London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Agenda

Monday 9 September 2013
4.00 pm
Courtyard Room - Hammersmith Town Hall

MEMBERSHIP

Councillor Marcus Ginn, Cabinet Member for Community Care (Chairman)
Dr Tim Spicer, Chair of H&F CCG (Vice-chairman)
Councillor Helen Binmore, Cabinet Member for Children's Services
Peter Brambleby, Interim Tri-borough Director of Public Health
Andrew Christie, Tri-borough Director of Children's Services
Sue Redmond, Interim Tri-borough Director of Adult Social Care
Trish Pashley, Local Healthwatch representative

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Date Issued: 30 August 2013

London Borough of Hammersmith & Fulham

Health & Wellbeing Board
Agenda

9 September 2013

Item		Pages
1.	**MINUTES AND ACTIONS**	1 - 7

1. To approve as an accurate record and the Chairman to sign the minutes of the meeting of the Health & Wellbeing Board held on 17 June 2013.

2. To note that the Council, having consulted the Health and Wellbeing Board (HWB) and having regard to the recommendation of the HWB, directs that the Clinical Commissioning Group (CCG) representative and the local Healthwatch representative are entitled to vote, but that Council officers on the HWB are not entitled to vote.

2. APOLOGIES FOR ABSENCE

3. DECLARATIONS OF INTEREST

Any Member of the Board, or any other Member present in the meeting room, who has a disclosable pecuniary interest in a matter to be considered at the meeting is reminded to disclose the interest to the meeting and to leave the room while any discussion or vote on the matter takes place.

Members are also reminded that if they have any other significant interest in a matter to be considered at the meeting, which they feel should be declared in the public interest, such interests should be declared to the meeting. In such circumstances Members should consider whether their continued participation, in the matter relating to the interest, would be reasonable in the circumstances, particularly if the interest may give rise to a perception of a conflict of interests, or whether they should leave the room while any discussion or vote on the matter takes place.

4. WORK PROGRAMME 8 - 9

The Board's proposed work programme for the municipal year is set out as Appendix 1 to this report.

The Board is requested to consider the items within the proposed work programme and suggest any amendments or additional topics to be included in the future.

The Board is requested to consider the oral update on the HWB workshop.

5. CLINICAL COMMISSIONING INTENTIONS 10 - 23

This report provides the Health & Wellbeing Board (HWB) with:

- An understanding of the overall development process and the underpinning principles
- A summary of the key areas of commissioning intent for 2014/15 and their strategic fit
- A summary of key strategic challenges
- How these challenges determine the focus for 2014/15
- A summary of further opportunities for involvement
- Sight of the proposed content and structure of the commissioning intentions document
- Some key questions for consideration.

6. JOINT STRATEGIC NEEDS ASSESSMENT: UPDATE 24 - 41

This report updates on the JSNA progress.

The Board is requested to approve final sign-off on the Employment Support JSNA Deep Dive.

7. NHS FUNDING TO SUPPORT SOCIAL CARE 2013/2014 42 - 49

This report sets out the proposals for the use of NHS Funding for Adult Social Care.

8. INTEGRATION TRANSFORMATION FUND 50 - 56

This report summarises the purpose and terms of the new fund and identifies actions which local health and social care organisations need to take to take advantage of this opportunity.

9. PARTNERSHIP AGREEMENT WITH THE NHS 57 - 65

This report explains the background to the development of a new Partnership Agreement for the Commissioning of Health, Wellbeing and Social Care between the London Borough of Hammersmith and Fulham and NHS Hammersmith and Fulham Clinical Commissioning Group.

10. DATES OF NEXT MEETINGS

The Board is asked to note that the dates of the meetings scheduled for the municipal year 2013/2014 are as follows:

4 November 2013
13 January 2014
24 March 2014

Agenda Item 1

London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Minutes

Monday 17 June 2013

PRESENT

Committee members:
Councillor Marcus Ginn, Cabinet Member for Community Care (Chairman)
Councillor Helen Binmore, Cabinet Member for Children's Services
Andrew Christie, Tri-borough Executive Director of Children's Services
Eva Hrobonova, Deputy Director of Public Health
Dr Susan McGoldrick, H&F, CCG (from 5pm)
Trish Pashley, Healthwatch Representative
Sue Redmond, Interim Tri-borough Executive Director, Adult Social Care
Dr Tim Spicer, Chair of H&F CCG (Vice-chairman) (to 5pm)

In attendance:
Councillor Georgie Cooney, Cabinet Member for Education
Abigail Hull, H&F, CCG
Janet Shepherd, Director of Nursing and Patient Experience for North West London, NHS England
David Evans, Senior Policy Officer
Sue Perrin, Committee Co-ordinator

1. MINUTES

RESOLVED THAT:

(i) The minutes of the Shadow Health and Wellbeing Board held on 25 March 2013 be approved and signed as a correct record of the proceedings, subject to the following amendment:

5. Priority 3: Supporting young people into a healthy adulthood to read:
'The work of the HWB and the Children's Trust Board should not duplicate each other'.

(ii) The following changes in the order of priorities be noted:

Priority 3: Every Child has the best start to life.
Priority 4: Childhood Obesity
Priority 5: Supporting young people into a healthy adulthood.

2. APOLOGIES FOR ABSENCE

Dr Spicer gave apologies for having to leave the meeting early.

3. DECLARATIONS OF INTEREST

There were no declarations of interest.

4. MEMBERSHIP AND TERMS OF REFERENCE

RESOLVED THAT:

(i) The terms of reference be noted.

(ii) The Board recommended that the Council makes a direction that the members of the Board who are entitled to vote alongside the Councillors are the representative of the CCG and the Local Healthwatch representative but not the Council officers on the Board.

(iii) The appointment of an Opposition Member to the Board be considered at a future meeting.

5. APPOINTMENT OF A VICE-CHAIRMAN

RESOLVED THAT:

Dr Tim Spicer be elected as Vice-chairman for the 2013/2014 municipal year.

6. WORK PROGRAMME

RESOLVED THAT:

(i) The work programme be noted.

(ii) A proposal for an informal meeting, with costs be brought to the September meeting.

Action: David Evans

(iii) That a report on housing for people with learning disabilities and for older people, and specifically better use of existing stock, be added to the work programme.

7. OUT OF HOSPITAL PROGRAMME UPDATE FOR HAMMERSMITH & FULHAM

Dr Spicer introduced the report which updated the Board on progress made by the H&F Clinical Commissioning Group (CCG), Tri-Borough and partners in delivering the Out of Hospital (OOH) strategy, identifying key achievements, whilst also considering the long term objectives.

The ‘Shaping a Healthier Future’ programme had addressed the need to rebalance the whole system of care away from over reliance on acute hospitals, with a move towards greater use of primary and community based services. For H&F, the OOH strategy would focus on developing plans for three sites to support five networks of care in the north, centre and south of the borough, including the use of Charing Cross Hospital as a hub/health centre offering primary care, therapies and further diagnostic services.

It was recognised that patients and users of health and social care services across H&F currently increasingly experienced a fragmented service. Whilst good progress had been made to develop improved collaborative working, it was recognised that a Whole Systems approach was needed to enable integrated care.

Dr Spicer commented on the intention of North West London to submit an expression of interest to become one of ten ‘Pioneer Sites’ in demonstrating an innovative and ambitious approach to integrating care. Co-design work had commenced in a number of areas. The programme was looking for support from the eight CCGs and local authorities to further progress the design work across each of the programme work streams. The advantages of scale would be beneficial in working with major acute providers.

The three boroughs (Hammersmith & Fulham, Kensington & Chelsea and Westminster) and their partners had a history of working closely together and, as a community budget pilot, had developed an understanding of how funds could be used differently to target key local priorities.

90% of acute activity happened within North West London, as opposed to a different sector, and therefore the shift of activity away from hospital based care, towards greater use of primary and community services was more likely to succeed. Some 20% of residents used 65% of health and social care resources.

Bids to become Pioneer Sites had to be submitted to the Department of Health by 28 June, but the decision would not be made until September. Further information would be reported to the Board at its next meeting.

Ms Pashley highlighted the importance of patient involvement, specifically hard to reach groups, and the discussion of the co-design work with patient representatives, and the HWB’s statutory duty to improve health inequalities.

Councillor Binmore queried the resources for the pilot and the provision of a community service across borough boundaries. Dr Spicer responded that funding was in place in tri-borough areas and they were able to account for activity and attribute to the right source. In other areas, there would need to be a reciprocal agreement.

Mr Christie queried the scope of the OOH programme, the evidence for the best areas in which to direct effort, health prevention to avoid in-patient admissions and the development of Urgent Care Boards.

Dr Spicer responded that the programme covered any provision which might be delivered in the acute sector. Organisations would put in place and co-ordinate services for high resource users, with the aim of slowing the development of long term conditions.

A tri-borough Urgent Care Board had been established covering Central London, West London and Hammersmith & Fulham CCGs and had met for the first time the previous week. Operational Groups would cover each Accident & Emergency Department.

The report updated on the current OOH schemes.

Ms Pashley queried the Virtual Ward model and the development of networks. Dr Spicer responded that the joint health and social care scheme would operate in a similar fashion to inpatient wards, using similar multi professional staffing and systems, except that people would be cared for in their own homes as opposed to an acute hospital. The model would be organised around a group of patients registered with a group of practices that were part of a network and, when fully developed, would be operational 24/7. Staff in the current out-of-hours service worked in silos and did not have access to patients' notes.

RESOLVED THAT:

1. The Board noted the progress for the OOH strategy.

2. The Board agreed in principle to proceed with the expression of interest in becoming a Pioneer Site.

8. JOINT HEALTH & WELLBEING STRATEGY

Mr Evans introduced the Joint Health & Well-being Strategy (JHWS) update report, which set out progress against the eight key priorities and outlined the next steps. The Council was also developing the Community Strategy 2014-2022, and the next steps would need to include consultation on the JHWS and priorities as part of the Community Strategy process.

Joint consultation would offer an opportunity to engage with a larger number and a wider cohort of stakeholders, identify the clear links to be made between the two strategies, and avoid confusion and duplications as well as realising better value for money by running a single consultation exercise rather than two. Mr Christie suggested that existing mechanisms for consultation be used, for example the borough youth forum.

The consultation on the JHWS would enable local people and stakeholders to contribute their views and for a final revision before endorsement by the HWB in January 2014.

'Priority 1: Integrated health and social care services which support prevention, early intervention and reduce hospital admissions' had not been included in the report, but had been covered in the previous item.

Mrs Redmond indicated that it would be more appropriate for the CCG, rather than Adult Social Care to lead on the priority; "Improving mental health services for service users and carers to promote independence and develop effective preventative services".

Mrs Redmond stated that the Partnership Board, which included the three CCG Chairs and lead Cabinet Members for Adult Social Care, would oversee both commissioning and service delivery led integration initiatives and would ensure that these were aligned and work co-ordinated. A joint interim Director for Adults Community Health and Social Care had been appointed by Tri-borough and CLCH (with CCG input) to lead the community services integration programme.

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RESOLVED THAT:

The JHWS be consulted upon as part of the programme to develop the Community Strategy.

9. JOINT STRATEGIC NEEDS ASSESSMENT

Ms Hrobonova presented the report, which set out a proposal for the process and governance structure of the Joint Strategic Needs Assessment (JSNA) programme, to maximise the use of the JSNA by commissioners and planners. The HWB was responsible for sign off and delivery of the JSNA.

Members considered how the HWB would help to steer the priorities for 'deep-dive' JSNA products and the workload of the task groups. Ms Hrobonova stated that the JSNA Steering Group would determine and prioritise requests through the use of the 'JSNA Prioritisation Scoring Tool'. Task and Finish Groups would be established to take on the work programme and complete the JSNA product.

'Deep-dive' priorities would be brought to the September meeting and included in the Annual Report, which, would be brought to the HWB for final sign off. In addition, the HWB would be informed of any 'deep-dive' products, which had been rejected.

Ms Pashley queried the involvement of patients and public in the process. Ms Hrobonova responded that the JSNA was publicised through the CCG and the JSNA website. JSNA managers would engage with communities to ensure public input and an appropriate user engagement strategy.

RESOLVED THAT:

1. The proposed Tri-borough JSNA Model should be managed by the Tri-borough Public Health Service and run in the way set out in the report be agreed.

2. The governance arrangements set out in the report be agreed.

3. The task of priority setting be delegated to the proposed JSNA Steering group.

10. LOCAL HEALTHWATCH

The Healthwatch Hammersmith & Fulham (Healthwatch HF) work programme 2013/0214, which set out the activities, priorities and expected outcomes was tabled. Members considered the Healthwatch HF work priorities and specifically how the work plan could contribute to the HWB strategy and how patient and user views could be integrated into commissioning decisions. The report set out the following aims:

- To provide information to the public about local health and social care services;

- To enable local people to have a voice in the development, delivery and equality of access to local health and care services and facilities; and

- To provide training and the development of skills for volunteers and the wider community in understanding, scrutinising, reviewing and monitoring local health and care services and facilities.

Healthwatch HF had identified the following draft priorities for the 2013/2014 work plan: Out of Hospital Care; Young People and Sexual Health; and Learning and Disability.

The draft priorities for the other boroughs were:

Healthwatch RBKC: Homecare, Personalisation, Making Complaints and Cancer

Healthwatch WCC: Hospital discharge, Dementia Care, Carers and Homeless Health

Members repeated earlier comments in respect of the value of consultation with established groups. The Chairman commented that user engagement reviews of the effectiveness of services had produced useful information for input into service redesign.

RESOLVED THAT:

The Healthwatch HF work programme be noted.

11. DATES OF NEXT MEETINGS

9 September 2013
4 November 2013
13 January 2014
24 March 2014

Meeting started: 4.05 pm
Meeting ended: 5.30 pm

Chairman .....

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Hammersmith & Fulham Health & Wellbeing Board
Work Programme 2013/14

Agenda Item		Report Sponsor/Author
Meeting Date: 17 June 2013		
Membership and Terms of Reference Appointment of Vice-chairman Out of Hospital Programme Update Joint Health & Wellbeing Strategy Joint Strategic Needs Assessment: Update Local Healthwatch Work Programme		
Meeting Date: 9 September 2013		
H& F CCG Commissioning Intentions 2014/2015: Development Process & Emerging Intentions Joint Strategic Needs Assessment 2013/14 and work programme Integration Transformation Fund NHS Funding to Support Social Care 2013/2014 Partnership Agreement with the NHS		
Meeting Date: 4 November 2013	***Report Deadline: 18 October 2013***	
Community Strategy		Peter Smith
H&F CCG Draft Commissioning Intentions 2014/15 HWB endorsement of CCG's Commissioning Intentions.		Tim Spicer/Philippa Jones
Joint Health & Well-being Strategy update		Martin Waddington
Keep Smiling Outreach Pilot in White City: Evaluation Report Update to focus on what the HWB can contribute.		Cllr Marcus Ginn/ Dr Claire Robertson
Public Health Business Plan Update for review and comment on progress.		Eva Hrobonova/Lynne Horne
White City Collaborative Care Centre: Looking ahead to the opening of the White City Collaborative Care Centre in 2014. The key issues which need to be addressed how the HWB can contribute to a smooth and successful completion of the project.		Tim Spicer/Rob Sainsbury
Meeting Date: 13 January 2014	***Report Deadline: 23 December 2013***	

Agenda Item		Report Sponsor/Author
Evaluation of home fire safety visits to adult social care service – 20 mins Presentation		LFB Borough Commander Steve Lumb
Integation Transformation Fund 2014/2016: Draft Plans		Cath Attlee
Joint Health & Wellbeing Strategy Following consultation, to endorse the strategy.		Martin Waddington/ David Evans/All priority owners
Public Health in Hammersmith & Fulham Following the transition of public health; Mid year progress, issues and how the HWB can support the next steps.		Public Health
Meeting Date: 24 March 2014	***Report Deadline: 7 March 2014***	
Housing for People with Learning Disabilities and for Older People, and Specifically Better U|se of Existing Stock		Martin Waddington
Integration Transformation Fund 2014/2016: Plans		Cath Attlee
Pharmaceutical Needs Assessment Delivery		Public Health
Review of HWB Membership		Cllr Marcus Ginn
2014/2015		

h&f the low tax borough	**London Borough of Hammersmith & Fulham** **HEALTH & WELLBEING BOARD** **9 September 2013**
HAMMERSMITH & FULHAM CCG COMMISSIONING INTENTIONS 2014/15: DEVELOPMENT PROCESS AND EMERGING INTENTIONS	
Report from Hammersmith & Fulham CCG	
Open Report	
Classification - For Review & Comment **Key Decision: No**	
Wards Affected: All	
Accountable Health & Well-being Board Member: Dr Tim Spicer, Chair of H&F CCG	
Report Author: Philippa Jones, Managing Director, H&F CCG	**Contact Details:** Tel: 02033504368 E-mail: Philippa.jones@nw.london.nhs.uk

1. SUMMARY

All Clinical Commissioning Groups (CCGs) develop and publish their commissioning intentions on an annual basis. Hammersmith & Fulham CCG has aimed to develop a proactive and inclusive approach to the development of its commissioning intentions for 2014/15, which meets the needs of its members, stakeholders, patients and the public.

Engagement so far has included discussions with the local authority (Tri-borough director and team, public health), joint commissioning colleagues, Healthwatch, and the CCG Governing Body and membership.

The Health & Well-being Board has a statutory duty to provide an opinion to NHS England on the extent to which it has been engaged in the development of the Commissioning Intentions. The Board is also required to assure itself that regard has been taken to both the JSNA and Joint Health & Well-being Strategy.

It is recognised that there are on-going discussions regarding best mechanisms of support to the HWB to allow full engagement to occur which the LA are leading on.

1.1. This paper provides the Health & Wellbeing Board (HWB) with:

- An understanding of the overall development process and the underpinning principles
- A summary of our key areas of commissioning intent for 2014/15 and their strategic fit
- A summary of key strategic challenges
- How these challenges determine our focus for 2014/15
- A summary of further opportunities for involvement
- Sight of the proposed content and structure of the commissioning intentions document
- Some key questions for consideration.

1.2. **The HWB is asked to:**

- Note and agree the principles underpinning the development of commissioning intentions
- Note the overall process and engagement to date
- Review and comment on the proposed content and structure of the commissioning intentions document
- Consider the questions posed in 1.3.

1.3. **The HW is asked to consider the following specific questions following discussion of the report:**

- Does the HWB support the principles & key messages set out in the paper?
- Do the highlighted priority areas for development seem appropriate?
- Are there areas that the HWB would like to have a focus on?

    - Suggestions have included:
        ..1. Out of hospital
        ..2. Joint commissioning, incl:
        ..3. CLCH
        ..4. Mental Health
        ..5. Nursing Homes
        ..6. Children

- Does the example update template (unscheduled care) provide a useful way of understanding progress from last year and the emerging direction of travel for 2014/15?
- Does the HWB agree that the proposed document structure and content areas look broadly right? What additions/amendments would be appropriate?
- Are there any critical areas we should address in the workshop on 26 September?
- What could helpfully be included on the agenda for the 4 November meeting?

Hammersmith and Fulham
Clinical Commissioning Group

Hammersmith & Fulham CCG Commissioning Intentions 2014-15: development process and emerging intentions

23rd August 2013

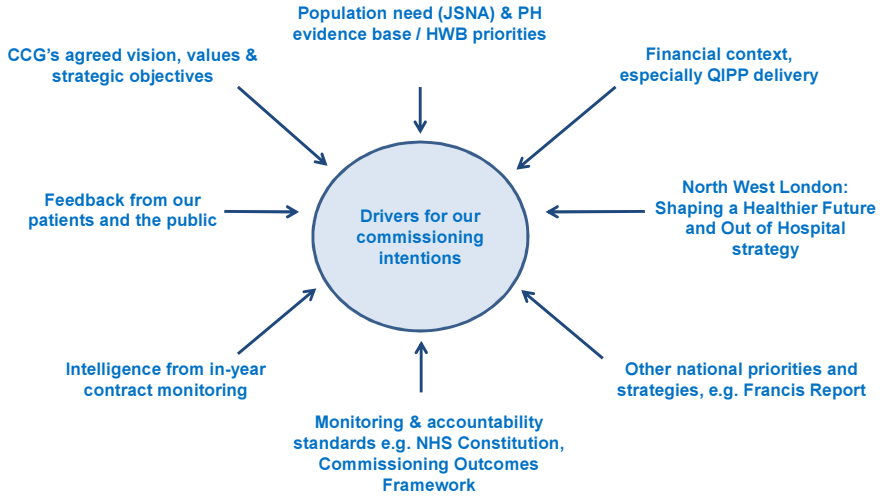
Introduction

Developing 2014/15 commissioning intentions

All Clinical Commissioning Groups (CCGs) develop and publish their commissioning intentions on an annual basis. Hammersmith & Fulham CCG has aimed to develop a proactive and inclusive approach to the development of its commissioning intentions for 2014/15, which meets the needs of its members, stakeholders, patients and the public. We want partnership to be at the heart of delivering this approach, recognising that new organisations and relationships are still evolving.

Commissioning intentions are there to signal to providers and other stakeholders what the CCG will be expecting and working on over the coming year.

The process for developing commissioning intentions is set clearly in the context in which we operate:



Stakeholders

The development process aims to provide scope for the comprehensive inclusion of all key stakeholders, including: H&F CCG Governing Body, networks, membership and management team; local authority colleagues; Health & Wellbeing Board (HWB); CSU commissioning & contracting leads; patients and the public; CWHH CCG colleagues; and input from providers as required to ensure appropriate intelligence at service level.

The purpose of this paper

This paper provides the Health & Wellbeing Board (HWB) with:

- An understanding of the overall development process and the underpinning principles
- A summary of our key areas of commissioning intent for 2014/15 and their strategic fit
- A summary of key strategic challenges
- How these challenges determine our focus for 2014/15
- A summary of further opportunities for involvement
- Sight of the proposed content and structure of the commissioning intentions document
- Some key questions for consideration.

Actions for the HWB

- To note and agree the principles underpinning the development of commissioning intentions
- To note the overall process and engagement to date
- To review and comment on the proposed content and structure of the commissioning intentions document
- Are there areas that the HWB would like to have a focus on? Suggestions have included:
    - Out of hospital
    - Joint commissioning, incl:
    - CLCH; Mental Health
    - Nursing Homes; Children

NHS
Hammersmith and Fulham Clinical Commissioning Group

Developing commissioning intentions 2014/15: principles & key messages

The basis for developing our commissioning intentions:

Our 2014/15 intentions will build on established foundations and an agreed direction of travel. We are considering the following underpinning principles:

- Delivery of **Shaping a Healthier Future**, the **Out of Hospital Strategy** and **QIPP**
- Moving towards whole systems **integrated care**
- Moving towards a **single patient record** through the implementation of new systems that are compatible with the GP IT system or through ensuring intraoperability
- Demonstrable, continuous improvement in **quality** services and processes in place for assuring quality
- Continued drive to **reduce non elective admissions** to hospital
- **Listening to patient feedback** and implementing change based on that feedback
- Services commissioned are **value for money**

How we will develop our intentions:

- We will involve all our stakeholders in developing our intentions
- Intentions will be written jointly with local authority colleagues for services and providers from whom we both commission
- We will work collaboratively with our neighbouring CCGs, particularly where we have shared intentions for our major providers
- We will identify specific areas where input from patients can have most impact for 2014/15 and begin to put processes in place to expand the scope of this input for 2015/16
- We will develop an engagement plan for 2014/15 so that patients and the public can contribute to commissioning of services.

Engagement so far…

We have discussed both the process and content of our commissioning intentions with a range of key stakeholders, including individuals and teams, regular operational meetings, and formal meetings:

Individuals and teams to date:

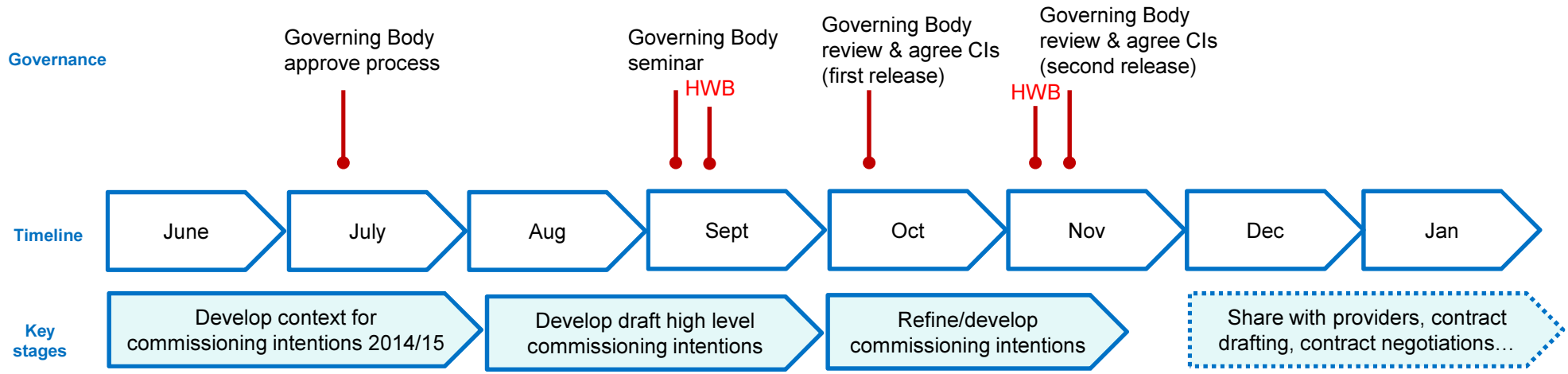
- **Martin Waddington and team,** Tri Borough Director, ASC Procurement, Business Intelligence and Workforce, LBHF
- **Cath Attlee and team,** Assistant Director Joint Commissioning, NHS NWL Commissioning Support Unit / Triborough Adult Social Care
- **Shelley Shenker**, Head of Joint Commissioning Mental Health
- **Ray Boateng,** Senior Joint Commissioning Manager - Older People & Vulnerable Adults, Joint Commissioning Team
- **Monique Carayol,** Head of Joint Commissioning Vulnerable Adults
- **Ike Anya**, Public Health Consultant, Tri-borough Public Health
- **James Hebblethwaite,** Senior Public Health Analyst, Tri-borough Public Health
- **Eva Hrobonova,** Public Health Consultant, Tri-borough Public Health
- **Samira Ben Omar,** Assistant Director Patient Experience and Equalities, CWHH
- **Paula Murphy,** Interim Director, Healthwatch Central West London
- **Cerith Lewis,** Director of Contracts and Information, CWHH

Operational and formal meetings to date:

- H&F CCG Governing Body (July & September 2013)
- H&F CCG Members' Event (August and September 2013)
- H&F CCG Network Leadership Group (July and August 2013)
- CWHH team meeting (weekly)
- HWB (September 2013)

Process for developing commissioning intentions: engagement and activities

Our timeline for developing commissioning intentions is shown below. We have incorporated key LA milestones into our process, e.g. JSNA refresh timelines, and we continue to ensure that timelines for key strategic pieces of work, the HWB strategy, are aligned.



Tasks

- Early discussions with stakeholders
- Understand the context for this year (strategic, financial, quality, population need etc)
- Understand progress from last year
- What do our patients think?
- Early meeting with public health to establish key likely messages from JSAN

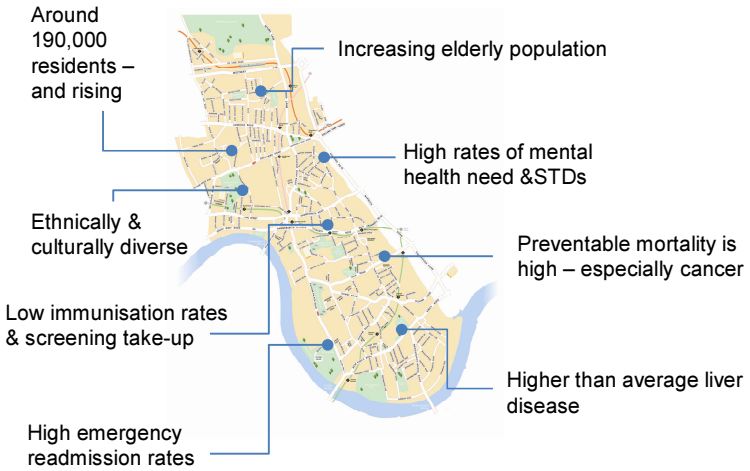
- Bring together all the suggestions and feedback at a stakeholder workshop
- Develop a high level set of intentions for next year
- Be clear about our priorities
- Give our providers early sight
- Check fit with emerging HWB strategy
- Feed in JSNA key messages when available from public health

- Dedicated patient workshop
- Incorporate feedback from first release intentions
- Refine our intentions for next year
- Ensure final alignment with published JSNA refresh
- Check fit with HWB strategy

Key strategic challenges and themes

As partners across the system, we must meet a range of key strategic challenges:

Meeting the needs of population as identified in the JSNA…



Delivering Shaping A Healthier Future…

…supported by Out of Hospital Strategy

- The need to reconfigure acute services and continue to develop preventative, primary and community care
- Supporting and encouraging patients, carers and communities to take greater control of their health, illness and treatment
- The need to assure quality across all provider services
- Securing patient and public feedback for service redesign and commissioning

Ensuring measurable changes in outcomes across our HWB priorities…

- Integration of health & social care
- Developing the White City Collaborative Care Centre
- Improving mental health services
- Improving sexual health services
- Supporting children and young people
- Better access to sheltered housing

Developing integration…

- Joining up our partners, e.g. housing, education and employment
- Bringing health and social care closer together
- Integrating steps in the pathway from preventative through to end of life

All to be delivered within the context of an estimated, recurring £10.6m QIPP gap…

Commissioning intentions 2014/15 and strategic fit

The table below illustrates how the themes have enabled us to structure 2014/15 service delivery and check their fit with our key strategic drivers.

Commissioning intentions	SaHF	OOH strategy	HWB strategy	JSNA	NHS Mandate	National priorities
Unscheduled care	◆	◆	◆	◆	◆	◆
Planned care	◆	◆	◆	◆	◆	◆
Mental health	◆	◆	◆	◆	◆	◆
Dementia	◆	◆	◆	◆	◆	◆
Community services	◆	◆	◆	◆	◆	◆
ASC: Older people & PD, carers, LD	◆	◆	◆	◆	◆	◆
Children, Young People, Maternity & Newborn	◆	◆	◆	◆	◆	◆
Prevention & Public Health			◆	◆	◆	◆
Transforming primary care	◆	◆		◆		
Moving towards integration	◆	◆	◆			◆
Patient engagement & equalities impact assessment	◆	◆	◆	◆	◆	◆

Our commissioning intentions: establishing progress from last year and specific plans for 2014/15

We are currently working with stakeholders to update each of the key areas of our 2013/14 commissioning intentions. The work to update all areas will allow us to present:

- **What we set out to do this year** – the broad direction of travel we anticipated, along with some specific examples of service changes that we aimed to implement
- **Progress made to date** – we are in the process of collating feedback from stakeholders in order to fully understand our progress from last year. We will be able to feedback and describe what we have achieved to date. This will be quantified where data quality and availability allow
- **The emerging direction for 2014/15** – based on the feedback to date for each commissioning area, together with what we know about our strategic drivers for next year, we will indicate what we anticipate will be our emerging direction for 2014/15.

The following slide sets a draft example of an update that we have begun for unscheduled care. We envisage being in a position to share updates of this kind for all our areas of commissioning intent at the stakeholder workshop planned for 26 September 2013.

Unscheduled care update – DRAFT EXAMPLE

What we set out to do 2013/14

Provision of effective care out of hospital, including:

- Multidisciplinary care planning for patients with LTCs (top 3 tiers), deployment of Health and Social Care Coordinators (HSCC)
- Integrated health, community and social care teams (Virtual Wards), plus medical (GP) input to virtual wards
- Active promotion of supported self-care
- Coordinate my care programme for end of life patients

Addressing mental health dimensions of LTC patients:

- Drive to meet or exceed IAPT referral and access targets and developing acute psychiatric liaison

Acute contractual levers (with impact on unscheduled care)

- Ratio of patients seen and discharged by UCCs (target 60%)
- UCC to A&E admits for which a community pathway exists.

Progress to date

- The CCG Network Plan includes incentives to increase care planning
- The Virtual Ward model is agreed, incorporating medical input
- HSCC 12 month pilot ended June 2013 & formal evaluation has commenced
- MDGs established under ICP
- Good progress (uptake) on the Coordinate my care programme
- CCG has invested in IAPT and Q1 data indicates targets will be met
- NWL-wide work is ongoing to assess the potential for acute psychiatric liaison - H&F has a known gap in ChX hospital – funding arrangements are still to be agreed,
- Enhanced mental health care planning and improved adherence for LTC patients: additional work is required.

NB. To be updated with quantifiable measures of progress where available

Emerging direction 2014/15

Emerging areas of continued, altered, or increased focus:

- Virtual Ward implementation – incorporating learning from HSCCs evaluation
- ICP Yr 2 will follow a different approach following King's Fund Yr 1 evaluation
- Active promotion of supported self-care needs much greater emphasis in the coming year, e.g. through a dedicated strategy, which could incorporate improving uptake of PPE; links to telehealth, and expanding personal health budgets (PHBs)
- Co-ordinate my care is a success – developing a more holistic approach to commissioning end of life care may be needed e.g. to take into account post-Liverpool Pathway recommendations, review hospice capacity and the role of care homes

Proposed document structure and content areas (1)

The following two slides set out the proposed structure and content of the commissioning intentions document. For each chapter, the heading, purpose and proposed high level content is indicated.

Chapter heading	Chapter purpose	Proposed content areas
Chair's foreword & executive summary	To reflect the key messages for H&F, emphasising the need for transformational change and a move towards integrated care, and summarise the key intentions	
Chapter 1: strategic context	To set out the key contextual information and drivers for commissioning intentions	• Overall vision and values of the CCG • SAHF • OOH strategy • National priorities (NHS Mandate, Outcomes Framework etc) • JSNA • Health & Wellbeing Strategy • Whole systems integrated pilot
Chapter 2 - H&F CCG's Medium Term Financial Strategy 2013/14 – 2017/18	To summarise key CCG risks and opportunities and the strategic approach to finance	• 5-year financial position • Set out the QIPP challenge • Set the QIPP target for 2014/15

Proposed document structure and content areas (2)

Chapter heading	Chapter purpose	Proposed content areas

Chapter 3 – detailed commissioning intentions	Main body of the document setting out the detail of the commissioning intentions	• Strategic contracting principles and intentions
		• CWHH collaborative commissioning intentions
		• CCG-specific commissioning intentions:
		  • Integrated care
		  • Integration fund
		  • Continuing care
		  • Emergency care
		  • Planned care
		  • Primary care
		• Joint Commissioning intentions – CCG & Local Authority
		  • Community services
		  • Mental health
		  • Children, Young People, Maternity & Newborn
		• Public health and prevention update
		• Provider impact analysis
		• Procurement intentions
		• Enablers: engagement, people and organisational development, information tools, estates and governance and performance management through networks
		• Stakeholder engagement
		• Conclusion

Appendices – TBC, but to include detailed provider impact analysis		

Opportunities for further contribution & questions for the HWB

Further opportunities for the HWB to contribute to the commissioning intentions development process are:

- **Hammersmith & Fulham CCG Stakeholder workshop:**
  - Aim: to agree the high level intentions with input from key stakeholders and further work required to finalise the intentions
  - To be held on 26 September 2013
- **Dedicated patient workshop:**
  - Aim: to share our commissioning intentions with patients and patient representatives and to gather feedback
  - To be held on 17 October 2013
- **Individual meetings and discussions**

Questions for the HWB today:

1. Does the HWB support the principles & key messages set out in the paper?
2. Do the highlighted priority areas for development seem appropriate?
3. Are there areas that the HWB would like to have a focus on?
   - Suggestions have included:
     - Out of hospital
     - Joint commissioning, incl:
     - CLCH
     - Mental Health
     - Nursing Homes
     - Children
4. Does the HWB agree that the proposed document structure and content areas look broadly right? What additions/amendments would be appropriate?
5. Are there any critical areas we should address in the workshop on 26 September?
6. What could helpfully be included on the agenda for the 4 November meeting?

h&f the low tax borough	**London Borough of Hammersmith & Fulham** **HEALTH & WELLBEING BOARD** **9 September 2013**
TITLE OF REPORT Joint Strategic Needs Assessment (JSNA) Update	
Report of the Interim Director of Public Health	
Open Report	
Classification - For Decision/For Information **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: Interim Director of Public Health	
Report Author: Colin Brodie, Public Health Knowledge Manager, Tri-borough Public Health	**Contact Details:** Tel: 020 7641 4632 E-mail: cbrodie@westminster.gov.uk

1. EXECUTIVE SUMMARY

1.1. As agreed at the last meeting of the Health and Wellbeing Board the JSNA will be a standing item on the HWB agenda. This update reports on progress made since the last Board meeting.

1.2. The Health and Wellbeing Board is requested to approve final sign-off on the Employment Support JSNA Deep Dive (attached as Appendix 1) for further dissemination and to facilitate action on the recommendations.

2. RECOMMENDATIONS

2.1. To consider and note progress on the JSNA governance and process arrangements, the JSNA Highlight Report and the JSNA 'Deep Dives'

2.2. The Health and Wellbeing Board is requested to approve final sign-off on the Employment Support JSNA Deep Dive

3. REASONS FOR DECISION

3.1. Final sign-off is requested for the Employment Support JSNA Deep Dive. As agreed in the governance arrangements for the JSNA, final sign-off is required from each of the three Health and Wellbeing Boards.

3.2. An Executive Summary for the Employment Support JSNA is attached which describes the burden of illness and economic inactivity, the provision of employment support services in the Tri-borough area, and makes evidence based recommendations for future services.

4. JSNA UPDATE

4.1 Governance and process

- Approval for the governance and process of the JSNA has been received from all three Health and Wellbeing Boards

- Approval has been received for the recruitment of the JSNA Programme Manager. This post is in the process of going out to advert and interviews are expected to be held at the end of September.

- The first JSNA Steering Group meeting will take place on the 18th September 3.30-5.00pm at Hammersmith Town Hall to begin to assess the priorities and future direction of the JSNA work programme

4.2 JSNA Highlight Report

- A draft of the 2013/14 highlight report will be complete by the second week of September 2013. This report will be circulated to the Health and Wellbeing Board members and other stakeholders.

- The report will contain a summary of the key public health issues and priority areas in the three boroughs, and will highlight where local commissioners may wish to focus on improvements to the health of the local population.

- Attached as Appendix 2 is a report which highlights some of the outliers for Hammersmith and Fulham (as well as the other two Boroughs). These are based on indicators from the Public Health Outcomes Framework where the indicators fall significantly below the London average.

4.3 Current Deep Dive JSNAs

4.3.1 Employment Support

- This JSNA has now been completed and awaiting final sign-off by each of the three Health and Wellbeing Boards.

- The Executive Summary is attached for information

4.3.2 Learning Disabilities

- The Learning disabilities tri-borough JSNA is in the final draft stage, awaiting final comments from contributors, and will be complete by mid-September

- The JSNA examines the current and future needs of the local population with learning disabilities, and highlights how local services are responding to these needs. It will be used to inform the commissioning process

- The JSNA highlights the higher than average reliance on residential care in Hammersmith and Fulham, as well as an increase in numbers and complexity of those transitioning into adult services. The findings of the JSNA indicate that the poor outcomes, high health needs, and diagnostic 'overshadowing' compared to the general population reinforces the need for universal health checks among the population with learning disabilities to improve identification of conditions.

4.3.3 Physical Activity

- The evidence review is complete with the data analysis being finalised

- Recommendations are being developed in collaboration with the Physical Activity Steering Group. These will be ready by end of October

- The final JSNA, with recommendations, should be ready by mid-November

- The findings highlight the benefits of physical activity for promoting physical and mental health and wellbeing and combating social isolation; the benefits of undertaking any type of physical activity rather than none; that the term physical activity covers a range of

relatively accessible activities (such as dancing, gardening, and walking) and not just sport and exercise. It evidences that there is a range of barriers which prevent people from being physically active but it also shows that there are some promising interventions to assist people to overcome these barriers.

4.3.4 Tuberculosis

- A first draft of the tuberculosis deep dive JSNA is currently being reviewed.

- Initial findings indicate a need for strengthening the service specification for clinical and community services, improving early identification in primary care and supporting vulnerable individuals and groups.

4.3.5 Child Poverty

- In the absence of the JSNA Steering Group meeting to date, the proposal for this JSNA will be taken to the Chairs of the three Health and Wellbeing Boards for approval. Approval has so far been received from Westminster, and Kensington and Chelsea.

- A Task & Finish Group met for the first time on Monday 5th August with regular meetings set up for September and October.

- The Task and Finish Group discussed the scope of the JSNA. It will build on existing strategic commitments and current portfolio of work to address child poverty. It will provide
    - An overview of national approaches and key issues specific to London
    - The local picture
    - Recommendations for action to address issues locally

- The team is aiming to have a draft report at the end of September with final version at the end of October 2013

- Proposal for final report and key findings to come to Health and Wellbeing Boards in December/January

4.3.6 Alcohol

- Acknowledging the relatively high number of lives lost prematurely due to liver disease and that alcohol consumption is a key contributing factor, the Public Health Intelligence team will coordinate with the Substance Misuse Service to address these issues in the Substance Misuse Needs Assessment

4.4 Applications pending

- Veterans health. This application is being further scoped and will be presented to the JSNA Steering Group on 18 September for discussion and prioritisation

5. CONSULTATION

5.1. The three Health and Wellbeing Boards have been consulted on the JSNA governance and process

5.2. Consultation with key stakeholders is undertaken for each JSNA as an integral part of the JSNA Rolling Programme

6. EQUALITY IMPLICATIONS

6.1. JSNAs must consider the health, wellbeing and social care needs for the local area addressing the whole local population from pre-conception to end of life.

6.2. The “local area” is that of the borough, and the population living in or accessing services within the area, and those people residing out of the area for whom CCGs and the local authority are responsible for commissioning services

6.3. The “whole local population” includes people in the most vulnerable circumstances or at risk of social exclusion (for example carers, disabled people, offenders, homeless people, people with mental health needs, Travellers etc.)

7. LEGAL IMPLICATIONS

7.1. The Joint Strategic Needs Assessment (JSNA) was introduced in the Local Government and Public Involvement in Health Act 2007

7.2. The Health and Social Care Act 2012 placed the duty to prepare a JSNA equally and explicitly on local authorities (LAs), Clinical Commissioning Groups (CCGs) and the Health and Wellbeing Boards (HWB).

8. FINANCIAL AND RESOURCES IMPLICATION

8.1. Dependent on the findings of individual JSNA reports

8.2. Implications verified/completed by: (Name, title and telephone of Finance Officer)

9. RISK MANAGEMENT

9.1. Dependent on the findings of individual JSNA reports

9.2. Implications verified/completed by: (Name, title and telephone of Risk Officer)

10. PROCUREMENT AND IT STRATEGY IMPLICATIONS

10.1. Dependent on the findings of individual JSNA reports

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

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

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	Public Health Outcomes Framework – Tri-borough Outliers	James Hebblethwaite T: 02076414631	Tri-borough Public Health
2.	Executive Summary Employment Support	Patricia Griffiths T: 02076414649	Tri-borough Public Health

LIST OF APPENDICES:

Appendix 1: A Review of Employment Support for People with Mental Illness, Physical Disabilities and Learning Disabilities

Appendix 2: Tri-borough Outliers Report

JSNA
Joint Strategic Needs Assessment

DRAFT
Pending approval by relevant Health and Wellbeing Boards

A Review of Employment Support for People with Mental Illness, Physical Disabilities and Learning Disabilities

EXECUTIVE SUMMARY

Tri-Borough Joint Strategic Needs Assessment (JSNA)

August 2013

Website: www.jsna.info

EXECUTIVE SUMMARY

Purpose of this document

This document reports the needs assessment and service mapping of local and national specialist employment support for Tri-borough residents with mental illness, physical and learning disabilities. The report also reviews the evidence of best practice and outlines the vision for a new evidence-based service.

Burden of illness and economic inactivity

Across the Tri-borough area, there are high levels of economic inactivity, particularly in relation to mental illness and physical disabilities.

Nationally, mental health conditions are the most common reason for people to be dependent on health-related benefits (3). Tri-borough rates of severe mental illness (SMI) are among the highest in London and England. Local levels of Incapacity Benefit (IB) and Employment Support Allowance (ESA) claims due to mental ill-health are also high compared to London, particularly in Hammersmith and Fulham (8th highest in London). Paid employment rates for clients with severe mental illness in Kensington and Chelsea (K&C) and Westminster are below the London and England averages. This is despite the fact that nationally up to 90% of all mental health service users want to work (1) and at least a third of those currently unemployed due to SMI would like to find work (4).

Rates of physical disabilities are also high in parts of the Tri-borough area compared to London, with large numbers of IB and ESA claims for physical ill-health in these areas. Hammersmith and Fulham (H&F) has particularly high levels (12th highest in London).

The numbers of people with learning disabilities are low in the Tri-borough area and employment rates are on a par with London levels. However, clients with learning disabilities have worse employment prospects than other disability groups. The current employment rate for disabled people nationally has risen to 48% overall but remains only 10% for those with learning disabilities (6). We know that 65% of people with learning disabilities nationally would like a paid job (6).

Sickness absence and presenteeism (reduced productivity at work related to ill health) are also likely to have major impacts in the Tri-borough area, based on what we know nationally (7). Based on population size, sickness absence is estimated to cost the Tri-borough economy £84 million per annum in employer costs, health and social care costs and welfare (8). Mental illness is the number one cause of long-term sickness absence, closely followed by musculoskeletal problems (9).

> **Not all people with severe mental health conditions want to be employed, but almost all want to 'work', that is to be engaged in some kind of valued activity that meets the expectations of others.**
>
> DWP and Department of Health joint commissioning guidance 2006 (2)

Costs of economic inactivity

The impacts of economic inactivity are felt by individuals, communities, employers, local authorities and the NHS.

Unemployed individuals have a higher risk of poor physical and mental health compared with those in employment. The health and social impacts of a long period of unemployment can last for years (10).

Health inequalities are closely linked to worklessness and its links to physical and mental health and wellbeing (10, 11). Both unemployment and mental illness impact on other wider determinants of health such as income and secure housing, and also affect the wellbeing of families and communities

Unemployed people have higher levels of GP consultations and longer in-patient stays (3). Extrapolating from national figures, the cost of mental illness locally is approximately £300 million in H&F, £250 million in K&C and £350 million in Westminster. Over a third of this is due to loss of economic output (over £80million per borough) and a fifth due to health and social care costs (over £5million per borough) (3). These figures are probably underestimates due to high local prevalence of severe mental illness and a larger working age population than the national average.

Evidence-based employment interventions

Evidence-based employment interventions can deliver jobs, improve health and wellbeing and generate substantial cost savings to local commissioners.

There is substantial evidence that specialist employment support, tailored to the needs of clients with mental illness or disabilities, can deliver jobs. The most cost effective models of support include *Individual Placement and Support* (IPS) for mental health clients and *Supported Employment* (SE) in the disabilities field.

There is also evidence to support a role for '*Very Supported*' employment opportunities (such as social enterprises) for clients with very complex needs.

In addition, Government policy advocates early intervention *in-work support* to help individuals to retain employment, to prevent the 'revolving door' of sickness absence and to avoid the negative health impacts of unemployment (3, 9).

Evidence shows that these approaches to employment support can deliver:

- Improved individual health and wellbeing
- Increased personal income
- Reduced use of health and social care services

Action on unemployment for these client groups is aligned with national policy on Welfare to Work and helps deliver expectations in the NHS and Adult Social Care Outcomes Frameworks (12, 13). Issues related to employment are part of Health and Wellbeing Board priorities in all three boroughs.

Costs Savings

Evidence-based employment support is, at least, cost neutral. At best it can generate significant cost savings to local commissioners.

Summary of evidence for cost saving

- A number of IPS trials found up to 50% reductions in health and social care costs (1).
- IPS reduces the need for and length of hospital stays (1, 3). A multi-site European randomized trial found that IPS delivered saving of around £6,000 per client in inpatient psychiatric care costs, compared to usual care (1).
- Social Return on Investment analysis has shown returns of between £5 and £13 for each £1 invested Supported Employment for clients with disabilities (5).

Mapping services

The JSNA team has undertaken an extensive mapping of existing local employment support for people with mental illness and disabilities.

Local specialist employment support was mapped using data from: contract monitoring, email and telephone interviews with national and local providers, Co-production meetings with local service users and providers and other service user feedback.

There are four national schemes available, 14 locally commissioned providers funded specifically for tailored employment support to the client groups, and over 30 other voluntary sector providers working with these clients.

Pathways within the service are complex. There is no single point of referral and silo working between providers means that there are major issues around communication. It is likely that overlaps in provision may also occur.

Current good practice – The mapping identified some areas of excellent practice, particularly where evidence-based approaches were being pursued. Feedback from Co-production meetings was positive about the increasing numbers of professionals with understanding of mental health issues.

> **Interviewing people at the day service, or other friendly and accessible facility works well**
>
> Service user at Coproduction meeting

Spend – The majority of spending is on mental health, which reflects the greater numbers of mental health clients in the Tri-borough, compared to the number of people with disabilities. However, spend by borough is not always allocated according to need. Westminster currently spends much less than other boroughs on support for clients with mental illness, despite having a significantly higher burden of these conditions; Kensington and Chelsea spends the most.

Gaps in provision of services for specific client groups were identified and are already being addressed. For example, Hammersmith and Fulham is currently working to fill its gap in provision of specialist support for clients with physical disabilities.

Stages of support – There are gaps in provision of some stages of employment support. In particular, there is significant need for in-work support both for clients getting jobs through specialist local support *and* for employed people struggling in work with common mental illnesses and musculoskeletal problems.

Outcomes – It is clear that some providers are achieving a far smaller number of outcomes for the money received compared to others. This will need to be investigated further to understand underlying reasons, as there may be legitimate reasons for this.

Limitations of the mapping and subsequent data analysis come from gaps in the data and inconsistent terminology. Providers use different definitions of interventions (e.g. what constitutes in-work support) and outcomes (e.g. what constitutes a job outcome). Many providers do not routinely collect details of jobs obtained or impacts on health and wellbeing. Comparisons of provider performance are further complicated by their clients having different levels of need.

National provision

There have been developments in national provision, with increased focus on supporting clients challenged in the open job market. However, national evidence has identified major issues for all four national programmes around their ability fully to meet the needs of clients with mental illness and disabilities.

JobCentre Plus (JCP) is the first point of contact for any client claiming benefits and offers generic employment support with some specialist provision for clients with health problems. However, a national review identified that JCP staff may have 'poor awareness of mental health issues' (4). Co-production feedback identified that service users felt that JCP advisers were not always trained to support people with disabilities, particularly in communicating with clients with learning disabilities.

The Work Programme is the Government's flagship Welfare to Work programme and is being delivered in West London by three Prime contractors. Started in 2011, it aims to support clients with additional barriers to work, including claimants of Employment Support Allowance (health-related) and Job Seekers Allowance (not health-related). There are concerns that current early performance is not yet up to the levels expected. The Public Accounts Committee described one-year performance as 'disappointing'. Overall outcomes were worse than previous programmes and considerably lower than DWP expectations (14). Clients with a disability were half as likely to have a job outcome as people without a disability. London performed worse for disabilities clients than the rest of the UK (15). However, there is considerable national and local commitment to improve on this early performance.

> **Work Programme Primes don't offer enough support for people with complex needs.**
>
> Co-production group feedback

The two schemes designed specifically for clients with registered disabilities (***Work Choice*** and ***Access to Work*** grants) are not available to clients already on the Work Programme. Furthermore, *Work Choice* requires clients to be able to work for 16 hours per week (16) which excludes many people with disabilities. A major national review

found that *Access to Work* is underused, particularly by clients with mental illness and learning disabilities (17).

Economic climate

Under the current economic climate and with reforms to welfare, investment in employment support is an even greater priority.

During an economic downturn, the job market is challenging, particularly to clients with disabilities and mental illness (where the prevalence increases during periods of recession (10)). With reforms to benefits, there is likely to be in influx of clients into the job market who have previously been considered 'too ill to work'. Employment support providers are likely to face additional challenges in successfully supporting clients into jobs at this time. However, if provision of employment support were reduced, the resultant impacts on individuals will ultimately be passed onto NHS and local authorities with increased use of services (3).

A future service

Local employment support provision is to be recommissioned by Adult Social Care and NHS Mental Health commissioners.

The JSNA has identified some key aims for a new service, based on local and national findings. Commissioners may want to consider the following:

1. **To maximise the effectiveness of existing national provision**

   There is scope for better partnership work (including delivery of mental health and disabilities awareness training) and improved referral pathways between local and national providers.

2. **To commission evidence-based specialist employment support** for clients not eligible for national schemes and for those whose needs are not currently being fully met by national provision

3. **To integrate in-work support as a key element of the specialist employment support service**

4. **To commission an early intervention in-work support service across the Tri-borough councils**

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APPENDIX 2

Public Health Outcomes Framework – Refresh August 2013

Tri-borough Outliers Report

This report uses recently 'refreshed' data from the Public Health Outcomes Framework (PHOF) website to identify indicators where the boroughs of Hammersmith and Fulham, Kensington and Chelsea and Westminster fall *significantly* below the London average.

In addition to providing the local and London rates, estimates of the size of the 'excess' number of cases have been calculated. Although crude, these give an idea of the level of change necessary on an annual basis to reach London levels.

The outliers identified are not necessarily meant to be a reflection of public health priorities – there may be many areas where the boroughs have more favourable rates but where sustained action is still recommended to improve health. However, more intense focus may be necessary for these areas highlighted.

There may also be a number of instances where more up to date local data is held which may show a change in trend, or where it has not been possible to carry out significance testing.

For the full data from the PHOF website: http://www.phoutcomes.info/

For PHOF borough reports:
http://www.nepho.org.uk/pdfs/public-health-outcomes-framework/E09000013.pdf
http://www.nepho.org.uk/pdfs/public-health-outcomes-framework/E09000020.pdf
http://www.nepho.org.uk/pdfs/public-health-outcomes-framework/E09000033.pdf

Key points:

- All three boroughs continue to experience challenges around population immunisation and screening uptake and coverage, not only in relation to England but also to London
- The location of the boroughs impacts on some wider determinants indicators, with high levels of road casualties and crime, influenced by the visiting population as well as resident. There are also high levels of poverty and homelessness/ temporary accommodation in some instances across the area
- Preventable mortality is particularly an issue in Hammersmith and Fulham, with cancer carrying a disproportionate burden. Liver disease is also high in the borough

Hammersmith and Fulham Outliers compared to London

Senior Public Health Analyst, August 2013

OUTLYING INDICATORS - those statistically significantly worse than London	Time Period	H&F rate	London rate	Annual number H&F	Estimated excess H&F
WIDER DETERMINANTS					
1.01 - Children in poverty	2010	**31.1%**	27.8%	9260	+980
1.04i - First time entrants to the youth justice system	2012	**792.9**	584.7	95	+25
1.10 - Killed and seriously injured casualties on England's roads	2009 - 11	**45.0**	36.9	81	+15
1.12i - Violent crime (including sexual violence) - hospital admissions for violence	2009/10 - 11/12	**99.9**	71.9	171	+48
1.12ii - Violent crime (including sexual violence) - violence offences	2011/12	**25.6**	19.7	4345	+999
1.13i - Re-offending levels - percentage of offenders who re-offend	2010	**30.7%**	26.6%	781	+104
1.13ii - Re-offending levels - average number of re-offences per offender	2010	**0.9**	0.7	2263	
1.15ii - Statutory homelessness - households in temporary accommodation	2011/12	**13.5**	11.3	1025	+164
HEALTH IMPROVEMENT					
2.20i - Cancer screening coverage - breast cancer	2012	**61.8%**	69.1%	8165	-964
2.20ii - Cancer screening coverage - cervical cancer	2012	**60.3%**	69.6%	41350	-6377
2.21vii - Access to non-cancer screening programmes - diabetic retinopathy	2011/12	**73.8%**	78.7%	4054	-269
2.22i - Take up of NHS Health Check Programme by those eligible - health check offered	2012/13	**16.4%**	20.6%	6568	-1682
2.24i - Injuries due to falls in people aged 65 and over (Persons)	2011/12	**2720**	1872	542	+169
HEALTH PROTECTION					
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (1 year old)	2011/12	**88.8%**	91.3%	2422	-69
3.03iv - Population vaccination coverage - MenC	2011/12	**87.1%**	89.9%	2376	-79
3.03ix - Population vaccination coverage - MMR for one dose (5 years old)	2011/12	**85.3%**	89.7%	2113	-110
3.03v - Population vaccination coverage - PCV	2011/12	**88.0%**	90.4%	2401	-66
3.03vi - Population vaccination coverage - Hib / MenC booster (2 years old)	2011/12	**84.8%**	86.8%	2366	-56
3.03vi - Population vaccination coverage - Hib / Men C booster (5 years)	2011/12	**76.8%**	80.1%	1903	-83
3.03vii - Population vaccination coverage - PCV booster	2011/12	**81.4%**	85.3%	2271	-109
3.03viii - Population vaccination coverage - MMR for one dose (2 years old)	2011/12	**82.6%**	86.1%	2304	-99
3.03x - Population vaccination coverage - MMR for two doses (5 years old)	2011/12	**73.1%**	80.2%	1811	-177
3.03xiii - Population vaccination coverage - PPV	2011/12	**59.0%**	62.6%	8216	-507
3.03xiv - Population vaccination coverage - Flu (aged 65+)	2011/12	**68.9%**	72.2%	12235	-598
3.03xv - Population vaccination coverage - Flu (at risk individuals)	2011/12	**43.4%**	51.4%	6494	-1205
HEALTHCARE AND PREMATURE MORTALITY					
4.03 - Mortality rate from causes considered preventable (provisional)	2009 - 11	**169.0**	137.6	243	+45
4.05i - Under 75 mortality rate from cancer (provisional)	2009 - 11	**116.9**	103.3	151	+18
4.05ii - Under 75 mortality rate from cancer considered preventable (provisional)	2009 - 11	**73.7**	59.3	96	+19
4.06i - Under 75 mortality rate from liver disease (provisional)	2009 - 11	**24.4**	15.1	33	+13
4.06ii - Under 75 mortality rate from liver disease considered preventable (provisional)	2009 - 11	**20.4**	12.9	27	+10
4.11 - Emergency readmissions within 30 days of discharge from hospital	2010/11	**13.3**	12.0	2528	+249

Kensington and Chelsea Outliers compared to London

OUTLYING INDICATORS - those statistically significantly worse than London	Time Period	K&C rate	London rate	Annual number K&C	Estimated excess K&C
WIDER DETERMINANTS					
1.05 - 16-18 year olds not in education employment or training	2012	**8.6%**	4.7%	190	+86
1.10 - Killed and seriously injured casualties on England's roads	2009 - 11	**53.2**	36.9	85	+26
1.14i - The percentage of the population affected by noise - Number of complaints about noise	2011/12	**31.1%**	16.4%	4922	+2326
1.15i - Statutory homelessness - homelessness acceptances	2011/12	**6.3**	3.9	534	+201
1.15ii - Statutory homelessness - households in temporary accommodation	2011/12	**16.1**	11.3	1372	+409
HEALTH IMPROVEMENT					
2.20i - Cancer screening coverage - breast cancer	2012	**59.4%**	69.1%	7485	-1227
2.20ii - Cancer screening coverage - cervical cancer	2012	**60.5%**	69.6%	29248	-4424
2.22i - Take up of NHS Health Check Programme by those eligible - health check offered	2012/13	**15.2%**	20.6%	7651	-2718
2.22ii - Take up of NHS Health Check programme by those eligible - health check take up	2012/13	**7.7%**	45.2%	590	-2873
2.24ii - Injuries due to falls in people aged 65 and over - aged 65-79	2011/12	**1378**	1072	199	+44
HEALTH PROTECTION					
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (1 year old)	2011/12	**85.1%**	91.3%	2070	-151
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (2 years old)	2011/12	**89.3%**	93.3%	2069	-94
3.03iv - Population vaccination coverage - MenC	2011/12	**81.6%**	89.9%	1985	-203
3.03ix - Population vaccination coverage - MMR for one dose (5 years old)	2011/12	**86.7%**	89.7%	1724	-60
3.03v - Population vaccination coverage - PCV	2011/12	**85.1%**	90.4%	2071	-128
3.03vi - Population vaccination coverage - Hib / Men C booster (5 years)	2011/12	**0.0%**	80.1%		Data missing
3.03vi - Population vaccination coverage - Hib / MenC booster (2 years old)	2011/12	**80.5%**	86.8%	1867	-144
3.03vii - Population vaccination coverage - PCV booster	2011/12	**80.5%**	85.3%	1866	-111
3.03viii - Population vaccination coverage - MMR for one dose (2 years old)	2011/12	**82.9%**	86.1%	1922	-73
3.03x - Population vaccination coverage - MMR for two doses (5 years old)	2011/12	**75.4%**	80.2%	1500	-95
3.03xiii - Population vaccination coverage - PPV	2011/12	**57.6%**	62.6%	9036	-784
3.03xiv - Population vaccination coverage - Flu (aged 65+)	2011/12	**70.3%**	72.2%	14508	-408
3.03xv - Population vaccination coverage - Flu (at risk individuals)	2011/12	**48.4%**	51.4%	6202	-393
HEALTHCARE AND PREMATURE MORTALITY					
No indicators					

Westminster Outliers compared to London

OUTLYING INDICATORS - those statistically significantly worse than London	Time Period	West rate	London rate	Annual number West	Estimated excess West
WIDER DETERMINANTS					
1.01 - Children in poverty	2010	**36.0%**	27.8%	11025	+2517
1.04i - First time entrants to the youth justice system	2012	**793.3**	584.7	108	+28
1.05 - 16-18 year olds not in education employment or training	2012	**7.5%**	4.7%	280	+105
1.10 - Killed and seriously injured casualties on England's roads	2009 - 11	**93.2**	36.9	202	+122
1.12ii - Violent crime (including sexual violence) - violence offences	2011/12	**32.7**	19.7	8287	+3297
1.13ii - Re-offending levels - average number of re-offences per offender	2010	**0.8**	0.7	2938	+340
1.14i - The percentage of the population affected by noise - Number of complaints about noise	2011/12	**58.4%**	16.4%	12823	+9224
1.15i - Statutory homelessness - homelessness acceptances	2011/12	**4.7**	3.9	561	+90
1.15ii - Statutory homelessness - households in temporary accommodation	2011/12	**16.0**	11.3	1916	+557
HEALTH IMPROVEMENT					
2.15i - Successful completion of drug treatment - opiate users	2011	**7.0**	9.9	79	-32
2.15ii - Successful completion of drug treatment - non-opiate users	2011	**27.2**	36.2	117	-38
2.20i - Cancer screening coverage - breast cancer	2012	**61.7%**	69.1%	9878	-1194
2.20ii - Cancer screening coverage - cervical cancer	2012	**62.2%**	69.6%	42389	-5032
HEALTH PROTECTION					
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (1 year old)	2011/12	**85.3%**	91.3%	2343	-163
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (2 years old)	2011/12	**85.7%**	93.3%	2234	-198
3.03iv - Population vaccination coverage - MenC	2011/12	**81.4%**	89.9%	2234	-236
3.03v - Population vaccination coverage - PCV	2011/12	**83.8%**	90.4%	2300	-182
3.03vi - Population vaccination coverage - Hib / MenC booster (2 years old)	2011/12	**81.8%**	86.8%	2132	-129
3.03vii - Population vaccination coverage - PCV booster	2011/12	**78.8%**	85.3%	2054	-168
3.03viii - Population vaccination coverage - MMR for one dose (2 years old)	2011/12	**82.1%**	86.1%	2140	-103
HEALTHCARE AND PREMATURE MORTALITY					
4.11 - Emergency readmissions within 30 days of discharge from hospital	2010/11	**12.8**	12.0	2570	+167

h&f the low tax borough	**London Borough of Hammersmith & Fulham** **HEALTH & WELLBEING BOARD** **9 September 2013**
TITLE OF REPORT NHS Funding to Support Social Care Services 2013-14	
Report of the Corporate Director	
Open Report	
Classification: **Key Decision: No** The Board is asked approve the proposals for the use of NHS Funding for Adult Social Care set out in the attached memorandum and schedule.	
Wards Affected: All	
Accountable Executive Director: **Sue Redmond, Interim Executive Director for Adult Social Care**	
Report Author: Cath Attlee Assistant Director Joint Commissioning Tri-borough Adult Social Care and NHS NWL CSU	**Contact Details:** Tel: 07903956961 E-mail: cattlee@westminster.gov.uk

NHS Funding to Support Social Care Services 2013-14

As in previous years, the Department of Health has made available funding in 2013-14 for the NHS to transfer to Local Authorities for social care services. This year the funding agreement will be with NHS England, taking on the responsibility previously undertaken by the Primary Care Trusts.[1]

1. Functions and activities in respect of which payment must be made

The payments must be used to support adult social care services which also have a health benefit. However, the Department has indicated that there is flexibility for local areas to determine how the investment in social care services is best used.

The funding can be used to support existing services or transformation programmes, where such services or programmes are of benefit to the wider health and care system, provide good outcomes for service users, or would be reduced due to budget pressures in local authorities without this investment.

Local authorities have to agree with their local clinical commissioning groups how the funding is best used within social care, and the outcomes expected from this investment. Authorities should have regard to the Joint Strategic Needs Assessment and local commissioning plans for both health and social care.

It is expected that the plans will be discussed and agreed at the Health and Wellbeing Board.

2. Financial Position of Adult Social Care

As a result of reductions in local government funding Adult Social Care (ASC) has to deliver substantial savings in 2013/14 (£4.4m LBHF; £2.1m RBKC; £2.9m WCC). These are very large savings which are much bigger than any other savings programme delivered in the local authorities in the past.

Amongst big reductions to back office and support functions, the savings programmes also include reductions in the use of packages and placements, the greatest area of spend for ASC. Some of the savings projects may be difficult to deliver or may take longer than anticipated.

ASC is required to fund its own growth – where a budget must be increased to fund a pressure, then savings must be found within ASC to balance that. This growth requirement is therefore included in the savings target.

Funding growth for packages and placements arises mainly in the Learning Disabilities, Mental Health and the Young Disabled care groups where client numbers are growing, but also in Older People, as people live longer and are supported in the community.

[1] The NHS Commissioning Board (Payments to Local Authorities) Directions 2013

2. Adult Social Care Strategic Outcomes

Tri-borough Adult Social Care is working towards delivery of the following strategic outcomes, reflecting local needs, national and local policy priorities.

Outcome 1	Maximising self-reliance, personal responsibility and enabling more people to find their own care solutions
Outcome 2	Providing people with the right help at the right time to facilitate recovery and regain independence
Outcome 3	Enabling people with long term conditions, to receive care closer to home, stay independent and live the lives they choose
Outcome 4	Balancing risk effectively between empowering and safeguarding individuals
Outcome 5	Enabling people with disabilities to be active citizens and enjoy independent lives
Outcome 6	Ensuring carers are identified and have their needs met within their caring role
Outcome 7	Enabling people to have a positive experience of social care services
Outcome 8	Achieving greater productivity and value for money

Tri-borough Adult Social Care has established a programme of work to deliver against these outcomes, including:

- Implementing personalisation
- Developing high quality care at home
- Alignment of adult social care
- Integration with community health services
- Participation in whole systems development.

The NHS funding for adult social care will support the implementation of this programme of work.

4. Proposals for the Use of the Funding

As already agreed with the Clinical Commissioning Groups, it is proposed that the funding will be used to sustain and develop Adult Social Care in the three boroughs, thereby supporting the discharge of patients from hospital, and contributing to the prevention of hospital admissions through enhanced out of hospital care.

The funding will be used for three main purposes:

- To sustain services, otherwise at risk from savings plans
- To support transformation of services, leading to increased efficiency and higher quality
- To meet growth pressures arising from increased out of hospital care

5. Recommendation

The Health and Wellbeing Board is invited to approved the proposals for the use of NHS Funding for Adult Social Care set out in the attached memorandum and schedule.

Memorandum of Agreement
For a Section 256 Grant
Under the National Health Service Act 2006
From NHS England to London Borough of Hammersmith and Fulham
For Social Care Services to Benefit Health
Covering the period 1st April 2013 to 31st March 2014

1. CONTEXT

1.1 This document records the agreement of a revenue grant from NHS England using its powers under Section 256 of the National Health Service Act 2006 to the London Borough of Hammersmith and Fulham (local authority) to provide health funding to support social care.

2. PARTIES TO THE AGREEMENT

2.1 The parties to this agreement are NHS England, the body paying the Section 256 grant, and the London Borough of Hammersmith and Fulham local authority, the recipient of the Section 256 grant.

2.2 The schedule of services set out in the Annex attached has been agreed with the Hammersmith and Fulham Clinical Commissioning Group.

2.3 The London Borough of Hammersmith and Fulham local authority will ensure that the services funded via the Section 256 grant are provided.

2.4 The London Borough of Hammersmith and Fulham local authority will assume the ultimate responsibility for monitoring service provision and client welfare. Since the express intention is for both the NHS England and the local authority to jointly monitor the provision of services, the London Borough of Hammersmith and Fulham local authority undertakes to share this monitoring information in accordance with the monitoring standards contained within this document.

3. PAYMENT TERMS

3.1 A revenue budget is attached and specifies £3,287,039 for Health Funding to Support Social Care as the revenue grant from Hammersmith and Fulham Clinical Commissioning Group to the London Borough of Hammersmith and Fulham for the period starting 1st April 2013 and ending 31st March 2014.

3.2 Once both parties sign this Memorandum of Agreement, NHS England will pay London Borough of Hammersmith and Fulham the full amount.

4. DURATION OF THE AGREEMENT

4.1 The agreement shall be effective from 1st April 2013 until 31st March 2014.

5. STANDARDS FOR MONITORING GRANT

5.1 The London Borough of Hammersmith and Fulham (LA) will ensure that funding is spent on the items agreed in the attached schedule.

5.2 The London Borough of Hammersmith and Fulham (LA) will provide NHS England with an annual audited voucher for each financial year to verify actual costs incurred under the Section 256 agreement. This will be presented in the following financial year, in draft form by July and signed by September.

5.3 Increased costs or any other changes to the Section 256 agreement will not be approved without written consent from Hammersmith and Fulham CCG.

6. STANDARDS FOR MONITORING CARE

6.1 Where appropriate Service Level Agreements stating financial arrangements including S256 grants and expectations required by the London Borough of Hammersmith and Fulham (LA) with regards to monitoring of standards will be presented to NHS England as part of the report on expenditure.

7. REVIEW OF GRANT EXPENDITURE

7.1 There are quarterly meetings between the commissioners from Hammersmith and Fulham CCG and the London Borough of Hammersmith and Fulham LA held in January, April, July and November. This scheduling is to enable a report to be submitted as part of a summary report to each quarterly meeting of the Joint Finance Partnership Group, which meets in February, May, September and December. *[not sure how NHSE will want this to take place]*

7.2 Both the London Borough of Hammersmith and Fulham (LA) and NHS England reserve the right to call meetings over and above the regular quarterly meetings to discuss particular issues.

8. AUTHORISATION

BETWEEN:	NHS England and the London Borough of Hammersmith and Fulham local authority
RE:	Health Funding for Social Care
FROM:	1st April 2013
TO:	31st March 2014
AGREED FUNDING:	Health Funding for Social Care £3,287,039

FOR: NHS ENGLAND

_____ _____
Signature Date

_____ _____
Name (Capitals) Designation (Capitals)

FOR: LONDON BOROUGH OF HAMMERSMITH AND FULAHM LOCAL AUTHORITY

_____ _____
Signature Date

_____ _____
Name (Capitals) Designation (Capitals)

Funding Transfer from NHS England to the London Borough of Hammersmith and Fulham

Funding Schedule 2013-14

Preamble

The funding will all be used for Adult Social Care in LBHF, and thus will support both the discharge of patients from hospital, and will contribute to the prevention of hospital admissions.

ASC is subject to growth pressures, and has to fund these by reducing other areas of spend.

ASC already has in place an objective to reduce its spend on packages and placements. This funding will enable those reductions to be implemented at a more measured pace.

Some of the savings projects in ASC are risky to deliver or may take longer than expected. These include extending supported housing, reducing grants to the third sector, and reducing commissioning and procurement posts. It is proposed to use the funding to introduce these initiatives in a more measured way, to avoid the adverse consequences of pushing these changes through very quickly, or having to make unplanned emergency reductions in-year.

Proposals	**2013-14**	**Comments**
Maintaining Eligibility Criteria:-Growth for more home packages and placements to meet demand arising from demographic change and shifting settings of care	£1,945,000	Avoids Adult Social Care having to make even larger savings to fund the growth pressures
Other Preventative Services Preventative Strategy	£426,093	Enabling efficiencies in the supported housing market
Mental Health Services	£593,000	Enabling efficiencies arising from the West London Framework agreement
Early Supported Hospital Discharge Schemes	£73,000	
Other Social Care:- a) Joint Commissioning Team Salaries b) Commissioning and Procurement Efficiencies	 £200,000 £50,000	a) Contribution towards Tri-Borough team b) Avoids the necessity to re-organise twice
Unallocated	0	
Total	**£3,287,093**	

h&f the low tax borough	**London Borough of Hammersmith & Fulham** **HEALTH & WELLBEING BOARD** **9 September 2013**
Integration Transformation Fund	
Report of the Health & Well-being Board	
Open Report	
Classification - For Information **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: Sue Redmond, Interim Tri-borough Director for Adult Social Care	
Report Author: Cath Attlee Assistant Director, Joint Commissioning Adults NHS NWL CSU / Tri-borough Adult Social Care	**Contact Details:** Tel: 0790 3956 961 e-mail: *cattlee@westminster.gov.uk*

Executive Summary

The 2013 Spending Round announced a fund of £3.8bn nationally to ensure closer integration of health and care services from 2015/16. This is referred to as the Integration Transformation Fund (ITF).

This paper summarises the purpose and terms of the new fund and identifies actions which local health and social care organisations need to take to take advantage of this opportunity, drawing on the recently published Local Government Association/NHS England joint statement[1] and briefing events.

Recommendations

It is recommended that the Partnership Board use the resources already identified within existing programmes, building on the work already being undertaken and reflecting the local priorities and targets already being identified, to produce this plan.

It is recommended that the Partnership Board identify a lead officer and leads from the partner authorities to take responsibility for developing and delivering the plan(s), drawing on the work already being undertaken by the integration programmes identified above.

It is recommended that the Partnership Board develops a single Tri-borough plan, albeit with borough specific sections bearing in mind the different financial positions of the three sovereign boroughs and the three Clinical Commissioning Groups

[1] LGA/NHSE Statement on the health and social care Integration Transformation Fund, August 2013, Gateway Ref.No.00314

INTEGRATION TRANSFORMATION FUND

1. Purpose of Paper

1.1 The 2013 Spending Round announced a fund of £3.8bn nationally to ensure closer integration of health and care services from 2015/16. This is referred to as the Integration Transformation Fund (ITF).

1.2 This paper summarises the purpose and terms of the new fund and identifies actions which local health and social care organisations need to take to take advantage of this opportunity, drawing on the recently published Local Government Association/NHS England joint statement[2] and briefing events.

1.3 It recommends developing a tri-borough plan using the existing Integration Programmes as a basis for the required two year plan, noting the fact that local organisations are well placed to access the fund.

2. What is the Integration Transformation Fund

2.1 The Integration Transformation Fund (ITF) is "a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities".

2.2 In *Integrated care and support: our shared commitment*, integration was helpfully defined by National Voices – from the perspective of the individual – as being able to "plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me". The ITF is a means to this end and by working together we can move toward fuller integration of health and social care for the benefit of the individual.

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

2.4 The ITF provides an opportunity to transform care so that people are provided with better integrated care and support. It will help deal with demographic pressures in adult social care and is an opportunity to take the integration agenda forward at scale and pace – it is a catalyst for change.

2.5 There is an expectation that the ITF will align with the strategy process set out by NHS England and supported by the LGA and others in *The*

[2] LGA/NHSE Statement on the health and social care Integration Transformation Fund, August 2013, Gateway Ref.No.00314

NHS belongs to the people: a call to action[3]. The ITF will provide part of the investment required to achieve the shared vision for health and social care.

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

3. How is the Fund being financed?

3.1 The national £3.8bn allocation is funded as follows:

Current Source of Funding	NHS or LA	New Money	Allocation
Carers breaks	NHS	No	£130m
Reablement	NHS	No	£300m
Disabled Facilities Grant	LA	No	£220m
Adult Social Care Capital Grants	LA	No	£134m
Additional NHS Transfer to LAs	LA	No	£200m
NHS Transfer	LA	No	£900m
Transfer of additional NHS funding, currently in CCG budgets		Yes	£1.9bn
TOTAL			£3.784bn

3.2 The NHS transfer above shown as £900m is assumed to be the social care to benefit health allocations which in 2013/14 total £859m.

3.3 The £1.9bn additional transfer includes funding to meet demographic pressures and costs arising from the Care Bill and is to be funded from existing CCG budgets.

3.4 Local partners will be able to put additional funding into the pooled budget from their existing allocations if they wish to do so.

3.5 £1bn of the ITF will be dependent on performance and local areas will need to set and monitor achievement of these outcomes during 2014/15 as the first half of the £1bn, paid on 1st April 2015, is likely to be based on performance in the previous year. Assessment of performance is likely to be based on a combination of national and locally chosen measures.

3.6 The methodology to determine local allocations is still to be worked out. London Councils suggests that the splits for the current S256 allocations are a reasonable planning proxy at this stage.

[3] http://www.england.nhs.uk/2013/07/11/call-to-action/

3.7 Additional funding of £200m is being made available in 2014/15 to enable CCGs and Local Authorities to build momentum towards delivering the expected transformation.

4. Conditions of Funding

4.1 To access the ITF each locality will be asked to develop a local plan by March 2014 covering the 2 years 2014/15 and 2015/16. This will need to set out how the pooled funding will be used in 2015/16 and the ways in which the national and local targets attached to the performance-related £1 billion will be met.

4.2 This plan will also set out how the £200m transfer to local authorities in 2014/15 will be used to make progress on priorities and build momentum.

4.3 Plans for the use of the pooled monies will need to be developed jointly by CCGs and local authorities and signed off by each of these parties and the local Health and Wellbeing Board.

4.4 The ITF will be a pooled budget which can be deployed locally on social care and health, subject to the following national conditions which will need to be addressed in the plans:

- plans to be jointly agreed;
- protection for social care services (not spending);
- as part of agreed local plans, 7 day working in health and social care to support patients being discharged and prevent unnecessary admissions at weekends;
- better data sharing between health and social care, based on the NHS number;
- ensure a joint approach to assessments and care planning;
- ensure that, where funding is used for integrated packages of care, there will be an accountable professional;
- risk-sharing principles and contingency plans if targets are not met and
- agreement on the consequential impact of changes in the acute sector.

5. Local Implications and Risks

5.1 CCGs will need to identify the funding to be invested in the ITF. This is in the context of a very small real terms increase in budget. This may have implications for services currently funded from health budgets. The scale of funding shift is unlikely to be achieved without service transformation

and the impact on service providers within the health and social care economy needs to be assessed and addressed.

5.2 There will be no automatic transfers of funding to local authorities, as there has been in recent years, but there will be flexibility to allow for some of the fund to be used to offset the impact of the funding reductions overall. The S256 transfers for 2013/14 are in the region of £900m. Some of these allocations are being used to fund key service budgets e.g. placements and home care. It will be possible for money to be transferred to councils by local agreement, although this process may be more difficult in the future. This is a risk for local authorities as most have built the funding into base budgets to cover increasing costs of adult social care.

5.3 There is a suggestion that funding may need to be 'redeployed' if targets/local agreements are not reached.

6. Development and Approval of Plans

6.1 Plans will need to be developed by local authorities and their respective CCGs, based on the joint strategic needs assessment, CCG commissioning strategies and local authority business plans. They will also need to reflect national priorities set out in the NHS Mandate and the NHS Planning Framework. They should be developed through engagement with local people and once prepared they will need to be signed off by the local Health and Wellbeing Board.

6.2 The plans will then go through an assurance process involving NHS England to assure Ministers.

7. Timetable for Development

August to October 2013	**Local planning discussions** *[Identify process and timetable]*
	National work defining conditions
November / December 2013	NHS Planning Framework issued
December 2013 / January 2014	Completion of plans
February 2014	Sign off by Health and Wellbeing Boards
March 2014	Plans assured by NHS England

8. Next Steps for Tri-borough

8.1 The tri-borough local authorities and CCGs are already working towards closer integration through the Whole Systems Programme, the Pioneer Bid, and the Integrated Care Pilots. During the early part of the year further collaboration has taken place in response to the requirement to improve Urgent Care systems and develop community independence services to prevent unnecessary admissions and facilitate early discharge from hospital. Work is already under way to agree commissioning intentions for 2014/15 which will need to be reflected in

the Integration plans.

8.2 There are established mechanisms in place for health and social care strategies to be shared and a common vision is being developed through the Tri-borough Integration Partnership Board. Health and Wellbeing Boards are now in place and will be reviewing the Funding Transfers from the NHS to Social Care for 2013-14 at their next meetings. Operational integration is being developed between adult social care and community health services. Considerable resource is currently being invested in these programmes.

8.3 The Tri-borough Local Authorities and CCGs are therefore well placed to set out the required two year plan to secure this funding for 2014-16.

8.4 It is recommended that the Partnership Board use the resources already identified within existing programmes, building on the work already being undertaken and reflecting the local priorities and targets already being identified, to produce this plan.

8.5 It is recommended that the Partnership Board identify a lead officer and leads from the partner authorities to take responsibility for developing and delivering the plan(s), drawing on the work already being undertaken by the integration programmes identified above.

8.6 It is recommended that the Partnership Board develops a single Tri-borough plan, albeit with borough specific sections bearing in mind the different financial positions of the three sovereign boroughs and the three Clinical Commissioning Groups.

h&f the low tax borough	**London Borough of Hammersmith & Fulham** **HEALTH & WELLBEING BOARD** **9 September 2013**
TITLE OF REPORT Partnership Agreement with the NHS	
Report of the Corporate Director	
Open Report	
Classification - For Information **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: **Sue Redmond, Interim Executive Director for Adult Social Care**	
Report Author: Cath Attlee Assistant Director Joint Commissioning Tri-borough Adult Social Care and NHS NWL CSU	**Contact Details:** Tel: 07903956961 E-mail: cattlee@westminster.gov.uk

1. EXECUTIVE SUMMARY

"Commissioning is the process used by local authorities and NHS bodies to arrange services for their local population. It is the process of translating local aspirations and assessed needs, by specifying and procuring services for their local population, into services for people that use them.

"Our aims are:

- ***To deliver the best possible social and healthcare and wellbeing outcomes, including promoting equality***
- ***To provide the best possible health and care provision***
- ***To achieve this within the best use of available resources"***

Department of Health

1.1. This paper explains the background to the development of a new Partnership Agreement for the Commissioning of Health, Wellbeing and Social Care between the London Borough of Hammersmith and Fulham and NHS Hammersmith and Fulham Clinical Commissioning Group.

1.2. In line with national guidance and local policy, and building on the previous partnership agreement with the NHS, the new agreements have been drafted to facilitate joint commissioning across all areas of health, wellbeing and social care for both adults and children.

2. RECOMMENDATIONS

2.1. The Chief Executive has signed this partnership agreement with NHS Hammersmith and Fulham Clinical Commissioning Group.

3. REASONS FOR DECISION

3.1. The purpose of this new agreement between the London Borough of Hammersmith and Fulham and NHS Hammersmith and Fulham Clinical Commissioning Group is to set out the governance, financial management and risk arrangements operating between the two authorities (in part 1 of the agreement) and to define those functions, activities and decisions to be transferred (in part 2 of the agreement).

3.2. It will deliver the function of the Health and Wellbeing Board to promote the integration of care around the needs of individuals by the use of pooled budgets, integrated provision and lead commissioning.

4. BACKGROUND, INCLUDING POLICY CONTEXT

The National Policy Context

4.1. Both national policy and local interests lead us to developing a closer partnership between the two major public service authorities in the City. Closer integration of health and social care and other relevant local government services has been a policy goal for many years. This goal was reinforced in the Health and Social Care Act 2012[1] which made provision for the establishment of Health and Wellbeing Boards in each upper tier local authority area and transferred the responsibility for public health from the NHS to local authorities.

4.2. Health and Wellbeing Boards have a duty[2] to encourage integrated working between commissioners of NHS, public health and social care services for the advancement of the health and wellbeing of the local population. They are required to provide advice, assistance or other support in order to encourage partnership arrangements under S75 of the NHS Act 2006, including encouraging those who arrange for the provision of services related to wider determinants of health, such as housing, to work closely with commissioners of health and social care services.

4.3. The Act imposes a duty[3] on local authorities and Clinical Commissioning Groups (CCGs) to prepare a Joint Strategic Needs Assessment and publish a Joint Health and Wellbeing Strategy for meeting the current and future needs of the local population and to consider using NHS Act 2006 flexibilities such as pooled budgets, in order to meet these needs.

4.4. Integrated care was also one of the four areas which the NHS Future Forum was asked to focus on in advising on the health reforms. There is a body of evidence that suggests that further integration is crucial to sustainability of services and to improving health and wellbeing outcomes.

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[1] Health and Social Care Act 2012 S194 http://tinyurl.com/c9dpdp5
[2] Health and Social Care Act 2012 S195
[3] Health and Social Care Act 2012 S192 and S193

4.5. The recent Concordat[4] between the Local Government Association and the NHS Commissioning Board[5] indicates that "collaboration between local government and the NHS is crucial to the future success of clinical commissioning, as part of the wider health and care system locally", and that Health and Wellbeing Boards are "the system leaders, bringing together partners to develop a new more integrated approach to resource allocation which reinvests efficiencies made in the whole system into agreed local priorities".

4.6. The 2013-14 Planning Guidance from the NHS Commissioning Board, Everyone Counts, underlines the importance of partnership working and the role of the Health and Wellbeing Board in delivering, in particular, higher standards and safer care (for example post Winterbourne) and greater compassion in care for all patients. In the section on Joined Up, Local Planning it emphasises that "at a time of economic challenge it is vital that all organisations can understand their contribution to joined up working. Making the best use of resources through the integration of provision around the needs of the service users should drive local priorities".

4.7. Health and social performance frameworks have increasingly been concentrating on improving outcomes for residents, rather than just measuring process. It is recognised that improving outcomes across the health and care system can only be achieved by different parts of the system working together, a point emphasised in the government's mandate to the NHS Commissioning Board[6].

4.8. Over the last few years there has been a steady progress towards the development of shared performance frameworks between health and social care and in November 2012 the Department of Health issued aligned outcomes frameworks[7] for the NHS, Adult Social Care and Public Health. These place greater emphasis on the use of shared and complementary indicators, highlighting shared responsibilities and goals and facilitating joint working.

4.9. During 2012 the Children and Young People's Health Outcomes Forum has been working on a new set of health and wellbeing outcomes for children and young people with an emphasis on commissioning coordinated across the whole spectrum of a child's needs, with key transitions from maternity and into adult services, and with related services meeting their wider needs including education and children's services.

[4] Concordat between: Local Government Association and NHS Commissioning Board, Sept 2012
[5] Later renamed NHS England
[6] DH Nov 2012 The Mandate: a mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015
[7] DH Nov 2012 Improving health and care: the role of the outcomes frameworks Gateway 18120 DH Nov 2012 The NHS Outcomes Framework 2013/14; DH Nov 2012 Adult Social Care Outcomes Framework 2013/14

Local Policies

4.10. Hammersmith and Fulham has a history of joint commissioning and service provision in relation to health, social care and housing for adults with learning disabilities, and mental health problems.

4.11. In the last two years the Council has taken forward the Continuity of Care Programme with NHS partners, developing more integrated approaches to the delivery of health and social care.

4.12. The NHS and Council have developed a Joint Strategic Needs Assessment which has provided a basis from which the Health and Wellbeing Strategy has been developing. The Health and Wellbeing Board has agreed strategic priorities for the medium term and is also committed to the implementation of a Community Budget to deliver an integrated care system through the pooling of health and social care budgets, having been one of the national pilots for this programme.

4.13. The Health and Wellbeing Strategy reflects the priorities set out in the Clinical Commissioning Group's Out of Hospital Strategy as well as the Council's commitment to Better for Less and the Mandates for Adult Social Care and for Children which recognise that a whole system approach is vital if the needs of local people are to be addressed. The themes of promoting independence and encouraging local communities to "take responsibility and create opportunities" sit alongside a commitment to provide care closer to home and reduce unnecessary admissions to hospital by delivering prevention, early intervention and support for people with long term conditions.

4.14. Both authorities acknowledge that this shared agenda cannot be delivered without close partnership working at both an operational and a strategic commissioning level. A joint commissioning infrastructure is already in place, with joint appointments between a number of departments of the Council and the NHS but the moves to Tri-borough working in the local authorities and the significant changes in responsibilities within the NHS require new arrangements to be put in place to facilitate a step change in joint commissioning for health and wellbeing.

Practical Arrangements for Partnership

4.15. In December 2012, the three CCGs and Tri-Borough Local Authorities considered a number of options for continuation of Partnership Arrangements from 2013/14 and beyond. It was agreed that new Health and Wellbeing Partnership Agreements would be established between each Tri-Borough Local Authority and their respective CCGs, covering service integration and joint commissioning across the whole spectrum of Local Authority and CCG responsibilities, including adults and children's services, within the compass of Health and Wellbeing Boards.

4.16. The agreement would be for five years, with the financial schedules reviewed on an annual basis, providing a consistent framework within which joint projects can be developed and monitored by the authorities concerned.

4.17. The agreement does not include integrated service provision. There are already well established integrated teams for mental health and learning disabilities and separate agreements have been developed in relation to these services. Integrated health and social care services for older people and people with long term conditions are currently being developed and will be subject to a separate operational agreement.

Conclusion

4.18. These new documents provides a legal agreement which:

- states the commitment of the London Borough of Hammersmith and Fulham and NHS Hammersmith and Fulham Clinical Commissioning Group to a commissioning alliance
- clearly sets out the terms and conditions relating to partnership arrangements and supports a delivery plan that is deliverable through existing service and finance frameworks
- includes governance arrangements that do not become an additional burden to local delivery but rather offer an effective means for managing partner relations and reviewing operations
- transparently defines priorities and developmental plans
- is effective in delivering outcomes that are in line with national policy and take forward local strategies for service improvement

4.19. The London Borough of Hammersmith and Fulham and NHS Hammersmith and Fulham Clinical Commissioning Group are committed to working within this framework, in the belief that it will enable the two organisations to deliver health and wellbeing to the people of Hammersmith and Fulham more effectively.

5. EQUALITY IMPLICATIONS

5.1. The Partnership Agreement provides a framework within which services can be commissioned jointly to address local needs and contribute to addressing health inequalities.

6. LEGAL IMPLICATIONS

6.1. The statutory duty of partnership on NHS bodies and local authorities was established under the Health Act 1999 and later the Health and Social Care (Community Health and Standards) Act 2003. The NHS Act 2006 consolidated this legislation, further enabling the Health Act Flexibilities set out in the 1999 Act. Local authorities and NHS organisations can now more easily delegate functions to one another to meet partnership objectives and create joint funding arrangements.

6.2. The NHS Act 2006 makes provision for the functions (statutory powers or duties) of one partner to be delivered by another partner, subject to agreed terms of delegation. Responsibility for undertaking certain functions, activities or decisions can be transferred from one partner to another to achieve the partnership objectives. Although the functions are delegated, partners remain responsible and accountable for ensuring they meet their own duties under the legislation and cannot pass on responsibility for services outside the agreed activity. The Audit Commission[8] have reminded authorities that governance, financial management and risk arrangements should be clearly defined and set out in a partnership agreement, including the extent of delegation agreed.

6.3. From 2002 a programme of partnership agreements between Hammersmith and Fulham Primary Care Trust and the London Borough of Hammersmith and Fulham was developed.

6.4. From April 2013, when Primary Care Trusts are abolished, many PCT commissioning responsibilities are being transferred to Clinical Commissioning Groups (CCGs). The Health and Social Care Act 2012 provides, under s300, for statutory schemes to shift contracts in bulk and legal advice suggests that S75 and S256 agreements would fall within this provision. S301 of the Act also provides for contracts to be renegotiated, on transfer, or after transfer.

6.5. In December 2012 the local authorities and CCGs considered these options but chose to develop these new Partnership Agreements to provide a framework for a more comprehensive programme of joint commissioning for health, wellbeing and social care.

[8] Clarifying joint financing arrangements: a briefing paper for health bodies and local authorities, Audit Commission, December 2008

7. FINANCIAL AND RESOURCES IMPLICATIONS

7.1. Part 1 - the Partnership Agreement - does not of itself contain financial commitments, it is an enabling document providing a framework within which funding can be transferred for the purposes of lead commissioning or pooled budgets. The Agreement is for five years.

7.2. Part 2 - Schedule of Agreed Services - contains details of funding to be transferred from the Clinical Commissioning Group to the Council under S75 and S256 of the NHS Act 2006 and funding to be transferred from the Council to the CCG under S76 for the purposes of the commissioning of health, wellbeing and social care services. This schedule is agreed on an annual basis and should be read in conjunction with Part 1 of the Agreement.

7.3. The 2013-14 Service Schedule for Hammersmith and Fulham contains around £16m NHS funding transfer to the local authority for the purposes of lead commissioning services for adults and children, including placements.

7.4. Funding transferred from the Council to the CCGs amounts to £300,000 relating to mental health placements and to a contribution towards the Joint Commissioning Teams.

8. CONSULTATION

8.1. A steering group was established for oversight of the new agreement, including representatives from each of the three local authorities and the three clinical commissioning groups in the tri-borough area. Legal advice has been received from Sharpe Pritchard and from the Bi-borough legal services for the local authorities, and from Beachcroft for the NHS.

8.2. The agreement and service schedules have been approved by the three Clinical Commissioning Groups, and have been signed off by the finance leads for each local authority.

8.3. The service schedules reflect local priorities for each of the care groups identified and are consistent with the Health and Wellbeing Strategies of each borough.

Local Government Act 1972 (as amended) – Background papers used in the preparation of this report

Partnership Agreement for the Commissioning of Health, Wellbeing and Social Care Services between the London Borough of Hammersmith and Fulham and NHS Hammersmith and Fulham Clinical Commissioning Group

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