London Borough of Hammersmith & Fulham

Housing, Health And Adult Social Care Select Committee

Agenda

Tuesday 15 February 2011
7.00 pm
Courtyard Room - Hammersmith Town Hall

MEMBERSHIP

Administration:	Opposition	Co-optees
Councillor Andrew Johnson (Chairman) Councillor Oliver Craig Councillor Charlie Dewhirst Councillor Gavin Donovan Councillor Marcus Ginn Councillor Steve Hamilton	Councillor Iain Coleman Councillor Stephen Cowan Councillor Rory Vaughan (Vice-Chairman)	Maria Brenton, HAFAD

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Date Issued: 07 February 2011

London Borough of Hammersmith & Fulham

Housing, Health And Adult Social Care Select Committee

Agenda

15 February 2011

Item		Pages
1.	**MINUTES AND ACTIONS**	1 - 14
	(a) To approve the minutes of the meeting held on 18 January 2011.	
	(b) To monitor the acceptance and implementation of recommendations as set out at Appendix 1.	
2.	**APOLOGIES FOR ABSENCE**	
3.	**DECLARATIONS OF INTEREST**	
	If a Councillor has any prejudicial or personal interest in a particular item they should declare the existence and nature of the interest at the commencement of the consideration of that item or as soon as it becomes apparent. At meetings where members of the public are allowed to be in attendance and speak, any Councillor with a prejudicial interest may also make representations, give evidence or answer questions about the matter. The Councillor must then withdraw immediately from the meeting before the matter is discussed and any vote taken unless a dispensation has been obtained from the Standards Committee. Where Members of the public are not allowed to be in attendance, then the Councillor with a prejudicial interest should withdraw from the meeting whilst the matter is under consideration unless the disability has been removed by the Standards Committee.	
4.	**LBHF AND THE 3RD SECTOR**	15 - 27
	This report responds to queries raised by HHASCSC co-opted member, Maria Brenton, Chair of Hammersmith & Fulham Action on Disability, regarding the Council's relationship and working with the local 3rd sector.	
5.	**HAMMERSMITH & FULHAM LINK UPDATE REPORT**	28 - 33
	This report updates the Committee on the work of Hammersmith & Fulham Local Involvement Network (H&F LINk): key activities, transition to Healthwatch and next steps.	
6.	**CASE FOR CHANGE: PROPOSED SEPARATION OF URGENT AND PLANNED ORTHOPAEDIC SURGERY**	34 - 50
	This report proposes the separation of urgent and planned orthopaedic surgery currently based at Charing Cross Hospital and St Mary's Hospital.	

7. BRINGING HOUSING SERVICES BACK TO THE COUNCIL 51 - 56

This report provides an update briefing on returning housing services to the Council and the creation of a new Housing and Regeneration Department.

8. HOUSING BENEFIT CAPS 57 - 64

This report provides an update on the Housing Benefit Caps, which will be in place from 1 April 2011.

9. DRAFT HAMMERSMITH & FULHAM DEMENTIA STRATEGY 2011 - 2013: FOR INFORMATION ONLY. 65 - 97

This report informs the committee of the National Dementia Strategy and how it will be delivered locally by NHS Hammersmith and Fulham and the London Borough of Hammersmith & Fulham.

10. WORK PROGRAMME AND FORWARD PLAN 2010-2011 98 - 112

The Committee's work programme for the current municipal year is set out as Appendix A to this report. The list of items has been drawn up in consultation with the Chairman, having regard to relevant items within the Forward Plan and actions and suggestions arising from previous meetings of the Committee.

The Committee is requested to consider the items within the proposed work programme and suggest any amendments or additional topics to be included in the future. Members might also like to consider whether it would be appropriate to invite residents, service users, partners or other relevant stakeholders to give evidence to the Committee in respect of any of the proposed reports.

Attached as Appendix B to this report is a copy of the Forward Plan items showing the decisions to be taken by the Executive at the Cabinet, including Key Decisions within the portfolio areas of the Cabinet Member for Housing and the Cabinet Member for Community Care, which will be open to scrutiny by this Committee.

11. DATE OF NEXT MEETING

The date of the remaining meeting scheduled for this municipal year is Tuesday 12 April 2011.

London Borough of Hammersmith & Fulham

Housing, Health And Adult Social Care Select Committee

Minutes

Tuesday 18 January 2011

PRESENT

Committee members: Councillors Andrew Johnson (Chairman), Stephen Cowan, Charlie Dewhirst, Gavin Donovan, Marcus Ginn, Steve Hamilton and Rory Vaughan (Vice-Chairman)

Co-opted members: Maria Brenton (HAFAD)

Other Councillors: Joe Carlebach, Lucy Ivimy and Peter Tobias

Officers: Geoff Alltimes (Chief Executive), Nick Johnson (Chief Executive, H&F Homes), Hitesh Jolapara (Deputy Director of Finance), Mark Jones (Assistant Director, Resources), Jane West (Director of Finance and Corporate Services), James Reilly (Director of Community Services) and Kathleen Corbett (Assistant Director, Finance and Resources, Housing Regeneration)

34. MINUTES AND ACTIONS

RESOLVED THAT:

The minutes of the meeting held on 16 November 2010 be approved and signed as an accurate record of the proceedings, subject to the following additions:

1. Councillor Cowan stated that he considered that the director and a housing benefits officer should have been present for the housing benefits report.
2. Councillor Vaughan stated that should staffing resources not be adequate to manage the potential increase in demand for services in a prompt and efficient way, there would be a corresponding increase in attendances at Councillors' Advice Sessions.

Councillor Cowan reported that he and Councillor Ivimy had met with Shelter, and representatives would attend the February meeting if the committee wished.

35. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Oliver Craig and Iain Coleman.

36. DECLARATIONS OF INTEREST

There were no declarations of interest.

37. WINTER FLU VACCINATION UPDATE

The Chairman had agreed to the addition of this item.

Dr David McCoy tabled a report on the winter flu season of 2010/2011, which focused on the prevention agenda and did not cover the treatment and care of individuals with symptomatic illness. The experience of the vaccination programme for the current year indicated a need to strengthen the local system of vaccination.

The number of consultations from the end of November onwards for influenza-like illness had appeared to have reached a peak and had not reached the epidemic threshold. As at 13 January 2011, the Health Protection Agency had confirmed a total of 112 deaths from flu across the UK. 15 of these were children and one had attended school in Hammersmith and Fulham. Information on vaccine status indicated that about 85% of the 'at risk' group who had died were unvaccinated.

The rate of GP consultations for influenza-like illness in London (as at 13 January) indicated that Hammersmith and Fulham had a rate of 65.1 per 100,000 population, which was below the London rate of 78 per 100,000.

Dr McCoy stated that the seasonal flu vaccination policy for the United Kingdom was set by the Department of Health, drawing on the advice of the Joint Committee on Vaccinations and Immunisations, which takes advice from the World Health Organisation. The current policy is to offer the vaccine to the following groups:

- Adults and children with underlying health problems that put them at risk of complications from influenza;
- All those aged 65 and over;
- All those who live in a residential or nursing home;
- All those who are the main carer of an older or disabled person;
- All pregnant women; and
- Poultry workers.

The purchase, storage and distribution of influenza vaccine in England is a decentralised system, requiring effective co-operation between surgeries, pharmacies, hospitals, PCTs and vaccine suppliers.

In 2009/2010, Hammersmith and Fulham achieved an uptake rate of 72.5%, which was the same as the London average uptake for that year. The data to 7 January 2011, shows an uptake of 65.1%.

Dr McCoy stated that there were problems with data measuring the vaccine uptake amongst pregnant women. Available data suggested that only 20% of pregnant women were being vaccinated at the end of December. Up until the end of December, pregnant women were not being vaccinated at antenatal clinics, but were being referred back to their GP practices.

Variation in GP practice performance, in terms of vaccination uptake rates and also the application of clinical guidance and data collection, needed to be addressed. Vaccinations needed to be provided to all pregnant women opportunistically and every point of contact should count; it should be considered unacceptable to refer a pregnant woman back to her GP for a flu vaccination.

Councillor Carlebach considered winter flu to be one of the most critical short term issues, and that even a single death from the lack of a vaccine was not acceptable. There needed to be a more pro-active communications plan for the following year.

Councillor Carlebach thanked Dr McCoy for his significant work in raising awareness.

Dr McCoy responded to a query that the definition of 'pandemic' was slightly arbitrary and there was no definitive threshold.

Dr McCoy endorsed comments in respect of the importance of cleanliness in preventing viruses.

Councillor Vaughan queried the start date of a winter flu vaccination programme and plans to ensure take up by at risk groups. Dr McCoy responded that each year, ahead of the influenza season, the World Health Organisation recommended which virus strains should be included in the seasonal flu vaccine for that year, and that the vaccination programme should start as soon as it is available. GPs were critical to the success of the programme and the best performance must become the average. In line with the Public Health White Paper outcomes framework, responsibility would transfer to GP consortia. Additionally, a more pro-active role for school nurses and children's centres in identifying high risk children was being proposed. Councillor Carlebach added that literature to identify vulnerable children had been given to parents in both state and independent schools.

In response to a query, Dr McCoy clarified that influenza A H1N1 (still referred to as 'swine' flu) and Influenza B remained the predominant strains, but they were constantly changing and mutating, and therefore a new vaccine

was required annually for the new variant. The previous year's vaccine would offer only partial protection. The World Health Organisation undertook global level monitoring, and nationally the Department of Health advised on the amount of vaccines that manufacturers needed to produce nationally. GPs purchased their own vaccines directly from the commercial sector, and national guidance was provided on how to calculate stock, based on population.

In response to a comment in respect of tabloid articles on deaths from flu and increased public risk, Dr McCoy stated that vaccine uptake rates were similar to the previous year.

Councillor Cowan stated that his GP practice was without a stock of vaccine and had to wait two weeks for a supply. Dr McCoy stated that the PCT was in constant communication with practices, and was not aware of any practice being out of stock.

ACTION:

Dr McCoy agreed to report back to the committee on the situation in respect of this practice and on stock levels of vaccine in the borough.

Action: Director of Public Health

38. THE WHITE PAPER FOR PUBLIC HEALTH: HEALTHY LIVES, HEALTHY PEOPLE

Dr McCoy presented the report and outlined the following key proposed reforms and changes:

- A new professionally-led and defined national public health service, 'Public Health England', would be established as part of the Department of Health and would incorporate the existing Health Protection Agency and the National Treatment Agency.
- Local public health functions would transfer from the NHS to local authorities.
- There would be close partnership working between Public Health England and the NHS at national level, and between local government, Directors of Public Health and GP consortia at local level.
- Public Health England would have a local presence in the form of Health Protection Units.
- A public health budget, believed to be £4 billion, would be ring-fenced, and a percentage allocated to local authorities on the basis of a formula to include population size and weighted for inequalities. A new 'health premium' would also be used to provide performance incentives.
- Local Health and Wellbeing Boards would be established to enable integrated and joined-up commissioning and provision.

- There would be a statutory requirement for GP consortia and local authorities to both produce and use and apply the findings of the Joint Strategic Needs Assessment.

Dr McCoy stated that the remit of Public Health England would include: health protection, emergency preparedness, recovery from drug dependency, sexual health, immunisation programmes, alcohol prevention, obesity, smoking cessation, nutrition, health checks, screening, child health promotion including those led by health visiting and school nursing, and some elements of the GP contract such as those relating to immunisation, contraception and dental public health.

Councillor Tobias referred to the role of scrutiny and potential for joint three boroughs scrutiny (Hammersmith & Fulham, Kensington & Chelsea and Westminster).

Councillor Carlebach considered that, in view of the significantly enhanced role of the local authority, it would be sensible for the existing type of scrutiny structure to continue.

Dr McCoy noted that the local Health Watch would be represented on the Health and Well Being Board.

Mr Alltimes stated that it was no longer intended that scrutiny should be included on the Health and Well Being Board. Local authorities would determine and set up an appropriate body in respect of health and other functions. In some areas, it would be appropriate to undertake scrutiny on a three borough basis. GPs would also be part of the process.

Councillor Dewhirst noted the current problems of a 'postcode lottery' and the need for the structure at local level to be adequately resourced. Dr McCoy responded that the budget in London would also have to fund the Mayor's statutory responsibility for tackling health inequalities. It had been proposed that a 3% top slice of the budget be allocated to a London-wide public health function, with a further 3% to be allocated at the discretion of London Boroughs.

Councillor Vaughan queried: the purpose of the changes and possible disadvantages; whether the budget would remain ring fenced; and the ability of Health Watch to represent the community on the Health and Well Being Board and undertake the current role of LINks.

Dr McCoy responded that the ringfencing of the budget was a positive development, as Public Health had previously subsidised acute and clinical services. The changes would bring about a closer link between Public Health and local government, and highlight the social determinants of health. The separation of Public Health from the remainder of the NHS was a potential disadvantage, although there would be opportunities for partnership working. Public Health would undertake both commissioning and provider activity. Detailed information in respect of the proposed structure was not yet known and good communication with the public would be important.

Councillor Cowan referred to concerns raised by the Hammersmith & Fulham Local Medical Committee at a previous meeting in respect of disruption to the workload which would be brought about by the structural changes. Councillor Cowan considered that the shadow GP consortium did not have significant resources or management support, and queried the business plan and risk analysis, and if there was one specific area of concern.

Dr McCoy responded that It was not possible to identify one specific area of concern. The PCT was reviewing all aspects of healthcare commissioning and. work was being undertaken to mitigate the effect of the changes. The merger of Hammersmith & Fulham, Kensington & Chelsea and Westminster to form a 'cluster' PCT was an example of how costs were being reduced.

Mr Alltimes responded that the PCT system remained accountable, not GPs, and PCTs were still responsibility for risk. London would be releasing approximately £50million to support GP consortia.

Councillor Cowan queried the evidence base, outline strategy and a detailed objective assessment of potential problems.

Mr Alltimes responded that the main area of concern was finance.

In response to a query from a member of the public, Mr Alltimes stated that the public right of attendance at PCT board meetings would continue during the transitional stage and it was likely that a meeting of the PCTs as one cluster would also be held in public. The Health and Well Being Board would meet in public.

RESOLVED THAT:

A comprehensive update on the health White Papers would be added to the work programme for April 2011, and that expert witnesses, including Dr Grewal of Hammersmith & Fulham Local Medical Committee would be invited.

ACTION
The committee to be updated on the future role of overview and scrutiny committees.

Action: Chief Executive

39. WHITE CITY HEALTH AND CARE CENTRE: FULL BUSINESS CASE

Ms Becky Wellburn presented the business case for approval from NHS London for the construction of a Health and Care Centre at White City.

Ms Wellburn set out the following case the change:

- Residents of White City currently have the greatest health needs in Hammersmith & Fulham, including poorly managed long term conditions and high levels of childhood obesity.
- Primary health services in the area are fragmented and difficult to navigate, leading to overuse of hospital care.
- Healthcare premises in the area are not fit for purpose and can not be brought into line with existing Disability Discrimination Act standards.

Interim solutions had been provided by: a Centre for Health at Hammersmith Hospital-Walk in and '8 to 8' GP services; and Canberra Centre for Health, an '8 to 8' GP Centre.

The integrated model would provide:
- A base for integrated services;
- Improved access ('8 to 8' services and disabled access);
- Family friendly environment;
- Delivery of cost effective care pathways, for example diabetics care;
- Supportive and collaborative working environment for GPs;
- Shift of out-patient services into the community;
- Savings on back office administration costs; and
- Multi-disciplinary working.

Ms Golda Okpala presented the financial aspect of the project including: the contracting route; capital affordability; and revenue affordability.

The scheme would include a range of residential accommodation under the management of Notting Hill Housing Association.

Councillor Dewhirst queried the disposal of PCT property. Ms Okpala responded that three properties were being recommended for sale. All services would be re-provided and there would be no double running costs. Agreement from NHS London to keep the proceeds would be negotiated.

Councillor Vaughan queried: why the development had taken so long; when it would be operational; and whether there were any funding risks.

Mr Freeman responded that the project had been long and complex going back to 2002/2003 and that the issues had included planning permission; judicial review; the PCT deficit; 'the wrong time' for the Council; and private finance initiatives The changes over this period, therefore required a different approach. The PCT had received best assurances from NHS London in respect of the money which had been 'given up', at a time when the budget was in danger of being top sliced to support PCTs with a deficit. A financial contribution from NHS London was unlikely.

Councillor Vaughan requested an example of the benefits of co-location of health and social care. Mr Freeman responded that the greatest benefits would be realised by patients with complex needs requiring pro-active management by different agencies. Co-located services would provide integrated care at one location.

Councillor Ginn queried the residential value of the building at the end of 25 years and if there were examples of similar schemes throughout the country. Mr Freeman stated that the residual value was a planning assumption and it was hoped that the actual value would be much higher. Bromley le Bow, Northern Ireland and Sunderland presented examples of integrated services, with a financial imperative to work closely together.

Mr Freeman confirmed that there would be an outreach programme to residents, and added that the cost would actually be greater if this service was not provided.

Councillor Cowan queried the funding structure. Mr Freeman responded that the details were still under discussion guided by NHS London, but there would be no changes to the structure of the deal.

RESOLVED:

That the committee noted the report.

40. REVENUE BUDGET AND COUNCIL TAX 2011/2012

Mr Jolapara presented the Cabinet's proposals for the Council's budget for 2011/12: Mr Jones presented the proposals for the Community Service Department and Ms Corbett for Regeneration and Housing Services.

As a consequence of the Government's intention to tackle the national fiscal deficit over a four year period the provisional two year Local Government Grant Settlement, announced on 13 December 2010, provided for an average funding reduction, excluding schools, of 8.5% in 2011/12 and 28.5% by 2014/15. Hammersmith & Fulham, designated as a band 1 'floor' authority by virtue of its high dependency on the grant as a proportion of its budget requirement (66%) was to receive an even greater funding reduction of 11.3% in 2011/12 and a further 7.4% the year after, comparable with other London authorities.

In cash terms the Council would receive Formula Grant of £124.5m in 2011/12 together with £20m in core revenue grants, an overall reduction of £22.9m compared to 2010/2011. A greater proportion of these resources could, however, now be allocated in line with local priorities since the 90 specific grant funding streams had been reduced to nine with the dedicated schools grant being the only ring fenced allocation.

Savings of £27m were required to balance the budget in 2011/12, some 12% of the base budget. The savings requirement would increase to £64m by 2013/14, 29% of the base budget. These reductions were in addition to the cumulative savings of £55m already delivered over the four year period to 2010/11. The budget had been shaped on the assumption that there would be no pay increase for staff and price inflation only where contract agreements were in place. Fees and charges would increase by an average of 2% and there would be no increases in the Council's pension employer contribution rate of 24.7%.

Front line services and Council Tax payers would be protected as far as possible with a Council Tax freeze proposed for 2011/12 and an assumed freeze over the following two years. The Council would benefit from a new grant which rewarded authorities freezing their Council Tax, estimated at £1.6m, or equivalent to a 2.5% increase in the tax. Budget growth of £11.797m would be offset by savings of £26.89m.

Mr Jones outlined the savings of £6.3 million in the Community Services Department, which were designed to minimise service reductions.

Mr Reilly responded to a query in respect of the £500,000 reduction in local voluntary sector grants, that the first tranche of grants, which had been agreed in July 2010 would not be reduced. The reduction was in respect of the second tranche, which would be awarded in Spring/Summer 2011, covering a range of areas and relating purely to grants.

Mr Jones then presented some further detail in respect of savings projects and responded to queries as follows:

- the transfer of occupational therapist cost to the HRA Capital Programme was a transfer of budget, not a reduction in headcount;
- the Council had secured lower average hourly procurement rates for the homecare market through the framework agreement and volume discounts;
- the Council would offer supported housing alternatives rather than residential placements;
- contributions to the cost of homecare was less than the income generated (figures to be provided);
- in respect of meal charges, Hammersmith & Fulham was currently joint fourth highest in London, before the 2011/2012 increases.

Ms Corbett presented the summary of movement in the budget, which included £2.3 million growth (£2million housing benefit support and £0.3million strategic regeneration funding arrangements).

Mr Johnson stated that 2,400 households would be above the income cap. Wherever possible, the Council would make provision to enable people to remain in existing accommodation. The Council would support people in appropriate housing and encourage landlords to reduce rental levels.

Mr Johnson responded to Councillor Cowan that the one-off grant of £400,000 was in addition to the growth figures given in the presentation.

Councillor Cowan queried the number of families in four bed properties at risk and whether the budget was adequate to prevent evictions. Mr Johnson responded that there were seven families in five bed accommodation and 33 in four bed accommodation for whom the Council had direct responsibility. The Council would aim to negotiate down the rental in each case and had been successful to date.

1,000 people were likely to be affected from April 2011, and a further 1,400 from October 2011. All new tenants from 1 April would be affected. The committee would receive a full update on housing benefits at its February meeting.

Ms West responded to a member of the public, that there was not a breakdown of the Council's debt. It had accumulated over a number of years, and had been taken on for specific purposes, for example renovation of properties. All debt was asset backed.

Mr Jolapara responded to Councillor Vaughan that the debt was mostly long term and he would circulate the average rate of interest.

(Councillor Cowan moved to extend the guillotine for the meeting to end at 10.30pm, which was not agreed by the Committee.)

Mr Reilly responded to Councillor Vaughan that:

- the staffing productivity savings would include staff redundancies;
- the re-organisation of advice services referred to the transfer of Shepherds Bush Advice Centre into Westfield Library; and
- measures were being introduced to improve the collection of and application of rules in respect of residential charges.

Councillor Cowan stated that he did not consider that the Chairman had allocated sufficient time for proper scrutiny of the budget.

ACTION:

1. The committee to be informed of the costs of financial assessments, raising invoices, and collection of contributions to the cost of homecare and the income generated;

Action: Assistant Director of Resources

2. The committee to be informed of the average rate of interest paid on the Council's debt.

Action: Deputy Director of Finance

RESOLVED THAT:

The report be noted.

41. TASK GROUP: HAMMERSMITH & FULHAM ESTATES: LIFT MAINTENANCE

The committee received a proposal for the establishment of a Task Group in respect of Hammersmith & Fulham Lift Maintenance.

RESOLVED THAT:

The committee recommended to the Overview and Scrutiny Board that a Task Group in respect of Hammersmith & Fulham Lift Maintenance be established and that Councillor Dewhirst be appointed as a member.

42. WORK PROGRAMME AND FORWARD PLAN 2010-2011

RESOLVED THAT:

The work programme be noted.

43. DATE OF NEXT MEETING

15 February 2011

The committee thanked Mr James Reilly for his outstanding contribution to the Council and wished him success in his new post.

Meeting started: 7.05 pm
Meeting ended: 10.05 pm

Chairman .....

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APPENDIX 1

Recommendation and Action Tracking

The monitoring of progress with the acceptance and implementation of recommendations enables the Committee to ensure that desired actions are carried out and to assess the impact of its work on policy development and service provision. Where necessary it also provides an opportunity to recall items where a recommendation has been accepted but the Committee is not satisfied with the speed or manner of implementation, thus enhancing accountability. It also enables the number of formal update reports submitted to the Committee to be kept to a minimum, thereby freeing up Members time for other reviews.

The schedule below sets out progress in respect of those substantive recommendations and actions arising from the Housing, Health & Adult Social Care Select Committee

Minute No.	Item	Action/recommendation Lead Responsibility	Progress/Outcome	Status
15.	Introduction to Housing Services	That the committee be informed of the date on which the housing register will be launched. **Chief Executive, H&F Homes**	• To be launched by the end of the financial year. (Launch is defined as publicity to applicants of what it means and how it will work.) • In the interim a self assessment form has been sent to all applicants who have identified a mobility/medical need on their housing application.	Review: March 2011
27.	Adult Social Care Day Services: Update	That the committee be provided with the outcome of the consultation to merge older and disabled people's day services and the outsourcing intentions of all in-house day service provision. **Assistant Director of Adult Social Care**	Circulated 07 February 2011	Complete

29.	Housing Benefits	That a written answer be provided in respect of: • The one-off grant of £400,000 and whether this grant was ringfenced; and • Whether people in shared rooms were included in the figure of 1300 people who would be above the revised cap. **Interim Assistant Director, Housing Options**	Circulated 19 January 2011 Circulated 14 January 2011	Complete Complete
37.	Winter Flu Vaccination Update	• An update report on the situation in respect of on stock levels of vaccine in the borough to be provided. **Director of Public Health**	Circulated 21 January 2011	Complete
38.	The White Paper for Public Health	• An update on the future role of overview and scrutiny committees to be provided. **Chief Executive**		
40.	Budget and Council Tax	• The costs of financial assessments, raising invoices, and collection of contributions to the cost of homecare and the income generated to be provided. **Assistant Director, Resources** • The interest rate on the Council's borrowing to be provided. **Deputy Director of Finance**	Circulated 31 January 2011 Circulated 19 January 2011	Complete Complete

41.	Task Group: Hammersmith & Fulham Estates, Lift Maintenance	**Recommended** to the Overview and Scrutiny Board that a Task Group in respect of Hammersmith & Fulham Lift Maintenance be established and that Councillor Dewhirst be appointed as a member.	The Overview and Scrutiny Board rejected the recommendation.	An officer report has been added to the work programme.

London Borough of Hammersmith & Fulham

HOUSING, HEALTH AND ADULT SOCIAL CARE SELECT COMMITTEE

DATE	TITLE	Wards
15th February 2011	LBHF and the 3rd Sector	All

SYNOPSIS

This report responds to queries raised by HHASCSC co-opted member, Maria Brenton, Chair of Hammersmith & Fulham Action on Disability, regarding the council's relationship and working with the local 3rd sector.

CONTRIBUTORS

Sue Spiller, Head of Community Investment
Kay Reeve, Head of Community Commissioning.
Community Services Department

RECOMMENDATION(S):

HHASCSC is asked to note the contents of this report.

CONTACT

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NEXT STEPS

The Cabinet Member for Community Care will consider the comments from HHASC Select Committee.

1. EXECUTIVE SUMMARY

1.1 The council's strategy for working with the 3rd sector is set out in the H&F 3rd Sector Strategy and the Compact.

1.2 The council sees the sectors main roles as:

- Promoting enterprising solutions to social, economic and environmental challenges
- Make a difference to local residents
- Providing self help, advocacy and a voice for residents and under-represented communities
- Participating in service design and review
- Input and participation in consultation activities
- Disseminating information to residents
- Empowering residents through Information, advice and guidance
- Establishing Independence and autonomy and
- Developing innovative and joined up responses through collaboration and partnership working:

1.3 The Council wishes to support the activities of the 3rd sector in order to improve and enrich our borough and the lives of residents and primarily in order to assist the council achieve our stated priorities. The council invests in 3rd sector infrastructure support to assist groups development and volunteering expertise, but does expect the 3rd sector to also exercise sound business skills in order to develop as strong, sustainable enterprises.

1.4 The council does not yet have a formal response to the Government's Big Society agenda, but anticipates opportunities for local organisations, community groups and residents to contribute to this agenda in the future.

1.5 Community Services Department commissions a high proportion of preventative services from the 3rd sector, and are supporting the sector to respond to the preventative agenda and Supporting Your Choice programme. The sector is responding to the challenges facing the borough, with a number of organisations demonstrating creative approaches to supporting local residents. However, more needs to be done to stimulate some parts of the sector to respond to the challenges ahead.

1.6 The essential difference between commissioning and grant funding is that in the commissioning process, the *service* is specified often with an expected or prescribed service model, whereas with the council's grants programme, the *outcome* is specified, leaving organisations to determine the type and model of service they wish to deliver which will achieve the specified outcomes.

1.7 The Local Government Finance Settlement confirmed that LBHF will receive a funding reduction of 11.3% (£27 million) in 2011/12, increasing to 29% (£64 million) in 2013/14. Westminster and Kensington and Chelsea are faced with similar percentage reductions in central government funding over the coming years. To minimise the impact of budget reductions, H&F is working with other commissioners – particularly the NHS, Kensington & Chelsea and Westminster. Cross-borough commissioning and procurement allows for greater purchasing power in the market to achieve better value for money. It also makes it easier for services to be planned and delivered across authority boundaries which improves access for vulnerable client groups. However, commissioning across boroughs

also has potential risks including, e.g. reduced local knowledge, less local intelligence about the impact of changes and reduced capacity to sustain smaller specialist service providers. The 3rd sector has a key role in helping to mitigate these risks through, for example:

- Facilitating the involvement of service users
- Helping commissioners to understanding 'value' from the resident and communities point of view
- Being involved in the development of services and engaged throughout the change process

1.8 The council's Community Investment Team manage a database of local groups and organisations. Information on the council's website includes how groups can be added to CIT mailing lists. Community Investment can provide mailing lists for local organisations under a number of categories, including BME communities, location and age group. The Community & Voluntary Sector Association (CaVSA) also manage a database of 3rd sector providers, and provide a communications channel for the sector, and for the council to reach local organisations. It is proposed to transfer the Community Investment database to CaVSA in order for CaVSA to offer a single point of communication for the third sector in the borough.

2. INTRODUCTION

2.1 The council remains committed to supporting the local 3rd sector – evidenced through our continued provision of grant funding which in 10-11 stands at £4.2m, with Hammersmith & Fulham ranking 6th in London in terms of overall grants budget, and 4th highest in terms of spend in relation to the population.

2.2 Cabinet in 2010 agreed a reduction of the overall 3rd sector grants budget by £700k overall, to £3.7m by 2013-14. This reduction represents a 16% reduction in the 3rd sector grants budget, which compares favourably with the 29% savings the council needs to achieve by 13-14.

2.3 This report was requested by the Housing, Health and Adult Social Care Select Committee following a recommendation by co-opted member, Maria Brenton – Chair of Hammersmith & Fulham Action on Disability.

A. The council's perspective on the place that 3rd sector organisations have in local affairs

- Is there a worked out position or strategy behind its dealings with the sector
- How does the council sees the sector's role now and developing in the future
- Does the Government's recent emphasis on the 'Big Society' have any bearing on this.
- What is the potential impact of expenditure cuts and the merging of commissioning across three boroughs.

B. Social care services and prevention: where the council sees the ideal balance of provision between the 3rd sector, direct services and the commercial sector. How important is it to the council to support and protect

the capacity of the local 3rd Sector to deliver services and if so how does it propose to do this?

C. How would the council define the essential difference between commissioning services and giving out grants? What does this mean in practical terms for relationships between it and local 3rd sector organisations?

D. In the merging of commissioning across three boroughs, what steps are being taken to maintain local knowledge, to stay in touch with the needs of vulnerable people and to sustain smaller and specialist community providers?

E. Given the speed of change and the loss of organisational intelligence that will come with loss of public sector staff, what contingencies are in place to pick up early warnings of the impact of changes on and any unintended consequences for vulnerable residents? How do you see the Third Sector's role in this?

3. THE COUNCIL'S PERSPECTIVE ON THE PLACE THAT 3RD SECTOR ORGANISATIONS HAVE IN LOCAL AFFAIRS

3.1 The Council's perspective of the 3rd Sector is most clearly articulated in the borough's 3rd Sector Strategy, agreed by Cabinet in September 2009:

> *"The Council recognises that the 3rd sector plays a significant role in achieving the Council's borough of opportunity vision and aspirations; adding value to the cultural, social and economic quality of life for our residents; helping to shape social and economic regeneration and contributing to civic renewal."*

3.2 The Compact provides an overall framework for promoting effective partnership working between government and the voluntary and community sector. The national framework for the Compact sets out that an effective partnership between government and the sector will help achieve the following outcomes:

- A strong, diverse and independent civil society
- Effective and transparent design and development of policies, programmes and public services
- Responsive and high-quality programmes and services
- Clear arrangements for managing changes to programmes and services
- An equal and fair society

3.3 In terms of how the council sees the sector role locally:

3.4 *Promoting enterprising solutions to social, economic and environmental challenges*: The council firmly believes that the 3rd sector is well placed to develop innovative solutions to the challenges facing the borough and local residents. The sector is often celebrated as able to offer more creative and cost effective solutions than statutory providers, and the council is keen for the sector to realise opportunities to consider different ways to deliver local solutions. It should be noted that this opportunity is not limited to the 3rd sector – the private sector is also in a good position to realise opportunities in delivering local services. However, the council believe that there are some areas of activity,

where it is likely that the council is not best placed to deliver services, and the private sector is likely to have limited interest, capacity or expertise to deliver.

3.5 We believe that 3rd sector organisations can rise to this challenge. We have some excellent local examples of 3rd sector organisations responding to the challenges ahead, for example HAFAD's recently launched Loyalty Card, and the H&F Circle which is delivering a subscription based service offer. Funding applications received for the council's main grants programme have included some excellent bids that demonstrate sustainability (e.g. through a diverse funding base) and creative service proposals that are likely to offer excellent outcomes for residents through a model which is creative, inclusive, cost effective and sustainable (e.g. The Challenge Network, which engages high numbers of young people from across the borough into community based projects). A large number of organisations work extensively with volunteers, for example the H&F Citizens Advice Bureau, which both maximises its service offer through delivering advice through trained and supported volunteers, but also offers volunteers valuable experience and training that often leads to employment opportunities for the individual volunteer.

3.6 However, there is a concern that not all organisations are fully realising the impact of change that is taking place locally, and nationwide. Some funding applications have lacked evidence that the organisation is thinking differently or creatively, or exploring different ways to deliver their services in order to, in essence, do more for less. This is an approach that the council has been undertaking for many years, with all services subject to strategic review and redesign, with a high number of services radically transformed in recent years. The council wishes to see local organisations, including the 3rd sector also take a similar approach.

3.7 *Make a difference to local residents:* Clearly this is a key role for the sector – and the council believes that many residents benefit from the support that local groups and organisations provide. The types of activities and services range from intensive support to particularly vulnerable residents to informal groups that offer friendship and social activities. In determining the sorts of services the council wishes to grant fund or commission, officers are reliant on the analysis of data from a range of sources, which in turn informs service specifications and service models. Traditionally, this has in the main been data from statutory services, e.g. presentation at A&E, domestic fires and burglaries, particular health conditions, take up of statutory services etc. There is a need for the council to better communicate to the sector our analysis of data and information that informs the council's priorities, and to improve how intelligence from 3rd sector organisations can also inform our understanding of local needs. The council hopes to make better use of 3rd Sector Investment Fund monitoring data to seek to understand the impact of third sector services. A difficulty for both the council and for 3rd sector organisations is to find a balance between facts and figures (quantitative data), and the more descriptive feedback from service users (qualitative data) on the impact the service has had on their life.

3.8 *Providing self help, advocacy and a voice for residents and under-represented communities*: the council also sees the role of the sector in supporting, stimulating and facilitating dialogue between the council and local residents – offering, for many, a preferred route of communication on council services, local priorities and issues of particular interest to individuals and communities. The council recognises that improvements need to be made to ensure the views of local

residents, expressed through local 3rd sector organisations are more easily communicated.

3.9 *Participating in service design and review::* 3rd Sector organisations are well placed to not only respond to local needs, but to also assist the council and health partners to identify emerging needs and issues, communicate with residents and users in specific areas or on particular subjects, and to assist residents to access other services or organisations that may help them. However, the Council also recognises the capacity of organisations may not always allow this to be done in all cases.

3.10 *Input and participation in consultation activities*: the 3rd sector is ideally placed, not only to respond to consultations based on their grassroots knowledge and expertise, but also to encourage Hammersmith & Fulham residents to respond to consultations where the service in question may have an impact on that individual or their community. However, although the council would expect this to be undertaken by organisations as part of their routine activities, it is not the case that the council would expect local organisations to conduct extensive consultations with their users on behalf of the council, unless this were a separately commissioned activity.

3.11 *Dissemination of information*: a consistent challenge for the council is how to provide information to local residents who may not be users of council services. Local groups are often considered as key routes through which information can reach a broad range of local residents. 3rd sector organisations funded by the council are expected to distribute information to their clients on local activities, services, consultations and events where practical, appropriate and achievable. The council also offers support to the sector to distribute information through its Community Investment team, who regularly distribute information from local 3rd sector groups to their database of over 900 local 3rd sector contacts. CaVSA also provide this function to local groups and organisations.

3.12 *Empowering residents through Information, advice and guidance*: local organisations are often the key contact point for local residents seeking information, advice or guidance on a range of issues. The experience of organisations gained from working at a grassroots level results in a wealth of knowledge and expertise that can be harnessed to enhance their service offer, and improve the quality of life for Hammersmith & Fulham residents. The council is keen for residents to be empowered – increasing their independence, taking control of and responsibility for their role as a local resident.

3.13 *Independence and autonomy:* 3rd sector organisations are able to access external funding to enhance their overall offer to local residents. Success in fundraising is not the only indicator of an organisations effectiveness, as there is fierce competition for all funding sources, limited funding sources in some areas and clearly not all applications can be successful. However, the council is keen for 3rd sector organisations to strive for independence from statutory funders, particularly in the light of the current difficult financial position.

3.14 *Collaborative and partnership working:* A number of local 3rd sector organisations already work closely with other groups, whether through cross referral of clients, or through working together to provide a seamless package of support to an individual. As a wider range of services are open to competitive tender, it is not always the case that a single organisation will have all the skills, or the capacity to deliver the complete package of services or outcomes that a funder is seeking,

but collaboration and effective partnership working is often the way that this can be achieved. 3rd sector groups seeking grant funding from the council will be expected to demonstrate their commitment to collaboration with other 3rd sector, private and statutory organisations, in order to maximise the overall "offer" to local residents, and to contribute to the overall knowledge base regarding how to stimulate, effect and sustain effective partnerships, collaboratives and co-operative approaches.

3.15 The Council wishes to support the activities of the 3rd sector in order to improve and enrich our borough and the lives of residents and primarily in order to assist us in achieving our stated priorities and Community Strategy targets – ensuring that Hammersmith & Fulham really is a borough of opportunity for all our residents.

3.16 The council invests in 3rd sector infrastructure support to assist groups development and volunteering expertise, but does expect the 3rd sector to also exercise sound business skills in order to develop strong, sustainable enterprises.

3.17 The council does not yet have an established response to the Government's Big Society agenda. However, the principles of Big Society are to give citizens, communities and local government the power and information they need to come together and solve the problems they face. The Big Society agenda includes a number of specific actions that central Government propose to implement, including:

Support co-ops, mutuals, charities and social enterprises

- We will support the creation and expansion of mutuals, co-operatives, charities and social enterprises, and support these groups to have much greater involvement in the running of public services.
- We will use funds from dormant bank accounts to establish a Big Society Bank, which will provide new finance for neighbourhood groups, charities, social enterprises and other nongovernmental bodies.

Encourage people to take an active role in their communities

- We will take a range of measures to encourage volunteering and involvement in social action, including launching a national 'Big Society Day' and making regular community involvement a key element of civil service staff appraisals.
- We will take a range of measures to encourage charitable giving and philanthropy.

3.18 Clearly Big Society could potentially offer exciting opportunities to 3rd sector organisations, and the council will work with the sector as this agenda progresses locally.

4. THE PREVENTATIVE AGENDA

4.1 The council recognises the benefits that can be achieved by supporting a balance of provision across the 3rd sector, independent providers and our council managed services. However, the council doe not have a position regarding the proportion of services it believes should be provided by across the three sectors – our priority is to focus on the outcomes for service users and ensuring high quality, value for money services are delivered.

4.2 The 3rd sector offer many community-based interventions that we believe prevent the more acute interventions for people in H&F. The 3rd sector is well represented in a number of service areas commissioned by Community Services Department, including (but not limited to):

4.2.1 Housing Support: There are currently 21 providers funded by LBH&F to deliver a range of housing support services to vulnerable people in H&F. These preventative services support people to maintain their accommodation and independence and make important contributions to housing, health, community safety and adult social care agendas.

- 19 of these providers are 3rd sector organisations, 1 is a commercial organisation and we have a number of direct services. Of the current £11.5m spent on housing support services in H&F, less than 1% of this spend is with the commercial sector; 6.5% is spent on direct services and over 90% with 3rd sector organisations.

4.2.2 Older and disabled services provided by the 3rd sector services include:

- Handyperson/ Care and Repair/Home Improvement Agency services delivered by 3rd sector aimed at promoting people's independence and enabling older and disabled to stay in their homes in security and comfort by carrying out simple preventative maintenance measures and helping to reduce falls in the home.
- The 3rd sector also provides services funded by the Innovation Fund for day-to-day *s*upport e.g. day to day queries and concerns, advice and assistance for tenants living in sheltered housing schemes within the borough.
- The council has commissioned the H&F Circle – a membership based service offering social activities and practical tasks delivered through paid or volunteer Neighbourhood Helpers. The project has a target of achieving 3,000 members by the end of their third year of operation (2013-14).

4.2.3 Stroke services: the borough has also just commissioned a service with a 3rd sector organisation to enable the borough deliver on the 20 quality markers (QMs) set in National Stroke Strategy (QMs) which are needed to raise the quality of care to stroke survivors and their carers in H&F and also address the areas for improvement identified by CQC Stroke reviews.

4.2.4 Direct Payment Support: the 3rd sector also delivers services integral to the effective delivery of the Supporting Your Choice programme in H&F. The Direct Payments Support service is delivered by 3rd sector (£105k) as well as the current arrangement for support brokerage. The advocacy service is also delivered by a 3rd sector partnership arrangement of HAFAD, H&F Mind and H&F Mencap (£132,500)

4.2.5 Sexual health services in H&F are also delivered primarily by 3rd sector organisations and the council contributes £82k to the PCT to commission these services.

4.3 The contribution of the 3rd sector is therefore very significant and we recognise the importance of actively engaging with and supporting the provider sector. Providers advise that information about council priorities and strategic direction is critical so that they can adapt their organisation or service models, where required.

4.4 The Supporting Your Choice engagement strategy includes Transition Planning, consisting of one to one meetings between providers and commissioners, with information from this process consolidated into a quarterly forum to enable the provider & commissioner community to work together.

4.5 Community Services have a well established programme for Supporting People providers, including a provider forum, information bulletins; provider representation on the Supporting People strategy group and efficiencies board.

4.6 The purpose of these approaches, which are in addition to the existing contract monitoring relationship and communications between the council and providers, is to ensure that providers can contribute to council commissioning and procurement priorities; that the council is aware of the implications of decisions for provider organisations; identify opportunities for improving service quality and value for money; identify provider training needs that the council may be able to assist with and other means of building provider capacity.

4.7 We acknowledge some of the difficulties presented to the 3rd sector when in competition with organisations who may have more resources at their disposal and we have provided additional support to the 3rd sector:

4.7.1 3rd sector Supporting Your Choice workshops to explore the opportunities that may be available in terms of expanding client base

4.7.2 Directory of services: In 2009 we developed a directory on the council's website, giving all organisations the opportunity to promote their services to residents and staff. 3rd Sector organisations were directly targeted and invited to register their services on this system, which service users and support planners access to identify local support service on offer.

4.7.3 Transition planning: Under the Supporting Your Choice programme CSD undertook a piece of work to look at supporting local market development in response to the introduction of Personal Budgets across Adult Social Care and under this work commissioners are working alongside third sector organisations (as well as independent providers) to develop a "transition plan" for each organisation to understand areas of their business that require further development.

- This gives organisations an opportunity to outline how the council can support them. By working with commissioners, focusing on developmental work, we believe that this will provide an added dimension to the commissioner-provider relationship. The opportunity for third sector organisations as well as commercial providers and commissioners to all come together on a regular basis to discuss common themes is another way of supporting the sharing of good practice and looking at different approaches.

4.8 It is challenging to note though, that these areas of support are not always taken up by 3rd sector organisations and the council would welcome any dialogue that explains this.

5. GRANT FUNDING VS. COMMISSIONING

5.1 The essential difference between commissioning and grant funding is that in the commissioning process, the *service* is specified together with the desired outcomes for service users, often with an expected or prescribed service model, whereas with the council's grants programme, the *outcome* is specified (whether

individual outcomes or outcomes for the community), leaving organisations to determine the type and model of service they wish to deliver which will achieve the outcomes.

5.2 Commissioning is the entire process of a public body assessing the needs of a community or client group, working out how to fulfil those needs, and subsequently designing and securing the provision of that service to that client group or community.

5.3 In Hammersmith & Fulham, the 3rd Sector Investment Fund programme seeks to fund services which will deliver a range of outcomes through a cluster of services – it is not always the case that a single provider would be expected to deliver all of the outcomes as set out in the service specification.

5.4 The challenge for some 3rd sector groups is that the council may wish to grant fund activities that do not always correspond with what organisations wish to do. Grant funding is often oversubscribed and there are also more organisations and groups looking for funding which means greater competition.

5.5 A challenge for the sector in terms of commissioned services is often the scale of the contract. Whilst many of our commissioned services are delivered by 3rd sector organisations (e.g. Supporting People), it is sometimes only larger 3rd sector organisations which have the capacity to deliver these contracts. The Community & Voluntary Sector Association (CaVSA) are funded through Big Lottery to support local organisation to develop effective consortia and partnerships in order to be better placed to compete for large contracts.

6. FUNDING REDUCTIONS AND CROSS-BOROUGH COMMISSIONING

6.1 The Local Government Finance Settlement announced on 13 December 2010 confirmed that Hammersmith and Fulham will receive a funding reduction of 11.3% (£27 million) in 2011/12, increasing to 29% (£64 million) in 2013/14. Westminster and Kensington and Chelsea are faced with similar percentage reductions in central government funding over the coming years. Protecting front line services for vulnerable people by making savings from productivity, efficiency, and innovation is therefore the major shared challenge facing councils, voluntary sector agencies, and service providers over the next few years.

6.2 To minimise the service impact of budget reductions of this magnitude, we must work in collaboration with other commissioning organisations – particularly the NHS, the Royal Borough of Kensington & Chelsea and the City of Westminster. Cross-borough commissioning and procurement allows for greater purchasing power in the market to achieve better value for money, whilst reducing duplication of effort for both commissioners and providers. It also makes it easier for services to be planned and delivered across authority boundaries which improves access for vulnerable client groups. Hammersmith & Fulham already works in collaboration with other West London authorities, and our experience to date is that sub-regional contracting approaches (for example in homecare and supporting people services) does lower service costs and raise quality through the use of common service specifications and monitoring requirements. Where different specifications and contracting approaches are in place, the best can be benchmarked and used across the region; just as providers can learn from each other through collaborative commissioning approaches, so can commissioning authorities as well.

6.3 However, commissioning across boroughs also has the potential to increase the risks inherent in designing and implementing savings programmes. These risks include reduced local knowledge, less local intelligence about the impact of changes and unintended consequences, and reduced capacity to sustain smaller specialist service providers. The 3rd sector has a key role in helping to mitigate these risks through, for example:

- Facilitating the involvement of service recipients in commissioning and service re-design activities to ensure that a client focus is maintained. Traditional contracting arrangements establish a commissioner/provider relationship, but the recipients of services have sometimes not had a voice in the contracting arrangements. Ensuring that service user viewpoints and issues can be raised improves the practices of both commissioners and providers. 3rd sector organisations have an important part to play in facilitating and supporting this involvement. They can play a particular role in ensuring the involvement of disadvantaged groups, who may otherwise struggle to be involved, and help ensure that priorities are set on the basis of need.
- Helping commissioners to understanding 'value' from the resident and communities point of view, for example, in terms of the promotion of equality, diversity, and meeting the needs of disadvantaged groups. This understanding enables commissioners to focus services on the social, environmental, and economic priorities of the people they serve rather than making value for money judgements in isolation. The Third sector has an important role in both representing communities, and as a provider of local community services.
- Being involved in the development of services and engaged throughout the change process. Involvement and partnering with 3rd sector providers in the commissioning process and remodelling of services allows for more creative solutions to be identified and service delivery to be shared across providers. For example, we are currently exploring the possibilities for sharing night cover across Supporting People providers which should reduce costs without impacting on quality. This is a savings initiative identified by providers themselves. The removal of most central government mandated grant funding streams to local authorities enables us to use all incoming funds flexibility and creatively to best meet need.

6.4 Increasingly in social care personal budgets are giving people and their carers more control and choice over their services. The full benefits of personal budgets rely on accessible information about local services and their performance being available so that people can make active decisions about their care and support arrangements. 3rd sector organisations already play an important role in empowering and supporting social care clients to make these decisions and implement their support plans. Community Services department has established a service directory on the LBHF website, and 3rd sector organisations were invited to register their service on this directory – however, there has been a disappointing take up of this promotion and information opportunity by local 3rd sector providers.

6.5 Going forward, the creation of HealthWatch and the commissioning of Public Health services by local authorities will also promote the local consumer voice, and help ensure that views and feedback are gathered from patients and the public to inform local commissioning across health and social care services. Again, 3rd sector organisations have in important role to play in supporting and

brokering community involvement in these new structures, particularly as a voice of less heard groups in local communities.

6.6 The government has recently announced that a new package of support will be made available to enable local organisations and statutory partners to strengthen their working relationships and address the current challenges facing them. The nature of this support package has not yet been clarified.

7. 3RD SECTOR DATA

7.1 The council's Community Investment Team manage a database of local groups and organisations. Information on the council's website directs people to the team information, which includes details of how groups can be added to our mailing lists.

7.2 When groups contact Community Investment, they are asked a few questions about their organisation (contact details, address etc.), and are also asked to detail the nature of the service they provide and communities they support. Groups are asked whether they wish the details of their organisation to be available to others enquiring about local 3rd sector organisations in the borough.

7.3 Community Investment can provide mailing lists for local organisations in the following categories:

Advice Agencies	Abroad	Arts
Asylum	African/Caribbean	Asian
BME	Children/Young People	Community Centres
Crime	Disability	Eastern European
Education	Faith Groups	Health
Homelessness	Housing	Iranian
Irish	Men	Older People
Polish	Refugees	Schools
Social	Somalian	Sports
Tenants & Residents	Training	Unemployed
Women	Volunteers	
W6 / W12 / W14 / SW6 / NW10 or by ward		

7.4 The Community & Voluntary Sector Association (CaVSA), as the lead umbrella organisation for the 3rd sector in the borough, also have a database of 3rd sector providers, and through this provide an excellent communications channel for the sector, and for the council to reach local organisations.

7.5 It is proposed to transfer the Community Investment database to CaVSA in order for CaVSA to offer a single point of communication for the third sector in the borough.

8. RECOMMENDATIONS

8.1 Housing, Health and Adult Social Care Select Committee is asked to note the contents of this report.

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	LBHF 3rd Sector Strategy	Sue Spiller ext 2483	CSD, 4th floor 77 Glenthorne Road

London Borough of Hammersmith & Fulham

HOUSING, HEALTH AND ADULT SOCIAL CARE SELECT COMMITTEE

DATE	TITLE	Wards
15 February 2011	Hammersmith & Fulham LINk: Update Report	All

SYNOPSIS

This report updates the Committee on the work of Hammersmith & Fulham Local Involvement Network (H&F LINk): key activities, transition to Healthwatch and next steps.

CONTRIBUTORS

Karen Lyon
Interim Community Engagement Coordinator, Hammersmith & Fulham LINk

RECOMMENDATION(S):

The Committee is asked to:

1. Consider this report.
2. Consider how members can contribute and support strategic discussions on the development of Healthwatch.

CONTACT

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NEXT STEPS

n/a

Hammersmith and Fulham Local Involvement Network (H&F LINk) Update Report

1. The LINk Steering Group

The Hammersmith and Fulham LINk Steering Group is at the heart of the LINk and is made up of a group of committed volunteers from the borough. The LINk Steering Group meets every 6 weeks to discuss the LINk work plan, strategic direction, budget and priorities and agree LINk action.

2. LINk action (work plan and referrals)

LINk Steering Group identified and agreed work plan priorities:

- Safeguarding
- Personalisation (individual budgets for health care and social care)
- Polysystems, GPs and Dentists Services
- Community mental health services
- Housing and wellbeing

An action plan has been developed for each of these priorities and the LINk will proactively seek the views of local voluntary and community groups, organisations and residents in addressing them.

2.1 Safeguarding

LINk participants and Steering Group representatives are involved in the Safeguarding Adults and Safeguarding Children working group, looking at issues like how to inform the wider community about safeguarding and how to ensure training on safeguarding for service providers is accessible to all.

2.2 Personalisation

H&F LINk has teamed up with K&C LINk to look at people's experience of Individual Budgets and work with the council and service providers to address issues. A community researcher will carry out surveys and facilitate focus groups to gather information about people's experience and perception of personal budgets, how information is being distributed, how the service is being promoted and what can be done to improve this. Results will be compared with information gathered in the same way in Kensington & Chelsea and with best practice studies from other London boroughs. A report will be produced and recommendations sent to the council for service improvement by March 2011.

2.3 Polysystems, GPs and Dentist Services

H&F LINk participants are working with NHS H&F to carry out mystery shopping in GP surgeries testing patient experience at the point of reception. The results of this will be used to make recommendations for service improvement. H&F LINk is also working in partnership with the Disability Forum to identify GP surgeries which do not meet the access needs of disabled patients. Participants will develop a mystery shopping check list and carry out checks in February 2011. Recommendations will be discussed with the GP consortium and individual GP surgeries in March 2011.

2.4 Community Mental Health Services

H&F LINk is in touch with West London Mental Health Trust and H&F MIND about the development of a service directory for mental health services. H&F MIND is currently updating this and H&F LINk is keen to review progress and support the identification of gaps to ensure the community has access to relevant information.

2.5 Housing and Well-being

The Chair of H&F LINk, Harry Audley is leading a piece of work to look at the connection between housing and well-being and how to improve people's health by improving their connections to local services and information. H&F LINk has agreed a specification for community research to investigate resident experience through a series of one to one interviews, surveys and by reviewing data gathered by groups like Turning Point. Recommendations will be submitted to service providers by March 2011.

2.6 Referrals

Through the H&F LINk community research project proposal scheme, the LINk has received 3 referrals from local organisations. The Steering Group will work with these organisations to agree support from the LINk to address the issues they have raised.

3. Consultation, representation and influencing

The LINk works with Service Providers to identify and promote engagement opportunities. LINk highlights the need to involve members of the community in designing, delivering or monitoring a service; identifies a specific opportunity to engage and promotes this to potential participants.

LINk participants are taking part in a variety of consultations and influencing opportunities including:

- Dental Services Consultation
- LBHF Home Support Implementation Group
- Supporting Your Choice Reference Group

- LBHF Safeguarding Adults and Safeguarding Children Working Groups
- JSNA Health and Well-being and Housing and Health meetings
- CITAS Interpreters Health and Well-being Network
- CaVSA's Networks
- Quality Accounts Steering Group, Imperial College HealthCare Trust

4. Joint working

H&F LINk continues to work closely with K&C LINk. In a project supported by Imperial College HealthCare Trust, NHS H&F and NHS K&C and funded by Macmillan, LINk participants have been trained to promote access to cancer screening programmes, investigate patient experience and find out about the barriers that prevent people from accessing these services.

H&F LINk is also working with K&C LINk to compare people's perception and experience of personal budgets.

H&F LINk is also initiating joint work with K&C LINk and Westminster LINk on the transition to Healthwatch.

5. H&F LINk Events

H&F LINk's response to the NHS White Paper was submitted in October 2010 following a series of public events to gather participant views and concerns. H&F LINk's response was referred to in the government's update report following consultation.

H&F LINk held a public event in November 2010 to look at NHS spending priorities and influence commissioners in advance of decisions. Participants put questions to Sarah Whiting, CEO, North-West London cluster and Tim Spicer, Chair, H&F GP Consortia. They also took part in workshops on spending priorities for mental health; older people; children's services; public health and long-term conditions with NHS commissioners. Commissioners gained a clearer understanding of community priorities in specialist areas. A report detailing NHS H&F's response to issues raised will be sent out to participants and stakeholders in February 2011.

H&F LINk also held its AGM in November 2010. The Chair presented a progress report and the Host provided a financial report. Participants asked questions about the LINk workplan and outcomes and were updated on plans to March 2011.

6. Training and Capacity Building

The LINk builds capacity within the community by creating a rolling programme of learning opportunities to keep them up to date with current developments and enable them to make change happen.

The LINk held training sessions for members of the community on 'Community Research Skills'; 'Identifying Community Needs'; 'Innovative Community Consultation'; 'Effective Meeting Skills'; 'Representation and Participation Skills'

and ‘Mystery Shopping’. The sessions supported members of the community to design research projects; collect evidence; develop and participate effectively in a wide variety of meetings and consultation groups; develop the basic skills and confidence to represent their community on partnership groups and other strategic bodies and carry out mystery shopping exercises.

Training lined up between January and March includes:

- Cancer Champions training
- GP access mystery shopping workshop

The Host team also identify and promote external learning opportunities to LINk participants, quarterly by post, monthly by email and regularly through uploads to the LINk website.

7. Advertising and Promotion of the LINk

The H&F LINk AGM and LINk public events on NHS spending priorities were publicised through the H&F News as well as voluntary and community sector networks and the LINk participant database. The LINk also regularly advertises in publications like ‘*Heartbeat’*, the Friends of Charing Cross Hospital Magazine and online sites like ‘www.w*14london.ing.com*’.

The LINk had stalls at Time of Your Life 2010 and the LBHF Carers Event in November 2010. Participants signed up to take part in projects like cancer champions and access to GP surgeries.

The H&F LINk website, www.hflink.org.uk is updated with information about events, activities and consultations on a monthly basis.

The current membership level is 284, of which 170 are organisational representatives. It is part of the LINk future strategy to ensure that more individuals and organisations are aware of the LINk and how they can become involved or contribute.

8. Transition to Healthwatch

H&F LINk is keen to initiate cross-borough discussions around transition to Healthwatch with key stakeholders in all 3 boroughs. Initial actions include planning a cross-borough strategic development day to set up and strengthen relations and sending a LINk letter to PCT Chief Executives requesting information on recent changes including:

- The community's interface with commissioners
- Plans to develop capacity of VCOs
- How the functions of the current NHS H&F Community Engagement team remit and public health department will be covered
- How LINk will be supported to develop towards Healthwatch and take part as an equal partner in strategic discussions
- How patients and excluded communities will be engaged throughout

London Borough of Hammersmith & Fulham

HOUSING HEALTH AND ADULT SOCIAL CARE SELECT COMMITTEE

DATE	TITLE	Wards
15 February 2011	Case for change: Proposed separation of urgent and planned orthopaedic surgery	All

SYNOPSIS

This report proposes the separation of urgent and planned orthopaedic surgery currently based at Charing Cross Hospital and St Mary's Hospital. Separation could either be on the same site or on a different site. The main objectives of this proposal are:

• to improve quality, clinical effectiveness, safety and patient experience;

• to support the Major Trauma Centre (MTC);

•to improve education, research and development opportunities; and

• to improve productivity and eliminate waste.

CONTRIBUTORS

Imperial College Healthcare NHS Trust

RECOMMENDATION(S):

The committee is asked to review and comment upon the case for change and consider the public engagement it would think beneficial.

Case for change

Proposed separation of urgent and planned orthopaedic surgery

CPG3 – Specialist Services

January 2011

Version 1.5

innovation respect care achievement pride

Proposed separation of urgent and planned orthopaedic surgery

CPG3 – Specialist Services

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Contents

1 Proposal

This report proposes the separation of urgent and planned orthopaedic surgery currently based at Charing Cross Hospital (CXH) and St Mary's Hospital (SMH). Separation could either be on the same site or on a different site.

The main objectives of this proposal are:

- to improve quality, clinical effectiveness, safety and patient experience;
- to support the Major Trauma Centre (MTC);
- to improve education, research and development opportunities; and
- to improve productivity and eliminate waste.

The Trust's Specialist Services Clinical Programme Group (CPG3) proposes to engage with GPs, Local Involvement Networks (LINks), Overview and Scrutiny Committees (OSCs) and a wide range of staff both formally and informally in order to bring a fully evidenced recommendation, business case and the results of the discussions with key stakeholders to the trust board in August 2011 for decision.

2 Current service

The Imperial College Healthcare Trust (ICHT) urgent and planned orthopaedic service is provided predominantly at Charing Cross Hospital and St Mary's Hospital and is managed within the Clinical Programme Group for Specialist Services (CPG3).

The vast majority of urgent and planned orthopaedic surgery involves bone fractures and joint replacements. The most common fractures are ankles, upper limbs and hips and the most common joint replacements are hips and knees.

Urgent admissions by procedure across
Source: Internal Trust Data

Diagnosis	Total admitted 2009/10
Neck of femur (hip)	23%
Upper limb	20%
Lower limb	10%
Ankle	29%
Spine	8%
Major orthopaedic trauma	4%
Pelvis	4%

In 2009/10 procedures were carried out on some 5,100 inpatients in roughly equal proportions across both sites and almost 40,000 outpatient appointments took place, as shown in the tables below.

Urgent admissions and planned procedures (day case and admitted by site 2009/10)

Source: Internal Trust Data

Type of procedure → / Hospital ↓	Urgent	Planned	Total
St Mary's	741	1670	2411
Charing Cross	764	1908	2672
Total	**1505**	**3578**	**5083**

Most patients come from the central, north and west London areas. Please note that these figures relate to broken or crumbling bones where an admission/surgery was needed. There is no suggestion to reconfigure the fractures clinics (located on both sites) which deal with broken bones that do not need surgery.

Where patients come from

Source: Internal Trust Data

Urgent	H&F	K&C	West	Ealing	Brent	H'low	Harrow	Hill'don	Rest of London	Out of London	Total
SMH	11	135	273	15	103	6	5	6	108	79	741
CXH	244	69	29	78	21	81	12	18	129	83	764
Total	255	204	302	93	124	87	17	24	237	162	1505

Planned	H&F	K&C	West	Ealing	Brent	H'slow	Harrow	Hill'don	Rest of London	Out of London	Total
SMH	77	278	551	109	315	21	21	7	188	103	1670
CX	559	131	120	469	99	198	14	20	198	100	1908
Total	636	409	671	578	414	219	35	27	386	203	3578

There are around 40,000 orthopaedic outpatient appointments.

Orthopaedics outpatient appointments by site 2009/10

Source: Internal Trust Data

	New	Follow-up	**Total**
St Mary's	7350	12,350	**19,700**
Charing Cross	6450	13,400	**19,850**
Total	**13,800**	**25,750**	**39,550**

The Trust has developed a very successful ortho-geriatric service which recognises the particular issues that face older people with broken or crumbling bones. This service has been very successful.

The Trust is also the primary provider of spinal surgery in north west London and the Trust is looking to develop and expand the service with spinal and neurosurgeons working together to provide excellent care for more patients.

Charing Cross Hospital site
The Charing Cross site offers planned and urgent surgery in dedicated laminar flow theatres[1], a fracture clinic and outpatient appointments.. Use is made of the robotics suite.

There are two orthopaedic wards on the CXH site, 7 South and 7 West. However, at present, the quality of ward infrastructure is inconsistent and could be provided in a more efficient manner.

Part of the specialty performing planned surgery on hands at CXH was shortlisted for a Health Service Journal (HSJ) 'Quality and Productivity' 2010 award.

The majority of urgent and planned orthopaedic research activity takes place at the CXH site and there are well-established links with the world-leading Kennedy Institute of Research (KIR). There is also an urgent and planned care orthopaedic private patient facility on the CXH site.

St Mary's Hospital site
The St Mary's site offers elective and non-elective surgery, a fracture clinic, and outpatient appointments. Paediatric (children's) orthopaedic services are also provided on the SMH site.

In 2009, ICHT was designated to host the major trauma centre to service north west London based on the SMH site. The MTC has been open 24 hours a day seven days a week since 10 January.

The orthopaedic ward is Valentine Ellis.

[1] Laminar flow describes the ventilation system used to reduce the number of infective organisms present in the air. Any bacteria, viruses or dust particles are extracted before the air enters the operating area.

3 Case for change

3.1 Strategic fit

The key objectives for the proposed change are to:

- improve quality: clinical effectiveness, safety and patient experience;
- support patients in the Major Trauma Centre (MTC);
- improve education, research and development opportunities; and
- improve productivity and eliminate waste.

These objectives link into the ICHT mission of becoming one of the top five global academic health science centres within the next ten years. They also support the attainment of excellence in research to provide world class healthcare for patients and the achievement of ICHT objectives to:

- provide the highest quality of health care to communities we serve;
- provide world-leading specialist care in our chosen fields;
- conduct world-class research and deliver the benefits of innovation to our patients and population;
- attract and retain a high-calibre workforce, offering excellence in educational and professional development; and
- achieve outstanding results in all our activities.

3.2 Future demand and current service delivery

One of the biggest challenges over the next ten to twenty years in London is likely to be caring for the growing and ageing population.

The fastest growing sections of the population are the 40-64 age group and the over 85's, both of which are known to have higher health needs than younger age groups. A population that is both bigger and older will have a significantly greater need for healthcare, and specifically orthopaedic health needs.

Total hip replacements are increasing at a rate of 20% per annum with demand for replacing worn out replacement hips and knees and total knee replacements doubling over the last ten years. The increase in demand is forecast to continue. With demographic change and expected increase in market share, a modest projection of growth in elective procedures is 10% year on year.

The biggest challenge currently for many acute trusts (including ICHT) is meeting the 18 week referral to treatment target[2] within elective orthopaedics. Sustaining the 18 week pathway in the face of growing and changing service demand will not be possible without significant service delivery redesign.

This case for change is not about doing more of the same, it is about rethinking the ways in which ICHT provides the service across the whole pathway/care system to ensure we see the right people, in the right place at the right time with the appropriate resources. This does not solely relate to adding capacity. It is about making full use of all the resources available to improve patient access and ultimately clinical outcomes.

[2] Although the 18 week referral to treatment target has been suspended, the Department of Health will be monitoring maximum waiting times, 95th percentile of waiting time and median waiting times.

3.3 Improving clinical effectiveness and safety

a) Separating planned and urgent orthopaedic services improves surgery, reduces the time to theatre, reduces infection rates, improves the patient experience and is more efficient.

There is good evidence that separating planned care results in fewer cancelled operations, reduced readmission rates and healthcare acquired infection rates and improved patient satisfaction[3,4]. For these reasons (explained in more detail below), the separation of services, facilities and rotas is recommended by the Royal College of Surgeons (2007)[5].

Improved surgery

The Royal College of Surgeons[6] of England (2007) states:

> *"Separating elective care from emergency pressures through the use of dedicated beds, theatres and staff can if well planned, resourced and managed…increase senior supervision of complex/emergency cases, and therefore improve the quality of care delivered to patients."*

At present, on both the CXH and SMH sites, the urgent and planned service share theatres and staff. Separating urgent and planned care means that surgeons are able to spend more time becoming expert in their sub-specialty areas.

Treating patients in a dedicated planned care environment would support an increase in Patient Recorded Outcome Measures (PROMs) scores. Currently ICHT's average pre-operative scores are almost at the national average, but the average post-operative scores are lower than both the London SHA and national averages. Although PROMs are in their infancy and some data quality issues have still to be resolved, these figures give a good indication that ICHT needs (and can) do better than it is now.

Better surgery is more efficient. There are fewer readmissions and patients recover more quickly.

Chapel Allerton Orthopaedic Centre (part of Leeds Teaching Hospital NHS Trust) opened January 2005. The NHS Institute for Innovation and Improvement[1] used the centre as a case study, explaining that

"The centre's big successes are:

- Surgery on day of admission for virtually all patients
- Reduced length of stay
- Very low infection rates
- Positive effects on mortality/morbidity rates
- Virtually no complaints
- No recruitment and retention problems"

NHS Institute for Innovation and Improvement (2006) *Delivering Quality and Value – Focus on: Primary Hip and Knee Replacement.*

Faster time to theatre

The creation of a ring-fenced urgent care facility ensures fast, dedicated urgent surgery. Patients needing an urgent operation do not need to wait for a surgeon and team to finish a planned operation or be called in to the hospital.

[3] House of Commons, Independent Sector Treatment Centres: Fourth Report of Session 2005-06, Vol 1

[4] Department of Health, Delivering the NHS Plan: Next steps on investment, next steps on reform, 2002

[5] The Royal College of Surgeons of England (2007) *Separating emergency and elective surgical care: Recommendations for practice*, London, Royal College of Surgeons of England

[6] Royal College of Surgeons (2007) *Separating emergency and elective surgical care: Recommendations for practice*

'Urgent surgery only' lists would support ICHT in increasing the number of hip fracture patients who have surgery within 48 hours. According to the National Hip Fracture Database National Report 2010[7], nationally 81% of patients had surgery within 48 hours and in London the figure was 80.4%. In the report both SMH and CXH were well below this at 64.2% and 52.6% respectively. However, there were data quality issues with the CXH figure, which is actually closer to 80%.

Reducing cancellations and waiting lists – better for patients

The Royal College of Surgeons (2007) states:

> *"The unplanned use of elective resources by emergency medical and surgical admissions has a large impact on the use of beds, theatres and staff for elective work and in turn on the management of waiting lists. In particular, emergencies tend to overflow into elective resources... Streaming elective and emergency care should lead to fewer cancellations and improve supervision of trainees, thus improving patient safety."*

Cancellation of surgery is inconvenient and upsetting for patients and their families. With dedicated urgent and planned surgery lists, planned patients would not be cancelled should a patient needing urgent surgery arrive. Conversely patients requiring urgent surgery would not be kept waiting (see section above).

These key improvements result in a range of benefits

	Reduced infection rates	Improved patient experience	Greater efficiency	Better training
Improved surgery – better outcomes and reduced mortality	*	*	*	*
Faster time to surgery	*	*		
Fewer cancellations	*	*	*	*

[7] National Hip Fracture Database (2010) *National Hip Fracture Database National Report 2010*, London, London Hip Fracture Database/NHS Information Centre

Reduced infection rates

The Trust's rate of Healthcare Associated Infections (HCAIs) for hip replacement, knee replacement and repair to neck of femur is 0.77%. Although this figure is low, and below the national average, it is still not acceptable for patients to develop infections whilst in hospital.

The introduction of a ring fenced orthopaedic ward for planned surgery and simple infection significantly reduces the incidence of all post-operative infections[8]. This is for two key reasons:

- Patients arriving for planned care can be screened for infections before being admitted so infections are not introduced to planned care patients from outside the hospital;
- The better care that results from the increased specialisation of surgeons and their teams and the increase in day case surgery reduces the time patients spend in hospital. A study of MRSA rates in hospitals estimated that probably more than half the 27% fall in MRSA rates across the country between 2001 and 2006 was simply due to the reduced time patients spent in hospitals[9].

The Royal College of Surgeons (2007) states:

> *"Separating emergency and elective care has significant benefits for patients and can offer early investigation, definitive treatment and better continuity of care. Hospital-acquired infections can be reduced (...and lengths of stay should be shorter...) by the provision of protected elective wards and avoiding admissions from the emergency department and transfers from within/outside the hospital."*

Patient experience

Patients prefer the shorter stay in hospital that comes from better surgery, fewer infections and more day case surgery – it is more convenient for them[10].

The planned care only ward at CXH and the combined planned and urgent care ward at SMH both have similar staffing mix, experience and management. Yet the I-track scores[11] show the ward at CXH receives consistently higher scores as shown in the table below.

I-track scores for orthopaedic wards at SMH and CXH

Source: Internal Trust Data

Month	SMH score	CXH score
Aug 2010	81%	96%
Sept 2010	74%	97%
Oct 2010	86%	97%

[8] Biant, L. C. et al. (2004) Eradication of methicillin resistant *Staphylococcus aureus* by "ring fencing" of elective orthopaedic beds, *British Medical Journal*, 329 : 149

[9] Fenn P: Variations in the frequency of MRSA infections across acute NHS hospitals, 2001-2006

[10] Naftalin N.J., Habiba M.A: Keeping patients out of hospital. Patients like it. BMJ 2000; 320 (7230)

[11] I-track is a programme of electronic patient surveys, which asks orthopaedic patients about 17 indicators

Greater efficiency

A study in 2002 demonstrated that over 50% of the delays and cancellations in operating theatres being used for both emergency and planned surgery were due to surgeons being called to attend emergencies[12]. In 2010 nearly one orthopaedic operation a day was cancelled at CXH and SMH.

Other efficiency savings from separating services include:

- greater use of operating theatres[13];
- increased efficiency of operating teams;
- reduced administration time spent rebooking cancelled operations; and
- fewer beds needed due to the reduced time patients stay in hospital.

It is estimated that separation of planned surgery and simple infection control can result in 17% more patients being treated[14].

These findings are supported by data from the Elective Orthopaedic Centre (EOC) at Epsom. Their beds, theatres and staff are ring fenced for elective work and their throughput and 18 weeks performance is one of the highest in the NHS.

The centre had no reported incidence of HCAIs in 2009/10.

The Elective Orthopaedic Centre (2009) *The EOC Annual Report 09 – One Step Ahead*, Epsom, The Elective Orthopaedic Centre

Improving productivity:

- would assist the trust in treating patients quickly;
- could reduce the running costs of the service; and
- would ensure there is sufficient capacity in the service to meet the expected growth in demand.

Training and research

Separating urgent and planned orthopaedics improves the training opportunities for junior staff, nurses and consultant surgeons.

The Royal College of Surgeons (2007) states:

> *"Separating elective care from emergency pressures through the use of dedicated beds, theatres and staff can if well planned, resourced and managed…achieve a more predictable workflow, provide excellent training opportunities… and therefore improve the quality of care delivered to patients."*

To run clinical trials of surgery requires good planning. Every major orthopaedic surgical centre which is currently delivering such trials exists with functional separation of urgent and planned services. This enables the planned workflow to be streamlined and to take place without interruptions, in a way that is impossible for emergency cases. Separating urgent and planned surgery would increase the number of trials taking place, which would support the Trust's objectives of doubling the number and volume of commercially sponsored clinical trials by March 2014 and raising the proportion of patients enrolled in a research protocol by 1% each year for the next five years.

[12] A.A. Weinbroum et al, The American Journal of Surgery (2003)
[13] The Elective Orthopaedic Centre has an operating theatre slot utilisation rate of 97%
[14] Biant, L. C. et al. (2004) Eradication of methicillin resistant *Staphylococcus aureus* by "ring fencing" of elective orthopaedic beds, *British Medical Journal*, 329 : 149

The Kennedy Institute of Research (KIR) states that consolidation of urgent and planned orthopaedic services across ICHT sites would promote associated research activities with the KIR, especially in the areas of translational research and clinical trials.

The predictable workflow is also the key to high-quality, efficient training. Trainee doctors can attend the operations or cases necessary to ensure they gain the experience required.

b) Surgeons and their teams performing more operations are better than teams performing small numbers of operations

A review of 18 articles[15] which studied different orthopaedic surgical procedures, particularly total hip and knee replacements concludes that:

> *"They nearly all confirm that outcome, measured in terms of mortality, re-admission, post-operative complications (such as dislocation, embolism or infection) and length of stay after operation, improves with the volume of activity of hospitals and/or surgeons."*

A review carried out in the USA in 2002[16] concluded that there is a positive volume-outcome relationship for orthopaedic procedures and a literature review of the volume-outcome relationship in total hip replacement[17] found that *"a general correlation between high volume and low complication rate could be identified."*

In 2005/6 the hip replacement patients of the consultants in the 10 trusts in the country carrying out the most procedures had consistently lower lengths of stay than those of the consultants in the 10 trusts in the country which carried out the fewest procedures[18].

Part of the elective hand surgery team at CXH was shortlisted for the prestigious HSJ 'Quality and Productivity' award 2010. If the elective part of the service is separated, elements of the hand surgery model such as high volume working with dedicated teams can be transferred into all elective surgery ensuring greater clinical effectiveness.

c) In general, day case procedures are clinically better and aid fast recovery

Because day case surgery generally provides timely treatment with less risk of last minute cancellation, a lower incidence of hospital-acquired infections (due to the reduced length of stay)[19] and because it tends to use less invasive techniques, patients show better, and quicker recovery[20]. Just as importantly, patients like it[21].

Whilst day case surgery ***can*** be performed in main theatres, best practice (and full attainment of the

[15] Com-Ruelle L., Or Z., Renaud T. (2008), *Volume d'activité et qualité dans les hôpitaux: enseignements de la littérature*, Paris, IRDES
[16] Halm, E. A., Lee, C. and Chassin, M. R (2002) Is Volume Related to Outcome in Health Care? A Systematic Review and Methodologic Critique of the Literature, *Annals of Internal Medicine* 137 no. 6
[17] Schräder P., Rath T. (2007) Volume-outcome-relationship in total hip replacement-literature review and model calculation of the health care situation *Z Orthop Unfall* May-Jun;145(3):281-90
[18] NHS Institute for Innovation and Improvement (2006) *Delivering Quality and Value – Focus on: Primary Hip and Knee Replacement*, Coventry, NHS Institute for Innovation and Improvement
[19] Manian FA, Meyer L., Surgical-site infection rates in patients who undergo elective surgery on the same day as their hospital admission. Infect Control Hosp Epidemiol. 1998 Jan;19(1):17-22.
[20] British Association of Day Surgery: Commissioning Day Surgery, A guide for Commissioners, Nov 2003
[21] Audit Commission: Measuring Quality: The Patient's View of Day Surgery, 1991

benefits) is not achieved unless this type of surgery is performed in a dedicated environment. The Riverside day surgery unit at CXH is currently underutilised.

d) The presence of senior surgeons improves outcomes

The Department of Health's Musculoskeletal Services Framework Document[22] states that the presence of senior surgeons for elective and emergency work enhances patient safety and quality of care.

e) Co-dependency with major trauma

Seventy per cent of major trauma patients need orthopaedic intervention[23]. At present, there is no dedicated 24/7 orthopaedic cover for patients needing urgent surgery in the Major Trauma Centre (MTC) team.

Conversely, evidence from a number of hospitals and critical care networks suggests that approximately 2% of orthopaedic trauma patients have some unexpected complication that requires specialist critical care support[24].

Co-location of a 24/7 orthopaedic trauma team with the MTC at SMH would benefit both major trauma patients needing surgery out of hours and orthopaedic patients needing specialist critical care as well as urgent surgery.

f) Single sex accommodation

In line with national requirements, ICHT is committed to providing every patient with same-sex accommodation. At present the orthopaedic surgery service is providing this for only 98% of our patients. Achieving same-sex accommodation would be easiest with the smallest number of different services. I.e. it would be easier to provide same-sex accommodation in one elective centre rather than in two.

3.4 Conclusion

There is a case for changing the way ICHT arranges its orthopaedic surgery that:

- separates urgent and planned orthopaedic operations;
- increases the number of patients with a particular condition being seen by each surgeon/team;
- increases the proportion of day surgery being carried out;
- increases the amount of time senior surgeons are present on wards;
- co-locates urgent orthopaedic surgery with the Major Trauma Centre; and
- ensures more patients are treated in single sex accommodation.

[22] The Department of Health (2006) *The Musculoskeletal Services Framework*
[23] Imperial College Healthcare NHS Trust Major Trauma Centre Business Case (2009)
[24] Royal College of Surgeons

4 Developing options - issues

The following issues also need to be considered when determining which option would be most suitable for a reconfigured service for ICHT.

Physical space available and cost
A solution that requires the least amount of building work and that is economical in terms of capital and/or running costs is more acceptable that expensive options that reduce the amount of funding available to treat other patients.

Space is particularly limited on the SMH site.

Travel
The road distance between CXH and SMH is around 4 miles. The blue light ambulance journey time is an average of approximately 14 minutes and around 21 minutes by private car.

For patients needing **urgent care** it should be noted that protocols are already in place at CXH and SMH and A&Es across the country for patients who are incorrectly transported or who self-present. Similar protocols are being discussed for orthopaedics. For all options, the number of patients that would potentially need a transfer would be small – between none and one a day. Some patients would also need to travel a little further. However, irrespective of this, clinicians believe that the more streamlined arrangements and dedicated resources would outweigh the extra travel and time to theatre would reduce not increase.

If **planned surgery** was consolidated onto one site around 1,700-1,900 patients would need to travel to a different hospital than now.

Arrangements would also need to be in place for patients to choose (whenever possible) to return to their local hospital for recuperation and rehabilitation after surgery.

5 Options appraisal

The programme intends to appraise viable options to consider their:

- clinical effectiveness, safety and patient experience
- education, research and development opportunities
- benefit for other services (e.g. MTC)
- Achievability – e.g. physical space requirements / capital and revenue costs
- Travel

Clinicians consider that the following options should be considered more fully:

Option	Description	Key issues – does the option address the issues described in the case for change?
1	Centralising planned surgery at CXH and urgent surgery at SMH	This option would address all the issues described in the case for change. The option appears achievable and affordable. However it requires some patients to travel a little further or be transferred.
2	Consolidating all planned and urgent surgery on one site	
	a) at SMH	This option would address most of the issues. However there is a risk that of overspill from urgent to planned care pathways as the two are on the site; the day surgery unit at Riverside (CXH site) is not utilised; the SMH site would need to be extensively developed and some patients would need to travel a little further or be transferred.
	b) at CXH	This option would address some of the issues. However there is a risk that of overspill from urgent to planned care pathways as the two are on the site; there would be no benefit of co-location of urgent care with the MTC (which would have to retain some orthopaedic urgent surgery rota) and some patients would need to travel a little further or be transferred.
3	Separating planned and urgent services at both CXH and SMH	This arrangement would address some of the issues. However there is a risk of overspill from urgent to planned care pathways as the two are on the site. No patients would need to travel further than they do now. However, the economy benefits, the advantages of surgeons performing more of the same type of surgery and more senior doctor presence would not be achieved. The benefit of co-location of urgent care with the MTC would only be partially achieved. The service would need additional accommodation to the current service.
4	Retaining urgent surgery on both sites but separating and consolidating all planned surgery on the CXH site	This option would address most of the issues. However, the economic benefits, the advantages of surgeons performing more of the same type of urgent surgery, co-location of urgent care with the MTC and more senior doctor presence would all be reduced compared to option 1. Some patients would need to travel a little further for their care or be transferred.

Options currently considered to be no better or worse than 'do nothing' are:

- Consolidation of operations onto the Hammersmith site as the site currently has no orthopaedic surgery services.
- Locating the urgent care service at CXH (not benefiting from the co-location with the MTC at SMH) and the planned service at SMH (not benefiting from the greater utilisation of the Riverside day surgery unit at CHX). This is the opposite of option 1.
- Retaining urgent surgery on both sites but separating and consolidating all planned surgery on the SMH site (which would require substantial building works and not utilise the Riverside day surgery unit on CXH. This is the opposite of option 4.

A pre-consultation business case is being developed and will provide an appraisal of each option.

6 Public and stakeholder engagement

6.1 Legislation and direction

Effective engagement is central to developing the highest quality health services. Benefits can be maximised and threats minimised by working with key stakeholders to:

- gain a better understanding of patient needs, supporting the design of services that improve the patient experience and health outcomes;
- ensuring new models have been thoroughly considered by all specialists; and
- improve public confidence in local NHS services and decision-making.

In addition to the requirements under the NHS Act, the Secretary of State issued guidance (June 2010) around four key tests that need to be met in order for service change to be acceptable:

- support from GPs / commissioners;
- strengthened public and patient engagement;
- clarity on the clinical evidence base; and
- consistency with current and prospective patient choice.

6.2 Stakeholders

Key stakeholders who will need to be involved / communicated with include:

Local authorities

- Council leader, Lead member for health (Cabinet)
- Chief executive, Head of adult health and social services, Head of children's services
- Health Overview and Scrutiny Committee (OSCs)

Staff / clinicians

- Other acute, sector and PCT staff; Mental health trust staff
- Community pharmacists and LPC, unions;
- London Ambulance Service (LAS);
- ICH Directors and CPG Directors
- Orthopaedic staff, A&E staff, Anaesthetists, Theatre, Plastics, Nursing, MTC team, Therapies, Imaging & diagnostics, Limb fitting, Outpatient clinic, Admissions, Discharge, Pharmacy, Clerical & admin, Finance, Estates and facilities, Porters, Cleaners, Patient transport, Security / Parking, Decontamination and sterilisation,

Medical records, Clinical coding, Communications, Planning & business development, Trust Board, executives, non-execs
- GPs, GP commissioners / GP consortia / Practice-based commissioners / Professional Executive Committee (PEC) or Clinical Executive Committee chairs, GP practice managers, LMCs

Patients and the public
- Local Involvement Networks (LINks); Patients and patient support groups
- User/Patient experience groups
- Expert patient groups, PALS, Carers, Friends of the trust, Community groups
- Local access groups (e.g. disability groups or the elderly)
- Traditionally under-represented groups (including people with specific cultural needs/Non-English speakers)
- Faith groups, Tenants and residents groups, Youth parliaments, CAB
- General public and other communities of interest

Organisations and representatives
- Local MPs and MEPs
- Mayor and GLA representatives
- Royal Colleges (RCS, RCA etc)
- Deanery
- Key third sector national and local charities
- Trade Unions (e.g. BMA)
- NHS London and NHS NW London

Media
- Local media (including BME, council magazines)
- National media and trade specific – i.e. Nursing Times, PULSE

6.3 Deliverables

The scale of any engagement needs to be appropriate for the changes involved and efficiently meet the objectives of better understanding patient needs and supporting the design of high-quality services that also improve the patient experience and health outcomes in an achievable model. Discussion with OSCs and LINks and further discussion with GPs will enable the Trust to shape its proposals, communications materials and the scale and detail of engagement.

6.4 Timings

There is a need for work to:
- further analyse the numbers of patients/procedure and where they travel/ are referred from and the financial implications;
- discuss proposed pathways and protocols – particularly regarding possible transfers;
- discuss the proposals in depth with the London Ambulance Service;
- assess the impact the proposals may have on equality groups, the environment and travel times; and
- consider the views of other stakeholders e.g. councils, OSCs and LINks.

Timing of any broad engagement is partially dependent on these discussions. However it is hoped that the Trust could be in a position to make a decision on reconfiguration in late summer/ early autumn.

London Borough of Hammersmith & Fulham

HOUSING HEALTH AND ADULT SOCIAL CARE SELECT COMMITTEE

DATE	TITLE	Wards
15th February 2011	Bringing Housing Services Back to the Council	All

SYNOPSIS

H&F Homes currently manages the Council's housing stock. It was set up as an Arms Length Management Organisation (ALMO) in 2004 to access funding for the £232 million Decent Homes Programme. The Decent Homes Programme and contract that H&F Homes have with the Council are scheduled to finish in March 2011.

The Board of H&F Homes has reviewed the options and believes that residents' interests will be best served by returning the management of housing services to the Council. Council tenants and leaseholders also gave their backing to a proposal to bring the management of their homes back under the Council's control. The result of a postal survey of residents suggested more than 70% of residents are in favour of the proposal to bring housing management back to Hammersmith & Fulham Council. On 10th January 2011 the Cabinet agreed to integrate the ALMO services back into the Council and create a new Housing and Regeneration department.

London Borough of Hammersmith & Fulham

HOUSING HEALTH AND ADULT SOCIAL CARE SELECT COMMITTEE

The integration is intended to save up to £400,000 a year and protect frontline services by deletion of vacant posts, which would otherwise be duplicated in the new structure, and the elimination of agency workers and contractors to whom TUPE does not apply.

CONTRIBUTORS
Housing Services
Finance & Resources

RECOMMENDATION(S):

That the Committee note the information regarding integration of the ALMO back into the Council.

CONTACT
Nick Johnson
Interim Director of
Housing and Regeneration

1.0 Introduction

1.1 The need to implement the requirement for the Council's housing stock to be improved to the 'decent homes' standard led to the formation of the 'arms length' management organisation (ALMO) – Hammersmith and Fulham Homes (H&FH) – in 2004. Since its creation H&FH has been undertaking a programme of the replacement of kitchens and bathrooms in all tenanted homes and completing extensive planned maintenance of estate and street based homes. By the end of 2010, when the programme will have been completed, over £230 million will have been spent on over 18000 homes.

1.2 Hammersmith and Fulham has achieved a great deal in the planning and implementation of housing services over the course of the last four years. The organisation has seen a steady increase in resident satisfaction with the services provided by H&F Homes (from 67% in 2007 to 73% in 2010). However, there have been significant challenges in the provision of better housing management, and in the long term planning for modern new homes.

1.3 To maximise the benefits of the proposed self-financing system it is important for the Housing Department to work closely with colleagues in other areas including Planning, Resident Services and Finance and Corporate Services. Therefore, on 10th January 2011 the Cabinet approved the creation of a single integrated Housing department. It is envisaged that the new department will foster close working relationships with other departments in the Council more effectively than maintaining an Arms Length Housing Management structure.

2.0 The ALMO Integration Project Board

2.1 In June 2010 the Council approved the setting up of a project board drawing membership from both the Council and H&F Homes which would have overall responsibility for the reintegration of housing management services. The Director of Finance & Corporate Services was appointed Chair and project sponsor. Furthermore, the project board comprises a Solicitor, the Assistant Director of Human Resources and Deputy Director of Finance and Director of Finance(HF Homes) to ensure due diligence.

2.2 The project board meets once a fortnight to monitor progress against the integration project plan. The project board ensures that the plans to integrate H&F Homes into the Council are up to date complete and realistic and responsibility for each task is clearly defined.

2.3 All aspects of integration have been considered by the ALMO integration Project team and included in the project plan. The project board has placed particular emphasis on the following aspects of the ALMO integration:

- Consultation with tenants and leaseholders (and other stakeholders such as voluntary groups)
- Engagement with staff
- Financial and legal considerations

3.0 Resident Consultation

3.1 A comprehensive consultation programme was undertaken to ensure residents were aware of the Council's proposal to create a single Housing Department. The consultation process clearly demonstrated that residents were in favour of the ALMO's re-integration (with less than 5% of residents stating that they would like the ALMO to maintain a separate identify from the Council's Housing Department).

3.2 In February 2011 a letter will be sent to all residents informing them of the Council's decision to take the ALMO back in-house, the letter confirms that there will be no reduction or changes in the service provision. In addition, a dedicated telephone helpline has been set up since September 2010 to answer any questions that residents may have about the ALMO integration process.

4.0 Engaging with Staff

4.1 Within H&F Homes the transfer back to the Council has not appeared to be controversial either with the majority of employees or our recognised Trade Unions. The aim is to recreate the roles that now exist in H&F Homes in an identical structure within the Council. H&F Homes employees will then "lift and shift", which means they simply transfer to those new roles in the Council. Employees rights will be protected by the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE).

4.2 Under TUPE people employed by one organisation before a transfer become the employees of the new organisation to which they are transferred on their previous terms and conditions of employment. The table below summarises the consultation process with staff, the outputs from all key events and meeting will be shared with staff through articles in the intranet and monthly team meetings.

Activity	**Date**
Notification to H&F Homes Trade Union representatives at regular monthly meeting of the Joint Negotiating Forum.	12th January
Facility time granted for meetings of ALMO trade union members with Branch Secretaries and Convenors.	12th January
Road shows in each H&F Homes office to explain TUPE and the transfer process	January
Road show by newly appointed Director of Housing and Regeneration and Assistant Director of Housing Services.	February
Discussion with H&F Homes Trade Union representatives at regular monthly meeting of the Joint Negotiating Forum.	9th March
Final approval and sign off of consultation by Director of Housing and Regeneration	30th March
Letter and welcome to the council pack sent to all employees confirming their transfer	31st March
Induction sessions for H&F Homes employees	April

5. Financial and Legal Considerations

5.1 All suppliers and contractors have been informed of the impending changes to the invoicing and payment systems that will come into affect in April 2011. Similarly, the novation of contracts of all existing H&F Homes contracts will be undertaken by the Council's legal team during the same period.

5.2 Deloitte has been appointed as internal auditors to oversee the integration of the ALMO's and the Council's financial accounting and IT systems.

6. Operational Issues

6.1 The project board focuses on strategic and legal issues. However, successful integration also requires operational issues to be consideration, for example, changing signs in offices, amending the HF Homes website, and staff uniforms and name badges are some of the issues that are being considered by 3 operational project teams.

- Communications and Branding
- IT and Website Team
- Housing Service / Housing Options team

6.2 Each team is made up of managers and frontline staff from across the existing HF Homes and Council Housing teams. The project teams have developed individual action plans and meet regularly to develop the processes and policies to ensure a smooth transition from the ALMO to the new Council Housing Department.

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
	None		

Agenda Item 8

London Borough of Hammersmith & Fulham

HOUSING HEALTH AND ADULT SOCIAL CARE SELECT COMMITTEE

DATE	TITLE	Wards
15th February 2011	Housing Benefit Caps from April 2011	All

SYNOPSIS

Government has announced a range of caps to Housing Benefit which will be in place from 1st April 2011. These include:
Caps on Local Housing Allowance claimable by residents in the private rented sector, and
Caps on Housing Benefit claimable by residents in Housing Association leased accommodation (leased from private landlords for the provision of homelessness services).

The Council is working closely with private landlords and Housing Associations to mitigate the impact on residents, focusing on proactive renegotiations to bring rents down to levels within the caps. Although the rents of approximately 2400 households in H&F are currently estimated to be affected, approximately 55% of landlords involved in leasing have already agreed that they will reduce their rents to levels within the caps. Because of this, it is projected that significantly fewer households will actually remain affected when the caps begin in April 2011.

Extra resources have been brought together to ensure that residents receive timely and accurate advice about their options. In addition to the usual services available from H&F Advice, a dedicated team called HB Assist has been established, which includes Housing Options advisers and Housing Benefit specialists. Housing Options is also working in partnership with Housing Associations, Adult Social Care and Children's Services to ensure that the needs of households

who remain over the caps are fully understood, and that appropriate solutions can be found.

Where rents cannot be renegotiated, eligible households may apply for Discretionary Housing Payments to bridge the gap between their rent and the caps. Where this is not possible, Housing Options can provide assistance to secure alternative, affordable accommodation, either through homelessness prevention services or as part of the Council's statutory housing duties. Temporary Accommodation for households accepted as statutorily homeless is regularly procured outside of the borough and any additional procurement in response to the caps will be in line with the usual procedures. Households who are concerned about the caps are encouraged to contact H&F Advice to discuss their situation and to find out more about the options available to them.

CONTRIBUTORS

Housing Options
Housing Benefit
Department

RECOMMENDATION(S):

That the Committee notes the information regarding proposed caps and mitigating actions.

CONTACT

Nick Johnson, Interim
Director of Housing and Regeneration

1. Housing Benefit caps from 1st April 2011

Government has announced a range of caps to Housing Benefit which will be in place from 1st April 2011. These include:

- Caps on Local Housing Allowance claimable by residents in the private rented sector, and
- Caps on Housing Benefit claimable by residents in Housing Association leased accommodation (leased from private landlords for the provision of homelessness services).

Please note that additional caps which have been announced by Government and which will apply from April 2012 onwards (as many require changes to primary legislation) are out of scope for this report, including:

- *April 2012: Increase single room rate age from 25 to 35 years of age*
- *April 2013 onwards: 10% reduction in HB entitlement after 12 months on Job Seeker's Allowance, etc.*

The impact of these caps will be analysed separately, as further information becomes available.

1.1 Local Housing Allowance - caps on the private rented sector

1.1.1 Description of Local Housing Allowance caps

- National bed-size caps:
  - National caps on Local Housing Allowance (LHA) will be in place, which will limit claims to a maximum value depending on the size of the property. These caps will apply to residents living in private rented sector properties. These cap values are shown in Item 1.1 in the table below.
- Local 30th percentile caps:
  - In addition, local caps will apply in each Broad Rental Market Area[1] (BRMA) which will limit LHA rates to the 30th percentile of local rental rates.
  - Currently, Local Housing Allowance rates are set to the 50th percentile (or median) of local rents, meaning that the lower half of the local rental market area should currently be affordable to LHA claimants. Once this 30th percentile cap is active, LHA will cover the lowest 30% of local market rents.
  - The Inner West BRMA covers most of H&F, with the cap values shown in Item 1.2 in the table below.

1.1.2 Timeline for introduction of Local Housing Allowance caps

The above caps on LHA will begin for all **new** LHA claimants from 1st April 2011, however **existing** claimants will not be affected by the caps until the anniversary of their claim date plus 9 months. This means the earliest date of impact for existing claimants will not actually be until January 2012.

The only exception to this will be where claimants have a change of circumstances which decreases their entitlement to LHA. In these cases, the caps will apply from the date of the re-assessment.

1.2 Housing Benefit subsidy - Housing Association Leasing scheme caps

1.2.1 Description of Housing Benefit Subsidy caps

[1] Broad Rental Market Areas (BRMAs) are defined by the government's Valuation Office Agency (VOA) for the administration of Local Housing Allowance. Each BRMA covers an area "within which a person could reasonably be expected to live" having regard to services (including health, education, leisure, and commercial services), transport links etc. Each BRMA contains a variety of accommodation tenures, including a large enough sector of private rented housing so as to give a representative indication of local rental values.

Councils and Housing Associations lease accommodation from private landlords in order to prevent and respond to homelessness. A "Housing Benefit subsidy" is paid to Housing Associations, comprised of the Housing Benefit that the tenant is eligible to claim, plus a small amount for costs associated with managing the property on the landlord's behalf. In London, the formula below applies:

Local Housing Allowance minus 10%, plus £40 for management costs

Councils are already subject to this cap on the amount of HB subsidy which they can claim for their leased properties, and Government has announced that properties leased by Housing Associations in relation to homelessness prevention will also be subject to these caps from 1st April 2011. The cap values for leased accommodation are shown in Item 1.3 in the table below.

1.2.2 Timeline for introduction of Leasing Subsidy caps

All subsidy payments for Housing Association Leased (HAL) properties will be capped from 1st April 2011. Government has confirmed that there will be no exceptions to this.

1.3 Housing Benefit Cap values

The range of caps on private rented sector and leased accommodation are set out below:

Table 1: Housing Benefit caps from April 2011

Item	Cap description	Property Size				
		Single room	1	2	3	4
Item 1.1	National LHA bed-size caps	N/A	£250.00	£290.00	£340.00	£400.00
Item 1.2	Local 30th percentile caps- Inner West London BRMA	£95.70	£220.00	£277.00	£333.70	£400.00
Item 1.3	Local Leased Accommodation Subsidy	N/A	£256.00	£323.50	£395.50	£500.00

*projected caps for April 2011- actual rates will not be know until March 2011

As in Table 1, the 30th percentile caps are lower than the bed-size caps across all property sizes, meaning that these will be the caps that will be applied to private rented sector claimants after 1st April 2011.

2. Affected Housing Benefit claims in Hammersmith & Fulham

There are over 23,000 active Housing Benefit claims in Hammersmith & Fulham and it is projected that only a very small proportion of these will be affected by the caps (approximately 2400, or 10%).

2.1 Private rented sector impacts

In the private rented sector (PRS), it is estimated that 1916 claims will be above the 30th percentile cap. Approximately 15% of these households have been assisted into their tenancies through the Council's Direct Lettings scheme[2], with the remainder having established the tenancies independently.

Table 2: Private rented sector claims affected by 30th percentile caps by bed size and average weekly reduction (£)

[2] Direct Lettings is a key homelessness prevention service, which helps match households at risk of homelessness into private rented sector tenancies.

Bed size	Number of affected claims	*Of which are Direct Lettings*	Average reduction per week (£)
Shared room	636	*1*	£17.16
1	614	*32*	£66.62
2	524	*244*	£67.32
3	114	*31*	£65.19
4 or more	28	*9*	£115.89
Total	**1916**	***317***	

2.2. Leased accommodation impacts

Current projections are that 546 households in Housing Association leased accommodation will be above the caps, as shown in Table 3 below.

Table 3: Housing Association Leased properties by bed size and average weekly reduction (£)

Bed size	Number of affected claims	Average reduction per week (£)
1	70	£30.00
2	173	£45.00
3	210	£79.00
4 or more	93	£72.00
Total	**546**	**£56.50**

The Council's Housing Options division is working proactively with landlords and Housing Association colleagues to bring as many of these rents as possible into line with the caps. Indications so far are very positive, with approximately 55% of landlords agreeing that they will reduce their rents to below cap levels, as shown in Table 4 below.

Table 4: Landlord indications about lowering rents to levels within caps- Housing Association Leased accommodation

Landlord indication	#	%
Landlord agreeing to lower rent to within cap	299	55%
Landlord not yet agreeing to lower rent to within cap	247	45%
Total	**546**	**100%**

3. Actions to mitigate the impact of caps on residents

3.1 Renegotiating rents

The Council's first course of action is always to assist residents to remain in their current accommodation where it is safe and appropriate to do so. The initial response to the HB caps is therefore to work proactively with landlords of both private rented and leased properties, to bring rents down to levels within the caps for as many households as possible.

The very positive indications from landlords of leased accommodation (as shown in Table 4) are anticipated to be mirrored with private sector landlords. Accordingly, it is projected that at least 55% of the 2400 households currently over caps will actually be unaffected by April 2011.

Whilst a thorough programme of resident and landlord communication is being jointly developed and implemented by the Housing Benefit department and Housing Options, all affected residents are encouraged to contact the Housing Options service to discuss their circumstances (see contact details at the end of this report). Personalised advice and assistance will be available to all affected residents to help them reach a solution which is appropriate for their household circumstances.

3.2 Dedicated "HB Assist" team to help affected residents

All residents can access advice on their housing options from H&F Advice (see contact details at the end of this report). The Council is committed to ensuring that affected residents receive appropriate and timely advice and, in addition to the support available from existing frontline services, a dedicated team of Housing Options advisers and Housing Benefit specialists has been established, called "HB Assist". This team is working closely with professionals in Adult Social Care and Childrens Services to ensure that residents' individual circumstances are understood.

Housing Options will work on residents' behalf to renegotiate rents with landlords wherever possible, and will provide tailored advice on available options if the rent cannot be brought into line with the caps. All staff in HB Assist and relevant frontline services will be fully trained, ensuring that residents needing advice are connected to the right service at the earliest opportunity.

3.3 Joint work with Housing Associations

In most cases, households in Housing Association Leased accommodation have been assisted into that accommodation by the council, either as a result of an acceptance of a statutory housing duty, or in order to prevent homelessness. Since the caps on Housing Association leasing subsidy were first announced the Council has been working extremely closely with affected Housing Associations to ensure a coordinated response for landlords and H&F residents.

A regular roundtable with key Housing Association partners has been established, and a strong partnership approach is in place at the operational level. These measures have been successful in ensuring that all landlords of affected housing association leased properties are proactively contacted with a view to renegotiating rents, and that all residents whose claims are affected will receive personalised advice and assistance which is fit for their needs.

3.4 Holistic work with Adult Social Care, Children's services and other key groups

Although indication from landlords are generally very positive regarding their intention to bring their rents down to levels within the caps, it is apparent that some households will still find themselves above the caps at 1st April. Should a landlord be unable or unwilling to reduce their rents to levels within the caps, H&F Advice and the HB Assist team will be available to assess the needs of affected households, and ensure that all available solutions are considered.

All households in Housing Association Leased properties whose rent will remain above the caps after April 2011 will have their needs thoroughly assessed in conjunction with Adult Social Care, Children's Services and other relevant services before any decisions are made about appropriate solutions.

Factors such as the following will be considered when determining suitable solutions with these households:

- Employment status and requirements of adults within the household
- Health and medical needs
- Adult social care involvement
- Children's Services and child protection involvement
- Ages of children and educational stages (i.e. GCSEs)

- Cultural and ethnicity-related issues
- Housing Association feedback on housing management issues
- Other support needs or vulnerabilities.

A panel process has been established with involvement from all key parties, to ensure that the holistic circumstances of the household are properly understood before solutions are proposed. Solutions may involve finding alternative affordable accommodation, making direct offers to assist households in Temporary Accommodation into permanent social housing, or where it is appropriate, additional financial support will be provided to enable households with special needs to remain in their current property.

3.5 Support to secure and resettle into new accommodation

If alternative, affordable accommodation is assessed as the appropriate solution for a household, the Council will help that household as appropriate to secure such accommodation, in an area as close as possible to the household's desired location. In accordance with the usual procurement practices, this may involve procurement of Temporary Accommodation outside of the borough.

3.5.1 Alternative Private Rented Accommodation

The Council's Direct Lettings service is proactively engaging with private landlords who are willing to let their properties at levels within the caps, with the aim of ensuring that affordable private rentals continue to be available within the local area. It is clear, however, that this will be challenging, especially for households requiring larger property sizes. Where alternative private rented accommodation is not available in order to prevent a household's homelessness, these households will be free to exercise their right to pursue a homelessness application.

3.5.2 Temporary Accommodation

Temporary Accommodation (TA- for households where the council has accepted a statutory housing duty) is already regularly sourced in areas outside H&F, particularly in neighbouring boroughs in West London. Continued out of borough procurement will be undertaken to enable affordable replacement properties for the Housing Association Leased portfolio to be sourced.

The HB Assist team will, in conjunction with relevant professionals and services, support all households requiring alternative accommodation from the beginning of their assessment through to resettlement into their new home. Depending on the household circumstances, this support may include practical assistance (such as removals, packing, and liaising with utilities companies), orientation to the new area's services and transport links, and formal links with schools and statutory and community services. Floating Support will also continue to be available to any household who requires it, as is the current practice within the TA service.

3.5.3 Direct offers into permanent social housing

The Council's Scheme of Allocations[3] sets out that residents in TA can be made direct offers of permanent social housing where there is stock availability and an urgent housing need, or other relevant household circumstances. Since 2007, over 30% of all annual allocations to permanent housing have been made through direct offers. Direct offers will continue to be used, as stock permits, to facilitate permanent moves for households in TA, including those who remain above the caps from the 1st April.

3.6 Financial assistance for households – Discretionary Housing Payments

The Government has made additional Discretionary Housing Payments (DHP) available to Housing Benefit departments to assist vulnerable households who will be affected by the caps. H&F will therefore receive an increase in DHP budgets in 2011 and 2012 (the total DHP budget

[3] H&F Scheme of Allocations: http://www.lbhf.gov.uk/Images/Housing%20Allocations%20Scheme%202nd%20ed%20Oct%202009_tcm21-63353.pdf

for these years being £180K and £240K respectively). Households affected by the caps from April 2011 will be free to make an application for DHP and each application will be assessed according to the individual needs of the household.

3.7 Council's financial provisions

The Council is committed to its statutory duty to provide reasonable and suitable accommodation for households in Temporary Accommodation, and its role in preventing homelessness. As such, financial provisions have been made to ensure that households in Housing Association Leased accommodation can remain in that accommodation unless and until it is assessed that it is reasonable to assist them into an alternative property. As above, they will then have the full support of HB Assist to ensure they are properly supported in the transition to their new accommodation.

Government has also provided H&F Council with a grant of £400K to ensure that resources are available to properly support residents through the transition to the caps. This funding has been wholly allocated to the HB Assist service to provide the following for affected residents:

- Dedicated Housing Options and Housing Benefit advice
- Dedicated property procurement assistance
- Floating Support for residents who require it
- Resettlement support for residents moving to alternative properties
- Removals assistance where necessary
- Other support and assistance, as determined on a household-by-household basis.

4. Contact details for Housing Options

Affected residents are encouraged to contact the Council to discuss their situation and the options available to them.

H&F Advice

Available between 9:00am and 5:00pm Monday to Friday as follows:

- In person: 145 King Street, Hammersmith, W6 9XY, or
- By telephone: 0845 313 3935

H&F Advice will provide initial information and will refer residents on to the dedicated HB Assist service if required.

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
	None		

London Borough of Hammersmith & Fulham

HOUSING HEALTH AND ADULT SOCIAL CARE SELECT COMMITTEE

DATE	TITLE	Wards
15 February 2011	Draft Hammersmith & Fulham Dementia Strategy 2011 - 2013	All wards

SYNOPSIS

This report is to inform the committee of the National Dementia strategy and how it will be delivered locally by NHS Hammersmith and Fulham and the London Borough of Hammersmith and Fulham. The strategy recommends a re-design of existing services to establish a single specialist Dementia service. It also describes the preferred service model. It highlights that the implementation will include clear care pathways between the specialist Dementia service and other services and set standards against which these services will be procured and monitored. The strategy will be implemented from within existing funding.

CONTRIBUTORS

Joint Commissioning Manager for Mental Health (Michael Roach) and the Adult Social Care Department.

RECOMMENDATION(S):

The Committee is asked to note the progress of the local implementation of the national dementia strategy, and specifically the intention to re-design dementia services to create a single specialist dementia team.

CONTACT

Michael Roach
Joint Commissioning Manager Mental Health
Tel: 0208 753 1865

NEXT STEPS

The strategy will be presented to the Borough Executive (PCT) for approval.
Work will continue on the implementation of the strategy as set out in the work plan outlined in the attached strategy.

1. COMMENTS OF THE DIRECTOR OF FINANCE AND CORPORATE SERVICES

1.1 There are no financial implications.

2. COMMENTS OF THE ASSISTANT DIRECTOR (LEGAL AND DEMOCRATIC SERVICES)

2.1 There are no direct legal implications for the purposes of this report.

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	National Dementia Strategy	Michael Roach ext 1865	QCP

DRAFT

HAMMERSMITH AND FULHAM DEMENTIA STRATEGY

2011 - 2013

EXECUTIVE SUMMARY

1.1.1 This report outlines how Hammersmith and Fulham will implement the National Dementia Strategy locally. It describes a single dementia specialist service model to deliver this. This will be from within resources and builds on success of the pilot memory service.

1.1.2 The key issues identified in the strategy are:

- Obtaining early and accurate diagnosis of the type of dementia to inform treatment and support needed.
- The availability of the right medication and other treatments or care which will keep people well as long as possible and at home as long as possible.
- Clear routes from one treatment intervention to another (or what we call the care pathway) and emotional and practical support throughout.
- Clear information about how to get help (for people with Dementia and their carers)
- Support for people that reduces isolation.
- For people with dementia and their carers to be treated with dignity and respect and to be offered opportunities for the best possible quality of life throughout their condition.
- For those with particularly complex needs to get the help they need.

1.1.3 The recommendations to address these issues and deliver the strategy are:

1.1.3.1 The feasibility of a standalone specialist dementia service should be considered to improve the consistency of approach in pathways for people with dementia. We should explore the options of re-designing existing services and resources to create a new integrated, Specialist Dementia Service community team (from now on referred to as ‘the community dementia team’). The intention is that the service will have a single manager.

1.1.3.2 The memory clinic will end as a pilot and its functions will be incorporated in the assessment and diagnosis clinic as the only point of diagnosis for dementia. It will be the preferred route of access into the community dementia team. The model will be reviewed in light of demand management issues which may arise.

1.1.3.3 The community dementia team will assist in preventing inappropriate admissions to mental health and acute wards. If an admission to a mental health ward is necessary, this will be to a dementia specialist ward. Commissioners should implement this either by spot purchasing or jointly commissioning a specialist dementia ward. The team will support discharge planning back into the community from mental health and acute wards.

1.1.3.4 Referral pathways from the memory clinic/other services supporting people with dementia and their carers to counselling and other support services will be established and consideration will be given to satellite provision within the memory clinic. The pathway will also include the provision of palliative care in dementia to take account of the End of Life strategy. Following national evaluation of the dementia adviser pilots, consideration will be given to developing a similar function locally.

1.1.3.5 Steps need to be taken to ensure that people with dementia are identified as they enter adult health and social care services where older people frequently present so that their needs can be met. In particular, steps should be taken to improve the recording of dementia as a diagnosis on Frameworki and Rio. As Frameworki is a social care record which does not currently record medical diagnoses as part of core data, we will need to establish a protocol for Frameworki to routinely record confidential healthcare information.

1.1.3.6 Adult health and social care services should also develop policies for triggering referrals to the memory clinic and referral protocols.

1.1.3.7 An expert group will be established to agree standards of care for people with dementia and their carers for health and social care services where people with dementia frequently present. The standards will also reflect how the needs of BME and other groups who may have specific needs are met within mainstream dementia services.

1.1.3.8 Arising from these standards, a workforce development plan needs to be established to ensure that practitioners are appropriately skilled in responding to the needs of all people with dementia and their carers.

1.1.3.9 These standards of care and workforce requirements will be built into service specifications and monitored as part of the contract and quality assurance process. This applies primarily and as a priority to the following services:

- Older People's social work functions, including assessment, support planning and care co-ordination.
- Short term re-ablement service (STARS), the community and re-ablement (CARS) service and district nursing.
- The homecare and housing related support service.
- Participle (Circles of Support peer support service).
- Care home provision.
- Acute care.

1.1.4.0 Steps will need to be taken to track outcomes for people with dementia and their carers who are using services to enable providers of those services and commissioners to monitor whether improvements are required.

1.1.4.1 Steps will be taken to ensure that the implementation of the Carers' Strategy addresses the needs of people care for those with dementia and that this can be evidenced in any review or evaluation of the outcomes from the strategy.

1.1.4.2 We will use the Department of Health Dementia information portal as a tool to guide and inform the implementation of the Strategy.

DRAFT

HAMMERSMITH AND FULHAM
DEMENTIA STRATEGY

1. Introduction

1.1 Hammersmith and Fulham agreed a commissioning strategy for the Mental Health Care of Older people for the period April 2006 to March 2009. This now needs to be reviewed and amended in the light of recommendations published in the National Dementia Strategy.

1.2 Living well with dementia a National Dementia Strategy[1] was published in February 2009. The aim of the strategy is to ensure that significant improvements are made to dementia services across three key areas: improved awareness, earlier diagnosis and intervention, and higher quality care. This report was commissioned to review Hammersmith and Fulham's existing response to the needs of people with dementia and sets out a strategy for delivering the national dementia strategy locally. This should result in significant improvements in the quality of services provided to people with dementia and their carers and should promote a greater understanding of the causes and consequences of dementia.

2. Some facts about dementia

2.1 Dementia is primarily a disease of the over 65s. There are several types of dementia, all of which cause memory loss and poor reasoning, often resulting in psychological and behavioural problems and the inability to carry out simple daily tasks. People with dementia experience a decline in their condition over a number of years. You can find out more about the different types of dementia by going to www.alzheimers.org.uk.

2.2 At present there is no cure for dementia but there are drugs available which can slow down the rate of decline in some cases. An early and accurate diagnosis helps people to plan for when their dementia becomes more severe and improves the chances of good quality of life throughout because the people around them understand their condition and can respond to it better. This can lessen some of the psychological and behavioural problems caused by the condition. Additionally, there are some new drugs in development which are likely to be even more effective in reducing the decline of people with dementia, so long as the condition is diagnosed early and this is another reason to make sure that we get better at diagnosing people as soon as possible.

2.3 There are a small number of people under 65 with a dementia. There are also small numbers of people with other conditions such as learning disabilities, HIV or mental illnesses such as schizophrenia who have dementia. Although these numbers are small, the needs of these individuals are complex and require special attention.

3. How was this strategy developed?

The development of this strategy has been undertaken through a process of one to one

[1] National Dementia Strategy

meetings with service users, carers and professionals and a stakeholder day as well as meetings with stakeholders on the Dementia Project Board. The issues raised and the recommendations are based on a combination of local intelligence from this consultation, the needs assessment and national audits and guidance.

4. What do we want from this strategy?

4.1 In our discussions with service users, carers and practitioners and other stakeholders we identified what results we want from the strategy. :

- An accurate diagnosis as early as possible. This includes the identification of the correct sub-type(s) which will inform the correct course of treatment and support.
- Availability of the right medication and other treatments or care which keep people well as long as possible and at home as long as possible.
- Clear accessible information about how to get help.
- Clear routes from one treatment intervention to another (or what we call the care pathway) and emotional and practical support throughout.
- Support for people with dementia that reduces social isolation and promotes equality.
- For people with dementia and their carers to be treated with dignity and respect and for people with dementia to be offered opportunities for good quality of life throughout their condition.
- For people with dementia and their carers to be supported in the sensitive planning and provision for end of life care in accordance with our End of Life Strategy.
- For those with particularly complex needs to get the help they need.

5. Needs assessment

5.1 Before we know how best to offer treatment and support to people with dementia in Hammersmith and Fulham we need to understand how many people in the borough have got dementia, how severe it is and other factors which might lead us to tailor care to meet specific needs - such as ethnicity, where people live and whether they have people to care for them. The full needs assessment for the borough is set out in appendix 1 but the main findings are as follows:

- Dementia is predominantly a disorder of later life. Prevalence rates for dementia would suggest that in this borough there are 1,217 people over the age of 65 with a diagnosis of dementia in 2009 rising to 1,534 in 2025.

- Prevalence rates for younger people would suggest 32 would have a diagnosis of dementia, and this will remain the same by 2025.

- Of those who have dementia 55% would have a mild dementia, 32% a moderate dementia and 13% a severe dementia

- Over the same period of time 2009 to 2025 the proportion of older people from BME communities is projected to increase from 18% to 25%. This means that the numbers of people with dementia who are from a BME community will also rise.

- 56% of our older people live alone

- Life expectancy rates mean there are more women than men over the age of 65. In addition there is a higher prevalence of dementia in women and more women who are carers.

- Hammersmith and Fulham is one of five local authorities in the country with the lowest proportion of carers in the country at 8%

- The number of people in the nationally identified under represented or at risk groups are likely to be small in number but because of their vulnerability need to be particularly included in service planning.

6. What did we find out?

We know what we want to achieve, so how close are we to getting there?

6.1 An accurate diagnosis as early as possible.

6.1.1 Hammersmith and Fulham has set up a memory clinic, which has been in operation just over a year. Before we had a memory clinic, people had to go to different doctors at different times to get a diagnosis and this was often distressing for patients and carers and confusing for them and the GPs who referred them. The memory clinic is a one-stop shop for anyone who has a memory problem. People start with an assessment in their own home and then get all the tests they need to determine if they have dementia. A service like this is vital to ensuring that people are getting the right diagnosis early. However, there are still a few more things we need to do to improve things.

6.1.2 There are many reasons why people with a dementia are diagnosed later than they should be. Firstly, there is a great deal of stigma and fear attached to dementia and a perception that nothing can be done to help them. So sometimes people are afraid to go to their GP even when they are worried about their memory.

6.1.3 Secondly, many people think that memory loss is a natural part of getting older and they ignore the symptoms of dementia until they become severe.

6.1.4 At the end of 2009/10, 33% of people with dementia were recorded on GP registers, one of the lowest rates in London. The number of prescriptions of dementia related drugs was 363, the third lowest for London in 2007/08.

6.1.5 We need to make it clear to the public, GPs and other professionals who commonly work with older people such as district nurses and social workers why it is important to diagnose dementia early and what kinds of memory loss might indicate that someone needs treatment.

6.1.6 The memory clinic is quite new and so we need to establish it and make sure everyone knows about it and knows that this is the best place to get an accurate diagnosis. However, the clinic is very busy and we also need to make sure that the service can meet demand as referrals increase.

6.1.7 Finally, we also need to make sure that when someone is diagnosed with a dementia, all the professionals involved in that person's care know that they have this diagnosis so that they know what to do to help them.

6.1.8 This means making sure that professionals record when someone has a dementia. Professionals use different systems to record diagnoses – for example the council uses Frameworki, GPs use Vision or Emis and community health staff and West London Mental Health Trust use Rio. The Imperial College Healthcare NHS Trust's hospitals (Charing Cross and Hammersmith Hospitals) use a different system. We need to find simple ways of using these systems to better effect for people with a dementia.

6.2 Availability of the right medication and other treatments or care which keep people well as long as possible and at home as long as possible.

6.2.1 From our needs assessment, we know that in Hammersmith and Fulham we have lower levels of prescribing for people with dementia than in other parts of London. We have set up an agreement called a shared care protocol which helps GPs to prescribe dementia medication with the support of dementia specialist doctors. This agreement is quite new and we need to establish it and make sure it is working.

6.2.2 As people's conditions decline they will often need support at home with daily living tasks such as cleaning, shopping and bathing (this kind of support is usually organised by social workers) or perhaps with physical health problems which require district nursing. We need to make sure that social workers, district nurses and care assistants providing home support understand the symptoms of dementia and how to respond. For example, people with dementia may need more time to be assisted to undertake daily living tasks and this should be taken into account when offering care to someone with dementia. The council is tendering out its homecare services and this is an excellent opportunity to make sure that new services can meet the needs of people with dementia.

6.2.3 Some teams, called intermediate care teams (in Hammersmith and Fulham these are called the Short Term Assessment and Re-ablement Service– STARS and the Community and Re-ablement Service - CARS), provide support to people after they have been discharged from hospital. They help to reduce the likelihood of them being re-admitted and it is also very important that we know that these teams are able to offer support to people with dementia.

6.2.4 We know that the professionals working with people with dementia have many skills, however, we know that there is often very limited dementia training offered to them and we need to address this. A programme of training is already being offered in care homes, extra care sheltered schemes and within district nursing and we need to build on this.

6.3 Clear routes from one treatment intervention to another (or what we call the care pathway) and emotional and practical support throughout.

6.3.1 A clear care pathway is very important because people with dementia will often need different care from different professionals at different times. It is therefore important that everyone knows what needs to happen once someone has a diagnosis of dementia. This will vary, depending on how early or late the diagnosis is given.

6.3.2 Mild dementia

6.3.2.1 In the early stages, people with dementia and their carers may only need emotional and practical support such as counselling, peer support or advice about planning for the future. Hammersmith and Fulham already provides support of this kind. Back on Track is a service run jointly by West London Mental Health Trust and West London Centre for

Counselling and provides different types of counselling. The Alzheimer's Society and the Older People's Community Mental Health Team (run jointly by West London Mental Health Trust and the council) can offer advice about living with dementia. The council has recently invested in a system of peer support called Circles of Support.

6.3.2.2 This is a very good start but it is not always clear how people can access these services and whether it is enough to meet demand. Also, much of this kind of support is not specifically for people with a dementia or their carers so we need to make sure that people with a dementia and their carers can benefit from it.

6.3.3 Moderate dementia

6.3.3.1 In addition to the above, people with a moderate dementia may need some of the care at home we have described in section 6.2.2. This usually means they will be allocated a social worker from the council's community team for adults. They might also need the help of a dementia nurse or consultant, who are in a different team - the Older People's Community Mental Health Team. This team runs the memory clinic in conjunction with Charing Cross Hospital and looks after all people with a mental health need over 65 (this includes people who have no dementia but have other mental health problems). They often discharge people to the council's community team for adults if they need help at home or once they are stable because there are more social workers in that team. This can cause problems as people are transferred.

6.3.3.2 We think this care could be better arranged so that it is simpler and so that there is more dementia specialism amongst the professionals. We want to do some work to see if we can set up a specialist dementia team with more social worker resource taken from the Community team for adults.

6.3.4 Severe dementia

6.3.4.1If someone has a more severe dementia they may be admitted to a hospital or a care home. We also know from our needs assessment that many people with dementia are admitted to a care home when they leave hospital.

6.3.4.2 People with dementia are often admitted to hospital as an emergency admission with a physical health problem. We've talked about what we need to do to prevent people being admitted to hospital. However, if they are admitted doctors need to know quickly that the person has a dementia or what to do if they suspect the person might have a dementia. The person with dementia will often be even more confused or distressed by being in unfamiliar surroundings. Professionals in the hospital need to know how to provide treatment to someone with dementia. This will help to prevent the physical condition from deteriorating and will reduce the likelihood of an unnecessary admission to a care home or re-admission to hospital.

6.3.4.3 We know that there are already systems in place in local hospitals to make sure that older people get the care they need and that they get a diagnosis of dementia if appropriate. For example a team called the Older People's Assessment and Liaison team (OPAL), helps support older people once they are admitted and psychiatric liaison, which helps with offering a dementia diagnosis, is also offered. However, we need to make sure that these services are meeting the needs of people with dementia and that the workforce is able to respond appropriately.

6.3.4.4 Occasionally we admit people with a dementia to a mental health ward. In this borough they will be admitted to a ward with people who may have schizophrenia or depression and whose mental health needs are different from those experienced by people with a dementia. This is not the best environment in which to treat people with dementia. We need to find an alternative way of securing inpatient mental health beds for people with dementia.

6.3.4.5 We think that there are clear pathways from hospital or home to care homes. We have delivered a good programme of training in local care homes and we need to build on this. We need to make sure that developments in end of life care meet the needs of people with dementia.

6.4 Clear information about how to get help.

6.4.1 Partly because the care pathway is not always clear, there has been no guide developed for people with dementia and their carers setting out what services are available to them and how they can access them. We need to develop such a guide as part of our communications plan and ensure that it is accessible to all communities including BME communities.

6.5 Support for people that reduces social isolation.

6.5.1 We invest in services which support people with dementia to be socially active and reduce social isolation. These include one day hospital for people with dementia (St Vincent's), one day centre (Alzheimer's Day Centre) and a re-ablement service which supports individuals to engage in activities in the community (Activity Plus). However, we know that there are many people with dementia using other services for older people which provide social activities and befriending – such as Age Concern, Bishop Creighton, Nubian and Shanti as well as the council's own day opportunities provision for older people. We need to make sure that these organisations have the capacity to work with people with a dementia where a referral would be appropriate.

6.5.2 This area of work is particularly important in Hammersmith and Fulham because of the large proportion of older people living alone and the relatively small number of carers.

6.6 For people with dementia and their carers to be treated with dignity and respect and to be offered opportunities for the best possible quality of life throughout their condition.

6.6.1 Some people with dementia report very positive experiences of the support and help they get in Hammersmith and Fulham, others less so. We need to make sure that we get it right more consistently. We think that the programme of training for professionals will help greatly in improving the lives of people with dementia but just as importantly we need to hear what people with dementia and their carers are saying about the services they receive and make changes to improve things where we can.

6.6.2 We have a number of groups for people with dementia and their carers but we need to build on this by working with services who provide care to older people to ensure that they are getting feedback from their service users who have a dementia and that they are getting a good service. This again means ensuring that we record when people with dementia are getting a service and how they have benefited from it.

6.7 For those with particularly complex needs to get the help they need.

6.7.1 There are an estimated 32 people under the age of 65 living with dementia in the borough. Younger people with dementia may have somewhat different needs than older people with dementia. For example, they are more likely to have dependent children or to be at risk of losing their jobs.

6.7.2 People with a history of excessive alcohol use are also at risk of getting an alcohol-related dementia.

6.7.3 There are also other people with particularly complex needs, such as people with learning disabilities who are more likely to acquire dementia at an earlier age. The learning disabilities service has a referral protocol with the memory clinic and this good practice should be replicated elsewhere.

6.7.4 We need to do more to ensure that where people have complex needs, these individuals are getting the right support and we think that we need to get clinicians from different disciplines involved in agreeing what this care looks like and how it will work.

7. The recommendations to deliver the strategy.

7.1.1 The feasibility of a standalone specialist dementia service should be considered to improve the consistency of approach in pathways for people with dementia. We should explore the options of re-designing existing services and resources to create a new integrated, Specialist Dementia Service community team (from now on referred to as 'the community dementia team'). The intention is that the service will have a single manager.

7.1.2 The memory clinic will end as a pilot and its functions will be incorporated in the assessment and diagnosis clinic as the only point of diagnosis for dementia. It will be the preferred route of access into the community dementia team. The model will be reviewed in light of demand management issues which may arise.

7.1.3 The community dementia team will assist in preventing inappropriate admissions to mental health and acute wards. If an admission to a mental health ward is necessary, this will be to a dementia specialist ward. Commissioners should implement this either by spot purchasing or jointly commissioning a specialist dementia ward. The team will support discharge planning back into the community from mental health and acute wards.

7.1.4 Referral pathways from the memory clinic/other services supporting people with dementia and their carers to counselling and other support services will be established and consideration will be given to satellite provision within the memory clinic. The pathway will also include the provision of palliative care in dementia to take account of the End of Life strategy. Following national evaluation of the dementia adviser pilots, consideration will be given to developing a similar function locally.

7.1.5 Steps need to be taken to ensure that people with dementia are identified as they enter adult health and social care services where older people frequently present so that their needs can be met. In particular, steps should be taken to improve the recording of dementia as a diagnosis on Frameworki and Rio. As Frameworki is a social care record which does not currently record medical diagnoses as part of core data, we will need to establish a protocol for Frameworki to routinely record confidential healthcare information.

7.1.6 Adult health and social care services should also develop policies for triggering referrals to the memory clinic and referral protocols.

7.1.7 An expert group will be established to agree standards of care for people with dementia and their carers for health and social care services where people with dementia frequently present. The standards will also reflect how the needs of BME and other groups who may have specific needs are met within mainstream dementia services.

7.1.8 Arising from these standards, a workforce development plan needs to be established to ensure that practitioners are appropriately skilled in responding to the needs of all people with dementia and their carers.

7.1.9 These standards of care and workforce requirements will be built into service specifications and monitored as part of the contract and quality assurance process. This applies primarily and as a priority to the following services:

- Older People's social work functions, including assessment, support planning and care co-ordination.
- Short term re-ablement service (STARS), the community and re-ablement (CARS) service and district nursing.
- The homecare and housing related support service.
- Participle (Circles of Support peer support service).
- Care home provision.
- Acute care.

7.2.0 Steps will need to be taken to track outcomes for people with dementia and their carers who are using services to enable providers of those services and commissioners to monitor whether improvements are required.

7.3.0 Steps will be taken to ensure that the implementation of the Carers' Strategy addresses the needs of people care for those with dementia and that this can be evidenced in any review or evaluation of the outcomes from the strategy.

7.4.0 We will use the Department of Health Dementia information portal as a tool to guide and inform the implementation of the Strategy.

8. How will we know if the strategy is working?

8.1 We will have explored the options to re-design existing services and resources and in year produce a proposal to create a new integrated, specialist dementia community team.

8.2 We will have a pathway for dementia that will reflect a single point of diagnosis for dementia via the memory service and clear pathways into other services supporting people with dementia, their carers and primary care and to include provision for end of life care.

8.3 Quality assurance and monitoring information of dementia services will improve and the data quality will be more accurate and reliable on the number and distribution of people with dementia and the services which they are receiving. This will include monitoring of; the use of psychotropic medication, admissions to hospital, the use of emergency placements, safeguarding alerts. This will help in the evaluation of existing services and planning for future improvements and commissioning of dementia services.

8.4 An expert group will have been established and have produced standards for providers of services for the care of people with dementia and their carers and by which they will be measured in quality assurance. This will also include standards for the training requirements for staff which will be included in the service specification of provider contracts.

9. Who will make the strategy happen?

See appendix 3

Given the wider and local changes in the NHS (PCT clustering arrangements and local authorities (merging of local authority operational functions), the governance arrangements for scrutiny and sign-off of the strategy is yet to be determined.

APPENDIX 1 – Needs Assessment

The impact of dementia in the UK [2]

- There are approximately 700,000 people with dementia in the UK
- This figure is expected to double to 1.4 million within 30 years
- The national cost of dementia is about £17 billion per year more than the cost of stroke, heart disease and cancer combined.
- Dementia is predominantly a disorder of later life although there are at least 15,000 people under the age of 65 who have the illness.
- 25 million people, or 42% of the population, are affected by dementia through knowing a close friend or family member with the condition.
- It affects men and women in all social groups
- Levels of UK diagnosis and treatment of people with dementia is generally low, with a 24-fold variation in activity between the highest and lowest activity by PCT.
- International comparisons suggest that the UK is in the bottom third of European performance in terms of diagnosis and treatment, with less than half the activity of France, Sweden, Ireland and Spain.
- Dementia is a terminal condition, but people may live with their dementia for 7-12 years. The condition is characterised by three stages which can be described as mild, moderate and severe with associated deterioration of physical and mental wellbeing.
- Dementia has profound negative effects on family members who provide the majority of care. Family carers are often old and frail themselves and have high levels of carer burden, depression and physical illness, and decreased quality of life.

Dementia in Hammersmith and Fulham

People who have dementia in Hammersmith and Fulham live in a small inner London borough with a population of 178,600 that is characterised as follows:

Young population 45% in their 20s and 30s, compared to London average of 35%

Highly mobile 7th highest mobility rate in England. 1 in 5 people move address each year.

Small households 40% are one person households, 30% couples, 10% lone parents, 20% families with one or more dependent children.

[2] Knapp M, Prince M, Albanese E et al. (2007)Dementia UK: The Full Report. London : Alzheimer's Society

Ethnicity 22% from non-white background, lower than the London average of 33%. Many small minority ethnic communities.

Extremes of wealth Half the population classed as well off, but 10,000 (37%) children living in low income homes.

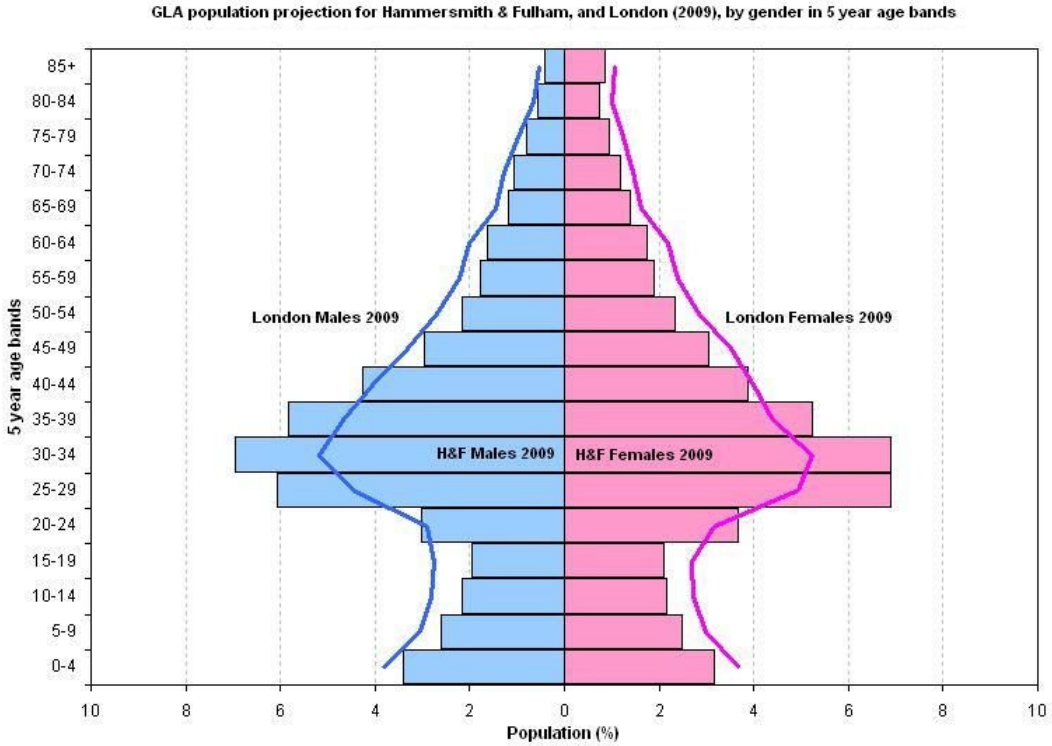
Small densely populated area with limited green space (6.4 square miles and seventh most densely populated area in England).

North generally more deprived though pockets of deprivation across the patch. (Ranked 59th most deprived local authority in England and 13th out of 33 in London).

Dementia is predominantly a disorder of later life. By understanding our current and future predicted over 65's population we can determine likely prevalence rates.

In 2009 it is estimated that there were 16,584 people in Hammersmith and Fulham who were over the age of 65.

Chart 1

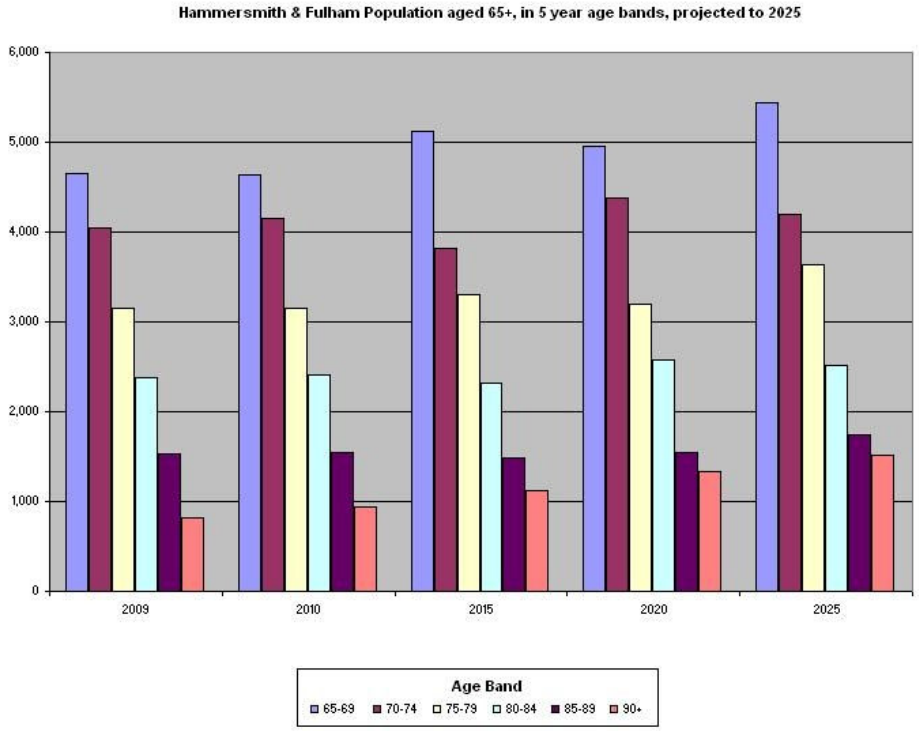


A fuller description of the population of Hammersmith and Fulham can be found in Chart 1.The differential in life expectancy rates as shown in Chart 1means there are more women in the over 65's population, in addition there is a higher prevalence of dementia in women.

This population is predicted to gradually increase to 17,172 by 2015 and 19,045 by 2025 but with a greater increase in the over 85 age group.[3] This is shown in Chart 2.

[3] GLA population projection for Hammersmith and Fulham

Chart 2



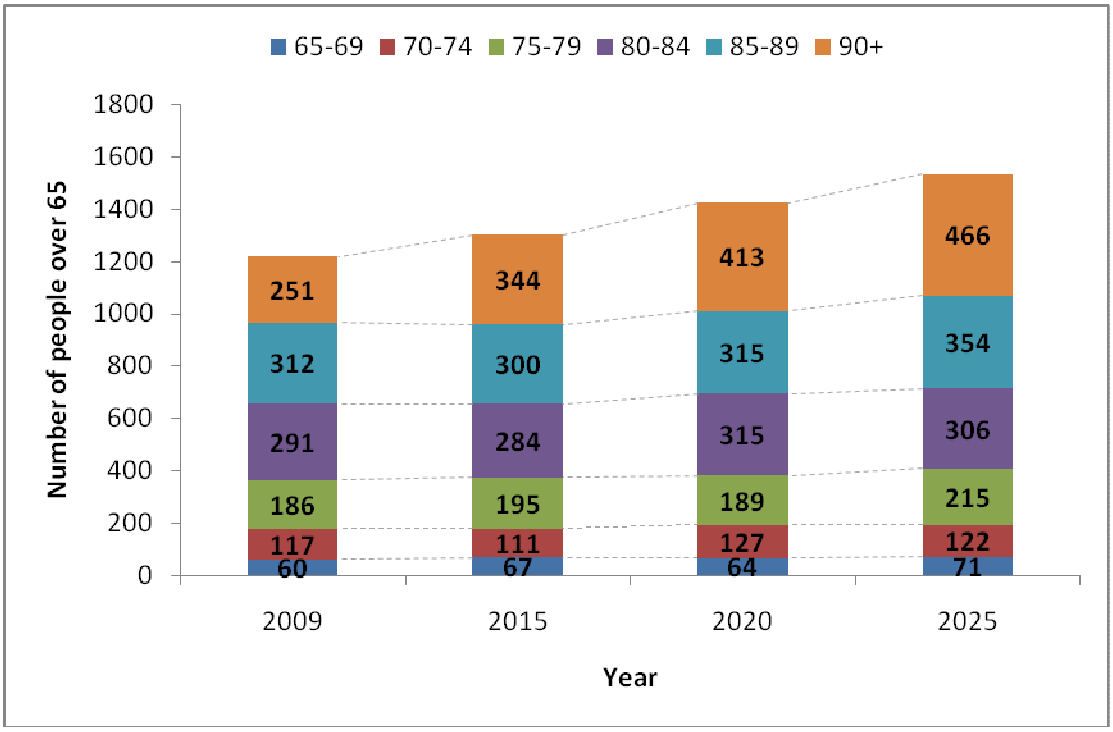
Although the prevalence of dementia increases with age using the prevalence rates describe in Dementia UK[4] it is suggested that 7.2% of the over 65-age group in Hammersmith and Fulham would have a dementia. Chart 3 details the specific prevalence rates by age group and their projection until 2025.

In Hammersmith and Fulham prevalence rates would suggest that:

- 1217 people who were over the age of 65 in 2009 would have a diagnosis of dementia
- This would increase to 1534 in 2025.
- Within the overall figure 55% would have mild dementia, 32% moderate dementia and 13% severe dementia.
- A further 32 people under the age of 65 would also have a dementia diagnosis. This prevalence rate is likely to remain the same during the period 2009 and 2025

[4] Dementia UK ,PSSRU at the London School of Economics, and the Institute of Psychiatry at King's College London prepared for the Alzheimer's Society 2007

Chart 3 Estimated prevalence of late onset dementia in Hammersmith and Fulham



How do we compare with the rest of London?

Hammersmith and Fulham as shown in Chart 1 has a relatively young population, because of this prevalence rates of dementia in 2007 would predict a rate for Hammersmith and Fulham that would be the third lowest across London local authorities. This position changes to second lowest by 2021 and is shown in Chart 4 and Chart 5.

Chart 4

Prevalence of Dementia (Aged 65+) 2007: All Persons Source

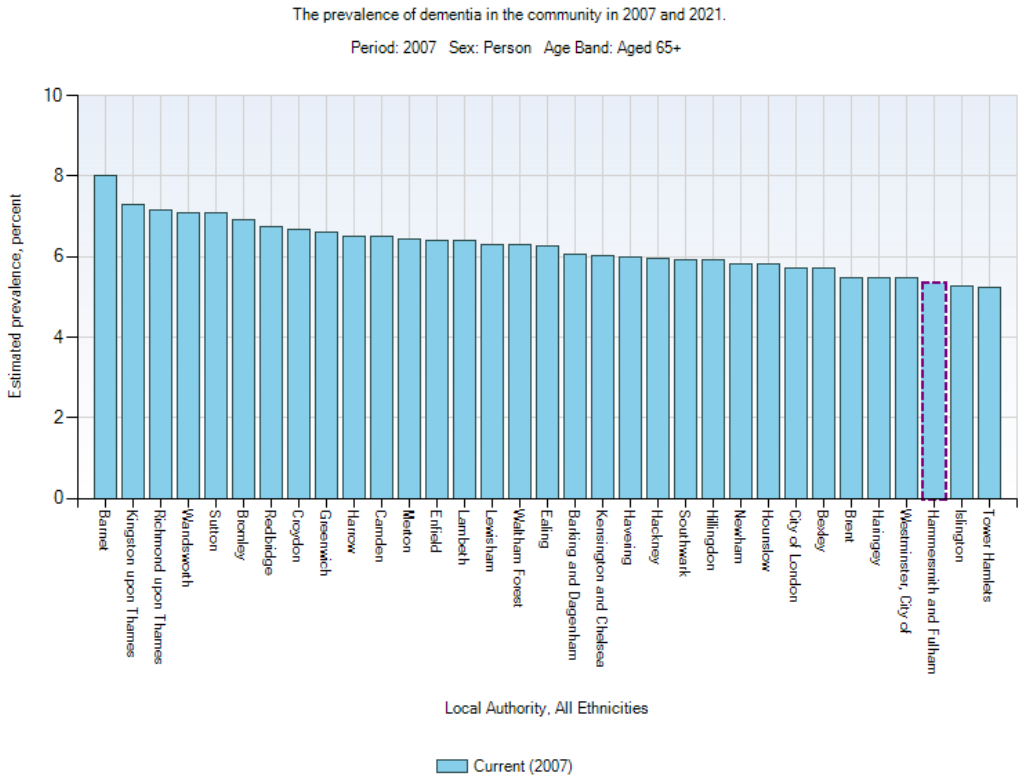
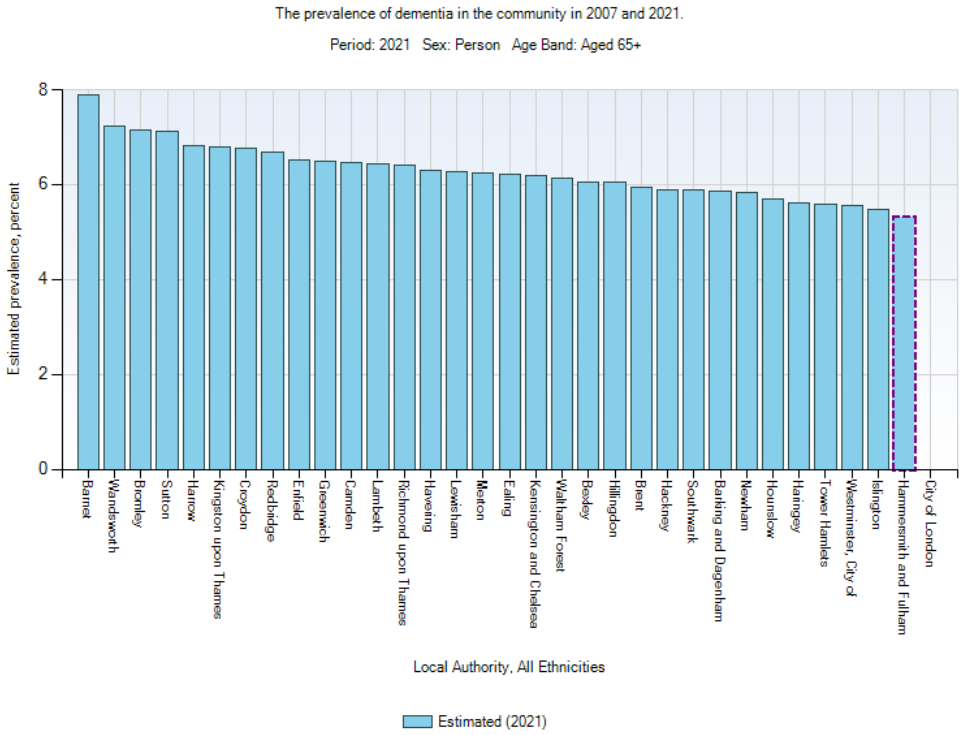


Chart 5

Estimated Prevalence of Dementia (Aged 65+) 2021: All Persons



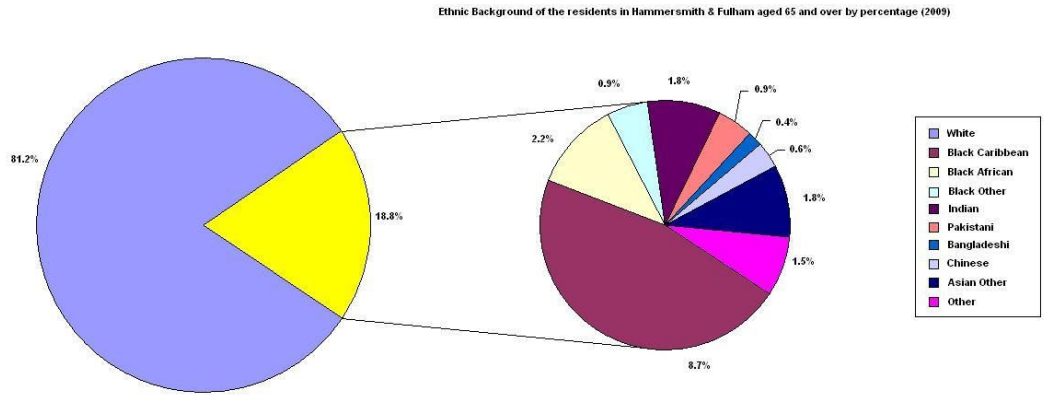
Dementia and BME Communities in Hammersmith and Fulham

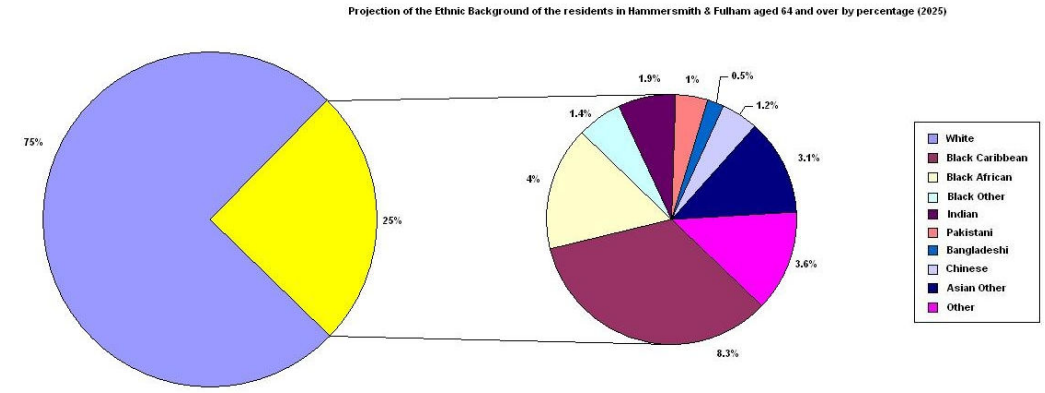
Currently BME Groups have a relatively young age profile in Hammersmith and Fulham and therefore the prevalence of dementia is reduced. However there will be an increase in the proportion of older people from BME communities from 18 % in 2009 to 25% in 2025. In addition there is an increased demand for care and support for those older people from these communities who experience an earlier onset of chronic diseases such as coronary heart disease, stroke and diabetes and associated vascular dementia.

The population changes and subsequent figures for people with dementia are based on broad ethnic groups – BME figures include all groups not in the “white” category. More detailed definitions of these groups, which for example, include people from Irish or Eastern European origins, would therefore contain greater numbers than those cited above. Chart 6 illustrates these projected changes.

Chart 6

H&F Population BME communities 2009 -2025 charts





Residential status

The living arrangements of people with dementia vary with age severity and family circumstances. The most common arrangements can be classified as:

- Living at home with family or others
- Living at home alone
- Living in a care home (residential or nursing home)

Living alone can be an indicator of isolation and lack of access to informal support. In Hammersmith and Fulham 56% of people aged 65 + live alone the third highest in London after Kensington and Chelsea and Westminster and accounting for 13% of all households in the borough. Table 1 describes the living arrangements of people aged 65 and over in Hammersmith in Fulham as projected in 5 year bands to 2025.During this time the number of men living alone is projected to increase by 23% as life expectancy for men increases.

Table 1

Living arrangements of people aged 65 and over, by age bands (65-74, and 75+), gender and numbers living alone, projected to 2025

	2008	2010	2015	2020	2025
Males aged 65-74 projected to live alone	697	680	697	731	748
Males aged 75+ projected to live alone	952	1,008	1,120	1,148	1,288
Females aged 65-74 projected to live alone	1,617	1,584	1,617	1,683	1,848
Females aged 75+ projected to live alone	2,891	2,891	2,950	2,950	3,245

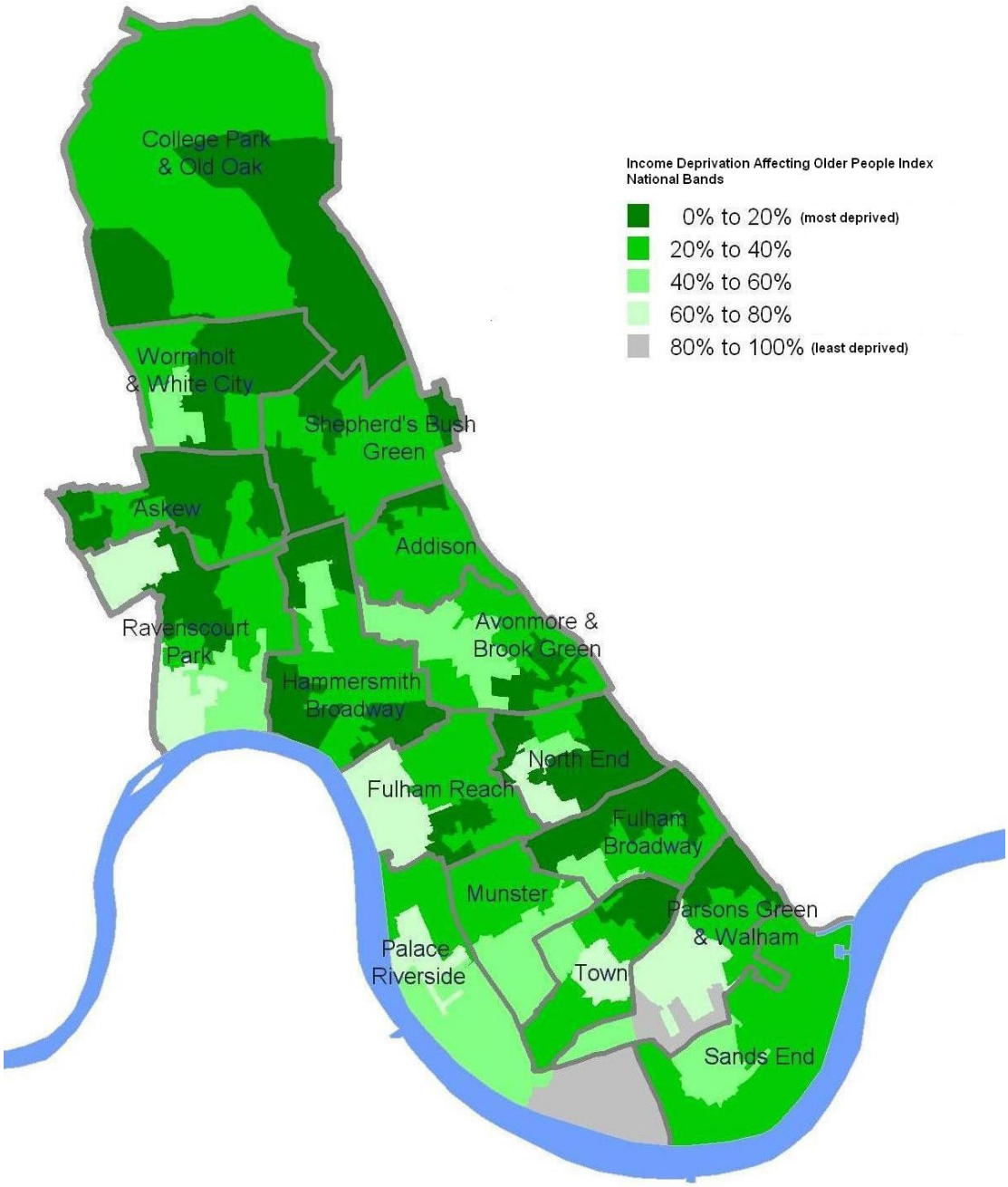
Nationally it is estimated that 63.5% of people with dementia live in their own home and 36.5 % are living in care homes. The proportion changes little between 65-74 and 75 – 84 and then alters substantially when 39.2% live in their own home and 60.8% live in a care home by the age of 90. In Hammersmith and Fulham there are only 4 registered care homes providing 355 places. They are all registered to provide nursing care and 311 of the places are specifically for older people with dementia which would indicate that there is likely to be a high population of people with dementia in these nursing homes that also have a higher proportion of residents in the over 85 age group. This could increase the actual numbers of people with a dementia in Hammersmith and Fulham.

Patterns of deprivation in Hammersmith and Fulham

Socio – economic inequalities affect all aspects of health ranging from risk factors to health outcomes to access to services. Much of the health inequalities agenda focuses on mortality rates and life expectancy but quality of life is also crucial. People with long term and progressive illnesses, such as dementia, are affected by their socio-economic position. Hammersmith and Fulham is a relatively deprived borough ranked as the 65th most deprived local authority in England out of 342. Overall, life expectancy in the borough has been increasing in line with national trends. Mortality rates are also in line with the decreases seen nationally.

However, the figures for the whole borough mask an increasing gap between the best and worst off wards. On average men living in the most deprived areas die nearly eight years earlier than men in the most affluent areas.

Map 1 Patterns of deprivation affecting older people index



The patterns of deprivation in Hammersmith and Fulham indicate significant pockets of deprivation (within the worst 10% in the country) affecting older people in the north of the borough. This in turn could lead to an increased prevalence of dementia within these communities. Map 1 provides a summary of areas of income deprivation affecting older people in Hammersmith and Fulham.

Identifying younger onset dementia and people with dementia from under represented or at risk groups

Whilst dementia is commonly a disorder of later life it does effect younger people but with a much lower prevalence rate of 2.2% people with dementia equating to 32 people in Hammersmith and Fulham. However the impact can be greater as they are commonly in

employment, have dependent partners and children, have heavy financial commitments such as a mortgage and are more physically fit and active. They are likely to have high levels of need that require specialist skill and knowledge. As the condition is so rare it can take longer to diagnose as the earlier stages are often confused with depression or anxiety.

People with learning disabilities live longer they are experiencing the illnesses of older age, including dementia. People with Down's syndrome over the age of thirty, for example, are at greater risk of developing the symptoms of dementia. By their fifties, approximately 50% will be showing evidence of memory and other problems associated with having Alzheimer's disease. Early detection is important for care and treatment. Yet, formally diagnosing dementia in people with learning disability, especially in people with Down's syndrome, can be difficult. Nationally, many people have no formal diagnosis, and are only suspected of having dementia. A number of other conditions that can affect people with Down's syndrome need to be excluded before a diagnosis of dementia can be made. These include depression, Thyroid disorder, hearing and visual impairments. Again the numbers are small (Prevalence rates would predict 7 people with Downs Syndrome would have a dementia and 8 people with other learning disabilities) but are an important consideration when commissioning and planning effective services for people with a learning disability.

In addition to younger people and people with learning disabilities there are other at risk groups, people with HIV and people who have a history of alcohol and substance misuse. Again prevalence rates would suggest that this would equate to low but sufficiently important numbers when planning services for these groups of people. The major issue is awareness of dementia in these groups, an appropriate diagnostic service and an understanding that people with these conditions are living longer, which will again increase the number of people with dementia.

A further specialist area is the prison population of Wormwood Scrubs. The over 65 prison population is nationally increasing. Older prisoners experience accelerated ageing which may mean they experience issues associated with older age from 50 years old.[5] However an analysis of the population of Wormwood Scrubs shows it has a capacity for 1277 adult male prisoners aged 21 and over although because of it's remand function the actual number of prisoners varies on a daily basis.10,000 prisoners pass through the prison every year. There are low numbers of prisoners within the over 50 age range and the issue for service planning is again increasing awareness and ensuring appropriate access to diagnostic services.

Although prevalence rates can be used to inform the number of people likely to have a dementia in Hammersmith and Fulham other local variants- the population of registered nursing homes and areas of high deprivation are likely to increase the level of prevalence.

Carers of people with dementia

Hammersmith and Fulham is one of five local authorities in England and Wales with the lowest proportion of carers at 8 %.

There are 8,261 people in the borough who care for less than 20 hours a week, nearly 1,363 care for between 20 and 50 hours a week, and 1976 care for 50 and above.[6]

[5] A pathway to care for older offenders – A toolkit for good practice Department of Health 2007
[6] A Carers Strategy for Hammersmith and Fulham 2005-2010

The caring profile in Hammersmith and Fulham is similar to the national profile. Nationally, people in their fifties are the group most likely to be providing care, with more than one in five doing so. A greater proportion of women than men are carers providing care to a partner or relative.

In Hammersmith and Fulham there are 2126 people over the age of 65 who are caring. Older carers predominantly care for older people- spouses, parents, and parents in law. They provide support often on low incomes, whilst suffering from a serious health condition or are frail themselves. There are no specific indications of how many carers care for people with a dementia.

Carers play a vital role in the provision of community support for people with dementia but without support carers can become overwhelmed by their constant caring role.

Family care enables people with dementia to continue living at home for a longer period of time, and nationally overall, those living with a family carer have been found to be 20 times less likely to be admitted to long term care.

In common with all carers those caring for someone with a dementia need to take care of their own health and well-being. Regrettably however there is still stigma and discrimination associated with dementia and very often this group of carers wish to keep both their caring role and the diagnosis of the cared for, a private matter. This can lead to the carer becoming isolated and unsupported and coping until a point of crisis is reached. In Hammersmith and Fulham this may be evidenced by the number of older people who have a named carer admitted to nursing care from hospital, having previously received low levels of support. This evidence would further support the urgent need to identify carers and provide them with support at a much earlier stage.

Our local needs can be summarised as follows:

- Dementia is predominantly a disorder of later life prevalence rates for dementia would suggest that there are 1217 people over the age of 65 with a diagnosis of dementia in 2009 rising to 1534 in 2025.

- Within that number there will be a greater number of people who are over the age of 85.

- Prevalence rates for younger people would suggest 32 would have a diagnosis of dementia, remaining the same by 2025.

- Of those who have dementia 55% would have a mild dementia, 32% a moderate dementia and 13% a severe dementia

- Over the same period of time 2009 to 2025 the proportion of older people from BME communities will increase from 18 to 25%. This would approximate to 2985 people in 2009 rising to 4761 people in 2025.

- When planning services for the future there is a recognition that Hammersmith and Fulham is predicted to have a gradual increase in it’s older population compared to many other London Boroughs.

- 56% of our older people live alone

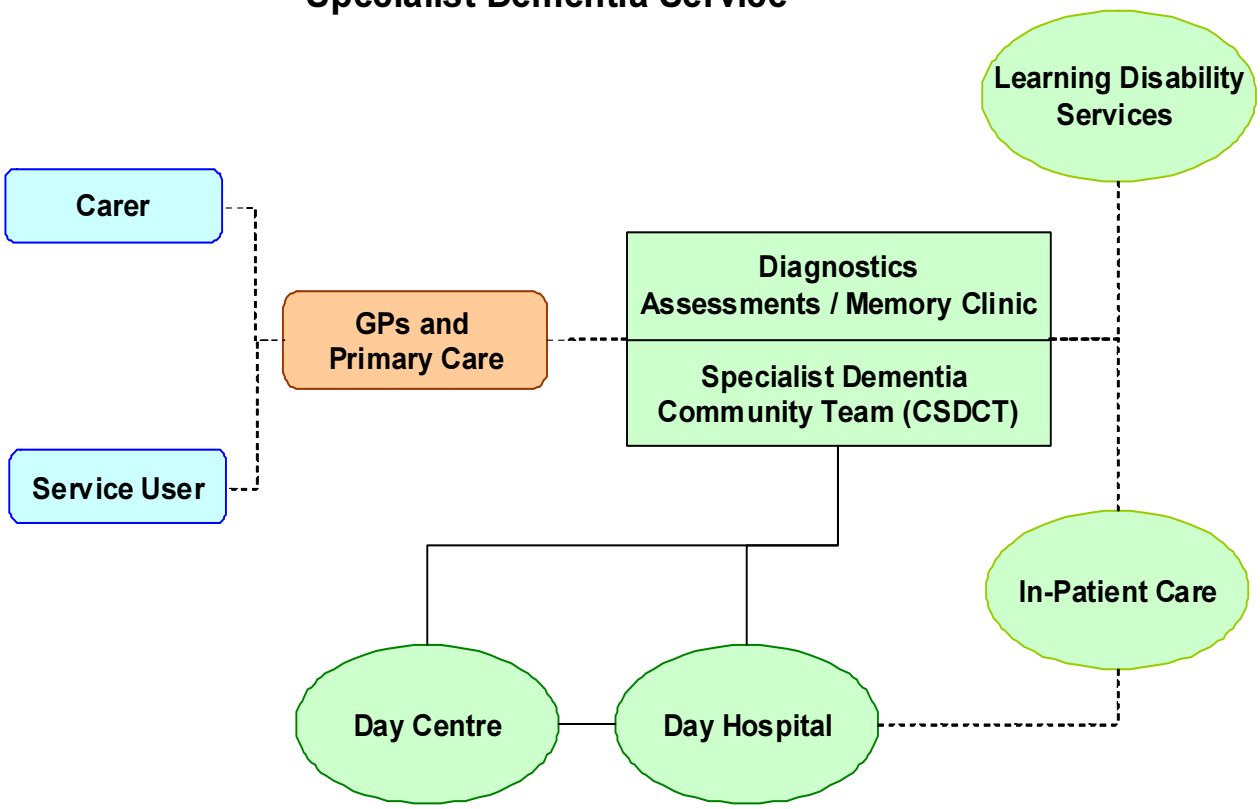
- Life expectancy rates mean there are more women than men over the age of 65 in addition there is a higher prevalence of dementia in women and more women who are carers

- Hammersmith and Fulham is one of five local authorities in the country with the lowest proportion of carers in the country at 8%

The number of people in the nationally identified under represented or at risk groups are likely to be small in number but because of their vulnerability need to be particularly included in service planning

Appendix 2a

Specialist Dementia Service



Key

-- - referral pathway to and from the service

___ referral pathway within the service

Appendix 2b
Specialist Dementia Service function table

The intention is for staff to work across the service in its various elements. The aim is for this to reduce the likelihood of the development of barriers across the various constituents of the single service. The criteria for the various functions and pathways are work that will be developed and further consulted on in the implementation of the strategy.

Service Function	Purpose	Resources required
The Diagnostic Assessments / Memory Clinic	• Assessment • Medical diagnosis • Prescribing(Initial and reviews) • Training and education • Primary Care Liaison • Research and Development	• Psychiatry • Neurology • Neuropsychiatry • Psychology • Nursing • Gerontology
Specialist Dementia Community Team (SDCT)	• Initial triage of referrals (open policy) • Assessment • Initial needs packages set up • Ongoing care coordination • Prescribing and ongoing medication management • Care reviews • Training education and support to nursing and care homes • GP and Primary Care Team liaison	• Social Work • Nursing • Occupational Therapy • Psychology • Psychiatry
Day Hospital and Day Centre	• Day treatment • Occupational therapies • Physiotherapies • Respite care • Advice and carer support	• Occupational Therapy • Nursing • Social Work
Inpatient Care	• Treatment of acute presentations • Stabilisation in preparation for return to the community	• Psychiatry • Nursing

Implementation plan

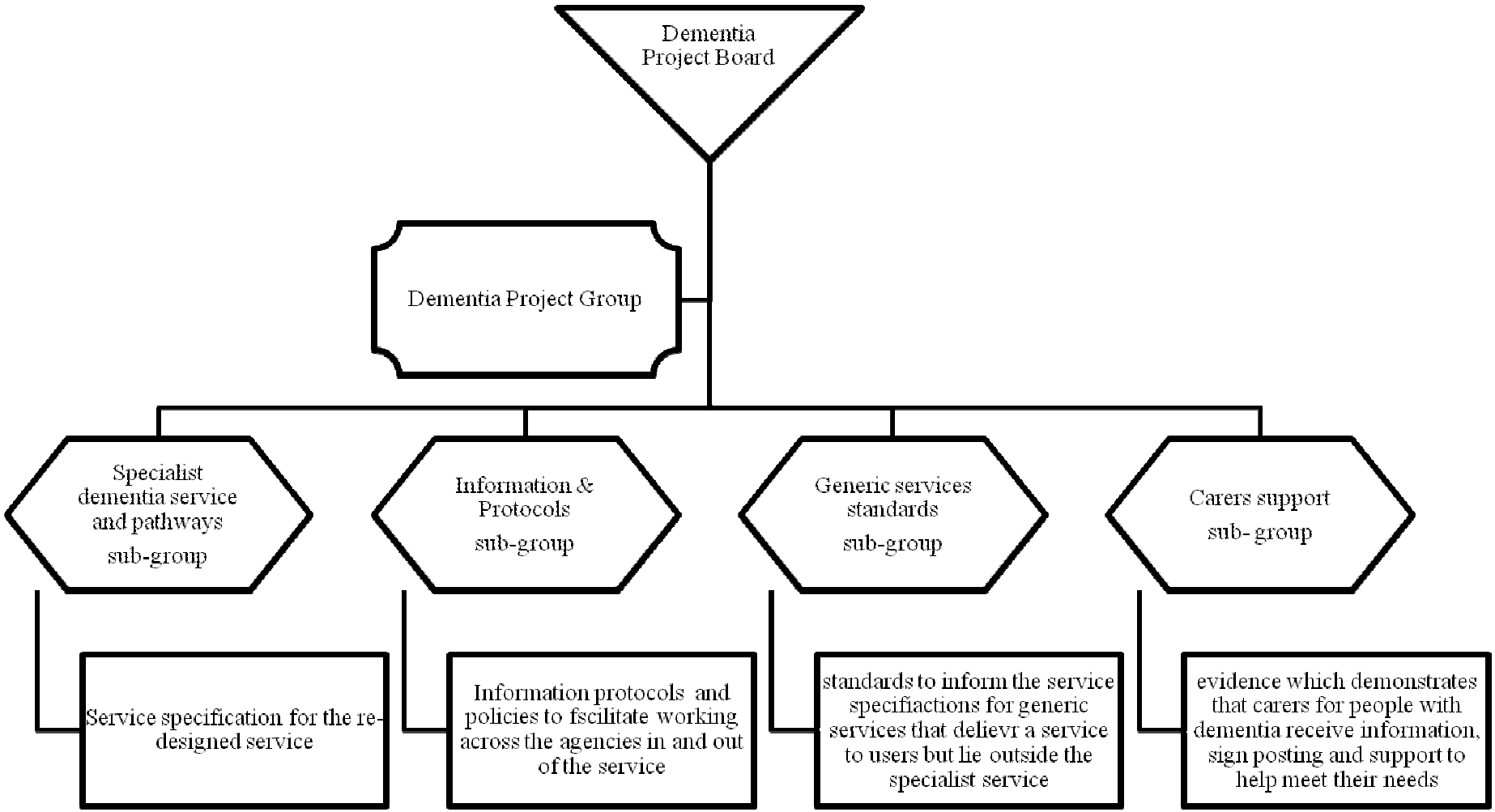
Recommendations	Actions	Timeframe	Leads
7.1.10 The feasibility of a standalone specialist dementia service should be considered to improve the consistency of approach in pathways for people with dementia. We should explore the options of re-designing existing services and resources to create a new integrated, Specialist Dementia Service community team (from now on referred to as 'the community dementia team'). 7.1.11 The memory clinic will end as a pilot and its functions will be incorporated in the assessment and diagnosis clinic as the only point of diagnosis for dementia. It will be the preferred route of access into the community dementia team. The model will be reviewed in light of demand management issues which may arise. 7.1.12 The community dementia team will assist in preventing inappropriate admissions to mental health and acute wards. If an admission to a mental health ward is necessary, this will be to a dementia specialist ward. Commissioners should implement this either by spot purchasing or jointly commissioning a specialist dementia ward. The team will support discharge planning back into the community from mental health and acute wards. 7.1.13 Referral pathways from the memory clinic/other services supporting people with dementia and their carers to counselling and other support services will be established and consideration will be given to satellite provision within the memory clinic. The pathway will also include the provision of palliative care in dementia to take account of the End of Life strategy. Following national evaluation of the dementia adviser pilots, consideration will be given to developing a similar function locally.	Set up a project group to implement the strategy (see appendix 3) to deliver the service change and model including: Identify the membership of the group to include commissioners, senior operational managers and clinical representatives from existing service providers, procurement, finance department, Human resources, carer and service user representatives, performance and information team, estates, GP representation. The project group will report to the Dementia Project Board Agree the terms of reference for the group, the scope of the various pieces of work and the likely lifespan of the group. The main group will meet at least monthly. As the piece of work is relatively complex, agree sub- working groups to lead on the various strands of work e.g. service pathways, data and information, resources. And that will report into the main project group. The subgroups will report into the main project group that will drive the work on the service changes. The service pathways groups will identify the service aims, the protocols and criteria for the pathways.	4 months 4 months	Mental Health commissioner and provider service leads
7.1.14 Steps need to be taken to ensure that people with dementia are identified as they enter adult health and social care services where older people frequently present so that their needs can be met. In particular, steps should be taken to improve the recording of	A working sub-group of the main group will be tasked with delivering on this objective. The membership will include representatives from the information and data team, operational managers from health and social care and other	4 months	Service leads from health and social care

	dementia as a diagnosis on Frameworki and Rio. As Frameworki is a social care record which does not currently record medical diagnoses as part of core data, we will need to establish a protocol for Frameworki to routinely record confidential healthcare information. 7.1.15 Adult health and social care services should also develop policies for triggering referrals to the memory clinic and referral protocols.	experts could be co-opted as needed onto this group. The work of this group will be closely related to work occurring in the various pathway sub-groups.		
	These standards of care and workforce requirements will be built into service specifications and monitored as part of the contract and quality assurance process. This applies primarily and as a priority to the following services: • Older People's social work functions, including assessment, support planning and care co-ordination. • Short term re-ablement service (STARS), the community and re-ablement (CARS) service and district nursing. • The homecare and housing related support service. • Participle (Circles of Support peer support service). • Care home provision. • Acute care. 7.1.7 Steps will need to be taken to track outcomes for people with dementia and their carers who are using services to enable providers of those services and commissioners to An expert group will be established to agree standards of care for people with dementia and their carers for health and social care services where people with dementia frequently present. The standards will also reflect how the needs of BME and other groups who may have specific needs are met within mainstream dementia services monitor whether improvements are required. 7.1.8 Arising from these standards, a workforce development plan needs to be established to ensure that practitioners are appropriately skilled in responding to the needs of all people with dementia and their carers.	Set up a multi-disciplinary and agency expert group to include representatives from commissioning, service providers, users and carers. It will also include representation from the identified priority services. The group will be led by senior clinical staff working in dementia and will work closely with the pathways sub-groups to inform them about the standards to be set for the various pathways and staff. They will be guided in the setting of these standards by using the [7]Department of Health Dementia Portal. The standards set will be incorporated into the service specification for the service and will be the basis to monitor the service delivery.	4 months	Commissioner with support from providers, service users and carers
7.3.0	Implementation of the Carers' strategy to meet the	The establishment of a carers support	4 months	Carers'

[7] *www.**dementia**.**dh**.gov.uk/objectivesAndResources/workforce/*

needs of people who care for those with dementia	group.		Commissioner

Appendix 3 Implementation Plan: Working Groups


Dementia
Project Board
Dementia Project Group
Specialist
dementia service
and pathways
sub-group
Information &
Protocols
sub-group
Generic services
standards
sub-group
Carers support
sub- group
Service specification for the re-designed service
Information protocols and policies to fscilitate working across the agencies in and out of the service
standards to inform the service specifiactions for generic services that delievr a service to users but lie outside the specialist service
evidence which demonstrates that carers for people with dementia receive information, sign posting and support to help meet their needs

London Borough of Hammersmith & Fulham

HOUSING, HEALTH AND ADULT SOCIAL CARE SELECT COMMITTEE

DATE	TITLE	Wards
15 February 2011	Work Programme and Forward Plan 2010-2011	All Wards

SYNOPSIS

The draft work programme has been drawn up, in consultation with the Chairman, from items in the Forward Plan and from action arising from previous meetings of the Housing, Health and Adult Social Care Select Committee and its predecessor committees.

The committee is requested to consider the items within the proposed work programme set out at Appendix A to this report and suggest any amendments or additional topics to be included in the future.

Attached as Appendix B to this report is a copy of the Forward Plan items showing the decisions to be taken by the Executive at the Cabinet.

CONTRIBUTORS

Finance and Corporate Services

RECOMMENDATION(S):

That the committee considers and agrees its proposed work programme, subject to update at subsequent meetings of the committee.

CONTACT

Sue Perrin
020 8753 2094

NEXT STEPS

n/a

Appendix A

HOUSING, HEALTH AND ADULT SOCIAL CARE SELECT COMMITTEE, WORK PROGRAMME 2010/2011

June 2010
The New Government's Proposals on Health and the Likely Impact on Hammersmith & Fulham
Introduction to Housing Services
Introduction to and Challenges in Adult Social Care
September 2010
The Implications for the Council of the White Paper: Equity and Excellence; Liberating the NHS
Carers' Strategy Review: Progress Update
Consultation with Residents on Bringing the Housing Services Back to the Council
November 2010
Comprehensive Spending Review
Housing Benefit Changes
The London Health Inequalities Strategy
Developments in Day Care: Briefing Report for Information
LINks Update/submission to White Paper consultation
January 2011
Revenue Budget and Council Tax, 2011 – 2012
The White Paper for Public Health: Health Lives, Healthy People
White City Health and Care Centre: Full Business Case
February 2011
Voluntary Sector – Working in Partnership
Imperial College Healthcare NHS Trust (ICHT): Proposed Separation of Urgent and Planned Orthopaedic Surgery
H&F Homes Update
Housing Benefits Update

LINKs Update Report
Dementia Strategy: For information
April 2011
ICHT: Report from Vascular Services Meeting
Health Reforms
Planned Procedures Policy
Health Inequalities Task Group: Final Report
Out of Hospital Care
Personal Budgets Update: For Information
Items for 2011/2012
GP Surgeries • Access • Incentives for GPs to move into the north of the borough • Patient Experience: Monitoring
Home Care and Housing Related Support: Update
Housing Allocations Scheme: Post Implementation Review
Housing Initiatives: Progress Report (to include Overcrowding)
Local Development Framework
Maternity Services, to include: Quality and continuity of care for mothers and babies
Older People's Strategy
Taxicard Scheme: Public Consultation
Briefing Reports
Safeguarding Adults: Annual Report

Appendix B

FORWARD PLAN OF KEY DECISIONS

Proposed to be made in the period February 2011 to May 2011

The following is a list of Key Decisions, as far as is known at this stage, which the Authority proposes to take in the period from February 2011 to May 2011.

KEY DECISIONS are those which are likely to result in one or more of the following:

- **Any expenditure or savings which are significant, regarding the Council's budget for the service function to which the decision relates in excess of £100,000;**
- **Anything affecting communities living or working in an area comprising of two or more wards in the borough;**
- **Anything significantly affecting communities within one ward (where practicable);**
- **Anything affecting the budget and policy framework set by the Council.**

The Forward Plan will be updated and published on the Council's website on a monthly basis. (New entries are highlighted in yellow).

NB: Key Decisions will generally be taken by the Executive at the Cabinet. The items on this Forward Plan are listed according to the date of the relevant decision-making meeting.

If you have any queries on this Forward Plan, please contact
***Katia Richardson** on 020 8753 2368 or by e-mail to katia.richardson@lbhf.gov.uk*

Consultation

Each report carries a brief summary explaining its purpose, shows when the decision is expected to be made, background documents used to prepare the report, and the member of the executive responsible. Every effort has been made to identify target groups for consultation in each case. Any person/organisation not listed who would like to be consulted, or who would like more information on the proposed decision, is encouraged to get in touch with the relevant Councillor and contact details are provided at the end of this document.

Reports

Reports will be available on the Council's website (www.lbhf.org.uk) a minimum of 5 working days before the relevant meeting.

Decisions

All decisions taken by Cabinet may be implemented 5 working days after the relevant Cabinet meeting, unless called in by Councillors.

Making your Views Heard

You can comment on any of the items in this Forward Plan by contacting the officer shown in column 6. You can also submit a deputation to the Cabinet. Full details of how to do this (and the date by which a deputation must be submitted) are on the front sheet of each Cabinet agenda.

LONDON BOROUGH OF HAMMERSMITH & FULHAM: CABINET 2010/11

Leader:	**Councillor Stephen Greenhalgh**
Deputy Leader (+Environment and Asset Management):	**Councillor Nicholas Botterill**
Cabinet Member for Children's Services:	**Councillor Helen Binmore**
Cabinet Member for Community Care:	**Councillor Joe Carlebach**
Cabinet Member for Community Engagement:	**Councillor Harry Phibbs**
Cabinet Member for Housing:	**Councillor Lucy Ivimy**
Cabinet Member for Residents Services:	**Councillor Greg Smith**
Cabinet Member for Strategy:	**Councillor Mark Loveday**

Forward Plan No 105 (published 14 January 2011)

LIST OF KEY DECISIONS PROPOSED FEBRUARY 2011 TO MAY 2011

Where the title bears the suffix (Exempt), the report for this proposed decision is likely to be exempt and full details cannot be published.

New entries are highlighted in yellow.

* All these decisions may be called in by Councillors; If a decision is called in, it will not be capable of implementation until a final decision is made.

Decision to be Made by: (ie Council or Cabinet)	**Date of Decision-Making Meeting and Reason**	**Proposed Key Decision**	**Lead Executive Councillor(s) and Wards Affected**
February			
Cabinet	7 Feb 2011 Reason: Expenditure more than £100,000	**The General Fund Capital Programme, Housing Revenue Capital Programme and Revenue Budget 2010/11 - Month 8 Amendments** Report seeks approval to changes to the Capital Programme and Revenue Budget.	Leader of the Council Ward(s): All Wards;
Cabinet	7 Feb 2011 Reason: Affects more than 1 ward	**Changes to day services: Merger of day services for older and disabled people and closure of 147 Stevenage Road, currently occupied by the Sunbury Independent Living Service** A consultation on the above proposal ran for 12 weeks from 23rd August - 29th October 2010. Officers are seeking a Cabinet decision on the recommendation to merge the day services for older and disabled people and provide them from two building rather than three, thus closing 147 Stevenage Road, which is the building currently occupied by Sunbury Independent Living Service (ILS).	Cabinet Member for Community Care Ward(s): All Wards;
Cabinet	7 Feb 2011 Reason: Expenditure more than £100,000	**Corporate Planned Maintenance Programme 2011/2012** 2011/2012 Corporate Planned Maintenance programme undertakes regular servicing and maintenance of plant and equipment as well as	Leader of the Council Ward(s): All Wards;

Decision to be Made by: (ie Council or Cabinet)	Date of Decision-Making Meeting and Reason	Proposed Key Decision	Lead Executive Councillor(s) and Wards Affected
		refurbishment and improvement works to all of the Council's property assets excluding schools and housing properties which have their own separate programmes.	
Cabinet Full Council	7 Feb 2011 23 Feb 2011	**Treasury Management Strategy Report** This report provides information on the Council's Treasury Management Strategy for 2011/12 including interest rate projections, borrowing and investment activity report. The report seeks approval for borrowing limits and authorisation for the Director of Finance and Corporate Services to arrange the Council's cashflow, borrowing and investments in the year 2011/12.	Leader of the Council
	Reason: Expenditure more than £100,000		Ward(s): All Wards;
Cabinet Full Council	7 Feb 2011 23 Feb 2011	**Capital Programme 2011/12 to 2015/16** This report sets out an updated resources forecast and a capital programme for 2011/12 to 2015/16.	Leader of the Council
	Reason: Expenditure more than £100,000		Ward(s): All Wards;
Cabinet Full Council	7 Feb 2011 23 Feb 2011	**Revenue Budget and Council Tax levels 2011/12** This report sets out the proposed 2011/12 revenue budget and associated Council Tax charge.	Leader of the Council
	Reason: Budg/pol framework		Ward(s): All Wards;
Cabinet	7 Feb 2011	**Housing Revenue Account Budget Strategy 2011-12** This report sets out the budget strategy for the Housing Revenue Account (HRA) to 2013/14, with detailed revenue estimates and the proposed rental and service charge increases for 2011/12.	Cabinet Member for Housing
	Reason: Expenditure more than £100,000		Ward(s): All Wards;
Cabinet	7 Feb 2011	**Framework contract award : independent advocacy service Mental Capacity Act**	Cabinet Member for Community Care

Decision to be Made by: (ie Council or Cabinet)	**Date of Decision-Making Meeting and Reason**	**Proposed Key Decision**	**Lead Executive Councillor(s) and Wards Affected**
	Reason: Expenditure more than £100,000	**2005 and paid relevant person's representative service 2011 - 2016** Seeking delegated authority for the lead Cabinet member to sign off on the award of contract for March 11.	Ward(s): All Wards;
Cabinet	7 Feb 2011	**Earls Court & West Kensington Opportunity Area Joint Borough Supplementary Planning Brief** Joint draft planning brief produced by LBHF, RBKC and GLA to guide redevelopment of the Earls Court and West Kensington Opportunity Area. The report seeks agreement to go out to consultation on the draft document.	Deputy Leader (+Environment and Asset Management), Leader of the Council
	Reason: Affects more than 1 ward		Ward(s): Fulham Broadway; North End;
Cabinet	7 Feb 2011	**H&F Buildings Report** This report outlines recommendations for the future of a number of H&F owned or leased buildings, recently the subject of a consultation exercise.	Cabinet Member for Community Care
	Reason: Affects more than 1 ward		Ward(s): All Wards;
Cabinet	7 Feb 2011	**Procurement and Market Testing Programme 2011-2014** The report sets out the Procurement and Market Testing Programme for 2011-1014.	Councillor Stephen Greenhalgh
	Reason: Expenditure more than £100,000		Ward(s): All Wards;
Cabinet	7 Feb 2011	**Linford Christie Outdoor Sports Centre - Allocation of S106 funding** This report seeks approval for the allocation of funding towards the Linford Christie Outdoor Sports Centre improvement project in order to allow a) the appointment of a contractor to carry out the necessary works b) to cover the costs associated with completing the project. This will require the allocation of £160,000 of funding from a	Cabinet Member for Residents Services
	Reason: Expenditure more than £100,000		Ward(s): College Park and Old Oak;

Decision to be Made by: (ie Council or Cabinet)	Date of Decision-Making Meeting and Reason	Proposed Key Decision	Lead Executive Councillor(s) and Wards Affected
		range of S106 agreements.	
Cabinet	7 Feb 2011 Reason: Expenditure more than £100,000	**E-booking project** To approve funding for an e-booking project which will will centralise the booking and payments of facilities and services provided by the Council and provide an online facility for residents.	Leader of the Council Ward(s): All Wards;
Cabinet	7 Feb 2011 Reason: Expenditure more than £100,000	**London Waste and Recycling Board - Funding Agreement** Following a successful funding bid to LWARB, LBHF have been awarded £222k to improve estates recycling services through a mixture of infrastructure improvements. This is matched by £60k funding from the Council, sourced from the exisiting Waste Performance Efficiency Grant. The funding agreement outlines the terms and conditions associated with this grant. This item requests confirmation of the acceptance of the grant, and approval for expenditure of the funding.	Councillor Greg Smith Ward(s): All Wards;
Cabinet	7 Feb 2011 Reason: Significant in 1 ward	**Sands End Community Centre** To consider the disposal of the Sands End Community Centre following the relocation/reconfiguration of current services within the Sand End Ward.	Cabinet Member for Children's Services Ward(s): Shepherds Bush Green;
Cabinet	16 Feb 2011 Reason: Affects more than 1 ward	**Shared Services across three Boroughs** The Council has been in discussion with neighbouring boroughs, Royal Borough of Kensington & Chelsea and City of Westminster, about the potential for shared services. This report will outline the initial proposals that will then go out for comment	Councillor Stephen Greenhalgh Ward(s): All Wards;

Decision to be Made by: (ie Council or Cabinet)	Date of Decision-Making Meeting and Reason	Proposed Key Decision	Lead Executive Councillor(s) and Wards Affected
Cabinet	21 Mar 2011	**Council's Corporate Plan 2012/14 & Executive Summary** The corporate plan and its executive summary encapsulates the Council's key priorities for improvement over the next 3 years. It is linked to the Local Area Agreement (LAA) and the national indicators. The plan has been developed from departmental plans following consultation with the Leader. Other Cabinet Members have been consulted by Directors concerning the departmental plans relevant to their portfolios. The plan will enable the Council to monitor progress against key priorities. The Corporate plan and executive summary are available under separate cover.	Leader of the Council
	Reason: Affects more than 1 ward		Ward(s): All Wards;
March			
Cabinet	21 Mar 2011	**The General Fund Capital Programme, Housing Revenue Capital Programme and Revenue Budget 2010/11 - Month 9 Amendments** Report seeks approval to changes to the Capital Programme and Revenue Budget.	Leader of the Council
	Reason: Expenditure more than £100,000		Ward(s): All Wards;
Cabinet	21 Mar 2011	**Tender award report for Phase 1C to the Key Decision on 13 July 2009 - the Centralisation and Improvements to CCTV on H&F Homes Estates** Report seeks approval for tender(s) award to new CCTV installation systems on White City/Batman Close, Becklow Gardens and Bayonne/Lampeter Square estates.	Cabinet Member for Residents Services
	Reason: Expenditure more than £100,000		Ward(s): Askew; Fulham Reach; Wormholt and White City;

Decision to be Made by: (ie Council or Cabinet)	Date of Decision-Making Meeting and Reason	Proposed Key Decision	Lead Executive Councillor(s) and Wards Affected
Cabinet	21 Mar 2011 Reason: Expenditure more than £100,000	**Disposal of 2 Byam Street, SW6** This property has been used to provide a supported housing service, which has been decommissioned.The property is surplus to the Council's requirements.	Cabinet Member for Community Care Ward(s): Sands End;
Cabinet	21 Mar 2011 Reason: Expenditure more than £100,000	**Shepherds Bush Common Improvement Project** Approval to appoint works contractors to undertake restoration works on Shepherds Bush Common.	Cabinet Member for Residents Services Ward(s): Shepherds Bush Green;
Cabinet	21 Mar 2011 Reason: Expenditure more than £100,000	**Closure of Tamworth supported housing** Closure of Tamworth supported housing, which is a 14 unit high/medium supported housing project for people with mental health issues.	Cabinet Member for Community Care Ward(s): All Wards;
Cabinet	21 Mar 2011 Reason: Expenditure more than £100,000	**Disposal of Air Rights at Planetree Court** This report recommends the disposal of air rights above the vehicular entrance of Council owned accommodation at Planetree Court to the adjacent Jacques Prevert school to facilitate classroom and playground expansion for the school.	Cabinet Member for Housing Ward(s): Avonmore and Brook Green;
Cabinet	21 Mar 2011 Reason: Expenditure more than £100,000	**2011/12 Transport for London integrated transport investment** This report summarises the Transport for London funded schemes proposed for 2010/11 for approximately £2 million investment in integrated transport in the borough.	Deputy Leader (+Environment and Asset Management) Ward(s): All Wards;
Cabinet	21 Mar 2011	**School Organisation Plan** 10 year capital strategy to	Cabinet Member for Children's Services

Decision to be Made by: (ie Council or Cabinet)	Date of Decision-Making Meeting and Reason	Proposed Key Decision	Lead Executive Councillor(s) and Wards Affected
	Reason: Affects more than 1 ward	provide accommodation for projected pupil demand for school places.	Ward(s): All Wards;
Cabinet	21 Mar 2011 Reason: Affects more than 1 ward	**Economic Development Update** This report updates Members on work to maximise jobs and employment opportunities for residents and to support business growth and retention.	Leader of the Council Ward(s): All Wards;
Cabinet	21 Mar 2011 Reason: Expenditure more than £100,000	**Provision of body collection and transportation services for the West London Coroner** Approval of contracts for the provision of body collection and transportation services on behalf of the West London Coroner. This report presents the recommendations from the recent procurement exercise. The contracts are for services to HM Coroner, whose jurisdiction covers six West London Boroughs, where H&F is by designation of the MoJ, the responsible Authority.	Cabinet Member for Residents Services Ward(s): All Wards;
Cabinet	21 Mar 2011 Reason: Expenditure more than £100,000	**Recruitment Advertising Contract** - Recruitment advertising, standard transactional and creative - Strategic HR support such as job fairs, materials, branding -Additional services such as response handling, public notices and outplacement	Leader of the Council Ward(s): All Wards;
Cabinet	21 Mar 2011 Reason: Expenditure more than £100,000	**Hammersmith Park Sports Facility project - appointment of works & services contractor** To approve the appointment of the contractor to undertake the works and services contract for the redevelopment of Hammersmith Park All Weather Pitch as selected and agreed by the project's Tender Appraisal Panel and approved by the Project Board.	Cabinet Member for Residents Services Ward(s): Wormholt and White City;

Decision to be Made by: (ie Council or Cabinet)	**Date of Decision-Making Meeting and Reason**	**Proposed Key Decision**	**Lead Executive Councillor(s) and Wards Affected**
Cabinet	21 Mar 2011	**Approval of the 2011/12 Highway Maintenance Programme** The purpose of the report is to seek approval for the projects listed within the Carriageway and Footway Planned Maintenance programme.	Deputy Leader (+Environment and Asset Management)
	Reason: Affects more than 1 ward		Ward(s): All Wards;
Cabinet	21 Mar 2011	**Short Breaks Service and Day Service for People with Learning Disabilities** Delegated authority is sought to award a contract to an external provider for provision of a Short Breaks Service for People with Learning Disabilities (currently an internal service). Delegated authority is also sought for the Head of Asset Strategy and Portfolio Manangment to grant leases for council buildings at 17 Rivercourt Road, W6, 280 Goldhawk Road, W12 and Ellerslie Day Centre, Ellerslie Road W12 (See February '11 Cabinet Report on Day Services)	Councillor Joe Carlebach
	Reason: Affects more than 1 ward		Ward(s): All Wards;
Cabinet	21 Mar 2011	**Housing Development Company** Consideration to establish organisational structures for a Local Housing Company.	Cabinet Member for Housing
	Reason: Affects more than 1 ward		Ward(s): All Wards;
April			
Cabinet	18 Apr 2011	**The General Fund Capital Programme, Housing Revenue Capital Programme and Revenue Budget 2010/11 - Month 10 Amendments** Report seeks approval to changes to the Capital Programme and Revenue Budget.	Leader of the Council
	Reason: Expenditure more than £100,000		Ward(s): All Wards;

Decision to be Made by: (ie Council or Cabinet)	**Date of Decision-Making Meeting and Reason**	**Proposed Key Decision**	**Lead Executive Councillor(s) and Wards Affected**
Cabinet	18 Apr 2011 Reason: Expenditure more than £100,000	**Request for remaining funds to complete SmartWorking Stage C rollout** Request for remaining funds from the overall sum requested at Cabinet on 1st July 2010 to complete the Stage C corporate rollout of SmartWorking.	Leader of the Council Ward(s): All Wards;
Cabinet	18 Apr 2011 Reason: Budg/pol framework	**A transport plan for Hammersmith & Fulham 2011 - 2031** The Local Transport Plan for Hammersmith & Fulham is a statutory document required by all London Boroughs to show how they intend to implement the Mayor's Transport Strategy.	Deputy Leader (+Environment and Asset Management) Ward(s): All Wards;
Cabinet	18 Apr 2011 Reason: Expenditure more than £100,000	**Sex and Relationships and Substance Misuse Education Tender** For Cabinet to approve the contract award in June 2011. This will be a 1 year contract with option to renew on a yearly basis with an approximate value of £125k in the first year (including £20k start up costs) The tender will seek a single provider to re-develop, manage and deliver the highly regarded sex and relationships and substance misuse programme currently delivered in LBHF schools, colleges and youth settings.	Cabinet Member for Children's Services Ward(s): All Wards;
Cabinet	18 Apr 2011 Reason: Expenditure more than £100,000	**Award of Term Contract for Tree Maintenance 2011-2014** Key Decision required to award this contract to the tenderer deemed to have submitted the most economically advantageous tender.	Deputy Leader (+Environment and Asset Management) Ward(s): All Wards;

Decision to be Made by: (ie Council or Cabinet)	**Date of Decision-Making Meeting and Reason**	**Proposed Key Decision**	**Lead Executive Councillor(s) and Wards Affected**
Cabinet	18 Apr 2011 Reason: Expenditure more than £100,000	**Decision to Award Term Contracts for Road2010 Condition Surveys** Road2010 Road Condition Surveys 2011-2013	Deputy Leader (+Environment and Asset Management) Ward(s): All Wards;
Cabinet	18 Apr 2011 Reason: Expenditure more than £100,000	**12 Zone Match day parking consultation results** This report details the results of the public consultation for a match day parking scheme proposal in Controlled Parking Zones in the 12 Zones south of the Talgarth Road. This report also give proposals for implementation.	Deputy Leader (+Environment and Asset Management) Ward(s): Fulham Broadway; Fulham Reach; Hammersmith Broadway; Munster; North End; Palace Riverside; Parsons Green and Walham; Sands End; Town;