London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Agenda

Monday 13 January 2014
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
Professor Sue Atkinson, Interim Tri-borough Director of Public Health
Liz Bruce, Tri-borough Director of Adult Social Care
Andrew Christie, Tri-borough Director of Children's Services
Trish Pashley, Local Healthwatch representative

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Date Issued: 03 January 2014

London Borough of Hammersmith & Fulham

Health & Wellbeing Board
Agenda

13 January 2014

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

(a) To approve as an accurate record and the Chairman to sign the minutes of the meeting of the Health & Wellbeing Board held on 4 November 2013.

(b) To note the outstanding actions.

2. APOLOGIES FOR ABSENCE

3. DECLARATIONS OF INTEREST

If a Member of the Board, or any other member present in the meeting has a disclosable pecuniary interest in a particular item, whether or not it is entered in the Authority's register of interests, or any other significant interest which they consider should be declared in the public interest, they should declare the existence and, unless it is a sensitive interest as defined in the Member Code of Conduct, the nature of the interest at the commencement of the consideration of that item or as soon as it becomes apparent.

At meetings where members of the public are allowed to be in attendance and speak, any Member with a disclosable pecuniary interest or other significant interest may also make representations, give evidence or answer questions about the matter. The Member must then withdraw immediately from the meeting before the matter is discussed and any vote taken.

Where members of the public are not allowed to be in attendance and speak, then the Member with a disclosable pecuniary interest should withdraw from the meeting whilst the matter is under consideration. Members who have declared other significant interests should also withdraw from the meeting if they consider their continued participation in the matter would not be reasonable in the circumstances and may give rise to a perception of a conflict of interest.

Members are not obliged to withdraw from the meeting where a dispensation to that effect has been obtained from the Audit, Pensions and Standards Committee.

4.	**JOINT HEALTH & WELLBEING STRATEGY: UPDATE**	8 - 43

This report updates on progress on each of the priorities and includes the summary of the Development Workshop.

5.	**BETTER CARE FUND PLAN 2014/2016**	44 - 71

This report provides the first draft of the Better Care Fund Plan.

6. JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) UPDATE — 72 - 78

This report provides a further update on progress with the 2013/14 JSNA work programme, presents the Tuberculosis JSNA for consideration and approval, and describes the next steps for developing the 2014/15 work programme.

7. UNDERSTANDING THE MENTAL HEALTH NEEDS OF YOUNG PEOPLE INVOLVED IN GANGS — 79 - 117

The Tri-borough Public Health Report which was produced on behalf of the Westminster Joint Health and Wellbeing Board attempts to address the mental health needs of young people involved in gangs, and to provide recommendations for local commissioners.

8. WORK PROGRAMME — 118 - 121

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.

9. DATE OF NEXT MEETING

The Board is asked to note that the date of the meeting is:

24 March 2014

London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Minutes

Monday 4 November 2013

PRESENT

Committee members:
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
Liz Bruce, Tri-borough Executive Director, Adult Social Care
Andrew Christie, Tri-borough Executive Director of Children's Services
Eva Hrobonova, Deputy Director of Public Health

In attendance:
Councillor Georgie Cooney, Cabinet Member for Education
Philippa Jones, H&F CCG
Keith Mallinson, H&F Healthwatch
Janet Shepherd, Director of Nursing and Patient Experience for North West London, NHS England
Peter Smith, Head of Policy and Strategy
David Evans, Service Development Projects Manager
Sue Perrin, Committee Co-ordinator

22. MINUTES AND ACTIONS

RESOLVED THAT:

(1) The minutes of the Health & Wellbeing Board held on 9 September 2013 be approved and signed as a correct record of the proceedings.

(2) The HWB would recommend to the Council that two additional members of the Hammersmith & Fulham Clinical Commissioning Group (CCG) should be appointed to the HWB and that all members of the HWB should be entitled to vote.

23. APOLOGIES FOR ABSENCE

Apologies were received from Trish Pashley.

24. DECLARATIONS OF INTEREST

Minutes are subject to confirmation at the next meeting as a correct record of the proceedings and any amendments arising will be recorded in the minutes of that subsequent meeting.

There were no declarations of interest.

25. WORK PROGRAMME

RESOLVED THAT:

The work programme be noted.

26. HAMMERSMITH & FULHAM CCG COMMISSIONING INTENTIONS 2014/2015

Dr Tim Spicer tabled a summary of the key areas of intent from the H&F CCG Commissioning Intentions for 2014/2015. There would be further changes to the document during the following week, but substantial alterations were not anticipated.

Dr Spicer referred to the graphic representation of the process, which indicated that the CCG was currently refining/developing commissioning intentions, which were summarised by joint CCG and local authority (LA) and CCG specific intentions. The latter had subsequently been split to indicate health only intentions.

In respect of Children's services, it was agreed that the work with LA social care and education partners to develop robust plans for delivering the new Children and Families Legislation (statute September 2014), which was included in the detail of the report, should also be brought forward as a headline.

Keith Mallinson referred to community dressing services and the high number of patients presenting to Urgent Care Centres (UCC). Dr Spicer responded that there were different models of tissue viability services across the country. H&F CCG was currently redrafting the details of the provider statement. Whilst there would always be a requirement for some home visits, patient experience and outcomes seemed to be better by centralising services, maybe at a local hospital.

Liz Bruce referred to joint commissioning of the Tri-Borough Community Independence Service specification and learning disabilities essential activity, and the cross cutting issues in respect of, for example transition from children's to adult services, including specialised education needs. Dr Spicer responded that transition was clearly a risk area from a clinical aspect.

Councillor Georgie Cooney queried the continued use of the hydro-therapy pool at Charing Cross. Dr Spicer responded that this would be dependent on which therapies the providers considered to be best.

Eva Hrobonova queried whether the commissioning intentions could alter spending patterns in terms of care and age groups. Dr Spicer responded that whilst the commissioning process made it difficult to give a definite answer at

this stage, it was intended to shift resources away from unplanned to planned care.

Andrew Christie commented that the forward plan for the Local Safeguarding Children's Board might overlap with that of the HWB, and there were a number of issues arising from serious case reviews, which might be relevant to the HWB, such as the CCG and LA working together to share information. A report could be brought to a future meeting as the basis for a discussion on how the two boards could ensure that vulnerable people were being supported. Ms Bruce stated that these issues linked with the HWB's responsibility for the implementation of the learning from the Winterbourne View Inquiry.

Mr Mallinson commented that education should also be included. There were specific issues in respect of children in bed and breakfast accommodation and encouraging parents to avail themselves of services on offer.

Action:

A report/discussion on support to vulnerable children and adults to be added to the work programme.

Action: Sue Perrin

Dr Spicer responded to a comment in respect of looked after children remaining with one GP that he was personally supportive, but ensuring consistency across the borough was outside his remit.

In response to a query from Councillor Helen Binmore, Dr Spicer agreed to provide a written response in respect of the definitions of Targeted CAMHS and CAMHS on call'.

Action: Tim Spicer/Philipa Jones

Dr Spicer confirmed that the work in respect of GP access included teenage pregnancy.

Members considered the move from a process based approach to an outcomes based approach and the greater involvement of Public Health. Dr Spicer noted a number of services were provided for individuals with chronic illnesses, who would never return to a healthy and independent state. The outcome would be in respect of improved health and ability to manage for themselves in their own home.

Philippa Jones clarified that the document set out the starting point for Consultant delivered care services seven days a week, with the aim of achieving 24/7 delivered care by 2017/18.

Mr Mallinson referred to the sustainability of services and queried the safeguards to ensure that quality was maintained. Dr Spicer responded that

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he did not believe that this had been fully achieved, and that there had been compromises between integration, competition and quality.

Ms Jones stated that the CCG was keen to improve the process for 2015/2016. Councillor Ginn noted the Council's responsibility to share appropriate documents, including the Business Plan with the CCG in future planning cycles.

RESOLVED THAT:

(i) The HWB endorsed the H&F CCG Commissioning Intentions for 2014/2015.

(ii) The HWB noted the CCG's efforts to engage with a wide group of stakeholders and the HWB.

(iii) The HWB, at its March meeting, would agree the process for developing Commissioning Intentions for 2015/2016.

27. FURTHERING THE BOROUGH OF OPPORTUNITY: A SHARED VISION FOR HAMMERSMITH & FULHAM 2014-2022

Peter Smith presented the strategy document, which had been drafted by Council officers and key partners, to present an overarching vision for the future of the borough. There was currently a public consultation, with a deadline of 16 December 2013.

The forward by the Leader of the Council set out the seven key priorities for delivering the Council's vision for the borough.

The section 'Improving Health and Wellbeing' had been drawn from the draft HWB strategy.

It was proposed that specific priorities be added in respect of children and young people and adult health and social care. The priorities needed to be developed into desired outcomes.

It was agreed that reference should be made to the substantial changes which would be brought about by the new Children and Families Legislation.

Action: Peter Smith

In response to a query in respect of the difference in life expectancy, Dr Spicer outlined one approach whereby an individual's risk was assessed and resources supplied to mitigate. Frequently, there were other factors such as housing and access to work. Ms Hrobonova added that it was not possible to say how great a difference could be made, but by better understanding the elements, it was possible to change behaviour and to put in place interventions. Access and better knowledge of data was essential, for example in respect of the biggest causes of preventable deaths.

RESOLVED THAT:

The strategy document be noted.

28. JOINT HEALTH & WELLBEING STRATEGY: UPDATE

David Evans presented the strategy, which was being consulted upon in parallel with the Community Strategy. Members considered priority 6, 'to develop better access to suitable housing for vulnerable older people'.

Members considered the role of the HWB, including the governance arrangements and the value added by the HWB. It was agreed that both the integrated health and social care services and the White City Collaborative Care Centre (Park View) would have happened without the HWB, but other priorities might not have happened without the HWB.

Members commented that the objectives, and specifically 'every child has the best start in life' were too broad.

Ms Bruce commented that the HWB had an important role in bringing together a range of partners to work collaboratively.

Ms Hrobonova confirmed that the priorities were broadly aligned with the CCG Commissioning Intentions.

RESOLVED THAT:

(i) The Cabinet Member for Housing and Executive Director for Housing be invited to the next meeting to discuss better access for vulnerable people to sheltered housing.

(ii) The HWB priorities should be amended to be more focused, with specific outcomes.

(iii) In respect of Governance Arrangements, the value added by the HWB should be linked into the consultative document.

(iv) An update on the priorities, with an additional column to indicate the value added by the HWB, should be a standard agenda item.

29. CHILD ORAL HEALTH IMPROVEMENT INITIATIVES

Dr Claire Robertson presented the update on child oral health improvement initiatives, including an overview of the 'Keep Smiling Programme', a school-based outreach programme.

Another child health day was being planned for the following year, this time for younger children.

Dr Robertson requested that the HWB recommended how the programme could engage with GPs. Dr Spicer responded that the programme could be promoted through the GP networks. It could also be a contractual issue in respect of provider expectations. It was agreed that Dr Robertson would meet with the CCG, and provide a brief update to the January HWB.

Action: Claire Robertson/Tim Spicer

Councillor Binmore requested that the original statistics be revisited, with a view to demonstrating the impact of the programme.

Mr Mallinson queried emergency provision for children who were not registered with a GP. Dr Robertson responded that the nurse led triage would ensure that those in immediate need would be allocated an urgent care slot with a clinician on the following day.

RESOLVED THAT:

The ongoing work be noted.

30. PUBLIC HEALTH BUSINESS PLAN UPDATE

Ms Hrobonova presented the report and highlighted that: the first meeting of the Tri-borough JSNA Steering group had taken place; the post of JSNA Manager had been advertised; there had been no new applications for JSNA 'Deep Dives' for the three boroughs; and the JSNA highlight report had been drafted.

Councillor Binmore proposed a female genital mutilation deep dive.

In respect of the highlights report, Councillor Binmore queried:

- the source and back up data for the report that the number of children reaching school readiness had dropped;
- the data in respect of education attainment.

Action: Eva Hrobonova

RESOLVED THAT:

The report be noted.

31. INTEGRATION TRANSFORMATION FUND:ORAL UPDATE

Ms Bruce stated that information in respect of Integration Transformation Fund allocations was expected in the Autumn statements for both health and local authorities.

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North West London had been successful in becoming a pioneer site to showcase innovative ways of creating change in the health service across the eight London boroughs.

The initiatives would include: prevention and early intervention to reduce the number of unplanned emergency admissions to hospitals, with better outcomes for patients and better experiences of care. Financial savings were also expected.

The plan would be submitted to the January meeting for approval and submission on 15 February.

RESOLVED THAT:

(i) The oral update be noted.

(ii) A report on the North West London site be added to the work programme.

32. DATES OF NEXT MEETINGS

Meeting started: 4pm

Meeting ended: 6pm

Chairman ....

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Minutes are subject to confirmation at the next meeting as a correct record of the proceedings and any amendments arising will be recorded in the minutes of that subsequent meeting.

Agenda Item 4

<table>
<tr><td> </td><td colspan="2">London Borough of Hammersmith & Fulham

HEALTH & WELLBEING BOARD

13 January 2014</td></tr>
<tr><td colspan="3">Joint Health & Well-being Strategy: Update</td></tr>
<tr><td colspan="3">Report of the Health & Well-being Board</td></tr>
<tr><td colspan="3">Open Report</td></tr>
<tr><td colspan="3">Classification - For Decision

Key Decision: No</td></tr>
<tr><td colspan="3">Wards Affected: All</td></tr>
<tr><td colspan="3">Accountable Executive Director: Liz Bruce, Tri-borough Director for Adult Social Care</td></tr>
<tr><td colspan="2">Report Author: David Evans, Service Development Projects Manager</td><td>Contact Details:
Tel: 020 8753 2154
E-mail: david.evans@lbhf.gov.uk</td></tr>
</table>

1. EXECUTIVE SUMMARY

1.1 The consultation exercise on the Joint Health & Well-being Strategy (JHWS) closed on 20 December 2013 and a clear message was that further work is needed to define what success would look like. Therefore, the next steps will be for the Board members to undertake further work on the priorities for the next meeting of the Board in March 2014.

1.2 Another message which emerged from the consultation programme is that as the Park View Centre for Health & Well-being is nearing completion, including a priority specifically on its delivery is now less relevant and therefore should be removed from the strategy.

1.3 The report from the Development Workshop on 8th October is included in and the Board is asked to consider taking forward the recommendations.

1.4 The updates on progress on each of the priorities since the last meeting in November 2013 are also included.

2. RECOMMENDATIONS

2.1 The Board is asked to consider:

- To agree the recommendations from the 8 October development workshop and contained in paragraph 3 and draw up a development plan for the Board.
- To note the findings of the Health & Well-being Strategy consultation exercise (Appendix 2) and take them into account when revising the priorities and defining what success will look like of the March 2014 Board meeting.

3. FINDINGS OF THE DEVELOPMENT WORKSHOP ON 8TH OCTOBER 2013

3.1 Richard Humphries' report on the 8th October Development Workshop is attached as Appendix 1 and the Board is asked to consider the recommendations which are summarised below.

Table 1: Summary of recommendations from the 8 October 2013, Health &Well-being Board Workshop	
1	To meet outside of formal meetings to invest in developing relationships within the Board and develop a better understanding of each other's pressures, priorities and agendas; assess its current work programme and have frank and open conversations.
2	Retain the existing programme of formal meetings, but with a discussion-only part of the agenda prior to or after the formal meeting;
3	Introduce a separate programme of seminars or workshops on specific topics and synchronised with the Board's cycle of formal business meetings.
4	The Board agree a fresh statement of purpose that sets out its role as the local system leader, with a high-level grip on the totality of public resources for heath, care and wellbeing across the Borough. This should include a clearer understanding of its role in relation to commissioning and its role regarding the Better Care Fund.
5	Strengthen the engagement of the vice-chair of the Board in the preparation of Board agendas and the Chair's briefing
6	As well as rebalancing the amount of time the Board spends in formal meetings, the Board consider different ways of working, for example by beginning meetings with a patient story and by meeting in different places or community settings other than the Town Hall.
7	NHS England should be encouraged to attend all meetings as an equal partner in terms of their commissioning role.
8	The Board undertake an annual review of its effectiveness and impact, using the LGA/NHS Confederation self-assessment tool, peer review or external assessment.

3.2 Richard Humphries report recommended a review of the membership of the Board which took place at the November 2013 meeting and included additional representation from the CCG and to enable officers to vote.

4. OUTCOMES FROM THE HEALTH & WELL-BEING STRATEGY CONSULTATION

4.1 The priorities agreed in June 2013 for the consultation are:

- Integrated health and social care services which support prevention, early intervention and reduce hospital admissions.
- Delivering the Park View Centre for Health and Well-being (White City Collaborative Care Centre) to improve care for residents and regenerate the White City Estate.
- Every child has the best start in life
- Tackling childhood obesity
- Supporting young people into Healthy Adulthood
- Better access for vulnerable people to Sheltered Housing.
- Improving mental health services for service users and carers to promote independence and develop effective preventative services.
- Better sexual health across Triborough with a focus on those communities most at risk of poor sexual health.

4.2 The Health & Well-being Strategy will develop over time, given the current scale and pace of change within the health, social care and public health economy it is unlikely that the all of the priorities are going to remain current and relevant for more than two years and the strategy needs to be sufficiently dynamic to reflect the pace of change.

4.3 The consultation process took place from October – December 2013 and a number of responses have been received and an analysis of which is attached as Appendix 2.

4.4 An analysis of the consultation responses is attached as Appendix 1 with the main findings summarised as:

- Broad agreement with the tone and direction of the strategy, however, it is ambitious in its scope and aspirational. There is a need to set out in more detail how the priorities would be achieved.
- More joint working between local government and the NHS is welcomed.
- There should be more effective communication and user engagement in service design and monitoring across the spectrum of user groups, including children, young people and older people.
- The voluntary and community sector, working with Healthwatch, could have a key role in developing a stronger user engagement approach.

- There is a need for a stronger customer focus through by improving the customer experience generally and information and advice services, particularly, in assisting and directing people in managing personal budgets.
- Within the broad strategic priorities there are a number of areas of concern that groups such as carers, people with disabilities and/or learning difficulties, young people and drug and alcohol.
- The principles of timely prevention and early intervention needs to be prioritised. The voluntary and community sector can support this approach through addressing issues such as loneliness and social isolation to improve well-being. The initiatives described in the submission by Hammersmith Community Gardens illustrate the role which the voluntary sector can also play in re-ablement and rehabilitation.
- There is a need to address health inequality generally across the borough and not just in the north.
- The strategy should explore how 'pooling budgets' and the 'Better Care Fund' (formerly the Integration Transformation Fund).
- The strategy does not consider the impact of Welfare Reform on health and well-being.

5. UPDATE ON PROGRESS AGAINST HEALTH & WELL BEING PRIORITIES

5.1 Table 2 summarises the issues which have been highlighted for the Board's attention arising from the update reports on each of the priorities. Appendix 3 has summary reports on each of the priorities.

Table 2: December 2013 RAG indicators for the Health & Well-being Strategy Priorities

Priority		Red/Amber/Green Rating	Comment
1	**Integrated health and social care services which support prevention, early intervention and reduce hospital admissions**	**Green**	There are currently no issues which need additional support from the Board
2	**Delivering the White City Collaborative Care Centre to improve care for residents and regenerate the White City Estate**	**Green**	There are currently no issues which need additional support from the Board. As this priority is reaching its completion it will no longer be included in future updates.

3	**Every child has the best start in life**	**Green**	The detail of the priority is being further developed. There are currently no issues which need additional support from the Board
4	**Tackling childhood obesity**	**Green**	There are currently no issues which need additional support from the Board
5	**Supporting young people into Healthy Adulthood**	**Green**	The detail of the priority is being further developed. There are currently no issues which need additional support from the Board
6	**To develop better access to suitable housing for vulnerable older people**	**Green**	There are currently no issues which need additional support from the Board
7	**Improving mental health services for service users and carers to promote independence and develop effective preventative services.**	**Green**	There are currently no issues which need additional support from the Board
8	**Better sexual health across Triborough with a focus on those communities most at risk of poor sexual health.**	**Green**	There are currently no issues which need additional support from the Board

Key	
Red	There are important and significant issues relating to the delivery of this priority which the Health & Well-being Board could address.
Amber	There are issues relating to the delivery of this priority which the Health & Well-being Board could address.
Green	There are no issues relating to the delivery of this priority which the Health & Well-being Board can currently contribute.

5.2 From February 2014, new arrangements will be put place whereby the Health &Well-being Boards in Hammersmith & Fulham, Kensington & Chelsea and Westminster will be supported on a tri-borough basis by Westminster Council's Strategy Team.

6 THE NEXT STEPS

6.1 Over the coming weeks each of the Board members will be asked to review and more clearly define what success would look like for each of the priorities and agree the final strategy at the 24 March meeting. The priority regarding the delivery of the Park View Centre for Health & Well-being will be no longer be included.

6.2 As new arrangements to support the Board are put in place from February 2014, consideration will be given to designing a development plan based on the findings of the 8th October workshop and how they will be taken forward as part of the Tri-borough support service.

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.	H&F Health & Well-being Strategy: Consultation Draft	David Evans Tel: 020 8753 2154	Tri-borough Adult Social Care, 77 Glenthorne Road.

APPENDIX 1

HAMMERSMITH AND FULHAM WELLBEING BOARD

SUMMARY OF DEVELOPMENT WORKSHOP
Hammersmith Town Hall 8th October 2013

1. Background and Purpose

1.1 Having operated in shadow form since summer 2011, the H&F Health and Wellbeing Board was formally established on in June 2013. The King’s Fund were commissioned to design and facilitate a half day event to take stock of the Board’s progress in its first year and to review and refresh its role and future development. This reports sets out the main conclusions and makes recommendations for the Board to consider,

1.2 The original purpose of the event was to explore the commissioning landscape and the role of the Board in shaping this and in delivering integrated care. Following telephone discussions with board members a set of revised outcomes were agreed. These were:

- A shared understanding of -
  the purpose and role of the Board
  the role of individual members on the Board
  what members want from the Board
  what members and their organisations will contribute to the Board
- Agreement on what needs to change for the Board to be effective
- Discussion of commissioning intentions

1.3 Prior to the event telephone interviews were conducted with 12 Board members and stakeholders, including local authority officers and members, the CCG, Healthwatch and Public Health colleagues. This report draws on the views that were expressed during these interviews; a desk review of minutes of Board meetings over the last 12 months; and the discussions held at the event itself.

1.4 Cllr Ginn welcomed everyone to the workshop, and emphasised the Council’s commitment to the Board and the importance of clarifying everyone’s understanding of the Board, its role and purpose, taking stock of the Board’s first year and agreeing what changes could be made to make the Board more effective.

2. Policy context & overview

2.1 The implementation of the Health and Social Care Act over the last 12 months has highlighted the relative complexity of the new structures

and there remains considerable uncertainty about how the new arrangements will work in practice. The relationship between CCGs and NHS England is evolving, as are other parts of the system including the role of Public Health England. There are some concerns about the fragmentation of commissioning on the health side.

2.2 The biggest challenge for the NHS and local authorities arises from the lack of improvement in the public finances and the prospect of a decade of austerity. Further cuts in central government grants to local government have been announced for 2014/15 - on top of the 28% reduction in the current spending review period Although NHS budgets are likely to be protected in the forthcoming spending review, the absence of any real terms increase creates a funding gap - 'the Nicholson challenge' - of at least £15b. Although the Government's decision to implement the recommendations of the Dilnot Commission have been welcomed, this will not address the underlying funding shortfall in adult social care. Managing the widening gap between needs and resources will become an even bigger challenge for the NHS and local authorities.

2.3 In the last 12 months integrated care has risen further up the policy agenda, with the imminent announcement of a new national framework for integration that will involve the selection of 'pioneers' - places with particularly ambitious and visionary plans for whole system integration – and a £3.8b Integration Transformation Fund that will be allocated locally subject to local plans for its use that each Health and Wellbeing Board will need to sign off.

2.4 Despite continuing controversy about many aspects of these challenges, Health and Wellbeing Boards continue to enjoy cross-party support and are seen by many as playing a pivotal role in addressing the above challenges at the local level - especially in leading the integration of services. However they will be grappling with fault lines in national policy and funding that have bedevilled many past initiatives and in the context of the worst financial environment in living memory. There remain concerns that the increasing weight of expectations placed on Boards will exceed their capacity to deliver them.

3. The role and purpose of the Board

3.1 Richard Humphries summarised the overall purpose of the Boards as set out in the Health and Social Care Act ('HWBs at a glance' in the attached slide set). The legal powers and duties of the Boards are as follows:

- The Board has a duty to promote integrated working
- The Local Authority and CCG each have a duty to produce a joint strategic needs assessment (JSNA) & joint health and wellbeing strategy (JHWS) which must be discharged through the Board.

NHS England is required to participate in these processes. The Board should take account of the mandate to NHS England;

- The CCG, local authority and NH England must 'have regard' to the JSNA and JHWS in exercising their functions
- The CCG must involve the Board in preparing and revising their commissioning plans
- The Board has the power to:
  - Appoint additional members
  - Require NHS England to attend meetings
  - Request information
  - Write to NHS England if it considers that the CCG's commissioning plan does not take account of the JSNA or JHWS
  - Express an opinion whether the local authority is having regard to the JSNA and JHWS.

3.2 It can be seen that the formal powers of Board are very limited - it does not for example have the power to sign-off CCG commissioning plans. Its effectiveness in practice depends less on legal powers and more on an interlocking set of duties placed upon the CCG, local authority and NHS England. The remit of the Board covers all of their relevant functions. Evidence to date points to the importance of the local authority/CCG partnership at the heart of the Board - it is as much about relationships as it is about meetings. The permissive nature of the legislation offers considerable scope to develop the role of the Board - if partners agree.

3.3 The local authority can delegate any of its functions to the Board except that of scrutiny. This is a key point, reflecting the spirit of legislation that the Boards should be vehicles for collaboration. Although organisations represented on Boards do need to find ways of holding each other to account, there does need to be a clear understanding of how this differs from the role of the Overview & Scrutiny Committee. Some Boards have agreed a protocol that clarifies the distinctive role of each group.

3.4 Department of Health guidance and the NHS Operating Framework for 2013/14 confirm the expectation that the Boards will function as a partnership between local authorities and the NHS.

4. Progress, Key Issues & Priorities

4.1 It was absolutely clear from telephone interviews and from discussion at the event that there were three points of fundamental agreement across all Board members:

- The Board needs to develop a much clearer sense of purpose and developed a shared agreement about its role; the perceptions of individual Board members tend to suggest that it operates as a

collection of individuals representing their own organisation or professional interest rather than a collective body with a shared vision for what they want to achieve. There have been different perceptions of the role of the Board in relation to the commissioning and for some NHS members the Board process has sometimes felt like an adversarial scrutiny process rather than a collaborative partnership;

- The Board's achievements in its first year have been very limited - most members struggled to identify tangible outcomes that the Board had achieved or achievements that would not have happened anyway.
- The Board has spent little time on its own development. Virtually all of its meetings have been formal meetings held in public. There have been some important changes in personnel during the year (Cabinet Member chair, Director of Adult Social Care, Director of Public Health). Opportunities to build fresh relationships with existing members outside of the constraints of a formal agenda have not been available.

4.2 Another consequence of the Board spending all of its time in formal meetings is that engagement with the wider public, patients, service users and carers and a wide range of stakeholder organisations appears to have been very limited. This suggests that awareness of the Board, its role and its work is likely to be very low beyond its immediate membership.

4.3 These conclusions should be tempered by a recognition that the Board is in its infancy and there is very clear evidence that effective partnerships and the relationships that underpin them taker time to mature and develop. Currently national expectations of what the Boards are expected to achieve – and how quickly – are running well ahead of actual Board development in most places. There are some positives. The Board has been established and has met regularly. It has agreed a revised JSNA and joint health and wellbeing strategy (JHWS) and has adopted a clear set of strategic priorities. Working relationships within the Board were generally described as good – though not without tensions – and thus far have survived the tensions arising from the 'Shaping our Healthier Future' proposals.

4.4 A further observation is that in relation to the Board's key purpose – to promote integration - Hammersmith & Fulham is part of a well established and advanced programme of integrated care which pre-dates the creation of the Board and therefore limits what it has been able to contribute that is genuinely different and adds value.

4.5 Board members were invited to set out how they see the role of the Board, what they want from it and how they see their own role and contribution. The common and generally shared themes were:

- a body that seeks to be transformational, overseeing and supporting real improvements to services and outcomes for the local population; this would require a different modus operandi with less reliance on formal business meetings alone:

- a body with real high-level influence and capacity to remove obstacles that get of better services – the ‘go to’ place to get problems tackled; not a body that passively receives ‘reports for information’;

- a body that has an overview of the total resources in the system – across the local authority and the NHS – the inter-dependency of separate organisational budgets and how well the total resource is being used to achieve better outcomes; this should include an asset-based approach (i.e. the natural resources of communities, social networks and of individual patients and people who use services)

- a body that can take an issue-based approach to population needs rather than being constrained by traditional service-led categories. Loneliness was offered as an example

- a body that has a clear and strong sense of its own identity that it can articulate and promote through its work and activities and one that is distinctive from other groups, with a higher public profile.

4.6 In considering what would need to be different for the Board to move forward in this direction, a range of ideas were put forward. These included:

- engaging in work outside of formal meetings e.g. by establishing task and finish groups on particular issues

- focus the agenda of formal meetings on strategic priorities and to be more proactive in initiating action rather than receiving and reacting to reports and information from elsewhere

- developing agendas (in a literal sense for Board meetings but also to guide future ambitions) that is genuinely shared and not determined by the local authority alone

- adopting a style of working within and beyond Board meetings that involves less critiquing of each other’s plans and more structured collaboration

- making much more use of the experience of patients and people who use services, for example beginning formal meetings with a patient’s story.

5.0 Commissioning intentions

5.1 This part of the event sought to establish a better understanding of the relationship between the CCGs commissioning intentions (presented at a previous workshop) and the priorities of the Board as set out in the JSNA and JHWS.

5.2 It is clear from this discussion that there have been different understandings not only of the role of Board in overseeing commissioning intentions but about how the commissioning process works in the NHS. The assumptions that underpin what is meant by commissioning for CCGs and local authorities are not necessarily the same and the language and terminology can be different also.

5.3 The Board collectively needs to be clear that its role is to produce a JHWS that sets an overall framework for all commissioning of local services. The Board is the place where the CCG, local authority and NHS England hold each other to account for ensuring that the priorities of the JHWS are reflected in their own commissioning plans and intentions. The challenge for the Board is to agree a set of arrangements that does involve a degree of mutual challenge but is driven by a shared collaborative commitment to seek the best outcomes possible with the total resource available to local commissioners.

5.4 There are some practical steps the Board could consider in developing its role in relation to commissioning and reaching a shared agreement about what this should be:

- to map the total resource available to commission local services and how this is disbursed currently;
- to bring together the different timelines of the commissioning and budgeting cycle for the local authority, CCG and NHS England (in respect of local primary care services) and identify key points of intersection, influencing & decision;
- to agree timelines for review of the JSNA/JHWS that fit with the above;
- to refresh the eight overall priorities of the JHWS and agree some more focused measures that would be easier to relate to commissioning intentions.

6. Areas for development & next steps

6.1 In summary, the H&F Health and Wellbeing Board like many others can claim very limited achievements in its first year but has satisfied the broad legislative requirements. Whilst the status of the Board as a statutory committee of the local authority has ensured a much stronger governance framework than previous arrangements, it has exposed the

fundamentally different cultures and ways of working in local government compared to the NHS. It takes time to work through and understand these differences. A sign of a healthy partnership is that tensions and disagreements can be aired. There is a clear and evident commitment to make the Board work.

6.2 Mid way through its first full year, the Board has begun to refresh its understanding of its role and purpose and to 'renew its vows'. To complete this it will be essential for the Board to f**ind time to meet outside of formal meetings** so can invest in developing relationships within the Board and developing a better understanding of each other's pressures, priorities and agendas; assess its current work programme and have frank and open conversations. The Board needs to invest in its own development. The time and capacity of members to contribute to the Board is pressured so the challenge is to find economical but effective ways of doing this. There are a number of possibilities:

- retaining the existing programme of formal meetings, but with a discussion-only part of the agenda prior to or after the formal meeting;

- introduce a separate programme of seminars or workshops. These could be on specific topics for example particular aspects of the JSNA, elements of the work programme, or focused on the Board's development and performance. These could be synchronised with the Board's cycle of formal business meetings.

6.3 The Board should consider agreeing a fresh **statement of purpose** that sets out its role as the local system leader, with a high-level grip on the totality of public resources for heath, care and wellbeing across the Borough. This should include a clearer understanding of its role in relation to commissioning and considering the steps suggested in 5.4. The new requirement for the Board to sign-off its share of the new Integration Transformation Fund will be an important test of the Board's collective capacity to offer system leadership.

6.4 Membership should be reviewed so that a better balance is achieved between local authority numbers and the NHS. The CCG should be able to nominate at least one further member. NHS England should be encouraged to attend all meetings as an equal partner in terms of their commissioning role. There are different views as to whether providers should be members of the Board, but their knowledge, expertise and resources are crucial and the Board should be seeking effective ways of ensuring their engagement.

6.4 The partnership between the CCG and local authority on the Board could be further improved by **strengthening the engagement of the vice-chair** of the Board in the preparation of Board agendas and the Chair's briefing

6.5 As well as rebalancing the amount of time the Board spends in formal meetings, it could **experiment with different ways of working**, for example by beginning meetings with a patient story and by meeting in different places or community settings other than the Town Hall.

6.6 Finally the Board should consider an **annual review of its effectiveness and impact**, using the LGA/NHS Confederation self-assessment tool, peer review or external assessment.

Richard Humphries
Assistant Director, Policy
The King's Fund

24th October 2013

APPENDIX 2

REPORT FROM THE HAMMERSMITH & FULHAM HEALTH & WELL-BEING STRATEGY CONSULTATION

1. Introduction

1.1 Hammersmith & Fulham Health & Well-being Board is developing its Health & Well-being Strategy and went out to public consultation in Autumn 2013. This report summarises the key outcomes from the consultation process.

2. Background

2.1 The Hammersmith & Fulham Health & Well-being Board was formally established in June 2013 and has agreed its vision and strategic priorities for 2013-2015 as Stronger Communities, Healthier Lives.

2.2 The Board's vision for health and well-being in the borough is:

- To enable local people to live longer, healthier and more prosperous lives.
- To enable our residents and communities to make a difference for themselves
- To ensure our residents have good access to the best services, advice and information
- To provide our residents with choice and services which meet their local needs
- To keep our community a safe, cohesive and vibrant place to live, work, learn and visit.
- To build on our strong history of working together to build integrated health and social care offers which improve the quality and sustainability of care

2.3 The Boards strategic priorities are:

- Integrated health and social care services which support prevention, early intervention and reduce hospital admissions.
- Delivering the White City Collaborative Care Centre to improve care for residents and regenerate the White City Estate.
- Every child has the best start in life
- Tackling childhood obesity
- Supporting young people into Healthy Adulthood
- Better access for vulnerable people to Sheltered Housing.
- Improving mental health services for service users and carers to promote independence and develop effective preventative services.
- Better sexual health across Triborough with a focus on those communities most at risk of poor sexual health.

2.4 It is envisaged that the Health & Well-being Strategy will develop over time, given the current scale and pace of change within the health, social care and public health economy it is unlikely that the all of the priorities are going to remain current and relevant for more than two years and the strategy needs to be sufficiently dynamic to reflect the pace of change.

2.5 The consultation process took place from October – December 2013 and a number of responses have been received from groups and individuals a list of which is attached as Annex 1.

2.6 A several groups responded and responses are attached as Appendix 2, they were:

- H&F Healthwatch
- Borough Youth Forum
- The Older People's Consultative Forum
- Voluntary and Community Sector Network
- Housing Health & Adult Social Care Select Committee
- Hammersmith Community Gardens Association & Phoenix High School
- H&F Community Sports and Physical Activity Network
- Only a couple of individual responses were received.

3. What you said

3.1 There were a number of detailed responses received and the headline messages are summarised as:

- Broad agreement with the tone and direction of the strategy, however, it is ambitious in its scope and aspirational. There is a need to set out in more detail how the priorities would be achieved.
- More joint working between local government and the NHS is welcomed.
- There should be more effective communication and user engagement in service design and monitoring across the spectrum of user groups, including children, young people and older people.
- The voluntary and community sector, working with Healthwatch, could have a key role in developing a stronger user engagement approach.
- There is a need for a stronger customer focus through by improving the customer experience generally and information and advice services, particularly, in assisting and directing people in managing personal budgets.
- Within the broad strategic priorities there are a number of areas of concern that groups such as carers, people with disabilities and/or learning difficulties, young people and drug and alcohol.
- The principles of timely prevention and early intervention needs to be prioritised. The voluntary and community sector can support this approach through addressing issues such as loneliness and social isolation to improve well-being. The initiatives described in the

submission by Hammersmith Community Gardens illustrate the role which the voluntary sector can also play in re-ablement and rehabilitation. H&F CSPAN (Community Sports and Physical Activity Network also highlighted the potential which their can offer to support people to lead healthier lifestyles.

- There is a need to address health inequality generally across the borough and not just in the north.
- The strategy should explore how 'pooling budgets' and the 'Better Care Fund' (formerly the Integration Transformation Fund).
- The strategy does not consider the impact of Welfare Reform on health and well-being.

3.2 The wealth of information contained in the responses will be used to inform the development of the priorities over the coming weeks as well as passed on to relevant service managers.

4. What the Health & Well-being Board will do

4.1 As the next steps, and in response to the consultation, further work will be undertaken to refine the priorities to make them more specific and measurable with the aim of agreeing the final strategy at the meeting on 24 March 2014, Health & Well-being Board meeting. The responses and the suggestions they contain will be used to inform this process.

4.2 As a statutory partner on the Board, Local Healthwatch have provided support to the consultation process by running an engagement event. It is anticipated that Healthwatch will continue to build on this work going forward through its range of engagement activities.

4.3 As it is in the final stages of delivery and due to open in Spring 2014, the priority regarding the delivery of the Park View Centre for Health & Well-being will no longer be included in the strategy. However, the Board will continue to take a keen interest in the development of the Centre.

Annex 1

Organisation	Response
H&F Healthwatch	HFHWBStrategyNov 13response (2).docx
Borough Youth Forum	LBHF Health and Wellbeing Consultatio
The Older People's Consultative Forum	131218 OPCF.doc
Voluntary and Community Sector Network	Hammersmith TCN - Key Points Comments
Hammersmith & Fulham Housing Health Housing Health & Adult Social Care Select Committee	See the draft minutes of the meeting of 13 November 2013 at the following link: http://democracy.lbhf.gov.uk/documents/s37819/07%20131114%20HWB%20Stratgey.pdf
Hammersmith Community Gardens Association & Phoenix High School	131219 Comm Gardens Phoenix Dec

APPENDIX 3

Headline report on the Joint Health & Well-being Priorities for November – December 2013

Priorities 1 & 2	**Integrated health and social care services which support prevention, early intervention and reduce hospital admissions.** **Delivering the Park View Centre for Health and Well-being (White City Collaborative Care Centre) to improve care for residents and regenerate the White City Estate.**
Lead Officer (Lead HWB Member)	Tim Spicer, Chair H&F CCG
Governance arrangements	H&F Out of Hospital Board, H&F Governing Body
Desired outcome	*Whole Systems integration becomes business as usual across health and social care (adults); delivering better outcomes for people more efficiently and enabling the delivery of out of hospital strategies.*
Progress towards achieving outcome over the period	This report provides an update on some of the key initiatives of the Out of Hospital (OOH) Strategy in Hammersmith and Fulham (H&F) following the paper prepared for the Board in September 2013. The CCG has been undertaking work on both the development of the local hospital and on updating the Out of Hospital Strategy which will be provided in Out of Hospital Delivery Strategy. The local hospital programme of work has been on going over the last few months and has involved stakeholders and patients and the public. This information has been used to support the development of a clinical service specification which in turn will support the development of a business case. The Out of Hospital Delivery Strategy will provide an update on the Out of Hospital Strategy and will help to develop further the implementation plans that support the out of hospital delivery. Progress has been noted against a number of key initiatives within the OOH strategy: 1. **Virtual Wards**: We continue to work with Central London Community Healthcare (CLCH) and the

	Community Independence Service (CIS) to develop how the model will operate. This includes designing the pathway for people who are admitted to the virtual ward including referral routes and the roles of the professionals within the multi-disciplinary team that supports it. We are agreeing the model for medical support to the virtual ward and the role of the GP within the multi-disciplinary team and are in discussion with LCW to provide these GPs during the pilot phase. CLCH have recruited five Health and Social Care Coordinators (HSCCs) who will be aligned to each virtual ward and are beginning to work with GP practices to identify high risk and frequent flyer patients who may be admitted to the Virtual Ward in the future. CLCH have almost concluded the recruitment for Community Matrons who will be the case managers for patients on the Virtual Ward. We are aiming to go live with the pilot during Q4. 2. **System One:** The roll out of the SystOne IT system across GP practices is progressing as planned. To date 28 GP practices have moved over to the new system and roll out to the remaining 3 GP practices is on track with completion by Mid February 2014. We are working with our providers to develop patient-led sharing of care records. 3. **Community Independence Service (CIS) Review**: Initial outputs from the Tri-borough review of CIS have been included in our commissioning intentions for 2014/15 which propose a longer term solution to providing a single integrated Community Independence Service across Tri-borough that supports the delivery of Out of Hospital strategies. 4. **Primary care update:** Network Coordinators have been working towards reviewing practice / network progress for the Q2 review (July – October). Network Coordinators developed the following documents to assist practices in completing their Quarter 2 review: • Network Plan Quarter 2 Evidence Template • Guidance for Completion and Evidence of Best Practice • Latest benchmarking performance information available The Quarter 2 review process has been completed and the Finance and Performance Committee received a paper which highlighted the outcomes of

	the Q2 review process and the priorities for practices and networks for Q3 onwards. The Finance and Performance Committee agreed with the recommendations set out in the paper and that funding to practices who did not demonstrate progress towards delivery of certain Network Plan Tasks should cease with immediate effect until such time that the CCG is assured of compliance. 5. **Mental Health:** The Primary Care Mental Health Workers have been welcomed into their respective practices. There are three in post and the remaining two will be recruited/start shortly. Patients are being identified who can be transferred from Community Mental Health Teams to enhanced primary care. We are using the mental health clustering as a guide to identify these patients, but ensuring that the patient and GP agree that they will be well supported by enhanced primary care. North West London CCGs have worked collectively to determine what psychiatric liaison services we currently commission and what we wish to commission in the future. As a result of this work, we are developing a model going forward for H&F psychiatric liaison services. 6. **Planned Care - Community Based Services** A key aspiration in delivering the Out of Hospital strategy is to increase the proportion of care that is planned but also to simplify the existing pathways with more of the diagnostics and decision making carried out in community settings. We currently have five community based services that offer planned care in the areas of Musculoskeletal, Diabetes, Respiratory, Dermatology and Gynaecology. Our Network Plan incentivises referrals to these services by GPs in order to reduce the number of referrals to acute based services. Across these five areas we are undertaken a number of actions to increase the number of referrals. 6a. **Musculoskeletal (MSK):** We are working across the collaborative of CCGs (Central, West London, H&F, Hounslow, Ealing) to evaluate the relative performance across the five MSK services and provide recommendations for the commissioning of the MSK service(s) in 2014/15 that will reduce the number of referrals to acute orthopaedic services. This will include making practical improvements to the existing services to achieve the

	reduction in referrals, which will be consistent with best practice implemented locally, agreeing criteria for referral and diagnostics with benchmarked data specific to each CCG and agreed by the GP's, consultants and radiologists across the CWHHE remit. The second area of work will focus on recommendations for discussion with key stakeholders on the options to improve further the MSK service in subsequent years. 6b. **Diabetes:** Provision of the diabetes services is, at times, uncoordinated and pathways are inconsistent across the borough. As a result a new Diabetes Strategy, planned to launch in 14/15, is being explored with a number of improvements which will allow an enhanced response to local needs to improve health outcomes. Key actions include identified GP practice leads for Diabetes, shared patient held record, improved structured patient education, unified clinician guidance and remodelling of primary care services. 6c**. Respiratory:** The replacement consultant for this service started in September 2013 and therefore we are taking forward a number of actions including raising the profile of the service through the introduction of the new consultant to practices via the Network meetings, communicating a full service specification to all practices, and peer review of referrals at Network meetings to understand current barriers to referral and identification of any resulting training needs. Discussions are also taking place to improve the service in 14/15 including targeted GP education and raising awareness of the Asthma arm of the service. 6d. **Dermatology:** Key actions being undertaken are exploring the potential for recruiting a second GP to support this service, communicating the referral criteria and pathway to all practices, and a practice survey to highlight any current barriers to referral and opinions on service development for 14/15. 6e. **Gynaecology:** Uptake for this service is good, waiting times are low and there is a good relationship with acute consultants in provider hospitals. Key actions to take forward involve distribution of a patient satisfaction survey and developing greater integration with acute specialists.

	7. **End of Life Care (EoLC):** As part of our GP Network Plan H&F CCG are committed to improving End of Life care for our residents including Care co-ordination and Patient Choice. Through our End of Life project we have increased the number of GP practices working to the Gold Standards Framework in EoL Care with 20/22 practices achieving the Foundation level and 6 achieving Advanced level. 28 practices now holding quarterly EoL meetings which often have a broader multi-disciplinary focus. GP Practices have been supported to use the Coordinate My Care (CMC) tool and there are currently 336 people with a CMC record (Dec 2013). A recent review of the tool showed that of the 39 patients who have a recorded place of death on CMC, 82% achieved their preferred place of death (Nov 2013). 8. **Winter pressures update:** Following a bidding process funding has been agreed for a number of Winter Pressures schemes that provide additional capacity and support in the areas of: redirection from A&E and Urgent Care Centres into primary care services to reduce pressure on these services; increasing emergency urgent care receiving capacity; increasing the senior clinical input within the UCC in order to reduce the number of A&E attendances; Step up and step down beds with extended therapy; Increased capacity in Community Independent Services (CIS) rapid response team; Senior decision maker in the Emergency Department and piloting 7-day GP access. The implementation of the majority of these schemes is being managed by the Urgent Care Board. 9. **Residential/Nursing/Extra Care Home Pilot:** H&F CCG is working with the Integrated Care Programme (ICP) team to deliver a pilot focusing on reducing London Ambulance Service (LAS) conveyances, A&E attendance and admissions from Residential, Nursing and Extra Care homes across H&F and K&C. The Pilot went live in early December and will work with 30 homes through providing 'top up' resource through proactive multi-disciplinary care teams with a particular focus on falls prevention and medications management. The teams will include expertise from a range of specialists including geriatric consultants, nursing, pharmacists, mental health and social care. Evaluation of the Pilot will be undertaken by CLAHRC.

	10. **Parkview Centre for Health & Wellbeing (White City CCC)**: Building work continues on track with snagging underway. The CCG expects that the site will be handed over in January. Work will be then be required to fit out the building to make it ready for services to use in late Spring. Work continues with all agreed service providers regarding their move to the Centre and plans continue to be developed. The CCG is also considering the feasibility of delivering urgent care provision from the Centre and are working to understand the impact of this.

Priority 3	**Every Child Has The Best Start In Life**
Lead Officer	Andrew Christie, Executive Director for Tri-borough Children's Services
Governance arrangements	A Tri-borough Working Group has been set up to coordinate outcomes, priorities and action plans and to identify who will deliver on each outcome either on a Tri-borough or single borough basis.
Desired outcome	A draft action plan will be ready by January detailing the outcomes we will strive to achieve by 2016 under this priority area. We have taken on board early consultation findings, including those from Healthwatch and the Youth Forum. Any additional feedback from consultations will be discussed by the Tri-borough Working Group and Children's Trust.
Progress towards achieving outcome over the period	A Tri-borough Working Group has been set up to cross reference priorities identifying where there are shared outcomes and confirming actions which will deliver these. An action plan is being developed to identify outcomes, performance indicators, specific actions to deliver the outcomes and proposed timescales.
Outputs, deliverables, milestones (stages) Timeline, and deadline for completion	• Ongoing development of the action plan by Working Group. Working Group to expand to include other stakeholders as required. • Children's Trust Board to discuss and sign off action plan • Tri-borough proposals being developed proposing future Children's Trust arrangements to ensure outcomes and actions of Health and Wellbeing Strategy are delivered and a coordinated approach to any outcomes which are shared across two or more boroughs
Performance (local, regional, national)	Further work taking place with Tri-borough partners to identify actions to meet the identified outcomes, and appropriate performance measures to monitor progress.
Key partners and stakeholders	LA Children's Services, CCGs and CSU, LA Public Health, CLCH, hospital and mental health trusts, children's centres, schools, LA Adult Services and Communications teams, NHS England and London, NHS dental services, Public Health England and London.
Budgets related to this work	To be determined.
Other information	No further information

Priority 4	**Tackling childhood obesity**
Lead Officer	Obesity Lead in the Tri-borough Public Health Team (Health and Wellbeing Board Member – Eva Hrobonova).
Governance arrangements	Cabinet members for public health steering group, Children Trust Boards
Desired outcome	Increase in percentage of children of healthy weight in reception and year 6
Progress towards achieving outcome over the period	a) The commissioning and procurement plan is progressing well and to timescale. b) Mapping of relevant services, establishing the evidence base and best practice for planned interventions has been undertaken. c) Market analysis of potential providers has been undertaken. d) A Stakeholder Meeting was held on 4th December for potential providers, current providers and other stakeholders including relevant Local Authority services to share our current thinking on the procurement strategy and to seek their contribution to shape the specification process. Children's Lead GPs were invited but unfortunately unable to attend. They will be updated with the output from the event. Representation from the CSU was present. e) Focus groups have been held with Community Champions from all three boroughs, to gain local insight from families about current services, their different needs and suggested commissioning priorities for their communities. f) Emerging findings from the focus groups completed to date have reinforced the need to include outreach and taster activities in local community settings as part of the service specification, to increase access to commissioned services. g) Local Authority services are currently being consulted via questionnaire about their current role and objectives for supporting children and families maintain a Healthy Weight and their

	recommendations for commissioning. h) Commissioning is also being informed by the findings from Phase 1 of the Tri-borough Early Help Services Compare and Contrast Review. i) The new post of Senior Public Health Officer – Children and Families Obesity Prevention has been advertised. j) We are working closely with Children & Family and Sports & Leisure Services to identify and plan training and development requirements to enable the workforce to support delivery of children and family obesity prevention across the Tri-borough.
Outputs, deliverables, milestones (stages) Timeline, and deadline for completion	A two tier programme approach is planned comprising of - first tier as a whole population (Tri-borough) intervention approach and the second a geographically defined small area, targeted spectrum of interventions approach to deliver tangible results over and above those achieved by services to date while gathering local evidence of effectiveness to be used in future commissioning across the tri-borough. Key deliverables: • Recruitment of a project officer • Production of an engagement and project plan • Identification of stakeholders and stakeholder engagement • Indicators and monitoring mechanism to be defined. • Mapping of relevant services and understanding of the evidence base for activities currently undertaken. • A new integrated approach to prevent children and family obesity, including a wide ranging review of relevant services offered across Tri-borough. This will ensure that the new children and family obesity prevention service is complementary to, and aligned with, other related services e.g. Children's Services, Sport and Leisure Services, School Nursing Services. The timeline for commissioning and procurement is as follows: • Commissioning strategy - by 31 March 2014. • Procurement process to commence in April 2014. • New provider or providers to be mobilised and in

	place by 1January 2015
Performance (local, regional, national)	To be determined
Key partners and stakeholders	Wider council stakeholders include planning, play, leisure, environmental health, transport, community safety. There is a need to explain and agree their role in achieving this complex process of putting in place effective interventions to support behaviour change. Engaging CCGs through the process of developing their commissioning intentions by highlighting family healthy weight management as one of the commissioning priorities for Public Health in 2014/15. Members of the Public Health team have been engaging individually and collectively with members of other council departments and outside of the organisation explaining and agreeing their role in delivering on public health outcomes. We are building trust and knowledge of these colleagues and are getting closer to some concrete actions and agreements.
Budgets and services related to this work	To follow the agreement of the approach after review of current services and need completed.
Other information	No further information

Priority 5	**Supporting Young People Into Healthy Adulthood**
Lead Officer	Andrew Christie, Executive Director for Tri-borough Children's Services
Governance arrangements	A Tri-borough Working Group has been set up to coordinate outcomes, priorities and action plans and to identify who will deliver on each outcome either on a Tri-borough or single borough basis.
Desired outcome	A draft Action Plan will be ready by January detailing the outcomes we will strive to achieve by 2016 under this priority area. We have taken on board early consultation findings, including those from Healthwatch and the Youth Forum. Any additional feedback from consultations will be discussed by the Tri-borough Working Group and Children's Trust.
Progress towards achieving outcome over the period	• A Tri-borough Working Group has been set up to cross reference priorities identifying where there are shared outcomes and confirming actions which will deliver these. • An action plan is being developed to identify outcomes, performance indicators, specific actions to deliver the outcomes and proposed timescales.
Outputs, deliverables, milestones (stages) Timeline, and deadline for completion	• Ongoing development and prioritisation of outcomes and action plan by Working Group. Working Group to expand to include other stakeholders as required. • Children's Trust Board to discuss and sign off action plan • Tri-borough proposals being developed proposing future Children's Trust arrangements to ensure outcomes and actions of Health and Wellbeing Strategy are delivered and a coordinated approach to any outcomes which are shared across two or more boroughs
Performance (local, regional, national)	Further work taking place with Tri-borough partners to identify shared priorities and appropriate performance measures
Key partners and stakeholders	LA Children's Services, CCGs and CSU, LA Public Health, CLCH, hospital and mental health trusts, schools and colleges, LA Adult Services and Communications teams, NHS England and London, Public Health England and London, Metropolitan Police, employers.
Budgets related to this work	To be determined
Other information	No further information

Priority 6	**To develop better access to suitable housing for vulnerable older people**
Lead Officer	Martin Waddington, (Liz Bruce)
Governance arrangements	Reports to H&F Business Board
Desired outcome	More people living in suitable accommodation as they age, which will allow them to manage their health and care needs at home rather than having to be admitted to hospital or needing to be placed in short or long term nursing care.
Progress towards achieving outcome over the period	1. Completion of feasibility study to identify suitable sites in the borough for potential new build extra care schemes of 25 – 105 units. One small site for 8 units of LD accommodation identified, but has issues. 2. Meeting with Director of HRD and Liz Bruce on 17th December to discuss ASC and HRD working better together on all land identified for development. 3. Links made with H&F Regeneration Planning department to consider new extra care housing within major regen sites in the borough. Links should influence the review of the Regeneration Core Strategy by updating the strategic policies regarding housing to reflect the need for more older people's housing.

Outputs, deliverables, milestones (stages) Timeline, and deadline for completion

Deliverable	Timeline	RAG
1. All key strategic documents to reference housing for older people – JSNA, Market Position Statement	Complete April 2013	G
2. Feasibility study to identify suitable sites for potential new build of 105 units of extra care and 24 units of LD accommodation	Complete Nov 2013	G
3. Mechanisms in place for reporting housing data to the board, to record the impact that housing has in numerical and cost terms (falls, hyperthermia etc...)	New timeline needed	A
4. Mechanisms are in place to capture structured data from older people about their future housing expectations	New timeline needed	A
5. Analyse to what extent current housing options for older people is meeting demand and need, the level of unmet need in the community and consult on what the current 'younger old' population will want from housing for older people, to inform any future investment	New timeline needed	A
6. There is a process for engaging with developers, which may include plans to release health, housing or social care land for development	In progress	A
7. Understand to what extent unsuitable housing impacts on people's health and	New timeline	A

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<tr><td></td><td>care needs as they get older</td><td>needed</td><td></td></tr>
<tr><td>8.</td><td>Consult with partners in Health regarding their understanding of sheltered housing and other housing options for older people and what gaps they may have identified and improve links between Housing and CCGs to deliver on shared, agreed outcomes</td><td>New timeline needed</td><td>A</td></tr>
<tr><td>9.</td><td>Pilot methods of improving access to sheltered housing, e.g. allocations and referrals (via ASC and Health rather than Housing), ASC managed housing, assistance/incentives to move, positive promotion</td><td>New timeline needed</td><td>A</td></tr>
</table></td></tr>
<tr><td>Performance (local, regional, national)</td><td>Performance measurements have not yet been benchmarked.</td></tr>
<tr><td>Key partners and stakeholders</td><td>Over the past year there have been other priorities in the Housing department that have affected the progress of this project. Piloting improved access into sheltered housing and gathering information on the current housing options for older people proved problematic when the new housing allocations policy was in a transitional stage and the sheltered housing staff team was under review.
Links with Health colleagues are being established and this will be progressed following the meeting with ASC and HRD on 17th December.</td></tr>
<tr><td>Budgets related to this work</td><td>There is Capital funding of £957k committed to building more extra care accommodation (Adults' Personal Social Services Grant).</td></tr>
<tr><td>Other information</td><td>As this project is now in a different phase it needs a new project plan, refreshed targets, identified and agreed resources and a new timeline.</td></tr>
</table>

Priority 7	**Improving mental health services for service users and carers to promote independence and develop effective preventative services.**
Lead Officer	Shelley Shenker (Liz Bruce, Tri-borough Executive Director Adult Social Care)
Governance arrangements	The Project Executive Group is the joint tri-borough and CWHH senior management team (called the joint SMT in this paper) reporting to their respective lead members and CCG Governing Bodies. An expert group has been set up to act in an advisory capacity to the Project Executive Group and this expert group will be further informed by other stakeholders.
Desired outcome	To develop an agreed 3/5 year strategy (aka Big Plan) to meet the changing needs and aspirations of people with mental health problems in H&F as part of a wider tri-borough approach to inform the commissioning and delivery of services.
Progress towards achieving outcome over the period	As set out previously, the expert group met on the 9th to review the emerging findings from a desktop analysis of data and from their areas of expertise begin to build a draft plan. This feedback was collated and written up and a further expert group meeting took place on the 11th December. At this meeting, group members were asked to refine the draft plan from the first session and suggest outcomes we could use to monitor whether we are achieving our joint vision. Next steps are now: -Refine plan based on 11th December session. -Wider consultation with other stakeholders in January and February. - Final draft plan to be approved by joint SMT in February. - Final approvals, including from HWB, in March.
Outputs, deliverables, milestones (stages) Timeline, and deadline for completion	The aim is to develop plan between October 2013 and March 14. A Tri-borough Big Plan setting out clearly: • The current and anticipated population of people with mental health problems and their changing health and social care needs (including analysis of children and young people with mental health needs to inform future needs for adult services) • A map of current services and developments already in progress, including current spend and benchmarking of the 3B spend against other authorities • A summary of the financial context for NHS and

	Council for the next five years and the implications for service commissioning • A summary of current policy and best practice in mental health services • Identification of key issues and concerns from people with mental health problems and carers to inform priorities for the future • A 3/5 year strategy identifying up to 10 areas for development and the targets to be achieved over that period, to include: • Housing • Employment • Health – primary, community, specialist • Care Needs • Active in the Community • Person centred plans and budgets • Carers • Keeping safe • Performance measurements to show progress towards targets over the strategy period
Performance (local, regional, national)	A plan will be developed against which the performance of the Council and the NHS can be accountable to local service users and carers and the wider community. This will include a clear framework of priorities against which specific development projects or contract renegotiations can be set.
Key partners and stakeholders	High level commitment is required from Adult Social Care, NHS, Housing and Children's Services Effective engagement of all stakeholders, particularly service users and carers is crucial to achieve ownership of the Big Plan
Budgets related to this work	Identification and commitment to appropriate resources will be undertaken as part of the development of the strategy and delivery plan.
Other information	No further information

Priority 8	**Better sexual health across Triborough with a focus on those communities most at risk of poor sexual health.**
Lead Officer	Ewan Jenkins (Dr Eva Hrobonova)
Governance arrangements	No change of governance has occurred since the last report.
Desired outcome	Maintenance and improvement of sexual health outcomes; delivery of seamless and accessible SH/HIV services; good working relationships are established across relevant commissioning organisations (LA, CCG, NHS England)
Progress towards achieving outcome over the period	• Review ongoing of Young People's Sexual Health Services in preparation for procurement in 2014-15. • Planning has started for reviews for HIV services and Community Sexual and Reproductive Health services. Reviews formally begin in Jan 2014. The reviews will inform re-procurement to take place in 2014-15. • Ongoing work is taking place with the current Community Sexual and Reproductive Health services to reconfigure delivery of existing service. This will result in a consolidation of delivery sites but we are working on short and medium term objectives to ensure increased efficiency whilst retaining access. • Leaders Committee at London Councils has approved recommendations for continued London Wide commissioning of some HIV prevention interventions. Condom distribution, communications and outreach for men who have sex with men will be reprocured. Additional prevention interventions may be required at a local level and the review of HIV services will further inform this. • Extension of existing contracts has now been sought to ensure that there are no service gaps whilst service reviews and subsequent re-procurements are completed. • Planning for the placement of Genito-Urinary Medicine contracts for 2014-15 has begun. The Tri-Borough Public Health Service has signalled its intent to continue with collaborative commissioning of these services. A timetable is being developed for the negotiation and placement of contracts.
Outputs, deliverables, milestones (stages) Timeline, and deadline for completion	• The Tri-Borough Sexual Health Strategy has been subject to delay although a new draft has been completed. Cabinet Members for Public Health are reviewing the draft in December 2013. It is intended that the draft now going forward to stakeholder engagement in January 2014. • Revised specifications for former 'Local Enhanced Services' delivered both within General Practices and

	Community Pharmacies have now been developed. These will be presented to Local Medical and Pharmacy Committees in January 2014. New services should be in place from April 2014. Where previous services were not delivered in Hammersmith and Fulham, consideration will be given as we move towards implementation as to how services delivered in other parts of the Tri-Borough can be made available in all Boroughs. Achieving this extension will increase access to services and should also contribute to improved outcomes.
Performance (local, regional, national)	• Chlamydia screening rates remain low. Additional work is required to try and improve screening rates. • Data from Quarter 3 2012 (Jul– Sep 2012) indicate an under 18 conception rate of 23.2 per thousand women aged 15 – 17. This is a slight drop compared to Quarter 2 and a substantial drop compared to the same quarter in 2011 when the rate was 35.3. The Hammersmith and Fulham rate is also lower than England (26.0), comparable to London (23.8) and lower than Inner London (25.9). • No additional data on HIV has been released since the last report.
Key partners and stakeholders	• The Sexual Health Commissioner continues to represent Public Health and Sexual health Commissioners on the NHS England HIV Service Review Expert Advisory Group. • The Sexual Health Commissioner also now sits on the London HIV Clinical Advisory Group. • The Sexual Health Commissioning Team remain actively involved in the London Sexual Health Commissioners Network. • The relationship with the West London Alliance Authorities continues specifically around the collaborative commissioning of GUM services. Discussions are taking place to increase the number of Local Authorities in this collaborative and specifically, it is hoped that Barnet, Camden, Haringey and Islington will become part of the collaborative for 2014-15. • Regular meetings are now taking place once again with providers across the sexual health portfolio.
Budgets related to this work	• There are still challenges to be resolved in relation to payments to GUM providers which have continued to prove to be difficult to negotiate. Work is ongoing on this matter. However, current projections are that the

	service should remain within budget for the year. • All other areas of the sexual health budget remain within or on expectations for the year to date.
Other information	No further information

<table>
<tr><td> </td><td>London Borough of Hammersmith & Fulham

HEALTH & WELLBEING BOARD

13 January 2014</td></tr>
<tr><td colspan="2">Better Care Fund Plan 2014-2016</td></tr>
<tr><td colspan="2">Report of the Health & Well-being Board</td></tr>
<tr><td colspan="2">Open Report</td></tr>
<tr><td colspan="2">Classification - For Decision

Key Decision: No</td></tr>
<tr><td colspan="2">Wards Affected: All</td></tr>
<tr><td colspan="2">Accountable Executive Director: Liz Bruce, Tri-borough Director for Adult Social Care</td></tr>
<tr><td>Report Author: Cath Attlee, Whole System Lead</td><td>Contact Details:
Tel:
E-mail:
cattlee@westminster.gov.uk</td></tr>
</table>

1. EXECUTIVE SUMMARY

1.1 As reported to the last meeting of the Board, local health and social care bodies are to be allocated funding to promote integrated working from 2014-15 (albeit some of this is relabelled existing funding). Triborough CCGs and Local Authorities have provided an early exemplar proposal for the Integration Transformation Fund, which has now been renamed the Better Care Fund

1.2 Appendix 1 is the first draft of the Better Care Fund Plan, developed by Triborough in partnership with the corresponding 3 Clinical Commissioning Groups with assistance provided by the Integrating Care team at PPL Consulting and the LGA.

1.3 It represents an initial response to the opportunities and challenges presented by the Better Care Fund. It is work-in-progress, subject to further consultation with key stakeholders across the 3 localities including our residents, voluntary and community sector, primary, acute and community health providers, and our social service teams.

1.4 At this stage the BCF submission represents no more than support and approval for the overall strategic direction and the ambition to achieve

better health and well-being for our residents by the targeted use of NHS financial investment in adult social care. Any numbers included at this stage are simply best current estimates, based on work-to-date; and these together with the overall proposals will invariably evolve and change through the consultation process and as our knowledge and understanding grows.

1.5 The intention is to share this work as an examplar at this early stage, to elicit feedback and support further development work through the LGA/DH programme in addressing the common challenges and the potential for shared improvements over the next 5 years.

2. RECOMMENDATIONS

2.1 The Board is asked to approve the plan as set out in Appendix 1.

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

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	N/A		

Triborough Integration Transformation Fund First Draft Submission

Appendix 1

Context

This document is a first draft, developed by the 3 London local authorities of the Triborough (the City of Westminster, the London Borough of Hammersmith & Fulham, and the Royal Borough of Kensington & Chelsea) in partnership with the corresponding 3 Clinical Commissioning Groups (NHS Central London CCG, NHS Hammersmith & Fulham CCG, and NHS West London CCG); with assistance provided by the Integrating Care team at PPL and the LGA.

It represents an initial response to the opportunities and challenges presented by the Integration Transformation Fund. It is explicitly work-in-progress, subject to further consultation with key stakeholders across the 3 localities including our citizens, voluntary and community sector, primary, acute and community health providers, and our social service teams. Any numbers included at this stage are simply best current estimates, based on work-to-date; and these together with our overall proposals will invariably evolve and change through the consultation process and as our knowledge and understanding grows.

The final section describes the next steps around this journey, and this document should be read in the context of the appendices as a whole.

The intention is to share this work at this early stage, to elicit feedback, to support further development work, and to ensure maximisation of the opportunity that the ITF represents – both within North West London and across the country as a whole, in addressing the common challenges and the potential for shared improvements over the next 5 years.

NHS
West London
Clinical Commissioning Group

NHS
Central London
Clinical Commissioning Group

Triborough
Integration Transformation Fund
First Draft Submission

Contents

Introduction 3
Our Vision - What this will mean for the people we serve 7
Our Vision - What this will mean for our health and social care services 11
The financial implications 16
How we will govern and manage these developments 23
Next steps 25
Appendices 26

Introduction

The Triborough consists of the 3 Local Authorities and 3 Clinical Commissioning Groups serving a diverse population of over 550,000 people in Westminster, Hammersmith & Fulham and Kensington & Chelsea.

From its inception, the Triborough has been about combining services across geographies to improve lives and make public funds go further for the people we serve. In common with the rest of England, we are experiencing an unprecedented period of growing demands on current services, with limited resources to meet these demands.

Despite progress in recent years, the resulting pressures are being reflected daily across our hospitals, our GP surgeries, our community healthcare teams and our social services. As our populations grow and people live longer, so the challenge of balancing available resources and local needs will continue to grow. Our starting point in responding to the challenge is that this is not simply a financial issue, nor can pressures in one part of our public services be solved in isolation from the others. Our vision for the next 5 years is therefore nothing less than a fundamental transformation of the quality and experience of care, across all elements of commissioning and provision, and on behalf of our communities as a whole.

Building on our experience of the Community Budget and Integrated Care Pilots, the work of National Voices, and on best-practice from across the UK and internationally, the Triborough is now a central part of the drive to develop person-centred, co-ordinated care.

We recognise that change on this scale will mean consistently providing people with the right care, in the right place, and at the right time; care that is planned and tailored to individual capabilities and needs; care that is delivered in partnership, to the highest possible standards. This will involve putting individuals at the heart of everything we do, not simply because it is what people tell us they want, because it is morally the right thing to do, or even because it is the most efficient way of doing things (although our experience demonstrates all of these statements are true); but because this is the only way we will ensure a sustainable, healthy future for the communities we serve.

Our vision is being realised through the North West London's *Whole System Integrated Care Programme*, as a part of the successful *Living Longer and Living Well* Pioneer application, through *Shaping a Healthier Future* and our supporting *Out of Hospital Strategies*.

This document brings together the strategic intent and operational planning that sits behind these, together with the *Triborough Market Position Statement* in which are set out the strategic priorities for adult social care, including:

- integrating reablement and intermediate care;
- building capacity in the community via the voluntary sector;
- shifting from a model of dependency and direct provision to supported self-management and care;

- linking formal and informal networks of support around individuals and within communities such that these better support and reinforce each other;
- improving understanding and use of resources across our populations and all those individuals and organisations providing support to those in need.

Together these documents capture not just our vision and commitment, but the practical steps we are taking in order to

- transform the quality of care for individuals, carers and families;
- empower and support people to maintain their independence;
- lead full lives as active participants in their community;
- shift resources to where they will make the biggest positive difference.

We believe that the Integration Transformation Fund (ITF) is a fundamental part of this journey.

We understand that this scale of change will not happen without significant and joined-up investment. Our ITF plans explicitly build upon progress to-date. Together, we have already agreed to pool our resources across many areas joining together. a significant amount of health funding on joint schemes with local social services. By working together across traditional public sector boundaries, keeping people well, and supporting their recovery after periods of illness, we know we can improve individual quality of life whilst also reducing demands upon local services.

However, we also recognise we need to go beyond what we are doing now. This is why we are proposing to pool a large proportion of our future health and social care funding, in excess of the minimum mandated by the ITF, in order to create new forms of joined-up support and care within our communities, in and around people's homes, covering both urgent and planned care, that will transform outcomes and transform lives.

The success of these changes will, from 2015/16 onwards, help drive reductions in emergency admissions to hospital, and the demand for nursing and residential home care, with benefits for individuals, the local authorities and the CCGs alike. This is about working together and working better, to put our health and social care systems on a steady footing, translating improved outcomes for individuals into long-term, sustainable support for our communities as a whole.

This is why we are investing now and in 2014/15 in working with individuals, communities and providers of health and care services. Such investments will develop our understanding, our organisations, our shared infrastructure, and the way in which our services operate to ensure real progress towards our vision for health and care services in 2018/19, with associated improvements in the quality and experience of care today.

Last but not least, this is why we are keen to share our proposals at this early stage.

We recognise that there is much more work to do, and that a number of uncertainties that still exist in relation to proposed investments and outcomes. This document is being shared as a first draft, and work in progress. The figures we are sharing are our best estimates based on work-to-date, and these will invariably evolve and change as our knowledge and understanding grows.

However, we believe we have an opportunity to contribute to the broader debate, and in turn benefit from feedback and experience across country as a whole. This is our opportunity to work together, to overcome barriers that have constrained us in the past, and to shape a better future for health and care services, and all of those we serve.

______________________________	______________________________
Dr Fiona Butler Chair, West London CCG	Councillor Mary Weale Cabinet Member for Adult Social Care & Public Health, RB Kensington & Chelsea
______________________________	______________________________
Dr Ruth O'Hare Chair of Central London CCG	Councillor Rachael Robathan Cabinet Member for Adults & Public Health, Westminster City Council
______________________________	______________________________
Dr Tim Spicer Chair of Hammersmith & Fulham CCG	Councillor Marcus Ginn Cabinet Member for Community Care LB Hammersmith & Fulham

Purpose

The submission combines commissioning intentions, local operating and service planning with our shared 5 year vision for the Triborough, as a part of North West London, including the NW London Integrated Care vision “Living Longer, Living Well” and “Shaping a Healthier Future” our hospital reconfiguration and out of hospital invest strategy.

Underpinning all of our plans is a focus on systems that support and remove barriers to integrated care through:

- Prevention and proactive support through care planning and co-ordination
- Caring for people in the most appropriate setting, starting at home
- Supporting independence through understanding individual capabilities and needs
- Tackling social isolation, with a “whole-person” approaches to wellbeing
- Using technology to develop networked, personalised health and care services
- Eliminating gaps, duplication and disconnects between our health and care services

Our vision for the future will require whole system change; how we commission work from providers, how providers interact with patients and with each other. Working together as the Triborough we are committed to effecting behavioural and attitudinal change in partnership all areas of the health & social care system, with a central role for the voluntary, community sectors, and not least our citizens themselves.

This document sets out our joint commissioning intentions and areas for development. It explains how our local authorities and clinical commissioning groups, working with individuals and communities, will mobilise resources to target areas of need and deliver improved outcomes, in 2015/16 and beyond. It captures why we need to do this, what the expected outcomes are on both an individual and locality-wide basis, and our best estimates currently of the specific investments required to make this happen.

Our Vision - What this will mean for the people we serve

Our aim is to provide care and support to the people of Westminster, Hammersmith & Fulham and Kensington & Chelsea, in their homes and in their communities, with services that:

- **co-ordinate around individuals**, targeted to their specific needs;
- **improve outcomes**, reducing premature mortality and reducing morbidity;
- **improve the experience of care**, with the right services available in the right place at the right time;
- **maximise independence** by providing more support at home and in the community, and by empowering people to manage their own health and wellbeing;
- **through proactive and joined up case management**, avoid unnecessary admissions to hospitals and care homes, and enable people rapidly to regain their independence after episodes of ill-health.

To do this, our starting point is our patients and service users themselves.

The following 3 "personas" are examples of those which have been developed to capture the experience of typical service users. They bring together feedback from real people and from the frontline professionals who are working to help them today. They allow us to focus our interventions on meeting the needs of individuals, working with them on the things which are most important to them.

Example Personas

Asmita

- *Asmita is 66 and lives in Westminster. She has a low income and lives alone in a rented basement flat. She is recently widowed. Her husband, who was her carer and organised her medicines also used to translate for her as English is not her first language*
- *She often feels lonely as her family lives abroad and she cannot communicate easily with her neighbours.*
- *Asmita has multiple long term conditions including diabetes, arthritis, chronic heart failure and early onset dementia. However, she does have some capacity at the moment.*
- *She receives a number of different services which include meals on wheels, two homecare visits a day to help her dress. Since her husband died, she makes frequent 999 calls and associated A&E visits. Her medicines are delivered by the pharmacy but she often misses her regular doses.*

April

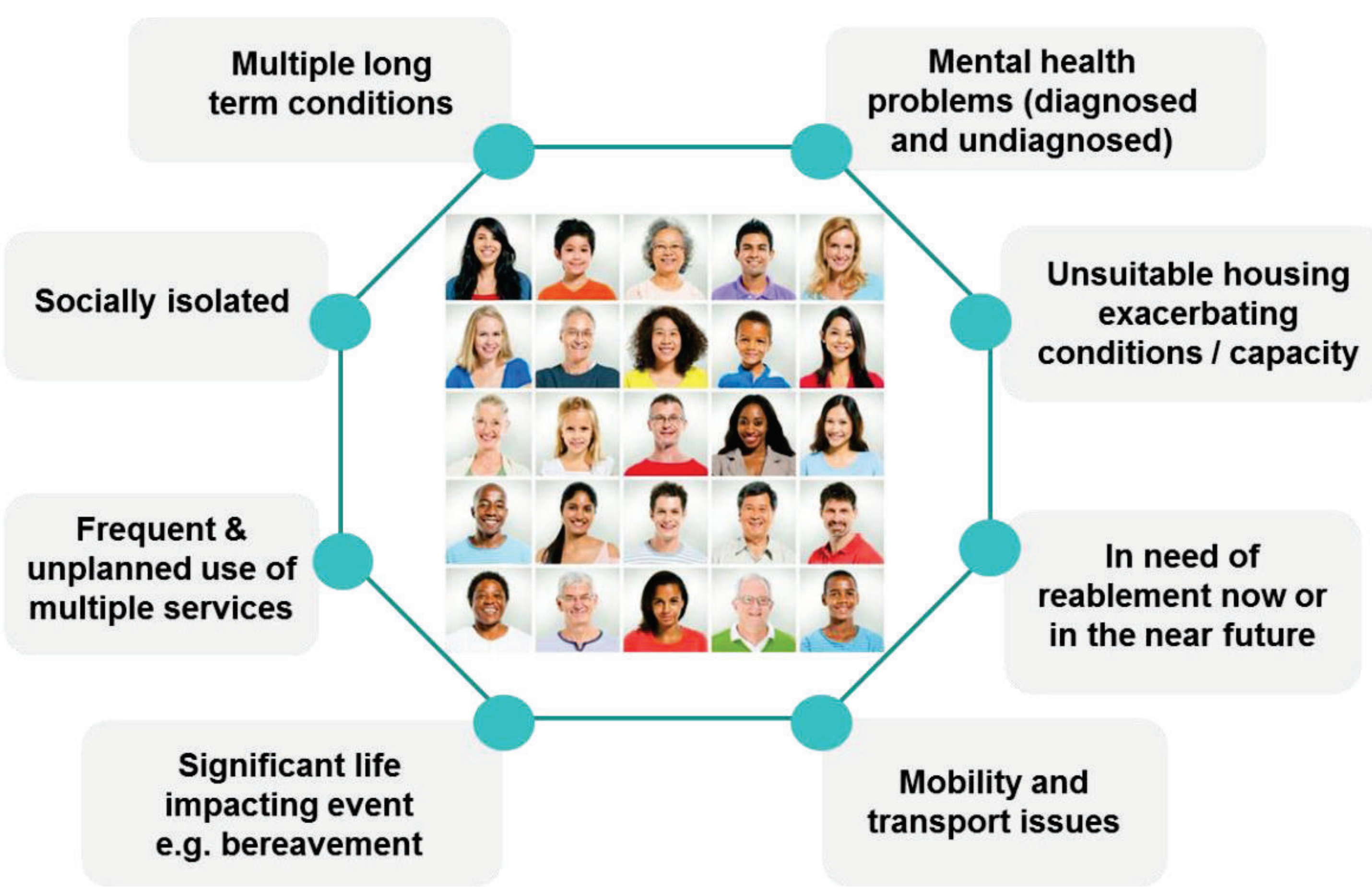
- *April is 82. She lives in a second floor, privately-rented flat near Holland Park. There is no lift and a stone staircase, so she is at high-risk of falling. She has had 2 hip replacements and is currently warfarinised following general anaesthetic for her second operation.*
- *She regularly visits her GP for blood pressure checks and has high levels of anxiety, leading to panic attacks. She has an informal support network in her block of flats, but her daughters live abroad and will not be returning to the UK.*
- *She has physio services for her hips and accesses transport services for hospital appointments. April has capacity at the present time, but is at high risk of losing her independence. She would benefit from help in the home to keep her in her current accommodation for as long as possible. She would benefit from some computer literacy, for example, to help with shopping, general contact etc.*

Les

- *Les lives in Hammersmith. He has two children. He lives on his own in social housing and is currently unemployed.*
- *Les feels isolated. He receives services in a reactive way, although he is on the brink of receiving more proactive services. He does not have a care manager.*
- *Les has multiple long term conditions including diabetes (which may not have been diagnosed). He is a smoker who has alcohol issues and heart problems. He also has mental health problems (a combination of depression and dementia).*
- *He frequently uses Charing Cross Hospital A&E (visits are often alcohol related). He has lots of disconnected referrals to care managers, social workers and district nurses. With the right advice and support Les could potentially care for himself.*

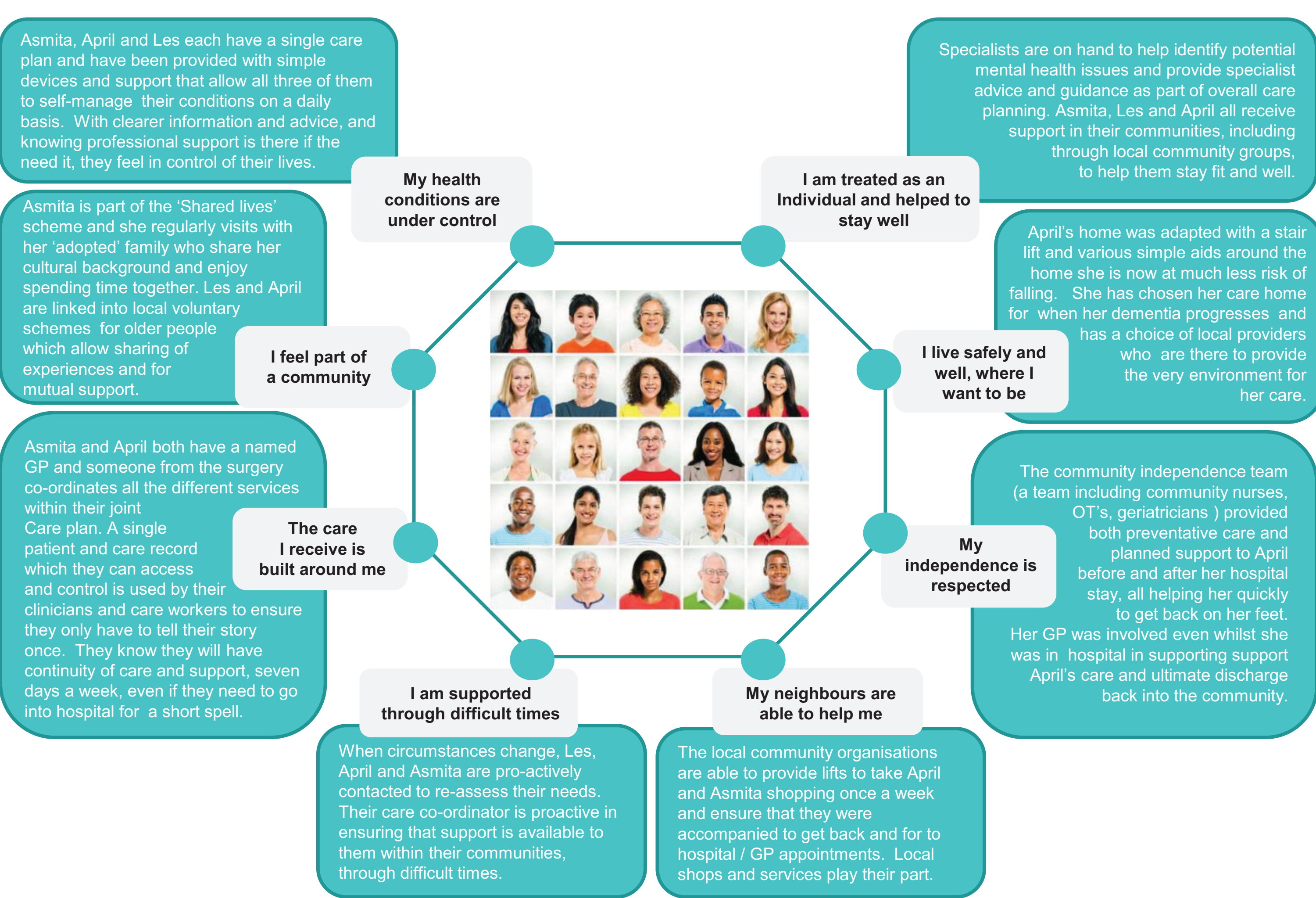
Transforming outcomes, transforming lives

As our work and engagement in this area has evolved, so increasing we have been able to identify a number of common challenges for those in greatest need, which if addressed, would genuinely transform the quality of life and wellbeing.



Our vision for those we serve

Our vision for 2018/19 is built around tackling these issues, empowering and supporting individuals to live longer and live well. This is about creating services that enable frontline professionals to work with individuals, their carers and families to maximise health and wellbeing and address specific individual needs.

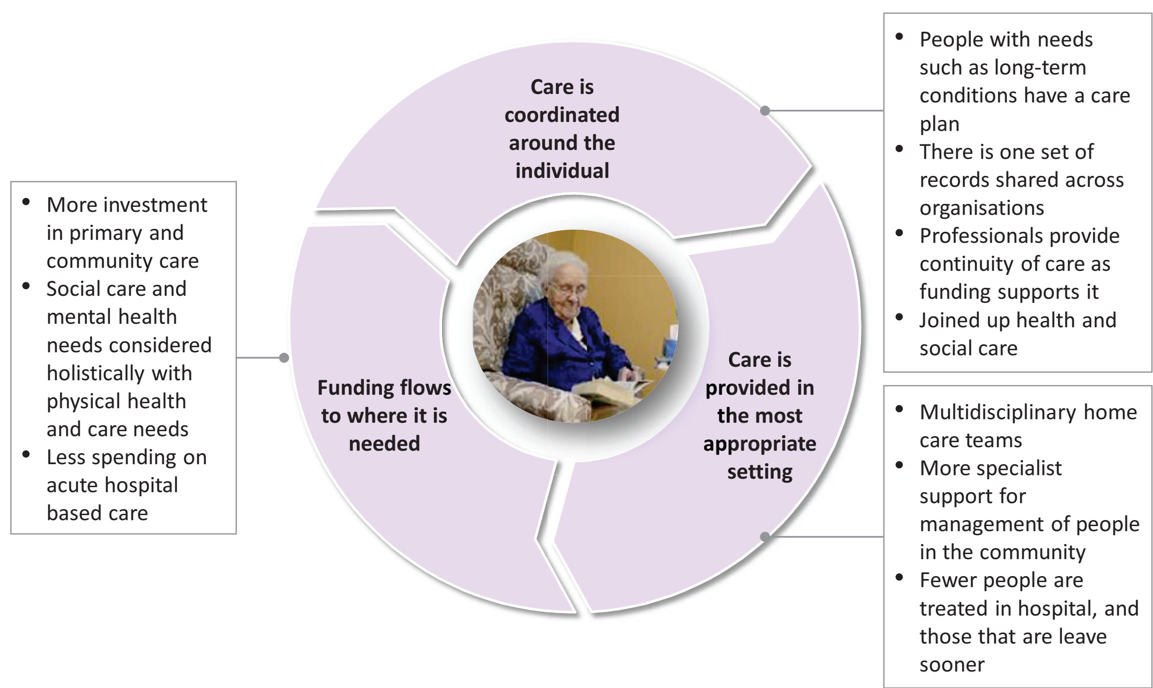


Our Vision - What this will mean for our health and social care services

Our vision for whole system integrated care is based on what people have told us is most important to them. Through patient and service user workshops, interviews and surveys across North West London (NWL), we know that what people want is choice and control, and for their care to be planned with people working together to help them reach their goals of living longer and living well. They want their care to be delivered by people and organisations who show dignity, compassion and respect at all times.

We recognise that realising this vision will mean significant change across the whole of our current health and care provider landscape. Whilst our GPs will play a pivotal role within this, all providers of health and care services will need to change how they work, and particularly how they interact with patients and each other. The CCGs and local authority commissioners who make up the Triborough are committed to working together to create a marketplace, and to effect the required behavioural and attitudinal change in the acute sector, to ensure that this happens at scale and at pace.

Integrated care means care that is coordinated around the individual, provided in the most appropriate place, and funding flows to where it is needed



In ***Living Longer and Living Well***, our application for Pioneer status, we set out our strategy for developing person-centred, co-ordinated care in North West London.

This strategy is based on **3 core principles**:

1. **People will be empowered** to direct their care and support, and to receive the care they need in their homes or local community.

2. **GPs will be at the centre** of organising and coordinating people's care.

3. **Our systems will enable and not hinder** the provision of integrated care. Our providers will assume joint accountability for achieving a person's outcomes and goals and will be required to show how this delivers efficiencies across the system

To achieve this we are engaging with local health and care providers, and associated public, private and voluntary and community sector groups, to “co-design” models of care that will engage with and meet people’s aspirations and needs. The following sections provide a summary of what this will mean, in practice, and the specific ITF investment areas for the next 2 years that will deliver on our aims and objectives.

People will be empowered to direct their care and support, and to receive the care they need in their homes or local community.

Over the next 5 years community healthcare and social care teams will work together in an increasingly integrated way, with single assessments for health and social care and rapid and effective joint responses to identified needs, provided in and around the home.

Our teams will work with the voluntary and community sector to ensure those not yet experiencing acute need, but requiring support, are helped to remain healthy, independent and well. We will invest in empowering local people through effective care navigation, peer support, mentoring, self-management and time-banking programmes to maximise their independence and wellbeing; and we will help identify and combat social isolation, as a major influence on overall health and wellbeing.

We will invest in integrated Community Independence teams that will provide a rapid response to support individuals in crisis and help them to remain at home. Community Independence will also work with individuals who have lost their independence through illness or accident and support them to build confidence, regain skills and, with appropriate information and support, to self-manage their health conditions and medication. The service will introduce individuals to the potential of assistive technologies and, where these are to be employed, will ensure individuals are familiarised and comfortable with their use.

Underpinning all of these developments, the ITF will enable us to start to release health funding to extend the quality and duration of our reablement services. By establishing universally accessible, joint services that proactively work with high-risk individuals irrespective of eligibility criteria, we will be able to:

- Improve our management of demand within both the health and care systems, through earlier and better engagement and intervention;

- Work sustainably within our current and future organisational resources, whilst at the same time expanding the scope and improving the quality of outcomes for individuals”

In doing so our plan is to go far beyond using ITF funding to back-fill existing social care budgets, instead working jointly to reduce long-term dependency across the health and care systems, promote independence and drive improvement in overall health and wellbeing.

Shaping a Healthier Future is the strategy which describes what success will require of and mean for our hospitals, with services adapting to ensure the highest quality of care is delivered in the most appropriate setting.

The volume of emergency activity in hospitals will be reduced and the planned care activity in hospitals will also reduce through alternative community-based services. A managed admissions and discharge process, fully integrated into local specialist provision and the Community Independence Service, will mean we will minimise delays in transfers of care, reduce pressures in our A&Es and wards, and ensure that people are helped to regain their independence after episodes of ill health as quickly as possible.

We recognise that there is no such thing as integrated care without mental health. Our plans are, therefore, designed to ensure that the work of community mental health teams is integrated with community health services and social care teams; organised around groups of practices; and enables mental health specialists to support GPs and their patients in a similar way to physical health specialists.

By improving the way we work with people to manage their conditions, we will reduce the demand not just on acute hospital services but also on nursing and residential care.

We will use the ITF to:

- **Help people self-manage and provide peer support** working in partnership with voluntary, community and long-term conditions groups.

- **Invest in developing personalised health and care budgets** working with patients and service users and frontline professionals to empower people to make informed decisions around their care.

- **Implement routine patient satisfaction surveying** from GP Practices to enable the capture and tracking of the experience of care.

- **Invest in reablement** through a new joint Triborough Community Independence Services, reducing hospital admissions and nursing and residential care costs.

- **Reduce Delayed Discharges,** through investment in Neuro-Rehabilitation services and strengthen 7 day social care provision in hospitals.

- **Integrate NHS and social care systems** around the NHS Number to ensure that frontline professionals, and ultimately all patients and service users, have access to all of the records and information they need.

- **Undertake a full review of the use of technology** to support primary and secondary prevention, enable self-management, improve customer experience and access, and free up professional resources to focus on individuals in greatest need.

GPs will be at the centre of organising and coordinating people's care.

Through investing in primary care, we will ensure that patients can get GP help and support in a timely way and via a range of channels, including email and telephone-based services. The GP will remain accountable for patient care, but with increasing support from other health and social care staff to co-ordinate and improve the quality of that care and the outcomes for the individuals involved.

We will deliver on the new provisions of GMS, including named GP for patients aged 75 and over, practices taking responsibility for out-of-hours services and individuals being able to register with a GP away from their home. Flexible provision over 7 days will be accompanied by greater integration with mental health services, and a closer relationship with pharmacy services. Our GP practices will collaborate in networks focused on populations over at least 20,000 within given geographies, with community, social care services and specialist provision organised to work effectively with these networks. A core focus will be on providing joined-up support for those individuals with long-term conditions and complex health needs.

As a result of all of these changes, some GPs may have smaller list sizes, with more complex patients, and with elements of basic care delivered by nurse practitioners. In the acute sector, our specialist clinicians will work increasingly flexibly, within and outside of the hospital boundaries, supporting GPs to manage complex needs in a “whole person” way.

We will use the ITF to:

- **Roll out the Whole Systems Integrated Care model** building on existing care planning, care co-ordination, risk stratification and multi-disciplinary teams.

- **Invest in 7 day GP access** in each locality and deliver on the new provision of the GMS.

Our systems will enable and not hinder the provision of integrated care. Our providers will assume joint accountability for achieving a person's outcomes and goals and will be required to show how this delivers efficiencies across the system.

Our CCG and Social Care commissioners will be commissioning jointly, focussed on improving outcomes for individuals within our communities.

In partnership with NHS England, we are identifying which populations will most benefit from integrated commissioning and provision; the outcomes for these populations; the budgets that will be contributed and the whole care payment that will be made for each person requiring care; and the performance management and governance arrangements to ensure effective delivery of this care.

In order that our systems will enable and not hinder the provision of integrated care, we will introduce payment systems that improve co-ordination of care, by incentivising providers to coordinate with one another. This means ensuring that there is accountability for the outcomes achieved for individuals, rather than just payment for specific activities. It also means encouraging the provision of care in the most appropriate setting, by allowing funding to flow to where it is needed, with investment in primary and community care and primary prevention.

This means co-ordinating the full range of public service investments and support, including not just NHS and adult social services but also housing, public health, the voluntary, community and private sectors. As importantly, it means working with individuals, their carers and families to ensure that people are enabled to manage their own health and wellbeing insofar as possible, and in doing so to live healthy and well lives.

In order to track the results, we will leverage investments in data warehousing, including total activity and cost data across health and social care for individuals and whole segments of our local populations. We are developing interoperability between all systems to provide both real time information and managerial analytics. By Autumn 2014, our GP practices will all be using the same IT system, providing the opportunity for our care providers to all use the same patient record; the ITF will help ensure this happens by joining up Health and Social Care data across the Triborough, linked via the NHS number, and guaranteeing that individual information is shared in an appropriate and timely way.

We are ensuring related activity will align, by working in close collaboration with the other boroughs in northwest London (NWL) in co-designing approaches to integrating care. This is designed to ensure shared providers have a consistent approach from their different commissioners, and that we are proactively sharing learning across borough boundaries. Our plans are aggregated into the NWL Pioneer Whole Systems Plan in order to accelerate learning and joint planning. On a NWL basis the NWL Integration Board provides oversight to this process, as described in the governance section below; with each locality Health & Wellbeing Board taking the lead in approving local joint commissioning plans.

We will use the ITF to:

- **Establish a Joint Integration Team** working across the local authorities and CCGs to support the implementation of integrated commissioning of health and social care.

- **Review all existing services**, including services commissioned under existing section 256 agreement, to ensure they represent VFM and re-procure services where necessary to enable integrated working.

- **Create a joint Nursing and Care Home Commissioning Team** focussed on improving outcomes through transforming the quality, consistency and co-ordination of care across the nursing and care homes of the Triborough.

- **Extend Psychiatric Core 24 services** to cover all acute sites in Tri-borough, providing holistic support for physical and mental health needs.

The financial implications

Our ambition

In developing our plans for jointly funded services from 2014/15 onwards, our starting point has been the scale and scope of our existing transfers from health to local government and the services that they support.

Within the Tri-borough there is a significant history of joint-commissioning, with £113m of Section 75/76 agreements in place for 2013/14 covering learning disabilities, mental health and older people's services; and a further £11m investment in social care to benefit health through the Section 256. Our proposal is to use the establishment of the ITF to build on this tradition, and significantly increase the scope and scale of joint commissioning.

Whilst these existing transfers have delivered benefits for individuals, communities and for our local public service organisations, we recognise that the financial challenges ahead are significant. We will need to build upon the work to-date if we are to provide high-quality services in a sustainable way.

Our estimate of the mandated value of the ITF across the tri-borough is £22.2m in 2014/15, which will grow to £46.9m in 2015/16; however, our ambition is to go much further than this.

The Tri-borough local authorities and the CCGs are exploring the possibility of expanding the shared fund so that there is joint commissioning of all residential and nursing homes, domiciliary care, community healthcare and the emergency patient pathway. If realised, this would see the jointly commissioned ITF grow to £442m, bringing together the commissioning of all these services and allow us to track and jointly manage the shift from acute hospital, nursing and residential home based care into community and domiciliary care settings.

Changing the dynamic of local health and care funding

At a time when we are planning to make significant investments in community-based, person-centred health and care services, pressures and demands on our acute services continue to grow, and local authority social care budgets are facing a prolonged period of real-term reduction, increasing the risk that individual care needs will not be met.

Our ITF plan is about applying targeted investments to convert this potentially negative cycle into a positive one, driven by improved outcomes for individuals, communities and the health and care economy as a whole.

This means:

- Supporting people to live independently and well
- Releasing pressure on our acute and social services
- Investing in high-quality, joined-up care in and around the home

Whilst detailed plans are currently in development, and subject to approval by our Health & Wellbeing Boards, we have identified a range of potential schemes to help make this shift a reality, and for each a likely range of expenditure and returns.

In 2014/15 we will be investing between £1.7m and £3.1m of additional health funding into the ITF. This investment is not about immediate financial returns, but rather creating the capabilities and infrastructure to enable outcomes in 2015/16; whilst ensuring local social services can continue to meet the care needs of our population.

No.	Scheme 2014/15	Description	Investment		
			Recurrent / Non-recurrent	Min £000	Max £000
ITF01	Strengthen 7 day social care provision in hospitals	This scheme will extend current arrangements for increasing social care provision in hospitals during the winter months, to provide full 7-day social care support all year. This will help to deliver the reduction in delayed discharges in ITF10.	**Recurrent**	950	1,650
ITF02	Developing self-management and peer support	Working with individuals and through local voluntary and community groups to co-design, co-develop and co-produce improved health and care outcomes, ensuring that the patient and service user capacity within the system is maximised	**Recurrent**	150	250

No.	Scheme 2014/15	Description	Investment		
			Recurrent / Non-recurrent	Min £000	Max £000
ITF03	Transforming Nursing & Care Home Commissioning	Project set up costs for creating a single nursing and care home commissioning team and outcomes-based specification, maximising efficiency and ensuring that appropriate and timely provision reduces the requirements on the acute sector	**Non-recurrent**	125	250
ITF04	Supporting Integration	Establishing a Joint Integration Team working across LA and CCGs to lead the implementation of integrated commissioning of health and social care	**Non-recurrent**	250	500
ITF05	IT Integration	Project costs to implement an IT solution to link Triborough Social Care Systems to the GP system and to ensure consistent use of the NHS Number as the primary identifier	**Non-recurrent**	125	250
ITF06	Transforming Patient Satisfaction	Project to set up routine collection of patient satisfaction from GP Practices to enable capture of experience of care for people with Long Term Conditions	**Non-recurrent**	125	250
		Total additional 2014/15		**1,725**	**3,150**

From 2015/16 onwards we will start to realise significant benefits in terms of both the quality and cost of care.

The ITF fund in 2015/16 will be in the range £47.0m to £69.3m (excluding existing Section 75 agreements but including investments in Social Care to Benefit Health).

The estimated value of the mandated ITF is expected to be £46.9m. The table below shows the current proposal for the ITF in 2015/16:

	Ref. to Invest -ment Table	Baseline ITF		New Investment		Total ITF	
		Min	Max	Min	Max	Min	Max
Section 256 Social Care to Benefit Health	ITF07	11,126	11,126	-	-	11,126	11,126
Community Health - Target Operating Model	ITF07	5,678	22,710	-	-	5,678	22,710
Community Independence functions	ITF08	13,000	13,000	5,400	5,400	18,400	18,400
Joint Nursing and Care Home Commissioning	ITF09	900	900	-	-	900	900
Reducing Delayed Discharges	ITF11	-	-	1,800	3,900	1,800	3,900
Psychiatric Liaison	ITF13	2,200	2,200	600	1,100	2,800	3,300
7 Day Social Care/7 Day GP Access	ITF10/ 15	-	-	2,550	4,850	2,550	4,850
Other Investments	ITF02/ 12/16	-	-	750	1,200	750	1,200
Disabled Facilities Grants		1,288	1,288	-	-	1,288	1,288
ASC Capital Grants		1,672	1,672	-	-	1,672	1,672
Total Proposed ITF in 2015/16		**35,864**	**52,896**	**11,100**	**16,450**	**46,964**	**69,346**
Mandated ITF Value 2015/16 (estimated)						*46,852*	

Detailed investment and benefit management plans will be refined throughout 2014/15, but already from our work on *Shaping a Healthier Future*, *Whole System Integration* and with support from *Integrating Care* and the *National Collaborative*, we have been able to identify and quantify a number of reductions in demand and cost that would accrue from better management of long-term health needs across our population.

<table>
<tr><th rowspan="2">No.</th><th rowspan="2">Scheme 2015/16</th><th rowspan="2">Description</th><th colspan="3">Investment</th><th colspan="2">Return</th></tr>
<tr><th>Recurrent / Non-recurrent</th><th>Min £000</th><th>Max £000</th><th>Min £000</th><th>Max £000</th></tr>
<tr><td>ITF02</td><td>Developing Self-Management and Peer Support</td><td>Working with individuals and through local voluntary and community groups to co-design, co-develop and co-produce improved health and care outcomes, ensuring that the patient and service user capacity within the system is maximised</td><td>Recurrent</td><td>150</td><td>250</td><td>0</td><td>0</td></tr>
<tr><td>ITF07</td><td>Review existing service portfolio</td><td>Project to review all existing services, including those services commissioned under existing section 256 agreements, to ensure services provide value for money and are aligned with the objective of transforming to integrated working.</td><td>Recurrent</td><td>0</td><td>0</td><td>0</td><td>4,000</td></tr>
<tr><td>ITF08</td><td>Community Independence</td><td>Investment in an integrated network of community support and multidisciplinary teams to provide step up and step down care, preventative care and reablement through a community independence approach. National and international evidence shows that this will significantly reduce NEL admissions and nursing and residential care costs. In addition, this service will ensure that the capacity existing within service users and patients is used to maintain independence positively and local analysis suggests significant savings as a result of the change.</td><td>Recurrent</td><td>5,400</td><td>5,400</td><td rowspan="2">11,700</td><td rowspan="2">25,100</td></tr>
<tr><td>ITF09</td><td>Joint Nursing and Care Home Commissioning</td><td>Create a single LA and CCG team for commissioning Nursing and Care Homes. This will achieve savings from better contract management and better procurement of nursing and residential care. It will also enable more appropriate use of acute provision, by ensuring that appropriate care is available to service users in their current care setting, where possible. Joint management will also enable strategic market management and development,</td><td>Recurrent</td><td>0</td><td>0</td></tr>
</table>

No.	Scheme 2015/16	Description	Investment			Return	
			Recurrent / Non-recurrent	Min £000	Max £000	Min £000	Max £000
		as well as joint assessment and monitoring of placements, leading to improved quality of care and safeguarding.					
ITF10	Reducing Delayed Discharges	We will increase our investment in additional capacity within the Tri-borough, particularly in relation to Neuro Rehab, and work to simplify and streamline the assessment processes in order to reduce delayed discharges and deliver a better experience for patients. Our aim is to improve the level of delayed discharges to match the top quartile of boroughs across England by 2015/16	Recurrent	1,800	3,900	2,900	7,500
ITF11	Strengthen 7 day social care provision in hospitals	This scheme will extend current arrangements for increasing social care provision in hospitals during the winter months to provide full 7-day social care support all year. This will help to deliver the reduction in delayed discharges in ITF10.	Recurrent	950	1,650	Included in ITF10	
ITF12	Patient Surveys	We will continue on a recurrent basis the routine collection of patient satisfaction from GP Practices to enable capture of experience of care for people with Long Term Conditions	Recurrent	500	750	0	0
ITF13	Psychiatric Liaison	This scheme will develop psychiatric liaison services (LPS) in line with the NWL-wide review, delivering a common specification and contracting of services to ensure equity of access, improved performance and consistent standards assurance reporting to deliver a reduction in inappropriate emergency admission avoidance, medication reviews and length of stay minimisation for mental health patients	Recurrent	600	1,100	0	2,000
ITF14	Ambulatory Care-Sensitive Conditions	Establishing ambulatory emergency care services, offering patients a safe alternative to hospitalisation with improved patient experience and avoiding unnecessary admissions.	Recurrent	TBD	TBD	Included in ITF08	

No.	Scheme 2015/16	Description	Investment			Return	
			Recurrent / Non-recurrent	Min £000	Max £000	Min £000	Max £000
ITF15	GP 7 Day Access	Investing in ensuring that everyone within the Tri-borough has access to GP services 7 days a week.	Recurrent	1,600	3,200	0	1,000
ITF16	Developing personal health and care budgets	Extend our current plans for personal health budgets, working with patients, service users and frontline professionals to empower people to make informed decisions around their care.	Recurrent	100	200	TBD	TBD
ITF17	Whole Systems Integration	Incorporating our current investment in the Whole Systems Programme and Pioneer status within the ITF, to build fully integrated and sustainable care planning, care co-ordination, risk stratification and multi-disciplinary teams across health and social care.	Recurrent	TBD	TBD	TBD	TBD
Total 2015/16				**11,100**	**16,450**	**14,600**	**39,600**

Whilst the above tables capture our current plans, our ambition is to expand the ITF fund to encompass our whole emergency care pathway budget. This would mean all of social care, all of community health and all of A&E and emergency admissions would come into pooled budget arrangements, allowing us to track the total shift from acute hospital and nursing and residential home based care, to community and home based care schemes.

How we will govern and manage these developments

Across the Triborough, we have invested significantly in building strong governance that transcends traditional boundaries. The Health and Wellbeing Board in each of our boroughs has matured well, and this year we have been able to write joint commissioning intentions covering all of our CCGs and local authorities. We have regular meetings between our 3 council cabinet members responsible for health-related services and our 3 CCG chairs, together with routine parallel meetings between the executive teams of our CCGs and local authorities. Our transformational plans and programmes are formally discussed and approved at local borough governance levels within each local authority and CCG.

However, we also recognise the opportunities to deepen these relationships in the context of the scale and ambition of our future joint fund.

A shared approach to leadership and management

To deliver the ambition contained in our ITF, we recognise the need to develop further our strategic and operational governance arrangements. We therefore propose to look at, as part of this process, how we start to bring together management responsibilities and accountability across care and health services, for our residents and patients and as whole. We would see our future management team accountable for the commissioning of integrated care, through the Health and Wellbeing Board, to both the Local Authorities and the CCGs. In parallel, we will ensure that the leadership of the CCG and Local Authority have clear and shared visibility and accountability in relation to the management of all aspects of the joint fund.

Our current proposal is to delegate specific functions between Local Authority and CCGs in areas that facilitate delivery of the ITF. The initial areas that we wish to consider are the commissioning of nursing and residential care homes, and the commissioning of care delivered in people's homes.

Our business case for the commissioning of nursing and residential care homes demonstrates that, if this were done as one team across our agencies, we would save money and improve quality. Our local authorities have a strong track record in this area, and we are therefore looking at options for our CCGs to delegate this responsibility to the local authorities. We envisage that these joint arrangements would enable us to deliver the full benefits of reablement and intermediate care services provided in people's homes, and to remove current gaps and duplication in provision.

The first step in doing this will be to pool our funding for these services, and to commission one team who will be responsible for this budget, the health and social care needs (including assessment, brokerage and in-house provision). We envisage that both the local authority teams and the CCG teams would be held to account for the delivery of these services by a strengthened Health and Wellbeing Board. Reviewing the Terms of Reference of our current Health and Wellbeing Boards, and ensuring they are in a position to provide effective governance for the new joint funding, will be a priority for the coming months.

Providing effective oversight and co-ordination

Regular briefings to Cabinet are designed to help to ensure effective debate and engagement at a borough level, and that our plans are directionally aligned with the priorities of local communities. Cabinets are the constitutional forum for key decision making and a core part of the due process for the changes envisaged in this document, which will also include scrutiny and challenge across each locality.

Throughout this process, we will ensure that the local Health and Wellbeing Boards for each borough remain central to the development and oversight of the proposed schemes making up our Integration Transformation Fund, with a principle of pooling as much health and care funding as is sensible to do so, and with a focus on developing our joint commissioning and outcomes frameworks to drive quality and value.

Across North West London, the North West London Whole System Integration Board, combining health and local authority membership, will continue to provide direction and sponsorship of the development of integrated care across the geography. The Shaping a Healthier Future Programme Board will continue to oversee the delivery of the acute hospital and Out of Hospital reconfigurations, and we will continue to be accountable to the CCG collaboration board made up of the 8 CCGs in NW London. This will ensure we have a comprehensive view of the impact of changes across North West London on the Triborough, and vice-versa; and that we are able to make the necessary shared investment across our region in overcoming common barriers, and maximising common opportunities.

Next steps

This document is a draft, designed to share current progress and thinking around the development of the ITF in the Triborough. The proposals within this document will be refined, developed and signed-off through the following timeframe:

Date	Governance Process
Dec 2013	First draft to Governing Bodies and key stakeholders (including Housing, Public Health, Health & Care Providers and the Voluntary sector)
Jan 2014	Iterations of comments and feedback and updating of document
8th Jan 2014	Central London CCG Governing Body
14th Jan 2014	H&F CCG Governing Body
28th Jan 2014	West London CCG Governing Body
31st Jan 2014	Final submission to the HWB for sign off
15th Feb 2014	Formal submission to NHSE

These dates are subject to confirmation based on national and local timetables. Throughout this process drafts will continue to be circulated to the Integration Partnership Board, Health and Well-being Boards, CCG Governing Bodies and Cabinet members.

Priority areas we will be exploring through this process include:

- **Our joint governance arrangements** including the terms of reference for our Health and Wellbeing Boards, to ensure these are fit-for-purpose in relation to the enhanced roles we wish these to play.
- **The role of planned medical activity** and the full evidence base for moving activity into the community and driving improved outcomes through better co-ordinated care.
- **A full options appraisal for pooled funding** including developing the detailed governance model, and describing the specific roles, accountabilities and responsibilities of a Joint integration Team
- **A detailed risk analysis**, and further development of mitigation strategies for the major risks identified so far; including in relation to avoiding "double-counting" of benefits, and managing a stable transition to any future provider arrangements.
- **The pathway for aligning and joining up IT strategies** for data warehousing and interoperability, including required investments in health and social care systems to ensure a single accessible care record.
- **The use of technology in supporting home-based care** including potential joint investments and benefits from telehealth and telecare.
- **Developing local, person-centred outcomes** to support outcome-based commissioning of future joint services, and to allow us to assess the results of these investments over the next 5 years.

Appendices

Please see attached files for

Appendix A Triborough ITF Populated Template

Appendix B Triborough ITF Outcomes and Finances

Appendix C "Living Longer and Living Well" North West London Pioneer Application

Appendix D Community Independence Service Outline Business Case

Appendix E Joint Nursing and Care Home Commissioning Outline Business Case

Appendix F "Delivering Seven Day Services": North West London's vision

Agenda Item 6

	London Borough of Hammersmith & Fulham **HEALTH & WELLBEING BOARD** **13 January 2014**
TITLE OF REPORT Joint Strategic Needs Assessment (JSNA) Update	
Report of the Interim Director of Public Health	
Open Report	
Classification - For Decision and Information **Key Decision: Yes**	
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 meeting of the Health and Wellbeing Board on 17 June 2013 the JSNA will be a standing item on the HWB agenda.

1.2. This report provides a further update on progress with the 2013/14 JSNA work programme, presents the Tuberculosis JSNA for consideration and approval, and describes the next steps for developing the 2014/15 work programme.

2. RECOMMENDATIONS

2.1. The Health and Wellbeing Board are requested to consider the progress being made against the 2013/14 JSNA programme

2.2. Review and agree to publish the findings and recommendations of the Tuberculosis JSNA

2.3. Consider and approve the approach to developing the 2014/15 work programme

3. JSNA UPDATE

3.1. Due to a large number of apologies the 2nd meeting of the JSNA Steering Group scheduled for 28 November was cancelled. The next meeting will take place on 21st January 2014 and will begin the process of setting the work programme for 2014/15.

3.2. Interviews have taken place for the JSNA Manager post and the successful candidate, Dan Lewer, will start early April 2014.

3.3. At the November meeting the JSNA Highlights report for Hammersmith and Fulham was approved. Final edits are being made and the report will be published on the JSNA website in the New Year.

4. CURRENT JSNA WORK PROGRAMME

4.1. The following deep dive JSNAs are in progress:

- The Learning Disabilities JSNA has now been completed and will come to the Health and Wellbeing Board along with the Tri-borough Learning Disabilities Plan

- Physical Activity JSNA. The final recommendations have been sent for approval by the Community Sport & Physical Activity Networks (CSPAN) and JSNA Steering group. These will come to the Health and Wellbeing Board in March 2014.

- Child Poverty JSNA. A well attended Engagement Summit was held on 12 November which informed key priority areas and recommendations for the final JSNA. These recommendations are being finalised and will come to the Health and Wellbeing Board in March 2014.

5. 2014/15 WORK PROGRAMME

5.1 One of the key responsibilities of the JSNA Steering Group is to establish the priorities for the JSNA work programme. Priorities may be identified from:

- the Joint Health and Wellbeing Strategies
- existing summary JSNA reports
- local and national policy drivers
- commissioning intentions and re-procurement plans
- specific requests for a JSNA

5.2 A meeting of the JSNA Steering Group will be dedicated to setting the priorities for the 2014/15 work programme. This will be held in early Spring 2014 to ensure alignment with the commissioning cycle and will be expanded to include key stakeholders to assist in identifying potential topics for deep dive JSNAs and developing the work programme.

5.3 No new applications have been submitted to the JSNA Steering Group for consideration, however the following topics are on the radar and may contribute to the 2014/15 work programme:

- Impact of parental mental health on children
- Female Genital Mutilation (FGM)
- Working population
- Rickets (Vitamin D)
- Housing (focussing on Older People)
- Bullying (including cyberbullying)
- Population and ward profiles
- Homeless with no recourse to public funds
- Co-morbidites among homeless

5.4 Any topic to be considered as part of the JSNA work programme will need to be fully scoped and each may require a different level of work

6. TUBERCULOSIS (TB) JSNA

6.1 This JSNA was commissioned in response to an identified need for a systematic programme for TB services and for new entrant identification and screening in primary care. It is also intended to inform a robust service specification for TB services commissioning in the future.

6.2 The JSNA reports on the prevalence and characteristics of TB across the Tri-borough, describes current service provision and makes recommendations to ensure services meet the needs of the local population.

6.3 TB is an airborne disease caused by a bacterium which usually affects the lungs but can develop in any part of the body. Pulmonary TB (affecting the lungs) can spread the disease to others. TB is curable in almost every case if the full treatment is taken (usually 6 months involving up to 4 drugs), otherwise the disease can return in a drug-resistant form (which

can take up to 2 years to treat and is associated with a higher mortality). TB is fatal in about 3% of cases.

6.4 The risk of TB and particularly drug resistant TB is increased in individuals who have one or more social risk factors such as homelessness, drug use, alcohol misuse, imprisonment associated with a high risk of non-adherence. Often a number of risk factors co-exist.

6.5 The prevalence of TB in London (41 per100,000 in 2012) is significantly higher than the national prevalence (13.9 per 100,000 in 2012). While lower than London, the prevalence in Hammersmith & Fulham is 26 (per 100,000), higher than the national prevalence. Royal Borough of Kensington and Chelsea is 21 (per 100,000) and Westminster is 23 (per 100,000).

6.6 TB presents a particular challenge for the tri-borough area because of its central London location with high levels of homelessness, high density of schools, colleges, universities, work places and neighbouring boroughs with very high TB prevalence, making TB prevention particularly resource intensive for the tri borough due to large scale and complex contact tracing exercises

6.7 Key findings of the TB JSNA:

a) Lack of clarity on the overall strategic planning and management of services, particularly since the demise of the TB Action Group. Now that the responsibility for commissioning sits with Clinical Commissioning Groups with input from the Health and Wellbeing Board, there are opportunities for CCGs, Adult Social Care, Public Health and other agencies to work together to address local issues and operate across boundaries

b) Management of services for active TB. There are four centres providing TB services with a large input of specialists for a small service. This current model does not offer economies of scale required for the provision of specialist clinics or adequate staffing levels to respond to increased demand. In addition, there are tensions and gaps in service provision arising from the fragmentation of services and funding arrangements. The latter means that aspects of TB prevention and treatment are not sufficiently ring-fenced.

6.8 Based on the findings of the JSNA a number of recommendations are highlighted:

a) Pooling staff, clinics and resources where appropriate. At present there are Trusts close together providing similar expertise for a relatively small workload which is unlikely to be cost efficient. A single service model has been shown to work in North Central London and a proposed model for Tri-borough could comprise two hubs with additional provision of community

services. Capacity could be mapped across the four sites in terms of accessibility.

b) Consider how hospital and community services can be provided more effectively. To prevent TB transmission efforts should be concentrated on new migrants to the UK in the last 5 years with primary care and community services playing a key role. One proposed solution is for the hospital services to lead on index case and latent TB infection (LTBI) case management. The community service would lead on the screening element of TB control and management such as new entrant screening and active case finding as well as providing support for hospital and primary care services.

c) Review current commissioning arrangements and establish service specification and service level agreement for TB. Currently TB payments are bundled into the acute respiratory block contract or respiratory services for CLCH. However, the TB service is different from the respiratory or infectious disease services in that an effective TB service is equally about prevention of TB, rather than just acute treatment. The Payments By Result (PBR) method does not allow for flexible allocation of the funds across all the various elements of TB care such as screening activities, data entry, cohort review, contact tracing and incident management. Commissioners should consider agreeing a service specification with the hospital services and unbundling the TB contract from the acute contract. Attaching costs to the various elements of the service may help hold back funds when they are needed for contact-tracing and incidence control.

d) Establish a local pathway for the management of TB. A joint pathway with local authorities for the management of patients with no recourse to public funds (e.g. some recent immigrants, homeless, drug users) would improve prevention of TB cases in high risk patients, particularly with regards to drug resistant TB. A dedicated social worker could make the service more effective and efficient by establishing good links between the housing department in the councils, the TB teams, and the third sector providers.

6.9 A briefing describing these key recommendations and implications for contractual arrangements has been sent to Central London Clinical Commissioning Group with a view that this will be shared across the three CCGs.

6.10 Since this JSNA has been written a London TB Control Board has been co-sponsored by Public Health England and NHS England. The objectives of this board are:

- Achieve a 50% reduction in TB rates by 2018
- Provide strategic oversight and direction to the control, commissioning, quality assurance and performance management of TB services across London
- Promote service specific improvements and a whole systems approach that address TB incidence of TB

- Ensure pan-London resources targeted at TB are commissioned and utilised effectively, provide value for money and improve health outcomes

6.11 The London TB Control Board will provide future strategic direction for TB services across London and recommendations will need to be considered in the context of this development. We envisage that the TB JSNA will feed into this London wide process.

7. CONSULTATION

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

8. EQUALITY IMPLICATIONS

8.1. 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.

8.2. 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

8.3. 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.)

9. LEGAL IMPLICATIONS

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

9.2. 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).

10. FINANCIAL AND RESOURCES IMPLICATION

10.1. Dependent on the findings of individual JSNA reports

11. RISK MANAGEMENT

11.1. Dependent on the findings of individual JSNA reports

12. PROCUREMENT AND IT STRATEGY IMPLICATIONS

12.1. Dependent on the findings of individual JSNA reports

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.	TB JSNA draft version_3Dec13	Colin Brodie, Tel: 02076414632	Tri-Borough Public Health

Agenda Item 7

<table>
<tr><td> </td><td colspan="2">London Borough of Hammersmith & Fulham

HEALTH & WELLBEING BOARD
13 January 2014</td></tr>
<tr><td colspan="3">TITLE OF REPORT: Understanding the Mental Health Needs of Young People Involved in Gangs</td></tr>
<tr><td colspan="3">Report of Interim Director of Public Health
Author:
Dr Vaishnavee Madden, Academic Clinical Fellow in Public Health, Inner North West London Tri-borough Public Health Department
Contributors:
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1. EXECUTIVE SUMMARY

Street gangs and associated serious violence have been a growing concern in the UK over the past decade. They are concentrated in poor, urban areas with high crime rates and multiple social problems. The mental health needs of young people involved in gangs have until recently been overlooked. This report is an attempt to address this situation, and to provide recommendations for local commissioners.

2. RECOMMENDATIONS

2.1. The Committee is asked to review and comment on the report.

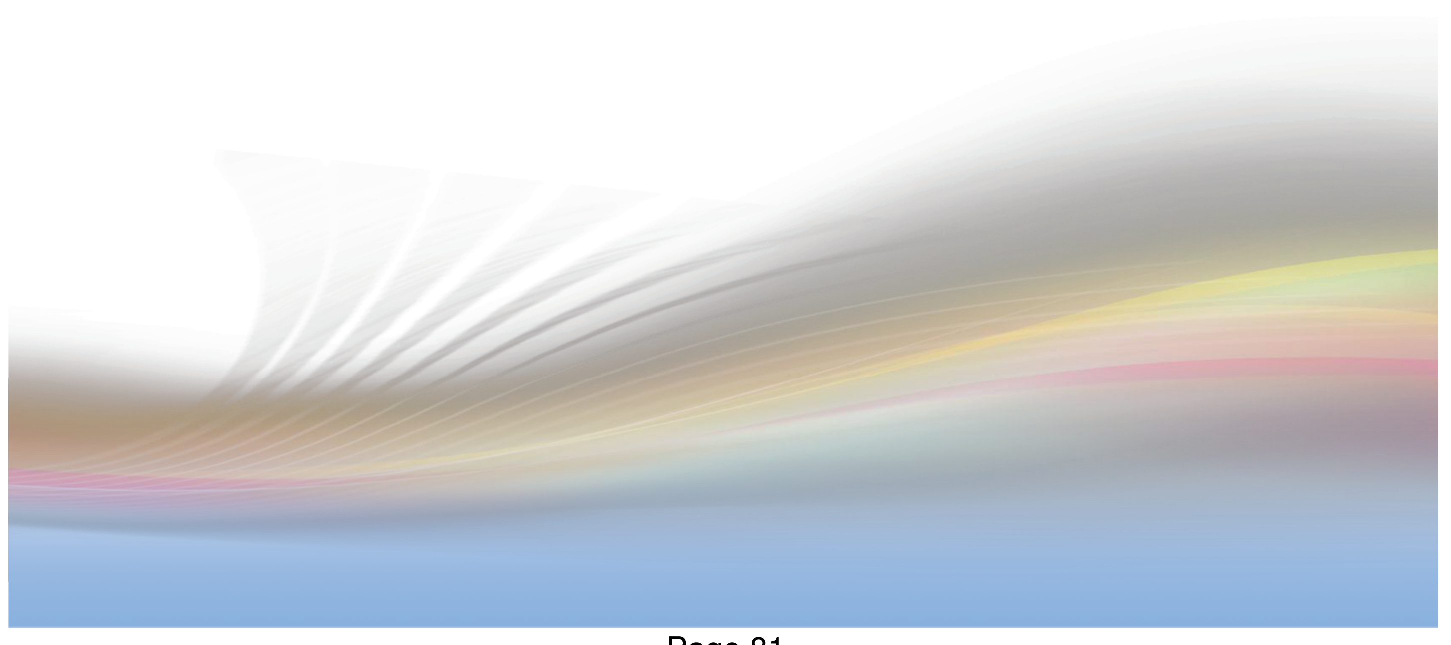
LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	Listed in report.		

Understanding the Mental Health Needs of Young People involved in Gangs

A Tri-borough Public Health Report produced on behalf of the Westminster Joint Health and Wellbeing Board

August 2013



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"Most mental illness begins before adulthood and often continues through life. Improving mental health early in life will reduce inequalities, improve physical health, reduce health-risk behaviour and increase life expectancy, economic productivity, social functioning and quality of life. The benefits of protecting and promoting mental health are felt across generations and accrue over many years."

- No health without public mental health[1]

Executive Summary

Street gangs and associated serious violence have been a growing concern in the UK over the past decade. They are concentrated in poor, urban areas with high crime rates and multiple social problems. The mental health needs of young people involved in gangs have until recently been overlooked. This report is an attempt to address this situation, and to provide recommendations for local commissioners.

The problem

Young people involved in gangs have much higher rates of a broad range of mental health problems. These higher rates (compared to both the general and young offender populations) include:

- Conduct disorder (in children and adolescents) and antisocial personality disorder in young adults, possibly due to common risk factors for gang membership and conduct disorder
- Anxiety disorders, possibly due to fear of violent victimisation
- Psychosis, possibly due to high cannabis use
- Suicide attempts, possibly due to impulsive violent acts directed inwardly

In addition, young people involved in gangs have higher rates of drug and alcohol misuse.

Box 1: Prevalence of mental health problems in young gang members

In a sample of 100 young gang members, it could be expected that:

- 86 will have conduct problems (<18 years) or antisocial personality disorder (18+ years)
- 67 will have alcohol dependence
- 59 will have anxiety disorders (including post traumatic stress disorder)
- 57 will have drug dependence (mainly cannabis)
- 34 will have attempted suicide
- 25 will have psychosis
- 20 will have depression

Possible solutions

Psychological interventions primarily aim to improve mental health. Many interventions also have the added benefit of reducing re-offending, an important 'wider determinant' of health. There have been virtually no studies on psychological interventions delivered specifically to gang members. As a result, this report draws on the evidence base of psychological interventions delivered to the general population and young offenders in order to improve mental health as well as reduce re-offending.

There is strong evidence of the importance of the relationship with the person providing care (therapist/social worker/key worker). A qualitative study of vulnerable young people in London demonstrated how they valued the role of a key worker in less formal settings, and had not found formal psychotherapy with scheduled appointments helpful.

Where mental health problems require specialist input, there are evidence-based interventions for the treatment of mental health problems in children, adolescents and young adults. These fall into

two major categories: cognitive behavioural interventions and systemic interventions. Cognitive behavioural therapy (CBT) is delivered to individuals or groups, and aims to re-evaluated patterns of thinking and behaving that are considered distressing or unhelpful. Systemic interventions, including family therapy and multi-systemic therapy (MST), are based on socio-ecological theories of human development, and aim to change dysfunctional social environments, including family, school and neighbourhood influences. These two categories of intervention are also effective in reducing reoffending.

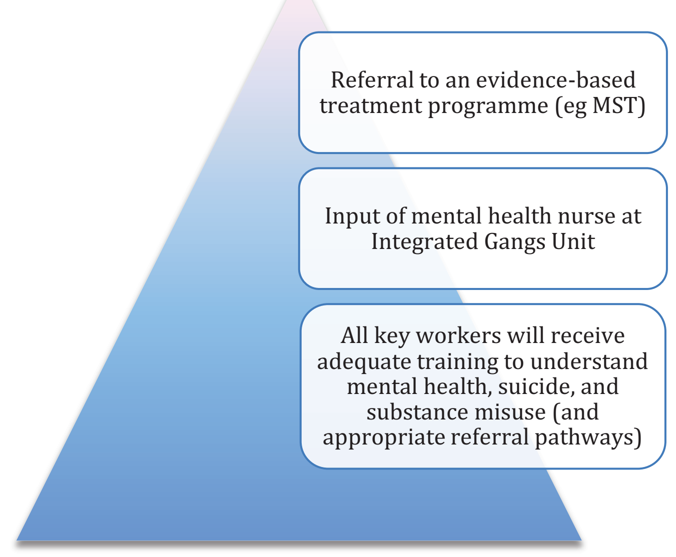
Recommendations

This report has demonstrated extremely high levels of mental health need in young people involved in gangs. Although some of the recommendations are specific to Westminster's Integrated Gangs Unit, they can also be applied across the tri-borough, as part of local young offending teams. A 'ladder of intervention' (Figure 1) is recommended, so that all young gang members who are engaged with tri-borough services, have some level of benefit. The main recommendations are:

- To increase the mental health literacy and skills of key workers working with young people involved in gangs, thus supporting their essential therapeutic role
    - By commissioning a 5 day mental health awareness training course for all key workers who work with young gang members
    - By ensuring that all key workers working with young gang members attend the 3 day tri-borough drug and alcohol awareness training
- To maintain links with local NHS mental health services
    - By commissioning ongoing input of a psychiatrist and mental health nurse into Westminster's Integrated Gangs Unit
- To increase access to multisystemic therapy for young people in gangs
    - By expanding the current tri-borough MST pilot to prioritise gang members (12-17 years, with conduct disorder and a history of offending)

All these recommendations should be fully evaluated when implemented.

Figure 1: Intervention ladder to tackle the mental health needs of young people involved in gangs in Westminster



1 Introduction

1.1 Background

Gangs are defined as 'a relatively durable, predominantly street-based group of young people who see themselves (and are recognised by others) as a discernible group for whom crime and violence is intrinsic to identity and practice'.[2] Street gangs and associated serious violence have been a growing concern in the UK over the past decade, and are concentrated in poor, urban areas, with high crime rates and multiple social problems.[3] It has been reported that almost 50% of shootings and 22% of serious violence in London is committed by known gang members.[3]

It is estimated that around 6% of young people (10-19 years) belong to a gang in the UK.[4] This figure may be higher in certain deprived areas, and peaks at around 15 years.[4] A recent survey of young men (18-34 years) in Hackney, found that 8.6% reported gang membership.[5] Predictors of gang membership include antisocial influences in the community (such as neighbourhood young offending), antisocial influences in the family (such as a sibling involvement in antisocial behaviour) and amongst peers, educational underachievement and early initiation of problem behaviour. These negative exposures act cumulatively, with the greater number of negative influences that a child is exposed to, the greater the likelihood of joining a gang.[6]

People join gangs for many reasons, not least to fulfil the 'universal needs among young people for status, identity and companionship'.[7,8] There is some evidence to suggest that low self-esteem has a significant relationship with the characteristic features of gang membership: aggression, antisocial and offending behaviour.[9] Other important psychological motivations contributing to gang membership include the need for money, protection against victimisation, connectedness to others in the gang, the need for status and respect, and excitement.[10]

This report has been produced by the Public Health Department in Inner North West London, in response to concerns about levels of gang-related serious youth violence in Westminster. The 'Your Choice' Programme was established in 2011 to tackle this issue in the borough for young people aged 10-24 years, and involves prevention, identification, diversion and enforcement strands.[11] A central feature of the programme is the Westminster Integrated Gangs Unit, which employs community outreach workers to work intensively with young people identified as at risk of or involved with gangs. A recent independent peer review of the programme assessed 'Your Choice' to be 'an excellent programme of work', but noted the lack of health sector involvement, particularly the lack of mental health interventions.

1.2 Aims

The main objectives of this report are to answer the following questions:

- What is the prevalence of mental health problems in young people involved in gangs?
- How does this differ to the prevalence of mental health problems in the general population of children, adolescents and young adults in the UK?
- Is substance misuse (drug and alcohol) associated with gang membership?
- Are there effective psychological interventions to tackle the mental health problems in young people involved in gangs?
- What are the recommendations to local commissioners?

The key audience for this report is commissioners of services for young people involved in gangs (primarily for Westminster, but can be applied across the tri-borough). This includes the local council, local clinical commissioning groups, and other sources of funding, such as the Home Office. It will be used in conjunction with findings from a 3 month pilot in Westminster Integrated Gangs Unit (June-September 2013). In this pilot, a community psychiatric nurse based at the Unit works with young people to conduct mental health assessments, in order to determine the mental health needs of this cohort.

1.3 Methods

In order to answer the main research questions, a formal review of the published literature was undertaken using the main medical, psychological and social care databases. In addition, an internet search yielded much of the 'grey literature' (non-peer-reviewed), including key policy documents and research reports. Where necessary, people involved in this area of work were consulted for further information.

1.4 Report structure

The results are outlined in Section 2 ('The Problem') and Section 3 ('Possible Solutions'). A discussion of the findings, including strengths and limitations of the report is given in Section 4. Recommendations for local commissioners are made in Section 5.

1.5 Mental health definitions

Mental health definitions are provided in Appendix 1.

2 The problem:

2.1 Increased prevalence of mental health problems among young people involved in gangs

Six studies were identified that all demonstrate **increased rates of mental health problems amongst gang members**. These rates are higher than both the general population and the young offender population. The first study is based on young men (aged 18-34 years) and demonstrates significantly increased rates of mental health problems across many psychiatric diagnoses.[5] The other five studies are based on a younger cohort (10-19 years) and confirm increased rates of mental health problems amongst gang members.[12,13,14,15,16] across all three major categories of mental health problems in children and adolescents:

- Emotional problems (including anxiety and depression)
- Conduct problems (including aggressive and antisocial behaviour)
- Hyperactivity problems (including inattention and impulsiveness)

The background prevalence of mental health problems among the general population of children, young people (5-16 years) and adults in the UK, and the prevalence in the young offending population, should be noted for comparison (table 1).

Table: 1 Prevalence of mental health problems among children and young people, adults and young offenders in UK community samples

Diagnosis	**Prevalence among children and young people (5-16 years)**[17]	**Prevalence among adults (18+ years)** [18]	**Prevalence among young offenders (11-15 years)**[19]
Conduct disorder	5.8%		
Antisocial personality disorder		0.3% (1.7% in 18-34 years)	
Anxiety disorders	3.3%	14% (9% mixed anxiety and depression, 5% generalised anxiety disorder)	10%
Depression	0.9%	2%	18%
Post Traumatic Stress Disorder	0.2%	3%	9%
Hyperkinetic disorders	1.5%	2.9% had 5 or 6 symptoms of Attention Deficit Hyperactivity Disorder	7% with hyperactivity
Suicide attempts		5.6%	9% history of self harm
Psychosis		0.4%	5%
Alcohol dependence		5.9%	11%
Drug dependence		3.4%	20%

Study 1 (Coid, 2013)[5]

The largest study was a cross-sectional survey administered to a nationally representative sample of 4664 young men (aged 18-34 years) in the UK. The survey also oversampled men from areas with high levels of gang-related violence, such as Glasgow and Hackney in London. Participants were asked about gang violence, attitudes towards and experience of violence, and use of mental health services. Psychiatric diagnoses were measured using standardized screening instruments.

The survey categorised men into three groups: gang members, violent men (not in a gang) and non-violent men.

Compared to non-violent men, gang members had increased rates of:

- **Antisocial personality disorder (57 times higher)**
- **Suicide attempts (13 times higher)**
- **Psychosis (4 times higher)**
- **Anxiety disorder (2 times higher)**

Table: 2 Prevalence and adjusted odds ratios of mental health problems in gang members (n=108)

Diagnosis	Prevalence in gang members (%)	Adjusted Odds Ratio (how much higher the rate is in gang members compared to non violent men)
Antisocial personality disorder	86	57 (Confidence Interval 24,138)
Suicide attempts	34	13 (CI 8,22)
Psychosis	25	4 (CI 2,13)
Anxiety disorder	59	2 (CI 1,5)

The only psychiatric diagnosis that had lower rates amongst gang members, compared to non violent men, was depression (when adjusted for confounding factors).

Table 3: Prevalence and adjusted odds ratios of depression in gang members (n=108)

Diagnosis	Prevalence in gang members (%)	Adjusted Odds Ratio
Depression	20	0.18 (CI 0.05, 0.63)

The study also found that **gang members were significantly more likely than non-violent men to have utilised mental health services**, with gang members being:

- 8 times more likely to have consulted a psychiatrist or psychologist
- 8 times more likely to have been admitted as a mental health inpatient
- 5 times more likely to have used psychotropic medication

The study found that **gang members' attitudes and experience of violence were significantly different to non-violent men**, with gang members being:

- 68 times more likely to be violent if disrespected
- 62 times more likely to have violent ruminations
- 10 times more likely to experience violent victimization.
- 9 times more likely to fear violent victimization

Study 2 (Padmore, 2013)[12]

This UK study is based on data yet to be published (Padmore, 2013). It is also a cross-sectional survey, but of a younger age group (11-17 year olds) from two inner city secondary schools and one young offenders' institution. It found that gang members:

- were **significantly more hyperactive and inattentive** than both non-gang offenders and the general population.
- were **significantly more likely to report frequent serious offences** than any other group.

- had **significantly more emotional problems** than the general population.

Study 3 (Centre for Mental Health, 2013)[13]
This UK report is based on an analysis of data collected for more than 8000 young people (10-18 years) from 37 youth point of arrest health screening initiatives in England in 2011-12. It found that, of the sample of girls involved in gangs:

- 26% were identified as having a suspected diagnosable mental health problem
- 30% were identified as self-harming or at risk of suicide
- 40% showed signs of behavioural problems before the age of 12 years.

In addition, compared to other women in the sample, young women linked to gangs were:

- **3 times more likely to be identified with signs of early persistent conduct problems**
- **5 times more likely to be involved in sexually risky or harmful behaviour**. The report identified these behaviours to include sexual activity as a gateway or initiation into gangs, sexual activity with multiple partners, regular exposure to sexually degrading experiences, young women feeling under threat to comply with sexual demands from male gang members and rape. Such experiences will have an impact on mental health.
- **2 times more likely to use violence**

Study 4 (Corcoran, 2005)[14]
A US study of 83 young people (aged 13-19 years) in prison, found that compared to non-gang members, gang members had:

- **significantly more mental health symptoms** (including anxiety, suicidal attempts and thought problems)
- **significantly more 'external' behaviour problems** (such as offending behaviour and self-destructiveness)

Study 5 (Macdaniel, 2011)[15]
Another US study used data from the 2004 Youth Violence Survey of 4131 high school students (aged 12-16 years) found that gang membership was:

- **associated with depressed mood and suicidal ideation** (the only two mental health symptoms assessed in the survey).

Study 6 (Madan 2011)[16]
The final US survey of 589 young people using data from the 2004 Youth Violence Survey found that gang membership was:

- **associated with suicidal behaviour and offending behaviour**, but not with anxiety or depression.

Appendix 2 provides a more detailed description of these studies.

2.2 Increased prevalence of drug and alcohol misuse among young people involved in gangs

There are only two UK studies of drug/alcohol use among gang members.

Coid, 2013 [5]
The major UK study on the prevalence of mental health problems among gang members also assessed for alcohol and drug dependence. Compared to non-violent men, gang members had increased rates of:

- **Drug dependence (13 times higher)**
- **Alcohol dependence (6 times higher)**

Table 4: Prevalence and adjusted odds ratio (compared to non violent men) of drug and alcohol dependence in gang members

Diagnosis	Prevalence in gang members (%)	Adjusted Odds Ratio
Drug dependence	57	13 (CI 4,44)
Alcohol dependence	67	6 (CI 3,14)

The survey did not assess which drugs gang members were dependent on. However, a second older UK study assessed this.

Bennett and Holloway, 2004 [20]
This study used data from the New English and Welsh Arrestee Drug Abuse Monitoring (NEW-ADAM) programme. This programme collected a wide range of information on the criminal behaviour of 2725 eligible arrestees across 16 representative sites in England and Wales between 1999 and 2002. The results demonstrated that, compared to arrested non-gang members, arrested gang members were:

- **significantly more likely to have used cannabis** in the past 12 months
- **not significantly different with regards to drug dependency or expenditure** on drugs in the past week
- **significantly less likely to both use heroin and to report injecting a drug**
- **less likely (but not significantly) to have used crack and cocaine**

Most evidence regarding substance misuse among gang members comes from the USA, and shows mixed results.[21] Some studies suggest increased use of drugs and alcohol, particularly in association with frequent 'partying'[21] while others describe how gangs do not permit excessive drug use as their members will be unreliable in criminal activity.[22] The current literature search yielded 12 US studies investigating the issue of drug and alcohol misuse in the USA, and on the whole demonstrate increased drug use among gang members. Appendix 3 provides more a more detailed summary from these US studies.

2.3 Increased prevalence of learning disabilities among young gang members

Learning disabilities may be a contributing factor to poor educational attainment, gang membership, poor mental health and substance misuse. A learning disability is defined by three criteria: an IQ score of less than 70, significant difficulties with everyday tasks, and onset prior to

adulthood.[23] While there are no specific studies investigating the prevalence of learning disabilities in gang members, there are studies that suggest increased prevalence among young offenders. It is estimated that the prevalence of general learning disability in custody is 23-32% (compared to 2-4% in the general population) and specific learning difficulties such as dyslexia may be as high as 43-57% in young offenders (compared with around 10% of the general population).[23] In addition, young offenders also have poorer speech and language skills, compared to the general population.[23] It is likely that many young offenders with learning disability, particularly in the mild range of impairment, may go undiagnosed, due to the predominance of their challenging behaviour.

2.4 Stigma associated with mental health problems

Stigma is defined as a sign of disgrace or discredit, which sets a person apart from others.[24] Stigma is a major reason why people who would benefit from mental health services do not pursue or disengage from them.[25] A study of 472 secondary students in the UK showed that most of the vocabulary used to describe mental health problems was derogatory.[26] While there is no study investigating stigma of mental illness among gang members, it is likely that there will be reluctance to engage with 'mental health' services.

2.5 Possible explanations for the increased prevalence of mental health problems and substance misuse among young gang members

The high prevalence of mental health problems in young people involved in gangs is not surprising given the shared risk factors for gang membership and mental health problems.

Possible explanations for this increased prevalence of mental health problems amongst gang members include the following:

- Overlapping risk factors for gang membership and mental health problems (Box 2)
- Young people with mental health problems join gangs: 'the selection hypothesis'
- Gang membership facilitates mental health problems: 'facilitation hypothesis'
- 'Selection and facilitation' work interactivity: 'enhancement hypothesis.[27]

Box 2: Risk factors for mental health problems in childhood

- From low-income households
- From families where parents are unemployed
- From families where parents have low educational attainment
- Are looked after by the local authority
- Have disabilities (including learning disabilities)
- From black and other ethnic minority groups
- Are in the criminal justice system
- Have a parent with a mental health problem
- Are misusing substances
- Are refugees or asylum seekers
- Are being abused/history of abuse

Source: National Psychiatric Morbidity Survey [17]

Conduct disorder and antisocial personality disorder: The high prevalence of these mental health problems is not surprising given the common risk factors for gang membership and these mental health problems. Violence before age 15 years persisting into adulthood is a criterion for the diagnosis of antisocial personality disorder. [5] It is known that violence and offending behaviour escalate during gang membership.[28] It is also known that early behaviour problems are a significant risk factor for prolonged gang involvement.[29]

Anxiety disorders, post traumatic stress disorder (PTSD) and psychosis: Coid et al investigated whether the high rates of mental health problems amongst gang members were due to their attitudes and experiences of violence.[5] Only anxiety disorders and psychosis could be partly explained by these factors, including violent ruminative thinking, violent victimization and fear of further victimization. It should be noted that the symptoms of anxiety and occasionally psychotic symptoms can be associated with PTSD.[5] The study authors hypothesise that exposure to violence may contribute to the development of PTSD in gang members. This has been corroborated by other studies which demonstrate that exposure to community violence, especially by victimisation or witnessing violence, has been associated with post traumatic stress and internalising (e.g. anxiety) and externalising (e.g. aggression) problems in young people.[30]

Psychosis and drug dependence: The above literature suggests that gang members experience elevated rates of cannabis use and elevated rates of psychosis. The former may be due to links with the local drugs economy.[20] Although the evidence has not investigated whether high rates of cannabis use among gang members leads to the development of psychosis in gang members, it is known that cannabis is a risk factor for the development of psychosis.[31] Indeed Coid's study suggested that violent ruminative thinking, violent victimization and fear of violent victimization could only partly explain the high rates of psychosis among gang members, but this study did not investigate cannabis as a potential contributing factor to the development of psychosis. Anecdotal comments from Westminster's Integrated Gangs Unit outreach workers suggest high use of high potency cannabis ('skunk') among young gang members in the area. It is known that 'skunk' users have an even higher risk of psychosis than those smoking cannabis of lower strengths.[32]

ADHD symptoms and substance misuse: Padmore et al found higher rates of hyperactivity and inattention in young gang members.[12] There is evidence to suggest that young people with ADHD symptoms are more likely to misuse drugs.[33]

Attempted suicide: The high rates of suicide among gang members may partly reflect other psychiatric morbidity, such as anxiety disorders and psychosis. However, it can be hypothesised that impulsive acts of violence can be directed both outward and inward.[5]

Depression: A lower rate of depression among gang members was seen in the major study[5] (when adjusted for confounding factors) and corroborated in some,[16] but not all,[15] of the other studies. The authors hypothesise two possible explanations for this. Firstly, violence is a 'displacement activity' that enhances self-esteem in order to reduce the negative effects of damaging childhood (ie gang membership and its associated behaviours reduces depression). The second hypothesis is that depressed individuals are less likely to join a gang. Since these studies are all cross-sectional studies, we are unable to determine the sequence of events between depression and gang membership.

3 Possible solutions:

What are the effective interventions to tackle the mental health problems in young people involved in gangs?

This report focuses on psychological interventions that target the cognitive, emotional and behavioural problems experienced by young people involved in gangs. While the evidence base around effective non-psychological interventions to tackle gang-related crime (including educational, vocational skills training, diversion, enforcement, criminal justice and social inclusion interventions) is minimal,[34] there is **virtually no research around the delivery of psychological therapy to gang members**. Indeed, the literature review found only one such study, [35] which was small and of low methodological quality.

It should be noted that the **primary outcome for any psychological intervention, is improvement in mental health**. Most studies on psychological interventions delivered to young offenders, however, **use a reduction in re-offending or antisocial behaviour as the primary outcome**. Both these outcomes are useful for the purposes of this report. The Public Health Outcomes Framework 2013-16 prioritises the reduction in first time entrants to the youth justice system, reduction in violent crime and reduction in re-offending levels, since these are all wider determinants of health, with both individual and population health benefits.[36]

This section will include:

- the role of the therapeutic relationship
- the role of cognitive-behavioural therapies
- the role of systemic therapies
- the role of other promising psychological approaches.

3.1 The role of the therapeutic relationship with a key worker

3.1.1 What is a key worker?

In the context of working with young people involved with gangs, key workers/outreach workers provide support and assistance to their caseload of clients. This includes support to exit the gang and to stop offending behaviour, and also to promote positive activities such as education, employment and training. Key workers help young people link up with other services, and reduce the number of professionals that the young person and their family have to deal with. Key workers/outreach workers may have a background is youth work or social work, and may be from the communities being targeted.

3.1.2 The value of the therapeutic relationship

It has been suggested that the **quality of the interpersonal encounter with the client is the most significant element in determining effectiveness in therapy**.[37] This has been demonstrated by numerous studies, which show that the quality of the relationship between the therapist and client is a consistent and strong predictor of outcomes across various forms of psychotherapy.[38] This is also the case for a wide range of professionals whose primary work

involves relationships with people, including teachers and social workers. The 'person-centred approach' widely used in counselling values being genuine, empathetic and fostering 'unconditional positive regard' for the client.[37] Key working is also based on attachment theory – which conceptualises the propensity of humans to make strong affectional bonds to particular others and explains various forms of emotional distress.[39]

3.1.3 The value of therapeutic relationships in young people involved in gangs

This report describes the work of two community-based charities working with vulnerable and excluded young people in London, including those involved in gangs: Kids Company and Music and Change UK (MAC-UK) – see boxes 3 and 4. Central to both charities is the role of a key worker, particularly in working with young people in less formal settings. These charities take a holistic, community focused approach, and incorporate the provision of psychological therapy into a broader model of care. There is evidence that gang members hold more negative attitudes towards authority [40] and as such, these charities may be more appealing to vulnerable young people.

The Kids Company approach in particular is based on psychodynamic theory, including attachment theory. It is felt that due to traumatic experiences in early childhood, there is a need for young people to feel powerful and in control. As such, acknowledging the need for psychological help, and accessing such help in a formal therapy setting, is challenging for these young people.[41]

Qualitative research, in the form of 18 semi-structured interviews of young people and key workers from Kids Company, highlighted important themes of what they valued. Some key findings:[41]

- **Young people valued centres as a 'place to hang out'**. Such a view serves to reduce their sense of exposure and vulnerability that may arise when using more formal health and social care services. Furthermore, the physical environment is seen as the first, safe 'attachment' – the so-called 'brick mother'.
- The **attachment process occurs gradually**, with initial practical assistance provided by the key worker forming the basis for trust and further more emotional engagement.
- **Young people appreciated the key worker's use of humour, flexible availability (including during times of crisis) and flexible modes of delivery**, all of which help the young person to feel safe. Conducting so-called 'corridor therapy' – conversations whilst out walking or in less formal settings (such as cafes) were particularly valued. Such encounters may feel 'safer' as the young person can move away/leave if the conversation becomes too emotionally-charged. They are also not associated with traditional power dynamics that occur in the therapy room ('patient' vs 'therapist'/'expert').
- The **majority of young people interviewed in this study had not found formal counselling and psychotherapy helpful when it involved scheduled appointments**. According to mentalization theory,[42] such a setting may be too emotionally-charged for the young person, inhibiting their capacity to 'mentalize'[a]

[a] 'Mentalization' is a form of imaginative mental activity about others or oneself, whereby the person who 'mentalizes' perceives and interprets human behaviour in terms of intentional mental states (such as desires, feelings, beliefs, purposes, etc). In mentalization theory, a failure to mentalize may damage interpersonal relationships, and may result in damaging actions/behaviours, as these actions are rarely considered accurately in mental state terms.[42]

Box 3

'Kids Company'

Kids Company is a community based charity founded in 1996, aiming to provide practical, emotional and educational support to inner-city children and young people, who have been the victims of abuse and deprivation of various kinds. Many of these children have social, emotional and behavioural problems, and at the core of Kids Company is the provision of a loving, supportive environment. Most of the work is based on 'attachment theory' and the therapeutic relationship with a key worker is a central part of the work. The charity has expanded since its origins, and its services currently reach 36 000 and intensively support 18 000 children across sites in London.

Kids Company has 3 centres in London, providing a safe, caring, family environmental in which support is tailored to the needs of the individual child/young person, providing food, activities and education. There is also an 'outreach' component, whereby Kids Company staff and volunteers reach out to young people in local estates and in schools.

Kids Company collaborates with several academic research centres, including neuroscientists. Research has focused on demonstrating the structural and physiological anomalies associated with prolonged stress response/hyper-arousal in children – the so-called 'violence adapting syndrome' in response to a chronic adversity including violence, abuse and neglect.[43]

Box 4

'Music and Change UK (MAC-UK)'

MAC-UK is a community-based charity founded in 2008 that works to deliver mental health interventions to young people involved in antisocial and/or gang-related activity.[44] MAC-UK has developed a model called Integrate© with the aim of reaching out to excluded young people. This approach is being piloted by multi-agency teams on three sites in London. The aims of the Integrate model are reducing serious youth violence and re-offending, getting young people engaged in training, education and/or employment or getting them back into existing services.

At the centre of the Integrate model, is a multidisciplinary team of youth workers, gang specialists, social workers and clinical psychologists, who engage young people in a community to help them lead a range of activities such as cooking, football or making music. Co-production of services is key. The team also assists in gaining qualifications and training. As such, Integrate seeks to address some of the social inequalities that may contribute to engaging in offending and antisocial behaviour.

Another component is delivering 'street therapy', in places where these young people spend time (often in cafes or stairwells in estates). As the young people get to know the professionals during their activities, this is hoped to shift their opinions of them, in order to engage in psychological therapy (such as CBT or counselling techniques).

Preliminary evaluation from the first 2 years of the charity shows promising findings: high levels of engagement, including participation in activities and street therapy. Due to the small sample size, the impact of the MAC-UK on offending behaviour is not yet established. However the Mental Health Foundation is currently evaluating the impact of MAC-UK interventions.

In Westminster, as part of the council's 'Your Choice' programme to tackle serious youth violence, there are 4 key workers at Integrated Gangs Unit working with young men, each with a caseload of 10-15 young people. There is also a women's advocate working with girls affiliated with gangs (particularly those who have experienced sexual violence). Since it was established, there has been a 59% reduction in serious youth violence in Westminster (between 2011/12 and 2012/13). It is unknown to what extent the work of the Integrated Gangs Unit, and the key workers, are involved in this decline. An evaluation of the 'Your Choice' programme, is currently being undertaken.

3.2 Role of cognitive behavioural interventions

3.2.1 What is Cognitive Behavioural Therapy (CBT)?

Cognitive Behavioural Therapy (CBT) is a brief, problem-oriented therapy, **based on the idea that thoughts, emotions and behaviours are linked**.[45] CBT aims to re-evaluate particular thoughts and patterns of thinking and behaving that are considered distressing or unhelpful. It is one of the most extensively researched forms of psychotherapy.[46]

3.2.2 The use of CBT for mental health problems

CBT is effective for the treatment of several psychiatric disorders. As such NICE recommends CBT for the treatment of depression,[47] PTSD,[48] ADHD,[49] conduct disorder,[50] psychosis[51] and alcohol dependence[52] in children and adolescents and for depression,[53] anxiety disorders,[54] PTSD,[48] psychosis,[55] antisocial personality disorder[56] and alcohol dependence in adults.[52] The evidence (section 2.1) suggests that these mental health problems are experienced at higher levels in gang members. However, there are no studies on the use of CBT to treat these mental health problems among gang members specifically. A Cochrane systematic review and meta-analysis of data from randomised controlled trials of young offenders experiencing emotional problems demonstrated that group-based CBT was effective in treating 'internalizing' problems of depression, anxiety and self harm.[57]

3.2.3 The use of CBT in reducing re-offending in young offenders

There is evidence to suggest **maladaptive patterns of thinking among young people who offend**. These include poor choice of solutions to social dilemmas, inability to exert self control and poor long term planning.[58] A large UK-based cross sectional study demonstrated that self-control and morality were the two key individual factors associated with young offending.[59]
Research suggests there are certain patterns of thinking associated with gang membership, such as inability to refuse, a fatalistic view of the world and positive attitudes towards antisocial behaviour or gang membership.[58]

As described, CBT is based on the tenet that adapting patterns of thinking can impact on behaviour – including offending behaviour. There are several varieties of CBT for young offenders, most widely implemented as group therapy in detention, and targeting different aspects of cognition, emotion and behaviour.[60] These include:

- Anger management – addressing the ability to respond effectively to stressful situations
- Cognitive skills training – enhancing reasoning and decision-making skills in order to reduce impulsivity, increase the consideration of alternative solutions and influence an individual's choice of action
- Moral reasoning – enhance awareness of the moral implications of an individual's actions
- Social skills training – addresses interpersonal issues such as the ability to interpret and respond to the behaviour of others

The effectiveness of CBT has been demonstrated in several meta-analyses, which report a 20-30% reduction in re-offending rates.[60] It should be noted that the effectiveness is much greater in demonstration sites (49%), than in routine practice (11%) possibly due to higher quality implementation in the former. Other factors that influence the effectiveness of CBT include the type of offender (more effective for more frequent offenders) and intensity of treatment (more

effective if more hours per week). However, the duration of treatment and setting (detention vs community) does not influence effectiveness.[60]

There is only one study of the use of CBT among gang members.[35] This study found that treatment of 80 adult men in prison with high intensity CBT resulted in significantly lower re-offending rates in both gang and non gang members than their untreated matched controls. However, this study was of poor methodological quality and based in a detention setting (see appendix 4).

A community group-based CBT programme ('Reasoning and Rehabilitation 2', R&R2) is currently being evaluated in South London (Box 5).

Box 5

'The Star Project'

In 2013, an exploratory pilot project, coordinated by a South London Child and Adolescent Mental Health Service (CAMHS) team and run in 4 young offending services, 2 CAMHS teams and 2 schools in South London, was established in order to address the 'gap in current multi agency provision in relation to the strong association between mental health problems in young people who commit or are at risk of committing serious youth violence and young people involved in street gangs'.

In this pilot, young people with a history or at risk of committing serious youth violence, are involved in street gangs or have conduct disorder, are referred to the project for assessment and intervention. The young person then receives the 'Reasoning and Rehabilitation 2' intervention (R and R 2).[61] This programme is designed for groups of adolescents with conduct problems at home and/or school, ADHD symptoms, have poor behaviour control and exhibit disruptive behaviour.

R and R 2 provides neuro-cognitive skills training techniques to improve attentional control, memory, impulse control and to develop achievement strategies by teaching constructive planning and management techniques. The behavioural control and listening skills they acquire help the participants to focus on the exercises that have been designed to develop pro-social attitudes, skills and values.

The 15 session programme is manualised and highly structured. A variety of training techniques are used to engage the individual by incorporating games, individual and group exercises and role-playing, and includes out-of-class assignments. Sessions may be delivered once a week or more frequently. The programme can be delivered in schools, learning centres, counselling centres, social service agencies, and in probation, prison or hospital settings. A key component of the programme is the use of mentors to provide support in between sessions.

The impact of this intervention has not yet been evaluated.

3.3 The role of systemic interventions

3.3.1 What are systemic interventions?

While CBT focuses on changing dysfunctional patterns of thinking, **systemic therapy focuses on changing dysfunctional social environments, including family, school and neighbourhood influences**. Systemic therapy is linked to socio-ecological theories of human development,[62] which include the notion that individuals do not act in a social vacuum. Understanding relationships, interactions and dynamics of groups, is central to treatment. Problematic behaviour within the group/family is identified and addressed practically rather than analytically. The main types of systemic interventions are parent training, family therapy and multi-modal therapies (such as multisystemic therapy).

3.3.2 The use of systemic therapy for mental health problems

Systemic interventions are effective for the treatment of several mental health problems in children and adolescents. As such, NICE recommends systemic interventions for the treatment of child and adolescent depression (family therapy),[47] ADHD (parent training),[49] conduct disorder (parent training, brief strategic family therapy, functional family therapy, multisystemic therapy)[50] and alcohol dependence/harmful alcohol use (brief strategic family therapy, functional family therapy, multisystemic therapy).[52] These mental health problems are experienced at higher levels in gang members. However there are no studies on the use of systemic interventions to treat these mental health problems among gang members specifically. There is evidence of the effectiveness of systemic interventions (such as multisystemic therapy and functional family therapy) in reducing mental health symptoms in young offenders.[63]

3.3.3 The use of systemic therapy in reducing re-offending in young offenders

Research suggests the **importance of systemic factors, especially the role of parents, in influencing gang membership**. For example, in a longitudinal study of 300 13-18 year old students in the USA, it was found that parental factors – especially behavioural control and warmth – moderated the relationship between gang involvement and problem behaviour.[64]

Multisystemic Therapy (MST)

MST is an intensive, short-term, home based intervention for young people with social, emotional and behavioural problems and their families.[65] It was initially developed to prevent re-offending and out-of-home placements. After initial assessment by the MST therapist, a set of treatment goals are defined to address specific needs for the young person and their family, which also includes liaising with other social systems such as peers and schools. Treatment can incorporate elements of CBT, communication skills, parenting skills, family relations, peer relations and improving school performance. MST therapists are available to their clients 24 hours a day, 7 days a week during the duration of treatment.

The Allen 'Early intervention' review reports the **effectiveness of MST in in reducing re-offending (25-70%), reducing out-of-home placements (47-64%), improving family functioning and decreasing mental health problems.**[66] There is one published study from the UK reporting the effectiveness of MST (appendix 5)[63] and an ongoing multi-site RCT currently being conducted in the UK by the Brandon Centre. MST is believed to be cost-effective. The Allen report

suggests a benefit to cost ratio of 2.5 to 1.[66] A recent Tri-borough public health report reviewed interim findings from the Brandon Centre Trial of MST and identified a net cost saving from MST to the public purse of £2223 per family (over 3 years), based on reductions in offending.[67]

However it should be noted that there is some debate about the true effectiveness of MST,[68] with a Cochrane review using pooled analyses of data from studies of varying quality suggesting that MST is not significantly different to alternative services.[65] It is clear that effectiveness is much higher in demonstration sites, run by MST developers. [65] As such, NICE guidelines recommends high quality implementation/treatment fidelity.

Functional Family Therapy (FFT)

While MST is focused on the individual, family and wider environment (school, community), FFT focuses more on the immediate family environment and uses family resources to change patterns of antisocial behaviour. [69] It is structured intervention, that aims to enhance protective factors and reduce risk factors in the family. It has three phases: the first to motivate the family towards change, the second teaches the family how to change a specific problem identified in the first phase and the final phase helps the family to generalise their problem-solving skills.

FFT is recommended by NICE guidelines and in the Allen report for the treatment of children and young people (11-17 years) with severe conduct problems and/or a history of offending. [50,66] It is also recommended as an option for children and young people who misuse alcohol and have significant co-morbidities and/or limited social support.[52] There are no UK studies published to date, but there is an ongoing RCT in Brighton.

While MST and FFT are two evidence-based interventions that are effective in treating adolescents with conduct disorder, there have been no studies directly comparing their clinical and cost effectiveness.[50] However, a recent review conducted by the Inner North West London Tri-borough Public Health Team, concluded that **both MST and FFT are effective for the needs of vulnerable families, however MST has a more robust evidence base than FFT**. It also concluded that although both MST and FFT are cost-effective, **MST appears to have a greater benefit to cost ratio**.[67]

Other family interventions

In addition to MST and FFT, there are several family-based interventions that occur locally. The Troubled Families Programme and Westminster's Family Recovery Programme are such examples. Three outreach workers from the Family Recovery Programme work closely with the Integrated Gangs Unit and work intensively with gang involved families. A review of family interventions (delivered to disadvantaged families in English local authorities between 2007 and 2011) highlighted that these family interventions provided a successful outcome in 50-65% of the families for the following issues:[70]

- Poor parenting
- Relationship or family breakdown
- Involvement in crime or antisocial behaviour
- Drug or alcohol misuse
- Truancy, exclusion or bad behaviour in school

3.4 The role of other approaches

Three other promising psychological approaches will be briefly described. They do not have an evidence base applied to young people in gangs, but have a theoretical base.

1) **Adolescent Mentalization-Based Integrative Therapy (AMBIT):**
   AMBIT is a new approach to working with the most hard to reach adolescents with severe complex mental health needs[70] and is currently being used by several teams across the UK, including the Star Project in South London (Box 5). It has received promising initial feedback, although formal evaluation and trials have not yet been conducted. Central to AMBIT is the use of 'mentalization'- a form of imaginative mental activity about others or oneself, whereby the person who 'mentalizes' perceives and interprets human behaviour in terms of intentional mental states (such as desires, feelings, beliefs, purposes, etc).[42] In mentalization theory, a failure to mentalize may damage interpersonal relationships, and may result in damaging actions/behaviours, as these actions are rarely considered accurately in mental state terms. Conversely, being able to mentalize can improve interpersonal relationships and improve ability to regulate emotions. Since mentalization is 'relational' in nature, there is emphasis not only on the therapeutic relationship between worker and client, but also other relationships such as families and professional teams.[71]

2) **Motivational Interviewing:**
   Motivational Interviewing is a directive client-centred counselling style, which aims to encourage refection on the risks associated with harmful behaviours, in the context of personal values and goals.[72] It has also been described as 'a non-authoritive approach to helping people to free up their own motivations and resources'.[73] It was originally developed for problem drinkers, but can be used in other contexts, such as for drug dependency and perhaps even for gang membership, although the latter has not been formally researched. There is evidence of effectiveness for the delivery of Motivational Interviewing by youth workers in routine conditions.[74]

3) **Solution-focused approaches:**
   Solution-focused brief therapy is an approach based on solution-building rather than problem-solving. It explores current resources and future hopes, rather than present problems and past causes. It is typically conducted in three to five sessions, and utilises goal setting. Solution-focused brief therapy has proved to be effective across a range of problems and groups of people, although no specific study has been done on delivering solution-focused therapy to gang members.[75]

4 Discussion

4.1 Strengths of the report

The mental health needs of young people involved in gangs have until recently been overlooked. This report is an attempt to address this situation, in order to influence local commissioning of services to tackle these unmet needs. It is an example of how public health departments in local authorities can work with colleagues in other sectors (such as criminal justice), to effectively target those at greatest need, thus improving the health of the population and reducing health inequalities.

The results were based on a comprehensive search of the literature. This includes data from one of the largest studies investigating psychiatric morbidity among gang members, which is both recent and UK-based.[5] The findings were further shaped by discussions with a wide range of colleagues working in this field. These included key workers in Westminster Integrated Gangs Unit and their Manager, the CAMHS nurse and consultant psychiatrist involved in the 3 month pilot at the Unit, a senior staff member of Kids Company (box 3) and a consultant nurse involved in establishing the 'Star Project' (box 5).

4.2 Limitations of the report

There are several limitations of the report. Firstly, there are limitations of the evidence base. The prevalence data all come from cross-sectional studies, and so little is known about whether mental health problems are the cause or consequence of gang membership (or both). Further longitudinal studies are warranted. In addition, the large prevalence study used in the report is based on young adults (18-34 years). It is known that the peak age of gang membership is around 15 years.[4] It is unknown whether these older (perhaps more entrenched) gang members have a different mental health profile to younger gang members. The lack of evidence about psychological interventions delivered to gang members, therefore extrapolating from evidence of interventions delivered to young offenders, is another limitation of the evidence base.

The scope of this report was to investigate the mental health problems of young people involved in gangs and effective psychological interventions to tackle these problems. This excludes more upstream primary prevention measures, which are fundamental to tackle the interacting problems of mental health, substance misuse, youth offending and violence. Many key policy documents recommend adopting a 'life course' approach to preventing mental health problems,[76] preventing violence[3,77] and reducing health inequalities.[78] The importance of early years initiative such as the Family Nurse Partnership and parenting programmes, early identification of mental health problems in childhood and school based interventions, should all be acknowledged.

It is important to note that young gang members also have physical health needs that need to be tackled, but was beyond the scope of this report. Risky behaviours include unsafe sexual practices, smoking, poor diet and activity levels, and poor engagement with primary care (including inadequate childhood vaccinations).[79]

5 Recommendations

There are five main recommendations to tackle the unmet mental health needs of young people involved in gangs:

1) **To increase the mental health literacy and skills of key workers working with young people involved in gangs, thus supporting their essential therapeutic role**
2) **To maintain links with local NHS mental health services by regular input of a mental health nurse in the Integrated Gangs Unit**
3) **To fund MST specifically for young gang members and their families**
4) **To evaluate the above interventions**
5) **To conduct further research to address research gaps identified in this report**

1) **To increase the mental health literacy and skills of key workers:**

   Rationale:
   - This report demonstrates the high rates of mental health problems and substance misuse in young people involved in gangs.[5] It also highlights the therapeutic value of the relationship with a key worker.[41]
   - This key worker model is a resource that already exists in Westminster Integrated Gangs Unit, and needs to be built on. Currently, the 'flexible gang workers' only receive safeguarding training. The sexual health advocate at the Gangs Unit receives well structured training (funded by the Home Office and devised by 'Against Violence and Abuse' and 'Women and Girls Network') to understand the issues faced by young women involved in gang-related sexual violence. This includes modules on the impact of trauma and young women's coping strategies. The flexible gang workers need to receive similar training, on a par with best practice nationally.

   Specific recommendation: to commission a 5 day training course for all key workers working with young people in gangs
   - MAC-UK (box 4) offers a 5 day training course for staff working with excluded young people, including those involved in gangs, which is particularly relevant to increase awareness of mental health and psychological issues. This course tackles many of the issues and approaches mentioned in this report, including an overview of psychiatric diagnoses, suicide awareness, psychological motivations for gang membership, attachment theory, mentalization and motivational interviewing.[80]

   Specific recommendation: to ensure that all key workers working with young people involved in gangs attend the tri-borough drug and alcohol training days
   - The tri-borough substance misuse team is currently commissioning training for tri-borough council staff who work with people at risk of drug and alcohol problems. Up to 3 days of training are available (on drug awareness, alcohol awareness and brief intervention/motivational interviewing). These training days, delivered by Turning Point, are available several times a year. In addition a 2 hour bespoke training (delivered by Turning Point) can be delivered to the Gangs Unit, based on the specific needs of the Unit.
   - Once these 'fundamental' courses are delivered to the key workers, it may be beneficial for them to undergo further training, such as enhanced motivational interviewing training, to assist outreach workers to explore motivations for gang membership and may be used as a technique to help young people exit gangs.

Specific recommendation: key workers in the gangs unit should receive regular supervision from a CAMHS psychiatrist and mental health nurse

- Ongoing input of the psychiatrist and mental health nurse to the Integrated Gangs Unit would benefit the key workers, as supervision will increase their awareness of the mental health issues.

2) **To maintain links with local NHS mental health services (CAMHS)**

Rationale:

- This report demonstrates the high rates of mental health problems and substance misuse in young people involved in gangs. NICE guidelines make recommendations about how these problems should be tackled.
- In June-September 2013, a mental health nurse (with consultant psychiatrist supervision) has been based in the Integrated Gangs Unit, mainly conducting mental health assessments on young people involved in gangs, in order to identify unmet need.

Specific recommendation: ongoing input of the mental health nurse (with psychiatrist supervision) at the Integrated Gangs Unit

- The proposed model will have the nurse based part time at the Unit, conducting mental health assessments, including finding out about substance misuse and screening for learning difficulties. The nurse will also conduct basic interventions or refer on to more specialist services if required.
- The nurse and consultant will also provide supervision to key workers to increase their awareness of mental health problems.
- The nurse could additionally perform a health promotion function. As part of the 3 month pilot, the nurse reported how she built up relationships with young people by discussing physical health issues, such as smoking and sexual health, before asking questions about emotions. This approach may be necessary in order to deal with the stigma and reluctance of young people to discuss their 'mental' health problems.

3) **To commission an evidence-based treatment programme for young people (12-17 years) with conduct disorder/antisocial behaviour**

Rationale:

- This report has highlighted increased rates of conduct disorder and antisocial problems among gang members.[5,12]
- The report suggests that cognitive and systemic interventions are effective at reducing offending behaviour. However, due to the community and systemic nature of gang membership, and evidence of effectiveness (including cost-effectiveness) MST would be the recommended choice.

Specific recommendation: to commission additional places on the tri-borough MST pilot for young people involved in gangs, who fulfil criteria for MST, based on referrals from the gangs unit.

- Gang membership is currently a low priority for entry into this pilot, although some gang members may fit the other criteria for MST.
- Further funding should be sought to enable a certain number of young people from the Integrated Gangs Unit to received MST each year.
- The effectiveness of MST in gang members should be analysed as part of the tri-borough MST evaluation

Recommendations 1-3 are also depicted in figure 1 and table 5 below.

4) **To evaluate the above recommendations (key worker training, mental health input in Gangs Unit and MST delivered to gang members) when implemented**

5) **To conduct further research to address research gaps**

Rationale:

- This report has highlighted a number of research gaps, perhaps due to the difficulty in conducting research on gang members.
- Westminster's Integrated Gangs Unit is ideally placed to fill some of the research gaps.

Specific recommendations:

- Box 6 highlights possible future research questions to be conducting in Westminster Integrated Gangs Unit

Box 6: Potential research questions

Prevalence of mental health problems:

- What is the prevalence of suicide attempts among young gang members in the unit?
- What is the prevalence of PTSD in young gang members?
- What are the mental health needs of young women affiliated with gang members who have experienced sexual violence/abuse by gang members?

Longitudinal studies:

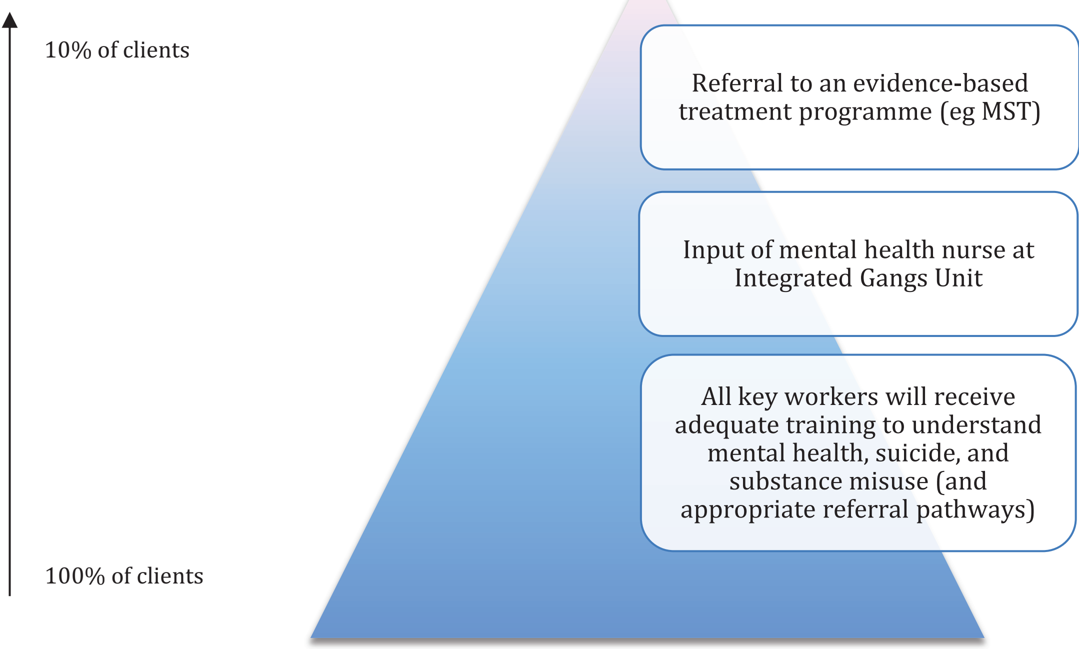
- Of those gang members who smoke cannabis (mild/moderate/heavy use), how many go on to develop psychosis?

Qualitative studies:

- What are the reasons for young gang members attempting suicide?

Figure 1: Intervention ladder to tackle the mental health needs of young people involved in gangs in Westminster

(Note: All young people at the Unit will benefit from key worker training, only few will be assessed by the mental health nurse and fewer still will be referred to a treatment programme such as MST)



Since tackling mental health problems in young gang members has a range of benefits, beyond health outcomes (particularly a reduction in re-offending), it is important that this is recognised when pooling together resources across departments and agencies (table 5).

Table 5: Recommendations and potential source of funding

Recommendations	**Potential funders**
1. To improve the mental health literacy and skills of key workers All key workers at the Integrated Gangs Unit (currently 5 workers) should attend a 5 day training course delivered by MAC-UK (costing £3600-£4000) All key workers at the Integrated Gangs Unit should attend all 3 days of the Tri-borough drug and alcohol awareness training, including training on brief intervention and motivational interviewing. The cost of the course is already covered by tri-borough substance misuse commissioners All key workers at the Integrated Gangs Unit should have regular supervision from a CAMHS psychiatrist and nurse (as part of their regular work in the unit)	Local authority Public health/Children's Services/Criminal Justice Substance Misuse commissioners (under Public Health directorate) CAMHS commissioners (Clinical Commissioning Groups, Commissioning Support Units)
2. **To maintain links with local NHS mental health services** A mental health nurse, with supervision from a psychiatrist, should be based (at least part-time) at the Integrated Gangs Unit in order to: • conduct mental health assessments on some of the young people in the Unit • deliver basic interventions to these young people, including psycho-education • refer on to secondary care services if required • provide advice and support to the key workers	CAMHS commissioners
3. Commission an evidence-based treatment programme for young people with conduct problems and a history of offending A number of gang members (12-17 years) with conduct problems and a history of offending, should receive Multisystemic therapy.	Home Office (eg Ending Gang and Youth Violence funding) Local authority departments CAMHS commissioners

Although the above recommendations are specific to Westminster (and its Integrated Gangs Unit), many of the **recommendations can be applied across the tri-borough**. For example, all youth workers who have regular contact with young people involved in gangs, should have their mental health literacy and skills increased by attending the training programme described above. In addition, local youth offending teams should have adequate mental health input, and should refer into the tri-borough MST pilot.

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Appendix 1: Mental health definitions for conditions prevalent in gang members

Anxiety disorders:

Generalised anxiety disorder is a common disorder and one of a range of anxiety disorders that includes panic disorder (with and without agoraphobia), post-traumatic stress disorder, obsessive–compulsive disorder, social phobia, specific phobias (for example, of spiders) and acute stress disorder. Anxiety disorders can exist in isolation but more commonly occur with other anxiety and depressive disorders. . The central feature of generalised anxiety disorder is excessive worry about a number of different events associated with heightened tension. Symptoms should be present for at least 6 months and should cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

Post-traumatic stress disorder (PTSD) develops following a stressful event or situation of an exceptionally threatening or catastrophic nature. Characteristic symptoms include re-experiencing symptoms (e.g. flashbacks), avoidance of reminder of the trauma and hyperarousal and hyper-vigilance for threat (e.g. exaggerated startle responses, irritability and difficulty concentrating) and emotional numbing.

Conduct disorders:

Conduct disorders are characterised by repeated and persistent misbehaviour much worse than would normally be expected in a child of that age. This may include stealing, fighting, vandalism and harming people or animals. These disorders are the most common reason for children to be referred to mental health services. Conduct disorders also often coexist with other mental health disorders, most commonly attention deficit hyperactivity disorder (ADHD).

Attention Deficit Hyperactivity Disorder (ADHD) of Hyperkinetic disorders:

ADHD is a heterogeneous behavioural syndrome characterised by the core symptoms of hyperactivity, impulsivity and inattention. While these symptoms tend to cluster together, some people are predominantly hyperactive and impulsive, while others are principally inattentive. Only those with significant impairment meet criteria for a diagnosis of ADHD.

Psychosis:

The term psychosis is used to describe a group of severe mental health disorders characterised by the presence of delusions and hallucinations that disrupt a person's perception, thoughts, emotions and behaviour. The main forms of psychosis are schizophrenia (including schizoaffective disorder, schizophreniform disorder and delusional disorder), bipolar disorder or other affective psychosis

Antisocial personality disorder:

People with antisocial personality disorder exhibit traits of impulsivity, high negative emotionality, low conscientiousness and associated behaviours including irresponsible and exploitative behaviour, recklessness and deceitfulness. This is manifest in unstable interpersonal relationships, disregard for the consequences of one's behaviour, a failure to learn from experience, egocentricity and a disregard for the feelings of others. The condition is associated with a wide range of interpersonal and social disturbance. Criminal behaviour is central to the diagnosis of antisocial personality disorder.

Alcohol or drug dependence:

This is characterised by craving, tolerance, a preoccupation with alcohol/drugs and continued drinking/drug-taking in spite of harmful consequences.

Harmful drinking:
A pattern of consumption causing health problems directly related to alcohol (including psychological problems such as depression, alcohol-related accidents or physical illness such as pancreatitis)

Alcohol misuse or substance misuse:
Often includes alcohol/drug dependence and harmful drinking/drug taking

Appendix 2: Studies that demonstrate the increased rates of mental health problems among gang members

Study description	Study results	Strengths and limitations
Coid et al (2013) This major UK study involved a cross-sectional survey of a nationally representative sample of 4664 young men (18-34 years), with oversampling of men from areas with high levels of gang-related violence. Participants completed questionnaires covering gang membership, violence, use of mental health services and psychiatric diagnoses measured using standardized screening instruments (Psychosis Screening Questionnaire, Personality Disorders Screening Questionnaire, Hospital Anxiety and Depression Scale, Alcohol Use Disorders Identification Test and Drug Use Disorders Identification Test).	Of the 4664 men sampled in the survey, 108 (2.1%) reported current gang membership. Gang membership was associated with increased psychiatric morbidity and substance misuse. Compared to non-gang members, gang members were 4 times more likely to experience psychosis, 2 times more likely to experience anxiety disorder, 6 times more likely to experience alcohol dependence, 13 times more likely to experience drug dependence, 57 times more likely to have antisocial personality disorder and 13 times more likely to have attempted to commit suicide. The study found that gang members had a much lower prevalence of depression than non violent men (OR 0.18, CI 1.05-0.83). In addition, gang members were much more likely than non-violent men to have utilised medical/psychiatric services. With regards to attitudes and experience of violence, gang members were 68 times more likely to be violent if disrespected, 62 times more likely to have violent ruminations, 9 times more likely to fear violent victimization and 10 times more likely to experience violent victimization. The study found that the high prevalence of anxiety disorders and psychosis among gang members may be due to violent ruminative thinking, violent victimization and fear of further victimization.	This is the largest study to investigate psychiatric morbidity among gang members. Its major strength is its large sample size of young men, chosen mainly by random location sampling. As such, it is a nationally representative sample. In addition, the additional over-sampling in areas of high levels of gang activity was useful to have an increased number of gang members in the sample. The survey uses reliable and validated screening instruments, that compare favourably with clinical interviews (the standard method used for diagnosis). Indeed, the 'baseline' prevalence figures of mental health problems among non-violent men in the sample, compares favourably with other community samples (McManus, 2007). There are some limitations with this study. The study investigates 'current gang membership' and not past membership. In addition, definitions of gang membership vary as gang structures have considerable heterogeneity. In addition, all the measures of gang membership, psychiatric morbidity and experience and attitudes to violence were all self-reported, and so may be under or over reported. As with all cross-sectional surveys, associations do not give further information about the temporal pattern of the association, so further longitudinal studies are warranted.

Padmore et al (2013): Unpublished data This yet to be published study involved a cross-sectional questionnaire survey of a sample of 506 young people from two inner city secondary schools (449) and a Young Offenders Institution (57) in the UK. The questionnaire utilises two instruments, the Eurogang Youth Survey (EYS) and the Strengths and Difficulties Questionnaire (SDQ).	Preliminary results indicate that gang members were significantly more hyperactive and inattentive than both non-gang offenders and the general population. These hyperactive and inattentive gang members were also more likely to report frequent serious offences than any other group. In addition, gang members had significantly more emotional problems than the general population. Non-gang offenders did not have a significantly different profile from the general population in this domain.	This is a very useful study for the purpose of this report, as it investigates the mental health needs of UK inner city gang members in the community and custody. It has a good sample size and uses reliable and valid measures. The results are consistent with the study by Corcoran et al (2005)[14], which showed that gang members exhibited more externalising behaviour problems (including delinquency and self-destructiveness) than non-gang offenders.
Corcoran et al (2005) This study compared gang members with non gang members from a sample of 73 young men (13 to 19 years) in prison. Mental health symptoms in the past 6 months, were identified using the Oregon Mental Health Referral Checklist. This instrument assesses 31 symptoms considered representative of the youth in the justice system, and has been shown to have good reliability and validity. Behaviour problems were also identified by the Child Behaviour Check List (CBCL), a widely used and well developed instrument.	The results suggest that gang members report significantly more mental health symptoms, more external behaviour problems (including delinquency and self-destructiveness) and thought problems, than non gang members. With regards to mental health symptoms, gang members were significantly more likely to report suicide attempts, desire to kill another, hallucinations, delusions or bizarre ideas, loss of reality/incoherence not due to drugs or alcohol, sexual acting out, repetitive thoughts or behaviours, to be withdrawn and to report more anxiety than non gang members.	This study is useful as it investigates mental health problems in the correct population (gang members). It demonstrates that gang members have greater mental health needs than young offenders generally, suggesting that any study of the mental health needs of young offenders is likely to be an underestimate. It also demonstrates the high rate of challenging/criminal behaviour, which may mask underlying mental health problems. It has a high response rate (86%) and uses valid and reliable measures. Limitations include the small sample size, the fact that these gang members are in custody (and so may not represent the mental health needs of gang members in the community). Also it is USA-based, and so may not be generalisable to UK gang members.
Macdaniel et al (2011) Macdaniel et al (2011) used data from the Youth Violence Survey conducted in 2004. This survey was administered to over 80% of eligible high school students (aged 12-16 years) – 4131 students in a high risk urban district in the USA.	Adjusting for all factors, gang membership was positively associated with depressed mood (OR 1.43, 95% CI 1.07 to 1.92) and suicidal ideation (OR 2.03, 95% CI 1.62 to 2.55) – the only two mental health problems assessed in the survey	This study's main strengths are the large sample size in a disadvantaged community and the relatively high response rate for the survey. However, there are a number of limitations, including generalisability for a UK context, its cross sectional nature, and the fact that a school based survey will exclude those gang members that do not attend school.
Madan et al (2011) The second study of mental health problems in gang members used data from the Birmingham Youth Violence Study (Mrug et al, 2008), which was conducted in an urban city in Alabama, USA in 2004-5.	The results suggest that 5% reported belonging to a gang, 11% reported suicidal behaviour, 72% reported any delinquent behaviour, and 33% witnessed community violence. Gang membership was positively	The report's authors acknowledged that the cross-sectional design was the major study limitation. As such, it is not possible to know the temporal relationship between gang membership, suicidal behaviour,

This study examined whether gang membership in early adolescence was associated with internalizing mental health problems (depression, anxiety and suicidal behaviour) and whether these associations were mediated by delinquency and witnessing community violence. Data was collected from all 589 participants that had valid data for all variables (out of 603 total participants), with a mean age of 13 years. Anxiety and depression were assessed using established instruments, such as the Revised Children's Manifest Anxiety Scale and the DISC Predictive Scales. Suicidal behaviour, delinquency and witnessing community violence was asked as a series of questions.	associated with suicidal behaviour, delinquency, and witnessing community violence, but not to anxiety or depression. In addition, delinquency and witnessing community violence were both positively related to suicidal behaviour. After adjusting for demographics, gang members were 3.4 times more likely to report suicidal behaviour than non-gang members. After adjusting for demographics, delinquency and exposure to violence, gang members were 2 times more likely to report suicidal behaviour than gang-members. Further test indicated that both mediated effects of gang membership on suicidal behaviour were significant.	delinquent behaviour or exposure to violence. For example, it is possible that those who engage in delinquent behaviour or are exposed to violence, or are more suicidal, are more likely to join gangs. In addition, the small number of youth to report gang membership (31) may have reduced the power of the study to detect a true effect. It is also possible that factors not measured in this study (such as death of friends, hopelessness, weak parental bonds) may also explain the association of suicidal behaviour and gang membership. Another possible mediator between gang membership and suicidal behaviour is PTSD symptoms (since exposure to community violence is associated with increased symptoms of PTSD).

Appendix 3: Studies that demonstrate increased rates of substance misuse in gang members

Study description	Study results	Strengths and limitations
Bennett and Holloway, 2004 This study used data from the New English and Welsh Arrestee Drug Abuse Monitoring (NEW-ADAM) programme. This programme collected a wide range of information on the criminal behaviour of all 2725 eligible arrestees across 16 representative sites in England and Wales between 1999 and 2002. The criteria for ineligibility were aged under 17 years, unfit for interview, unable to comprehend or provide informed consent or a potential danger to the interviewer.	The prevalence of gang membership amongst arrestees was 4% (CI 3, 5) for current gang members and 11% (CI 6.7, 15.3) for ex-gang members. Current gang members were significantly more likely than non gang members to have used cannabis in the past 12 months ($p<0.01$). However, there was no significant difference between gang members and non-gang members with regards to drug dependency or expenditure on drugs in the past week. Indeed, gang members were significantly less likely than non-gang members to both use heroin and to report injecting a drug. They were also less likely (but not significantly) to have used crack and cocaine.	This is very useful data from a UK context, from multiple sites across the country. It shows that gang members were more likely to use cannabis than non-gang offenders, but less likely to use more 'hard' street drugs. A limitation is that the data is over a decade old, and so more recent studies investigating drug use amongst gang members are warranted.

Study description	Study results
De et al (2006) conducted 76 interviews on Latino gang members.	The results indicate that age at the time of interview and lower age of drug onset were associated with a greater number of drug use transitions. Positive family attitudes towards deviance, friend drug use, school truancy, conflict with parents and living in high-crime neighbourhoods, were also found to be associated with increased drug use transitions.

De at al (2005) conducted a retrospective ethnographic study of 76 Latino gang members, who joined gangs when they were younger.	The study found that the average age of onset of drug abuse behaviour was 11.2, which led to a rapid progression to more dangerous drugs, within 6 years.
Facundo et al (2008) conducted a study of 175 young gang members in Mexico.	The results found a significant effect of personal factors on drug use, including gender, age, mental problems, relationship with friends who have maladaptive behaviours and inappropriate relationships with parents.
Gatti et al (2005) conducted one of the few longitudinal studies of gang membership, delinquent behaviour and drug use. The sample initially consisted of 1161 boys in kindergarten classes in deprived areas of Montreal in 1984. Annual evaluations were then undertaken, starting at age 10 (reports made by parents, teachers, classmates and the children themselves). Data was available for 756 participants (aged 10 to 16 years). Questionnaires asked for gang membership, in addition to delinquent behaviour and drug use. Data for confounding factors were also collected (demographic information, disruptive behaviour, delinquency, parental supervision, friends' deviancy and school difficulties).	The study found that gang members displayed far higher rates of delinquent behaviour and drug use than non-gang members. This includes a higher level of involvement in drug sales amongst stable gang members than non gang members. In terms of drug use, the frequency of drug use increases over time for all groups. Transient drug members display an increased frequency of drug use when they join the gang, but no significant decrease when they leave.
Harper et al (2008) interviewed 69 homeless African American young men	The study found that gang members had more frequent lifetime alcohol and marijuana use, compared to non-gang members.
Lanier et al (2010) conducted focus groups and interviews on African American male gang members in prison to identify differences in rates of illicit substance misuse between gang and non-gang members.	The study found that for each illicit substance, use was higher among gang members, whether former or current.
MacKenzie et al (2005) drew data from a larger qualitative study of 383 male street gang members in San Francisco.	The study found the integration and normalization of recreational drug use (specifically marijuana) within their day-to-day activities and cultural practices.
McCoy et al (2010) examined alcohol and marijuana use among 410 Latino adolescents (14-19 years) in San Francisco.	Frequent use of both alcohol and marijuana was associated with being male, sexually active, 'gang exposed' and to have less parental monitoring.
Mouttapa et al (2010) conducted a survey on 91 male young offenders in probation camps in California.	The study found that gang membership was associated with heavy alcohol use in the past 30 days prior to incarceration.
Sanders et al (2010) interviewed 60 young gang members in Los Angeles.	One finding described mixing together of substances, particularly cannabis and alcohol, as well as the use of prescription medication, such as codeine.
Swahn et al (2010) used data from the Youth Violence Survey conducted in 2004. This survey was administered to over 80% of eligible high school students (aged 12-16 years) – 4141 students in a high risk urban district in the USA.	The results demonstrate 8% of students report gang membership. Students who initiated alcohol before 13 years (OR=4.90, 95% CI:3.65-3.58), who drank alcohol 3 or more times per week (OR=9.57, 95% CI:6.09-15.03) and who used drugs 3 or more times per week (OR=6.51. 95% CI 4.59-9.25) were more likely to report gang membership than students who did not report alcohol or drug use.
Macdaniel et al (2011) also used data from the Youth Violence Survey (on 4131 school children aged 12-16 years in a disadvantaged community).	Adjusting for all factors, gang membership was associated with frequent alcohol use (OR 2.62, 95% ci 1.85 to 3.72) and frequent drug use (OR 1.95, 95% CI 1.15 to 3.29).

Appendix 4: Study of CBT in gang members

Study description	Study results	Strengths and limitations
Di Placido et al (2006) This study investigated the use of CBT to 80 male offenders (40 gang members and 40 non gang members) in prison (compared with 80 untreated controls). Treated' offenders were those who received one of three treatment programmes: 'Aggressive Behavioural Control' (form of CBT), Clearwater Sex Offender programme (form of CBT) or Psychiatric Rehabilitation for those with a major psychiatric illness (psychotropic medication, group and individual therapy, occupational therapy).	Treatment of men in prison with high intensity CBT resulted in a significantly lower reoffending rates in both gang and non gang members than their untreated matched controls.	This is the only controlled intervention study investigating the effectiveness of psychological therapy for gang members. However, the sample size is small and it is not randomised. In addition, the study looked at adults (not young offenders) in prison (not the community). Also, the main aim was to investigate 'treatment' vs 'no treatment', although treatment modalities were different.

Appendix 5: Study of MST in UK

Study description	Study results	Strengths and limitations
Butler et al (2011) In this study, 108 families were randomised to either MST or comprehensive and targeted usual services delivered by youth offending teams.	The study found that although young people receiving both MST and YOT interventions showed a reduction in re-offending, MST had several further advantages. Those who received MST had: • Significantly reduced likelihood of non-violent offending during an 18 month follow up • Greater reductions in youth-reported delinquency • Greater reductions in parental reports of aggressive and delinquent behaviour	This randomised control trial is the only UK study to date demonstrating the effectiveness of MST (compared to current services). It should be noted that the lack of difference in rates of violent offending, should be considered in the context of the low rate of violent offending at randomisation, as well as the modest sample size.

Agenda Item 8

<table>
<tr><td> </td><td colspan="2">London Borough of Hammersmith & Fulham

HEALTH & WELLBEING BOARD

13 January 2014</td></tr>
<tr><td colspan="3">WORK PROGRAMME AND FORWARD PLAN 2013-2014</td></tr>
<tr><td colspan="3">Report of the Director of Law</td></tr>
<tr><td colspan="3">Open Report</td></tr>
<tr><td colspan="3">Classification - For Scrutiny Review & Comment

Key Decision: No</td></tr>
<tr><td colspan="3">Wards Affected: All</td></tr>
<tr><td colspan="3">Accountable Executive Director: Jane West, Executive Director of Finance and Corporate Governance</td></tr>
<tr><td colspan="2">Report Author: Sue Perrin, Committee Co-ordinator</td><td>Contact Details:
Tel: 020 8753 2094
E-mail:
sue.perrin@lbhf.gov.uk</td></tr>
</table>

1. EXECUTIVE SUMMARY

1.1 The Committee is asked to give consideration to its work programme for this municipal year, as set out in Appendix 1 of the report.

2. RECOMMENDATIONS

2.1 The Committee is asked to consider and agree its proposed work programme, subject to update at subsequent meetings of the Committee.

3. INTRODUCTION AND BACKGROUND

3.1 The purpose of this report is to enable the Committee to determine its work programme for this municipal year 2013/14.

4. PROPOSAL AND ISSUES

4.1 A draft work programme is set out at Appendix 1, which has been drawn up in consultation with the Chairman, having regard to actions and

suggestions arising from previous meetings of the Shadow Health & Wellbeing Board.

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

5. OPTIONS AND ANALYSIS OF OPTIONS

5.1. As set out above.

6. CONSULTATION

6.1. Not applicable.

7. EQUALITY IMPLICATIONS

7.1. Not applicable.

8. LEGAL IMPLICATIONS

8.1. Not applicable.

9. FINANCIAL AND RESOURCES IMPLICATIONS

9.1. Not applicable.

10. RISK MANAGEMENT

10.1. Not applicable.

11. PROCUREMENT AND IT STRATEGY IMPLICATIONS

11.1. Not applicable.

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.	None		

LIST OF APPENDICES:

Appendix 1 - List of work programme items

Appendix 1

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	
Community Strategy H&F CCG Commissioning Intentions 2014/15 Integration Transformation Fund Update Joint Health & Well-being Strategy Update Keep Smiling Outreach Pilot in White City Update Public Health JSNA Update	
Meeting Date: 13 January 2014	
Joint Health & Wellbeing Strategy: Update Better Care Fund Plan 2014/2016 JSNA Update Understanding the Mental Health Needs of Young People Involved in Gangs	
Meeting Date: 24 March 2014	***Report Deadline: 7 March 2014***
Evaluation of home fire safety visits to adult social care service: Presentation	LFB Borough Commander, Jane Philpott
H&F Commissioning Intentions: 2015/2016 Process	Tim Spicer/Philippa Jones
Housing (including Sheltered Housing) for People with Learning Disabilities and for Older People, and Specifically Better Use of Existing Stock	Martin Waddington

Agenda Item	Report Sponsor/Author
Better Care Fund Plan 2014/2016	Cath Attlee
Child Poverty JSNA	Anna Waterman
Joint Health & Wellbeing Strategy: Final Agreement	David Evans
Annual Review of Health & Wellbeing Board	Cllr Marcus Ginn
Pharmaceutical Needs Assessment Delivery	Public Health
Public Health in Hammersmith & Fulham: Mid year progress, issues and how the HWB can support the next steps.	Public Health
2014/2015	
North West London: Pioneer Site Update Vulnerable Children and Adults: Support Provided	