London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Agenda

Monday 8 September 2014
4pm
Courtyard Room - Hammersmith Town Hall

MEMBERSHIP

Councillor Vivienne Lukey, Cabinet Member for Health and Adult Social Care (Chair)
Dr Tim Spicer, Chair of H&F CCG)
Councillor Sue Macmillan, Cabinet Member for Children and Education
Liz Bruce, Tri-borough Executive Director of Adult Social Care
Andrew Christie, Tri-borough Director of Children's Services
Philippa Jones, Managing Director, H&F CCG
Dr Susan McGoldrick, Vice-Chair, H&F CCG
Trish Pashley, Local Healthwatch representative
Meradin Peachey, Tri-borough Director of Public Health

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Date Issued: 03 September 2014

Health & Wellbeing Board
Agenda

8 September 2014

London Borough of Hammersmith & Fulham **HEALTH & WELLBEING BOARD** **08 September 2014**	
TITLE OF REPORT **BETTER CARE FUND RESUBMISSION SEPTEMBER 2014**	
Report of the Cabinet Member for Adult Social Care and Health Councillor Vivienne Lukey	
Open Report	
Classification - For Decision **Key Decision: Yes**	
Wards Affected: All	
Accountable Executive Director: Liz Bruce, Executive Director Adult Social Care	
Report Author: Cath Attlee, Whole Systems Lead	**Contact Details:** Tel: 07903 956 961 E-mail: cattlee@westminster.gov.uk

1. EXECUTIVE SUMMARY

1.1. This paper reports on the requirement on the Health and Wellbeing Board to resubmit the Better Care Fund (BCF) Plan which was agreed on 24th March and submitted to the Department of Health (DH) in April 2014.

1.2. The plan is currently being revised but is not yet ready for presentation to the Board. However it has to be submitted on 19th September. The Health and Wellbeing Board is therefore asked to delegate authority to the Board Chair and Vice Chair to sign off the final document for submission on that date.

1.3. The report explains that the revised plan will contain some additional material and revision following further guidance and a revised template from the DH and the Department of Communities and Local Government (DCLG).

1.4. The key changes relate to the Pay for Performance and Risk Sharing arrangements which mitigate the risk of local areas failing to achieve the key target of reduced emergency admissions, but reduce the investment in integrated care, and potentially increase the risk to social care.

2. RECOMMENDATION

2.1. The Health and Wellbeing Board is recommended to note the requirement for resubmission and to agree to delegate to the Chair and Vice Chair final approval of the revised BCF Plan for submission to NHS England by 19th September.

3. REASONS FOR DECISION

3.1. The Health and Wellbeing Board approved the BCF Plan 2014-16 at the meeting held on 24th March 2014 and the Plan was subsequently submitted to NHS England on 4th April.

3.2. However, subsequently the DH and DCLG have issued revised plan requirements and the Local Authority and Clinical Commissioning Group are required to resubmit the BCF Plan.

3.3. Work is still being completed on the financial assumptions and the revised plan is therefore not ready for presentation to the Health and Wellbeing Board at this time.

3.4. This report therefore summarises the key revisions to the plan for the Health and Wellbeing Board to consider and asks the Board to delegate final approval to the Chair and Vice Chair of the updated plan templates for submission on 19th September 2014.

4. INTRODUCTION AND BACKGROUND

4.1. The BCF is “a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities”. A national allocation of £3.8bn was announced in the summer of 2013 for this purpose.

4.2. The BCF does not come into full effect until 2015/16, but an additional £200m was transferred to local government from the NHS in 2014/15 (on top of the £900m already planned) and it is expected that Clinical Commissioning Groups (CCGs) and local authorities will use these funds this year to transform the system. Consequently, a two year plan for the period 2014/16 had to be put in place by March 2014.

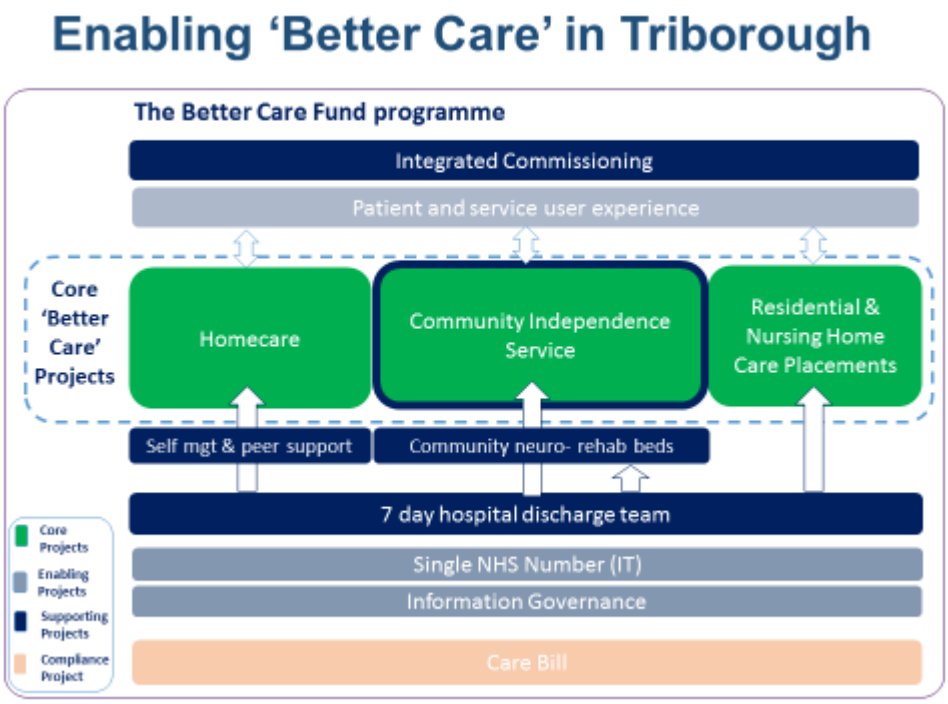
4.3. The BCF will support the aim of providing people with the right care, in the right place, at the right time, including expansion of care in community settings. This will build on CCG Out of Hospital strategies and local authority plans expressed locally through the Community Budget and Pioneer programmes.

4.4. The development of an integrated BCF Plan is a requirement of the DH and the DCLG. Funding allocations to the Local Authority and to the local NHS in 2014-16 are dependent on agreement between the parties on the BCF Plan. In addition, the programme of work is consistent with the stated vision and objectives of the partners within the Health and Wellbeing Board, and is a mechanism for delivering the outcomes and efficiencies required.

4.5. The Better Care Fund Plan was developed within the existing Whole Systems partnership between the local authority and the NHS, with service providers and with service user and carer representatives including Healthwatch, and reflects the shared aspirations for integrated care.

5. REQUIREMENT FOR RESUBMISSION

5.1. The Health and Wellbeing Board approved the BCF Plan 2014-16 at the meeting held on 24th March 2014 and the Plan was subsequently submitted to NHS England on 4th April. A summary of the BCF schemes is captured in the diagram below.



5.2. The Tri-borough BCF Plan was considered of good quality by NHS England (NHSE), the Local Government Association (LGA), DH and DCLG, and the three authorities were among a small number approached in July to be "fast-track" BCF authorities, providing a further example to other authorities of how an acceptable BCF Plan could be developed (although this offer was declined). The plan was rated 2nd nationally following more detailed work on finance and metrics and external assurance.

5.3. Other parts of the country, however, were not able to submit satisfactory plans. In addition concerns were expressed, particularly by the hospital sector, about the arrangements for local risk sharing and pay for performance. A key ambition of the BCF is reducing pressures arising from unplanned admissions to hospital. There was a lack of confidence in the ability of CCGs and local authorities to deliver the necessary changes to achieve this ambition within the timescale and, consequently, a fear that funding would be transferred from the NHS to local authorities but that acute activity would continue unabated.

5.4. Consequently, in July 2014, Health and Wellbeing Board Chairs received letters from the DH and the DCLG announcing some changes to the BCF Programme. The changes related to the Pay for Performance and Risk Sharing arrangements which commence in 2015-16.

5.5. Each area has been asked to demonstrate how the BCF Plan will reduce emergency admissions, as a clear indicator of the effectiveness of local health and care services in working better together to support people's health and independence in the community.

5.6. A proportion of the performance allocation (the local share of the national £1bn performance element of the £3.8bn fund) will be payable for delivery of a locally set target for reducing emergency admissions (they suggested at least 3.5% reduction). The balance of the allocation will be available upfront to spend on out of hospital NHS commissioned services, as agreed by the Health and Wellbeing Board. This provides greater assurance to the NHS and mitigates the risk of unplanned acute activity. If the target for reducing admissions is not met, a proportion of the £1bn funding will remain with the NHS and not transfer to the BCF for joint use.

5.7. The reduction in unplanned admissions indicator will be the only indicator underpinning the pay for performance element of the BCF. Hospital providers are being asked to confirm agreement with the proposed reduction in non-elective activity.

6. THE REVISED BETTER CARE FUND PLAN

6.1. On 25th July NHS England and the Local Government Association sent Health and Wellbeing Board Chairs revised BCF guidance and planning and templates for completion and submission by 19th September 2014. A revised BCF Plan is being prepared. The key changes from the BCF Plan previously approved by the Health and Wellbeing Board are as follows:

6.2. Target reduction of around 3.5% in total emergency admissions (replaces the previous metric of approximately 5 % reduction in avoidable emergency admissions). Funding linked to achievement of this target will be released by the CCG into the pooled budget on a quarterly basis, depending on performance, starting in May 2015, based on Q4 performance in 2014-15.

6.3. The remainder of the £1bn national fund (the performance element of the £3.8bn) will be released to the CCG upfront in Quarter 1 in 2015-16.

6.4. If the locally set target for reduction in emergency admissions is achieved, all of the funding linked to performance will be released to the Health and Wellbeing Board to spend on BCF activities. Achievement will be measured against the total figure for the whole area, not just against those activities within the BCF Plan.

6.5. It should be noted that if the target is not achieved, the remaining performance money will not leave the local area, it will remain with the CCG to compensate for unplanned acute activity or spend on NHS commissioned services, in consultation with partners on the Health and Wellbeing Board.

6.6. The system is designed to mitigate the financial risk to the CCG, whilst at the same time providing flexibility to deliver schemes that reduce acute activity. The revised arrangements need to be taken into account in both CCG and Local Authority planning for 2015-16.

6.7. Local authorities nationally have expressed concerns at the changes which step back from the core purpose of promoting locally led integrated care and reduce the resources available locally to protect social care and prevention initiatives.

6.8. However, within the Tri-borough area there is confidence that the target level of reduction in emergency admissions can be achieved so that the maximum level of allocation will be transferred to the BCF pooled budget for integrated services.

6.9. The NHS commissioned services can include NHS spend on those services currently commissioned by the local authority on behalf of the NHS or commissioned jointly through s75 agreements, which form a significant element in the Tri-borough BCF.

6.10. There is, however, a risk to Adult Social Care from these changes and the position will need to be monitored closely through the year to assess progress against target and the impact of any shortfall in the pooled budget on integrated services. A reduction in emergency admissions is likely to lead to an increased use of social care which needs to be funded.

6.11. The revised plan will provide additional material in relation to the following areas:

6.12. **The case for change** – analysis and risk stratified understanding of where care can be improved by integration, which has informed the key BCF workstreams of community independence services including reablement and 7 day working.

6.13. **A plan of action** – a clear evidence based description of the delivery chain which will support a reduction of emergency admissions, developed with all local stakeholders and aligned with CCG, local authority, provider and whole system strategies.

6.14. **Strong governance** – confirmation of local management and accountability arrangements and description of tracking arrangements to monitor the impact of interventions, take action to address slippage, and robust contingency plans and risk sharing arrangements across providers and commissioners locally.

6.15. **Protection of social care** – this reflects existing funding transferred via s256 from NHS England for current levels of work. The level of protection of social care identified for LBHF in 2014-15 is £3.287m with £85k identified for implementation of the Care Act; in 2015-16 £3.287m with £454k for the Care Act.

6.16. **Alignment with acute sector and wider planning** – evidence of alignment with the NHS two-year operational plans, five year strategic plans, and plans for primary care as well as the local authority. Evidence is provided that providers are engaged in the BCF programme and have understood the impact of the plan on their services.

6.17. In addition the revised BCF Plan will set out in more detail the amount of funding going into carer support and the nature of that support.

7. CONSULTATION

7.1. The revised BCF template seeks evidence of provider engagement in the development of the BCF programme and understanding of the impact which BCF changes would make to activity. Discussions have been held with major providers, acute and community, during June-September to increase their awareness of the detailed BCF programme. The strategic plans already agreed with local hospitals include a significant shift of work into the community and a reduction in emergency admissions.

7.2. Shaping a Healthier Future (SaHF) and the Out of Hospital Strategies set out the plan to reconfigure hospital services to focus on the needs of patients. These plans have been developed and consulted upon, with local authority, acute, community and mental health services and other local stakeholders fully engaged. The plans contained in the BCF are consistent with SaHF plans to shift work to community / primary care settings.

7.3. Acute Trusts are aware of the BCF and its intention to strengthen and harmonise the approach to community care and confidence in out of hospital provision, particularly through links to the Urgent Care Boards. The CCGs currently have risk sharing arrangements in place with local acute providers relating to activity reductions, and these would be maintained. Arrangements for further engagement at Chief Executive level prior to plan re-submission are in progress. There will also be further engagement with all providers over the coming months to involve them in co-design of in depth solutions facing the health and social care economy in Tri-borough.

7.4. The BCF draws on the Joint Health and Wellbeing Strategy and Joint Strategic Needs Assessments across all boroughs, informed by patient and service user feedback. The approach to developing the BCF is characterised by co-design and co-delivery, supported by extensive stakeholder engagement, including with clinicians, other CCGs and local authorities, provider organisations and national bodies.

8. EQUALITY IMPLICATIONS

8.1. Each workstream within the BCF programme will be preparing an Equality Impact Assessment and as the programme develops a programme-wide EIA will be prepared. The programme contributes to the implementation of integrated health and care services across the tri-borough area and will improve services for the most vulnerable adults in the community.

9. LEGAL IMPLICATIONS

9.1. The DH and the DCLG have established a multi-year fund, confirmed in the Autumn Statement, as an incentive for councils and local NHS organisations to jointly plan and deliver services, so that integrated care becomes the norm by 2018. A fund will be allocated to local areas in 2015/16 to be put into pooled budgets under Section 75 joint governance arrangements between CCGs and Councils. A condition of accessing the money in the Fund is that CCGs and councils must jointly agree plans for how the money will be spent, and these plans must meet certain requirements.

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

9.3. Implications verified by: Andre Jaskowiak, Senior Solicitor, Bi-Borough Contract Law Team. Tel: 020 7361 2756

10. FINANCIAL AND RESOURCES IMPLICATIONS

10.1. A summary of the financial implications included in the original BCF Plan is in the table below.

10.2. In 2015-16 the minimum value required of the BCF Pooled Budget across Tri-borough is £47.836m and the Tri-borough authorities are proposing around £210m, which mostly reflects existing pooled budgets or jointly commissioned services. Of this, around £47m will come from the London Borough of Hammersmith and Fulham) and around £32m from H&FCCG. **These figures will be refined prior to resubmission**.

10.3. The BCF Plan estimated that the programme will contribute to the delivery of around £15m in savings across Tri-borough partners in 2015/16, if targets are fully met, as shown in the table below**. This figure will be refined prior to resubmission.**

10.4. We have constructed and are finalising a detailed financial and activity model which demonstrates the linkages and flows of costs and benefits across health and social care as a result of the new proposed ICR/CIS. The model is based on current data and agreed assumptions of the Technical Working group. At the core of this is the new Integrated Crisis Response / Community independence Service and the linkages between that service, homecare and residential and nursing home placements.

10.5. The model will enable the local authority and CCGs to take an informed view over the different pressures and costs of redesigning core components of out of hospital care and the subsequent shift in activity and flows of people in order to come to a mutually beneficial agreement over the impacts and associated reimbursements. . **This is required to provide reassurance to the local authorities that social care will not be negatively impacted by the BCF.**

10.6. The revised BCF Plan will include figures based on latest estimates of costs and savings. These are continually being refined and it is anticipated that revised proposals will be submitted periodically through 2014-15 as the detailed modelling of the integration work is undertaken.

Tri-borough Better Care Fund Financial Summary (July 2014 figures)

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15 '000	Minimum contribution (15/16) '000	Actual contribution (15/16) '000	Anticipated Benefit
Westminster City Council	Y	*28,765*	*1,379*	*26,252*	4,896
Royal Borough of Kensington and Chelsea	Y	*22,946*	*874*	*22,004*	
London Borough of Hammersmith and Fulham	Y	*49,720*	*1,052*	*47,781*	
Central London CCG	N	*26,171*	*13,553*	*42,768*	3,366
West London CCG	N	*15,811*	*17,830*	*39,746*	3,572
Hammersmith and Fulham CCG	N	*12,630*	*13,148*	*31,923*	3,873
BCF Total		**156,043**	**47,836**	**210,474**	**15,707**

Actual savings will be tracked by borough or, where at tri-borough level, will be pro-rated by population. Our intention is for the local authorities to hold the pooled budget, but the pooling agreement will recognise that each scheme will be led by the most appropriate commissioner, either LA or CCG.

10.7. Implications verified/completed by: Rachel Wigley, Director of Finance, Tri-borough Adult Social Care.

11. RISK MANAGEMENT

11.1. The BCF Plan includes a section on risks and mitigating actions.

11.2. Implications verified/completed by: Mike Rogers, Risk Lead Adult Social Care [confirm]

12. PROCUREMENT AND IT STRATEGY IMPLICATIONS

12.1. There are no specific procurement and IT strategy implications relating to the BCF Plan except that one of the national conditions

12.2. Procurement and IT Strategy implications relating to individual initiatives within the Better Care Fund Plan will be brought separately to the Cabinet and, where appropriate, to the Health and Wellbeing Board, for consideration.

12.3. Implications verified/completed by: (name, title and telephone of Procurement Officer)

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	Better Care Fund Plan March 2014		

	London Borough of Hammersmith & Fulham **HEALTH & WELLBEING BOARD** **08 September 2014**
Measles Mumps and Rubella Vaccination in Hammersmith & Fulham	
Report of NHS England	
Open Report	
Classification - For Discussion **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: N/A	
Report Author: Gemma Harris, Acting Patch Lead NWL NHS England (London Region)	**Contact Details:** E-mail: gemmaharris1@nhs.net

1. EXECUTIVE SUMMARY

1.1. The paper provides a background to the childhood immunisations programmes, with a focus on MMR; outlines roles and responsibilities of organisations in relation to the section 7a immunisations programmes; provides the local context and data for H&F; sets out NHS England's work streams and what partner organisations should be doing in order to support an improvement in uptake of immunisations programmes.

2. RECOMMENDATIONS

2.1 The board is asked to note the partnership working between the three organisations to date. In addition, the board is asked to support the continuation of an evidenced based approach to joint working in the future to ensure sustainable improvements in MMR (and the remaining childhood vaccinations) uptake can be realised for H&F.

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	n/a		

Measles Mumps and Rubella Vaccination in Hammersmith & Fulham

1.0 SUMMARY

This paper was requested by the health and wellbeing board to provide an update on the position of measles mumps and rubella vaccination (MMR) in Hammersmith and Fulham (H&F). The paper provides a background to the childhood immunisations programmes, with a focus on MMR; outlines roles and responsibilities of organisations in relation to the section 7a immunisations programmes; provides the local context and data for H&F; sets out NHS England's work streams and what partner organisations should be doing in order to support an improvement in uptake of immunisations programmes. Whilst this paper remains focussed on MMR it should be noted that the NHS England approach and commitment required from other organisations remains relevant to the wider childhood immunisations programmes.

Risks and mitigations to immunisations:

1. COMMISSIONING FOR H&F POPULATION	
RISKS	**MITIGATION**
Lack of information flow across the newly formed organisations	A variety of meetings (with robust governance structures) have been organised to ensure that the different sectors of the health economy are engaged in the immunisation programme. These meetings include the NWL Quality Board Immunisation meeting and the London Immunisation Improvement Board. At these meetings immunisation assurance is provided to Directors of Public Health. There is also the local Tri –borough (Westminster and K&C and H&F) meeting which take place between NHS England, Tri-borough LA and the local CCGs.
2. UPTAKE & COVERAGE	
RISKS	**MITIGATION**
Immunisation uptake rates remain static	**Trajectory setting:** NHS England, the Local Authority and local CCG are working together to ensure that reasoned and upward trajectories are set for the COVER indicators.
Increasing unregistered cohort	There has been a steady increase in the unregistered cohort (community data) which has negatively impacted

	on COVER uptake. NHS England & the local CCG are working together to understand the root causes for this increase. An action plan will be developed that will include what primary care and the provider need to undertake.
3. DATA / DATA FLOWS	
RISKS	**MITIGATION**
Community Provider Clinical System change	The community provider is changing from Rio to System One. Though this would ensure there is greater compatibility between the GP practices & the community provider- there is still potential for data error whilst the changeover is taking place. Currently implementation of this is on hold until assurance has been provided to NHS England that information data flows will not be adversely affected.
Interrupted data flows due to GP Clinical system change	Practices in H&F have now migrated to System One. Work is underway to ensure that the recording of immunisations on the new clinical system is standard across all practices.

2.0 INTRODUCTION

2.1 Immunisation is described by the World Health Organisation as one of the most effective things we can do to protect individuals and the community from serious diseases.

Immunisation against infectious disease (known as 'The Green Book'), a UK document, issued by Public Health England, provides guidance and the main evidence base for all immunisation programmes (link in appendix 1).
The aim of vaccination programmes is to provide immunity for individuals and the population from a disease, interrupt the spread of the diseases and reduce the associated morbidity and mortality.

As uptake of an immunisation increases there are fewer individuals left susceptible and once a critical proportion is reached the reduction in onward transmission is greatly reduced as is the potential for outbreaks. This is referred to as community resilience against vaccine preventable diseases. The proportion of the population to be immunised to reach community resilience varies by disease but in the childhood vaccinations schedule usually sits around 95%.

The aim of vaccination programmes in England is to achieve community resilience. The effectiveness of our national childhood routine immunisation programme is carefully monitored by the Department of Health (DH) through COVER (Cover of Vaccination Evaluated Rapidly) information e.g. the percentage of the population who has received vaccination by age 1, age 2 and age 5 within specific timeframes (i.e. quarter and annual). COVER also includes the proportion of 12-13 year old girls who receive the 3 doses of HPV by year.

2.2 MMR Vaccine

Measles, mumps and rubella vaccine is a combined live attenuated vaccine that protects against measles, mumps and rubella, all highly infectious viral infections. MMR vaccine was introduced as a single dose schedule in 1988 and a two-dose schedule in 1996 with the aim of eliminating measles and rubella (and congenital rubella) from the UK population. Between 5 and 10% of children are not fully immune after the first dose. The second dose provides a further opportunity to protect children who did not respond to the first dose of MMR, with less than 1% of children remaining susceptible after receiving the two recommended dose. Further information about the diseases is provided in in Appendix 2.

3.0 ROLES AND RESPONSIBILITIES IN THE NEW SYSTEM

Prior to transition and the new structure of the health system, immunisations were commissioned by Primary Care Trusts (PCTs) and delivered by local providers to local populations. PCTs often had a role in their structure known as an immunisation coordinator. This role usually had oversight of the locally commissioned vaccinations services. In addition, these post holders were often public health professionals whose skill set enabled them to understand the factors affecting uptake in the local population, and ensure service provision or projects were commissioned to improve uptake.

As of the 1st April 2013 and the introduction of the new health service landscape, roles and responsibilities related to immunisations programmes changed. This has not only changed the way services are commissioned and monitored but has also created various new opportunities. These opportunities will be discussed in further detail later in the report.

The service specification document “NHS public health functions agreement 2014-15: Public health functions to be exercised by NHS England” (see Appendix 3 for link) is the service specification for the public health programmes that forms part of the agreement made under the section 7a of the National Health Service Act 2008. It sets out requirements for evidence underpinning a service to be commissioned by NHS England. The document describes the shared vision between Department of Health (DH), NHS England and Public Health England (PHE) of working in partnership to achieve the benefits of this agreement for the people of England. In line with the Government’s strategies for the NHS and the public health system, the aim is to:

- improve public health outcomes and reduce health inequalities, and
- contribute to a more sustainable public health, health and care system

The roles and responsibilities of the different organisations associated with the section 7a immunisations programs are summarised in table 1 below.

Table 1: Roles & Responsibilities of organisations in the New Health Economy

Organisation	**Responsibility in relation immunisations programmes**
Department of Health (DH)	DH is responsible for national strategic oversight, policy and finance for the national screening and immunisation programmes which includes overall system stewardship, based in part on information provided by PHE, and for holding NHS England and PHE to account through their respective framework agreements, the Mandate and the Section 7A agreement.
Public Health England (PHE)	An executive agency of the DH. PHE is responsible for supporting both DH and NHS England, with system leadership, national planning and implementation of immunisation programmes (including the procurement of vaccines and immunoglobulins) and specialist advice and information to ensure consistency in efficacy and safety across the country. PHE undertakes the purchase, storage and distribution of vaccines at a national level. It holds the coverage and surveillance data and has the public health expertise for analysing the coverage of, and other aspects of, immunisation services. PHE will also support the Directors of Public Health in local authorities in their role as leaders of health locally provides clinical advice and works with NHS England at national and regional levels in outbreak management.
NHS England (London region)	NHS England is responsible for commissioning the local provision of immunisation services and the implementation of new programmes though general practice and all other providers. It is accountable to the Secretary of State for Health for delivery of those services. Other bodies in the new comprehensive health system also have key roles to play and are vital to ensuring strong working relationships.
Directors of Public Health (DsPH) - Local Authority	Local government has responsibility for taking steps to improve the public's health, supported by the independent expertise of PHE. DsPH based in local authorities play a key role in providing independent scrutiny and challenge and will publish reports on the health of the population in their areas, which could include information on local immunisation services and views on how immunisation services might be improved.

	In addition, provide local leadership and liaise with local councillors and children & young people's services to ensure support to improve uptake. DsPH and their local authorities will support community and schools engagement with the programme, providing advice to the CCGs and encouraging primary care participation.
Clinical commissioning groups (CCGs)	Clinical Commissioning Groups are groups of General Practices that work together to plan and design local health services in England. Clinical Commissioning Groups work with patients and health and social care partners (e.g. local hospitals, local authorities, local community groups etc.) to commission services that meet local needs. CCGs have a duty to put and keep in place arrangements for the purpose of monitoring and improving the quality of health care provided by and for that body.
Commissioning Support Units (CSUs)	CSUs provide a variety of support functions to CCGs. NWL CSU provide a range of high quality IT services to general practice that cost effectively address their core needs for clinical and management IT systems.

Within NHS England, the commissioning of immunisations programmes sits in the Public Health, Health in the Justice System and Military Health team. The structure of the team incorporates roles that have a pan London remit and those located within patch teams that have a locally facing remit. Within the patch teams there are commissioning managers who are aligned to specific boroughs.

4.0 THE LOCAL PICTURE IN HAMMERSMITH AND FULHAM

4.1 Local population profile

Whilst some 20% of the overall London population are children aged 0-15 years (the key ages for immunisation), the situation in Tri-borough is different. In Hammersmith & Fulham, the proportion is 16%. Of greater significance is the population churn, that is the number of people moving in and out of the borough each year: whilst it is some 10% in London overall, it is as high as 30% in the Tri-borough. And whilst all London boroughs have a mixture of people living in deprived areas and others in affluent areas (which influences attitudes to childhood immunisation), Hammersmith and Fulham, has pockets of very affluent areas. A further influence on attitudes to immunisation is ethnicity and thus culture, values and beliefs. Again, Hammersmith and Fulham is different, with one quarter of the population being born abroad, with between a quarter and a third of the population not having English as a first language; this also influences the impact of promotion of, and information about, immunisation.

4.2 Uptake rates in Hammersmith & Fulham

In H&F uptake of childhood vaccinations is lower than the London average. Rates are roughly comparable with other inner north west London boroughs, but, do not reach levels required for herd immunity. The picture has remained relatively static during the transition from PCTs to the new commissioning arrangements.

Table 2 below provides a breakdown of uptake rates of MMR in H&F by quarter during 2013/14, with a comparison to 2012/13 annual data. Data is provided for the same period for the other routine childhood vaccinations in Appendix 5.

Table 2. Hammersmith & Fulham MMR1 & MMR2 Uptake – 2013/14

Indicator	Quarter 1 2013/14*	Quarter 2 2013/14	Quarter 3 2013/14	Quarter 4 2013/14	Annual 2013/14 (Provisional & unpublished)	Annual 2012/13
2 yr – 1st dose MMR	-	76.7%	77.4%	81.8%	*Available End of September 2014*	83.7%
5 yr- 2nd dose MMR	-	59.3%	58.2%	72.0%		81.4%

* Quarter 1 data not published due to data quality issues

4.3 Data trends- MMR 1 (dose 1, age 12-13months)

Quarter 1 data for 2013/14 was not published due to data quality issues.
The table shows that from quarter 2 to 4, there has been a quarter on quarter increase. However, until the annual data for 2013/14 is published comparisons with the previous years data cannot be made.

4.4 Data trends- MM2 (dose 2, age 3 years four months or soon after)

Quarter 1 data for 2013/14 was not published due to data quality issues.
The table shows that there has been a wide variation of uptake between quarter 2,3 and 4. However, a full comparison of 2013/14 uptake with 2012/13 cannot be made until the annual data is published at the end of September 2014.

4.5 Population characteristics that impact on immunisation uptake

The following factors contribute to the apparent gap between reported uptake and that required to reach community resilience in the MMR programme (95% uptake).

Certain populations' characteristics are known to be associated with variation in uptake of vaccinations. The following factors are known to impact on the level of uptake of vaccinations in the borough of Hammersmith & Fulham:

- International and local migration - there are high levels of families moving in and out of the borough from international countries (see table below). Hammersmith and Fulham had the fifth highest population mobility rate in England and Wales in 2001, with one in five residents moving address in the previous year. (*H&F JSNA*).

  There are also high rates of relocation of families within the borough. These issues make it more challenging to keep an accurate record of the true eligible population (denominator), and to hold correct contact information to able successful invitation and therefore immunisation of these children.

Table 3. Internal and international migration comparison in North West London

	Rate per 1,000	
Migration Indicator	**INWL (Hammersmith & Fulham, Kensington & Chelsea, Westminster)**	**Outer NWL (Ealing, Hillingdon, Hounslow)**
Internal Migration - In	82	65
Internal Migration - Out	86	69
International Migration - In	38	24
International Migration - Out	38	14

- European schedule – children who spend a proportion of the year in another country or families that have strong links with their country of origin may follow the immunisation schedule of that country. Schedules (timings of immunisations) often differ from country to country, thus creating challenges for providers to monitor vaccination status or timeliness of vaccinations to provide community resilience.

- Data quality – ensuring vaccination histories are accurate and consistency of reporting and recording by providers has been challenging in H&F. Clinical system change in H&F GP practices has also had an impact on data being reported to COVER.

- Local population variations – as referred to above in the population profile, particular populations characteristics are associated with variation in uptake of vaccinations. In addition, media coverage has impacted the MMR uptake in the Wakefield cohort (MMR catch up campaign described in further detail below).

- Unregistered Cohort- the unregistered cohort in H&F that is reported to COVER data has been steadily increasing. This has an impact on uptake rates.

5.0 WHAT IS CURRENTLY BEING DONE TO ADDRESS ISSUES IN MMR UPTAKE IN HAMMERSMITH AND FULHAM?

As mentioned above, the new configuration of the health system has created various opportunities to improve the quality of commissioning, service provision and the uptake of vaccination programmes. Opportunities fall into two broad categories:

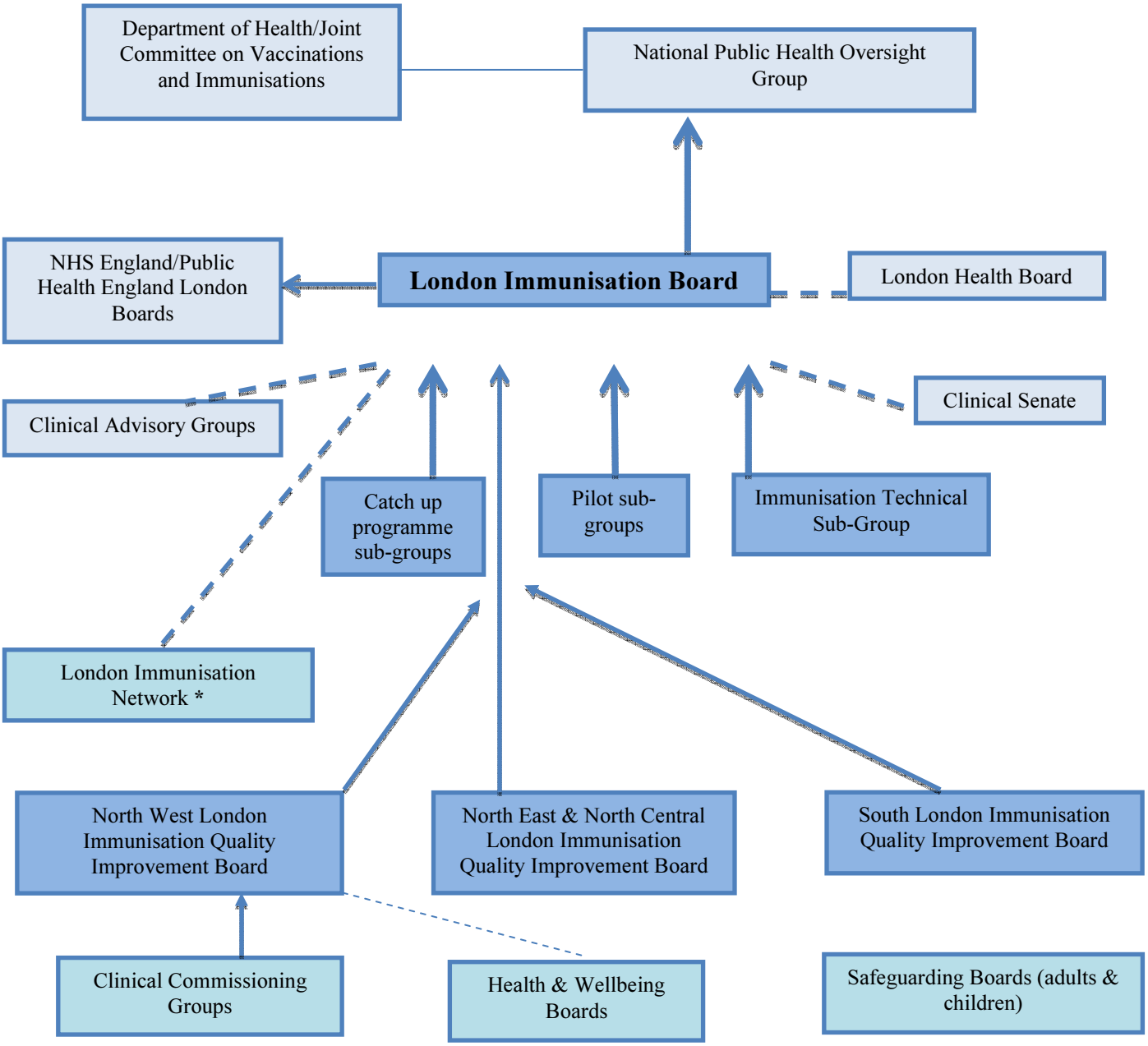
- Systems & levers
- interventions & projects

5.1 Systems & levers

In London, NHS England has a single commissioning team for immunisations. This has enabled the development of robust processes for contracting, commissioning and monitoring providers of immunisations. This in turn supports a consistent approach to driving up the quality of immunisation provision and improve uptake. By utilising a consistent approach to contracting it allows NHS England to identify and hold providers to account where the performance and quality is sub-optimal. Contract levers can then be utilised to support improvement in performance and quality and ultimately increase uptake.

In addition to robust contracting, NHS England has developed strong governance arrangements that have clear lines of accountability through to the national oversight group (see diagram 1).

Diagram 1: Local & National Immunisation Governance Structure.
The boxes in dark blue represent NHS England groups, the remaining boxes represent external groups or boards. Some have direct reporting mechanisms for accountability, depicted by arrows. Dotted lines indicate information exchange/stakeholder input.



*Professional networks are an important mechanism for disease management through sharing of good practice and links between existing networks and proposed governance structures have been included.

The London Immunisation Board is the key mechanism by which NHS England (London region) will provide assurance on delivery of the immunisation programmes in the section 7a mandate.

The table in Appendix 6 describes the various NHS England boards/groups and their functions.

Through strong governance structures and consistent application of the NHS standard contract with all providers the system in London is set up to have robust oversight and management of the services provided across London. It enables timely identification of issues/concerns/outliers. It supports a consistent contract management approach to address underperformance and utilises an evidence based approach to identifying and commissioning interventions.

NHS England's vision for immunisations programmes is illustrated using a single slide (Appendix 7). This incorporates both the system mechanisms and provides an indication of some of the work streams that will be taken forward.

5.2 Interventions & projects

NHS England has a number of projects/actions in place across London that contributes to realising the vision. These are and will have an impact within H&F:

- Primary care – Project to map & review all GMS / PMS and APMS contracts including the key performance indicators (KPI's) across London identifying problems with consistency / accuracy and the impact of new immunisation programmes.
- CHIS –
    - Data linkage between GPs and CHIS. This project aims to improve the data flows between primary care and the CHIS to ensure high quality data reporting for the COVER reports. Progress is reported to the NWL Immunisations Quality Improvement Board.
    - A protocol has been put into place across London for earlier scrutiny of immunisation rates prior to submission to COVER by the patch and central immunisation commissioning teams in NHSE. This is helped by the new minimum child health dataset (implemented 1st September 2013) which enables monthly reports on immunisations to the NHSE immunisation teams.
    - Regular meetings with CHIS providers to address data quality issues.
    - NHS England CHIS community of practice created to drive service development and ensure services are fit for purpose, now and in the future.
- System wide –
    - Ambition plans are being developed by NHS England via the technical subgroup. These plans will provide indicative trajectories that will be influenced by interventions. Once signed off, these will be monitored via the NWL Quality Improvement Board.
    - An incident protocol is currently being developed and tested before formal roll out. Once embedded this will assist in ensuring stakeholders understand their roles and responsibilities in relation to immunisations incidents. This will enable good oversight and sharing of learning from incidents therefore reducing the likelihood of repetition.

The work programmes/projects etc. listed above have a specific impact on MMR vaccination uptake. It should be noted that there are other work programmes/projects not listed that impact on the other immunisations programmes. Information on these is available on request.

It is also important to recognise that since the establishment of NHS England on 1st April 2013, there is evidence of various success stories:

- Successful response to the national outbreak of MMR
    - Based on evidence gathered by auditing 10 years' worth of child records. Partner organisations including NHS England, PHE, CCGs and LA's worked together to provide a response to a national outbreak. The response enabled assurance to be provided that the onward spread and continued outbreak was brought under control.
- Successful introduction of rotavirus vaccination
    - NHS England commissioned a new national programme in its first year, which has already brought about a measurable reduction in A&E admissions in infants across London.

5.3 What this means for H&F

NHS England has a solid work programme aimed at commissioning high quality immunisation services. Where these services are of sub-optimal quality and/performance, mechanisms are being put in place to address these issues.

The programmes/projects and structures described above describe how NHS England is working to drive up performance and quality of immunisations services in H&F.

However, it is widely acknowledged that partnership working across multiple agencies is the only way in which sustainable improvements can be achieved.

6.0 HOW DO PARTNER AGENCIES WORK TOGETHER TO MAKE SUSTAINABLE IMPROVEMENTS IN UPTAKE RATES?

There are various opportunities for NHS England, CCGs and Local Authority Public Health (plus other departments) to collaborate to ensure sustainable improvements in uptake rates.

Below is a description of what NHS England will be doing, followed by a description of what CCGs and Public health in the Local Authority are doing and suggestions of further opportunities to work together.

6.1 NHS England

- Use appropriate commissioning arrangements to ensure immunisation services that are accessible and of high quality
- Recognise the potential impact of interventions including system interventions e.g. data linkage from primary care to CHIS via the technical subgroup of the London immunisations board
- Where possible co-commission or use other appropriate mechanisms to introduce evidence based interventions – such as data linkage project,
- contract manage providers and hold them to account where sub optimal performance/variation is evidenced

6.2 HAMMERSMITH and FULHAM CCG

As part of the section 7a agreement CCGs are required to drive up quality of primary care. This should be done by using best practice evidence to change behaviour.

Partnership working between NHS England and H&F CCG should be based on best practice evidence (NICE 2009). Roles that the CCG should enact fall under the following themes:

- IT - Endorsing systems and robust data flows such as the data linkage from primary care to CHIS, and systematic coding
- CPD - Advocating commitment to CPD within primary care
- Communication - Facilitate communication between NHS England and general practice particularly around profiling policy and schedule amendments
- Addressing local issues - Collaborate with NHS England to understand/address specific issues with practice delivery of immunisations

Good relationships have been developed between NHS England and H&F CCG. Listed below are various projects underway as part of a partnership between NHS England and H&F CCG during 2013/14 and 2014/15.

- H&F CCG meet regularly with their CHIS provider
- H&F CCG has a commitment to CPD – via Health Education England & Nursing
- Forums
- A 'Good practice guidance' on immunisations was developed and sent out to
- Member practices last year
- Regular vaccine updates and newsletters are circulated to practices via GP
- Bulletins and updated on the CCG extranet
- H&F CCG provides representation at NWL Immunisation Quality Board meetings.
- As well as attending the technical sub-group to set up immunisation
- Improvement ambition plans and trajectories for the next 5 years and at performance boards.
- The CCG has been part of 'Celebrate and Protect' immunisations birthday cards Initiative for the last 2 years and continue to use this initiative (CCG funded from April 2014 for 12 months).

NHS England is also working with the CCG and CHIS provider to seek assurance on development of robust data flows for immunisation programmes.

6.3 Local Authority Public Health Team

The DPH has a local health system leadership role. In relation to immunisations this can be enacted by:

- Facilitating development of relationships between commissioners of NHS and local authority services e.g. children's services to support engagement of underserved population cohorts
- Supporting information sharing about immunisations through other local authority commissioned services. One example may be leaflets in libraries or housing offices
- Sharing public health intelligence with NHS England and CCGs to understand how to reach underserviced population cohorts
- Signpost/raise awareness using PHE national immunisations resources

NHS England has developed good relationships with the local authority public health team. This has resulted in partnership working in the following areas:

- DPH (or deputy) attendance at NWL Immunisations Quality Improvement Board – for assurance of immunisations programmes
- Triborough CCGs public health steering group – operational group to facilitate delivery of local actions from NWL quality improvement board

7.0 CONCLUSION

On 1st April 2013 roles and responsibilities for commissioning and oversight of immunisations programmes changed considerably. Various organisations are required to work in partnership to ensure sustainable improvements in the quality and performance of immunisations programmes.

In the lead up to and post transition, the position in H&F has remained relatively static. Uptake for MMR remains lower than the London and national average. However structures, processes have been developed to enable partners to work together. Noting the population's characteristics that provide challenges to the achievement of community resilience in H&F, NHS England would like to assure the board that plans are in place and being enacted that will see a measurable improvement in the position for H&F.

The board is asked to note the partnership working between the three organisations to date. In addition, the board is asked to support the continuation of an evidenced based approach to joint working in the future to ensure sustainable improvements in MMR (and the remaining childhood vaccinations) uptake can be realised for H&F.

Appendices

APPENDIX 1 – The green book

The green book - https://www.gov.uk/government/organisations/public-health-england/series/immunisation-against-infectious-disease-the-green-book

APPENDIX 2 – Information about measles, mumps and rubella

Measles - A highly infectious viral illness that is characterised by coryza, cough, conjunctivitis and fever. Koplik spots (small bluish white spots on the buccal mucosa) are present about one to three days before the onset of the rash and although characteristic of measles are not found in all cases. After a few days a maculo-papular (red-brown spotty) rash will appear. Measles can be extremely unpleasant and can lead to complications such as meningitis and pneumonia, in rare cases people can die from measles. Statutory reporting of measles began in England and Wales in 1940. Before the introduction of a measles vaccine in 1968, annual notifications varied between 160,000 and 800,000, with peaks every two years, and around 100 deaths from acute measles occurred each yea

Mumps - Mumps is a viral infection that causes an acute illness with swelling of the parotid glands. Mumps is spread in the same way as colds and flu, by infected drops of saliva that can be inhaled or picked up from surfaces and passed into the mouth or nose. Serious complications are rare but it can lead to viral meningitis, orchitis and pancreatitis.

Rubella - Rubella (also known as German measles) is a viral infection that was a common childhood infection prior to the introduction of routine immunisation. Rubella is generally a mild infection in children characterised by a maculo-papular rash and lymphadenopathy. Complications can occur and these include thrombocytopenia and rarely, post infectious encephalitis. In adults, rubella infection can (rarely) result in arthralgia.

APPENDIX 3 – Link to document "NHS public health functions agreement 2014-15: Public health functions to be exercised by NHS England"

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/256502/nhs_public_health_functions_agreement_2014-15.pdf

APPENDIX 4 – The table below shows the complete routine immunisation schedule for England form the summer of 2014:

NHS

The complete routine immunisation schedule from summer 2014

When to immunise	Diseases protected against	Vaccine given	Immunisation site[1]
Two months old	Diphtheria, tetanus, pertussis (whooping cough), polio and *Haemophilus influenzae* type b (Hib)	DTaP/IPV/Hib (Pediacel or Infanrix IPV Hib)[2]	Thigh
	Pneumococcal disease	PCV (Prevenar 13)	Thigh
	Rotavirus	Rotavirus (Rotarix)	By mouth
Three months old	Diphtheria, tetanus, pertussis, polio and Hib	DTaP/IPV/Hib (Pediacel or Infanrix IPV Hib)	Thigh
	Meningococcal group C disease (MenC)	Men C (NeisVac-C or Menjugate)[2]	Thigh
	Rotavirus	Rotavirus (Rotarix)	By mouth
Four months old	Diphtheria, tetanus, pertussis, polio and Hib	DTaP/IPV/Hib (Pediacel or Infanrix IPV Hib)	Thigh
	Pneumococcal disease	PCV (Prevenar 13)	Thigh
Between 12 and 13 months old – within a month of the first birthday	Hib/MenC	Hib/MenC (Menitorix)	Upper arm/thigh
	Pneumococcal disease	PCV (Prevenar 13)	Upper arm/thigh
	Measles, mumps and rubella (German measles)	MMR (Priorix or MMR VaxPRO)[2]	Upper arm/thigh
Two, three and four years old[3]	Influenza[4] (from September)	Flu nasal spray (Fluenz Tetra) (annual) (if Fluenz unsuitable, use inactivated flu vaccine)	Nostrils Upper arm
Three years four months old or soon after	Diphtheria, tetanus, pertussis and polio	DTaP/IPV (Infanrix IPV or Repevax)[7]	Upper arm
	Measles, mumps and rubella	MMR (Priorix or MMR VaxPRO) (check first dose has been given)[2]	Upper arm
Girls aged 12 to 13 years old	Cervical cancer caused by human papillomavirus types 16 and 18 (and genital warts caused by types 6 and 11)	HPV (Gardasil)	Upper arm
Around 14 years old	Tetanus, diphtheria and polio	Td/IPV (Revaxis), and check MMR status	Upper arm
	MenC[5]	MenC (Meningitec, Menjugate or NeisVac-C)[2, 5]	Upper arm
65 years old	Pneumococcal disease	PPV Pneumococcal polysaccharide vaccine (Pneumovax II)	Upper arm
65 years of age and older	Influenza[4]	Flu injection (annual)	Upper arm
70 years old	Shingles (from September)	Shingles (Zostavax)	Upper arm (subcutaneous)

Immunisations for those at risk[6]

At birth, 1 month old, 2 months old and 12 months old	Hepatitis B	Hep B	Thigh
At birth	Tuberculosis	BCG	Upper arm (intradermal)
Six months up to two years	Influenza[4]	Inactivated flu vaccine (annual)	Upper arm/thigh
Two years up to under 65 years	Pneumococcal disease	PPV Pneumococcal polysaccharide vaccine (Pneumovax II)	Upper arm
Over two up to less than 18 years	Influenza[4] (from September)	Flu nasal spray (Fluenz Tetra) (annual) (if Fluenz unsuitable, use inactivated flu vaccine)	Nostrils Upper arm
18 up to under 65 years	Influenza[4]	Inactivated flu vaccine (annual)	Upper arm
From 28 weeks of pregnancy[7]	Pertussis	dTaP/IPV (Boostrix-IPV)[8]	Upper arm

[1] Where two or more injections are required at once, these should ideally be given in different limbs. Where this is not possible, injections in the same limb should be given 2.5cm apart. For more details see Chapters 4 and 11 in the Green Book. All vaccines are given intramuscularly unless stated otherwise.

[2] Where two or more products to protect against the same disease are available, it may, on occasion be necessary to substitute an alternative brand.

[3] This is defined as children aged two, three or four year (but not five years) on 1 September 2014.

[4] The vaccine is given prior to the flu season – usually in September and October.

[5] Meningitec and Menjugate are currently not available to order through ImmForm – only NeisVac-C is available at the moment.

[6] See individual chapters of the Green Book for clinical risk groups.

[7] See CMO letter of October 2012.

[8] Repevax should continue to be used until 1 July 2014.

immunisation

The safest way to protect children and adults

APPENDIX 5 – Hammersmith & Fulham COVER Uptake by Quarter (2013/14):

Indicator	Quarter 1 2013/14* (01 Apr '13- 30 Jun '13)	Quarter 2 2013/14 (01 Jul '13- 30 Sep '13)	Quarter 3 2013/14 (01 Oct '13- 31 Dec '13)	Quarter 4 2013/14 (01 Jan- 31 Mar '14)	Annual 2013/14	Annual 2012/13
1 yr – 3 doses DTAP/IPV/HIB	-	78.9%	79.2%	76.2%	*Available End of September 2014*	89.8%
2 yr – PCV Booster	-	74.5%	81.8%	78.1%		82.2%
2 yr – HiB/MenC Booster	-	73.6%	82.6%	80.2%		84.0%
2 yr – 1st dose MMR	-	74.2%	81.3%	81.8%		83.7%
5 yr – DTAP/IPV Booster	-	68.7%	27.9%**	31.3%**		82.7%
5 yr- 2nd dose MMR	-	69.7%	73.4%	72.0%		81.4%

* Quarter 1 data not published.

** The decrease in reported uptake figures is due to changes in information flows- and work is underway to address this.

APPENDIX 6 - Local Immunisation Groups & their Functions

Meeting/group	Function	What this means for Hammersmith & Fulham	Decision making/ advisory/ operational
London Immunisation Board	Sets the strategic direction for immunisations commissioning in London. maintains oversight for quality and performance of immunisations provision	Reviews performance, noting, underperformance and seeking assurance those robust plans are in place to address issues, seeks support from partners.	Decision making
Technical subgroup of the London Immunisation Board	establish and quality check a technical methodology that supports the development of uptake improvement plans, assesses the robustness of plans and evaluates the outcome of those plans	Supports the development of robust plans to improve uptake in H&F, using evidence based methodology, and assists in evaluation of plans.	advisory
NWL Quality and Performance Group	Deliver measurable improvements in quality and performance for NHS commissioned immunisation	• Strengthens relationships between stakeholders and commissioning partners to understand population need • Local intelligence is shared to inform decision making relating to providers and/or programmes • Reviews local data quality and data reporting systems and makes recommendations on how these can be enhanced • Benchmark quality and performance of	• Decision making

		services in Westminster • Provides operational assurance to commissioning partners such as CCGs and Local authorities	
INWL CCG/LA (Public health) & NHS England Group	This meeting looks at a range of Public Health issues affecting INWL of which immunisation is an aspect of it. Issues requiring an operational stance are discussed here.	The group takes oversight of implementation of local operational issues that come out of the NWL Immunisations Quality Board meeting or local action plans	Operational
CHIS contract monitoring meetings	To hold providers to account for performance against their contract	NHS standard contract has been used with all CHIS providers. Providers are performance monitored against a national service specification within the contract. In addition there are London requirements that contracted such as the minimum data set that provides borough level surveillance.	Decision making

Appendix 7 – NHS England Immunisation plan on a page