efficient practices* *Clear understanding communicated to patients of how the practice works – including details about telephone access (not just speaking to a machine), how to make appointments etc* *User friendly practice websites* Patient representatives report that they would like to see equitable standards of quality in practices – most in Barnet are of a good quality but where there are issues Barnet Healthwatch is keen to work with PPGs. The representatives are also keen to hear what outcomes CQC determine from the visits and what plans are in place where there are issues raised.	The CCG has developed a quality strategy and the primary care team are working closely with the quality team, NHS England and the Care Quality Commission to ensure that practices are supported where there are challenges in delivering quality of care. Primary care estate is a key focus for the CCG and we are working with NHS England to ensure that we have a robust prioritisation process for developing and supporting the improvement of primary care estate – accessing national, regional and local funding to resource developments as needed. The CCG, in partnership with NHS E and our development partners, Primary Care Commissioning will be working with our constituent practice managers to support them in developing their practice teams to meet patient needs, with focus on effective and efficient practices and buddying systems whereby successful practice managers can work closely in supporting new managers. It is a contractual requirement for all practices to have an effective practice website. The CCG will work with Barnet Healthwatch and NHS England to ensure all is in place and our primary care engagement lead will work with PPGs to ensure that practice websites are kept up to date and are responsive to patient needs.

Appendix 7: Action Plan for Barnet – implementing the priorities locally from the Standard Commissioning Framework (SCF) aligning to Transforming Primary Care in London.

Proactive Care P1	
Primary care teams will work with communities, patients, their families, charities and voluntary sector organisations to co-design approaches to improve the health and wellbeing of the local population	The CCG's Patient Reference Group is a group of local people and local organisations representing the interests of the different groups in our local community. We have set up the PRG to: Create a two-way communication channel between patients, carers, local residents, and the CCG Create a forum where the CCG can engage with patients and the public in the planning, co-design of health services. Specific events organised for providers and service users to allow to help the CCG to identify what our commissioning priorities should be and to develop commissioning intentions for 2016/17 The CCG Continuing Health Care team are working case by case, engaging patients, carers and families to profile support for End Of Life to ensure more people live and die in their preferred choice. Existing Support Services commissioned from voluntary sector such as Alzheimer's Society: "Singing for the Brain"; "Day Service"; "Dementia Advisers"; "Dementia Cafes"; "Altogether Better"; "Later Life Planning". The demographics of Barnet is such that we do not have many hard to reach groups in the same way as populations of other London CCGs, however we have one small initiative where doctors from local practices provide regular sessions at a Homelessness centre
Proactive Care P2	
Primary care teams will work with others to develop and map the local social capital and resources that could empower people to remain healthy; and to feel connected to others and to support in their local community	Re-imagining Mental Health Programme - to develop hubs in Primary Care with a vision to support Mental Health Patients at all levels, signposting them to the right health and social service/organisations to live a healthy and independent life, offering them a full package. This will be co-designed with Service users, carers and ex-users of service. Initiatives already in place are the Twining project - providing employment support to MH patients; the Eclipse project - linking with Job Centre Plus and voluntary organisations.
Proactive Care P3	
Where appropriate, people will be asked about their wellbeing, capacity for improving their own health and their health improvement goals	The priorities for the Public Health team is mainly on preventive care and health and wellbeing. Health Checks for patients and carers taking place in practices; pharmacies and many local authority buildings across Barnet. Care Planning for the Frail & Elderly under the AUA DES and the over 75s national directive.
Proactive Care P4	
Primary care teams will enable and assist people to access information, advice and connections that will allow them to achieve better health and wellbeing. This liaison function will extend into schools, workplaces and other community settings	BILT (Barnet Integrated Locality Team) is a Pilot programme which aim to support the vision of the MDT programme (below) and it includes therapeutic intervention and services. The positive evaluation means that this will now be rolled out across Barnet. Barnet Frail and elderly MDT is a Pan-Barnet initiative - referrals from primary care and acute sector seeing coordinated care plans being put in place to reduce the risk of unplanned admissions and premature placement into nursing or care homes
Proactive Care P5	

Primary care teams will design ways to reach people who do not routinely access services and who may be at higher risk of ill health	Barnet CCG commission sessions from GPs in homelessness project which includes GPs providing locally commissioned services for entrenched and transient homeless.
Proactive Care P6	
Case finding and review service for the top 2% of complex patients	The CCG will be working as a first wave pilot for Right Care to identify the top 2% complex patients to ensure case finding and management can improve their health outcomes and support efficiency. From 3 February 2016 onwards for the duration of the 12 month first wave Right Care pilot.
Proactive Care P7	
Case finding and review for the top 2% of complex patients	The CCG has deployed a risk stratification tool in GP practices. Each patient list has been stratified, with high risk patients being classified using the defined algorithm. Clinical judgement also plays a part in confirming/identifying high risers (who have not been picked up in between system data refreshes). Currently GPs are asked to review the top 2% of the identified high risk patient (level 3) as part of the admissions avoidance work. The work is taken through the CCG's integrated Care programme.
Accessible Care A1	
Patients will be given a choice of access options and should be able to decide on the consultation most appropriate to their needs.	With the systems resilience funding the CCG has actively provided additional primary care access in order to reduce on A&E and the WIC (1 million). Additional GP and Nurse sessions for Winter Pressures 2014/15 and April 15. Practices participating in the AUA DES will already have for call & recall systems in place for vulnerable patients. CCG are developing a wider Frail and Elderly strategy. Direct Urgent booking into GP appointments by 111. Patients are signposted to appropriate clinical needs and patients have a choice of services that are available. Barnet has 3 Walk In Centres providing urgent primary care access from 8 to 8 and weekends. Additional to this the CCG is developing 7 day access to GMS services (pre bookable appointments) as per the Five Year Forward View challenge, the NHSE Transforming Primary Care in London A Strategic Commissioning Framework. Learning is being applied from the PMCF application process and working with neighbouring CCGs to develop a system wide solution. The plan is to commission this service at scale and get local providers (OOH; WICs; and networks) to collaborate in provision. The high level proposal has been approved. Submission has been made as part of the Systems Resilience funding for 2015/16.This funding if made available will be invested to extend The primary care access scheme - two hubs initially with a wider extension of this should central funding be confirmed.
Accessible Care A2	
Patients will be required to only make one call, click or contact in order to make an appointment. Primary care teams will maximize the use of technology and actively promote online services to patients including appointment booking,	Data Sharing project - Initial plan is to enable practices to share patient records, and second stage to connect provider organisations to GP systems with the use of MIG to ensure enhanced and seamless service. The community license agreements have been agreed by the LMC and will be rolled out for sign up Sep 15.

prescription ordering, viewing medical records and email consultations.	
Accessible Care A3	
Email consultations (A2)	The CCG| supports support the implementation of electronic consultations across all our practices, planning work at NCL to support the development of a joint bid for e-consult to facilitate the rollout of electronic consultations to be put into place for 2016/17.
Accessible Care A4	
Patients will be able to access pre-bookable routine appointments with a primary health care professional (see 'workforce implications' for the proposed primary care team) at all practices 8am – 6.30pm Monday to Friday and 8am to 12 noon on Saturdays. An alternative equivalent patient offer may be provided where there is a clear, evidenced local need.	As A1 above
Accessible Care A5	
Routine opening hours	The pilot for the delivery of this service which is accessible by all GP practices in Barnet, through shared access to records and appointment book commenced in December 2015, it will be evaluated to assess the effectiveness, and patient experience. On the day booking arrangements, currently directed through 111, looking into the ability for A&E to book direct. Recurrent funding is required to take forward the pilot (dependent on the evaluation) from May 2016. Pilot – December 2015 to April 2016. Recurrent funding applied for
Accessible Care A6	
Extended opening hours	There are three WICs in the Barnet area that see in excess of 125,000 patients per year in three convenient locations within the Borough. Opening hours of two WIC until 10pm 7 days a week. Looking at the potential for the Barnet Federation to locate a GP at the front door of the A&E to prevent unwarranted admissions.
Accessible Care A7	
Extended opening hours	In addition to Saturday morning extended appointment, the Barnet Federation is also providing additional appointments on a Friday and Monday evening and Sunday morning. Discussions are on-going about the ability to extend additional access to weekdays. The pilot will be evaluated, see A3 above. We are engaging with Barnet Healthwatch regarding patient need for additional hours – initial feedback is a preference for more weekday appointments rather than weekend appointments. 6 month contract with an option to extend for a further 12 months prior to sustainable service procurement.
Coordinated Care C1	
Practices will identify patients who would benefit from coordinated care and continuity with a named clinician, and will proactively review those	BILT (Barnet Integrated Locality Team) is a Pilot programme which aim to support the vision of the MDT programme (below) and it includes therapeutic intervention and services. Following positive evaluation this pilot will now be rolled out across Barnet Barnet Frail and elderly MDT is a Pan-Barnet initiative - referrals from primary care and acute sector seeing coordinated care plans being

that are identified on a regular basis.	put in place to reduce the risk of unplanned admissions and premature placement into nursing or care homes. This provides intensive support to patients at risk. A weekly meeting of senior level MDT takes place to provide case by case review. Practices participating in the AUA DES will already have for call & recall systems in place for vulnerable patients. CCG are developing a wider Frail and Elderly strategy.
Coordinated Care C2	
Patients identified as needing coordinated care will have a named professional who oversees their care and ensures continuity.	As above – this is part of the BILT programme across Barnet
Coordinated Care C3	
Continuity of Care – patient having a named GP	It is a contractual requirement that every patient has a named GP. Capital IT bid submitted to implement the digital shared record in 2016/17.

Appendix 8: Public Health input for Strategic Framework for Primary Care

Public Health Priorities:

Better CVD management	**Improve diabetes management**
Mental Wellbeing	**Greater focus on latent TB programme**
Wider tobacco control such as shisha	Obesity - particularly children and pregnant women and commissioning of tier 3 services
	Linking into early years services

Better CVD management (greater focus on prevention & address variation in primary care (diagnosis, management and early intervention))

In the London Borough of Barnet (LBB), CVD is the top cause of premature mortality, especially among the population under 75 years of age. Data for 2012-2014 show that the Barnet death rate due to preventable CVD in those aged less than 75 years was 39.3 per 100,000 and was higher in males (57.1) compared to females (23.5).

Barnet spends too much on acute hospital care for CVD. Primary care can help reduce the need for this. Making Every Contact Count (MECC) could prove very useful. MECC is about encouraging and helping people to make healthier choices to achieve positive long-term behaviour change. To do this, organisations need to build a culture and operating environment that supports continuous health improvement through the contacts it has with individuals.

MECC involves:

• systematically promoting the benefits of healthy living across the organisation
• asking individuals about their lifestyle and changes they may wish to make, when there is an appropriate opportunity to do so
• responding appropriately to the lifestyle issue/s once raised
• taking the appropriate action to either give information, signpost or refer individuals to the support they need.

Commissioning for value focus pack Clinical commissioning group: CVD pathway - NHS BARNET CCG, December 2014

This focus pack or deep dive looked at an agreed programme area (CVD) to understand variation and improve the value of commissioned services across the pathway.

Overarching messages for the CCG

- Significant benefit to patients if improvement to primary care management indicators were made
- High cost for stroke emergency admissions

- High number of admissions for: CHD emergency admissions (male), stroke emergency admissions (male), heart failure emergency admissions (female)
- High length of stay for: CHD elective admissions (male), angiography procedures (female)
- Low percentage of stroke patients discharged to usual place of residence

Summary - Primary care

- 19 out of 27 primary care indicators are worse than the benchmark.
- QOF indicators have been used but exceptions have been included in the denominator.
- The following 5 indicators are in the worst quintile, the potential benefits based on achieving the benchmark are shown in brackets:
    - AF & CHADS2 score >1, % anti-coagulation drug therapy (182 more people)
    - % stroke patients referred for further investigation (105 more people)
    - % MI patients treated with ACE-I, Anti-platelet, BB, statin (47 more people)
    - AF & CHADS2 score of 1, % anti-coag/platelet drug therapy (29 more people)
    - % HF patients due to LVSD treated with ACE-I or ARB (20 more people).

Number of Indicators where CCG has room for improvement

Prevention

1/5 prevention indicators worse than England benchmark:

- Percentage of adults with low levels of physical activity = 5, 451 people

Prevalence

2/3 of the observed to expected prevalence ratios are worse than the England benchmark:

- Hypertension observed to expected prevalence ratio = 3,834 people
- Stroke observed to expected prevalence ratio = 326 people
- CHD observed to expected prevalence ratio = N/A (not below benchmark)

7/7 disease groups had a higher prevalence than the England benchmark:

- CVD prevention register = 1,589 people
- Atrial fibrillation = 182 people
- Peripheral arterial disease = 35 people
- Heart Failure = 127 people
- Hypertension = 610 people
- Stroke = 504 people
- CHD = 938 people

Improve diabetes management

With the present levels of obesity and the estimated increases in the size of the population, the number of cases of diabetes is set to rise dramatically. Increasing prevalence of long term conditions, particularly diabetes, chronic cardiac conditions and dementia will severely stretch the emergency and hospital services unless better management in the community is achieved.

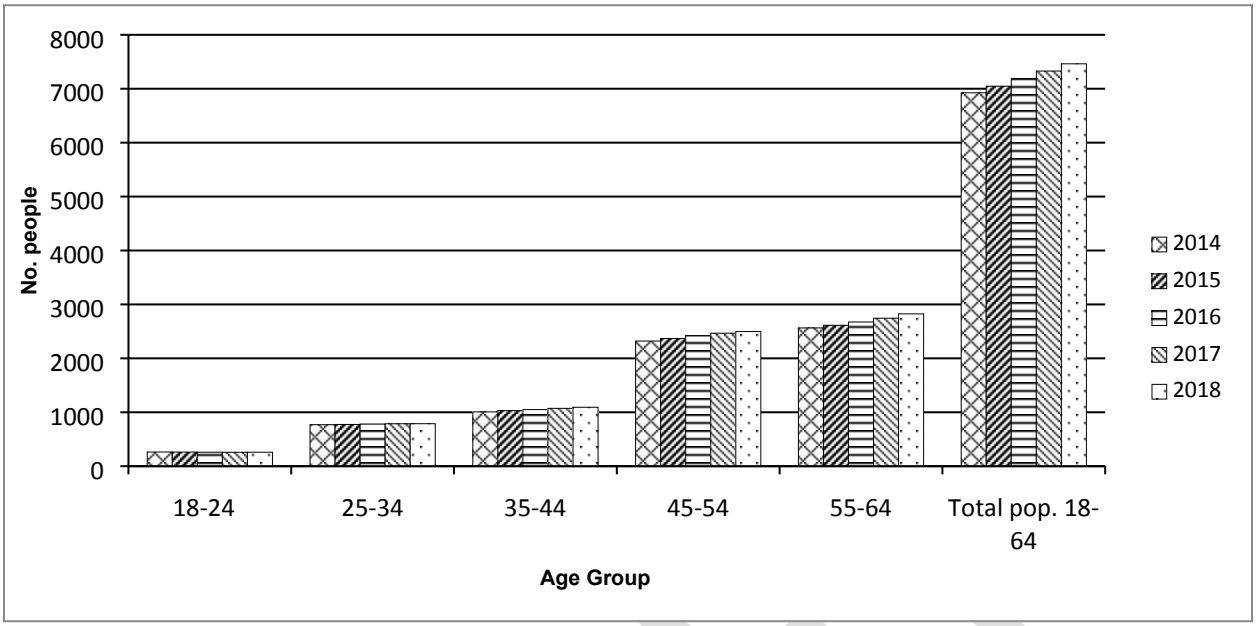


Figure 1. People aged 18-64 predicted to have either Type 1 or Type 2 diabetes, by age and gender, projected to 2018.

Source: Projecting Adult Needs and Service Information System.

According to 2014/15 QOF data, the prevalence of diabetes in Barnet (amongst people aged 17 and above) is 6.0% and significantly lower than the level in both England and London. Estimated total (diagnosed and undiagnosed) prevalence of diabetes in 2015 in Barnet adults (8.3%)[11]

However, the National Diabetes Audit 2012-2013 recommended that the Barnet CCG should review its diabetes care providers to reduce the risks associated with diabetes and use different approaches including exercise, diet composition, weight management, smoking, glucose control, blood pressure control and cholesterol control. These recommendations should be taken seriously and

North Central London Transformation Plan - CVD

Recommendations

- Patient and community participation in healthy lifestyle and self-management
- Scale up secondary prevention and early detection initiatives.

Outcomes

- Earlier diagnosis
- An additional 85,000 cases of high blood pressure detected and controlled
- Improved self-management.

Impact

- 900 fewer strokes over 5 year period after we reach Canadian levels of BP control
- 400 fewer hear attacks over 5 year period
- Over £18million saving to NHS over 5 year period
- 5000 fewer patients with diabetes with poorly controlled BP
- 10,000 fewer people with diabetes with high cholesterol levels
- Increased number of newly diagnosed diabetes cases receiving structured patient education

[11] Public Health England. Diabetes Prevalence Model for Local Authorities and CCGs.

- Reduction in undermanaged AF
- Reduction in early deaths
- Reduced health costs.

North Central London Transformation Plan -Mental Wellbeing

Recommendations

- Better diagnosis and early identification
- Timely access to effective treatment services – CAHMS, IAPT
- Systematic scaling up of effective employment and support programmes
- Addressing stigma and discrimination.

Outcomes

- Earlier diagnosis and treatment
- Increase in employment for people with mental health

Impact

- Reduction in health costs
- Reduce morbidity, deaths and inequality gaps

Greater focus on latent TB programme

TB in Barnet is more common in men in all age groups but it involves more females in the 20-29 years age group. The majority of TB patients were born abroad and about 28 % came to the UK within the previous 4 years. In Barnet, the most common ethnic group having TB is people of Indian origin (35%), which is followed by mixed / other ethnic background (26%) and black Africans (20%). In addition, Barnet has a higher number of drug resistant TB cases than the average number of these cases in London[12]

Evidence shows that involvement of local communities helps in creating awareness and successful completion of treatment of latent TB[13]. To raise TB awareness in local communities identified as being most likely to be affected by TB, Barnet and Harrow public health commissioned a number of TB awareness training sessions during January – March 2015. The training sessions were attended by more than 60 local community groups, service managers and interested individuals. In addition, TB workshops and a seminar on the world TB day (24th March) were organised that brought together local advocacy and community groups, national TB and local clinical and public health expertise to discuss TB related issues and local needs. A local TB grant scheme has been developed and opportunities for local community groups and organisations to bid for small sums to support local TB advocacy awareness are now being rolled out.

[12] Public Health England. (2013) Local authority TB profiles (2012 data).

[13] Gupta et al. (2015) Tuberculosis among the Homeless — Preventing another Outbreak through Community Action. *N. Engl. J. Med.* 372 (16):1483-1485.

NHS
Barnet Clinical Commissioning Group

Barnet Clinical Commissioning Group Strategic Framework for Primary Care 2016-2020

Dr Debbie Frost, Chair, Barnet CCG

Sean Barnett, Programme Manager, Barnet CCG

12th May 2016

Overview

- Background
- Engagement
- Current Status
- Immediate Future
- Longer term Future
- Next steps

Background

- 62 GP Practices
  - ❖ Mix of General Medical Services (GMS) and
  - ❖ Personal Medical Services (PMS)
- Different levels of funding
- Varying levels of service provision
- On the whole performing well across Barnet in terms of referrals, A&E attendances and Quality Outcome Framework (QoF).

- Above average number of single/dual partner practices
- List sizes per practices lower than average
- 30% of GP workforce above age 55
- 60% of GPs are female
- 244 GPs working with 204 wte

- Slightly worsening patient feedback in last national survey

- Relatively low levels of deprivation – but some hotspots

Engagement

- Good level of engagement with HealthWatch in late 2015
- Young People's forum via the council
- CCG and LBB joint commissioning officers
- CEPN – our education partners
- RightCare – with NHS E providing analysis of impact
- Practice Managers
- Local GPs

Current Status

- DRAFT strategy- for your information, your input and your support
- Discussed within CCG and stakeholders such as HealthWatch.

- **Accessible care** - Better access to primary care professionals, at a time and through a method that is convenient and with a professional of choice.
- **Co-ordinated care** - Greater continuity of care between NHS and other health services, named clinicians, and more time with patients who need it.
- **Proactive care** - More health prevention by working in partnerships to reduce morbidity, premature mortality, health inequalities, and the future burden of disease in the borough. Treating the causes, not just the symptoms.

Accessible Care

- GP Access Hub for evening and weekend slots
- Utilisation of support partner PCC in aiding better utilisation of slots in practice
- Telephone consultations
- Wider range of health care professionals
- WiC/111/Urgent care
- Patient online booking
- Electronic record sharing with patients

I'm now able to book my appointment online, making it really easy from work, and also see my last results and information in my record. It helps me to take responsibility for my own health needs, like reducing my cholesterol.

Coordinated Care

- Named GP and case worker for vulnerable patients – to provide continuity
- Extension of the BILT team pilot across the CCG
- MDT sessions for complex patients with range of professionals/organisations
- Data sharing agreements in place
- Shared care plans with patient, carers and professionals

I have 3 children and I work part time. I noticed that one of them was unwell and was really pleased that when I rang the practice after 5pm they could still offer me an appointment. It wasn't at my usual practice or with my usual doctor but at a practice down the road and at least with a professional who was able to prescribe medication. Later in the night she got worse so I called the Out of Hours GP who could see my child's record on line. It turned out to be something more serious and arranged for her to be admitted. It took 10 days for her to be well again – so glad that staff acted quickly.

Proactive Care

- Case findings with integrated teams to prevent admission to hospital
- Outreach to patients deemed difficult to reach such as homeless
- Information and advice outside healthcare settings such as school and workplaces
- Co-design of services with community and voluntary sector to maintain health and wellbeing

My dad has COPD and becomes anxious when the weather turns cold and damp. The Barnet Integrated care team are great at offering a direct dial number where he can get reassurance. His named worker knows him well and can tell quickly when his breathing is affected. He has a “steroid rescue pack” in the bathroom which means he can stay safe over the weekend.

Immediate Future

- PMS review
  - Reduce funding for top practices
  - Transition process for those most heavily affected
  - Level of equitable services
  - Commissioned services that have high impact
- Estates utilisation survey
- Primary Care Improvement Grant applications via CCG
- Estates feasibility studies in
  - East Barnet/Barnet Town
  - Hendon/Cricklewood/Golders Green
  - East Finchley
- CCG team for delivery to include workforce, estates, locality planning, finance and IM&T support officers
- Commission a referral management service that supports clinical decision making
- Development of IT to support patient access
- Evaluation and commissioning of GP Access Hub
- Commission a new Risk Stratification Tool across health and social care
- Establish effective Patient Participation Groups at practice and locality level

Long Term Future

- Application for Level 3 commissioning – fully devolved – by April 2017, possibly earlier
- Local monitoring of performance
- Estates rationalisation with access to Primary Care Transformation Funds (c£1m)
- IM&T to support treatment plans and health prevention services
- Providing a wider range of services with other local partners especially community services such as district nursing and mental health providers and voluntary sector.
- Establish a robust recruitment, retention and training plan for primary care, including new roles and joint posts with other providers

Next Steps

- Update the Strategic Framework for Primary Care from feedback today
- Formally adopt the framework through the our Clinical Cabinet and CCG Board
- Action the Implementation Plan including monitoring and evaluation/benefits realisation steps
- Recruit delivery team
- Write a patient-friendly version.
- Continue engagement with practices and public.

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AGENDA ITEM 7

	Health and Wellbeing Board **12 May 2016**
Title	**Better Care Fund plan for 2016/17**
Report of	Commissioning Director – Adults and Health CCG Accountable Officer
Wards	All
Date added to Forward Plan	September 2015
Status	Public
Urgent	No
Key	Yes
Enclosures	Appendix 1: BCF plan for 2016/17
Officer Contact Details	Kirstie Haines, Strategic Lead Adults and Health Kirstie.haines@barnet.gov.uk Muyi Adekoya, Acting Head of Service (Joint Commissioning) Muyi.adekoya@barnetccg.nhs.uk Leigh Griffin, Director of Strategic Development Leigh.Griffin@barnetccg.nhs.uk

Summary

This report presents the Final Better Care Fund (BCF) Plan for 2016/17, submitted to NHS England on 3 May 2016, for ratification by the Health and Wellbeing Board (HWBB). The plan was agreed by the Chairman and Vice Chairman of the Board along with the Chief Executive of the Council prior to submission.

The Council and Barnet CCG have updated the BCF Plan following a request from NHS England to include more details of the schemes of work and their individual impact. This report also updates the Board on delivery progress on integrated health and social care services for older people (as detailed in the Business Case for integration presented on 18 September 2014) and the work plan to set up the pooled budget required to determine and

manage investment and spend to deliver the schemes of work in the Plan.

Recommendations

1. **That the Health and Wellbeing Board ratifies the Better Care Fund plan for 2016/17, submitted with agreement from the Chairman, Vice Chairman and the Council's Chief Executive, to NHS England on 3 May 2016.**

2. **That the Health and Wellbeing Board notes the next steps described under section 4 of this paper and section 3 of the plan following approval of the Plan.**

3. **That the Board notes and comments on progress on delivering and embedding the 5 Tier Integrated Care Model.**

1. WHY IS THE REPORT NEEDED

1.1 Background

1.1.1 This report presents the Final Better Care Fund (BCF) Plan 2016/17 (appendix 1) submitted to NHS England (NHSE) on 3 May 2016, following the previous Plan presented to HWBB on 29 January 2015 and submitted to NHSE on 9 January 2015.

1.1.2 In 2015-2016 we submitted a plan for our use of Better Care Fund resources. In 2016-2017 we intend to continue to work to the vision set out in this plan.

1.1.3 As an example of the BCF work to date, please view this video about the Barnet Integrated Locality Team (BILT) – https://www.barnet.gov.uk/citizen-home/adult-social-care/Barnet-Integrated-Locality-Team.html

1.1.4 In 3 to 5 years' time, we will have developed a fully integrated health and social care system for the frail and elderly population through implementation of our model so that it:

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

1.1.5 The development of the local Sustainability and Transformation Plan for

North Central London (NCL) will result in us revisiting our integrated care plans in 2016-2017 but for the purposes of this submission we have referenced new and emerging NCL work-strands where these will have an impact on the achievement of the BCF national conditions.

2. REASONS FOR RECOMMENDATIONS

2.1.1 Following comments from NHS England, the Final BCF Plan now includes significant additional detail to demonstrate the scale, quality and impact of the schemes of work planned to meet locally agreed targets related to reducing non-elective emergency admissions for the cohorts identified within the plan alongside supporting the required improvements in relation to delayed transfers of care as well as a reduction in residential placements.

2.1.2 It illustrates how each scheme contributes towards achieving the benefits and outcomes identified and the expected change in activity and financial benefit derived. This is given for how the schemes will support frail elderly people for the level of risk of admission to hospital or residential/nursing care (analysed via risk segmentation tools) and the level of investment or cost involved.

2.1.3 The Final Plan therefore underlines our ambitious plans for transforming and integrating health and social care in Barnet. The clear, analytically driven case for transforming care has been quality assured again and is now more robust.

2.1.4 BCF remains a key delivery vehicle for realising CCG QIPP plans and savings and Council Commissioning Plan priorities and savings. The Plan explains the work done and planned to maximise the chances of success in meeting these aims.

2.1.5 The BCF Plan has been subject to consultation and agreement with all key stakeholders in the Barnet health and social care economy. It demonstrates how we will use s256, CCG and LBB adult social care funding to invest to put in place new models of care.

2.1.6 The need to update the plan has diverted resources from the on-going delivery of the schemes of work detailed. Endorsing the Plan and agreeing on progress to date and work to set up the required Pooled Budget for BCF will enable us to continue at pace to deliver the schemes of work and realise all the benefits and outcomes identified for 2016/17 and beyond.

2.1.7 Due to the timescales for submission, set out by NHS England, the Chief Executive of the Council with the Chairman and Vice Chairman of the Health and Wellbeing Board, signed off the plan which is being reported back to the Health and Wellbeing Board in this paper.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Not applicable, all areas are required to submit a BCF Plan based on greater integration of health and social care.

4. POST DECISION IMPLEMENTATION

4.1.1 In anticipation of NHS England approval of the BCF Plan in May 2016, we will continue work to implement the schemes of work described and pooled budget, governance and benefits management arrangements, to evidence the successful delivery of the Plan and achieving the target benefits/outcomes.

4.1.2 In 2016-2017 we will undertake a systematic review of BCF commissioned activities to assess (1) Effectiveness of activity on reducing current (and future) demand (2) cost effectiveness of interventions and (3) adherence to NICE guidelines. Where it is appropriate we will use the outcome of these reviews to redesign our BCF services for 2017-2018 and to inform our conversations with providers.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 The BCF Plan aligns with the twin overarching aims of our Barnet Joint Health and Wellbeing Strategy 2015 to 2020; Keeping Well; and Promoting Independence. There are also clear links with the Barnet Council Corporate Plan, the Priorities and Spending Review, the outline aims of Council 5 year commissioning intentions for adult social care and Barnet CCG Operating Plan.

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

5.2.1 The BCF Plan details the financial LBB and CCG contributions which will likely comprise the pooled budget used to deliver integrated health and social care services to improved outcomes for patients and service users.

5.2.2 For 2016-2017 the overall Better Care Fund pot has increased by a £797,000 uplift to core the CCG allocation, £17,059 additional CCG funding and £100,000 increase in Disabled Facilities Grants (DFG) funding. Therefore, the Better Care Fund Allocation for Barnet in 2016/17 is £24,324,521, which includes the Barnet CCG minimum contribution of £22,336,331, additional CCG contribution of £17,059 and Barnet Council's Contribution of £1,971,131. Further details on spend on specific programmes can be found in the BCF Plan (attached at appendix 1).

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.

5.3.2 Social Value will be considered during procurement and review activity detailed as part of the BCF plans for 2016/17. Our plans clearly recognise 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.

5.4 **Legal and Constitutional References**

5.4.1 The BCF is allocated to Local Areas and placed into pooled budgets under joint governance arrangements detailed in S75 Agreements for Integrated Care between CCGs and councils (Section 75 of the NHS Act 2006, provides for CCGs and local authorities to pool budgets). In Barnet, S75 agreements and spend are monitored by the Joint Commissioning Executive Group (JCEG) which reports its minutes to the HWBB.

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

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

5.4.4 The DFG is included to incorporate the provision of adaptations into strategic considerations and planning of investment to improve outcomes for service users. DFG will be paid to upper-tier local authorities in 2015/16. However, the statutory duty on local housing authorities to provide DFG to those who qualify for it will remain. Therefore each area will have to allocate DFG funding to their respective housing authorities (district councils in two-tier areas) from the pooled budget so they can continue to meet their statutory duty to adapt the homes of disabled people, including for young people aged up to 17.

5.4.5 Special conditions will be added to the DFG Conditions of Grant Usage (under Section 31 of the Local Government Act 2003). They will stipulate that, where relevant, upper-tier local authorities or CCGs must ensure they cascade the DFG allocation to district council level in a timely manner so it can be spent in year. Further indicative minimum allocations for DFG will be provided for all upper-tier authorities, with further breakdowns for allocations at district council level as the holders of the fund may decide additional funding is appropriate to top up the minimum DFG funding levels. Nationally, the increase in the DFG of £174m outstrips the removal of the Social Care (Capital) Grant, which came to £134m in 2015/16.

5.4.6 Under the Council's Constitution, Responsibility for Functions (Annex A) the Health and Wellbeing Board has the following responsibility within its Terms of Reference:

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

(9); Specific responsibility for:

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

5.5 **Risk Management**

5.5.1 The BCF refresh has involved a comprehensive review of the proposed spending plan for 2016/17. JCEG have led the detailed work to review the performance of the BCF plan in 2015/16. At a CCG level this has involved assessing the financial performance, risks and the outputs of the associated Managing Crisis Better QIPP. At a council level the senior team have also reviewed the deliverables in line with the medium term financial savings plan.

5.5.2 As part of managing the resilience across the system, partners have considered the overall pressures within the BCF spending plan, the level of investment needed to meet the BCF metrics and national conditions.

5.5.3 These discussions have taken place in the context of wider financial pressures affecting all partners in the health and care system, plus the need to balance priorities within a complex planning environment and a health and care economy which continues to face significant sustainability risks linked the over use of acute care. Evidenced by the engagement exercises around establishing the local commissioning intentions[1] within the CCG and the Council.

5.5.4 The Joint Commissioning Executive Group (JCEG) meetings bi-monthly and is the executive for the Better Care Fund pooled budget and delivery of the BCF plan, therefore the JCEG will receive progress updates, finance and risk reports and monitor the delivery of the Section 75. The JCEG reports, with its minutes, to the HWBB.

5.6 **Equalities and Diversity**

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

5.6.2 The broad purpose of this duty is to integrate considerations regarding equality and good relations into day to day business, requiring equality considerations to be reflected into the design of policies and the delivery of

[1] http://www.barnetccg.nhs.uk/Downloads/Publications/Strategies/NHS-Barnet-CCG-Commissioning-intentions-plan-2016-17.pdf

services and for these to be kept under review.

5.6.3 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.

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

5.7 **Consultation and Engagement**

5.7.1 The BCF Plan details the public engagement with patients and service users as well as with providers. The content of our Better Care Fund (BCF) has been discussed with providers, users, clinicians and carers as an integral part of our strategic planning processes. The starting point for all discussions has been our jointly-agreed JSNA and the priorities and plans agreed by the Health and Wellbeing Board (HWBB). Through co-producing these documents, and basing our planning on evidence and feedback, we have worked hard to establish our engagement on the basis of partnership working over many months. In this context we have had many engagement events, including with GP leads and service providers. For further information see section 7 of Appendix 1.

5.8 **Insight**

5.8.1 Our plans for 2016-2017 are informed by the:

- Refreshed Barnet Joint Strategic Needs Assessment (JSNA)
- The evaluation of the Barnet Integrated Locality Team (BILT) pilot programme, completed in September 2015 from this we found the need to engage with GPs in a more systematic way and clearly identified opportunities to extend the cohort we were working with
- Findings of the CSU deep dives completed in 2015-2016 for the following areas: admissions to residential care from hospital, non-elective admissions to hospital, and falls related injuries. Our learning from these enquiries included the need to embed local voluntary sector provision within pathways, the need to refresh our commissioning specifications in light of updated NICE guidance and the identification of the importance of carers in preventing A+E admissions and admission to residential care

- A review of the 'trigger points' for entry to the adult social care system and the factors associated with individuals moving to higher levels of dependency once they are within the system. We identified an opportunity to redesign our accommodation offer to reduce the number of people who are delayed in hospital because their accommodation is unsuitable and the importance of helping individuals manage their conditions including work with those receiving an early dementia diagnosis.

6. BACKGROUND PAPERS

6.1 Better Care Fund Update, 29 January 2015, item 6: https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=177&MId=7784&Ver=4

Barnet Better Care Fund Plan – 2016/17

Local Authority	**Barnet Council**
Clinical Commissioning Groups	**Barnet Clinical Commissioning Group**
Boundary Differences	**Coterminous, however, the GP-registered population includes patients who reside in another LA's area. Barnet's integrated care model includes these patients.**
Date agreed at Health and Well-Being Board:	**12 May 2016**
Date submitted:	**3 May 2016**
Total agreed value of pooled budget: 2016/17	**£24,324,521**
2016/17	

a) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	Dr Debbie Frost
Position	Chair
Date	28.4.16

Signed on behalf of the Council	
By	Andrew Travers
Position	Chief Executive
Date	28.4.16

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Councillor Helena Hart
Date	28.4.2016.

b) Related documentation

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

Document or information title	Selected Links
Barnet Health and Social Care Concordat	
Barnet Integrated Health and Social Care Model 2013	
Barnet Health and Well-Being Strategy	
Barnet Council Corporate Plan	
Barnet Council Priority & Spending Review	
Barnet CCG Operational Plan	
Barnet Joint Strategic Needs Assessment	Others available upon request
Health and Social Care Integration Board Terms of Reference	
Health and Social Care Integration Board Programme Governance	
Barnet, Enfield & Haringey Clinical Strategy	
Health and Social Care Integration Business Base (Sept 2014)	

a) Related documentation

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

Document or information title	Selected Links
Barnet Health and Social Care Concordat Barnet Integrated Health and Social Care Model 2013 Barnet Joint Health and Wellbeing Strategy Barnet Council Corporate Plan Barnet Council Priority & Spending Review Barnet CCG Operational Plan Barnet Joint Strategic Needs Assessment Health and Social Care Integration Board Terms of Reference Health and Social Care Integration Board Programme Governance Barnet, Enfield & Haringey Clinical Strategy Health and Social Care Integration Business Base (Sept 2014)	Available upon request

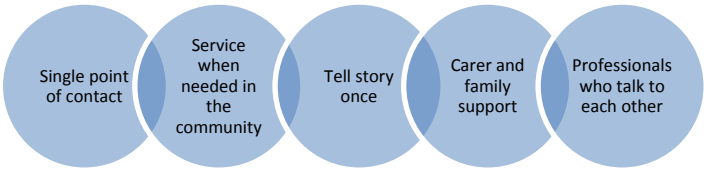
Contents

1. Our Vision for Health and Social Care Integration

1.1. Our Vision

In 2015-2016 we submitted a plan[1] for our use of Better Care Fund resources. In 2016-2017 we intend to continue to work to the vision set out in this plan.

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



Our vision was built upon fundamental strategic drivers such as our local Health and Wellbeing Strategy, all of which still continue to be fundamental to our integration plans from 2016/17 onwards.

In 3 to 5 years' time, we will have developed a fully integrated health and social care system for the frail and elderly population through implementation of our model so that it:

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

[1] Better Care Fund Plan 2015 - 16 - https://barnet.moderngov.co.uk/documents/s20674/Appendix%201%20Final%20BCF%20Plan%20Part%201%20v1.1%2014%20Jan%202015.pdf

Our Barnet Health & Social Care Integration Business Plan[2] sets out the details of how this will be achieved.

1.2. Transition from 2015/16 to 2016/17 BCF

Our plans for 2016-2017 are informed by the:

(1) Refreshed Barnet Joint Strategic Needs Assessment (JSNA[3]), as agreed by the Health and Wellbeing Board in September 2015

(2) Joint Health & Wellbeing Strategy (2015 – 2020[4]), adopted by the Health and Wellbeing Board in November 2015

(3) The evaluation of the Barnet Integrated Locality Team (BILT) pilot programme, completed in September 2015 from this we found the need to engage with GPs in a more systematic way and clearly identified opportunities to extend the cohort we were working with

(4) Findings of the CSU deep dives completed in 2015-2016 for the following areas: admissions to residential care from hospital, non-elective admissions to hospital, and falls related injuries. Our learning from these enquiries included the need to embed local voluntary sector provision within pathways, the need to refresh our commissioning specifications in light of updated NICE guidance and the identification of the importance of carers in preventing A+E admissions and admission to residential care

(5) A review of the 'trigger points' for entry to the adult social care system and the factors associated with individuals moving to higher levels of dependency once they are within the system. We identified an opportunity to redesign our accommodation offer to reduce the number of people who are delayed in hospital because their accommodation is unsuitable and the importance of helping individuals manage their conditions including work with those receiving an early dementia diagnosis.

Together these will provide a joint framework for commissioning services that respond to local population need in ways that will minimise, wherever possible, unplanned admissions to hospitals and residential care. In 2016-2017 we will make a number of changes to our BCF programme to reflect our learning from 2015-2016. This will include an expansion of our integrated locality teams, increased emphasis on services to carers and targeting of our early intervention and prevention offer at those at greatest risk of increased dependency.

In 2016-2017 we will undertake a systematic review of BCF commissioned activities to assess (1) Effectiveness of activity on reducing current (and future) demand (2) cost

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[2] https://barnet.moderngov.co.uk/documents/s18033/Business%20Case%20for%20Barnet%20Health%20and%20Social%20Care%20-%20Integration%20of%20Services.pdf

[3] JSNA - https://www.barnet.gov.uk/citizen-home/council-and-democracy/council-and-community/maps-statistics-and-census-information/JSNA.html

[4] JHWB Strategy - https://barnet.gov.uk/citizen-home/public-health/Joint-Health-and-Wellbeing-Strategy-2015-2020.html

effectiveness of interventions and (3) adherence to NICE guidelines. Where it is appropriate we will use the outcome of these reviews to redesign our BCF services for 2017-2018 and to inform our conversations with providers.

We recognise that the development of the local Sustainability and Transformation Plan for North Central London will result in us revisiting our integrated care plans in 2016-2017 but for the purposes of this submission we have referenced new and emerging NCL work-strands where these will have an impact on the achievement of the BCF national conditions.

1.3. The Impact of Policy and Planning Developments

Since commencing with the delivery of the Better Care Plan the policy landscape for health and care has continued to evolve at pace and is complex. Locally, we have reflected on the impact of the current policies on our local vision and approach. This is evident in the delivery progress to date and the milestones that have been set out in our 2016/17 plan. We have also considered how related local developments (The Strategic commissioning framework for primary care, Digital road map, system resilience planning etc.) link into this Better Care Plan.

1.4. Key Challenges for the Plan in 2016-17

We understand the significant health and social care challenges we face. The latest JSNA[5] states that Barnet is the largest Borough in London and is continuing to grow rapidly with large areas of regeneration especially in the West of the Borough. The population of Barnet is, like most of the UK, ageing with the proportion of people aged over 65 forecast to grow up to three times as fast as the overall Barnet population.

Barnet has one of the largest numbers of care homes in Greater London (79 residential and 23 nursing homes: CQC June 2015), leading to a significant net import of residents with health needs moving to Barnet from other areas.

Locally primary care faces operational, clinical and financial challenges – not least a challenge with recruitment to GP vacancies, primary care estate, increased patient demand and regional contract reviews which are all putting pressure on the local system.

Financial Constraints:

As previously stated in the 2015/16 plan, given the financial position of the Barnet health economy, significant emphasis will still be applied to delivery of targets related to reducing non-elective emergency admissions for the cohorts identified within the plan alongside supporting the required improvements in relation to delayed transfers of care as well as a reduction in residential placements.

Data Integration:

[5] JSNA summary https://www.barnet.gov.uk/citizen-home/council-and-democracy/council-and-community/maps-statistics-and-census-information/JSNA.htm

Locally, progress has been made on data integration using NHS numbers, with all practices having migrated over to using EMIS clinical data recording tool alongside having access the a risk stratification tool for identification of patients at risk of an unplanned attendance. LBB have also start the process of moving towards utilising the recently procured MOSAICs system (NHS numbers can be stored). However, further work is required on the integration of records and data across agencies for direct care and case management in a community setting; which will be further developed under the CCGs IMT programme board.

Across the local health and care economy it is acknowledged that there is a need to embrace the goals of the new national information framework which supports the effective delivery of technology enabled personalised and seamless care.

Despite these challenges both the CCG and LBB are jointly committed to using identified schemes within the Better Care fund to support the development of services for older people in line with national strategies and statutory requirements (The Care Act (2014); The NHS Outcomes Framework 2015/16, Department of Health (2014); A Vision for Adult Social Care: Capable Communities and Active Citizens (2010); Putting People First (2007); Care Services Efficiency Delivery (2011) and the NHS Five Year Forward View (2014)).

1.5. Aims of the Barnet's 2016-17 Plan

For 2016-2017 the overall BCF pot has increased by a £797,000 uplift to core the CCG allocation, £17,059 additional CCG funding and £100,000 increase in DFG funding.

	2015-2016 £000s	2016-2017 £000s
Total BCF Allocation	£23,412	£24,307
DFGs Allocation (not included in CCG BCF Allocation)	£1,872	£1,971
CCG Allocation	£21,540	£22,336
Change %	n/a	£797 = 3.4%

This now translates to:

	Gross Contribution
Total Local Authority Contribution	**£1,971,131**
Total Minimum CCG Contribution	**£22,336,331**
Total Additional CCG Contribution	**£17,059**
Total BCF pooled budget for 2016-17	**£24,324,521**

The aims of the Barnet BCF plan have been refreshed in light of the strategic policy context and the work to develop our vision and ambition post March 2016.

The table below shows how we have planned to use these resources in 2016-2017. These decisions have been made in light of our analysis of performance, national evidence and negotiations on additionally with providers. It should be noted that no providers will receive any uplift against 2015-2016 allocations.

Scheme	Area of Spend	Amount 2015/16	Amount 2016/17
Theme: Seven Working			
7 day social Work	Social Care	£100,000	£100,000
Adult Social Care - sustaining 7 day working	Social Care		£797,000 (New)
Intermediate Care in the Community	Continuing Care	£340,522	£340,522
Rapid Response	Community Health	£1,014,618	£1,014,618
Single Point of Access	Community Health	£290,520	£290,520
Social Care Demand Pressures	Social Care	£2,260,000	£2,260,000
Theme: Assistive Technologies			
Community Equipment	Community Health	£1,076,000	£1,076,000
Theme: Improving healthcare services to care homes			
Primary care commissioned service	Primary Care	£400,000	£400,000
Quality in Care Home Team	Social Care	£231,000	£231,000
Children's Commissioning	Social Care	£100,000	£100,000
Theme: Integrated Care Teams			
Integrated Care Locality Team	Community Health	£862,366	£862,366
JCU funding for Heads of Service	Social Care	£200,000	£200,000
Primary care commissioned service	Primary Care	£270,000	£270,000
Shared Care Records	Social Care	£262,000	£262,000
Social care integrated practice	Community Health	New	£151,360
Supporting delivery of BCF Plan	Social Care	£200,000	£200,000
Transitions	Social Care	£100,000	£100,000
Integrated Locality Team – LBB	Social Care	£131,000	£131,000
Theme: Intermediate Care Services			
Intermediate Care in the Community	Community Health	£8,488,189	£8,488,189
Stroke support services	Community Health	£195,000	£195,000
Fracture Liaison Service	Acute	£97,337	£97,337
Theme: Personalised Support / Care at Home			
Ageing Well	Social Care	£350,000	£350,000
End of Life care	Continuing Care	£1,364,609	£1,364,609

IT Interoperability	Primary Care	£69,000	£69,000
Safeguarding	Social Care	£120,000	£120,000
Memory Assessment	Mental Health	£215,000	£215,000
Mental Health Pressures	Social Care	£300,000	£300,000
Dementia	Social Care	£180,000	£180,000
Theme: Reablement Services			
DFG	Other	£1,870,000	£1,970,000
Enablement	Social Care	£200,000	£200,000
Stroke Support Services	Social Care	£37,000	£37,000
Theme: Support for carers			
Care Act	Other	£846,000	£846,000
Carers Support	Social Care	£300,000	£300,000
Carers Support – CCG	Social Care	£806,000	£806,000

For 2016/17, the deployment of additional resources to Social Care Activity brings the Barnet position closer to the Relative Needs Formula for Social Care, without destabilising the existing schemes. Beyond the protection of social care and DFGs, most of the remaining budget remains committed to the NHS commissioned community health services.

The Barnet Health & Social Care economy is facing significant financial challenges. Demand is increasing and budgets are under severe pressure. The Health and Social Care workforce is challenged in terms of both recruitment and skills to respond to this demand. It is clear that in 2016-2017 Barnet, alongside its North Central London colleagues will need to accelerate its work to create new models of integration that reduce and mitigate demands on the health and social care economy.

2. LOCAL CASE FOR CHANGE

2.1. Context on the Case for Change

The Case for change in Barnet is still based on the five underlying factors set out in the original business case (page 16).

Recent National publications in respect of care for older people convey the challenges faced across the United Kingdom. These challenges in a nutshell encompass huge increases in spend that are set to continue to rise if not addressed with a continuing evidenced decrease in the quality of the care delivered.

This is the position in Barnet as spend on unplanned admissions has increased significantly and identified as an outlier within the 'Right Care – Better Value Data Packs' published in January 2016. https://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/lond-2016

Nationally the Five Year Forward View challenges providers to look to new models of care, creating accountable care systems (ACS) where commissioners and providers come together to determine priorities and assess need together.

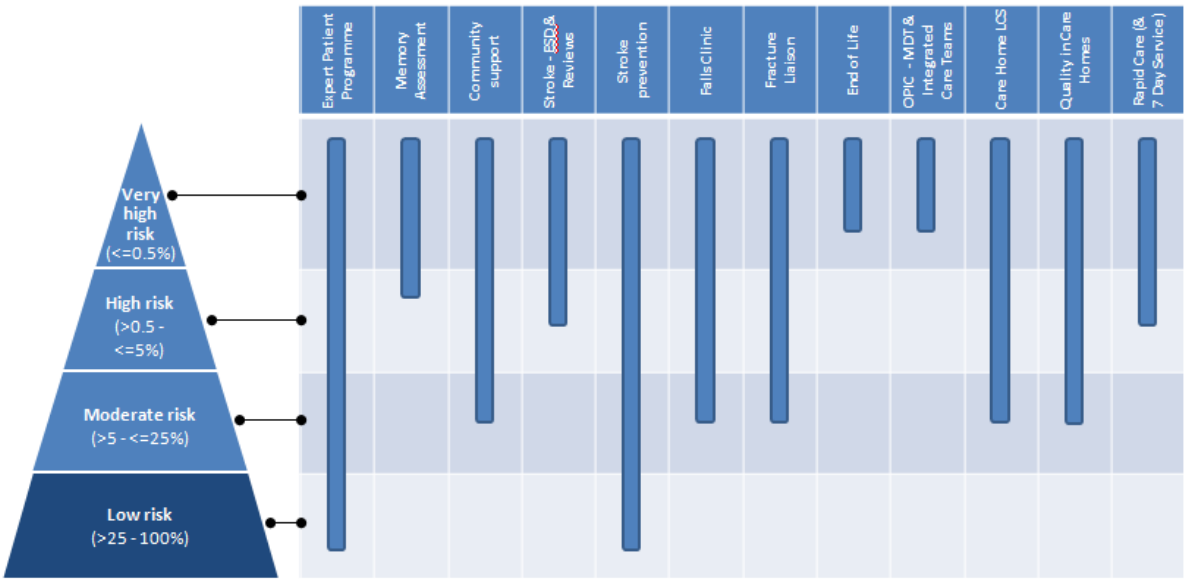
In 2016-2017 we expect to continue to target joint performance improvement activity at the outcomes identified in the 2015-2016 Better Care Fund Plan:

- Delayed Transfers of Care
- Self-Directed Support
- Non Elective Admissions
- Permanent Admissions to Residential Care 65 Years+
- Effectiveness of Reablement
- Patient Satisfaction.

We will continue to review and adapt the programme to ensure that BCF funds are deployed in ways that secure reductions in the use of unplanned high-cost health and care services.

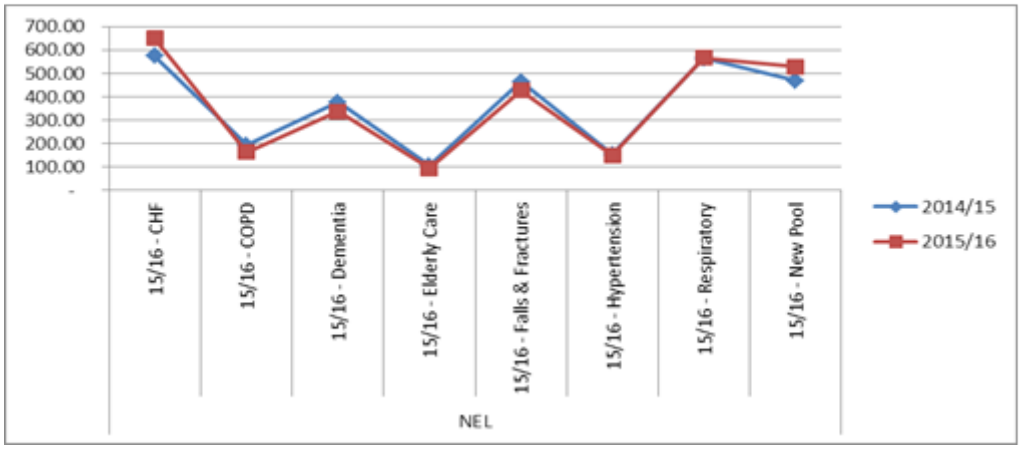
2.2. An evidence base supporting the case for change

The diagram on the next page, reiterates the impact on each risk category for the elements of each of the Schemes taken forward in 2015/16.



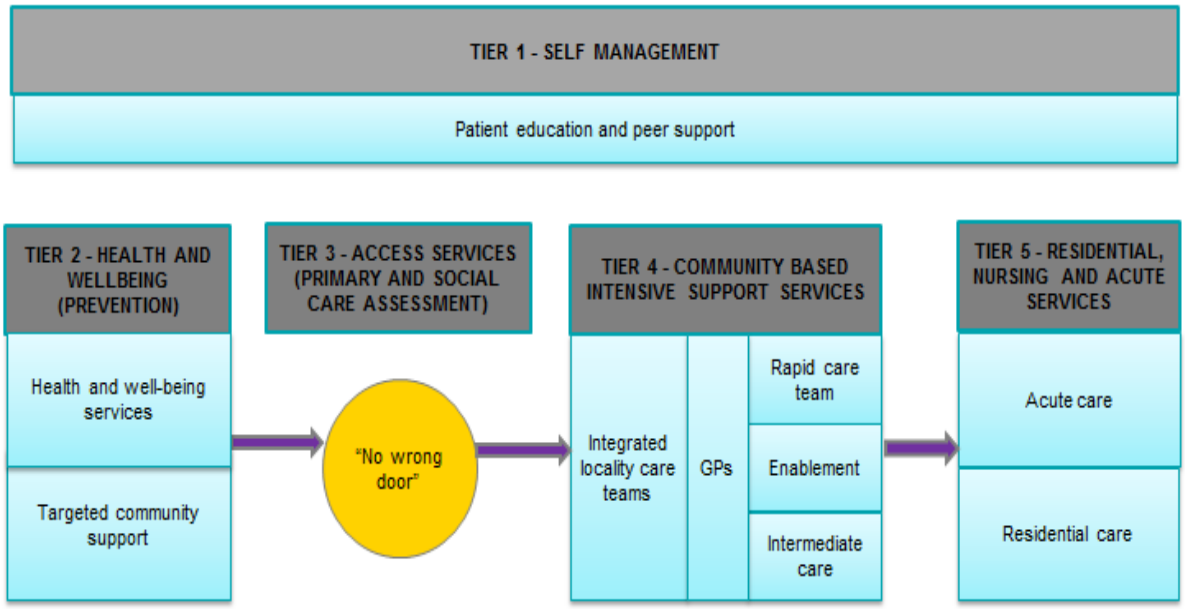
Risk Stratification *– classifications targeted by elements of schemes of work*

The first year of implementing the programmes within the Better Care Fund has demonstrated where a positive impact has been seen in (reduced activity) and those that continue to represent a cost pressure and hence will need to be targeted in the 16/17 plan. The table below is an excerpt that depicts the activity changes in some of the key service areas targeted in 15/16 *managing crisis better* QIPP scheme.



Positive change can be noted with COPD, Dementia, falls and fractures. Areas requiring attention are Chronic Heart Failure, Respiratory, and New Pool which comprises of the additional services (to address gaps in current provision) that will be in place through the implementation of a Barnet wide integrated locality team, closer integrated links between the TREAT and PACE services and the additional work that will be implemented under the Dementia Strategy, the Care Home Strategy and the work underway to support our local delayed transfer of care processes. The tables in the following pages provides a snap shot of the deliverables attained in the 2015/16 schemes.

2.3. Progress achieved by the 2015/16 Schemes



The Barnet BCF Plan is based around the 5 Tier model of care, with each identified scheme targeting the key deliverables outlined within the model care under each tier.

The five tier model delivery is managed and governed effectively within the local integration programme. The contributions and outputs from the schemes are connected effectively to the wider Barnet LBB and CCG governance structures, where applicable via the Joint Commissioning Executive Group.

Scheme ref no: 1 – Funded from PH Grant not BCF Pool
Scheme name: Expert Patient Programme
Scheme description
Pilot scheme and roll out of generic and disease-specific Expert Patient Programmes – organised by individuals who have existing long-term conditions.
Overview of the scheme
Enables community social care professionals (health and primary care) to refer older people who have just been diagnosed with a long-term condition, into the Expert Patient Programme. The scheme is organised by people with existing long-term conditions, and who are therefore sensitive towards individual issues and needs. In addition, trainers have the ability to signpost the patient to other local support services such as long-term conditions Mentors. Structured patient education programmes based on specific long-term conditions have also been introduced alongside the generic Expert Patient Programme. The content and structure of these courses is determined by a systematic review of needs evidence and service piloting results. Thel focus is on one or more of the following long-term conditions: diabetes, CHD, pain management, respiratory conditions, dementia or depression.
Impact of scheme
Extensive financial modelling to support implementation of the 5 tier model has been completed including mapping of cost benefit analysis of all current projects. There is overlap in benefits between a number of schemes particularly 1, 2a, 2b and 2c and 3. **T**he evidence base suggests that savings of between £452 (DoH) and £987 (SM:UK) can be expected per person with respect to reduced admissions. Using these assumptions the impact is estimated at 142 (23 + 119) reduced non-elective admissions over the BCF period as indicated above. Diagnostic work in 2015-2016 has revealed that specific support for people to manage conditions was required through structured education, health champions, social prescribing and Making Every Contact Count. Joint planning with Health Education England, NHS Providers, Barnet CCG, Public Health and Adult Social Care through the Ageing Well Programme has resulted in a number of schemes being commissioned to deliver these activities. A joint Mental Health Enablement and Ageing Well borough wide social prescribing scheme was also launched.

Scheme ref no. 2a

Scheme name: Long-term Health Conditions (dementia, stroke, falls and palliative care)

Scheme description: Increase the scale of services to support people with long-term conditions.

Overview of the scheme

The scheme comprises of the following services, full descriptions of service provision is available in the BCF plan 2015/16 on page 62.

01 Dementia Services:

1. **Memory assessment service** - re-design of the existing memory service to create a discrete fully functioning memory service.
2. Development of a **community support offer for people with dementia and their carers**. To include dementia hub.

02 Stroke Services:

1. **Early stroke discharge** -increase the provision of specialist intermediate care / rehabilitation for stroke in the patient's.
2. **Stroke reviews** - to establish a formal stroke review service
3. **Stroke prevention** - to support an increase in the recorded prevalence of Atrial Fibrillation in primary care, and treat them with anticoagulation across the sector using the GRASP AF tool.

03 Falls Service:

1. **Falls Clinic** – re-configured clinic modelled to best practice standards focussing on therapy led interventions (with medical support) to provide a seamless patient-centred, integrated and comprehensive service.
2. **Fracture Liaison Service** - identify people at risk of further falls or fractures in acute settings, providing comprehensive assessment and specific treatment recommendations.
3. **Falls co-ordinator** - support the development of an integrated falls system in across Barnet

04 Palliative / End of Life Care:

1. **Home based palliative care service** providing a key link between district nursing and hospice / acute service to support patients and carers in the last few weeks of life.
2. **Palliative care provided through hospices**. This includes access to in-patient beds, out-patients consultant and nurse-led clinics, home visits and counselling/bereavement services.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Extensive financial modelling to support implementation of the 5 tier model was completed as there is an overlap in benefits between a number of schemes particularly 1, 2a, 2b and 2c and 3.

Area	Service	2015/16 Target	Performance to date
Non-elective admissions	*Falls*	*Estimated relative impacts of 10%, 25% and 35% related to reduced admissions for falls and fractured neck of femur over the next 3 years.*	*Across the pathway the falls service has seen a reduction in 2015/16 especially in hip trauma and sprain strain, this has led to a cost reduction on the previous year of £163k.*
Care homes/ Delayed transfers of care	Dementia	22% reduction in admissions to care homes based on the "Department of Health (2009) "Living well with dementia: A National Dementia Strategy". Reduction in excess bed days by 272 over BCF period in line with current projections in our local Business Case.	Across the pathway it data shows a movement in the case mix alongside an overall reduction in activity of 30, this has led to savings of £300k in 2015/16
Delayed transfers of care	Stroke	Reduction in excess bed days by 272 over BCF period in line with current projections in our local Business Case.	

Scheme ref no:2b

Scheme name: Older People Integrated Care (OPIC)

Scheme description

OPIC is the combined view of a number of different existing projects/services: Multi-Disciplinary Team Case Conference (MDT), Care Navigation Service (CNS), Barnet, Community Point of Access (CPA), Risk Stratification Tool (RST), Barnet Integrated Locality Team. All focus on the delivery of assessment, care planning and co-ordination.

Overview of the scheme

01 Multi-Disciplinary Team Case Conference (MDT)

The MDT conference brings together health and social care professionals into a weekly case conference to assess and agree a care plan for the individual needs of frail and elderly patients, the service is targeted at the most complex cases where standard measures have been unsuccessful or a particular risk is identified.

02 Care Navigation Service (CNS)

The Care Navigation is the interface between the MDT, the Integrated Locality Team (ILT) and the patient. Target cohort generally originates from the MDT or the ILT. Over time the team will become an integral part of the ILT.

03 Barnet Integrated Locality Team

MDT comprising health and social care professionals, mental health support and end of life support and voluntary sector input. Team support adults in the community, in partnership with local GPs, who are living with multi-morbidity and complex long-term conditions.

04 Risk Stratification Tool (RST)

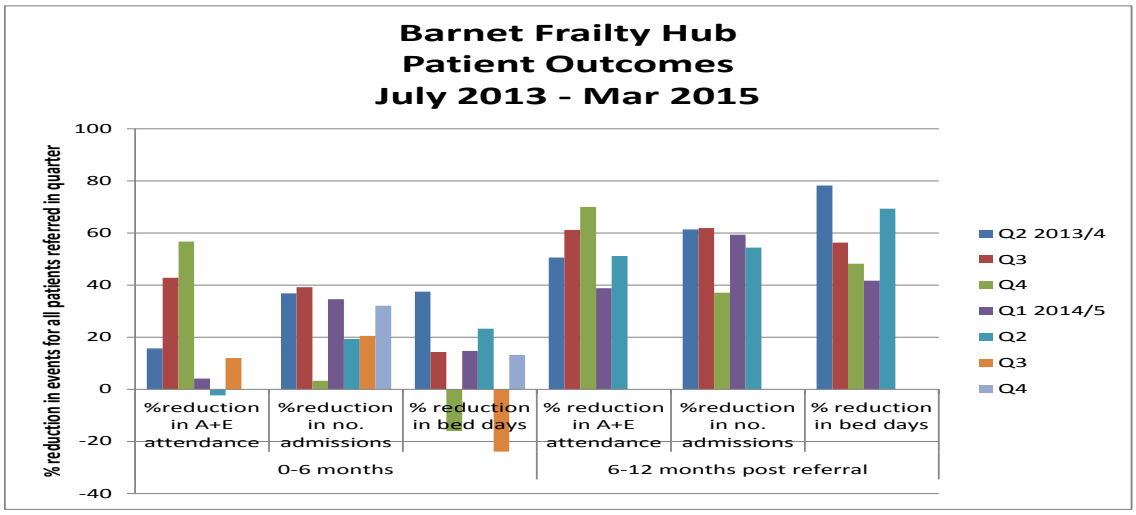
A software based risk stratification tool is being used to identify frail and elderly patients at risk of future unplanned hospital attendance or deterioration in health.

05 Barnet Community Point of Access (CPA)

The Barnet Community Point of Access acts as a central point to receive and manage referrals for adult community health services.

Impact of scheme

There is overlap in benefits between a number of schemes particularly 1, 2a, 2b and 2c and 3



The above graph shows the percentage reduction in adverse clinical outcomes (A+E, admission, emergency bed days) in the six month period after referral to the Frailty MDT and for the period 6-12months after. It breaks the changes down to each quarter.

The data for 0-6 months is from July 2013 to March 2015 (follow up to Sept 2015) and for the one year follow up July 2013 to end Sept 2014 (follow up to Sept 2015).

Columns above the zero line reflect improvement.

Scheme ref no: 3 (a & b)

Scheme name: Rapid Care and Seven Day Working

Scheme description: The Rapid Care service works to deliver an immediate response to a health or social care crisis.

Overview of the scheme

The inter-linkage between the two services provides an urgent but co-ordinated approach to an unplanned episode of ill-health or crisis.

1. **Rapid Care -** The primary aims of the Rapid Care expansion are to reduce unnecessary hospital admissions, better manage acute complications, and support end of life care so that people can remain in their own homes as long as possible. Key service deliverables:
   a. Triaged response via Community Point of Access.
   b. 2 hour response time.
   c. 7 day service.
   d. Use of skill mix including emergency nurse practitioners.
   e. Consultant cover.

   Target groups are all over 65s at risk of admission. Operational delivery is targeted towards those conditions that we have identified as high volume e.g. pneumonia, urinary tract infection and heart failure.

2. **7 Day Social Work & Enablement** – Supporting the Rapid Care service is 7 day access to social work assessment in the acute hospital setting and enablement services.

Impact of scheme

Benefits will manifest primarily in terms of admissions avoidance and effectiveness of rehab/reablement.

Area	2015/16 Target	Performance to date
Non-elective admissions/Reablement	Reduction of hospital activity in the most at risk cohort identified from risk stratification. Assumptions for delivery of 486 (155 & 331) over BCF period.	Across the pathway data demonstrates that there has been an alteration in case mix with a reduction in cases of urinary tract infections with complications. Alongside this an overall activity reduction has led to savings of £39k. COPD – Has a reduction in activity that driven by a reduction in chronic obstructive pulmonary disease by 39, this has led to an efficiency of £146k. Hypertension – £60k efficiency has been driven by a change to the case mix in 2015/16 as activity has seen a marginal reduction.

Scheme ref no: 4 (a & b)

Scheme name: Enablers – service and administrative

Scheme description: A suite of services or projects intrinsically linked to BCF pool as key enablers.

Overview of the scheme

The table below outlines the key elements of the enablers.

Scheme	Service line	Provider type	15-16 (£)	15-16 (£)
Scheme 4a. Enablers (services)	Carers services	Charity/Voluntary Sector	300,000	300,000
	Later life planners	Charity/Voluntary Sector	150,000	150,000
	Ageing Well	Local Authority	150,000	150,000
	Shared Care Records	Local Authority	262,021	262,021
	Community Equipment	Private Sector		1,169,761
	Other Community Services	NHS Community Provider		6,965,100
	Carers Breaks & additional enablement funds	BCCG		1,641,926
	Protecting social care	Local Authority	3,080,000	3,080,000
	Care Act Implementation	Local Authority		846,000
Scheme 4b. Enablers (administrative)	BCF Plan delivery	Local Authority	200,000	200,000
	DFG & Adult social care capital grant	Local Authority		1,872,000

Impact of scheme

In 2015-2016 we delivered 268 adaptions to people's homes to help them stay at home longer. We introduced an extended carers' offer to help residents with a dementia diagnosis manage their condition. We have seen a reduction in the numbers of older people having first contact with adult social care through an unplanned admission with an increase in the number of older people making contact through our universal neighbourhood offer.

We have undertaken additional **financial analysis of the affordability and deliverability of the revised integrated care model** to address the critical question for the Barnet economy of how we will continue to achieve better health and wellbeing outcomes and improve user experience for the frail, older population in Barnet in a financially sustainable way.

3. Barnet 2016/17 Plan

3.1. Working towards achieving Our Strategic Goals

Our Better Care Plan is strongly aligned to the Barnet CCG Operational Plan for Patients, 2016/17and the current Five Year Strategic Plan of the Clinical Commissioning Group. The Council's Five Year Plan has a strategic vision for integration and shifting the balance of care from institutional to personal solutions.

There is a housing strategy which explicitly addresses the needs of older people and the Council's capital plan includes £15m for the provision of new extra care accommodation in 2017 to reduce the numbers of older people falling into residential care.

The development of the NCL Sustainability and Transformation Plan has also been a key influence in our Better Care Plan and wider ambitions for integrating health and social care. Our expansion programme for extra care housing provision and the development of more step up/step down in the community will facilitate timely discharge from hospital.

3.2. Feedback on the schemes in 15/16 that have informed the refreshed plan

- ✓ Findings from engagement with service users on introducing community based locality teams and the multi-disciplinary meetings across health and social care have been used to inform the future options and solutions.
- ✓ Findings from the engagement with service users undertaken during the evaluation of the pilot Barnet integrated locality team schemes
- ✓ The CSU deep dives completed in 2015-2016 for the following areas: admissions to residential care from hospital, non-elective admissions to hospital, and falls related injuries
- ✓ The independent review on non-electives by CHKS

Other Reference Sources of Data and Analysis that underpin our BCF plan

- NHSE Benchmarking data (e.g. readmissions within 30 days)
- LAS Conveyances Reports
- System Resilience data
- Risk Stratification data from Primary Care
- LA Benchmarking: e.g. on permanent admissions to residential care
- Adult Social Care Performance Reports and Dashboards
- Regional and National BCF analysis from the Central team

3.3. BCF Metrics supporting the refreshed plan

3.3.1. Non-Elective Admissions

Performance Overview 2014-2016:

- The baseline activity for 2014 non-elective admissions was 30,055;
- The 2015 plan was 29,419 admission, a 2% reduction on 2014 admissions;
- Actual non-elective admissions in 2015 was 30,241, although it should be noted that activity is estimated for several contributing CCGs (Brent, Harrow and Westminster CCGs, contributing to 3.3% of the HWB population) due to data availability;
- Actual admissions in 2015 were 2.8% higher than plan and 0.8% higher than in 2014.

Trajectory for 2016-2017:

- The 2016/17 target is based on 2015/16 month 9 forecast outturn non-elective admissions from SUS SEM data.
- Local output of national Indicative Activity Hospital Modelling (IHAM) growth (2.5%) is then applied to the 2015/16 baseline for Barnet CCGs element of the non-elective activity.
- Barnet CCG demand mitigations in the form of QIPP schemes that impact on non-elective admissions (including the integrated care and Better Care Fund schemes) are built into the CCGs Operating Plan and are reflected in the 2016/17 plans. The demand mitigations reduced the planned growth to 1.8% over 2015/16 forecast outturn.

Non Elective Admissions

	Q1 (Apr 16 - Jun 16)	Q2 (Jul 16 - Sep 16)	Q3 (Oct 16 - Dec 16)	Q4 (Jan 17 - Mar 17)
Quarterly rate	7530	7234	7747	7581

Context and Key Activities:

The demands on the acute care system are the local health and care economy's greatest risk to sustainability.

We have reviewed the impact of QIPP schemes and found that they have started to mitigate the underlying growth in non-elective admissions. In 2016-2017 we will be extending the cohort included in our High Risk Group – both by geography and condition to secure further reductions in the NEAs.

We have recently completely a review of our falls services and identified improvements to the services to reduce the numbers of over 85s admitted falling a fall. In 2016-2017 we will ensure that we implement the whole of the NICE recommended pathway.

The extended Integrated Locality Team will work with an extended cohort of individuals who are at risk of a non-elective admission including frail elderly and those with poor management of long-term conditions. The Dementia Pathway, including an enhanced support for carers looking after individuals with dementia, will form part of the Integrated offer. This will ensure that there is a single unified support system for older people with physical and mental health conditions.

Building on the integrated approach to housing solutions developed in partnership with Barnet's regeneration company (Re) and our housing provider Barnet Homes will deliver measurable health and wellbeing benefits. In 2016-2017 we intend to review our DFG, community equipment and enablement pathway to identify where further changes are needed. In 2015-2017 we delivered 238 DFGs to help keep individuals at home and to minimise the need for residential care. In November 2017 LBB will open a further extra 50 care units for individuals with complex needs (including dementia) to help them remain safely at home

3.3.2. Permanent Admissions to Residential Care 65+

Performance Overview 2014-2016:

- The baseline for 2014/15 was 467.83 admissions per 100,000 population. The 2015/16 target aimed to achieve a 15% reduction on this baseline and was set at 399.0 admissions per 100,000 population.
- These rates were calculated on the pre-SALT definition of residential admissions which excludes a number of cases from the measure (for example, full cost payers and property disregard cases).
- Performance in the first three quarters of 2015/16 is as set out in the table below. The rate of admissions remained below the interim target levels despite the last quarter reflecting a winter peak and may see an increase in the rate.

Quarter	Admissions per 100,000
Q1	**91.1**
Q2	**155.1**
Q3	**292.77**

Trajectory for 2016-2017:

- The 2016/17 target has been baselined and set using the new SALT definition of residential admissions.
- 2016/17 interim targets have been set to adjust for the winter peak.
- The trajectory for Q3 and Q4 is provisional because of the introduction of a new case management system for Adult Social Care may have an impact on the numbers and will require review once the impact of new methods of data capture is known. The quarterly targets are set as below:

Quarter	Admissions per 100,000
Q1	**120**
Q2	**240**
Q3	**360**
Q4	**530**

Target Rationale:

- The target is set at 530 admissions per 100,000.
- This aims to maintain the 15% reduction in admissions set as the target for 2015/16, baselined and calculated using the new SALT definition for residential admissions.

Context and Key Activities:

LB Barnet has a higher rate of permanent admissions to residential care 65+ than other London Boroughs and in 2015-2016 we have undertaken work to identify the reasons for this. The following areas for further work have been identified:

- Discharge from hospital to residential care, following elective and non-elective admissions.
- Limited supply of accommodation suitable for people with extra needs but not requiring residential care.
- Attitudes and expectations of health and social care professionals and families.
- Lack of access to neighbourhood support for carers and individuals at risk of a hospital admission.
- The London Borough of Barnet has more residential and nursing beds than any other London Borough.

In 2016-2017 we will publish an Accommodation Strategy for Vulnerable People. This strategy provides the rational for a rapid increase in extra care units, new models of step up/step down provision and an integrated approach to DFGs, enablement and community equipment.

We will also work through the Local Medical Committee and the, HEE facilitated, NHS staff peer learning sets to increase knowledge of new types of accommodation. Opportunities to further develop the use of assistive and digital technology has already been highlighted as part of our DTOC plans but in 2016-2017 we will explore opportunities to use these technologies to avoid non elective admissions for older people, those with dementia and some Long Term Conditions.

In 2016-2017 the Ageing Well neighbourhood programme will be extended from 4 to 6 neighbourhoods and our Older People's Day Offer (Age UK) will be redesigned to enable a referral pathway from the Integrated Locality Team for those individuals at risk of a hospital admission.

As part of the Joint System Resilience work we will continue to identify and address system issues that result in individuals being admitted for electives not being discharged home. Our joint work to reduce non-elective admissions will also help to reduce the numbers discharged to residential care.

3.3.3. Delayed Transfer of Care

Performance Overview 2015-2016

Delayed Transfer of Care 2015-2016 Performance

	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Quarterly rate	620.6	611.7	705.2	693.4
Numerator	1,813	1,787	2,060	2,058
Denominator	292,125	292,125	292,125	296,808

Trajectory 2016-2017

	Q1 (Apr 16 - Jun 16)	Q2 (Jul 16 - Sep 16)	Q3 (Oct 16 - Dec 16)	Q4 (Jan 17 - Mar 17)
Quarterly rate	598.6	590.0	680.2	669.3
Numerator	1,777	1,751	2,019	2,017
Denominator	296,808	296,808	296,808	301,320

Context and Key Activities

Improving DTOC performance relies on the range of recently commissioned activities continuing to maintain their impact, and continuing to commission the eight high impact changes outlined in self-assessment tool recently published by the Department of Health. We have developed a joint local action plan to ensure that activity is co-ordinated and impact monitored.

Adult Social Care performance on DTOC is better than the London level of performance and we recognise that it is important to maintain those activities (such a 24/7 social work, mental health support and a social work presence in A&E) that have helped to secure this level of performance.

Following the acquisition of Barnet and Chase Farm Hospitals NHS Trust (BCF) by the Royal Free London NHS Foundation Trust (RFL) on the 1 July 2014, there was a requirement to transform services to build on the benefits of each legacy organisation and to build this into the broader scope across the enlarged organisation. Discharge forms one of the 8 pillars within Improving Hospital Flow programme and an integrated discharge team is a key enabler to effective Discharge Planning and management.

A review of the discharge needs across the Royal Free London Trust took place, looking at the factors which influence the level of complexity associated with the planning of patient discharge including:

- Baseline pre-admission care needs / level of independence of the patient
- Current individual care needs and likelihood for improvement towards baseline
- Immediate care needs required in order to facilitate discharge
- Support network in place at normal place of residence including family, friends or formal carers
- Physical environment that the patient needs in order to facilitate a safe discharge from hospital

These factors result in an individual patient falling into one of three broad categories, which will have defined discharge support:

- Routine discharges managed at ward level by the ward teams
- Patients with on-going needs would be supported by the site based flow team
- Care needs requiring specialist input would be supported by the discharge navigator team

3.3.4. Reablement

Performance Overview 2014-2016:

- Reablement data is reported one year in arrears. The table below shows the figures reported in the years 2014-2016.
- Barnet's performance was consistently above 83% from 2010/11 to 2012/13, exceeding the national average.
- There was a sudden drop in performance in 2013/14. This was primarily due to data quality issues.
- Performance climbed again in 2014/15 but did not reach the in-year target of 81.5%.
- A dedicated project is underway to resolve the data quality issues associated with this measure and improve the accuracy of the return. Barnet will report under these arrangements in 2016/17 for the first time.

Year	2012/13	2013/14	2014/15
Barnet %	83.2	71.9	**77.1**
NSN average %	84.2	85.1	**86.6**
England average %	**81.4**	**81.9**	**82.1**

Trajectory for 2016-2017:

- This is an annual measure with no in-year trajectory

Target Rationale:

- Barnet has a target to reach the top quartile of comparator boroughs by 2020.
- The 2015/16 target was set to increase performance to 81.5%, which would take Barnet above the national average. This was not met (as shown in the 2014/15 data above).

- The target for 2016/17 aims to increase performance to the level intended in 2015/16 and return Barnet to performance which exceeds the national average.

Context and Key Activities:

- In 2015-2016 we reviewed our enablement services to ensure that they are better targeted at those individual where needs could be stabilised or reduced. There is on-going work to ensure that the service is appropriate used and targeted at those individuals where cost benefit will be realised (no increase in needs for 32 weeks). In 2016-2017 we will review our enablement pathway.
- A review of those readmitted to hospital was undertaken with hospital social work teams. This review identified that readmission to hospital is increased for individuals with complex community service and reablement packages at discharge. In 2016-2017 we will extend the scope of our integrated locality team (including MDT) to support those individuals identified as at risk of readmission or escalation of social care needs following discharge.
- As part of the development of our two local mental health programmes: re-imaging mental health (CCG lead) and Mental Health Enablement (LB Barnet lead) we will commission a number of services to support individuals to recovery and manage their conditions outside hospital. These will include employment support, new accommodation models and primary care support. We expect to see the impact of this new mental health enablement offer in 2016-2017 on enablement outcomes and delayed transfers of care.
- Stroke and dementia services have been commissioned to provide appropriate reablement support to this cohort. The further development of our stroke review service will happen in 2016-2017.

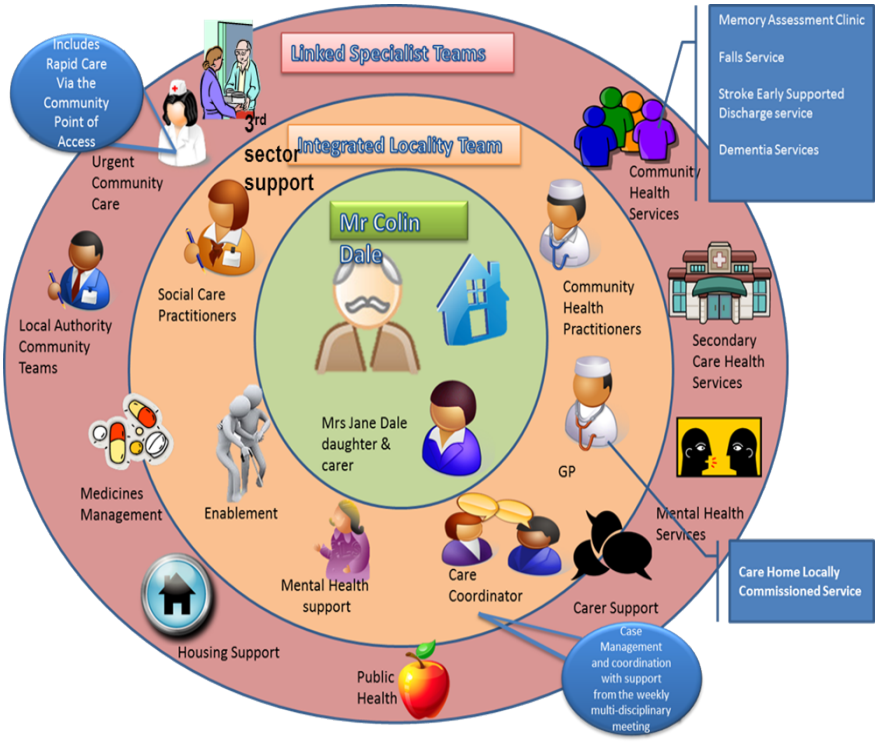
3.4. Disabled Facilities Grants

As a London Borough, the disbursement of DFGs forms part of the overall approach to prevention and early intervention to ensure people can remain at home and in their communities. DFGs will be used, in conjunction with the Council's Accommodation Strategy for Vulnerable People, to secure early discharge from hospitals and reduce non-elective admissions.

3.5. Details on 16/17 Schemes

Locally we will be rolling over key schemes from the 15/16 plan; see pages Annex 1 of the 15-16 plans (page 56).

Our aim is to continue support the delivery of care that provides a seamless management approach to coordinating the resources required. The diagram below depicts the integrated approach to supporting patients/service users and carers.



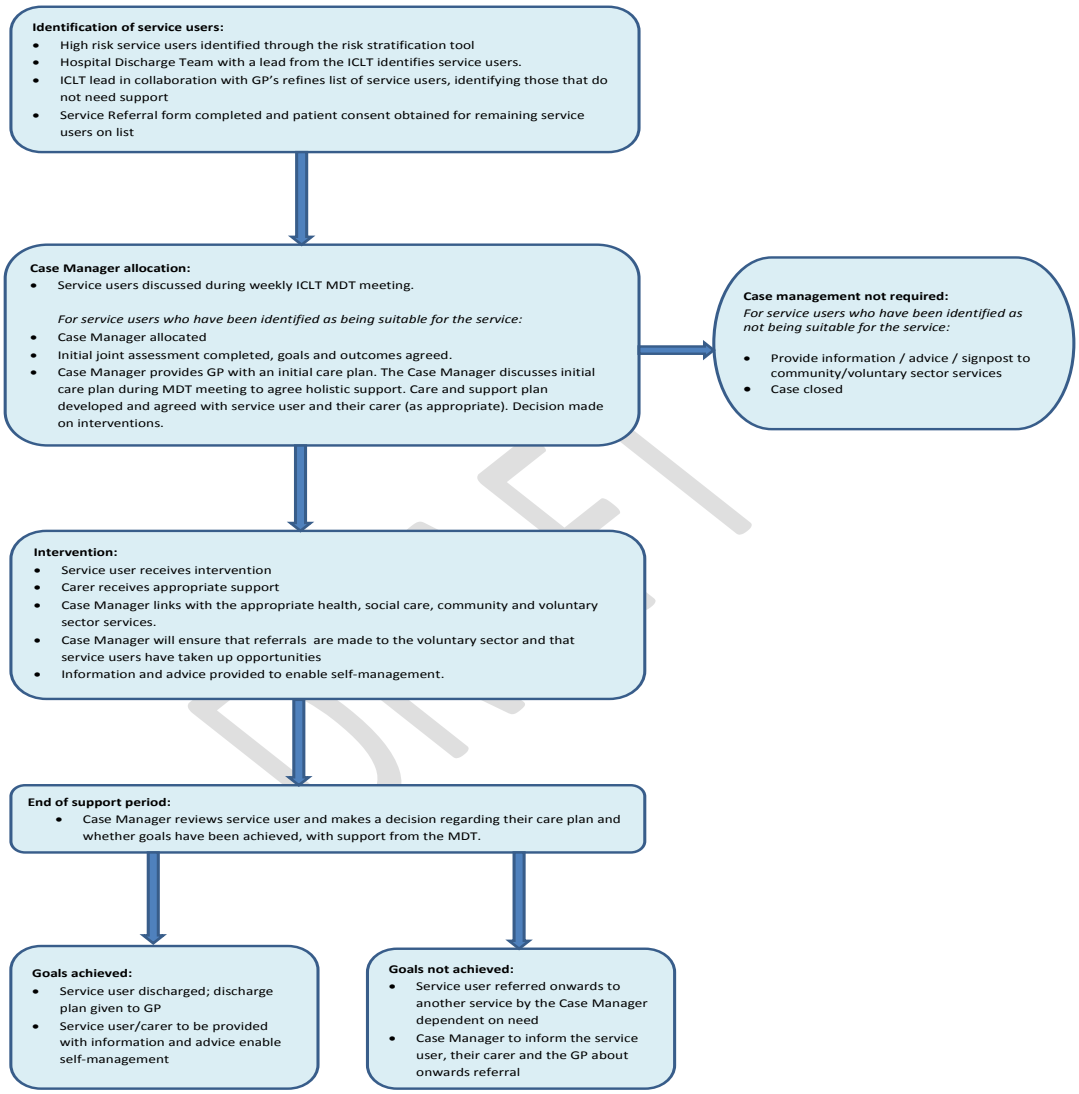
As per the 5-Tier model diagram in section 2.3 the rolled over schemes include:

- **Scheme 1: Self-Management and Health and Wellbeing Services:** This reflects Tier 1, i.e. people and their families are supported to manage their own health and wellbeing wherever they can and for as long as possible.
- **Scheme 2: Access services including primary and social care assessment:** identify early and proactively target those at risk of becoming frail or unwell. When necessary a support package focused around the individual will be put in place that optimises Mr Dale's skills, increases his quality of life and prevents deterioration.
- **Scheme 3: Community based intensive services (Tiers 3 and 4):** Intensive community based support services are readily accessible and react quickly to need.
- **Scheme 4:** Enablers: supports the delivery of the three schemes above and consists of a range of successful operational services, including planning for later life (a team of advisors that help people prepare for their old age), shared digital care records (to enable all professionals and teams to work together to deliver care and support to Mr Dale) and other community health services. These services do not directly deliver the 6 core BCF targets but support their achievement through other indirect benefits and underpin the delivery of the different tiers in our integrated care model.

3.5.1. Integrated Teams in the Community

An extended model of integrated care is being rolled out widely across Barnet in 16/17. The model of care is based on co-production and collaboration across the local health economy, the outputs of the pilot ILT in the West of the borough and based on key principles including the national evidence for care to be integrated so that better, more person-centred care can be provided for the growing number of older people with social care needs and multiple long-term conditions is well documented and is now established as NICE Guidance Older people with social care needs and multiple long-term conditions (NG22).

The proportion of the local population that will receive case management is derived from the Risk Stratification Tool and who are identified as being at the highest risk of hospital admission (i.e level 3 patients). 1971 patients have been identified at level 3. As the expanded Barnet Intergrated Locality Team (BILT) mobilises over the forthcoming months it is expected the service will start seeing complex patients with 3 or more long term conditions from quarter 2 onwards. The cohort will be reviewed in quarter 3.

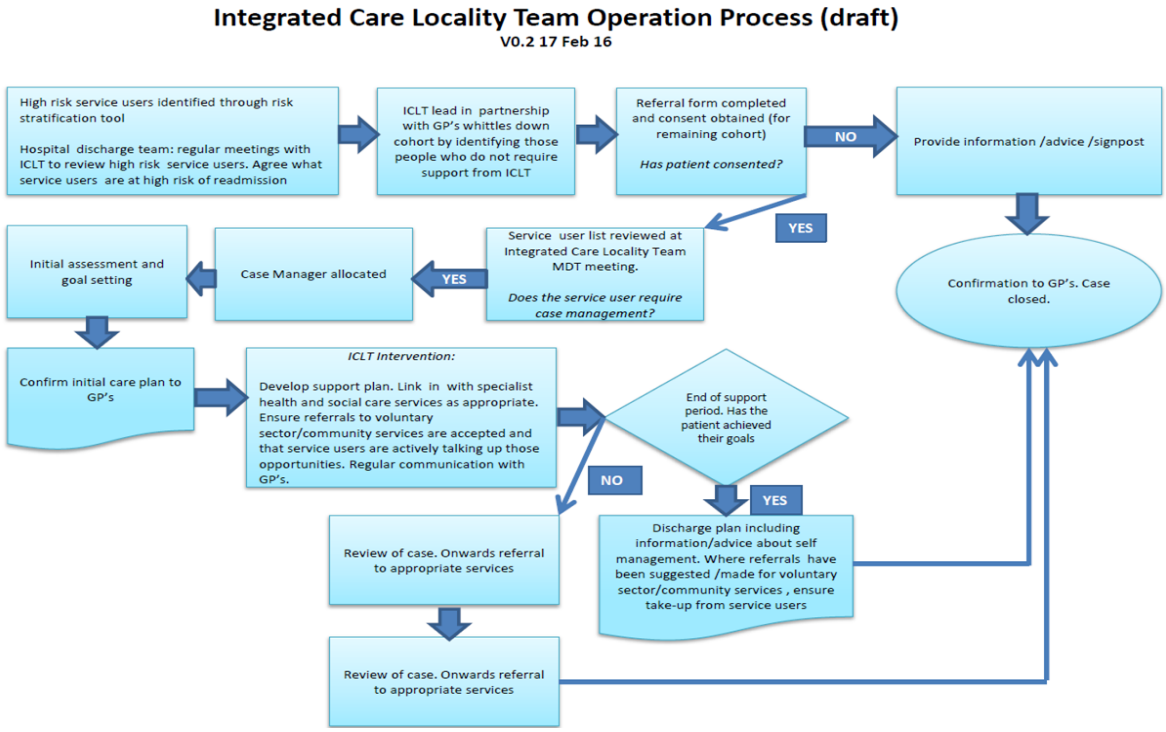


The aim of BILT is to deliver appropriate care to older people in the community. This should reduce avoidable hospital admissions, reduce use of unplanned care, deliver high quality community services for people who have been identified as in need of preventative care and reduce duplication across health and social care services. This includes:

- Partnership working with social care, health services, the voluntary sector and community services
- Providing coordinated care and case management through the appropriate pathways, linking acute, primary care, social care services, voluntary sector and community services
- A co-ordinated care plan with an agreed lead professional and care co-ordinator
- Using risk stratification and clinical/professional judgement to identify those who are at high risk of unplanned hospital admissions and/or residential or nursing care homes
- Promoting and embedding a culture of integrated working among the team to deliver the service
- Identifying and providing early interventions as appropriate, preventing avoidable A&E attendance and unplanned admissions to hospital by providing a 'joined-up' service to people with complex health and social care conditions and supporting people who require end of life care
- Working closely with service users, carers, GP's, health and social care professionals and community/voluntary services to ensure care is managed at home as the place of choice
- Promoting self-care planning and self-care management through provision of information and advice, thereby supporting service users and their carers to make informed choices and take control of their health and wellbeing
- Increased use of the Directory of Services and signposting via 111 and, once in place, the citizen portal, which will be available on the London Borough of Barnet website.

The overarching philosophy around the development of the integrated locality team service is a risk stratification approach linked to GP practices so that admission to secondary care and/or residential or nursing care homes should be the last resort for any service user where it is clinically appropriate and that supported discharge home from acute care should be achieved as quickly and efficiently as possible.

The service's ultimate objective is to promote and maximise independence by enabling people to continue to live safely at home as long as they are able to or wish to do so.



Key areas within the service model:

- **Multidisciplinary approach:** provide an integrated, multidisciplinary service that can provide users with a coordinated assessment and intervention

- **Integrated and coordinated services:** integrate all elements required by the service user and work to ensure interventions are delivered efficiently and effectively across the main service delivery areas minimising duplication of paperwork and personnel

- **Whole system focus:** work closely with multiple agencies in the wider health and social care system. This will include but not be limited to, primary care, social care, carer agencies, acute hospitals and third sector in identification and management of people who are at higher risk of hospital admission and/or have complex needs. Provide a point of access to agencies and through joint assessment. Provide effective triage and navigation of service users to the most appropriate pathway.

The model is focused around health and social care delivering early interventions, signposting and the management of older adults by enabling more alternatives to hospital admission or care home placements, delivering care closer to home through a pathway of care using a systematic approach, as depicted on the previous page.

High level Milestones	Who	Date
Specification and costs to be agreed by JCEG	JCEG	25 April
Business Case, specification, Equalities Impact Assessment and Quality Impact Assessment approved by: **QUIPP** **FPQ**	 QUIPP FPQ	 May May

Develop, agree and sign of Information Sharing Agreement and Memorandum of Understanding	Project Manager	May - July
Contract negotiation with CLCH	Head of JCU	April - May
Develop and agree Performance Framework	Project Manager/Provider	May - June
Reconfigure existing BILT, MDT and CNS to align with new service specification	Provider	May - June
Communication activities with GP's, service users/carers, staff, service user groups	Project Manager	May - July
Extended service go live	Provider	4 July 2016

3.5.2. Developing the Workforce

The table below shows that there is a total workforce of 10,200 people across Adult Social Care in Barnet. Almost 90% of the workforce is in the private sector which is greater than the national average of approximately 78%.

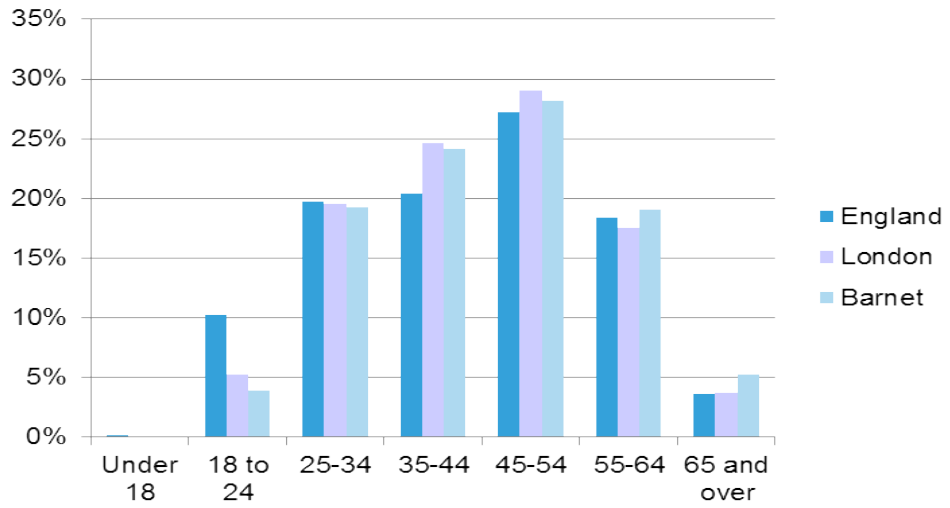
Sector	Jobs	
	Number	Percentage
Independent	9,000	88%
Statutory local authority	300	3%
Jobs for / direct payments recipients	900	9%
Total**	10,200	

Barnet Adult Health and Social Care Workforce. (SfC – NMDS Adult Social Care, 2013)

Barnet experiences a higher than average turnover of adult social care staff. A National Minimum Data Set (2013) for Adult Social Care indicates that turnover rates in Barnet have been:

- 18% across the sector as a whole
- 43% for Registered Nurses (31 leavers)
- **22% for Care Workers (248 leavers)**
- 9% for Senior Care Workers (14 leavers)
- 7% for Senior Management (less than 5 leavers)

The adult social care workforce in Barnet is also generally older than the average across London and England which has implications for sustainability depicted in the chart on the next page. This along with a high turnover of staff means that Barnet will need to recruit significant numbers of staff to the sector to maintain services (Skills for Health, 2015).



The age of the current adult social care workforce in Barnet (Skills for Health, 2015)

The Table below shows that the majority of the Barnet's adult social care workforce (35%) has no qualification.

Qualification	England	London	Barnet
Entry or Level 1	1%	0%	0%
Level 2	23%	19%	30%
Level 3	16%	15%	12%
Level 4	14%	16%	18%
Other (social care)	8%	9%	2%
Any other qualification	4%	4%	3%
No qualification held	35%	36%	35%

Qualifications of Barnet's Adult Social care workforce Skills for Health, 2015

Training and Development

In Barnet there are a number of training initiatives both being planned and delivered through various providers. Health Education North Central and East London- Community Education Provider Network (CEPN) that are targeting the priorities identified within the Care Home Pilot (2013) including:

1. Improved multi-agency working between care homes, health, social care and other organisations.

2. Improving the quality and consistency of clinical care around:
   - pressure sores,
   - medicines management
   - the deteriorating patient
   - dementia

- End of life care.

The 2015/16 Locality Funding Investment Plan for the Barnet Community Education Provider Network has included a number the initiatives that provide training for those providing care to care homes; care home staff; GP's and community nursing staff and carers (Table below).

Local Education Training Board Priority	**Method delivered**
Long Term Conditions Complex needs	Case studies (theoretical or real) discussed in multidisciplinary groups addressing the complexity of managing these cases
End of Life (EoL)	In particular education about EoL care outside of cancer diagnosis; in particular focusing on supporting people dying of heart failure to do so at home if they so wish. Collaboration with North London Hospice Education team providing co-facilitation
Improve integration	Multi-professional engagement in groups (facilitated by CEPN faculty members)
Patient empowerment/ preventative health	Session/s on empowerment. Involvement patient representation to explain how they manage to improve their own health outcomes by taking control of their own health
Mental Health Training	Two to three sessions led by Primary Care Academy (education arm of BEH Mental Health Trust) addressing management of medically unexplained symptoms (MUS) and long term mental health conditions – areas identified as learning needs of Barnet health workforce and in keeping with ~Barnet CCG commissioning intentions.
Public Health perspective	Working with public health colleagues to ensure attendees aware of the bigger population picture and not just individual patient need.
NHS Values and Behaviours	Faculty development embedding these values and behaviours in facilitators and role modelling to groups
Supporting 5-Year Forward View new models of care	Breaking down barriers between primary and acute care and Integrating physical, mental and social care (especially to support management LTC) by learning together and considering complex cases which demand integrated working practice.
Engaging communities	Involving voluntary groups in the CLGs thus creating stronger partnerships.

The 2015/16 Locality Funding Investment Plan for the Barnet Community Education Provider Network

One of the projects proposed is aimed at increasing the number of apprenticeships in the Barnet healthcare economy working in Bands 1-4. Working with CITE (Communities into Training and Employment) the aim would be to recruit new personnel and provide a training scheme crossing the traditional barriers between primary, secondary and community care providing experience in GP surgeries, care homes, in hospital setting and in the community. This will increase not only capacity in the care system but the skills and flexibility of the workforce including within local care homes.

The Cavendish Review recommended that there should be common introductory training for health and social care workers who have direct contact with patients. As of 1 April 2015, it

became mandatory for all employees in Barnet to complete the Care Certificate within 12 weeks of employment.

The Health Care Support Worker Academy aims to support Health Care Support Workers currently employed in Barnet to gain their Care Certificates by signposting them to appropriate resources that already exist (e.g. LMC programme) and also by providing educational opportunities to attain the competency areas which are harder to cover. The aim is to work with partner organisations including CLCH and the Royal Free London NHS Foundation Trust. This work will be supported by Barnet CCG's Workforce Lead Nurse and London Borough of Barnet's' Integrated Quality in Care Homes (IQICH) Team and the Nurses Forum.

Integrated Working Staff Development Programme 2016-2017 Key Activities

Activity	Timescales	Leadership
Every Contact Counts up-skill over 300 members of the frontline workforce (such as housing officers, customer service advisors) to be able to communicate wellbeing messages to our residents, at risk of non-elective admissions	- April – June 2016: train the trainer devised and development sessions scheduled. - April, July and September 2016 cohorts recruited for training - October – November 2016 – evaluation and review. Modification of training materials - December 2016 and February 2017 2nd round cohort recruited.	LBB Public Health
The Community Centred Practice (CCP) programme, working with selected GP practices across the borough, will integrate volunteers and the voluntary and community sector with primary care provision.	- April to June 2016: GP recruitment - June to Sept 2016: volunteers recruited and matched - Sept 2016 to Jan 2017 Training and Review - February 2017: Review and Progression.	LBB Public Health
Develop strengths based practice across social care	Integrated Locality Teams: Integrated Development Sessions scheduled for Sept 2016 and Jan 2017	CLCH – Integrated Locality Team Provider LBB Adult Social Care

Activity	Timescales	Leadership
and NHS integrated teams.	- Adult Social Care Workforce – strengths based practice learning sets established. April to July 2016 - Mental Health 'trailblazer' multi-discipline learning sets established – March 2016 – May 2016	Barnet CCG
Integrated Case Management - staff co-design (MDT and Integrated Locality Team)	Reflective learning sessions – journey so far and improvement opportunities. Sept 2016 and January 2016.	Barnet CCG

4. National Conditions

4.1. Agreement on a local action plan to reduce delayed transfers of care

Local context and performance

In accordance with National Guidance the Clinical Commissioning Group and the Local Authority works in partnership with system partners to prevent delayed transfers of care. The System Resilience Group meets monthly and receives performance reports to monitor overall performance across all three of the Royal free Hospital sites (Hampstead, Barnet and Chase Farm). Members of the System resilience Group include system resilience leads from Enfield, Haringey and Camden and Hertfordshire.

A capacity and escalation plan is also operational across all CCGs, and during times of anticipated additional pressure and increased demand daily telephone conference calls take place to assist to assist with discharges that are more complex to ensure maximum performance.

Context for joint working

System resilience leads have regular contact and meet with operational leads from the Royal Free Hospital, CLCH and the Local Authority. A system resilience Task and Finish Action Group meets every Tuesday to review and monitor progress and agree actions that are recorded within a jointly agreed Action Plan.

Our third sector partners: the Red Cross and Age UK provide Home from Hospital and Enablement services as part of the discharge pathway for our older frail patients. North London Hospice and Marie Curie are linked into the pathway for end of life and palliative care.

A weekly MDT meeting takes place every Tuesday between multi-providers including LAS, Mental Health, Acute, Community Services provider, palliative care and with pharmacy input.

The Action plan is updated and circulated weekly to all partners with overall progress of initiatives monitored each month at the SRG Meetings

Challenges for 2015-2016

- The lack of complex Neurology Rehabilitation Beds
- High numbers of admissions from Care Homes that block capacity which could have been avoided
- Recruitment difficulties across health and social care
- Industrial Action resulting in compromised capacity
- Ambulances being conveyed to London from EAST into the RFL sites
- Admissions of patients into Barnet from across the borders of Hertfordshire
- The need for additional NWB rehabilitation capacity
- Demand for Packages of Care to enable quicker discharge
- The need for a co-ordinated discharge to assess model, system and process

Changes from 15/16

- New requirement for 2016-2017
- In 2015-2016 providers and commissioners have worked together to create a joint local system resilience plan.
- This plan is aligned to Barnet's BCF objectives.
- The most recent version of this plan is attached as appendix A.

Plan for 2016-2017 – Additions to 2015-2016 Programme

- Align Better Care Fund and System Resilience programmes.
- Review Resilience Programme funding and consider for pooling within BCF.
- Agree strategy for delayed transfer of mental health patients (dementia) arising from limited supply of residential beds for this cohort.
- Review current Voluntary Sector and Small contracts with both LBB and BCCG that support reductions in DToCs
- Review and develop a Discharge to Assess Model
- Establish a Care Home MDT service based upon the 'Silver Book'
- Implementing additional OOH Capacity
- Expanding the Rapid Response service in times of surge
- Establish a weekly Task and Finish Group that drives service improvements to prevent A&E attendances and DToC
- Daily reports of DToC position at all 3 RFL sites and escalated action where appropriate
- Continue 7 day a week on side social work service and introduction of additional Social Worker time to support discharge and MDT Assessments
- Procurement of a new Risk Stratification Tool that identifies those at risk and those using NHS and Social Care services more frequently than expected

4.2. Maintaining Provision of Social Care Services

Barnet Council has set a five year Financial Strategy (MTFS) to 2020 agreed by full Council in March 2016. The Council has agreed a balanced (breakeven) budget for this five year period. The Adult Social Care budget is balanced (breakeven) throughout this period.

In 2016-2017 the total Council general revenue budget will be £278m and spend on Adult Social Care (ASC) is £86,336,349 (33% of the total Council budget). In 2016-2017 Adult Social Care savings are £3.4m - this represents 21% of the total Council savings and reflects the Council's commitment to protect services to the vulnerable by applying a lower savings target to ASC than to other areas.

Demographic funding of £1.8M has been applied to the adult social care budget for 16/17 and demography has been modelled into the 5 year financial strategy. Inflationary pressures are addressed through central inflation funds, which are applied to each area of the Council based on actual inflationary impact from contracts and therefore ASC will receive sufficient inflation funding to cover actual inflation demands. National Living wage implications are being factored into inflationary funding. An assessment of the impact of the NLW has been

undertaken and requests for fee uplifts are being managed through a standardised process with other Councils in the West London Alliance.

The RNF allocation of £6.7M has been applied for the protection of adult social care in the Better Care Fund, along with the nationally mandated amount for Care Act 2014 new burdens (£833K). The social care precept has also been applied in Barnet and is adding a further £2.7M of adult social care protected funding. Prevention spend on the Adult Social Care Budget is £2.85m. Prevention services are also provided through the public health budget.

Changes from 15/16

- Increased investment in Adult Social Care Commissioned Services – the BCF allocation is now in-line with the Relative Needs Formula amount for LB Barnet £6.71m
- Increased emphasis on managing out the key triggers for entry to high cost acute and residential settings.
- Review of entry points to residential care from hospital settings and development of an action plan to address.
- Renewed focus on supporting carers and reducing risk of break-down of care.

Plan for 2016-2017 – Additions to 2015-2016 Programme

- Renewed emphasis and recognition of the role of social care services in preventing unplanned hospital admissions and mitigating length of hospital stay.
- Increased investment in carers' services – to reduce risk of non-elective admissions and admission to residential care.
- New carers and dementia pathway to reduce risk of break-down of care & to support individuals to manage their condition.
- Expanded offer of early intervention services for older people – expanding from four neighbourhoods to include two additional neighbourhoods – through our expansion of the Ageing Well Programme.
- Increased investment in seven day social work to minimise admissions through A&E for older/frail cohort.
- Sustained investment in activities to manage population pressure and ensure that individuals are supported within social care and neighbourhood services.
- Expanded role for Adult Social Care within the Integrated Locality team located within the community services provider.
- Continuation of joint work to manage delayed transfers of care.

4.3. Joint approach to assessments and care planning/accountable professional for Care Management

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

- Use of risk stratification in primary care to identify those most at risk of admission to ensure that they are actively case managed.
- A weekly multi-disciplinary team meeting that provides a formal setting for multidisciplinary assessment and health and social care planning for very complex high risk patients who require specialist input. This accepts referrals from multiple sources including primary, secondary and social care and results in collective ownership of a planned care approach.
- Admissions avoidance DES as per GP contracts for 2014/15 where new responsibilities for the management of complex health and care needs for those who may be at high risk of unplanned admission to hospital have been introduced. In particular, to case manage vulnerable patients (both those with physical and mental health conditions) proactively through developing, sharing and regularly reviewing personalised care plans, including identifying a named accountable GP and care coordinator.
- Planned expansion of the Integrated Locality Teams incorporating health and social care with anticipated streamlining of care according to patient need rather than referral point. This will also bring into play a generic long-term condition approach which will enable early identification and care planning for future management of exacerbations.
- An enhanced GP service focussed on care homes to provide a much more holistic management approach to supporting homes to reduce admissions.

Barnet has an agreed format for assessment, allocating lead professional, planning care and monitoring success measures of interventions. To date this has been led by the MDT. It has fed directly from risk stratification undertaken manually by GPs.

With implementation of the risk stratification tool and the planned expansion of the Integrated Locality Team, we have an increased ability to target those most at risk of admission and so see a shift in approach and activity.

A key principle of using the bottom-up build operational model is to provide the freedom and the permission for partners, including GP practices, to work together to develop and agree a robust framework for joint assessment and care planning.

To remove potential barriers to success we have focussed the work around the needs of the patient and, in particular, are advocating an outcomes based approach to make the benefits tangible to those delivering care. We have also created an environment that supports innovation and ownership of the model with the commissioner only providing high level outlines of requirements to allow for innovation and advocating a hands off commissioner position to allow for problem solving and planning by the teams themselves. Development of a risk and issues log will identify clearly the possible barriers to implementation of the model on a longer term or wider basis that can then be addressed as part of on-going implementation. It is intended that this work taken forward will include:

- Working directly with GP practices to assess risk stratification data together to determine how best to prioritise the numbers of people who need care planning and case management to address those most at need and high climbers (those with a significant change in risk score over a short period of time).
- Agreeing an on-going outcomes-based mechanism to allocating of accountable lead professional across a range of providers and clinicians. This is envisaged as the single contact point for the patient and other professionals in relation to the on-going care plan for an individual. They may not be fully responsible for the delivery of all care to that patient but will have an overview of what the care plan encompasses, what next steps may be required for the patients and can support timely decision making.
- Developing a joint assessment framework that can be utilised and is accepted across the system.
- Developing and introducing a standard care plan.
- Assessing and evaluating the inter-dependency between the team and the Admissions Avoidance DES to ensure that GPs are supported in being accountable for co-ordinating patient centred care.
- Identify any gaps in service, including evaluating whether current systems accommodate to the needs of those with dementia and mental health problems adequately.
- Active consideration and challenge to crossing boundaries of care to reduce the numbers of people working directly with the patients and to explore possible opportunities and efficiencies.
- Outlining how often patients should have their care plan re-evaluated and hence could move within the framework.

Changes from 15/16

- Expanded and redesigned integrated service offer will single point of assessment.
- Population cohort expanded to include patients identified as having the highest risk via the risk stratification tool. This will include those identified at risk of readmission at transfer of care
- Community Services provider (CLCH) as lead provider.
- Multi-disciplinary team and care navigators integrated into single service.
- Planned development of the transition to palliative care pathway for some clients.

Plan for 2016-2017 – Additions to 2015-2016 Programme

- Barnet Integrated Locality Team expanded from West Barnet to whole population.
- Additional support to GPs to use risk profiling tool.
- Expansion of ‘at risk’ cohort to those with LTC/ co-morbidities
- Revision to Risk Assessment Tool to include risk factors for entry to adult social care services.
- Case management approach.
- Revised dementia pathway – including support for carers and increased use of third sector community support programmes.

4.4. Agreement on the consequential impact of the changes on the providers

Approval of the BCF plan by all partners, including agreeing the impact on providers and how the services funded through the BCF are contractualised, is an essential part of the governance associated with the Barnet Integration Programme.

NHS Foundation Trusts and NHS Trusts:

Key NHS partners include Royal Free NHS Foundation Trust (following the recent merger with Barnet & Chase Farm NHS Trust), Barnet, Enfield and Haringey Mental Health Trust, our community health services provider, Central London Community Healthcare NHS Trust, hospices and London Ambulance Service.

Our BCF plan has its foundations in the Barnet Health and Social Care Concordat – a clearly articulated vision for integrated care agreed by all parties.

There are a range of plans, schemes and projects where service providers are active participants in collaboratively designing, implementing and managing services with commissioners which as a collective take into consideration the changes that will take place across the local health economy over the next few years.

Primary care providers:

The primary care infrastructure in Barnet includes 67 GP practices, our out-of-hours provider Barndoc and 77 community pharmacies. GP practices are structured in localities with designated BCCG Board member and management leads. In additional to practices operating individually we are seeing an increasing shift towards network development resulting in increased service delivery on this basis. This will be explored further in terms of a future delivery model.

GP's are fully involved in the development of our 5 tier integrated care model with a number providing input and challenge as the programme progresses.

The wider GP network has been engaged through presentations at locality meetings and through discussions with the LPC.

We recognise that extensive engagement is essential to implement integrated care and are in the processes of developing a primary care strategy.

Social care providers and providers from the voluntary and community sector:

Current plans have been jointly developed with anticipated delivery largely expected through Joint Commissioning.

Strong working partnerships exist between commissioners and provider side teams within LBB (e.g. social work) with sponsorship of key projects and with an established co-production approach.

The on-going work has also supported a facilitative approach to building key stakeholder partnerships across the system, particularly between social care and community services, and collectively we are now working collaboratively to understand respective organisational perspectives, concerns and issues.

Other key partners have been in included in developing integrated health and social care services, such as Housing 21, other care agencies, Barnet Homes, and various voluntary sector providers (Healthwatch Barnet, Age UK and the Alzheimer's Society and British red

Cross). There is very much a growing interest in this area from partners and we are harnessing the energy, enthusiasm and skill by inclusion in steering groups and experts by experience panels as appropriate.

Acute providers:

Our main acute provider is now Royal Free NHS Foundation Trust working through 2 key sites in Hampstead and Barnet.

The on-going financial position of BCCG is well known by acute partners including a recognition that extensive service re-design and a robust QIPP programme is required to deliver a stable system in financial balance. Therefore we have a very strong focus on:

- Transformational change of the health system by providing integrated care for patients with complex needs as defined in this plan. With proactive identification, care planning and integrated management of care for such patients we will seek to avert crises, thus reducing the unplanned use of acute care;
- Reducing elective acute care through the robust management of referrals and the re-design of care pathways to provide upstream early intervention, a greater range of care in primary care settings and community based alternative care.

Relationships with providers of acute services are proactive and constructive and they actively demonstrate support for our over-arching strategy behind BCF and its aims.

<u>Changes from 15/16</u>

- There will be no change in approach to 2016/17 blocks.
- Consequential impacts were managed through in 2015-2016 – approach will remain consistent for 2016-2017

<u>Plan for 2016-2017 – Additions to 2015-2016 Programme</u>

- Non-elective activity for 2016/17 is currently planned as 2015/16 forecast outturn plus 3% growth plus the impact of commissioner integrated care and diabetes & endocrinology QIPP schemes.
- The programme of work set out in the Better Care Fund comprises of schemes that are expected to have an increased impact on service provision over the next two years. Clearly defined service specific key performance indicators (KPI's) are in place to support the initial review of the performance and wider healthy economy impact during 2016/17.
- Barnet will work with the North Central London (NCL) and West London Alliance collaborative to develop a consistent approach to residential and nursing home prices and a joint approach to addressing gaps in provision.

4.5. Agreement to invest in NHS commissioned out-of-hospital services

The detailed spending plan submitted in the NHSE Submission template demonstrates the breadth of the Barnet BCF plan in investing in NHS commissioned services out of hospital. This includes not only NHS community services and social care services but a range of prevention services included in the Ageing Well programme, the mobilisation of Dementia Hubs, the carers support services, palliative/end of live services and the locality teams.

Changes from 15/16

- Reviewed and revised current schemes to identify opportunities to increase scale or to target as those mostly likely to enter the health and social care system through A&E, be re-admitted following discharge and/or have a delayed transfer of care.
- Procurement of risk assessment tool, additional support to GPs and expanded integrated locality team will be rolled out in 2016-2017.
- Barnet wide integrated service mobilised to provide out of hospital support
- Resilience funding in place to provide seamless approach for discharging and managing patients in the community

Plan for 2016-2017 – Additions to 2015-2016 Programme

- Funding to be retained in out of hospital services
- BILT evaluation, deep dives and reviews have been used to reshape offer to ensure further reduction of non-elective admissions.
- Expansion of at risk cohort identified for BILT services- with a higher number of people diverted from non-elective admissions or unplanned care through the use of a revised case management approach
- Expansion of primary care activities to support self-management.
  Rolling programme of review and assessment of BCF commissioned programmes to assess impact and assurance of evidence based practice.

4.6. Better Data Sharing between Health and Social Care

Locally we recognise the importance of joint working across all health and social care services. The NHS Number will be used as the primary identifier for integrated case management, data exchange and care reviews. It is already used as the unique identifier for most NHS organisations across Barnet.

Social Care includes the NHS Number with some client records; however, this is not currently required for all client information. Adult Social Care is in the process of procuring a new case management system, which will be implemented in 2016 and will result in the recording of the NHS Number for all social care clients from this point forwards.

LBB / BCCG operate within an established information governance (IG) framework, including compliance with IG Toolkit requirements and the seven principles in Caldicott 2.

In addition Barnet CCG is looking to work collaboratively with all care providers within the local health economy by encouraging the sharing of patient records with the view to improve care and enable patients to be seen in a variety of settings, with the benefit of care professionals accessing care record from the various provider (where possible) at the point of care. The sharing of care records would include sharing between secondary, community, social care providers and primary care GP Federation(s) leveraging on existing clinical systems and the agreed interoperability platforms to allow patient care records to flow between the various clinical systems.

Changes from 15/16

- North Central London confirmed as digital road map footprint.
- Digital maturity self-assessments are in the process of being completed for providers locally
- This provides us with a baseline (provider) position on the use of digital technology to operate paper-free at the point of care.
- Continue to build on interoperability between primary care, community care and secondary care.
- Interoperability between social care and NHS care records was delayed as LBB commissioned and implemented a new care record system.

Plan for 2016-2017 – Additions to 2015-2016 Programme

- Implementation of MOSAIC system for adult social care clients in April 2016 will enable the electronic care record for Adult Social Care Clients to record the associated NHS number for linkages across to health services accessed by adult social care clients.
- North Central London (NCL) CCGs are working together on a digital roadmap.
- Plan for implementation of the road map to be developed across 2016/17.

4.6.1. Approach to communication with local people on use of their data set out

We are committed to providing local people with as much information as possible about how data is shared about them in accordance with the Data Protection Act and where appropriate services will seek patient consent before any onward referrals to other services.

An example of how this was managed in 2015/16 is depicted below.

Information on how initiatives will provide appropriate governance is also evidenced by the information Sharing Agreement has been put in place for the Barnet Integrated Locality Team (BILT) which clearly sets out a requirement to gain patient consent before a referral is accepted.

The BILT patient leaflet articulates how information will be shared, the need for patient consent and reassurance that people do not have to provide consent and this will not affect any care they require regular health and care services. Patient consent is a prerequisite for any referrals to BILT.

BILT will be expanded over the forthcoming months and we plan to write to all GP practices to inform them of our approach to identify patients for the service and an accompanying letter seeking patient consent will also be provided, which will set out a request to gain patient consent, why information needs to be shared and the option for people not to provide consent if they are not happy to do so.

Information Sharing Engaging with the Public

- We are committed to providing local people with as much information as possible about how data is shared about them in accordance with the Data Protection Act and where appropriate services will seek patient consent before any onward referrals to other services. For example an Information Sharing Agreement has been put in place for the Barnet Integrated Locality Team (BILT) which clearly sets out a requirement to gain pain consent before a referral is accepted. The BILT patient leaflet articulates how information will be shared, the need for patient consent and reassurance that people do not have to provide consent and this will not affect any care they require regular health and care services. Patient consent is a prerequisite for any referrals to BILT.

- BILT will be expanded over the forthcoming months and we plan to write to all GP practices to inform them of our approach to identify patients for the service and an accompanying letter seeking patient consent will also be provided, which will set out a request to gain patient consent, why information needs to be shared and the option for people not to provide consent if they are not happy to do so.

- See Attachment section for an example of the information provided to patients who access the BILT service

4.7. Plans to support seven day services across Health and Social Care

There is a national requirement to deliver against a set of 10 clinical standards for seven day services (7DS)[6] which NHS organisations are expected to meet by 2017. The standards include delivery of 7DS improvements within acute settings including diagnostic availability, and delivery of improvements in 7DS across other system wide settings such as primary, community mental health, and social care.

These developments aim to improve clinical outcomes and patient experience, reduce the risk of morbidity and mortality, and provide consistent NHS services across seven days. Specifically the following outcomes are intended to be delivered as a result of implementing the 10 standards:

- Reduced admissions
- Reduced variation in:
- Length of stay by day of week
    - Mortality by day of week
    - Re-admittance by day of week (variation 1.8% between highest and lowest number across 7 days from Q2 2016)
    - Access to diagnostics (achievement of clinical standards 2, 5, 6 & 8)

- Reduced delays in clinical decision making
- Reduction in decompensation especially for the elderly
- Reduced risk especially for longer lengths of stay e.g. falls, HAI rate.

Local Progress

Locally we recognise that discharge from hospital is a process not an isolated event and that it should involve the development and implementation of a plan to transfer an individual from hospital to home or an appropriate setting.

The System Resilience Group has a number of initiatives that are progressing alongside Urgent Care Projects, QIPP Projects and MH Concordat and Planned Care initiatives. These have been mapped together with interdependencies of all projects identified so that they all concentrate on three priorities:

- Keeping people out of hospital when they can be better cared for in the community.
- Patient journey during hospital stay.
- Discharging people home with support that prevents a readmission and reduces the need for Residential or Nursing Care.

Initiatives

Initiative	Objective
Tracker Nurses in place across the three main provider sites	• Facilitate early discharge of patients from acute hospital • Reduce length of stay in acute hospital.
2 hour Rapid Response Service in the	Reduction in A&E attendance.

[6] http://www.nhsiq.nhs.uk/media/2638611/clinical_standards.pdf

Community	Reduction in non-elective admissions
Home from Hospital Service will provide older patients living in the London Borough of Barnet support and practical help, enabling a smooth transition back home from hospital following discharge; or to	prevent A&E attendance/ hospital admission

Changes from 15/16

- Revised programme of work with care homes
- New approach to service delivery via the out of hours 111 service (procurement led by Enfield CCG)
- Early intervention and prevention programme embedded in the BCF programme will expand to a further two wards.
- Targeted early intervention and prevention working with cohorts at risk of unplanned admissions to hospital and residential care.

Plan for 2016-2017 – Additions to 2015-2016 Programme

- In 2016-2017 the Barnet BCF programme will include:
- Integrated Locality Team to support patients/carers/service in the community enabling the reduction of non-elective admissions and unplanned care for ‘at risk’ cohort
- Utilisation of an expanded rapid response service model with increased staffing and longer opening hours, supporting patients and carers in the community. The service will respond to referrals within two hours and reduces the requirement for unplanned attendances in an acute setting
- An expanded prevention and early intervention programme to divert individuals from secondary care and high dependency social care services.
- Continued investment in community services that provide seven day services to individuals
- Introduction of a care home pilot supporting identified top referring homes (unscheduled attendances/ LAS non conveyances). Team will provide clinical training advice and support to improve the management of patients who are most at risk of an emergency admission, based on best practice in the silver book.
- Further development of our joint DTOC plan and alignment of key activities (care homes, home from hospital, reablement) with BCF programme.
- Joint work to address availability of accommodation for dementia cohort at risk of delayed transfer of care.
- Developing a discharge to assess model.

High Level Action Plan

Activity	Timescales	Leadership
Review of 2015-2016 7 Day Working Programme	May – July 2016	Joint Executive Commissioning Group
Programme development and expansion proposals developed	July- Oct 2016	CCG BCF Lead
De-commissioning/ Re-commissioning programme Agreed	Oct 2016	Joint Executive Commissioning Group
Staff consultation and engagement	July to Oct 2016	CCG and LBB BCF Leads
Provider negotiations	Oct to Jan 2016	CCG and LBB BCF Leads
Revised service implemented	April 2017	

5. Risk Management in 16/17

The BCF refresh has involved a comprehensive review of the proposed spending plan for 2016/17. JCEG have led the detailed work to review the performance of the BCF plan in 2015/16. At a CCG level this has involved assessing the financial performance, risks and the outputs of the associated *Managing Crisis Better* QIPP. At a Council level the senior team have also reviewed the deliverables in line with the medium term financial savings plan.

As part of managing the resilience across the system, partners have considered the overall pressures within the BCF spending plan, the level of investment needed to meet the BCF metrics and national conditions.

These discussions have taken place in the context of wider financial pressures affecting all partners in the health and care system, plus the need to balance priorities within a complex planning environment and a health and care economy which continues to face significant sustainability risks linked the over use of acute care. Evidenced by the engagement exercises around establishing the local commissioning intentions[7] within the CCG and the Council.

5.1. Local Approach to Risk Sharing

The potential risks associated with the Barnet BCF plan are based on:

> Cost of non-electives: The cost of non-delivery of the reduction in non-elective activity anticipated through the Better Care Fund in 16/17 is £560k. This cost is derived from the data used in our "managing crisis better" QIPP scheme, as outlined in the 15/16 BCF Plan. More data is below.

The 2015/16 BCF plan established a risk and contingency process, embedded into our S75 agreement, which operated effectively in the first year of the pooled fund. This mechanism is in addition to existing risk mechanisms that currently exist in the health and care economy for expenditure that sits outside of the BCF pooled fund services. Our approach is to draw on contingency held centrally, should it be needed, as this represents the most efficient mechanism for commissioners. For 2016/17 the established BCF pooled fund risk sharing mechanisms will remain as per the 2015/16 arrangements, with contingency being drawn from organisational contingency funds.

In developing our approach, we have fully considered the complexities in the health and care economy in relation to patient flows and the success of our targeted schemes to reduce non-elective activity for the cohorts targeted in our Better Care Fund plan (the success of these is set out in the section below – data behind rationale). The acute hospital sites contained within our Better Care Fund plan admit patients from a large number of other London boroughs and counties outside London in the east of England region and our approach to risk sharing and contingency has fully considered the impact of these flows.

[7] http://www.barnetccg.nhs.uk/Downloads/Publications/Strategies/NHS-Barnet-CCG-Commissioning-intentions-plan-2016-17.pdf

5.2. Rational Supporting Local Approach

The rational is based on the cost of non-electives using SUS PbR activity data based on the requirements identified in the “managing crisis better” QIPP scheme.

In 15/16 this QUIPP scheme delivered a reduction in activity for the conditions targeted through the designated enablers in the BCF plan. Each enabler was targeted at specific HRGs to reduce activity. HRGs were grouped into a ‘master condition’ for monitoring purposes. These schemes achieved a reduction in activity in15/16.

Master Condition	2014/15	2015/16
15/16 - COPD	331	281
15/16 - Dementia	645	578
15/16 - Elderly Care	183	161
15/16 - Falls & Fracture	797	730
15/16 - Respiratory	980	972
Total	**2936**	**2722**
15/16 - New Pool	802	905

The 16/17 “managing crisis better” QIPP scheme builds on the achievements of 15/16, with an increase in the HRGs being monitored. Evidence from 15/16 shows that the enablers in position are being effective at the targeted HRGs and that the ‘new pool’ master conditions (activity increase in 15/16), will see a reduction due to the active enablers.

Master Condition	Target Activity Baseline 2015/16	Target Activity reduction	Total QIPP 2016/2017
16/17 - COPD	281	27	64,827
16/17 - Dementia	578	62	254,301
16/17 - Elderly Care	161	11	27,310
16/17 -Falls & Fractures	730	53	126,420
16/17 - New Pool	905	34	78,621
16/17 - Respiratory	972	3	8,178
Grand Total	**3,627**	**190**	**559,657**

5.3. Mitigation Approach

The Barnet Better Care Fund Plan is governed by a Section 75 agreement between Barnet Council and NHS Barnet CCG. This agreement sets out the detailed arrangements for the BCF pooled fund, including risk sharing, risk management, and escalation routes. For 2016/17 the legally agreed BCF pooled fund risk sharing mechanisms will remain in place as per the 2015/16 arrangements.

The mechanism recognises that the initial level of risk sharing is at an individual organisation or project/programme level, utilising established contingencies, which are in existence outside of the core BCF pool to mitigate risks in the first instance. Expenditure on Protecting Social Care Services, Disabled Facilities Grants, Social Care Capital and Care Act Implementation is explicitly assumed to remain within the allocation and thus deemed to be expenditure that is not risk shared.

Should risks exceed those that can be managed at a project/programme level, an escalation route to the Joint Commissioning Executive (a sub-group of the Health and Wellbeing Board - HWBB) and to the HWBB itself is in place. The committee will consider various options to mitigate any risk. These include an appraisal of actions that can be implemented to contain expenditure, use of wider organisational contingency funds, under spends from other project/programmes from the BCF pool and how any risk or overspend will be apportioned.

Appropriate Commissioning and Contracting Mechanisms also exist and are built into provider contracts to manage and minimise the impact of any variation to the system. Moreover, the main focus of the schemes in the plan is geared towards management of the target group of service users/patients in a community setting through admissions avoidance and reducing delayed transfers of care. The implementation of these schemes will be done in a planned and managed to way to allow flexibility to transfer resource should there be slippage within the schemes.

5.4. BCF Risk Log

The table in this section details the most important risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government. Details of the mitigating steps that will be taken are also provided.

Risk	Impact (1 - 5)	Prob (1 - 5)	Rating (I*L)	Mitigating actions and steps
Health and Social Care System Risks				
Reduction in non-elective admissions target is undeliverable in the context of significant local challenge and past performance	4	4	16	Scale-up interventions that demonstrated impact in 2015-2016 on non-electives Review all projects for effectiveness and impact

Risk	Impact (1 - 5)	Prob (1 - 5)	Rating (I*L)	Mitigating actions and steps
DTOC Reduction is undeliverable in the context of local challenge in the acute sector	4	3.5	14	Local action plan Targeting of population cohorts and care homes with high admissions rates Sustained joint action on discharge
An underlying deficit in the health economy impacts on service delivery and/or investment	4	4	16	Systematic review of all investments to ensure that resources follow investments with high ROI/ CBA.
The local authority's financial position is challenging and significant savings from all service areas are needed to deliver cost savings and realise benefits within the planned timeline	4	3	12	In 2016-2016 we will review all activities to make sure that we target resources in activities that mitigate and manage
Social care is not adequately protected due to increased pressure impacting the delivery of services	4	3	12	Work with partners on developing plan for protection of services
Implementation of day seven hospital and primary care services delayed	3	3	9	Impact and timescales to be regularly reviewed through joint governance
Programme Risks				
Lack of nursing/residential placements for complex mental health cases (dementia) increases risk of delayed discharges	4	4	16	Working with neighbouring trusts and LAs to increase supply of places. Review lessons learnt from current cases and implement revised approach

Risk	Impact (1 - 5)	Prob (1 - 5)	Rating (I*L)	Mitigating actions and steps
Milestones are missed due to the complexity and scale of change/ review programme	3.5	3	10.5	Structured programme management with senior commissioner leadership established for 2016-2017.
The baseline data used to inform projected performance improvements are incorrect and thus the	4	3	12	Validation of assumptions and savings target with respective finance
performance and financial targets are unrealistic/unachievable	4	3	12	Define any detailed mapping and consolidation of opportunities and costs to validate plans. Develop strong patient and service user
Preventative, self-management and improved quality of care fail to translate to reduced acute, nursing and care home expenditure, impacting the level of funding available in future years	5	2	10	Assumptions are modelled on the best available evidence of impact, including metrics from other areas and support from the National Collaborative Use 2014/15 to test and
Shifting resources to fund new joint interventions and schemes could de- stabilise current service providers and create financial and operational pressures.	2	2	4	Impact assessment of expanded integrated care model to allow for greater understanding of the wider impact across the health economy Co-design and transitional planning with providers is in place Ongoing review of impact through regular provider lead

Risk	Impact (1 - 5)	Prob (1 - 5)	Rating (I*L)	Mitigating actions and steps
Front line /clinical staff leads do not deliver integrated care due to organisational and operational pressures or lack of buy-in to the proposed agenda	2	3	6	Engagement of social work and clinical staff in co-design and assessment reviews Front line/ clinical staff engagement and input in developing integrated care model and plans Communications strategy with staff across the system Maintain formal and informal networks where providers and commissioners can design solutions.

6. Governance Arrangements

6.1. Health and Wellbeing Board Oversight and Sign Off of Plan

Barnet has a well-established and effective programme governance structure, which is designed to ensure that there is transparency on decision making, momentum in the delivery of the agreed schemes and utilisation of a co-production approach for ensuring wider engagement in shaping and mobilisation integration on the changed protocols and pathways. Providers, commissioners and Public Health work together to co-produce solutions and take joint accountability for decisions and leadership on the delivery.

Barnet's Health and Wellbeing Board has overall responsibility for both operational and financial delivery of the Better Care Fund, totalling £24,324,521 and will maintain oversight of the outcomes. The Health and Wellbeing Board has delegated the day to day delivery and oversight of the integration programme to the Joint Commissioning Executive Group (JCEG).

From 2015-16 BCF funding has been underpinned by a Section 75 pooled budget arrangement jointly governed by the LA and CCG under an existing overarching arrangement. This will continue for 2016/17.

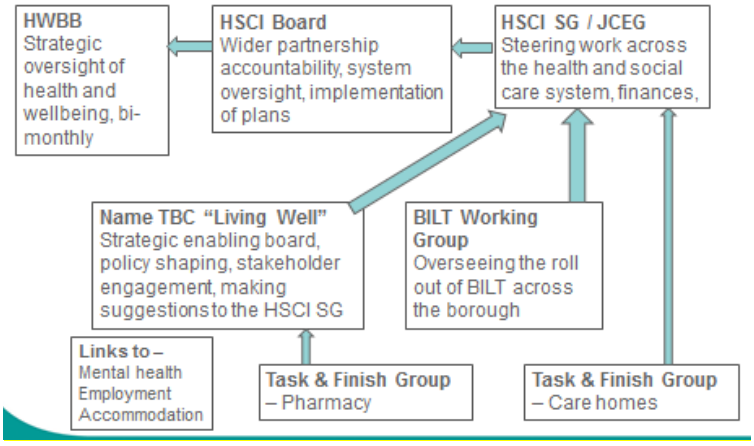
The final plan will be signed off by the Health and Wellbeing Board and shared with the Council and CCG's Governing Body.

The JCEG is a joint commissioning group with a membership of senior commissioners and finance directors from the CCG and Council. The JCEG oversees and reviews all aspects of joint NHS and local authority commissioning economy and has the responsible for overseeing the performance of the delivery of the BCF Schemes and will report to the Health and Wellbeing Board. The Health and Wellbeing Board has also approved a scheme of delegation for the Pooled Budget and Section 75 agreements.

In addition the CCG and the Council through existing, robust governance mechanisms will ensure there is appropriate oversight and decision making.

6.2. Health and Social Care Integration – Provider/Commissioner Governance

In 2015-2016 we refreshed the governance of the Health & Social Care Integration Programme to ensure that we have a structure that can deliver our ambitions with clear accountability and engagement with appropriate stakeholders, led by the Barnet Health and Wellbeing Board. The revised structure ensures that prevention and early intervention activities are under a single governance structure. The programme is led by the chief operating officer of NHS Barnet CCG and the Director of Adult Social Services (DASS) at London Borough of Barnet, with support from the Director of Public Health.



Governance Arrangements Flow

The new structure retains, builds on and extends our engagement with residents and providers (such as secondary care, pharmacy) who are core members of our (name still to be finalised) "Living Well", HSCI Board and BILT working group. The structure also has stronger links to broader programmes and other mechanisms of engagement with service users such as the CCG's Public and Patient Engagement Committee and Adult Social Care Service User engagement structures.

The Operational Groups that support the delivery of the programmes meet monthly and comprise senior operational managers from the relevant partner organisations. These groups coordinate the day to day delivery of the individual projects and services within the approved spending plan, produces the Integration Executive's finance and performance analysis reporting on a monthly basis, ensuring the delivery of the individual milestones within projects and the programme as a whole, assesses and addresses policy developments at an operational level, ensures matrix working and resourcing across organisational boundaries within individual projects, and directs the engagement plan between the integration programme and the structure and governance arrangements of all partner organisations as well as the communications and engagement plan with wider stakeholders, including the public.

The functions, duties, and delegation in terms of decision making are reflected in the terms of reference for the groups operating at the respective tiers of the programme governance structure diagram, with terms of reference updated and refreshed at least annually. Sample Terms of References for the working groups are provided.

6.3. Joint Working

A relevant section 75 agreement is in place. Regular meetings take place at system leadership level between the Council and CCG. A Joint Commissioning Executive Group provides direction and oversight to joint investments and improvement plan activity.

In the 2016-2017 Better Care submission we have committed to undertake a systematic review of BCF commissioned activities to assess:

- Effectiveness of activity on reducing current (and future) demand;
- Cost effectiveness of interventions; and

- Adherence to NICE/ best practice guidelines.

6.4. Key Activities 2016-2017

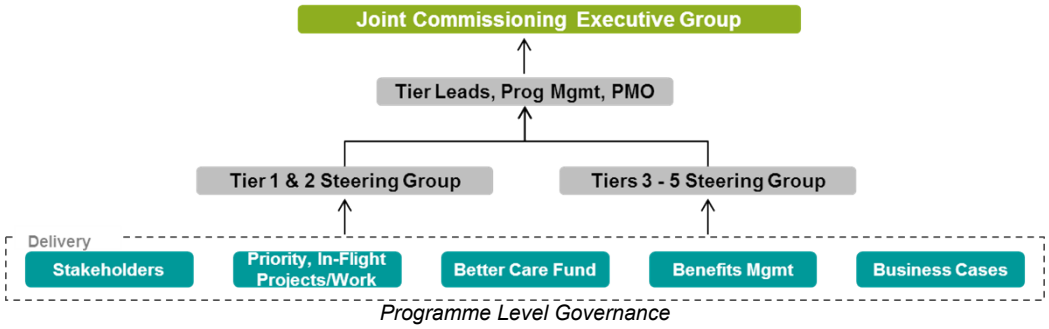
Over quarter 1 of 2016/17 London Borough of Barnet and Barnet CCG will identify and agree further KPI's to enable assessment of the impact of the Better Care Fund in enhancing the outcomes and experiences of Barnet residents;

- Individual schemes and their impact will be reviewed by the Joint Commissioning Executive Group as part of its work programme, through Quarters 1 and 2 of 2016/17
- The application of funding will be evaluated in Quarter 3 of 2016/17 to inform planning for 2017/18

BCF Programme Level Management Approach 2016-2017

In 2016/17 our BCF funded activities are clustered into thematic groups with each of the themes being overseen by a strategic (senior) commissioner from either the CCG or local authority. Each of the thematic clusters will include activities commissioned by the CCG and local authority. This approach should enable the CCG and local authority to take a whole systems approach to managing down demand within the local health & social care system. In light of the significant overlap between the community equipment s75 agreement and the system resilience programme it is proposed that these are included with the scope of the project/BCF spend reviews.

The structure for managing the oversight of the various schemes is depicted below and links back to our 5 Tier model in the original plan



Programme Level Governance

The charts on the next few pages provide the suggested clustering of BCF areas of spend/ projects and proposals on strategic commissioning lead responsible for overseeing delivery.

Seven Day Working and Services to Care Homes
Strategic Commissioner: Commissioning Director Adults & Health LBB Planned Expenditure £5,433,660

Project	Area of Spend	Commissioner	2016/17 Expenditure (£)	Primary Outcome Measures
7 day social work	Social Care	Local Authority	£100,000	Non elective admissions Delated Transfer of Care
Adult Social Care - sustaining 7 day working	Social Care	Local Authority	£797,000	
Intermediate Care in the Community	Continuing Care	CCG	£340,522	
Rapid Response	Community Health	CCG	£1,014,618	
Single Point of Access	Community Health	CCG	£290,520	
Social Care Demand Pressures	Social Care	Local Authority	£2,260,000	
Primary care commissioned service	Primary Care	CCG	£400,000	
Quality in Care Home Team	Social Care	Local Authority	£231,000	

It is proposed that the system resilience programme is included in this block for review

Personalised Support at Home
Strategic Commissioner: Director of Operations and Delivery BCCG Planned Expenditure £2,598,609

Project	Area of Spend	Commissioner	2016/17 Expenditure (£)	Primary Outcome Measures
Ageing Well	Social Care	Local Authority	£350,000	Admissions to Residential Care Delayed Transfer of Care
End of Life care	Continuing Care	CCG	£1,364,609	
IT Interoperability	Primary Care	CCG	£69,000	
Safeguarding	Social Care	Local Authority	£120,000	
Memory Assessment	Mental Health	CCG	£215,000	
Mental Health Pressures	Social Care	Local Authority	£300,000	
Dementia	Social Care	Local Authority	£180,000	

Intermediate Care
Strategic Commissioner Head of Joint Commissioning Unit BCCG Planned Expenditure £8,780,526

Project	Area of Spend	Commissioner	2016/17 Expenditure (£)	Primary Outcome Measures
Intermediate Care in the Community	Community Health	CCG	£8,488,189	Non electives Delayed Transfer of Care
Stroke support services	Community Health	CCG	£195,000	
Fracture Liaison service	Acute	CCG	£97,337	

Reablement and Support for Carers
Strategic Commissioner: Adults Wellbeing Being Strategic Lead LBB Planned Expenditure £5,235,000

Project	Area of Spend	Commissioner	2016/17 Expenditure (£)	Primary Outcome Measures
DFG	Other	Local Authority	£1,970,000	Admissions to Residential Care Non elective admissions Delayed transfer of care
Enablement	Social Care	CCG	£200,000	
Stroke support services	Social Care	Local Authority	£37,000	
Care Act	Other	Local Authority	£846,000	
Carers Support	Social Care	Local Authority	£300,000	
Carers Support – CCG	Social Care	CCG	£806,000	
Community Equipment	Community Health	CCG	£1,076,000	

It is proposed that the LBB Community Equipment element is included within this block for the purposes of the review.

Enabling Activity
Strategic Commissioners: Adults Wellbeing Being Strategic Lead LBB and Head of Joint Commissioning Unit BCCG
Planned Expenditure £2,276,726

Project	Area of Spend	Commissioner	2016/17 Expenditure (£)	Primary Outcome Measures
Children's Commissioning	Social Care	Local Authority	£100,000	Self-management Satisfaction with services Admissions to Residential Care Non electives
Integrated Care Locality Team	Community Health	CCG	£862,366	
JCU funding for Heads of Service	Social Care	Local Authority	£200,000	
Primary care commissioned service	Primary Care	CCG	£270,000	
Shared Care Records	Social Care	Local Authority	£262,000	
Social care integrated practice	Community Health	Local Authority	£151,360	
Supporting delivery of BCF Plan	Social Care	Local Authority	£200,000	
Transitions	Social Care	Local Authority	£100,000	
Integrated Locality Team - LBB	Social Care	CCG	£131,000	

6.5. Measuring the Impact of the Plan

The 15/16 plan documents the benefits realisation approach for each of the schemes; these have been rolled forward and adapted to reflect the changes in the deliverables (where appropriate).

The impact of the plan will also be measured:

1. Quarterly,:
    a. Using a national template into NHS England. This measures the delivery of each local plan in relation to the *BCF national conditions* and *BCF national metrics* as detailed by definitions provided in Annex A and B of the BCF policy framework 2016/17.
    b. Locally via JCEG who have oversight of the BCF section 75.
    c. Locally to Health and Wellbeing Board.

2. Monthly:
    a. Locally via the Programme performance dashboard providing performance summary across the whole programme/metrics (example at Appendix 16).
    b. Locally via individual project/theme level governance boards, with monthly operational oversight by the BCF operational group. Allowing for much more in-depth discussion on specific milestones, trajectories and KPIs at project level.

3. Via specific evaluation activity e.g. clinical audits, independent evaluations (the BILT review is an example of how this was carried out in 15/16).

This plan is signed on the understanding and agreement by both parties that:

- Over quarter 1 of 2016/17 London Borough of Barnet and Barnet CCG will identify and agree further KPI's to enable assessment of the impact of the Better Care Fund in enhancing the outcomes and experiences of Barnet residents;

- Individual schemes and their impact will be reviewed by the Joint Commissioning Executive Group as part of its work programme, through Quarters 1 and 2 of 2016/17

- The application of funding will be evaluated in Quarter 3 of 2016/17 to inform planning for 2017/18

6.6. Programme Milestones

HSCI High Level Plan 2016-2017	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Programme Planning	Draft programme 25th April		19th June									
Programme Milestone plan	Agreed 25th April											
Develop Performance framework	Agreed 25th April											
S75 in place (revised)				31st July								
Review of previous year performance		19th May										
Data sharing approach		31st May										
Stakeholder engagement re future strategy post 2016/17		5th May										
Review Personalised Support at Home Programme			Review start		Review completed 16th August							
Recommendations Personalised Support at Home Programme					Draft 31/08							
Board sign off - Personalised Support at Home commissioning						25-Sep						

Commissioning and Decommissioning Programme Agreed (JCEG)							10/10/2016					
Prevention Review			Project initiation		Final Report			Committee Sign Off				
Prevention Review Communication events						Provider workshop						
Prevention activity - decommissioning and commissioning agreed					Inclusion in final report							
Revised Health Champion - Roll Out		Initial Recruitment			Phase 2 recruitment		Phase 3 Recruitment					
Health champions Stg1 GP and residents engagement					Review		Revised programme					
Health champions stg2 - procurement					Commissioning review	Market Engagement &Testing	Tender					
Implement Extended Ageing Well Model				Review meeting 10th July			Review & Recommendations for next stage 31st October 2016					

Develop extended social prescribing				Review meeting 10th July								
Visbuzz roll out		All sites identified 24th May										
Evaluation of Making Every Contact Count E-module roll out										Phase 1 Testing		Phase 2 Testing
Enablement and Support for Carers Review				Project Initiation			Project Report 24/10					
Recommendations Enablement and Support for Carers programme							Recommendations Report					

Enablement and Support for Carers Commissioning and Decommissioning Programme Agreed (JCEG)								19th Recommendations Report					
Board sign off - Reformed Enablement and Support for Carers Commissions													
Extended BILT Evaluation										Commissioned		Reported 16/02	
BILT Data tracking	Risk tool matching scheme agreed												
7 day working and Care Home Programme Review				Project Initiation			Project Report 24/10						
Recommendations 7 day working and care home programme							Recommendations Report 24/10						

Commissioning and Decommissioning Programme Agreed (JCEG)							Draft report 24/10	Final Report 19/11				
Board sign off - Reformed Seven day working and Care Homes Commissions			Project initiation			Project Report Date TBC						
Intermediate Care Programme Review						Recommendations Report TBC						
Recommendations Intermediate Care programme							Final Report					
Commissioning and Decommissioning Programme Agreed (JCEG)									12/12/2016			

Board sign off - Intermediate Care Commissions												
Integrated Locality Teams Evaluation Report												Final Report
Palliative Care Pathway Review						Project Initiation						
Palliative Care recommissioning agreed (JCEG)							Recommendations 24/10					
Board sign off - Intermediate Care Commissions								Final report 19/11				
Digital Road Map Design (NCL)		Provider self-assessments		NCL Plan agreed								

Recommendations - Digital Road Map NCL					Phase 1 Activity	Phase 2 Activity	Phase 3 Activity						
NHS number incorporation into ASC Records	MOSAIC Implemented	NHS Number flagged											
Revised client tracking using NHS number		Collection Development											
Review of revised risk assessment tool			Project initiation	Project Report									
Explore further integration of care records provider and social care				Stakeholder workshops	Recommendations report 31/08								

recommendations for further integration of care records					Draft report 31/08	Final report 30/09							
BCF Quarter 1 period													
Q1 Reporting deadline													
BCF Quarter 2 Reporting period													
Q2 Reporting deadline													

BCF Quarter 3 Reporting period													
Q3 Reporting deadline													
BCF Quarter 4 Reporting period													
Q4 Reporting deadline													
Design 2017-2020 Better Care Programme													

Commissioning Decisions 2017-2020 Programme (following review programme)												
HSCI Board		7th										
Health & Well Being Board		12th		21st								
HSCI Steering Group			3th									
Joint Commissioning Executive Group	25th		20th									

7. Engagement Activities

Both Clinical Commissioning Group (BCCG) and London borough of Barnet (LBB) have well established mechanisms for provider engagement. Regular provider forums take place across commissioners and client groups. Open days bring together providers to discuss emerging trends in the population, strategic and financial issues, and commissioning intentions.

In adult social care, regular Provider Forums take place. Large events bring together providers across the borough, while more specific activity takes place focussed on client groups (such as older people), services (such as home care), and sectors (including targeted voluntary sector engagement, for example). Forums are followed up with other regular communication; including newsletters, further information, and consultation. Open communication is maintained throughout as a key part of the commissioning cycle. One-to-one leadership sessions with the acute providers and key providers in the area also take place.

The content of our Better Care Fund (BCF) has been discussed with providers, users, clinicians and carers as an integral part of our strategic planning processes. The starting point for all discussions has been our jointly-agreed JSNA and the priorities and plans agreed by the Health and Wellbeing Board (HWBB). Through co-producing these documents, and basing our planning on evidence and feedback, we have worked hard to establish our engagement on the basis of partnership working over many months. In this context we have had many engagement events, including with GP leads and service providers. We recognise BCF as a significant opportunity to accelerate our progress in delivering our existing ambitions and plans, including our established programmes to improve services for older people.

We have engaged through a number of different forums:

Work stream	Type of engagement	Details	Number of patients	When	Outcome
Development of Barnet Integrated Locality Teams	Patient input into developing the service	Patients who accessed the service where asked to complete a questionnaire on the service they received. What worked well, areas of improvement	All patients who have accessed the service	Ongoing	Outputs have been used to develop the service currently being commissioned from a lead provider
	GP	Workshops held with West locality GP's that participated	GP	Bi-monthly	Feedback from GP's used to make

A&E and DToC Plan of Action following weekly T&F Group Meetings

Work stream	Type of engagement	Details	Number of patients	When	Outcome
	engagement	in the pilot Attendance at GP locality meetings	practices N/A	Various locality meetings throughout the year	continuous improvements to pilot Raising awareness of the service
	Voluntary sector engagement	Workshops held with Healthwatch and voluntary sector providers	N/A	Various throughout the year	Feedback from the voluntary sector used to to strengthen links between BILT and voluntary sector services
	Engagement with community groups	Presentation at LBB Communities Together Network	N/A	March 2016	Links established with a few community groups
Delivering the Dementia Manifesto					
Learning Disabilities Partnership Board	Engagement with PWLD and stakeholders (vol sec, carers, providers)	Workshops, presentations and discussions on Transforming Care for PWLD and Autism	Representation at LDPB varies usually between 4 – 6 PWLD	Regular meetings during 2015/16 - @ 2 – 3 months	• Comments on proposals included in responses to consultations • PWLD informed and aware of changes to service models
Health Development Group	Engagement with PWLD and	PWLD are represented on the group which contributes to the development of health	1 - 2	Meetings during 2015/16 - @	• Identifying issues and concerns • Developing health objectives/outcomes

A&E and DToC Plan of Action following weekly T&F Group Meetings

Work stream	Type of engagement	Details	Number of patients	When	Outcome
	stakeholders (vol sec, carers, providers and clinical staff from community LD service)	objectives and priorities for service development		2 – 3 months	• Developing proposals for service development (business cases)
Autism Steering Group	Engagement with people with Autism and stakeholders (vol sec, carers, providers)	People with Autism and carers are represented on the steering group and some task/project groups	2	The steering group met twice in 2015/16	• Contributing to Autism work and oversight of strategy • Identifying priority issues and activity required to address
Patient Care & Treatment Reviews (CTRS)	Individual reviews of patient care and treatment (in assessment and treatment / hospitals)	NHSE requirement for CTRs within 10 days of admission and community CTRs for those e at risk of admission	15 or advocates where patients do not have capacity	N/A	• Comprehensive review of care and treatment including input form external experts (clinical and by experience) • Recommendations and action plan for each individual • Themes identified across providers
Reimagining Mental Health	Breakfast Club meetings	An event which brings together all co-design groups (see below) plus members of the community, public and third sector to discuss and celebrate the progress of Re-Imagining Mental Health	40+	Six-weekly	• Members of community are engaged about the RMH programme / services. • Open space to discuss thoughts and ideas.

A&E and DToC Plan of Action following weekly T&F Group Meetings

Work stream	Type of engagement	Details	Number of patients	When	Outcome
		Programme. (RMH)			
	Co-design Groups	A professionally mixed group (voluntary, Council, NHS and people with lived experience) that will focus on different agendas and subject matters for the Re-Imagining Health Programme i.e children & YP, MH training	2-3	Every 1 – 2 months	• All those involved are actively contributing to the re-imagining health programme • The groups help identify priority issues which need to be addressed and also offer possible solutions.
Visbuzz	Engagement with potential champions and users of the service	Promotion at events and groups to engage residents who could become Visbuzz users, champions or refer friends/neighbours to the service. Including – Barnet Senior Assembly event, Dementia Club for people with dementia and their carers, Barnet Elderly Asian Group, Sheltered Housing residents	180	One off	• Identified 12 Visbuzz Champions • 5 referrals to Visbuzz
Ageing Well	Developing branding	Design workshop to develop branding for Ageing Well	15	One off	• Input into name of strategic board and prevention work • Feedback on developing a brand for Ageing Well workstream
Partnership Boards	Engagement	5 x Partnership Board (carers; PSI; mental health; LD; older adults) that bring together	~ 50	Quarterly plus 2 seminars a	• Input into strategy and service development • Feedback on user experience

A&E and DToC Plan of Action following weekly T&F Group Meetings

Work stream	Type of engagement	Details	Number of patients	When	Outcome
		service users, carers, voluntary and community sector providers and commissioners		year	
Ageing Well	Engagement	review into data sharing in health and social care	12	One off	• To contribute to the National Data Guardian's review of standards of data security for patients' confidential data
Ageing Well	Engagement	4 x Locality Summits that brings together service users, carers, voluntary and community sector providers and local businesses	20-30 per meeting	Quarterly	• Input into strategy and service development • Development of new primary and secondary preventative activities and groups

Meetings with all key providers to secure agreement on any consequential impact of the 2016/17 BCF Plan have taken place across March 2016.

8. Appendix One: Supporting Documents:

8.1. DTOC- TASK AND FINISH GROUP ACTION PLAN

Avoidance of Attendance and Unplanned Admissions and

(Formerly Delayed Transfer of Care)

Action Plan – Update 22th March 2016

Dial in: 0844 4 737373 PIN 60 89 26

	Action	Description	Progress	Clinical Lead	Lead	Timescale
1	**Care Homes**	A Care Home Team Model that supports people living in Care Homes, specialist advice and access to Consultant support and joint training with LLB.	• Top 10 homes –identified information shared • Draft service speciation shared for comment • Model of care 3 PAs- RFH responded 02/02 requesting fuller discussion on the future model. CLCH responded 02/02. • COO requested further conversations to be undertaken at SRG 10/2 to identify ways in which support can be provided to the care home that does not create risks. Agenda item action plan • Draft Specification with Model	**JL** **JL**	**MJ/DM** **MJ/DM** **FG**	Completed Completed Completed

	Action	Description	Progress	Clinical Lead	Lead	Timescale
			Staffing and Support went to Executive Team 2 February. Agreed in principle subject to Clinical Cabinet 28 Feb. Signed off by Clinical Cabinet on 28 Feb. • Mobilisation / Implementation group meeting being held on 25 Feb. Engaging all partners and IT, Estates, Performance, Communications etc. • KS comments emailed to DM for consideration • FG comments to specification emailed for consideration • Develop a Contract variation for RFL • Pharmacy has been mobilised against service specification • Create an operate – operational policy • Communication Plan • Frequent Flyers to be identified by RFL: two sub groups in existence o Elderly – Penny Wiseman	**BS** **JL** **JL**	**BD/DM** **MJ/DM** **MJ/DM** **MJ**	Completed Completed Version 2 Future meetings fortnightly on a Thursday to accommodate Clinical Lead In development in line with mobilisation timescales 8 March

	Action	Description	Progress	Clinical Lead	Lead	Timescale
			○ Frequent attenders FG to obtain membership, TOR and understanding of reporting / connectivity with SRG/care homes projects	**JL** **JL**	**CD** **SC**	On-going evaluation at end of March CV completed and sent for sign off
			• Set up Stakeholder/project team group meeting to finalise draft • Create programme mobilisation plan	**JL**	**FG**	Part of mobilisation planning KS and FG have met and agreeing SoP and phased recruitment process
			Programme Interdependencies with procurement of Risk Stratification Tool	**JL**	**MJ/ KS**	FG Chasing data to be shared at stakeholder group meeting TBC
			Project Board established initial meeting held Full membership and ToR to be confirmed	**JL**	**MJ/DM**	On-going
			Learning to be shared from CHAT Team operational in Enfield	**JL**	**FG**	Meeting Fortnightly. SRG representation / links being made to progress agree actions across tehe system

	Action	Description	Progress	Clinical Lead	Lead	Timescale
					MJ	Risk stratification tool out to OJEU Bids expected end of Jan 2016
					GT	On-going
					GT	Monthly meetings being arranged
					MJ/MA	

	Action	Description	Progress	Clinical Lead	Lead	Timescale
					JB/MJ	
		OOH care home support Jan-March	• Top 10 Care homes Agreed linked to 1 above • applied learning from HCCG model • Agreed referral process • Service spec in draft • outcome measures/ performance near agreement • operational Policy • Meetings with Care Homes • Start date 22 February	**BS**	**BSH**	Completed Completed Completed Completed Completed Completed Completed

	Action	Description	Progress	Clinical Lead	Lead	Timescale
2	**Additional GP Slots / increased capacity in Primary Care**	Delivering additional bookable appointments during the weekend	In place and operational since 11 December. More capacity being considered in late afternoon/evening and weekends :- • GPs to be based in acute site(s) or nearest practice GP • Review St Thomas model • Slots to be directly bookable from ED • Find space at RFL sites for GPs to work from RFL or local GP surgeries to provide • EMIS training for RFL staff • Obtained GP Federation support • SRG support gained in principle • Review Enfield model – JB sending details • Internal meeting to develop the model and service specification and understand links with other services being confirmed by Primary Care Lead. Meeting held 25/2 Actions agreed: • Obtain A&E hourly data to support decision making and inform peak times cover is required	**BS** **BS** **BS**	**BW** **BW/BD** **BW** **BD** **BW** **KF** **BW** **BD** **BW**	Mobilised and operational from 11 December. TBC Awaiting contact details TBC TBC TBC Completed Completed – explore to models 22/02 SRG requested meeting to

	Action	Description	Progress	Clinical Lead	Lead	Timescale
			• Email networks to establish availability and capacity identify Monday 4.00 – early afternoon as an immediate requirement • Obtain standard operating procedures / pathways criteria from Lambeth, Camden and Enfield • Obtain learning from St Thomas • Facilitate discussion with Camden federation • Establish clinical reference group to review pathway • Internal discussion to review finance budget / governance sign off • Further discussion with federations regarding model • Barndoc to provide update of KPIs		**KF** **BW/FG** **KF/BW**	discuss model and how it will operate to include BSH/BW/RW/ KS with existing provider Date of meeting March 15th In principle agreed with Network now working through the detail suggested times 5 – 9pm. But to be confirmed

	Action	Description	Progress	Clinical Lead	Lead	Timescale
					BW **TBC** **BS/BW** **BS/BW** **BHS**	 Agreed in principle by federation / network 15 March End of March
3	**A&E – MH Liaison**	24 hour response and support	In Place • Issues in Jan exception report identified Re: MH assessments delays. FG to pick internally to be shared with MH Leads • MH Leads to attend weekly meetings • specification included in 16/17 contract • The Service specification to be slightly amended to also include the team's	CB	**FG/RD/ PA** **JC /DD**	Completed

A&E and DToC Plan of Action following weekly T&F Group Meetings

	Action	Description	Progress	Clinical Lead	Lead	Timescale

			input into bed meetings and discharge planning to assist with preventing Dtoc
			• Meeting being arranged by MH Leads to negotiate recurrent service specification and movement into BEHMHT Baseline.
			  • Engagement Sally Duson at RFL
			  • Business Plan next year (16/17) to be reviewed separate line for CAMH (Transformation Plan)
			  • Julia Chappell is lead
					AJ/DM
					
					PA/ JC/KD
						Meeting taking place on 22 March then engagement with RFL lead

	Action	Description	Progress	Clinical Lead	Lead	Timescale
4	**Review capacity** **NWB and Rehab and Enablement**	Create additional step down bed capacity within the within Care Homes. Targeted at NWB patients and those needing extended rehabilitation	10 Beds commissioned from Care Homes against a Access Protocols for NWB and Rehab and Enablement (Attached) 2 at Magnolia care home with nursing – 2 referrals 2 at Elmstead care home with nursing – dementia 3 at Apthorpe –- residential 3 at Dellfield Court – residential Pathway and protocol needs to be the same as for NWB and Rehab and enablement Merging protocols Send LF copy of protocol developed for step down for review and comments / changes Ensure timely assessments and accurate EDD's are in place as part of the patient journey to ensure they are returning home ASAP Meetings taken place between CCG and LBB and CLCH and CCG draft pathways in place		**AB** **AB/LF/KS**	COMPLETED -Mobilised and operational. Protocols in place for all step down capacity with weekly monitoring of admissions and through put. Completed Completed

A&E and DToC Plan of Action following weekly T&F Group Meetings

	Action	Description	Progress	Clinical Lead	Lead	Timescale
			Financial envelope agreed for step down beds. Review being undertaken on spend against allocated funds and forecast outturn Documentation and Governance arrangements in draft to be signed off		**AB** **AB**	Completed Completed Operational completed
		Develop step down support / NWB in community in patients home	Financial envelop agreed Recruitment being mobilised Contract variation to be linked to Rapid Response		**BD/DM** **KS** **DM/AM**	Completed Completed Completed CV being developed to extend for 2 months to link with D2A and longer term resilience

	Action	Description	Progress	Clinical Lead	Lead	Timescale
		Enablement service commissioned from Housing 21 do not take NWB)	System understanding of capacity need including BCF allocations and existing contracts to ensure appropriate resourcing Review specification of Housing 21 to include NWB in criteria LBB re procurement of Housing 21 / Enablement. Currently published on OJEU. Linked to BCF and Integration Requested review of additional capacity opportunities with LBB – BCCG LBB explored no additional capacity explored Requested review of all patients to ensure they meet criteria		**DM** **KS/LF** **LF** **LF**	Pathway and inclusion of Housing 21 to be part of the pathway / protocol 13 Feb Both protocols shared with LBB and CLCH Review of current contract with LBB as currently out to Tender Referral criteria and clients using service to be reviewed to ensure appropriate capacity. Meeting in diary with Contract lead LBB Currently on-going Expected response 22 March

	Action	Description	Progress	Clinical Lead	Lead	Timescale
		Work with HVCCG to review rehab capacity /process	Ongoing Commissioner to commissioner dialog to ensure continuous flow. SRG requested a meeting to discuss wider Resilence patient flows. Draft agenda agreed 15/02 Requested information on 17 HVCCG patients within 09/03 teleconference identified awaiting response from RFL		**BD/DM** **FG/BD**	Completed Now linked to System wide capacity and escalation plan now operational Date of meeting with draft agenda circulated for availability and meeting date secured On-going review during assurance of Easter and times of SURGE
5	**Create a time limited budget and process to enable patients to go home and unblock delays**	Ability to create bespoke care packages in the community that complement existing capacity at pace	Agreed budget allocated Develop with Budget holder a process for authorisation and sign off This will be logged and reviewed and changes made to current arrangements / contracts if delays are caused through poor response from existing capacity / services Use bed meetings to identify 'one off requirement' Assess call on the budget and gaps in services to inform future changes to		**AB with BD and DM**	Completed Funding identified completed Ongoing Review – call on budget being logged to understand reasons for use

	Action	Description	Progress	Clinical Lead	Lead	Timescale
			contracts or commissioning of new support Approval process revised Requested expenditure against plan		**AB**	By End of March
	Review MFP including opportunities for discharge to **Assess – ideally in peoples own homes**	Explore Discharge to Assess opportunities and potential outcomes Develop Pathways and Capacity	Regular reporting being established -Need-weekly numbers, sites/ward, PACE discharge to assess Teleconference held 22 Jan SRG requested a meeting to agree Discharge to Assess actions and principles members to include LBB, RFL, CLCH, CCGs. LF to review data and revert to group 16/02. Data received by LBB assessing impact of 180 patients. How many PACE likely to need long term care. Reduced capacity within LBB Admin has delayed	**BS**	**AB** **LF**	RFL undertaking regular awaiting results PACE discharge to assess meeting to taken place. A wider Discharge to assess meeting arranged for 2/3 10.30 – 11.30 Patient assessment numbers meeting between FG/LF by 22 March

	Action	Description	Progress	Clinical Lead	Lead	Timescale
			review due to training requirements Linked to Step Down and NWB. Also reviewing the DST with CHC colleagues to ensure that the checklist is undertaken in a timely manner to ensure Fast Track patients are dealt with as a priority. DST Meeting held on 2 March. Paper of proposed model to be submitted to SRG Fast Tracks are always prioritised, and following local agreement full assessments from Royal Free sites are prioritised. Additional Band 6 capacity being recruited to deal with growth in demand CHC Deep dive identified delays, action plan in place. Submission of CHAT Tool submitted 22 Jan Approved by COO in process of Finance and HR sign off Issue raised that DNs no longer undertaking DSTs	**BS**	**DM/BD** **AB / NP**	D2A Model to be agreed based upon South Warwickshire Best Practice example from Monitor Further meeting arranged to align Model to Barnet System **Completed** NP escalating through contract lead and Director – may be escalated to SRG

	Action	Description	Progress	Clinical Lead	Lead	Timescale
			Meeting held on the 9th March agreed principle of Discharge to assess with members in attendance. Paper circulated and agreed in principle by SRG for wider discussion and approval		**AB/NP** **AB / NP** **BD/DM /FG/ KS**	Awaiting review meeting in April Paper circulated for comment 5th March service draft specification to be developed for discussion at wider stakeholder meeting
		Review MFP(medically optimised)numbers at Barnet and Barnet & chase	Establish expected numbers ongoing Review process/ definition/utilisation. Received by CCG shared with FG.	**BS**	**AB/FG** **AP**	On going Barnet site undertaken by AB 10/02 now on-going daily and discussed at RFL bed meetings Additional support from SRG to be provided at Hampstead site

	Action	Description	Progress	Clinical Lead	Lead	Timescale
		Review Discharge Management / Teams at each hospital site	Review internal MDT operational processes. Meeting of staff to walk through the pathway, assess patient flow and agree improvements to	**BS**	**FG/KS** **DM/SM**	Internal review completed. 2 hour session being planned to audit existing practice and ensure co-ordinated approach and best practice. Now pending action as part of Discharge to Assess. TBC
7	**PACE and Treat and Enablement Capacity**	Develop service specifications against services that can be monitored and assessed for sustainability	Specification's in draft CV in draft KPIs received Finalisation of specification Stakeholder meeting FG to review Pace specification Service specification to go to Clinical Cabinet	**BS**	**BD/DM /FG/KS**	Completed specification agreeing baselines Clinical cabinet mtg. 24 March
8	**Bring together data and information of all frequent users of NHS services across Acute**	Recognised that frequent users of services are known to many agencies. Need a system wide integrated planning response	Developing the information and sharing arrangements across agencies • Procurement Pack published on		**BD/DM**	Ongoing. Project Manager started at CCG 4 Jan this has now been identified as on oh his prioritises. Currently scoping existing information and

	Action	Description	Progress	Clinical Lead	Lead	Timescale
	Hospital, GPs, LAS, BEHMHT, and CLCH.		OJEU 20 Jan • Draft Project Brief for Frequent User Project prior to procurement of Tool by End of Jan • Data shared with LLB • To share with system leaders at MDT meeting before end of February • FG to chase information from RFL		**GT**	agreeing project brief and outcome measures. Moderation phase early March Completion TBC Now also being reviewed as part of 1 CHT
9	**Neuro Rehabilitation**	There is a lack of capacity of complex Neuro Rehabilitation Beds. Look to lowering the threshold	Linked to NWB and a wider re-design programme just being scoped across Barnet and Camden Clinical meeting across 2 CCGs – 5 Feb Project Support and Project Management to be agreed at meeting Progress to a re-design project / Business Case for Neurological Model of conditions	**SB/DF**	**DM/AB**	OBC – 9 March –approved Project Board to meet in April

	Action	Description	Progress	Clinical Lead	Lead	Timescale
			including Rehab OBC going to QIPP 9 march – approved		**DM**	Workshop to build model April
10	**Communication Plan across all initiatives**	Communication Plan	Communication plan approved at Jan SRG Information / leaflets being developed and circulated Engagement across all initiatives through Leads across SRG Members Budget being identified High number of LAS conveyances being explored alongside availability of diagnostic tests at the weekend and Eve New CCG communications Mananger been appointed- to attend T&F ad hoc/as required. Revised communication plan to be completed for April SRG across all SRG schemes	**BS**	**SC** **AP/JG**	Ongoing Handover completed Meeting to take place – revised Plan April SRG

A&E and DToC Plan of Action following weekly T&F Group Meetings

	Action	Description	Progress	Clinical Lead	Lead	Timescale
			Review of local standby coms requested for times of surge particularly between WIC and ED's which support national coms			09/03 for social media Update on progress meeting with SRG lead and Comms Lead TBC for March
11	**Production of CCG Operational Plan**	To work with ABa to ensure alignment with SRG initiatives`	A B attended meeting and will provide updates on progress as plans emerge		**ABa**	Second submission of the Operational Plan submitted to Unify2 on 2 March Midday as required. Next submission April 11
12	**Diagnostics extension at WIC**	Review need and opportunities to extend existing WIC diagnostic requirements	Discussion with CLCH/ RFH to identify opportunity to extend current working practice at FMH	**BS**	**FJ/BD**	Update 8/03 FG chased
13	**DToC Submission**	Submission required by NHSE on 19 February	Submission coordinated and signed off – submitted 19 Feb. Awaiting feedback	**BS**	**BD**	Completed
14	**Jnr Dr Submission**	Assurance during 8/9 March	Submission being made and signed off 2 March	**BS**	**BD/DM**	by CoP – 2 March- completed

	Action	Description	Progress	Clinical Lead	Lead	Timescale
15	**Easter Assurance**	Assurance for Easter submission being made on 7 March	Currently being completed. To be Co-ordinated by SURGE prior to submission on 7 March	**BS**	**BD/DM**	By CoP 7 March- completed
	Escalation Capacity and Access	Template of available capacity across all CCGs and Local Authorities	In draft and circulated to SRG members for comment with additional information identified as required as it gets utilised and becomes operational.	3	Escalation Capacity and Access	COMPLETE Template of available capacity across all CCGs and Local Authorities
	Enhanced Rapid Response	Additional Capacity to prevent A&E and unplanned admissions	In place since November 7 days PW.	4	Enhanced Rapid Response	COMPLETE Additional Capacity to prevent A&E and unplanned admissions
	Establish a Task and Finish Group to explore 'What we can do differently@	An action focus group of system representatives to agree urgent solutions to preventing delayed discharges	In place Attendees • Buz Dodd • Diane Meddick • Fran Gertler • Karen Spooner • Marsha Jones • Aji Michael • Kirstie Haines • Liam Furlong • Beverley Wilding • Rebecca Thornley	BS	BD/DM	COMPLETE NLBP Weekly Tuesday 10.00.am meeting Membership extended to include LBB, MH as well as RFL and CLCH No formal ToR objective to expedite initiatives and schemes and take immediate actions

A&E and DToC Plan of Action following weekly T&F Group Meetings

	Action	Description	Progress	Clinical Lead	Lead	Timescale
			• Alan Brackpool • Paula Arnell • Rodney D'Costa • Bob Ryan T&F Group to replace Urgent Care Operational Group agreed at SRG. SRG will be the monitoring Group of progress			within the system. Replacing UCOG decision 12 Jan at UCOG Meeting / SRG Completed and ongoing weekly

Name	Abbreviation	Organisation
Dr Debbie Frost	DF	Barnet CCG
Dr Barry Subel	BS	Barnet CCG
Dr Jonathan Lubin	JL	Barnet CCG
Dr Charlotte Benjamin	CB	Barnet CCG
Colin Daff	CD	Barnet CCG
Buz Dodd	BD	Barnet CCG
Diane Meddick	DM	Barnet CCG
Bhavini Shah	BSH	Barnet CCG
Marsha Jones	MJ	Barnet CCG (Darzi Fellow)
Aji Michael	AJ	Barnet CCG
Beverley Wilding	BW	Barnet CCG
Alan Brackpool	AB	Barnet CCG
Paula Arnell	PA	Barnet CCG
Samantha Campbell		Barnet CCG
Rodney D'Costa	RDC	Barnet CCG/LBB
Rebecca Thornley	RT	Barnet CCG
Garrett Turbett	GT	Barnet CCG

Aji Michael	AM	Barnet CCG
Sharon McFarlane	SM	Barnet CCG
Kirstie Haines	KH	London Borough Barnet(LBB)
Liam Furlong	LF	London Borough Barnet (LBB)
Karen Spooner	KS	Central London Community Hospital (CLCH)
Fran Gertler	FG	Royal Free Hospital (RFL)
Fiona Jackson	FJ	Royal Free Hospital (RFL)
Alex Pinches	AP	Royal free Hospital (RFL)

8.2. Examples of Information Sharing Arrangements and Approach to Patient Consent

8.2.1. MOU between providers

Provided on request

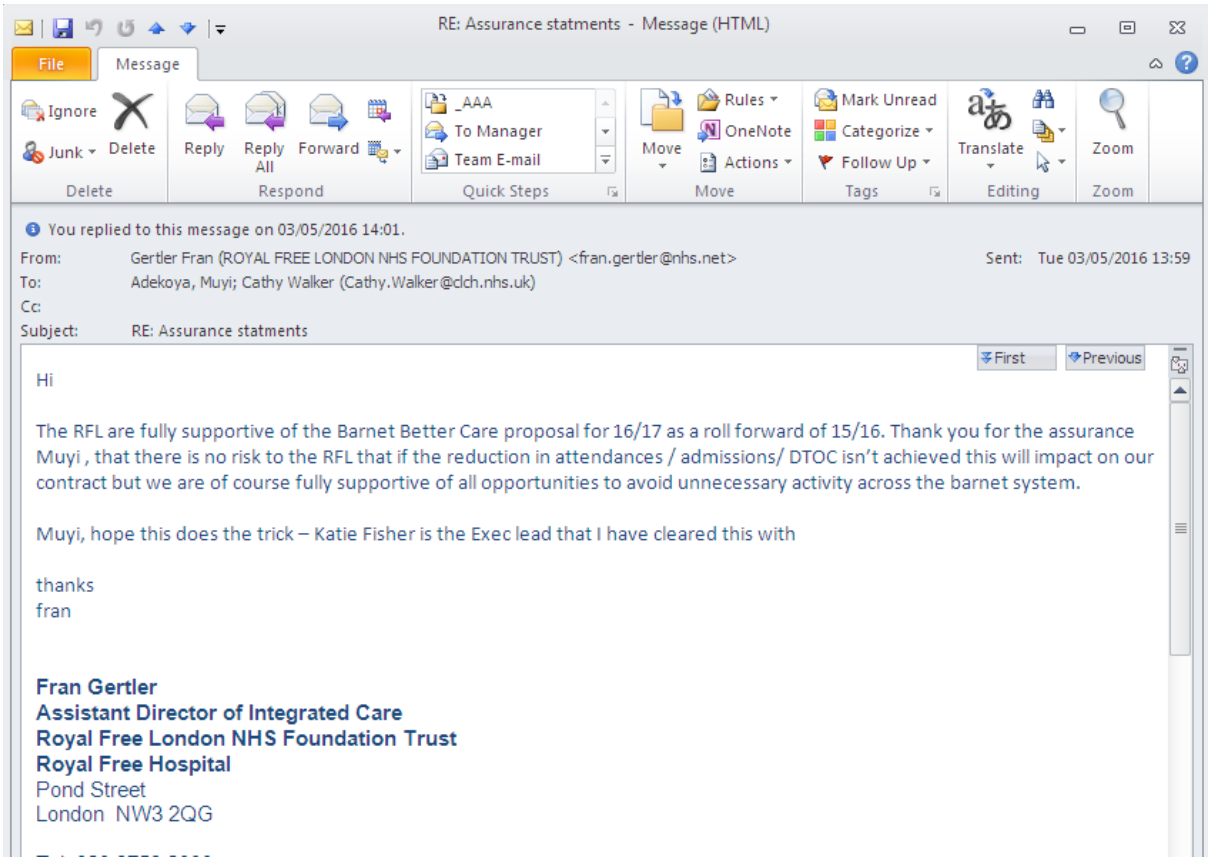
8.2.2. Information provided for patients

Provided on request

8.2.3. Operational Flows for managing patient consent

Provided on request

Assurances from Provider



ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Barnet
Name of Provider organisation	CLCH
Name of Provider CEO	Cathy Walker Divisional Director
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	2013/14 Outturn	
	2014/15 Plan	
	2015/16 Plan	
	14/15 Change compared to 13/14 outturn	
	15/16 Change compared to planned 14/15 outturn	
	How many non-elective admissions is the BCF planned to prevent in 14-15?	
	How many non-elective admissions is the BCF planned to prevent in 15-16?	

For Provider to populate:

	Question	Response
1.	Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?	yes
2.	If you answered 'no' to Q2 above, please explain why you do not agree with the projected impact?	
3.	Can you confirm that you have considered the resultant implications on services provided by your organisation?	yes

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AGENDA ITEM 8

	Health and Wellbeing Board **12 May 2016**
Title	**Update on childhood immunisations 0-5 years**
Report of	Dr Andrew Howe, Director of Public Health Kenny Gibson, Head of Early Years, Immunisation and Military Health, NHS England (London Region) Amanda Goulden - Population Health Practitioner Manager, NHS England
Wards	All
Status	Public
Urgent	No
Key	No
Enclosures	Appendix 1 - NHS England report on Update on child hood immunisations 0-5 years Appendix 2 – Barnet Immunisation Action Plan 2015/2017 Appendix 3 – Q2 and Q3 Immunisation data
Officer Contact Details	Dr Laura Fabunmi Consultant Public Health Medicine Laura.fabunmi@harrow.gov.uk

Summary

Following two previous reports from NHS England to the Health and Wellbeing Board on the low rates of childhood immunisations, 0-5 years, a third report has been requested due to poor progress.

The accompanying report from NHS England, as in the previous reports reiterates that the current low vaccination rates in Barnet are primarily due to data issues and not that children are missing vaccinations. The report identifies this as a national issue which has also affected other areas in London. The provisional data for Q4 is reported to show some improvement as these issues are being addressed.

The report explains the reasons for the data problems and outlines an action plan to improve immunisation rates in Barnet.

Recommendations
1. **That the Health and Wellbeing Board notes the assurance given from NHS England that reported childhood immunisation rates in Barnet are not an accurate reflection of immunisation uptake in the borough.**
2. **That the Health and Wellbeing Board seeks assurance from NHS England that sufficient action is being taken to address this issue and that alternative surveillance measures are in place whilst childhood immunisation (COVER) data is inaccurate.**
3. **That the Board recommends that the Health Overview and Scrutiny Committee consider a referral for remedy to the Department of Health if performance does not improve.**

1. WHY THIS REPORT IS NEEDED

1.1 In September 2014, a report was presented to the Health and Wellbeing Board from NHS England to explain persistent low immunisation rates (COVER) since April 2013. This followed a previous report in November 2013 where a number of actions were identified and assurance was given by NHS England to deal with the significant drop in reported childhood immunisation rates identified at that time.

1.2 NHS England gave assurance that the decline in rates was not representative of the proportion of children in Barnet receiving the recommended vaccinations but rather due to a data linkage problem and proposed a number of solutions to tackle the issue.

1.3 A report has been requested again because the immunisation rates are still persistently low and are consistently flagged as red in the Joint Health and Well-being board Implementation plan.

1.4 The Board is concerned about the lack of progress and have written to NHS England to ask that the following is addressed:

- What the present immunisation coverage in Barnet is
- A clear explanation on why the immunisation rates are still low
- A detailed action plan to address this
- Clear timescale for when the board can expect to have an accurate picture of immunisation coverage in Barnet

The response to these queries is outlined in the report from NHS England in Appendix 1 and Appendix 2.

2. REASONS FOR RECOMMENDATIONS

2.1 Barnet council has a responsibility to scrutinise immunisation rates in Barnet to assure that there is sufficient uptake of vaccinations across all age groups. If enough people in a community are vaccinated, it is harder for a disease to pass between people who have not been vaccinated. The London target for childhood immunisation 0-5 years is 95%. Immunisation rates for children in Barnet are below this target.

2.2 NHS England has previously stated that the data is inaccurate and is an underestimate of childhood immunisation rates in Barnet. However, this problem has remained unresolved since April 2013 and therefore represents a significant risk in itself. Without accurate data, Barnet council cannot effectively monitor immunisation rates and cannot provide assurance that residents are protected from vaccine-preventable diseases.

2.3 This issue has been escalated for a third time to the Barnet Health and Wellbeing Board to highlight these significant concerns, facilitate discussion with partners at a senior level and to assure that sufficient and timely action will be taken to address the problems identified.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 Without adequate immunity in the community, outbreaks of disease can occur– as demonstrated with measles in the last decade. Effective immunisation is central to preventing disease and death.

3.2 The Public Health team has been and will continue to monitor immunisation rates in Barnet. They have been working with NHS England to understand the underlying issues and have sought assurance that the problems would be resolved in a timely fashion. However, given the importance of this element of public health activity and the length of time the issue has remained unresolved, it is now appropriate to escalate discussions to the Health and Wellbeing Board who can provide strategic support to partners.

4. POST DECISION IMPLEMENTATION

4.1 It is currently not possible to accurately monitor immunisation rates in Barnet and assure that the population of Barnet is protected from threats to their health. It is anticipated that NHSE will be meeting with CLCH in the next quarter to follow up on process and operability.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 The Council's Corporate Plan 2015-2020 recognises Public Health as a priority theme across all services in the Council.

5.1.2 This work supports the Joint Health and Wellbeing Strategy 2015-2020 aim to give every child in Barnet the best possible start to live a healthy life. Specifically, the Health and Wellbeing Board have committed to a performance measure to increase uptake of childhood immunisations to be at or above the England average.

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

5.2.1 Commissioning of immunisation services is the responsibility of NHS England. There are no financial implications for the council.

5.3 **Social Value**

5.3.1 Not applicable. (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 Under regulation 8 of the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013, made under section 6C of the National Health Service Act 2006, local authorities have a duty to provide information and advice to relevant organisations to protect the population's health; this can be reasonably assumed to include screening and immunisation. Local authorities also provide independent scrutiny and challenge of the arrangements of NHS England, PHE and providers to ensure all parties discharge their roles effectively for the protection of the local population.

5.4.2 It is NHS England's responsibility to commission immunisation programmes as specified in the Section 7A of The NHS Act 2006 agreement: public health functions to be exercised by NHS England. In this capacity, NHS England will be accountable for ensuring local providers of services will deliver against the national service specifications and meet agreed population uptake and coverage levels, as specified in the Public Health Outcome Indicators and KPIs. NHS England will be responsible for monitoring providers' performance and for supporting providers in delivering improvements in quality and changes in the programmes when required.

5.4.3 The terms of reference of the Health and Wellbeing Board is set out in the Council's Constitution, Responsibility for Functions Annex A and includes the following responsibilities:

- 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.
- Receive the Annual Report of the Director of Public Health 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 Absence of accurate data about immunisation rates in Barnet presents a significant risk to the health of the population. The implication is that real changes in vaccination uptake remain undetected, early warning signs of potential outbreaks of disease are missed and opportunities for mitigating action are delayed. Further, it is not possible at present to accurately monitor the impact of media stories or vaccination campaigns or analyse and improve pockets of poor coverage in vulnerable populations.

5.6 **Equalities and Diversity**

5.6.1 The burden of infectious, including vaccine-preventable diseases falls disproportionately on the disadvantaged. There tends to be lower than average uptake for all vaccines amongst socially deprived and ethnic minorities.

5.6.2 Availability of data is vital to examine coverage by different age groups and inequalities, such as coverage in disadvantaged groups.

5.6.3 The general duty on public bodies is set out in section 149 of the Equality Act 2010. A public authority must, in the exercise of its functions, have due regard to the need to:

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

5.7 **Consultation and Engagement**

N/A

5.8 **Insight**

N/A

6. BACKGROUND PAPERS

6.1 Health and Wellbeing Board, 18 September 2014, Agenda item 13, Report on immunisation coverage in Barnet
http://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=177&MId=7782&Ver=4

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Barnet

Update for Health and Wellbeing Board: 0-5 Immunisations

12th May 2016

Childhood Immunisations in Barnet

Prepared by:

Amanda Goulden, Immunisation Commissioner

Final version: 12th April 2016

Classification: OFFICIAL

The NHS Commissioning Board (NHS CB) was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

Summary

This report has been requested to build on the assurance that appropriate governance arrangements are in place within NHS England in relation to immunisations for 0-5 year olds, in order to protect the health of people in Barnet. It gives an update on the local picture of childhood Immunisations in Barnet, NHS England's plans to improve uptake and local actions being undertaken to address these.

1.0 Background to 7a immunisation programmes

Immunisation is the most effective method of preventing disease and maintaining the public health of the population. Immunisation protects children against disease that can cause long-term ill health and in some cases even death.

Vaccine preventable diseases have markedly declined in the UK, largely due to the efforts of the national immunisation programme. A negative output has been that many members of the public and health professionals have forgotten about the severity of these diseases and can become complacent about vaccinations. In addition, the complexity of the immunisation schedule and the increasing volume of vaccine-related information – some of which may be misleading or inaccurate – can make it challenging to achieve the 95% herd immunity level.

Throughout England, the National Routine Childhood Immunisation Programme is delivered in a variety of settings by a large number of professionals from different disciplines. In London, immunisation uptake rates remain below the 95% levels required to achieve herd immunity. Reasons for the low coverage include:

- the increasing birth rate in London which results in a growing 0-5 population and puts pressure on existing resources such as GP practices
- London's high population mobility
- Recent changes in data collection systems
- difficulties in data collection particularly as there is no real incentive for GPs to send data for Cohort of Vaccination Evaluated Rapidly (COVER) statistics
- large numbers of deprived or vulnerable groups.

These reasons are all applicable to Barnet's ever changing population.

2.0 Initiatives and Actions

- The decrease in COVER from April 2013 highlights the previous work that was being done locally with individual practices to manipulate data prior to the dissolution of the PCT.

- At the beginning of 2015 NHSE reviewed records in Barnet based against 10 data items, including immunisation, covering the milestones of the child record for the first year of life. The aim of the review was to establish the completeness of the child record in order to report back the findings to NHSE and to feed into a national STEIS review. This improved the alignment of child records in Barnet between GP and CHIS by 40% and improved COVER by 13%.

- The recent move to TTP System One has meant that there was no data published for Q2. Issues with TTP System One have been raised as a high risk nationally as the system is unable to accurately report the required data for COVER.

- Note that three other boroughs in North London who have recently moved to TTP System One also show reduced coverage in 5 year olds.

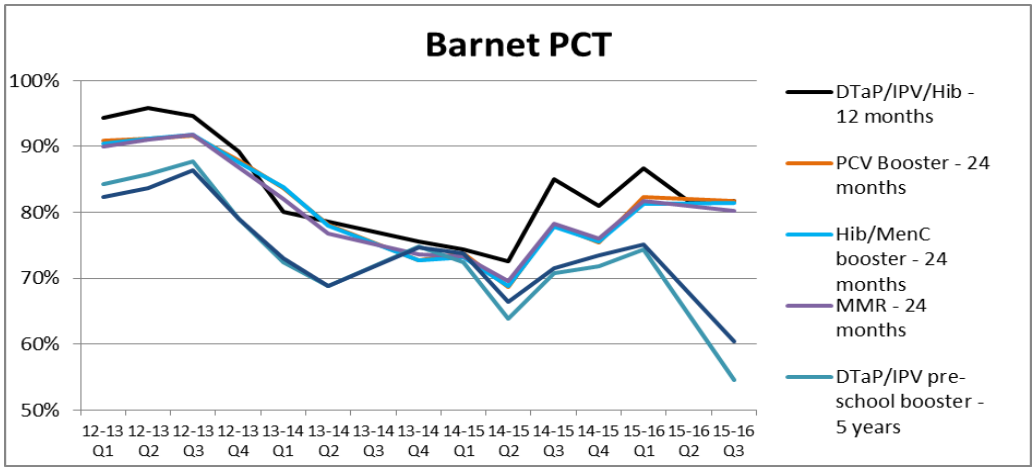
Comparison COVER data Q3 2014/15 and 2015/16

	Diphtheria, Tetanus, Polio, Pertussis and Haemophilus influenza type b (DTaP/IPV/Hib) - 3 Doses		**Pneumococcal infection (PCV booster)**		**Haemophilus influenza type b and meningitis C (Hib/MenC)**		**Measles, mumps and rubella (MMR)**		**Diphtheria, Tetanus, Polio, Pertussis (DTaP/IPV) - pre-school booster**		**Measles, mumps and rubella (MMR2)**	
PCT	12 Months		2 Years		2 Years		2 Years		5 Years		5 Years	
	14-15 Q3	15-16 Q3	14-15 Q3	15-16 Q3	14-15 Q3	15-16 Q3	14-15 Q3	15-16 Q3	14-15 Q3	15-16 Q3	14-15 Q3	15-16 Q3
Barnet	85.0%	81.8%	78.1%	81.7%	77.9 %	81.4%	78.3%	80.2%	70.7%	54.6%	71.6%	60.5%
Hammersmith & Fulham									64.9%	63.4%	66.9%	62.3%
Kensington & Chelsea									59.8%	53.0%	62.5%	52.0%
Westminster									65.0%	55.2%	65.5%	53.4%

- All practices in Barnet are now signed up to QMS enabling GP's to send their immunisation data safely and easily to the Child Health Department. There are still a small number of GP's who do not refresh this data on a monthly basis but these are followed up by QMS and NHSE. It has taken a great deal of time and resources to achieve a COVER report from the new system. Central London Community Health (CLCH) has experienced challenges converting data received from practices into a format that can be produced for COVER. This has been exacerbated by the move to TTP System One.

- Published Q3 data shows that the one and 2 year old uptake remains steady and work is continuing with the 5 year olds. The original parameters for COVER submission were not fully aligned with the minimum dataset; these issues have now been resolved and it is encouraging that these gains have been made. CLCH will now re-look at quarters one and two which will hopefully complete figures for the annual COVER publication in September.

  Barnet COVER data since 2013



- A protocol has been put into place across London for early scrutiny of immunisation rates prior to submission to COVER. Embedded in this protocol are steps to escalate and address any discrepancies to mitigate risks of poor quality data submission. This is helped by the new minimum child health dataset which enables monthly reporting on immunisations to the NHS England immunisation commissioners.

- NHSE has undertaken practice visits to approx. 20 GP Barnet practices with lowest coverage for MMR2. This has been part of a London wide project to support practices that are having difficulty achieving sufficient

uptake. For Primary vaccinations the majority of practices only need to immunise between 1 and 6 more children to achieve the 95% coverage required for herd immunity. We are working towards producing these reports for every practice when the data is more robust. The aim of the visits is to support GP Practices in achieving higher COVER rates. NHS England will be producing an evaluation of the GP practice visits in the near future. Many practices had higher uptake results than reported showing that this is primarily a data issue and not due to poor delivery rates.

- NHS England (London) have collaborated with CCG and LA and are working to a borough specific plan (Appendix 2-Barnet Immunisation Action Plan 2015/2016) in an effort to improve vaccine uptake and reduce health inequalities across London. These plans sit with the pan-London approaches overseen by the London Immunisation Board and the improved contractual management and quality assurance processes that NHS England (London) are operating to improve quality of delivery and performance of all Section 7a programmes. The plan has been collectively contributed to and was discussed and agreed with the CCG and Local Authority and is discussed quarterly at the CCG Public Health meetings.

3.0 Rotavirus

- Rotavirus vaccine was introduced into the Routine Childhood Immunisation Schedule in 2013/14 and is measured monthly. Since June 2014 both London and England averages have been 90% or over.
- The programme has been very successful in reducing incidences of rotavirus with laboratory reports of rotavirus for July 2013 – June 2014 being 67% lower than the ten season average for the same period in the seasons 2003/04 to 2012/13.
- The latest available data for Barnet CCG is for January 2016, whereby 87.7% of babies received first dose of rotavirus and 80.1% received the two doses.

3.1 Men B

- Since September 2015, all infants are offered a course of meningococcal B vaccine as part of the Routine Childhood Schedule. Eligible infants were those babies born on or after 1st July 2015 with a small catch up programme for babies born on or after 1st Many 2015.

- There are preliminary data for babies aged 26 weeks in January 2016. In Barnet, 90.3% of those infants had received their first dose of Men B with 79.4% having received two doses.

3.2 Child flu

	% of 2 year olds	% of 3 year olds	% of 4 year olds	% of year 1	% of year 2
Barnet	27.4	32.1	22.7	43	41.7
London	**26.5**	**28.8**	**21.8**	**42.4**	**39.9**
England	**35.4**	**37.3**	**30.1**	**55.6**	**54.3**

4.0 Conclusion

The current low vaccination rates in Barnet are primarily due to data issues and not that children are missing vaccinations. As stated in the report this has been a national issue and has also affected other areas in London. Provisional data for Q4 shows some improvement as these issues are being addressed, however, overall improvement is reliant on TTP System One who NHSE does not commission but with whom there is ongoing discussion.
NHSE will be meeting with CLCH in the next quarter to follow up on process and operability.

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2015/17 Barnet Immunisation Action Plan

Background:

Immunisation is the most effective method of preventing disease and maintaining the public health of the local population and vaccination and immunisation service exists to ensure the safe and effective delivery of all vaccine programmes. Barnet Immunisation Plan sets out actions to be undertaken by all key stakeholders in support of coordinated immunisation activities thereby ensuring that vaccines are available and given to the eligible groups at the recommended times.

NHS England, Public Health England, Clinical Commissioning Groups (CCG) and Local Authorities all have defined role to play, with NHS England assuming the lead commissioning role in line with Section 7A mandate.

The roles and responsibilities of the partners are:

NHS England (NHSE):

- Commissioning of all national immunisation and screening programmes described in Section 7A of the mandate
- Commission immunisation and vaccination services from primary care, community providers (e.g. school nursing teams) and other providers which are specific to national standards
- Monitoring of provider's performance and for supporting providers in delivering improvements in quality and changes in the programmes when required
- Accountable for ensuring local providers meet agreed population uptake and coverage levels against the national service specification and as specified in the Public Health Outcome Indicators and KPIs
- Work with the Department of Health and Public Health England in national planning and implementation of immunisation programmes and in quality assurance
- Emergency Planning Responses and Resilience (EPRR) where this involves vaccine preventable diseases.

Public Health England (PHE):

- Lead the response to outbreaks of vaccine preventable disease and provide expert advice to NHS England in cases of immunisation incidents. PHE will provide access to national expertise on vaccination and immunisation queries.
- Professional support to the PHE staff embedded in the NHSE Area Teams including access to continuing professional appraisal and revalidation system

- Provide information to support the monitoring of immunisation programmes
- Publishes Cohort of Vaccination Evaluated Rapidly (COVER) data

Clinical Commissioning Groups (CCGs):

- Have a duty of quality improvement and this extends to primary medical care services delivered by GP practices (such as immunisation and screening) – as such, they should be able to provide support where NHSE need to liaise or contact specific primary care facilities.
- CCGs have a crucial role in commissioning pathways of care that effectively interface with screening services, have adequate capacity to treat screen positive patients and meet quality standards
- CCGs hold the contracts for maternity services, and are providers of antenatal and new-born screening (neonatal BCG and infant Hepatitis B). Barnet CCG have contracts with Central London Community Health (CLCH) who are commissioned by NHS E to provide the local Child Health Information System (CHIS) service.

Local Authorities:

- Leader of the local public health system and is responsible for improving and protecting the health of local population and communities.
- Provide information and advice to relevant bodies within its areas to protect the population's health (whilst not explicitly stated in the regulations, this can reasonably be assumed to include immunisation)
- Provide local intelligence information on population health requirements e.g. JSNA
- Independent scrutiny and challenge of the arrangements of NHSE, PHE and providers.
- Local authorities will need to work closely with Area Teams including arrangements for the NHS response to the need for surge capacity in the cases of outbreaks.

General Practitioners (GPs):

- General practices are contracted by NHSE to deliver the Childhood Routine Immunisation Schedule to their registered child population. They are the main mode of delivery in England.

Community Services Providers:

- Child Health Information System (CHIS) is housed within community service providers and incorporates the child health records department which holds clinical records on all children and young people. COVER data is submitted from CHIS to PHE.
- The community provider may have an immunisation team that provides outreach or 'catch-up' for childhood immunisations (e.g. for unregistered populations) and for BCG.

- Health visitors have a role to play in promoting the importance of vaccinations to parents.
- Many community services providers have immunisation clinical leads or coordinators who provide clinical advice and input into immunisation services locally.

Barnet Immunisation Action Plan

- Achieving high levels of immunisation coverage in London remains challenging.
- This action plan has been developed as part of NHS England's ongoing work to improve immunisation coverage in London and outlines ways in which partner organisations could contribute to the work to ensure high levels of immunisation coverage are achieved and sustained in Barnet. This is in recognition of the key elements and partnerships that are essential to the delivery of an effective, equitable and quality assured immunisation service.

- The 2015/16 Barnet Immunisation Action Plan is underpinned by NHS England's immunisation strategic objectives which are:

1. To achieve improved immunisation coverage across London.
2. To reduce inequalities in immunisation uptake between GP Practices and populations.
3. To improve patient choice and access to immunisations across London.

Key Area	Output	Outcome	Actions	Due Date	Led by	Risks to completion & Mitigation	RAG
Commissioning & Performance Management	All practices are signed up to QMS to improve the recording of immunisation data	COVER submissions reflect an increase in recorded uptake rates. Stabilisation of reported immunisation rates in Barnet	Ensure Barnet GP Practices have access to I.T. for support. Follow up practices monthly who fail to upload immunisation data to QMS. Two practices to be visited regarding difficulties in following QMS process. Practices have been visited.	Monthly 20th August 2015	Barnet NHSE/Barnet CCG Amanda Goulden (AG)	Remaining practice refuses to comply. Continue manual submission.	
			100% of children who persistently miss GP immunisation appointments actively followed up to ensure they are up to date with immunisations.	Ongoing	NHS England / Barnet CCG/CHIS[1]	GP practices may not be clearing ghost patients. Need for efficient call/recall systems.	

[1] Child Health Information Systems (CHIS) currently provided by Central London Community Health CLCH

Key Area	Output	Outcome	Actions	Due Date	Led by	Risks to completion & Mitigation	RAG
	Reduce the variation in immunisation performance between best performing and worst performing GP Practices.	Improved immunisation data quality resulting in accurate reporting of immunisation coverage	Work with practices to improve uptake of childhood immunisations in Barnet. Inform LA when visiting practices. Identify what works in the best performing practices and share work with poor performing practices in troubleshooting the barriers to increasing uptake. Practice visits by commissioner.	Ongoing July 2015-March 2016	NHS England / Barnet CCG/Barnet LA Amanda Goulden	GP practices may not record the data accurately. E.g. correct coding	
	Improve COVER reporting following move to TTP System One	Barnet rates are more accurate and reflect true uptake and coverage	Work with the national supplier to improve technical system Work with practices to ensure correct coding and monthly upload to QMS Work with CHIS to improve reporting	Ongoing May/June 2016 Quarter 1 2017 report	Kenny Gibson NHSE/CHIS NHSE/CHIS	The national system cannot complete required fields.	

Key Area	Output	Outcome	Actions	Due Date	Led by	Risks to completion & Mitigation	RAG
	Performance data by GP practice provided to local meetings Children moving in/out of Barnet are managed effectively to ensure they do not miss out on public health interventions	Accurate reporting of immunisation coverage for Barnet	CHIS service will send Cover data 4-6 week prior to the final submission Ensure CHIS follow movers in/movers out Stander Operational Procedure	Quarterly	CLCH- CHIS CHIS Manager Joy Gayle	Reports not accurate. Continue to work with CHIS.	
	Barnet LA to procure school age immunisation service	To commission an efficient school age immunisation service.	LA to assist with the procurement.	August 2015	NHSE/LA	Delay in procurement process	
	To deliver roll out of child flu to years 1,2 and 3	Maximum coverage of cohort	Include delivery with school immunisation co-commissioning	September 2016 and 2017	NHSE/LA		
	To deliver and oversee measurable improvements in quality and performance for Barnet immunisation services	Improved immunisations uptake in Barnet	Set up PH Work plan meetings NHS England to liaise with CCGs, LA, Primary care commissioners and PHE	Ongoing	NHSE/LA		

Key Area	Output	Outcome	Actions	Due Date	Led by	Risks to completion & Mitigation	RAG
	Work with maternity to set up hospital services to deliver the neonatal BCG immunisation programme	100% of babies offered BCG immunisation at birth	Move to universal delivery. Arrange meeting with Clare Stephens and Judy Mace. Recruiting nurses for delivery on 2 sites	September 2015 March 2016	NHSE/CCG Amanda Goulden Maternity services	The provider not delivering the service	
Neo-natal and Hep B vaccination programme	Implement recommendations to improve the Hep B antenatal and neonatal immunisation pathways	To monitor coverage by ensuring all babies have completed the programme (including 1st dose in hospital) Ensure missed/DNA/ lost to follow up are followed through. Ensure data is captured Link in with the Pan London Hep B Plan.	Ensure the correct pathways are followed to target at risk babies.	March 2016	CCG/CHIS Joy Gayle/ Judy Mace	Neonatal programme not completed and babies lost to follow up.	
	NHSE commissioned Flu and Pertussis vaccinations delivered and promoted throughout primary care providers	Increase in reported rates on flu vaccine uptake and pertussis uptake amongst pregnant women Increased reported flu vaccine uptake across	Work with GP practices to improve flu vaccine uptake. Commission the flu pharmacy scheme to improve access	September 2016 and 2017	NHSE/CCG Contact Beverly Wilding	NHSE doesn't communicate winter strategy in timely manner NHSE will inform all stakeholders re delays	

Key Area	Output	Outcome	Actions	Due Date	Led by	Risks to completion & Mitigation	RAG
		named at risk groups	subject to findings from the economic evaluation of the flu pharmacy initiative. Barnet has signed up to DN SLA to deliver flu. Commission hospital to offer the flu and pertussis vaccinations to pregnant women Recruiting nurses for delivery	March 2016	Maternity services		
	All immunisers have had their annual refresher training and all new immunisers have completed the mandatory 2 day course	Barnet population will receive high quality and safe immunisation services as delivered by a competent and knowledgeable workforce.	NHSE to work with PHE and LETB to secure and commission immunisation training modules	Training programme now being delivered through Herts University.	Barnet Community Education Network (CEPN)	Immunisation training not being delivered Work with Barnet CCG to locally deliver in house immunisations training tailored to the needs of Barnet nurses.	
Communication, Stakeholder & Community	Information relating to immunisation programmes are	Improved communications with all stake holders	NHSE, LA, CCG and PHE will liaise. Any comms to go out can	As required	NHSE/LA-Laura Fabunmi/CC	NHSE doesn't communicate winter strategy in timely manner	

Key Area	Output	Outcome	Actions	Due Date	Led by	Risks to completion & Mitigation	RAG
Engagement (Including Voluntary Sector)	disseminated to all key stakeholders e.g. changes to the schedule and introduction of new programmes across the health care system		be sent to CCG for bulletin. LA to insert links to NHS Choices from the council website.		G-Robin Sandler		
	Performance data shared with Barnet CCG and Barnet LA quarterly	All key players are up-to-date on performance information within the borough and enabled to use this information to inform their own delivery practices	Work with CCG to identify immunisation leads in individual practices	Ongoing	NHSE Amanda Goulden	NHSE doesn't share in timely manner	
	Flu immunisations, shingles and pneumococcal vaccinations are promoted in all care homes and included as a requirement in LA contracts with providers of social care services.	Contributes to increased uptake of winter vaccination uptake i.e. flu , shingle and PPV within these populations	Leaflets promoting immunisations are included in information packs. Immunisations are promoted to care homes	Sep 2016 and 2017	NHSE/ LA	Information is not disseminated in a timely manner NHSE communicate Winter strategy to all stake holders by end of June	
	All Ofsted registered child care providers, nurseries and preschools promote and check	Increased numbers of children have completed the childhood immunisation programme by age 5	LA to work with childcare providers on the importance of having children immunised and	March 2016	LA public health	Childcare managers and providers do not see the importance – this can be mitigated by regular information sessions	

Key Area	Output	Outcome	Actions	Due Date	Led by	Risks to completion & Mitigation	RAG
	immunisation status of the children they care for		mechanisms to remind parents of the childhood immunisation programme schedule to ensure it is completed before starting school			through existing communication mechanisms used by LA	
	Children's Centres engaged in promoting immunisations and vaccinations for families	Greater awareness about the childhood immunisation programmes and other vaccination programmes.	Information sessions on immunisation; staff trained to provide information with parent/baby groups and other users; Inclusion of immunisation information in child checks/baby weighing clinics.	March 2016	LA public health	Immunisation not high on the agenda for children's centres - availability of informal training of staff in understanding the benefits of immunisation	

MILLWAY MEDICAL PRACTICE	**E83016**
ST. GEORGES MEDICAL CENTRE	E83020
OAK LODGE MEDICAL CENTRE	E83032
JAI MEDICAL CENTRE	E83038
CORNWALL HOUSE SURGERY	E83013
ROSEMARY SURGERY	E83639
GREENFIELD MEDICAL CENTRE	E83006
PHGH DOCTORS	E83009

TORRINGTON PARK GROUP PRACTICE	E83021
ADLER JS-THE SURGERY	E83600
DERWENT CRESCENT MEDICAL CENTRE	E83037
LANGSTONE WAY SURGERY	E83049
THE SPEEDWELL PRACTICE	E83010
WATLING MEDICAL CENTRE	E83018
WENTWORTH MEDICAL PRACTICE.	E83035
LANE END MEDICAL GROUP	E83053
THE HODFORD ROAD PRACTICE	E83649
THE PHOENIX PRACTICE (E83653)	E83653
CHERRY TREE SURGERY (E83631)	E83631

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Q3 15/16 versus Q2 15/16

Immunisation - 15-16 Q3 compared to 15-16 Q2	Diphtheria, Tetanus, Polio, Pertussis and Haemophilus influenza type b (DTaP/IPV/Hib) - 3 Doses			Pneumococcal infection (PCV booster)			Haemophilus influenza type b and meningitis C (Hib/MenC)			Measles, mumps and rubella (MMR)			Diphtheria, Tetanus, Polio, Pertussis (DTaP/IPV) - pre-school booster			Measles, mumps and rubella (MMR2)		
Cohort	12 Months			2 Years			2 Years			2 Years			5 Years			5 Years		
PCT Name	**15-16 Q2**	**15-16 Q3**	**Signif. change**	**15-16 Q2**	**15-16 Q3**	**Signif. change**	**15-16 Q2**	**15-16 Q3**	**Signif. change**	**15-16 Q2**	**15-16 Q3**	**Signif. change**	**15-16 Q2**	**15-16 Q3**	**Signif. change**	**15-16 Q2**	**15-16 Q3**	**Signif. change**
North Central & East London (NCEL)																		
Barking and Dagenham PCT	93.0%	93.0%	⇨	86.8%	89.0%	⇨	86.4%	88.7%	⇨	86.6%	89.3%	⇨	83.8%	84.0%	⇨	81.2%	80.3%	⇨
Barnet PCT	81.7%	81.8%	⇨		81.7%			81.4%			80.2%			54.6%			60.5%	
Camden PCT	87.0%	89.4%	⇨	86.1%	89.4%	⇨	85.7%	88.2%	⇨	86.2%	87.7%	⇨	71.0%	71.4%	⇨	72.6%	73.0%	⇨
City and Hackney Teaching PCT	84.5%	82.0%	⇨	86.2%	84.4%	⇨	85.5%	83.5%	⇨	84.9%	84.4%	⇨	79.4%	77.1%	⇨	83.4%	81.5%	⇨
Enfield PCT	88.3%	89.7%	⇨	81.2%	82.7%	⇨	82.3%	82.8%	⇨	81.2%	82.6%	⇨		80.0%		77.2%	79.0%	⇨
Haringey Teaching PCT	89.2%	89.4%	⇨	85.5%	85.4%	⇨	86.8%	86.4%	⇨	86.2%	85.2%	⇨	82.5%	83.1%	⇨	82.8%	82.4%	⇨
Havering PCT	94.3%	96.1%	⇨	93.2%	93.1%	⇨	92.5%	93.1%	⇨	92.4%	92.7%	⇨	89.6%	90.6%	⇨	88.7%	88.9%	⇨
Islington PCT	95.6%	95.7%	⇨	92.6%	88.2%	⇨	92.1%	88.7%	⇨	91.3%	88.8%	⇨	90.8%	79.9%	⇩	90.0%	81.0%	⇩
Newham PCT	89.2%	87.9%	⇨	87.8%	85.3%	⇨	88.5%	86.5%	⇨	88.5%	86.2%	⇨	75.4%	74.1%	⇨	76.7%	75.3%	⇨
Redbridge PCT	93.7%	94.3%	⇨	90.0%	91.6%	⇨	89.9%	91.8%	⇨	90.3%	92.0%	⇨	84.1%	87.8%	⇨	83.6%	87.9%	⇧
Tower Hamlets PCT	91.3%	91.1%	⇨	84.9%	90.1%	⇧	84.4%	89.5%	⇧	84.5%	90.0%	⇧	78.0%	82.4%	⇨	85.9%	87.7%	⇨
Waltham Forest PCT	90.5%	85.9%	⇩	85.6%	84.0%	⇨	83.2%	83.0%	⇨	83.7%	83.8%	⇨	83.1%	82.8%	⇨	81.3%	82.6%	⇨
North West London (NW)																		
Brent Teaching PCT	92.7%	91.6%	⇨	87.8%	86.1%	⇨	89.2%	87.0%	⇨	88.6%	86.5%	⇨	83.7%	81.9%	⇨	82.9%	80.5%	⇨
Westminster PCT	79.4%	79.6%	⇨	68.2%	72.7%	⇨	68.2%	73.1%	⇨	66.6%	69.0%	⇨	62.2%	55.2%	⇨	59.5%	53.4%	⇨
Ealing PCT	92.0%	91.4%	⇨	87.3%	85.3%	⇨	86.3%	84.7%	⇨	85.2%	83.6%	⇨	83.4%	82.5%	⇨	81.9%	81.3%	⇨
Hammersmith and Fulham PCT	85.2%	88.5%	⇨	80.8%	79.5%	⇨	80.3%	80.1%	⇨	76.9%	77.6%	⇨		63.4%		59.0%	62.3%	⇨
Harrow PCT	91.7%	91.5%	⇨	85.4%	88.9%	⇨	86.9%	88.6%	⇨	86.4%	89.2%	⇨	84.3%	83.8%	⇨	83.4%	83.1%	⇨
Hillingdon PCT	90.5%	90.0%	⇨	90.4%	82.4%	⇩	90.3%	82.8%	⇩	88.3%	80.9%	⇩	87.1%	86.2%	⇨	85.1%	85.4%	⇨
Hounslow PCT	92.2%	85.5%	⇩	87.7%	77.5%	⇩	87.1%	80.0%	⇩	84.3%	79.3%	⇩	73.6%	66.5%	⇩	73.8%	51.2%	⇩
Kensington and Chelsea PCT	77.7%	76.2%	⇨	69.2%	66.9%	⇨	70.4%	65.7%	⇨	68.5%	64.7%	⇨		53.0%		55.8%	52.0%	⇨
South London (SL)																		
Bexley Care Trust	92.8%	94.3%	⇨	88.0%	87.4%	⇨	87.7%	88.0%	⇨	86.0%	86.0%	⇨	76.5%	79.7%	⇨	85.6%	86.3%	⇨
Bromley PCT	93.1%	92.9%	⇨	88.7%	89.9%	⇨	87.6%	89.2%	⇨	88.5%	89.1%	⇨	80.3%	75.7%	⇨	85.9%	82.4%	⇨
Croydon PCT	90.1%	89.6%	⇨	87.7%	85.3%	⇨	86.5%	84.7%	⇨	87.7%	85.8%	⇨	79.9%	80.6%	⇨	78.7%	80.3%	⇨
Greenwich Teaching PCT	90.5%	90.1%	⇨	85.8%	85.1%	⇨	85.4%	85.1%	⇨	85.4%	85.5%	⇨	65.5%	76.9%	⇧	89.0%	88.8%	⇨
Kingston PCT	95.5%	95.4%	⇨	89.6%	95.3%	⇧	90.4%	89.6%	⇨	90.4%	90.5%	⇨	87.1%	85.7%	⇨	87.4%	88.9%	⇨
Lambeth PCT	93.0%			90.5%			90.5%			90.3%			87.0%			92.0%		
Lewisham PCT	92.7%	91.4%	⇨	85.2%	86.9%	⇨	85.4%	87.2%	⇨	85.6%	88.2%	⇨	84.2%	81.6%	⇨	68.0%	62.1%	⇩
Richmond and Twickenham PCT	90.0%	85.9%	⇨	89.1%	79.2%	⇩	86.5%	81.8%	⇨	86.0%	82.1%	⇨	73.8%	63.7%	⇩	75.1%	74.2%	⇨
Southwark PCT	91.1%			86.9%			86.9%			87.1%			83.4%			89.2%		
Sutton and Merton PCT	93.0%	93.0%	⇨	89.4%	87.7%	⇨	89.9%	87.7%	⇨	89.5%	88.1%	⇨	73.3%	75.6%	⇨	80.1%	80.3%	⇨
Wandsworth PCT	89.3%	90.5%	⇨	83.9%	84.2%	⇨	84.9%	85.0%	⇨	85.6%	85.3%	⇨	70.6%	70.4%	⇨	81.5%	83.9%	⇨
London	90.2%	89.6%	⇨	86.5%	85.2%	⇩	86.4%	85.2%	⇩	86.0%	85.0%	⇩	79.8%	76.5%	⇩	80.5%	77.6%	⇩

National COVER data is provisional by PCT and the local authority reporting remains experimental.

Q3 15/16 versus Q3 14/15

Immunisation - 15-16 Q3 compared to 14-15 Q3	Diphtheria, Tetanus, Polio, Pertussis and Haemophilus influenza type b (DTaP/IPV/Hib) - 3 Doses			Pneumococcal infection (PCV booster)			Haemophilus influenza type b and meningitis C (Hib/MenC)			Measles, mumps and rubella (MMR)			Diphtheria, Tetanus, Polio, Pertussis (DTaP/IPV) - pre-school booster			Measles, mumps and rubella (MMR2)		
Cohort	12 Months			2 Years			2 Years			2 Years			5 Years			5 Years		
PCT Name	**14-15 Q3**	**15-16 Q3**	**Signif. change**	**14-15 Q3**	**15-16 Q3**	**Signif. change**	**14-15 Q3**	**15-16 Q3**	**Signif. change**	**14-15 Q3**	**15-16 Q3**	**Signif. change**	**14-15 Q3**	**15-16 Q3**	**Signif. change**	**14-15 Q3**	**15-16 Q3**	**Signif. change**
North Central & East London (NCEL)																		
Barking and Dagenham PCT	92.0%	93.0%	⇨	85.9%	89.0%	⇨	86.5%	88.7%	⇨	85.9%	89.3%	⇨	80.9%	84.0%	⇨	78.8%	80.3%	⇨
Barnet PCT	85.0%	81.8%	⇨	78.1%	81.7%	⇨	77.9%	81.4%	⇨	78.3%	80.2%	⇨	70.7%	54.6%	⇩	71.6%	60.5%	⇩
Camden PCT	93.2%	89.4%	⇨	86.9%	89.4%	⇨	86.8%	88.2%	⇨	86.1%	87.7%	⇨	83.4%	71.4%	⇩	81.1%	73.0%	⇩
City and Hackney Teaching PCT	85.5%	82.0%	⇨	88.5%	84.4%	⇩	88.4%	83.5%	⇩	87.6%	84.4%	⇨	83.4%	77.1%	⇩	87.2%	81.5%	⇩
Enfield PCT	86.7%	89.7%	⇨	86.0%	82.7%	⇨	88.3%	82.8%	⇩	87.1%	82.6%	⇩	85.1%	80.0%	⇩	85.1%	79.0%	⇩
Haringey Teaching PCT	94.2%	89.4%	⇩	85.3%	85.4%	⇨	87.0%	86.4%	⇨	86.5%	85.2%	⇨	84.9%	83.1%	⇨	84.2%	82.4%	⇨
Havering PCT	93.8%	96.1%	⇨	88.1%	93.1%	⇧	88.5%	93.1%	⇧	87.0%	92.7%	⇧	82.5%	90.6%	⇧	81.4%	88.9%	⇧
Islington PCT	96.6%	95.7%	⇨	95.0%	88.2%	⇩	94.8%	88.7%	⇩	94.6%	88.8%	⇩	90.3%	79.9%	⇩	90.1%	81.0%	⇩
Newham PCT	92.5%	87.9%	⇩	88.6%	85.3%	⇨	89.0%	86.5%	⇨	89.1%	86.2%	⇨	81.2%	74.1%	⇩	81.8%	75.3%	⇩
Redbridge PCT	90.5%	94.3%	⇧	84.4%	91.6%	⇧	83.8%	91.8%	⇧	83.3%	92.0%	⇧	76.9%	87.8%	⇧	74.6%	87.9%	⇧
Tower Hamlets PCT	95.8%	91.1%	⇩	90.3%	90.1%	⇨	96.4%	89.5%	⇩	89.0%	90.0%	⇨	84.0%	82.4%	⇨	91.5%	87.7%	⇨
Waltham Forest PCT	89.7%	85.9%	⇩	83.5%	84.0%	⇨	83.2%	83.0%	⇨	83.6%	83.8%	⇨	81.0%	82.8%	⇨	80.3%	82.6%	⇨
North West London (NW)																		
Brent Teaching PCT	92.0%	91.6%	⇨	85.9%	86.1%	⇨	86.8%	87.0%	⇨	86.4%	86.5%	⇨	81.3%	81.9%	⇨	81.8%	80.5%	⇨
Westminster PCT	73.2%	79.6%	⇨	72.1%	72.7%	⇨	72.3%	73.1%	⇨	72.4%	69.0%	⇨	65.0%	55.2%	⇩	65.5%	53.4%	⇩
Ealing PCT	84.4%	91.4%	⇧	85.3%	85.3%	⇨	83.9%	84.7%	⇨	84.4%	83.6%	⇨	80.6%	82.5%	⇨	81.7%	81.3%	⇨
Hammersmith and Fulham PCT	81.8%	88.5%	⇧	71.9%	79.5%	⇧	75.6%	80.1%	⇨	74.0%	77.6%	⇨	64.9%	63.4%	⇨	66.9%	62.3%	⇨
Harrow PCT	92.1%	91.5%	⇨	84.9%	88.9%	⇨	88.3%	88.6%	⇨	89.6%	89.2%	⇨	79.6%	83.8%	⇨	82.4%	83.1%	⇨
Hillingdon PCT	92.7%	90.0%	⇨	88.2%	82.4%	⇩	88.8%	82.8%	⇩	87.8%	80.9%	⇩	87.8%	86.2%	⇨	87.9%	85.4%	⇨
Hounslow PCT	91.1%	85.5%	⇩	79.5%	77.5%	⇨	81.5%	80.0%	⇨	81.7%	79.3%	⇨	62.6%	66.5%	⇨	72.4%	51.2%	⇩
Kensington and Chelsea PCT	71.5%	76.2%	⇨	65.7%	66.9%	⇨	68.8%	65.7%	⇨	68.8%	64.7%	⇨	59.8%	53.0%	⇨	62.5%	52.0%	⇩
South London (SL)																		
Bexley Care Trust	93.6%	94.3%		90.9%	87.4%		90.0%	88.0%		90.0%	86.0%		82.7%	79.7%		86.5%	86.3%	
Bromley PCT	94.7%	92.9%	⇨	88.3%	89.9%	⇨	89.7%	89.2%	⇨	89.3%	89.1%	⇨	81.2%	75.7%	⇩	88.9%	82.4%	⇩
Croydon PCT	87.6%	89.6%	⇨	86.0%	85.3%	⇨	85.1%	84.7%	⇨	85.9%	85.8%	⇨	64.1%	80.6%	⇧	64.8%	80.3%	⇧
Greenwich Teaching PCT	90.9%	90.1%	⇨	88.8%	85.1%	⇨	88.0%	85.1%	⇨	88.8%	85.5%	⇨	73.2%	76.9%	⇨	88.7%	88.8%	⇨
Kingston PCT	93.7%	95.4%	⇨	90.7%	95.3%	⇧	88.9%	89.6%	⇨	90.7%	90.5%	⇨	87.4%	85.7%	⇨	87.6%	88.9%	⇨
Lambeth PCT	92.4%			88.4%			88.2%			89.5%			87.4%			89.3%		
Lewisham PCT	91.0%	91.4%	⇨	87.3%	86.9%	⇨	86.9%	87.2%	⇨	88.9%	88.2%	⇨	78.5%	81.6%	⇨	71.6%	62.1%	⇩
Richmond and Twickenham PCT	89.8%	85.9%	⇨	86.7%	79.2%	⇩	86.9%	81.8%	⇨	87.3%	82.1%	⇩	71.3%	63.7%	⇩	77.4%	74.2%	⇨
Southwark PCT	91.1%			86.4%			86.9%			86.9%			86.0%			89.9%		
Sutton and Merton PCT	91.1%	93.0%	⇨	87.8%	87.7%	⇨	88.9%	87.7%	⇨	88.7%	88.1%	⇨	73.6%	75.6%	⇨	80.3%	80.3%	⇨
Wandsworth PCT	92.4%	90.5%	⇨	84.9%	84.2%	⇨	85.8%	85.0%	⇨	87.1%	85.3%	⇨	70.9%	70.4%	⇨	81.5%	83.9%	⇨
London	90.0%	89.6%	⇨	85.5%	85.2%	⇨	86.1%	85.2%	⇩	86.0%	85.0%	⇩	78.0%	76.5%	⇩	80.5%	77.6%	⇩

National COVER data is provisional by PCT and the local authority reporting remains experimental.

AGENDA ITEM 9

	Health and Wellbeing Board **12 May 2016**
Title	**Joint Health and Wellbeing Strategy Implementation plan (2015 – 2020) progress update**
Report of	Commissioning Director – Adults and Health CCG Accountable Officer
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) exceptions report
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 and the approval of the implementation plan in January 2016, this paper provides the HWBB with an update on the progress to deliver against the implementation plan.

Recommendations

1. **That the Health and Wellbeing Board notes and comments on progress to deliver the Joint Health and Wellbeing Strategy (2015-2020) and agrees further action where necessary.**

1. WHY IS THE REPORT NEEDED

1.1 Background

1.1.1 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.

1.1.2 The 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.

1.1.3 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.

1.1.4 The Implementation Plan was presented to and agreed by the Health and Wellbeing Board in January 2016. 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.

1.1.5 The Joint Commissioning Executive Group (JCEG) manage the delivery of the JHWB Strategy and review detailed activity and targets (when available) at each meeting (every two months).

1.1.6 Health and Wellbeing Board agreed to receive progress reports at each meeting, the progress reports will highlight key achievements, concerns and remedial action and provide the Board with an opportunity to review and

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

comment on the progress to deliver the JHWB Strategy. The HWBB is able to ask for follow up reports on specific topics of interest or concern to its forward plan.

1.1.7 The targets and indicators in the JHWB Strategy will be reported when they become available. Each November the Board will receive a full annual report on progress including targets, indicators and activity which will allow the Board to review progress and refine priorities for the coming year, feeding into business planning processes.

1.1.8 The following Red, Amber and Green (RAG) status criteria have been applied to progress made:

- Red: requires remedial action to achieve objectives. The timeline, cost and/or objective are at risk
- Amber: there is a problem but activity is being taken to resolve it or a potential problem has been identified and no action has been taken but it being closely monitored. The timeline, cost and/or objectives may be at risk
- Green: on target to succeed. The timeline, cost and/or objectives are within plan
- Grey: completed

1.1.9 Items on the Health and Wellbeing Board agenda and workplan provide more detailed updates on specific areas of the Strategy.

1.2 **Delivering our Joint Health and Wellbeing Strategy**

1.2.1 The progress updated covers the period from March 2016 to May 2016. Due to data collection for the targets being quarterly or annually, this update mainly covers activity (programmes are RAG rated based on activity progress rather than targets).

1.2.2 Overall, activity to progress our plans is considered to be good as: 71% green, 28% amber and 1% red. However, there are 16% more amber rated actions in this report in comparison to the progress report from March 2016.

1.2.3 The table below contains is a list of key highlights reflecting areas which are progressing well:

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
Highlights
• Nine centres for children are now accredited as Healthy Children Centres with on achieving an outstanding rating • CLCH Breastfeeding Peer Support continues to meet and exceed KPIs • 74% of families with children under 5 are using centres for children (against

a target of 60%)

- Children and Young People's Plan in out to consultation before the final plan being presented for approval at Children, Education, Libraries and Safeguarding Committee in June 2016
- New UK Youth Parliament members were elected in March 2016 with over 800 children and young people voting
- Nine start up organisations have already been supported by CommUNITY Barnet since January 2016, a successful Funders Fair was also held in January 2016 with over 40 organisations benefitting from the event
- A domestic violence expert is now in the MASH three days a week
- Nineteen Oral Health Champions now trained; excellent engagement with hard to reach groups

Wellbeing in the community: Creating circumstances that enable people to have greater life opportunities

- Focus on improving mental health and wellbeing for all – year one priority
- Support people to gain and retain employment and promote healthy workplaces

- Psychiatric liaison has been identified as a priority for the North Central London Mental Health programme. NCL commissioners continue to meet monthly and have commenced discussions to review and develop a core 24 model for psychiatric liaison
- Triborough (Barnet, Enfield and Haringey) discussions have progressed with regards to the crisis concordat, work in Barnet is focusing on preventing crisis through strengthening early intervention, primary care mental health liaison service development with secondary care and developing a wellbeing hub and spoke model
- In terms of exploring personal health budgets for people with personality disorders, commissioners are reviewing best practice and working with the Mental Health Trust to review current Mentalisation Therapy Service provision
- Trailblazer Action Learning Sets have been booked to progress Reimagining Mental Health; this is expected to deliver a new pathway model, collaborative development of wellbeing hubs and pilot innovative approaches to supporting people in the community. This is aligned with the Local Authorities mental health social work project.
- Child and Adolescent Mental Health Service (CAMHS) Transformation plan submitted and aligned with transforming care. There is on-going work with the Eating Disorder Service on waiting times
- Procurement of the support phase for Community Centred Practices is being led by Public Health, engagement with GPs has been positive and availability of funding will determine final numbers
- The Neighbourhood Services contract has been extended for two years; during 2016/17 the Provider Group will further expand activities, increase reach and further utilise volunteers
- Two successful appointment based adult social care hubs are in operation in the borough
- Burnt Oak Opportunity Support Team (BOOST) met its target supporting 121

people into work in 2015/16. BOOST need to reach more people on sickness benefit through referrals from Job Centre Plus and GPs • Barnet Council signed the Time to Change pledge and is committed to delivering an action plan to improve the mental health and wellbeing of its employees • Twenty Winterwell Grants and 43 packs have been distributed to the boroughs most vulnerable residents. Groundwork have completed 57 advice sessions and recruited 15 volunteers to deliver home visits.
How we live: Encouraging healthier lifestyles • Focus on reducing obesity and preventing long term conditions through promoting physical activity • Assure promotion and uptake of all screening including cancer screening and the early identification of disease
• Pre-procurement market testing took place in March 2016 which included 21 sessions with seven providers • Resident engagement sessions were held to explore the initial designs for New Barnet Leisure Centre and Barnet Copthall • In terms of increasing participation; from September 2015 – March 2016 usage of leisure centres has increased by 21.1%, with significance in aquatics attendances +24.2%; 13.4% increase in usage by people over 45, 25.9% increase in usage by females and 33.3% increase in usage by children and young people • Sport and Physical Activity Strategy currently in draft with engagement planned between April – June including a Disability Sub Group with link to the Fit and Active Barnet (FAB) Network • The Obesity Strategy is being developed by Public Health, a draft strategy and action plan will be available in June 2016 • Substance misuse service continues to deliver support to young people and adults; all service users leaving treatment early will have their case reviewed by Service Managers to ascertain what re-engagement was attempted. An alcohol / detox treatment pathway is being developed.
Care when needed • Focus on identifying unknown carers and improving the health of carers (especially young carers) • Work to integrate health and social care services
• Barnet's Carers Strategy (2015 – 2020) was submitted and agreed by Policy and Resources Committee (16 February 2016); reference group is being established to implement the strategy • Carers and young carers support service specification has been drafted and went live in April 2016; includes specific targeted support regarding raising awareness of employment rights of carers with businesses and with carers and young carers • Adults and Communities are managing a project to establish a new team by June 2016 which will deliver a specialist programme of support to carers of people with dementia through assessments, support planning and facilitating a targeted training programme

- Barnet's dementia diagnosis rate has increased to 77.6% and the 12 week referral to diagnosis target continues to be met by providers. The re-commissioned dementia support service delivered by Alzheimer's Society commenced on 1 April 2016. Dementia Alliance is being established with an event during Dementia Awareness Week in May
- Quality Review Visits have been completed of the Acute Stroke Units – good access to timely stroke rehabilitation, effective stroke community services and review service. Re-commissioned stroke service commenced on 1 April 2016 (stroke navigator service, community support service and 6 month reviews)
- Events organised for Dying Matters Week (9 – 15 May) which have been developed by CCG, Jewish Care, Public Health, Marie Curie, Healthwatch and North London Hospice

1.2.4 Areas considered to be performing less well (Red / Amber) are listed below, further commentary and detail around mitigating actions, can be found in appendix 1:

- Implementing the healthy child programme
- Increasing the supply and demand for the two year old (free childcare) offer
- Social action projects delivered by our Volunteering Service
- Monitoring Safeguarding referrals for advice on the issue of FGM
- Review, update and deliver Barnet's DV and VAWG Strategy
- Updating Barnet's Safeguarding Children's Board Business plan
- All initial health assessments for Looked After Children (LAC) completed within time frame (28 days)
- Uptake of childhood immunisations
- CAMHS and Eating Disorder Services: Develop school traded approach
- Participation (sports and physical activity)
- Target NHS Health Checks: high risk groups to be identified
- Develop a training resource to up skill staff who interact with residents to maximise opportunities to promote good health (Making Every Contact Count Training)
- Roll out of BILT
- Develop programmes to support self-management
- Performance of general practice
- Falls prevention.

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.

2.1.1 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.

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.

3.2 Receiving regular performance and activity reports allows the HWBB to review and ensure progress is being made to deliver the JHWB Strategy.

4. POST DECISION IMPLEMENTATION

4.1.1 Action will continue as outlined in the report.

4.1.2 JCEG will receive detailed activity updates.

4.1.3 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.

5.5.2 Receiving regular performance and activity reports allows the HWBB to review and ensure progress is being made to deliver the JHWB Strategy.

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 Implementation Plan (2015 – 2020) progress update, Health and Wellbeing Board 10 March 2016, item 9: https://barnet.moderngov.co.uk/documents/s30322/JHWB%20Strategy%20implementation%20plan%20March%202016.pdf

6.2 Joint Health and Wellbeing Strategy Implementation Plan (2015 – 2020), Health and Wellbeing Board 21 January 2016, item 7: https://barnet.moderngov.co.uk/ieListDocuments.aspx?CId=177&MId=8389&Ver=4

6.3 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

6.4 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

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

Implementation Plan 2015 – 2020: Progress update May 2016

Reporting by exception (A = Amber and R = Red)

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					
Key action	**Update**	**Strategic Lead**	**Operational Lead**	**RAG**	**Mitigating action**
Implement the healthy child programme – integrate provision of service in readiness to undertake competitive procurement	There is now a named Health Visitor in each locality. Delivery of 0-19 Healthy Child Programme presentation to be delivered at the Healthy Schools Network meeting in March 2016. Continued challenges with recruitment to both the Health Visiting and School Nursing contracts which is impacting on delivery of key components of contract.	Commissioning Director Children and Young People	Head of Joint Children's Commissioning	A	2 year integrated review (a model for integration for two early year health checks) briefing submitted for comments, plan to pilot model in April 2016 with roll out over the summer. CLCH to produce a clear time lined action plan and data quality reports.
Improve early years' service offer: Increase the supply and demand for the two year old (free childcare) offer	Strategic links with Health Partners and JCP established and maintained Feasibility of library sites explored Training to centre for children staff on Free Early Education (FEE) 2 eligibility and application process.	Commissioning Director Children and Young People	Head of Early Years and Early Help	A	FEE2 capital grant next round followed by tailored business support to PVIs to ensure viability of the new/extended provision. Tailored support to existing providers being provided to encourage increasing take up

	New marketing in place.				in areas of high demand.
Five social action projects a year in areas of high need, resulting in increased volunteering (10 in total by December 2016)	Output of the Groundwork Volunteering Service Contract (with the Council). Further 1 social action completed in January 2016 (total of 3 / 10 complete)	Commissioning Director Adults and Health	Local Infrastructure Organisations	A	Six social action activities planned including community gardening and a Christmas event. One remains to be organised. LBB will closely monitor the contract.
Monitor and increase the number of Safeguarding referrals for advice on the issue of FGM.	Staff identifying FGM are aware of referral requirements. Health organisations are required to report on identified cases of FGM to NHS England.	Head of Community Safety	DVA and VAWG Coordinator	A	The Domestic Violence and Abuse (DVA) Violence Against Women and Girls (VAWG) Strategy Board is looking to develop a performance monitoring dashboard for VAWG (during 2016).
Review, update and deliver Barnet's DVA and VAWG Strategy	Strategy being developed, consultation has been completed.	Head of Community Safety	DVA and VAWG Coordinator	A	Strategy and action plan will run from 2016 - 2020. Strategy will be presented for sign off at the Safer Communities Partnership later in the year.
Support the delivery of the Barnet Safeguarding Children's Board Business plan	Priorities developed and agreed by the partnership.	Commissioning Director Children and Young People	Barnet Safeguarding Childrens Board Chair	A	The plan will be signed off in June 2016.

All initial health assessments for Looked After Children (LAC) completed within time frame (28 days)	2/5 Jan, 9/19 Feb, 10/24 Mar 2016. 20/48 in quarter 4. Capacity and bottlenecks are being assessed and appropriate steps taken to ensure LAC team has early warning of children moving into care. Additional surgery now in place – 20 sessions available per month (increase by 50%).	Commissioning Director Children and Young People	Head of Joint Children's Commissioning	A	Designated Doctor for Looked After Children: Interim Arrangements had been in pace from June 2015 with Consultant cover provided by Community Paediatricians from the Royal Free Hospital. A permanent appointment has been made and commenced on 1st April. Designated Nurse for Looked After Children: The current post holder is due to commence Maternity leave at the end of April 2016. Commissioners have worked with CLCH to ensure appropriate cover and capacity is in place. Will be monitored closely by Children's JCU.
Increase uptake of childhood immunisations	Currently below England average for each vaccination	NHS England – London Regional Lead	Public Health / Childrens JCU	R	Full report to be reported to the HWBB by NHSE in May 2016; the paper recommends a referral to HOSC subject to HWBB approval.

Wellbeing in the community: Creating circumstances that enable people to have greater life opportunities • Focus on improving mental health and wellbeing for all – year one priority • Support people to gain and retain employment and promote healthy workplaces					
Key action	**Update**	**Strategic Lead**	**Operational Lead**	**RAG**	**Mitigating action**
CAMHS and Eating Disorder Services: Develop school traded approach	Meeting organised between JCU and LB Barnet Commissioning to proceed with planning for recommissioning to progress this action.	Commissioning Director Children and Young People	Head of Joint Children's Commissioning	A	Meeting organised to take forward.

How we live: Encouraging healthier lifestyles • Focus on reducing obesity and preventing long term conditions through promoting physical activity • Assure promotion and uptake of all screening including cancer screening and the early identification of disease					
Key action	**Update**	**Strategic Lead**	**Operational Lead**	**RAG**	**Mitigating action**
Target NHS Health Checks: high risk groups to be identified	GP practices are still uploading their Q4 data; from the data available it is not clear that the incentive payments have improved	Director of Public Health	Public Health	A	Public Health are reviewing payment methods to improve the process for GPs and encourage uptake.

	performance.				The new Commissioning Manager for this service has been in post for 6 weeks and is working on the new approach. The aim is for this to feed in to the new contracts with GP practices by the end of Q1 16/17.
Develop a training resource to up skill staff (300 in first phase) who interact with residents to maximise opportunities to promote good health (Making Every Contact Count Training)	Procurement unsuccessful.	Commissioning Director Adults and Health	Commissioning Lead Health and Wellbeing	A	Delivery model being reviewed. Training to be available from late July 2016.

How we live: Encouraging healthier lifestyles

- Focus on reducing obesity and preventing long term conditions through promoting physical activity
- Assure promotion and uptake of all screening including cancer screening and the early identification of disease

Key action	Update	Strategic Lead	Operational Lead	RAG	Mitigating action
Working with NHS England and partner organisations to reduce the proportion of people reporting a very poor GP experience (monitored locally).	Performance has improved: 1.7% reporting a poor experience of primary care (2% previously). However this is still higher than the national average (1.3%).	Head of Primary Care Commissioning	NHS England	A	As a Joint commissioner of Primary Care, the CCG is working closely with NHSE to look at the quality and performance of general practices in the Barnet area.

Roll out of BILT across the Borough.	BILT still being delivered in the West of the Borough. Specification for roll out has been developed.	Commissioning Director Adults and Health / Director of Strategic Development	Head of Service, Joint Commissioning	A	Specification to be finalised, expected to go live in July 2016.
Develop programmes to support self-management	Structured education options have been explored; delays experienced due to CCG availability for discussions.	Director of Public Health	Consultant in Public Health	A	Public Health exploring options, will be reported to the Ageing Well/Tier 1 and 2 Programme Board in June.
Improve falls prevention	Pathway review planned to become NICE compliant.	Head of Service, Joint Commissioning		A	Monitor the current provision ahead of recommendations from the review. Report to a future HWBB.

AGENDA ITEM 10

	Health and Wellbeing Board **12 May 2016**
Title	**Creating Healthy Places – opportunities to align public health outcomes and planning**
Report of	Director of Public Health
Wards	All
Status	Public
Urgent	No
Key	Yes
Enclosures	None
Officer Contact Details	Rachel Wells - Consultant in Public Health Rachel.Wells@harrow.gov.uk Adam Driscoll – Commissioning Lead, Planning Adam.Driscoll@barnet.gov.uk Kitran Eastman – Strategic Lead, Environment Kitran.Eastman@Barnet.gov.uk

Summary

There are a range of opportunities to encourage healthy behaviours and choices through the planning and development of new environments, whether these are parks and open spaces, new communities, town centres, travel options or the provision of services and choices available to residents. Barnet has a wealth of possibilities with regards to how people can be encouraged to choose to live healthy lives and we want to ensure that our places in Barnet reflect this, whilst supporting the regeneration and growth of local communities. This paper looks to present some of the opportunities and give examples of where these might work.

Recommendations
1. **That the Health and Wellbeing Board notes the collaborative work between Planning (Re and colleagues from Growth and Regeneration) and Public Health teams to date and on-going future plans.**
2. **That the Health and Wellbeing Board adopts the concept of 'Healthy Places as a charter of excellence and tasks Public Health to develop a suitable criteria for its application in practice as well as how this will align with the Council's priorities and strategies. Progress will be reported back to the Health and Wellbeing Board.**
3. **That the Health and Wellbeing Board requests that Public Health work with Planning to develop pilot projects to drawn from the following identified areas of opportunity –** **a. Using planning tools and pre-application discussions to influence the design of larger developments, as well as shaping policy discussions** **b. Help to shape place-based commissioning projects (such as the identified opportunities to create on 'healthy high streets'),** **c. Help to shape proposals for new or improved on open spaces in relation to the identified site opportunities.**
4. **That the Health and Wellbeing Board requests that Public Health develop embedded relationships with key planning and regeneration project teams, in particular for Colindale and Brent Cross.**
5. **That the Health and Wellbeing Board requests that Public Health work with colleagues in estates and regeneration services to identify suitable land / buildings that could assist with the introduction of Meanwhile Uses into regeneration areas and town centres, in particular with a public health focus.**
6. **That the Health and Wellbeing Board recommends that measures which help address public health issues are built into existing and new corporate planning and licensing programmes or projects, where appropriate. Public Health to lead work with other Council officers to embed this approach.**

1. WHY THIS REPORT IS NEEDED

1.1 BACKGROUND

1.1.1 The impact of the built and physical environment on health has been well documented. The opportunities to encourage healthy living and healthier choices through planning and regeneration are many and varied, but often operate and impact over medium- to long-term timeframes.

1.1.2 This paper identifies a range of approaches and actions that can bring together a range of statutory, regulatory and influencing roles together to:

a) Align objectives across Council and Partner policies and strategies.

b) Develop the model of 'healthy places' as a proof of concept aligning strategy with public health outcomes and behaviour change.

c) Create a number of 'Healthy Places' where public health resource can be focused on influencing the design and creation of new places or buildings being delivered by developers or the Council.

d) Investigate the potential for specific targeted areas of work focused on key areas of public health concern and regulatory activities.

e) Identify opportunities to improve processes around regulatory functions and improve with these gateways to ensure there is stronger consideration / weight given to public health matters.

1.1.3 The relationship between the determinants of health is shown in figure 1. This identifies how significant the built environment and activities are for health.

Figure 1- The determinants of health.

1.2 ALIGNING POLICY AND STRATEGY

1.2.1 The Council has a range of key objectives in the spheres of Public Health and the Built Environment; these are driven by the Corporate Plan and Joint Strategic Needs Assessment (JSNA)

1.2.2 The objectives influence the policies that interface particularly through the Local Plan, together with aspects of the Regeneration Strategy, the Housing Strategy, the Parks and Open Spaces Strategy[1], the Sports and Physical Activity Strategy and a number of other strategies. To date these adopted

[1] Parks and Open Spaces Strategy - https://engage.barnet.gov.uk/consultation-team/parks-and-open-spaces-strategy

and forthcoming policies have not been systematically reviewed in relation to public health though attention has been paid to incorporating this where possible.

1.2.3 Work to influence, review and edit the detail of emerging strategies has been tested through joint-work on the Parks and Open Spaces Strategy. The learning from this process includes:

(i) Opportunities for Public Health staff to be members of internal governance boards in order that they are aware of, and can collaborate on any emerging strategies, action plans and individual project opportunities.

(ii) Recognition of the need for processes of internal consideration and collaboration within Public Health to ensure opportunities linked to projects and strategies are identified and the full potential for alignment with priority health objectives is achieved.

1.2.4 Many strategies and policies have an annual update, but are generally comprehensively reviewed about every five years. It is proposed that Public Health undertake a review of existing spatially-related policies and strategies to identify any key areas for opportunities over the next few years.

1.2.5 The critical outcome required is for the spatial objectives of public health efforts to become clear and consistent in the way they are expressed and recognised across Council policies, strategies and action plans.

1.3 APPLYING SPATIAL FOCUS: CREATING HEALTHY PLACES

1.3.1 Barnet is the largest Borough in London by population and is continuing to grow. The highest rates of population growth are forecast to occur around the planned development works in the west of the Borough, with significant growth in Golders Green and Colindale. Across the borough a disproportionate increase in the over 65 population is also expected.

Place-making (Medium- and long-term measures)

1.3.2 The ‘place-making’ function of the Council includes approval of building and landscaping designs, as well as the commissioning and design of proposed streetscape improvements, town centre regeneration projects and proposals linked to the design and management of quality open spaces. The potential to design-in healthier environments is particularly significant in growth and development locations. Here there are a range of opportunities for shaping and influencing plans and capital investments:

(i) *Planning approvals for housing* – details such as the location of stairs and lifts, and the way developments promote active travel. Additionally challenging developers around access to outdoor spaces, on site landscaping and the design of new play spaces. Attention would be focused on (a) policy guidance to planners and (b) larger and more comprehensive development schemes.

(ii) *Detailed design and planning of public buildings* – these include where the Council and its partners are delivering new schools, community facilities and health centres where there is even more opportunity to influence building design, internal spatial behaviours and landscaping proposals. Key opportunities link to the Council's Community Assets Strategy and Community Hub proposals, alongside the Education Capital Programme.

(iii) *Capital investment in public realm and open spaces* – with significant sums expected to be spent on open spaces (£20m), combined with public realm and transport investments (£500m), the offer for creating healthy places can be built in from the beginning. A small level of investment at the design stage can demonstrate public health benefits over the lifetime of the operation of each facility. Currently public health has influenced the design of the new leisure centres to ensure public health outcomes are reflected in the design of the buildings.

1.3.3 The Joint Health and Wellbeing Strategy recognises a particular opportunity around Brent Cross and Colindale for more intensive close working around the design of proposals in relation to planning pre-application processes. For example the plans for the expanded Brent Cross Shopping Centre are expected to be submitted in the next 12-24 months. The Council will soon begin the pre-application review of proposals for which the designs will influence the activity and behaviours of hundreds of thousands of people.

1.3.4 Additionally linked to the Colindale and Brent Cross growth areas is the potential for a new 'data hub' partnership with Middlesex University. This would bring together a wide range of information to enable evidence-led piloting of targeted health improvement projects, together with the effective review of health impacts broadly associated with regeneration activities.

Meanwhile uses (Short- and medium-term measures)

1.3.5 A key challenge associated with regeneration activities are the timeframes that schemes take to deliver housing and infrastructure outcomes. For example the Grahame Park Regeneration Scheme was approved by residents in 2003, but redevelopment of the central concourse areas is only anticipated towards the end of this decade (circa 15 years later). This means a decade or longer can pass by with people living as neighbours to large building sites whilst experiencing limited direct benefits as individuals, a matter that careful planning of proposals and timing of infrastructure delivery needs to consider.

1.3.6 Learning from public health research into the benefits of regeneration activities and specific successful regeneration schemes such as Kings Cross, we are exploring the role of 'meanwhile uses'; this is the temporary use of space or buildings for community led activities or engagement, or on occasion also business or retail activities. Within areas that are the focus of regeneration, short term and temporary uses of space particularly where this promotes healthier living and positive health outcomes. We will begin by developing an options paper to identify suitable sites / buildings for temporary activities, alongside the identification of a small fund to assist these meanwhile activities and activation of spaces to come forward.

1.3.7 Regeneration of a number of town centres in the borough, coordinated through 'place-based commissioning' activities, provides an additional avenue for shaping healthier environments. Where smaller scale capital investments are planned, meanwhile activities could additionally help foster healthy behaviour changes in the local population. Town centre grants programmes are beginning to recognise and seek proposals that promote 'Healthy Town Centres' in addition to other more traditional measures focused on the Town Centre economy. The Council have incorporated 'healthy town centre' requirements into the tender brief for Finchley Church End to explore and pilot how this might work for Barnet. This would enable steps around food, active travel, well designed spaces to promote activity, and ways to promote the Five Ways to Mental Health, in this context.

1.3.8 Examples of meanwhile sites from other boroughs include:

- The squares and open spaces around Kings Cross have been turned over to various events and activities, including food festivals and stalls, outdoor dance classes, an art project that created a temporary lido, and skip gardens. More details are available at https://www.kingscross.co.uk/whats-on. This demonstrates the value of meanwhile uses within regeneration areas and key locations needing activation such as town centres.

- No.s 504 and 505 are renovated railway arches in Loughborough Junction. Quiet shared workspace and a small meeting space are provided in Arch 505 and an event space is located in Arch 504. Both are free to use by applicants. Arch 505 can accommodate 5 start-up businesses at a time. Arch 504 is a flexible event space that has hosted events from poetry, to theatre, to family-friendly community tennis. This example shows how spaces of seemingly limited value can provide good niche uses of economic and/or social benefit.

1.4 REGULATORY FUNCTIONS

1.4.1 Planning interfaces that are most commonly associated with the public's health are the regulatory functions of the Council including development management and licensing decisions in relation to specific types of use; in this area of work specific issues such as Hot Food Takeaways and Shisha Bars are examples of areas for discussion and action.

1.4.2 More indirectly there are a range of influences on the structure of the built environment that can affect health outcomes; particularly in relation to key issues such as physical activity and obesity, but also in relation to poorer housing. Already the Additional Licensing Scheme for HMOs has been approved and work on protecting vulnerable residents through Winterwell continues to develop, providing emergency aid in cold weather and advice and advice on fuel efficiency, debt and poverty.

1.4.3 We have considered the merit of developing a specific supplementary policy guidance on health matters, and though this may still emerge think that our efforts will be better focused on evidence gathering to feed into the Local Plan Review in 2017, to ensure that that policies of the local plan are providing the right regulatory framework for considerations around new developments.

1.4.4 At a more localised scale, the majority of people visiting town centres in Barnet do so by foot, bicycle or public transport. Encouraging this, particularly in less healthy areas, could drive good lifestyle behaviours and reduced demand for health and social care services. Therefore joint work with the Travel Planning team, town teams and the highways service (around the development of the cycling strategy) could be of benefit.

1.4.5 At this stage it is proposed that there are two key town centres to which energies will be focused, using Burnt Oak and Finchley Church End as our primary examples but expanding to other areas as opportunities arise and where capacity is available.

1.5 *Healthy High Streets and Town Centres – (Food and Local Economy)*

1.5.1 The Council are developing the Healthy High streets offer as part of the Town centres work and fostering relationships with local communities on developing healthier high streets, with a focus on weight management. This would include exploring a requirement for new food businesses, particularly those with an A5 use to commit to the Healthier Catering Commitment (HCC), and a continued focus on hot food takeaways to undertake the award, this complements the enforcement and advice role already undertaken by Environmental Health.

1.5.2 In addition identifying further clear steps that can be taken to regulate Shisha, both pre and post planning and enforcement, alongside promoting safer use and greater understanding. This would aim to complement other steps being developed to tackle shisha.

1.6 *Using Planning Tools (Building Design, Neighbourhood spaces)*

1.6.1 This would focus on three areas; firstly the development of health appraisal tools to be incorporated into planning decisions to maximise assessments on health of some planning decisions, an accompanying criteria would be developed and the assessment of planning applications would include pre-application discussions, building on the current use of the Healthy Urban Development Unit tools.

1.6.2 Secondly Health Impact Assessments would aim to become part of the process where the criteria indicate that a HIA or rapid HIA should be undertaken. Already this has been used successfully with the proposed new Leisure centres in Barnet. We have secured HIA training for one planner and one member of public health staff to date.

1.7 *Pre-application work on open spaces investments and landscaping*

1.7.1 Finally as transformative investments in parks and open spaces requires planning permission, a number of pilot sites for Healthy Open Spaces can be developed where there is alignment between planned investment and delivery of the Open Spaces Strategy. The Council would be looking to work with circa four pilot projects:

a. ***Victoria Recreation Ground, New Barnet*** – Linked to investment secured through planned redevelopment of former Gas Works site / and the integration of the park with the leisure centre proposals.

b. ***Upper Dollis Valley / Barnet Playing Fields / Brook Farm*** - The Dollis Brook river corridor and east-west green belt fields along the top of the borough deliver poor outcomes from such large areas of public open space. Investment secured through Dollis Valley Estate development, the Ark Academy Secondary School and through the Parks and Open Spaces Strategy will enable options for improvements to be considered and a long term plan for the area.

c. ***Copthall Estate*** – Subsequent to the development of the Planning Brief / Masterplan, and proposals for the new leisure centre, we will work with partners to shape an action plan for the area that will deliver investments in a way that integrates public health priorities.

d. ***Burnt Oak / Colindale –*** The capital programme incorporates a £5m investment in Montrose Playing Fields / Silk Stream Park, and major improvements to other open spaces and public realm are planned. We will therefore work with delivery partners to ensure public health considerations are fully integrated into new proposals.

1.7.2 Coordination of SPA, Open Spaces Strategy and development of friends groups to align all these activities and support Barnet's parks and open spaces service will enable them to take a more active role in promoting Health and Wellbeing.

2. REASONS FOR RECOMMENDATIONS

2.1 This approach is at the forefront of borough based development in London with regards to planning and public health and supports the approach initiated by the GLA and TfL to incorporate public health outcomes into planning to create healthy places.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 The alternative option is to do nothing. This has not been recommended as there is already a momentum to integrating public health into environment, growth and regeneration and housing.

4. POST DECISION IMPLEMENTATION

4.1 The programme will include the development of:

a) Detailed work plan and cost programme
b) The concept of 'Healthy Places'

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 The council identifies in the Corporate Plan an intention to implement its Community Participation Strategy and Action Plan to achieve its vision of greater community collaboration and resilience build stronger partnerships

with community groups co-ordinate and improve the support it gives to communities. The development of local space, regeneration and growth and the initiation of community based responses to health impact of these are central to this intention.

5.1.2 Also in the Corporate Plan public health has been identified as central to future regeneration schemes, with the borough's changes to the 'built environment' needing to be designed to help people keep fit and active.

5.1.3 The development of more innovative ways of maintaining its parks and green spaces, including through greater partnerships with community groups and focus on using parks to achieve wider public health priorities for the borough.

5.1.4 In addition the commitments to growth and business identified in Entrepreneurial Barnet[2] provide an excellent springboard from which to further develop the positive experience of those who work, live and study in Barnet through integrating responses to key public health issues and town centres.

5.1.5 Deprivation, heart disease and obesity are important factors for life long health. The JSNA identifies that Coronary Heart Disease is the number one cause of death amongst both men and women in Barnet. As male life expectancy continues to converge with that of women it is likely that the prevalence of some long term conditions will increase in men faster than in women.

5.1.6 Adult and child obesity is currently lower in Barnet than the average rates for London. However adult hospital admission rates due to obesity are higher suggesting a need for targeted interventions.

5.1.7 The areas with the highest rates of child obesity are Colindale, Burnt Oak and Underhill. These are also the areas with amongst the lowest levels of participation in sport, the lowest levels of park use, and the lowest rate of volunteering. Public Health involvement in pilots has been aligned with these locations.

5.1.8 The opportunities for physical activity and addressing obesity are closely tied to the built environment and access to open spaces, in addition to access to a variety of good quality food choices.

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

5.2.1 This paper aims to explore the potential for taking forward the planning and public health options and integrating these into existing programmes or seeking to identify resource implications for future consideration by the Board or relevant board. At this stage, there are no financial implications as a direct result of this report; it identifies a series of potential projects. The public health team have identified time in order to support the development of this

[2] Entrepreneurial Barnet - https://www.barnet.gov.uk/citizen-home/business/Entrepreneurial-Barnet.html

programme.

5.2.2 Authorisation at this stage is only to work up the details of each of the elements of the programme and identify where existing resources could be utilised. Further reports will be brought to the Board on progress and identifying additional funding or resources.

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. 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. This would be integral to Healthy Places where and if procurement takes place.

5.3.2 To date the Finchley Church End commission has been the first commission to explicitly suggest the potential for supporting the achievement of public health outcomes as part of the social value component of commissions.

5.4 **Legal and Constitutional References**

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

5.4.2 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.

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

5.4.4 To directly address health inequalities through its strategies and have 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.

5.4.5 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.

5.4.6 Specific responsibilities for:

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

5.5 **Risk Management**

5.5.1 There is a risk that the opportunities for public health presented by current strategy on regeneration and development will be missed unless appropriate resources can be brought on a scale proportionate to the opportunities.

5.6 **Equalities and Diversity**

5.6.1 The 2010 Equality Act sets out 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 CCGs are public bodies. The relevant protected characteristics are age; disability; gender reassignment; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

5.6.2 Each component of the healthy places will assess or be assessed against criteria of groups of protective characteristics, and/or those groups where a particular impact is expected to occur.

5.7 **Consultation and Engagement**

5.7.1 Consultation and engagement will be an important component and where this is not already built into existing work – and Health Impact Assessment for example, it will be added.

5.8 **Insight**

5.8.1 Public Health data has been used to inform the health needs described primarily from the JSNA[3]. Insight data present in Entrepreunial Barnet will have informed other information but no specific requests were made to Insight has this was not required.

6. BACKGROUND PAPERS

6.1 None.

[3] JSNA – www.barnet.gov.uk/JSNA

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AGENDA ITEM 11

	Health and Wellbeing Board **12 May 2016**
Title	**Barnet CCG Draft Annual Report and Accounts 2015-16**
Report of	CCG Accountable Officer
Wards	All
Status	Public
Key	No
Enclosures	Appendix 1: NHS Barnet CCG Draft Annual Report and Accounts 2015-16 (To follow)
Officer Contact Details	Roger Hammond, Chief Financial Officer roger.hammond@barnetccg.nhs.uk Fiona Barr, (Interim) Assistant Director of Governance & Corporate Affairs fiona.barr@barnetccg.nhs.uk Adrian Phelan, (Interim) Communications Manager adrian.phelan@barnetccg.nhs.uk

Summary

In accordance with the Health & Social Care Act 2012, in preparing their annual report each clinical commissioning group must evidence how it has consulted their Health and Wellbeing Board.

The Health and Wellbeing Board (HWBB) is asked to consider NHS Barnet CCG's Draft Annual Report and Accounts and comment on the extent to which the CCG has contributed to the delivery of the Joint Health and Wellbeing Strategy 2015-2020.

Members of the Health and Wellbeing Board are asked to note:

- They are receiving a draft version of the NHS Barnet CCG Annual Report and Accounts as of the 5 May 2016
- The NHS Barnet CCG Annual Report and Accounts are subject to review and approval at the NHS Barnet Audit Committee May meeting and Governing Body meeting on 26 May 2016.

Recommendations

1. **That the Board consider NHS Barnet CCG's Draft Annual Report and Accounts and comment on the extent to which the CCG has met the priorities set out in the Joint Health and Wellbeing Strategy 2015-2020.**

1. WHY THIS REPORT IS NEEDED

1.1 The CCG's Annual Report and Accounts are prepared in accordance with International Financial Reporting Standards (IFRS) and national guidance, primarily the NHS Manual for Accounts and CCG Annual Reporting Guidance, and to a national completion deadline date. The format of the annual report and accounts is nationally prescribed, although the CCG can add further disclosures / notes, where necessary.

2. REASONS FOR RECOMMENDATIONS

2.1 In accordance with the Health and Social Care Act 2012, in preparing their annual report each CCG must evidence how it has consulted with the relevant Health and Wellbeing Board (HWBB).

2.2 The HWBB is asked to consider NHS Barnet CCG's draft annual report and accounts.

3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 The process for review and approval of the CCG's Annual Report and Accounts includes provision for comment and review by the Health and Well Being Board in line with the statutory framework. To not submit the annual report to the HWBB would mean that the requirements set out by NHS England would not be met.

4. POST DECISION IMPLEMENTATION

4.1 Following internal review by the CCG and submission to NHS England on 26 May 2016, the 2015-16 Annual Report and Accounts will be published on the CCG website on 10 June and a copy will be circulated to the Health and Wellbeing Board in July for information.

5. IMPLICATIONS OF DECISION

5.1 Corporate Priorities and Performance

5.1.1 This report will help towards delivering the overarching aims of the Barnet's Joint Health and Well-Being Strategy 2015 to 2020.

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

5.2.1 N/A

5.3 Legal and Constitutional References

5.3.1 The Department of Health Group Manual for Accounts 2015-16 states that Clinical Commissioning Groups should ensure they include sufficient

information on the delivery of their statutory duties to comply with the requirements of Section 14Z15 Paragraph 2 of the National Health Service Act 2006 (as amended) and the CCG Assurance Framework.

The NHS Act 2006 (as amended) at Section 14Z15 states:

(1) In each financial year other than its first financial year, a clinical commissioning group must prepare a report (an "annual report") on how it has discharged its functions in the previous financial year.

(2) An annual report must, in particular-

(a) Explain how the clinical commissioning group has discharged its duties under sections 14R, 14T and 14Z, and

(b) Review the extent to which the group has contributed to the delivery of any joint health and wellbeing strategy to which it was required to have regard under section 116B(1)(b) of the Local Government and Public Involvement in Health Act 2007.

(6) A clinical commissioning group must-

(a) Publish its annual report, and

(b) Hold a meeting for the purpose of presenting the report to members of the public.

5.3.2 The CCG is required to confirm to NHS England the actions it has taken to consult with the HWB in preparing the Annual Report and Accounts and evidence how they have done this in the report.

5.3.3 The Terms of Reference of the Health and Well-Being Board are set out in the Council's Constitution – Responsibility for Functions (Appendix A) which sets out the following responsibilities:

- 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.
- 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.

5.4 **Risk Management**

5.4.1 N/A

5.5 **Equalities and Diversity**

5.6 Ensures that BCCG meets its Equalities Duties

5.7 **Consultation and Engagement**

5.7.1 Engagement has taken place with multiple internal stakeholders during the development of the Annual Report and Accounts, including the CCG Chair and Accountable Officer, the CCG's Internal Audit and External Audit providers**.**

5.7 **Insight**

5.7.1 N/A

6. BACKGROUND PAPERS

6.1 Department of Health Guidance, Group Manual for Accounts 2015-16: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/427554/FRAB_123_07_2015-16_MfA.pdf

AGENDA ITEM 13

	Health and Wellbeing Board **12 May 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 Wellbeing Board Appendix 2- Forward work programme of Council Committees and Barnet CCG's Board
Officer Contact Details	Zoë Garbett Commissioning Lead – Health and Wellbeing zoe.garbett@barnet.gov.uk 0208 359 3478

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 and 2016/17 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 eleven month period until the end of March 2017.

1.3 The forward work programme attached to this report at Appendix 1 supersedes the previous work programme presented to the Board on 10 March 2016 and suggests a refreshed schedule of reports and items for the following eleven 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 Agendas are 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 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 and 2016/17 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 None in the context of this report.

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 particularly 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

May 2016 – March 2017

Contact: Zoë Garbett
Commissioning Lead – Health and Wellbeing (LBB)
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Subject	Decision requested	Report Of	Contributing Officer(s)	Key decision*
12 May				
DISCUSSION				
Primary Care Strategy	**The Board is asked to note the Primary Care Strategy**	CCG Accountable Officer	**Interim Programme Manager**	No
Childhood Immunisation	**The Board is asked to consider the progress made by NHS England to improve uptake of childhood immunisations.**	NHS England – Immunisations manager	**Consultant in Public Health**	No
Better Care Fund 2016/17	**The Board is asked to endorse the final BCF plan for 2016/17**	CCG Accountable Officer Commissioning Director – Adults and Health	**Strategic Lead Adults and Health** **Acting Head of Service for Joint Commissioning** **Director of Strategic Development**	No
NOTE				
Opportunities to align health outcomes and planning	**The Board is asked to comment on 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
CCG Annual Report and Accounts	**The Board is asked to comment and note the report.**	CCG Accountable Officer	**TBC**	
JHWB Strategy Implementation Plan	**The Board is asked 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
Minutes of the Health and Wellbeing Board Working Groups:	**The Board is asked to approve the minutes of the Joint Commissioning Executive**	Commissioning Director – Adults and Health CCG Accountable 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*
• Joint Commissioning Executive Group	**Group and Health and Social Care Integration Programme Board**			
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
21 July 2016				
DISCUSSION				
Family Friendly Barnet	**The Board is asked to discuss 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
Reducing 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 Accountable Officer	**Director of Integrated Commissioning** **Joint Commissioning Manager**	No
NOTE				
Better Care Fund plan 16/17 plan and update on delivery	**The Board is asked to note and comment on Better Care Fund Plans for 2016/17.**	Commissioning Director Adults and Health CCG Accountable Officer	**Director of Strategic Development** **Strategic Lead Adults Health** **Acting Head of Service for Joint Commissioning**	No
JHWB Strategy Implementation Plan	**The Board is asked 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**	CCG Accountable Officer Commissioning Director –	**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*
	and contribution to the developments across North Central London (NCL).	Adults and Health		
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 Joint Commissioning Executive Group and Health and Social Care Integration Programme Board**	Commissioning Director – Adults and Health CCG Accountable 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
15 September 2016				
DISCUSSION				
Primary Care Strategy Implementation plan including an update on primary care co-commissioning	**The Board is asked to review and comment on the CCG progress to implement the Primary Care Strategy.**	CCG Accountable Officer	**Director of Primary Care**	No
Mental Health services – CAMHS, Reimagining Mental Health and Mental Health Social Work including IAPT review led by Healthwatch	**The Board is asked to consider and discuss the progress made to improve mental health and wellbeing for all.**	Commissioning Director – Adults and Health Commissioning Director – Children and Young People CCG Accountable Officer	**Joint Commissioning Manager** **Head of Healthwatch**	No
Screening update including a Healthwatch consultation report	**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** **Head of Healthwatch**	No

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Subject	Decision requested	Report Of	Contributing Officer(s)	Key decision*
Adults and Communities Engagement Summit and Work Programme	**The Board is asked to review and comment on the work programme of the Adults and Communities Engagement Structures.**	Adults and Communities Director	**Engagement Lead**	No
NOTE				
JHWB Strategy Implementation Plan	**The Board is asked 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 including progress in delivering the local Health Checks programme	**The Board is asked to comment on the progress Public Health made in 2015/16**	Director of Public Health	**Consultant in Public Health**	No
Assuring Transformation	**The Board is asked to not the contents of the paper, the progress made with regards to the Winterbourne View Concordat and the current position.**	Commissioning Director Adults and Health CCG Accountable Officer	**Joint Commissioning Manager**	No
Update on Substance Misuse services for Adults 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
Section 75s	**The Board is asked to note and comment on the annual report on the section 75s.**	Commissioning Director – Adults and Health Commissioning Director – Children and Young People CCG Accountable Officer	**Strategic Lead – Adults Wellbeing**	No
Reports of the Safeguarding Adults Board and Safeguarding Childrens Board	**The Board is asked to note and comment on the work of the borough's safeguarding Boards.**	Independent Chair of Safeguarding Adults	**Policy and Program Children Board Manager**	
Progress report: NCL working	**The Board is asked to**	CCG Accountable Officer	**TBC**	No

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Subject	Decision requested	Report Of	Contributing Officer(s)	Key decision*
	comment on Barnet's roles and contribution to the developments across North Central London (NCL).	Commissioning Director – Adults and Health		
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 Joint Commissioning Executive Group and Health and Social Care Integration Programme Board**	Commissioning Director – Adults and Health CCG Accountable 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
10 November 2016				
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
Update from the Tackling Shisha Task and Finish Group	**The Board is asked to comment on and direct the activity of the Task and Finish Group**	Director of Public Health	**Consultant in Public Health** **Client Commissioning Lead for Enforcement**	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 Accountable Officer	**Commissioning Lead – Health and Wellbeing**	Yes

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Subject	Decision requested	Report Of	Contributing Officer(s)	Key decision*
NOTE				
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
Procurement of sexual health services	**The Board is asked to note the progress of the procurement of sexual health services**	Director of Public Health	**Head of Public Health Commissioning**	No
Section 75 agreements: annual report	**The Board is asked to review the status, activity and finances associated with all Section 75 agreements.**	Commissioning Director – Adults and Health Commissioning Director – Children and Young People CCG Accountable Officer	**Strategic Lead Adults Health**	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 Joint Commissioning Executive Group and Health and Social Care Integration Programme Board**	Commissioning Director – Adults and Health CCG Accountable 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
19 January 2017				
DISCUSSION				
Draft CCG Commissioning Intentions 2017/19	**The Board is asked to review and comment on the draft CCG Commissioning Intentions.**	CCG Accountable Officer	**TBC**	Yes
NOTE				
Joint Health and Wellbeing	**The Board is asked to**	Commissioning Director –	**Commissioning Lead –**	Yes

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Subject	Decision requested	Report Of	Contributing Officer(s)	Key decision*
Strategy Implementation plan – performance report	**consider the progress made to deliver the Joint Health and Wellbeing Strategy.**	Adults and Health Commissioning Director – Children and Young People Director of Public Health CCG Accountable Officer	**Health and Wellbeing**	
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 Joint Commissioning Executive Group and Health and Social Care Integration Programme Board**	Commissioning Director – Adults and Health CCG Accountable 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
9 March 2017				
DISCUSSION				
CCG Commissioning Intentions 2017/19	**The Board is asked to review and comment on the CCG Commissioning Intentions.**	CCG Accountable Officer		Yes
NOTE				
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 Accountable Officer	**Commissioning Lead – Health and Wellbeing**	Yes
Minutes of the Health and Wellbeing Board Working Groups (where available): • Joint Commissioning Executive Group	**The Board is asked to approve the minutes of the Joint Commissioning Executive Group and Health and Social Care Integration Programme**	Commissioning Director – Adults and Health CCG Accountable 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*
• Health and Social Care Integration Programme Board	**Board**			
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
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
Devolution – estates	**The Board is asked to comment on Barnet's roles and contribution to the developments across North**	Commissioning Director – Adults and Health CCG Accountable Officer	**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*
	Central London (NCL).			

***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 (April 2016 - January 2017)

Calendar month	Strategic Board	Agenda Item	Nature of item (if known)
May			
11 May 2016	Housing Committee	Review of the " One Offer Only" policy in the Housing Association Scheme	To compulsorily acquire underused or ineffectively used property for residential purposes where there is a compelling case in the public interest for its acquisition to meet general housing need in the area
		Review of the Landlords Incentive Scheme	
16 May 2016	Health Overview and Scrutiny Committee	NHS Trust Quality Accounts	Committee to consider and comment upon the Quailty Accounts of NHS Trusts for the year 2015/16.
		Finchley Memorial Hospital - Update Report	At their meeting in October 2015, the Committee receive a joint report from Barnet Clinical Commissioning Group (CCG) and NHS England which provided the Committee with an update on plans to improve utilisation of the Finchley Memorial Hospital site. The committee have requested to receive another update at their May meeting.
		North West London, Barnet & Brent Wheelchairs Service Redesign	At their meeting in October 2015, the Committee received a report on the North West London, Barnet & Brent Wheelchairs Service Redesign. The Committee have requested to receive a further report on the progress of the project at their meeting in May 2016
18 May 2016	Children, Education, Libraries & Safeguarding Committee	Childrens Mental Health and Eating Disorders	Following the consideration of a Member's Item in the name of Councillor Trevethan, the Committee have requested to receive a report on children's mental health and eating disorders.
		Strategic Outline Case - Alternative Delivery Model for Family Services	Relates to straetgic outline case for the alternative delivery model for family services
		Report from Barnet Youth Assembly	Committee to receive report from Barnet Youth Assembly
		Education White Paper and LBB Response	Committee to receive a report on the Education White Paper and LBBs response
		Barnet Youth Parliament Members	Report relates to incoming and outgoing Youth Parliament members
16 June	Adults and Safeguarding Committee	Impact of the Care Act	Committee to receive a report on the impact of the Care Act
		Review of YCB Contract	Committee to receive a report on the review of the YCB contract
		Barnet Multi-Agency Safeguarding Adults Board Business Plan 2016-18	That the Committee note the contents of the Draft Safeguarding Adults Board Business Plan 2016-18.
13 July	Adults and Safeguarding Committee	Statutory Adult Social Care Annual Complaints Report 2015/16	1. Note the information in the report; 2. Approve draft for final publishing
		Business Planning	
		Adults and Safeguarding Performance Report including the Adult Social Care Local Account	1. Committee notes progress made during 2015/16 and agree to use the information provided to help in future decision making; 2. Committee notes information contained in Adult Social Care Local Account and approves the version for publishing as final on Council website
19 September	Adults and Safeguarding Committee	Revised Business Case on Single Adult Social Care Alternative Delivery Vehicle	Committee to receive a report on Adult Social Care Alternative Delivery Model project Outline Business Case.
		Business Planning	
		Barnet Multi-Agency Safeguarding Adults Board Annual Report 2014/15	That the Committee note the information contained within the Draft Barnet Multi-Agency Safeguarding Adults Board Annual Report 2015-16 which is due to be approved by the Multi- Agency Safeguarding Adults Board on 21st July 2016 and will be published after this date.
10 November	Adults and Safeguarding Committee	Annual Fees and Charges	Committee to receive a report on annual fees and charges
		Business Planning	
23 January 2017	Adults and Safeguarding Committee	Adults and Safeguarding Performance Report including the Adult Social Care Local Account	1. Committee notes progress made during 2015/16 and agree to use the information provided to help in future decision making; 2. Committee notes information contained in Adult Social Care Local Account and approves the version for publishing as final on Council website
Unallocated item			
	Health Overview and Scrutiny Committee	Dehydration in patients admitted to hospital from care homes	Committee to receive a report on the admission of patients with dehydration to hospital
	Adults and Safeguarding Committee	Commissioning Strategy for Supported Living	Committee to receive a commissioning strategy for supported living

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