London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Agenda

Monday 24 March 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
Liz Bruce, Tri-borough Director of Adult Social Care
Andrew Christie, Tri-borough Director of Children's Services
Philippa Jones, Managing Director, H&F CCG
Dr Susan McGoldrick, Vice-Chair, H&F, CCG
Trish Pashley, Local Healthwatch representative
Meradin Peachey, Tri-borough Director of Public Health

CONTACT OFFICER: Sue Perrin
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http://www.lbhf.gov.uk/Directory/Council_and_Democracy

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Date Issued: 14 March 2014

London Borough of Hammersmith & Fulham

Health & Wellbeing Board
Agenda

24 March 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 13 January 2014.

(b) To note that the Council has approved the recommendation of the Health & Wellbeing Board (HWB) 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.

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. HOME FIRE SAFETY VISITS TO ADULT SOCIAL CARE SERVICES

Station Manager, Steve Cunningham will present an evaluation of the Home Fire Safety Visits to Adult Social Care Services.

5. BETTER CARE FUND 2014/2016: FINAL PLAN SUBMISSION 8 - 61

This report contains the “near-final” version of the Better Care Fund Plan for sign off by the Health and Wellbeing Board.

6. STRATEGIC & OPERATIONAL PLANNING PROCESS & PROPOSED SUBMISSION 2014/2015 - 2018/19 62 - 72

As part of the NHS England planning cycle, Clinical Commissioning Groups are required to submit improvement trajectories for a range of indicators. This paper outlines the indicators in question and NHS Hammersmith & Fulham CCG’s approach to setting improvement trajectories.

7. JOINT HEALTH & WELLBEING STRATEGY: FINAL AGREEMENT 73 - 97

The HWB agreed that a revised draft of the Health & Well-being Strategy, setting out what success in 2016 would look like and how success would be measured, would be brought back to the Board for sign off. The existing high level vision and intent remains, as does the agreed priorities but they are now supported by clear actions.

8. WORK PROGRAMME

The Board is requested to suggest topics to be included in the work programme for 2014/2015.

9. JSNA UPDATE 98 - 113

This report provides an update on progress with the 2013/14 JSNA work programme and describes the next steps for developing the 2014/15 work programme.

10. DATE OF NEXT MEETING

The dates of the meetings scheduled for the municipal year 2014/2015 are to be advised.

London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Minutes

Monday 13 January 2014

PRESENT

Committee members: Councillor Marcus Ginn, Cabinet Member for Community Care (Chairman)
Councillor Helen Binmore, Cabinet Member for Children's Services
Liz Bruce, Tri-Borough Executive Director of Adult Social Care
Eva Hrobonova, Deputy Director, Tri-borough Public Health
Dr Susan McGoldrick, Vice-Chair, H&F CCG
Karen Tyerman, Tri-Borough Director for Commissioning
Trish Pashley, H&F Healthwatch Representative

Other Councillors: Georgie Cooney, Cabinet Member for Education

Officers: Colin Brodie (Public Health Knowledge Manager), David Evans (Service Development Project Manager, ASC), Nicholas Holgate (Chief Executive), Holly Manktelow (Senior Policy Officer) and Sue Perrin (Committee Co-ordinator)

33. MINUTES AND ACTIONS

RESOLVED THAT:

The minutes of the Health & Wellbeing Board held on 4 November 2013 be approved and signed as an accurate record of the proceedings.

34. APOLOGIES FOR ABSENCE

Apologies for absence were received from Dr Tim Spicer, Professor Sue Atkinson, Andrew Christie and Janet Shepherd (NHSE).

35. DECLARATIONS OF INTEREST

There were no declarations of interest.

36. JOINT HEALTH & WELLBEING STRATEGY: UPDATE

Mr Evans introduced the report which included:

- Findings of the Development Workshop on 8 October 2013;
- Outcomes from the Joint Health & Wellbeing Strategy (JHWS) Consultation; and
- Progress Against Health & Wellbeing Priorities.

Clear messages had been received that:

- The HWB should meet outside formal meetings to develop relationships within the Board and a better understanding of each other's pressures, priorities and agenda; assess its current work programme; and have frank and open conversations.
- Further work was needed to define what success would look like and how it would be measured.
- The Park View Centre for Health & Wellbeing, which is nearing completion should be removed from the strategy.

Dr McGoldrick considered that the Park View Centre service model should be retained as a priority for at least one year. The new building, on its own, would not change the way in which people worked. The allocation of space within the building was still being considered.

Dr McGoldrick responded to a query that the Delivery Board, which included all providers, the CCG, local authority social services and the CLCH would organise the move into the building, which was likely to be phased. The date was not yet known.

Dr McGoldrick did not know if urgent care would be delivered from the Centre. The impact and options in respect of the closure of Hammersmith Hospital Accident & Emergency were being considered and, should it be proposed to transfer the UCC to the Park View Centre, there would be wider consultation.

Councillor Ginn considered that the priorities should be expressed more strongly. Ms Bruce agreed to lead discussions with priority owners to agree a tighter and more specific form of words for SMART objectives for approval by the HWB at the March meeting.

Action: Liz Bruce

Councillor Ginn requested that a further draft report be circulated, before the final version was provided to the HWB.

Action: David Evans

Councillor Ginn considered the JHWS priorities to be a good starting point for an engaged purposeful HWB and management of some aspects of the work by a sub-group, for example the Better Care Fund (BCF), could be considered at a subsequent meeting.

Ms Bruce stated that there was a requirement to formalise the role of the HWB in ratifying the BCF Commissioning Intentions.

Ms Bruce reported that the Care Bill had been delayed in order to include strategic housing plans. Housing was an important element in the enabling environment, which would support people to remain in the community longer.

RESOLVED THAT:

The final version of the Joint Health & Wellbeing Strategy would be brought to the March meeting for approval.

37. BETTER CARE FUND PLAN 2014/2016

Members received the first draft of the Tri-borough BCF Plan, which had been developed in partnership with the corresponding CCGs as an early exemplar proposal. The Plan was an initial response to the challenges presented by the BCF and was work in progress, subject to further consultation with key stakeholders across the three boroughs. The current stage of the process requires a formal submission to NHS England by 15 February, with the final submission being made on 4 April 2014.

The submission combined commissioning intentions, local operating and service planning with the shared five year vision for the Triborough. The plans were underpinned by a focus on systems that supported and removed barriers to integrated care. The strategy was based on three core principles:

- People will be empowered to direct their care and support, and to receive the care they need in their homes or local community.
- GPs would be at the centre of organising and co-ordinating people's care.
- The systems would enable and not hinder the provision of integrated care. Providers would assume joint accountability for achieving a person's outcomes and goals and would be required to show how this delivers efficiencies across the system.

The initial areas for consideration were the commissioning of nursing and residential homes and the commissioning of care delivered in people's homes. The business case for the commissioning of nursing and residential care homes demonstrated that, if this was done as one team across the agencies, there would be financial savings and improved quality.

Ms Pashley was concerned that there was not an Equalities Impact Assessment alongside the Plan.

Ms Bruce responded to a query that the Plan did not include children. The current focus was on older people who might have multiple conditions and consequently blocked acute beds.

RESOLVED THAT:

The Board approved the first draft of the Better Care Plan and noted the challenges.

38. JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) UPDATE

Mr Colin Brodie presented the Joint Strategic Needs Assessment (JSNA) update, which included the Tuberculosis (TB) JSNA.

The JSNA Steering Group, at its meeting on 21 January, would commence the process of setting the work programme for 2014/2015. The programme would be co-ordinated by a JSNA Manager, who would start in early April.

The JSNA Highlights report would be published on the JSNA website and the link sent to members.

The Learning Disabilities JSNA had been completed and would come to the HWB along with the Tri-borough Learning Disabilities Plan. The Physical Activities JSNA and the Child Poverty JSNA would come to the March HWB.

Mr Brodie stated that TB prevalence was lower than the London average, but higher than the national average. There were a number of key recommendations:

- Pooling staff, clinics and resources where appropriate.
- Consider how hospital and community services could be provided more effectively.
- Review current commissioning arrangements and establish service specification and service level agreement.
- Establish a local pathway for the management of TB.

Councillor Ginn noted the challenges and queried how they should be addressed. Mr Brodie stated that it was intended to send the JSNA to the CCGs for review.

Dr McGoldrick stated that H&F CCG recognised TB as a significant issue and would review the pathway, to get agreement from the three CCGs in conjunction with Imperial College Healthcare NHS Trust and Chelsea and Westminster Healthcare NHS Foundation Trust.

Members queried the submission of JSNA applications and their academic nature. Mr Brodie stated that the JSNA Steering Group was responsible for identifying JSNAs which would contribute to the 2014/2015 work programme. Specific requests would be assessed against the Tri-borough priorities framework and would need to have clear benefits.

Completed JSNAs had been used to inform the decision making process and agree priorities. The JSNA scoping process identified the specific issues and the amount of work was variable. The TB JSNA had involved a relatively small workload.

Ms Pashley considered that an Equality Impact Assessment (EIA) should be attached to each JSNA, and the work promoted through the commissioning process. The requirement for a detailed EIA from concept as opposed to at the point of decision making would be clarified.

Action: Liz Bruce

Ms Hrobonova referred to the recommendation in respect of better joint care for TB. Currently, a range of complex cases were being treated in the community, with four centres providing TB services. This model needed to be rationalised with provision of specialist Tri-borough clinics and adequate staffing levels to respond to increased demand. In addition, a joint pathway with local authorities for the management of patients with no recourse to public funds would improve prevention of TB cases in high risk patients, particularly with regards to drug resistant TB.

Councillor Ginn suggested that the JSNA could include a brief section to indicate how the findings would impact on strategies and to identify any gaps and areas outside scope.

RESOLVED THAT:

The report be noted.

39. UNDERSTANDING THE MENTAL HEALTH NEEDS OF YOUNG PEOPLE INVOLVED IN GANGS

Ms Hrobonova presented 'Understanding the Mental Health Needs of Young People involved in Gangs', a Tri-borough Public Health Report produced on behalf of the Westminster Joint HWB.

Ms Hrobonova stated that the young people involved in gangs had much higher rates of a broad range of mental health problems, which until recently had been overlooked. In addition, young people involved in gangs had a higher rate of drug and alcohol misuse. Where mental health problems required specialist input, there were evidence-based interventions for treatment, which fall into two major categories: cognitive behavioural interventions and systemic interventions, both of which are also effective in reducing re-offending.

The key recommendations of the report were to:

- Increase the mental health literacy and skills of key workers working with young people involved in gangs;
- Maintain links with local NHS mental health services; and
- Increase access to multi-systemic therapy for young people in gangs.

Ms Hrobonova responded to a comment in respect of a more holistic approach to include family background that broadening the scope of the

report to a broader population would dilute the work, which had primarily been based on literature.

In response to a query in respect of accessing therapies, Ms Hrobonova responded that rather than commissioning the therapies, it would be necessary to identify young people who would benefit.

RESOLVED THAT:

The report be noted.

40. WORK PROGRAMME

A revised work programme was tabled.

RESOLVED THAT:

- Future meetings would include items 'for information'.
- A workshop should be arranged for 24 March, immediately prior to the HWB.

41. DATE OF NEXT MEETING

24 March 2014

42. RESPONSE TO THE LOCAL HEALTH COMMISSION: CALL FOR EVIDENCE

Councillor Ginn introduced the report. In September 2013, the Mayor of London had set up the independent London Health Commission to find innovative ways to meet London's health and healthcare needs. To inform this work a 'Call for Evidence', was made in December 2013 asking the public, service providers and all other parties a range of questions.

A draft response setting out the views of the Tri-borough Cabinet Members for Adults and Public Health was tabled. The deadline for submissions was Friday 17 January 2014.

Ms Manktelow stated that some information was currently outstanding. The draft response had been circulated to the three CCGs.

ACTION:

The HWB was asked to comment on the draft Tri-borough response, within the next 48 hours.

Meeting started: 4.00 pm
Meeting ended: 5.30 pm

Chairman .....

Contact officer: Sue Perrin
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Hammersmith & Fulham Health and Wellbeing Board

Title: Better Care Fund Plan 2014-16	**Date** 24th March 2014

Summary

This report contains the "near-final" version of the Better Care Fund Plan for sign off by the Health and Wellbeing Board. The Plan has been prepared according to the DH template and sets out the vision for health and social care services, aims and objectives and planned changes encompassing 18 workstreams to deliver integrated operational services, integrated commissioning and contracting, supported self care, personal health and care budgets and improved patient experience, and integrated infrastructure such as IT and information governance.

The report sets out the governance arrangements to ensure that the Health and Wellbeing Board receives regular reports on progress with implementation and achievement of outcomes. It proposes bringing existing budgets together into a pooled budget within the legal framework of the s75 Partnership Agreement and identifies the risks associated with partnership working and the actions being taken to mitigate these risks. The report explains how service providers, service users and other stakeholders have been involved in preparing the plan to date, and sets out a plan for further engagement in the detailed development and implementation of the plan.

The report addresses the national conditions as required, which are:

a) protecting social care services
b) 7 day services to support discharge
c) Data sharing
d) Joint assessments and accountable lead professional

Finally, the plan includes a set of Outcomes and Metrics, of which four have been set nationally; one relates to patient/service user experience for which two measures (one for health and one for social care) are proposed; and one local indicator which is for agreement.

The Plan is being taken to the three Cabinet Members in Tri-borough, the three Clinical Commissioning Group Governing Bodies, and the three Health and Wellbeing Boards for consideration and approval. There may therefore be minor amendments prior to the submission date of 4th April.

FOR DECISION

Next Steps

The Health and Wellbeing Board is recommended to approve the Plan and

specifically the following elements:

i. The establishment of a Better Care Fund Programme of work relating to integrated operational services; service user experience; integrated contracting and commissioning; and programme delivery.

ii. The development of a Better Care Fund pooled budget, to be held by the local authority on behalf of both the council and the NHS, (recognising that each scheme will be led by the most appropriate commissioners, either LA or CCG) to enable the development of integrated health and social care services for the people of Hammersmith and Fulham.

iii. The allocation of £47,781,199 local authority existing budgets and £31,923,371 HFCCG existing budgets to the pooled budget in 2015/16. This is a minimum figure based on existing partnership commitments and during 2014-15 further proposals may be brought to the Cabinet Member (and the CCG Governing Bodies) for possible inclusion in the pooled budget.

iv. Confirmation of the Integration Partnership Board as the BCF Implementation Board, reporting to the Hammersmith and Fulham Health and Wellbeing Board on delivery of the BCF Programme.

v. Agreement that, following sign off, any significant variations to the Plan relating to the allocation of funds by the local authority will be brought back to the Cabinet Member for approval.

Reference papers

Tri-borough Better Care Fund Plan – “near-final” March 2014

Tri-borough BCF Finance and Outcomes Spreadsheet “near-final” March 2014

Lead Officer

Name: Cath Attlee
Title: Whole Systems Lead, Tri-borough Adult Social Care
Tel: 0790 3956 961
e-mail: *cattlee@westminster.gov.uk*

1. REASONS FOR DECISION

1.1. As reported to Cabinet in January, development of an integrated Better Care Fund Plan is a requirement of the Department of Health and the Department for Communities and Local Government. Funding allocations to the Local Authority and to the local NHS in 2014-16 are dependent on agreement between the parties on the BCF Plan. In addition, the programme of work is consistent with the stated vision and objectives of the partners within the Hammersmith and Fulham Health and Wellbeing Board, and is a mechanism for delivering the outcomes and efficiencies required.

2. INTRODUCTION AND BACKGROUND

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

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

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

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

2.5. The BCF will align with the strategy process set out by NHS England and supported by the LGA and others in *The NHS belongs to the people: a call to action*[1]. The BCF will provide part of the investment required to achieve the shared vision for health and social care.

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

3. CONSULTATION

3.1. The Better Care Fund has been developed within the existing Whole Systems partnership between the local authority and the NHS, with service providers and with service user and carer representatives including Healthwatch, and reflects the shared aspirations for integrated care. The draft plan has been made available to partners for comment, in the knowledge that it captures a range of workstreams which already involve local stakeholders. An engagement plan is being developed with all stakeholders to ensure full involvement and, where possible, co-production of the specific initiatives going forward.

4. EQUALITY IMPLICATIONS

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

5. LEGAL IMPLICATIONS

7.1 The Department of Health and the Department for Communities and Local Government have established a multi-year fund, confirmed in the Autumn Statement, as an incentive for councils and local NHS organisations to jointly plan and deliver services, so that integrated care becomes the norm by 2018. A fund will be allocated to local areas in 2015/16 to be put into pooled budgets under Section 75 joint governance arrangements between CCGs and Councils. A condition of accessing the

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

money in the Fund is that CCGs and councils must jointly agree plans for how the money will be spent, and these plans must meet certain requirements.

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

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

8 FINANCIAL AND RESOURCES IMPLICATIONS

8.1 In 2014-15 the minimum value required of the BCF Pooled Budget is £2,590,000; Tri-borough partners are proposing at least £157,110,353 which includes the funding in existing s75 and s256 agreements. Of this, £49,715,999 will come from the London Borough of Hammersmith and Fulham and £12,629,786 from Hammersmith and Fulham CCG. The detailed budgets are shown in Part 2 of the BCF Plan and a summary appears in the table below.

8.2 In 2015-16 the minimum value required of the BCF Pooled Budget is £47,836,000 and the Tri-borough authorities are proposing at least £211,460,612. Of this, £47,781,199 will come from the London Borough of Hammersmith and Fulham and £31,923,371 from Hammersmith and Fulham CCG.

8.3 It is estimated that the programme will contribute to the delivery of around £15m in savings across Tri-borough partners by the end of 2015/16, if targets are fully met, as shown in the table blow.

8.4 In addition to the identified savings we will be constructing a financial model which enables NHS revenue to flow into out of hospital services delivered by social care, and reimburses the local authority against agreed targets. This will reflect an agreed portion of the savings which will accrue to the NHS by preventing unnecessary admissions and facilitating timely discharge from hospital.

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

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

Tri-borough Better Care Fund Financial Summary

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)	Anticipated Benefit
Westminster City Council	Y	*28,761,068*	*1,379,000*	*26,252,068*	4,895,193
Royal Borough of Kensington and Chelsea	Y	*22,942,850*	*874,000*	*22,003,850*	
London Borough of Hammersmith and Fulham	Y	*49,715,999*	*1,052,000*	*47,781,199*	
Central London CCG	N	*27,137,037*	*13,553,000*	*43,754,621*	3,366,231
West London CCG	N	*15,923,613*	*17,830,000*	*39,745,502*	3,572,468
Hammersmith and Fulham CCG	N	*12,629,786*	*13,148,000*	*31,923,371*	3,873,119
BCF Total		**157,110,353**	**47,836,000**	**211,460,612**	**15,707,010**

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

Tri-borough Better Care Fund – Part 1

1) PLAN DETAILS

a) Summary of Plan

Local Authority
City of Westminster
London Borough of Hammersmith and Fulham
Royal Borough of Kensington and Chelsea

Clinical Commissioning Groups
Central London Clinical Commissioning Group
Hammersmith & Fulham Clinical Commissioning Group
West London Clinical Commissioning Group

Boundary Differences
Co-terminus (limited exceptions)
The Plan covers all three boroughs so the CCG boundary exception is not relevant to the narrative. The finance section sets out local authority funding by borough and CCG funding by CCG so the NHS figures for Westminster are split between CLCCG (78%) and WLCCG (22%).

Date to be agreed at Health and Well-Being Boards:
24/03/2014
(draft agreed in December 2013/January 2014)

Date submitted:
To be completed

Minimum required value of BCF pooled budget:	**2014/15**	£2,590,000
	2015/16	£47,836,000
Total proposed value of pooled budget:	**2014/15**	£157,110,353
	2015/16	£211,460,612

b) Authorisation and sign off

Dr Fiona Butler
Chair,
NHS West London CCG

Date _____

Councillor Mary Weale
Cabinet Member for Adult Social Care &
Public Health, RB Kensington and Chelsea
And Chair, RBKC Health & Wellbeing Board

Date _____

Dr Ruth O'Hare
Chair,
NHS Central London CCG

Date _____

Councillor Rachael Robathan
Cabinet Member for Adults &
Public Health, Westminster City Council
And Chair, WCC Health & Wellbeing Board

Date _____

Dr Tim Spicer
Chair,
NHS Hammersmith & Fulham CCG

Date _____

Councillor Marcus Ginn
Cabinet Member for Community Care,
LB Hammersmith and Fulham
And Chair, LBHF Health & Wellbeing Board

Date _____

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

This plan reflects a number of existing programmes which have included health providers as active participants. Together with a range of local social care providers, and our voluntary and community sector as a whole, providers are now also being engaged in developing future plans.

Details of existing consultation work can be found in *Shaping a Healthier Future*, our agreed *Out of Hospital Strategies* and *Living Longer and Living Well*, and our successful application to become an Integrated Care Pioneer.

A joint commissioner and provider forum across North West London forms a core part of the co-design work in our Whole Systems Integrated Care Programme. A number of the BCF workstreams are particularly relevant to our community health services providers and we are involving them closely in these developments.

As part of creating the Tri-borough Market Position statement the local authorities have been developing a more regular dialogue with local providers of social care, including community organisations. In developing the Better Care Fund plans for the future we are looking to link this wider range of social care and community providers to the Whole Systems forum as a reference group for the BCF and for the wider Health and Wellbeing programmes.

d) Patient, service user and public engagement

Please describe how patients, services users and the public have been involved in the development of this plan, and the extent to which they are party to it

Our vision for whole system integrated care is based on what people have told us is most important to them: high quality, integrated care provided in people's homes and communities, tailored to their needs.

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.

A North West London Patient and Public Representative Group has now been established, including CCG Patient and Public Involvement lay members, representatives from HealthWatch and from service user and carer groups to ensure that the patient perspective is reflected in all our programmes as they develop.

At a borough and CCG level, service users and carers are involved in developing person centred services; and each Health and Wellbeing Board has adopted the National Voices approach, involving service users in identifying local measures of success.

Tri-borough Adult Social Care is currently undertaking a Customer Journey project to understand better the views of service users and carers on their experience of social care. This builds on the information already received through the national survey and will inform our integrated operational working.

We will be building on these existing approaches to develop a strong service user and community voice within the Better Care Fund to ensure that our integration plans deliver better outcomes and experiences for all our citizens. The draft engagement plan is included in the supplementary documents.

e) Related documentation

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

The following list is a current synopsis of some of the key source documents that have informed this submission, together with a brief synopsis of each.

Ref	Document	Synopsis
D1	**"Living Longer, Living Well" Pioneer Application June 2013**	The vision for whole system integrated care in NW London, including that people, their carers and families will be empowered to exercise choice and control; GPs will be at the centre of organising and co-ordinating people's care; and systems will not hinder the provision of integrated care.
D2	**"Shaping a Healthier Future" NHS North West London**	The strategy for future healthcare services in North West London including how care will be brought nearer to people; how hospital provision will change, including centralising specialist hospital care onto specific sites so that more expertise is available more of the time; and how this will be incorporated into a co-ordinated system of care so that all the organisations and facilities involved in caring for the people of North West London can deliver high-quality care and an excellent experience.
D3	**Out of Hospital Strategies**	NHS West London CCG, NHS Hammersmith & Fulham CCG, and NHS Central London CCG's strategies for commissioning and delivering better care for people, closer to home. These focus on local care provided out of hospital, integrating with the future development of acute services across the region as outlined in "Shaping a Healthier Future".
D3	**Joint Strategic Needs Assessment (JSNA)**	Joint local authority and CCG assessments of the health needs of a local population in order to improve the physical and mental health and well-being of individuals and communities for each of the 3 localities.
D4	**Joint Health & Wellbeing Strategy(JHWS)**	The Joint Health and Wellbeing Strategy sets out the priorities and actions which the Health and Wellbeing Board are planning to carry out in the period 2013 to 2016 for each of the 3 localities.

Ref	Document	Synopsis
D5	**Joint Commissioning Intentions**	A single view of commissioning intentions across the Triborough health and social care landscape. The CCGs commissioning intentions for 2014/15 have been mapped against each other and also against the Triborough market statement (which brings together Local Authority Social Care commissioning intentions across Westminster, Kensington & Chelsea, and Hammersmith & Fulham).
D6	**CIS Business Case**	This outline business case argues for the development of a detailed single specification for a Triborough Community Independence Service (CIS) which will integrate and enhance existing local models and delivery frameworks to achieve common and improved outcomes for the populations of Hammersmith & Fulham, Kensington and Chelsea and Westminster.
D7	**Delivering Seven Day Services**	North West London's vision to be an early adopter for seven day services across health and care.
D8	**Individual CCG QIPP, operating and local authority corporate and service plans**	Detailed plans by the CCGs and Local Authorities for the funding and delivery of services and associated efficiency targets for 2014/15 and 2015/16.
D9	**Borough/CCG Health and Wellbeing Partnership Agreements**	S75 Partnership Agreements established between each local authority and CCG as a framework within which integrated commissioning can be implemented; along with annually agreed service schedules of those services jointly commissioned or in a pooled budget.

2) VISION AND SCHEMES

a) Vision for Health and Care Services

Please describe the vision for health and social care services for this community for 2018/19. - What changes will have been delivered in the pattern and configuration of services over the next five years? - What difference will this make to patient and service user outcomes?

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

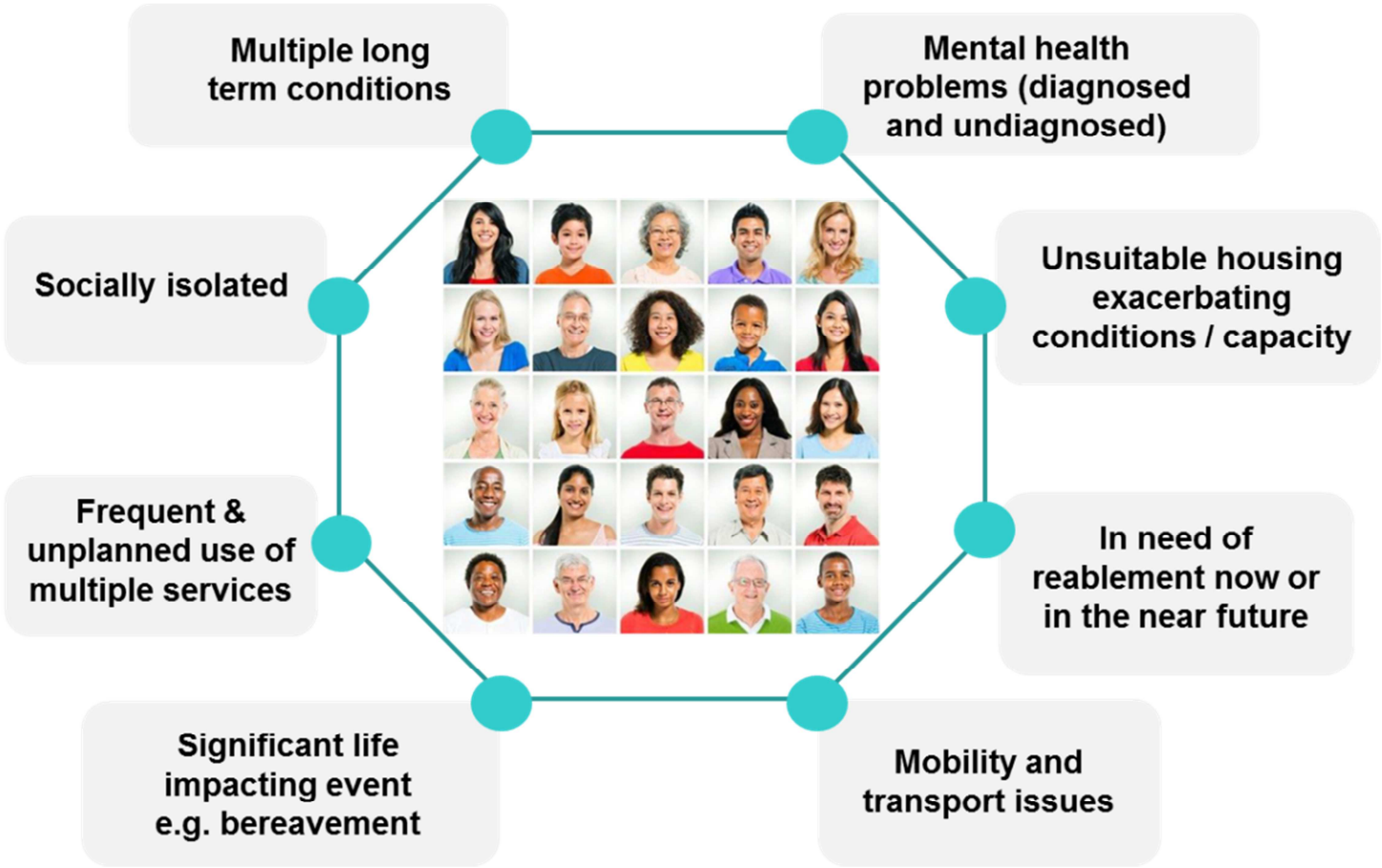
- *April is 82. She lives in a second floor, privately-rented flat near Holland Park. There is no lift and a stone staircase, so she is at high-risk of falling. She has had 2 hip replacements and is currently taking warfarin following general anaesthetic for her second operation.*
- *She regularly visits 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 at this stage). 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.*

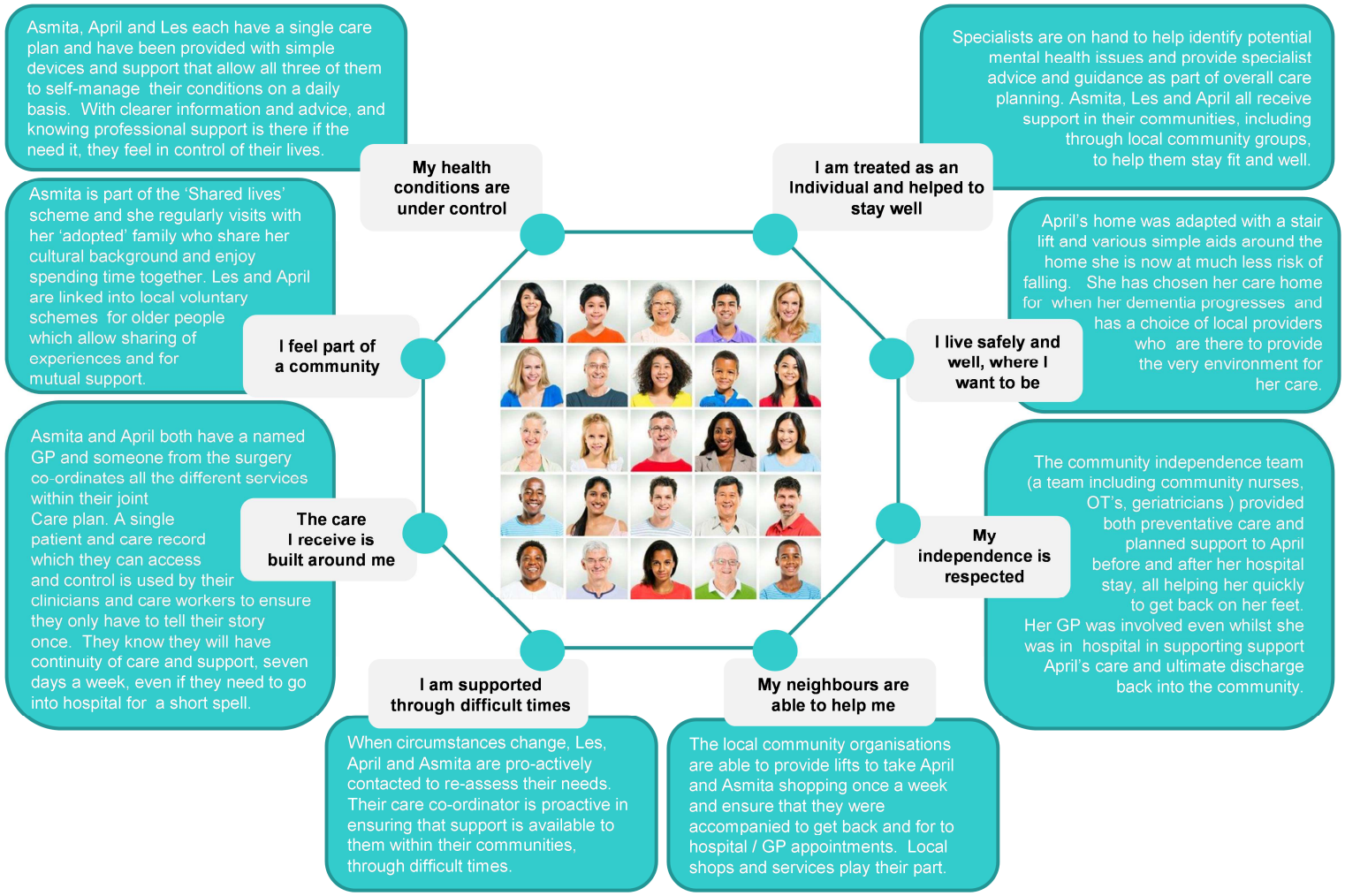
Transforming outcomes, transforming lives

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.

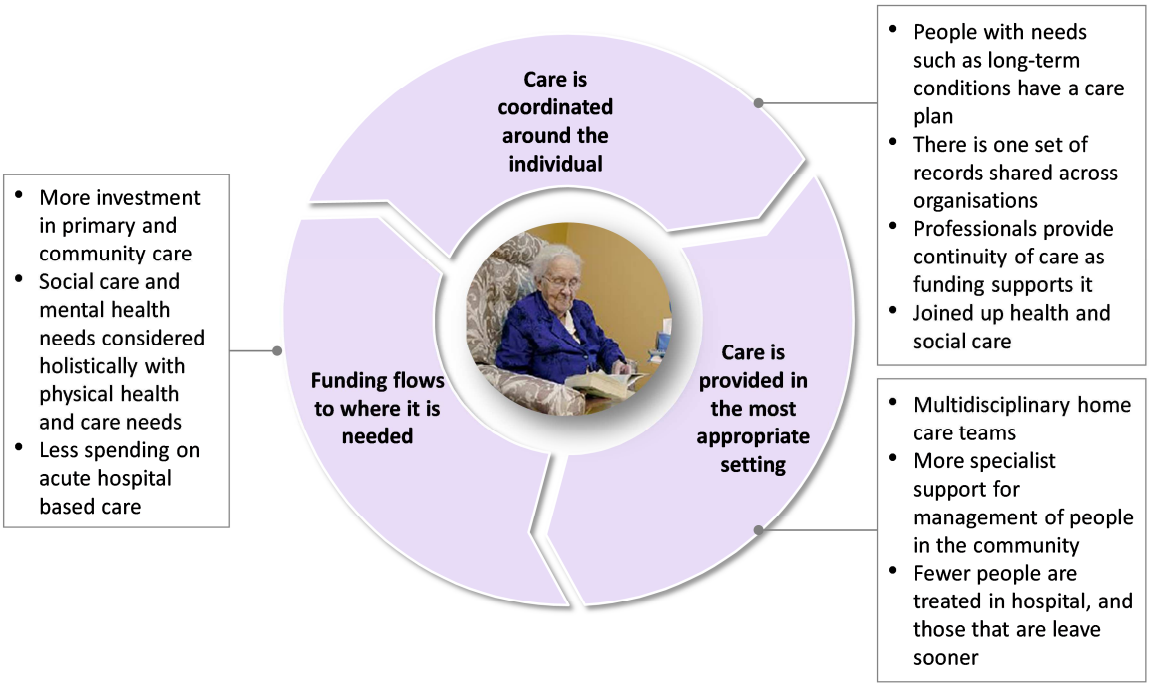


Our Vision - What this will mean for our health and social care services

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

This work starts and ends with the individual experience of care. Through mapping the current experiences, capabilities and needs of our patients and service users, and working with them to develop the future models of care, we have focussed on a number of priority areas. This is about not simply looking at people in terms of the cost of their care, or the types of interactions they currently have with local public services, but looking further to the root cause of the challenges many experience today, and how these can be converted into more positive experiences and outcomes in the future.

For Asmita, April and Les – typical individuals who are being supported by a range of local health and social services within the Tri-borough today, but have been identified as being at high risk of losing their independence – our focus is on helping them to manage their physical or mental health conditions, and enabling them to live safe, well and comfortably in their own homes and communities for as long as possible.

In practice, this means that from 2015/16 we will work towards the following vision:

- **The care I receive is built around me:** Asmita and April both have a named GP and someone from the surgery co-ordinates all the different services within their joint Care plan. A single patient and care record which they can access and control is used by the clinicians and care workers who are involved in their care, to ensure they only ever have to tell their story once. They know they will have continuity of care and support, seven days a week, even if they need to go into hospital for a short spell.

- **My health conditions are under control:** Asmita, April and Les each have a single care plan and have been provided with simple devices and support that allow all three of them to self-manage their conditions on a daily basis. With clearer information and advice, and knowing that professional support is there if they need it, they feel in control of their lives

- **I feel part of a community:** Asmita is part of the 'Shared lives' scheme and she regularly visits with her 'adopted' family who share her cultural background and enjoy spending time together. Les and April are linked into local voluntary schemes for older people, which allow sharing of experiences and for mutual support.

- **I am supported through difficult times:** When circumstances change, Les, April and Asmita are contacted to re-assess their needs. Their care co-ordinator is proactive in ensuring that support is available to them within their communities, through difficult times.

- **My neighbours are able to help me:** The local community organisations are able to provide lifts to take April and Asmita shopping once a week and ensure that they were accompanied to get back and forth for hospital and GP appointments. Local shops and other community-based services play their part in helping to ensure that they are able to live healthy, well lives in their own homes.

- **My independence is respected:** The community independence team (a team including community nurses, OT's, geriatricians) provided both preventative care and planned support to April before and after her hospital stay, all helping her quickly to get back on her feet. Her GP was involved even whilst she was in hospital, supporting April's ongoing care, and ultimate discharge back into the community

- **I live safely and well, where I want to be**: April's home was adapted with a stair lift and various simple aids around the home she is now at much less risk of falling. She has a choice of local providers who are there to provide the very best environment for her care.

- **I am treated as an individual and helped to stay well:** Specialists are on hand to help identify potential mental health issues and provide specialist advice and guidance as part of overall care planning. Asmita, Les and April all receive support in their communities, including through local community groups, to help them stay fit and well.

As a result of these changes, Asmita, Les and April and those around them feel confident in the care they are receiving in their communities and homes. Their conditions are better managed and their attendances and reliance on acute services, including their local A&E departments, are significantly reduced. If they do require a stay in hospital then they are helped to regain their independence and are appropriately discharged as soon as they are ready to leave, with continuity of care before, during and after the admission.

They routinely report that they feel in control of their care, informed and included in decision-making, are supported in joined-up way, and are empowered and enabled to live well.

Overall pressures on our hospitals and health budgets have reduced, as we shift from high-cost reactive to lower cost preventative services, supporting greater self-management and community based care; and our social service budgets are going further, as new joint commissioning arrangements deliver better value and improved care at home reduces the need for high-cost nursing and care home placements.

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.

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.

At the heart of this will be 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 BCF will enable us to start to release health funding to extend the quality and duration of our re-ablement 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 BCF 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 describes what success in this area 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 Community Independence provision, will mean we will eliminate 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 therefore are 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 the need for nursing and residential care.

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 size with more complex patients and with elements of basic care delivered by nurse practitioners; and 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.

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 and procuring 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 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 that will provide both real time information and managerial analytics, starting by ensuring that GP and Social Care systems across the Tri-borough are integrated around the NHS number, and individual information 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.

b) Aims & Objectives

Please describe your overall aims and objectives for integrated care and provide information on how the Better Care Fund will secure improved outcomes in health and care in your area. Suggested points to cover:
• What are the aims and objectives of your integrated system?
• How will you measure these aims and objectives?
• What measures of health gain will you apply to your population?

Our aim is to provide care and support to people in their own homes and communities, with services that:

- **co-ordinate around individuals** and are 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;
- **maximising 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.

We recognise that this journey will involve further significant changes to the way in which services are designed and delivered, but that journey is now underway. From 2014/15,

- **Our CCG and Social Care commissioners will be commissioning and procuring jointly**, focussed on improving outcomes for individuals within our communities starting with enhanced Community Independence and Nursing and Residential Care.

- **Our community providers** will be implementing new models of service delivery, driven by clinical staff on the ground, and integrated with our broader health and wellbeing strategies.

  This will involve a single approach to assessing and meeting the needs of individuals in their homes and communities, with seamless delivery of health and care functions.

- **Our GP practices will be collaborating in networks** focused on populations over at least 20,000 within given geographies.

  Community, social care services and specialist mental and physical health services will be organised to work effectively with these networks, enabling GPs to ensure their patients are getting the very best person-centred care.

  We will deliver on the new provisions of GMS, including named GP for patients aged 75 and over; and practices will take responsibility for out of hours services and individuals will be able to register with a GP away from their home.

- **We will be investing in co-ordinated care** that promotes a holistic view of individual needs and works with people to empower them and enable them to stay as independent as possible.

  This means ensuring there is a good quality care plan in place for all those at risk, backed by co-ordinated provision commissioned to deliver on the required support and outcomes envisaged in each and every plan.

- **The volume of emergency and planned care activity in hospitals, together with the number of residential and nursing care placements, will be reduced** through enhanced preventative and community independence functions, and improved support in the community and in the home.

  By improving individual health and wellbeing, and access to home and community based services, we will relieve pressures on our acute services and help to eliminate the costs that arise from failures to provide adequate help to those at greatest risk of deterioration.

In parallel, results of investment in 7 day social care provision and critical capacity areas such as neuro-rehabilitation will help us to eliminate delayed transfers of care.

In order to manage and track outcomes, 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 BCF will help ensure this happens by joining up Health and Social Care data across the Tri-borough, linked via the NHS number.

We will guarantee that individual information is shared in an appropriate and timely way to maximise safeguarding, wellbeing and user experience; and aggregated to allow effective identification and management of need and outcomes across our health and care economy as a whole.

In parallel, we will be investing in developing our infrastructure around understanding the experience of care, including introducing in 2014/15 regular customer satisfaction surveying for those with one or more long-term conditions, looking holistically at their experience of care.

Part 2 describes how we expect these changes to impact on key performance measures, including our proposed local measure.

c) Description of Planned Changes

Please provide an overview of the schemes and changes covered by your joint work programme, including: 1. The key success factors including an outline of processes, end points and time frames for delivery 2. How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

We recognise that achieving our 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 Tri-borough are committed to working together to create a marketplace, and effect the required behavioural and attitudinal change in the acute sector, to ensure that this happens at scale and at pace.

Across North West London, our process for achieving our vision, as set out in our joint commissioning intentions means:

- **Local health and social care commissioners**, supported by public health and in partnership with NHS England where necessary, identifying what 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; the performance management and governance arrangements to ensure effective delivery of this care. Commissioning plans will reflect local priorities set out in the joint strategic needs assessments for each borough and captured in the Health and Wellbeing Strategies.

- **Local health and care providers**, and associated public, private and voluntary and community sector groups, co-designing the care models that will deliver these outcomes; transitioning resources into these models to deliver the outcomes required; ensuring governance and organisational arrangements are in place to manage these resources; agreeing the process for managing risks and savings achieved through improving outcomes; establishing information flows to support delivery; and ensuring effective alignment of responsibilities and accountability across all the organisations concerned.

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

We will use the BCF to:

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

- **Invest in developing personal 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 re-ablement** through a new joint Tri-borough approach to Community Independence, reducing hospital admissions and nursing and residential care admissions.

- **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 front-ine 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.

We will use the BCF 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.

We will use the BCF 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 75, 76 and section 256 agreements, to ensure they represent VFM and effectively deliver integrated working

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

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

The full list of schemes which we propose to take forward in 2014-15 and 2015-16 appears below:

Group A – Integrated Operational Services				
BCF Scheme	**Scheme Description**	**Condition/ Metric relevant**	**Milestones**	**Timeframe**
BCF01 & BCF15 7 Day Services – Social Care and GPs	As part of the NWL Early Adopter for 7 Day Services, extend social care to provide 7 day access particularly to facilitate early discharge; and extend primary care offer to prevent unnecessary attendances at A&E	7 day services; avoidable admissions; delayed transfers of care	Review of 13-14 arrangements Business case for extension Implementation	Apr-May 2014 June- July 2014 October 2014
BCF 08 - Community Independence Services	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.	reduce non-elective admissions and nursing and residential care costs and maximise service user independence	Complete business case Undertake procurement Implement new service	Apr-June 2014 July – Dec 2014 April 2015
BCF10 - Rehabilitation and Re-ablement Services	Increase investment in additional community and bed based capacity, particularly for neuro-rehabilitation; streamline process Extend community rehabilitation period up to 12 weeks in the community including home care	Reduce delayed discharges; better experience for patients; reduce admissions to care homes	Complete business case Undertake procurement Implement improved services	Apr- June 2014 July-Dec 2014 April 2015
BCF11 – Integrated Services for People with Long Term Conditions	Develop integrated approach to prevention and early intervention for people with, or likely to have, long term conditions including housing interventions and home care – Links to Whole Systems Early Adopters (BCF17)	Joint approach to assessment and care planning, service user experience; reduce admissions to care homes	Early adopters develop business cases Pilot models Roll out models	Feb-Apr 2014 Apr 2014 – March 2015 April 2015
BCF13 – Psychiatric Liaison [will be taken forward as part of BCF01 and BCF08]	Develop psychiatric liaison services in line with the NWL wide review, delivering a common specification and contracting of services to ensure equity of access, improve performance and consistent standards assurance	Joint approach to assessment and care planning; service user experience; 7 day services	Service specification developed Procurement Implementation	Apr-June 2014 October 2014

Group B – Service User Experience				
BCF Scheme	**Scheme Description**	**Condition/ Metric relevant**	**Milestones**	**Timeframe**
BCF02 – Developing Self Management and Peer Support	Working with individuals and community groups to co-design, co-develop and co-produce improved health and care outcomes, maximising service user capacity within the system	Joint approach to assessment and care planning Service user experience	Project plan to be developed	Feb-May 2014
BCF06 & BCF12– Patient Satisfaction/Service User Experience/Patient Surveys	Set up routine collection of patient satisfaction from GP practices to enable capture of experience of care for people with long term conditions	Service user experience; evaluation of the whole programme	Project plan to be developed	Feb-May 2014
BCF16 – Developing Personal Health and Care Budgets	Extend our current arrangements for personal health budgets, working with patients, service users and front line professionals to empower people with long term conditions to make informed decisions around their care; link to BCF02	Joint approach to assessment and care planning; service user experience	PHBs for continuing healthcare in place PHBs for long term conditions in preparation Implementation	April 2014 April-Dec 2014 April 2015

Group C – Integrated contracting and commissioning				
BCF Scheme	**Scheme Description**	**Condition/ Metric relevant**	**Milestones**	**Timeframe**
BCF03 – Transforming Nursing and Care Home Contracting	Create a single care home placement contracting team across health and social care; develop outcomes based specifications, maximise value and ensure appropriate and timely provision reduces pressure on hospitals	Admissions to care homes; delayed transfers of care	Business case developed Consultation on changes Implementation	Jan-March 2014 April – June 2014 October 2014
BCF07 – Review Portfolio of Jointly Commissioned Services	Review all existing jointly commissioned services with S75 and S256 partnership arrangements, to ensure services provide value for money and are aligned with the objective of integrated working	Plans to be jointly agreed; joint approach to assessment and care panning; reablement	Review programmes Include recommendations in Commissioning Intentions	April – August 2014 Sept 2014
BCF09 – Integrated Commissioning	Review range of health and social care services to be jointly commissioned and infrastructure required including establishment of an Integrated Commissioning Team - Links to BCF programme implementation and joint commissioning review	Plans to be jointly agreed; data sharing; joint approach to assessment and care planning	Scoping future integrated commissioning programme Identifying infrastructure required	March-May 2014

BCF17 – Whole Systems Integrated Care Early Adopter Pilots	Incorporating current investment in the Whole Systems Integrated Care programme into the BCF, to build fully integrated and sustainable risk stratification, care planning, care coordination, and multi-disciplinary team working across health and social care	Plans to be joint agreed; integrated approach to assessment and care planning; service user experience	Early adopter pilots agreed Pilots under way Evaluation and roll out	March 2014 April 2014 April 2015

Group D – Programme Delivery				
BCF Scheme	**Scheme Description**	**Condition/ Metric relevant**	**Milestones**	**Timeframe**
BCF04 – Better Care Fund Programme - including Performance and Governance	Programme for development, implementation and monitoring of delivery of the BCF	Plans to be jointly agreed; all elements	Programme developed Governance structure in place Implementation and reporting	Nov 2013 – March 2014 March 2014 April 2015 onwards
BCF05 – Information Technology and Information Governance	Implementation of IT and IG solutions to link tri-borough social care systems to the GP systems and to ensure consistent use of the NHS number as primary identifier	Data sharing; joint approach to assessment and care planning	Implementation plans developed Implementation to be completed	March 2014 March 2015
BCF18 – Care Bill Implementation	Programme of work to implement all aspects of the new Care Bill	Protection for social care spending; all elements	Preparatory work Detailed preparations	Oct 2013 – March 2014 April 2014 – March 2015

An overview of the overall timeline on both a North West London and Tri-borough perspective is provided below:

August - December 2013:

- On a North West London-wide basis, we created a framework and supporting toolkit that identifies target population segments, their desired outcomes, and the finances available.

- On a North West London-wide basis, we developed approaches to some of the most difficult practical aspects of making integration across providers effective, for example, information requirements and explored how we will put these in place, how GP and Provider Networks could contract to incentivise collaborative working and developing options for joint commissioning governance model.

- Across the Tri-borough, we have developed joint commissioning intentions, outline specifications, business cases and plans to support the greater co-ordination and integration of priority services, including in relation to community health and adult social care.

January – March 2014:

- On a North West London-wide basis, we are developing locality integration plans, which set out the scope of commissioners' plans for integrated care, including target population, desired outcomes and budgets available, as well as providers' responses.

- Across the Tri-borough, prepare the detailed specifications and plans for joint commissioning and provision in 2014/15 as per the priority areas outlined above.

- Planning in detail each of the constituent schemes, identifying interdependencies, gaining engagement and support from key stakeholders and mobilising ready for implementation in April.

- Understanding in greater detail the potential impact of the schemes on service delivery on a provider-by-provider basis – we will be working closely with our local NHS and social care providers to model this.

- Discussing and agreeing the local metrics at HWBs throughout March

- In-depth understanding of the impact should scheme outcomes not be delivered or in the case of savings not materialising, and creating clear contingency plans to mitigate against this

- Further work on our approach for joint governance arrangements to support delivery of the BCF plan, including a detailed focus on how risk will be shared

- Further provider engagement to ensure alignment and buy-in across the Tri-borough

- Further discussion and agreement with the governing bodies, cabinet members and Health and Wellbeing Boards on the most efficient and effective vehicle for the pooled budget(s), understanding the implications of the various options

- In addition, we are currently undertaking a comprehensive review of anticipated financial and non-financial benefits to ensure they are as robust as possible.

April 2014 – March 2015

- On a North West London-wide basis, we will complete detailed planning to implement concepts developed during the co-design phase to achieve our objectives.

- On a North West London-wide basis, we will use Wave One Whole System sites to test models and share learning.

- On a North West London-wide basis, we will monitor financial flows in shadow budgets to evaluate financial impact of possible models on different providers and on total cost to commissioners.

- Across the Tri-borough, we will manage the implementation and benefits tracking for the newly integrated services that are "live" and developing our next tranche of joint commissioning plans in line with local needs and the Whole Systems approach.

- Introduce regular customer satisfaction surveying to develop our baseline for user experience.

From April 2015

- Use preparation from planning using co-designed materials and learning from Wave One sites and local schemes to implement new models of care at scale with actual budgets attached.

We are ensuring related activity will align by working in close collaboration with the other boroughs in North West 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.

Each Health and Wellbeing Board has agreed a Health and Wellbeing Strategy based on local joint strategic needs assessment and identifying key priority areas for action. The Better Care Fund programme is consistent with these priorities and

will be reported regularly to the Health and Wellbeing Board as part of evidencing delivery against these actions.

Within Tri-borough, building on the Community Budget programme, we are developing an approach to strengthening self care and preventative action by drawing on community assets within our neighbourhoods to complement the out of hospital strategies developed by the CCGs.

d) Implications for the Acute Sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

Shaping a Healthier Future and our ***Out of Hospital Strategies*** set out how we plan to reconfigure hospital services in North West London to focus on the needs of our patients. These plans have been developed and consulted upon with local authority, hospitals, community and mental health services and other local stakeholders fully engaged.

Achieving our targets will require significant investment in primary and community care and reduced acute activity, as described in our *Out of Hospital Strategy*. In *Shaping a Healthier Future*, we set out major changes in how services will be configured in our health economy over the next 3-5 years, including:

- **Central Middlesex** becoming a local hospital and elective hospital
- **Charing Cross** becoming a local hospital
- **Ealing** becoming a local hospital
- **Hammersmith** becoming a specialist hospital with obstetric-led maternity unit and a local hospital
- **St Mary's** – a local hospital, a major hospital, a Hyper Acute Stroke Unit (moved from Charing Cross Hospital) and a specialist ophthalmology hospital (moving the Western Eye Hospital onto the site)

Following Secretary of State agreement, implementation of *Shaping a Healthier Future* is now being taken forward. This depends on development of local hospital arrangements and local primary and community hubs in each borough. Business cases for local hospitals are currently in preparation and will be confirmed during 2014-15. Local hubs business cases are also in development, with the new north hub in Hammersmith (White City) about to open in Spring 2014.

The ***North West London Whole Systems Integrated Care (WSIC) Programme*** and related initiatives are focussed supporting these developments through improving patient pathways to reduce hospital stays, by number and length of stay. We have evaluated our proposed changes on the Value for Money criterion. These covered activity, capacity, estates and finance analyses, including commissioner forecasts, Trust forecasts, the out of hospital forecasts and the capital requirement to deliver the proposed changes.

The analysis indicates that commissioner forecasts over the five years (across NWL) involve a gross QIPP of £550m, with reinvestment in out of hospital services of £190m.

Our local community health services provider, **Central London Community Healthcare (CLCH)** and mental health trusts, **Central and North West London Mental Health NHS Foundation Trust (CNWL)** and **West London Mental Health Trust (WLMHT)** have been fully involved in the development of community services and in the co-production of different models of care to deliver the changes described above. The WSIC pilot schemes will see providers working together to offer integrated services to improve both patient experience and value for money.

We expect our changes to improve the delivery of NHS services. Specifically, we expect them to reduce mortality through better access to senior doctors; improve access to GPs and other services so patients can be seen more quickly and at a time convenient to them; reduce complications and poor outcomes for people with long-term conditions by providing more coordinated care and specialist services in the community; and ensure less time is spent in hospital by providing services in a broader range of settings.

If we do not deliver activity reductions through improved out of hospital care, we expect most NWL sites to move into deficit, with no overall net surplus. In the downside scenario there would be an overall deficit of £89m, with all bar one acute site in deficit.

We anticipate that the changes proposed will have a significant impact on community services, and both statutory and independent providers of health and social care will be partners with us in delivering this Better Care Fund Plan. We will be assessing this impact scheme by scheme in the next few months.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

Across the Tri-borough, 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 as well as signing off Health and Wellbeing Strategies, based on the joint strategic needs assessments. We have regular meetings between our 3 council cabinet members responsible for health-related services and our 3 CCG chairs, (The Integration Partnership Board) together with joint monthly 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.

We have formal Health and Wellbeing Partnership Agreements in place between each borough and CCG providing a legal framework for closer integration of commissioning and an established programme of jointly commissioned services which are already overseen by the joint executive team referred to above. This will enable us to put in place the new pooled budget required by April 2015. We anticipate that this will be hosted by the local authorities, in view of the practical advantages which this offers in relation to treatment of VAT and the carrying forward of funding, but the pooling agreement will recognise that each scheme will be led by the most appropriate commissioner, be that local authority or 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

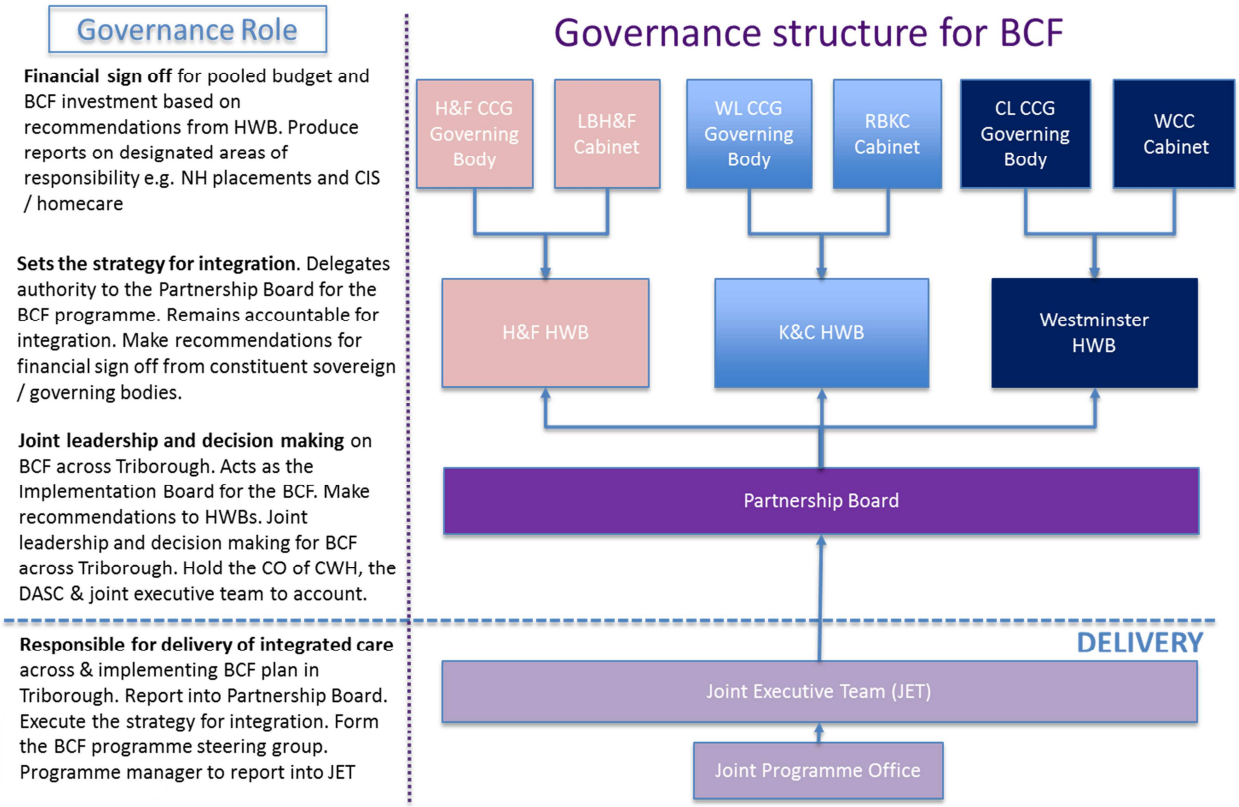
To deliver the ambition contained in our BCF, we recognise the need to develop further our strategic and operational governance arrangements. We therefore propose to look at, as part of this process, how we bring together management responsibilities and accountability across care and health services, for our residents and patients 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 BCF. The initial areas that we wish to

consider are the contracting of nursing and residential care placements, and the contracting of care delivered in people's homes.
Our business case for the contracting of nursing and residential care home placements 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 remove current gaps and duplication in procurement and improve oversight of quality and safety within this area of service provision.

In addition, joint commissioning of community independence and re-ablement services will enable us to procure integrated and effective services in the community and in people's homes, preventing unnecessary admissions to hospital and reducing length of stay for those who are admitted.

The first step in doing this will be to pool our funding for these services, and to establish one team who will be responsible for managing the health and social care budget for these functions (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. The diagram below outlines our proposed governance structure across Tri-borough.



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 Better Care 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, reflecting the needs of our local communities as identified through the joint strategic needs assessment and captured in the Health and Wellbeing Strategies.

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.

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 (SaHF) 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 Tri-borough, 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.

In terms of operational governance, the Integration Partnership Board (3 Cabinet members and 3 CCG chairs) will act as the BCF implementation Board. They will be accountable for the delivery of the BCF programme. The Joint Executive Team will be responsible for delivery and report into the Partnership Board. A joint programme office will be established to oversee, manage and co-ordinate this major transformation programme across the 6 partner organisations, to ensure the effective engagement of partners – service users, carers, citizens as well as service providers – and to evaluate the success of the programme, reporting to the Health and Wellbeing Boards on progress in achieving the outcomes agreed.

2) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting social care services.

Protecting social care services in the Tri-borough means ensuring that those in need within our local communities continue to receive the support they need, in a time of growing demand and budgetary pressures. Whilst maintaining current eligibility thresholds is one aspect of this, our primary focus is on developing new forms of joined up care which help ensure that individuals remain healthy and well, and have maximum independence, with benefits to both themselves and their communities, and the local health and care economy as a whole. By proactively intervening to support people at the earliest opportunity and ensuring that they remain well, are engaged in the management of their own wellbeing, and wherever possible enabled to stay within their own homes, our focus is on protecting and enhancing the quality of care by tackling the causes of ill-health and poor quality of life, rather than simply focussing on the supply of services.

Please explain how local social care services will be protected within your plans.

Funding currently allocated under the Social Care to Benefit Health grant has been used to enable the local authorities to sustain the current level of eligibility criteria and to provide timely assessment, care management and review and commissioned services to clients who have substantial or critical needs and information and signposting to those who are not FACS eligible.

This will need to be sustained, if not increased, within the funding allocations for 2014/15 and beyond if this level of offer is to be maintained, both in order to deliver 7 day services and in particular as the new Social Care Bill requires additional assessments to be undertaken for people who did not previously access Social Services.

It is proposed that additional resources will be invested in social care to deliver enhanced rehabilitation / re-ablement services which will reduce hospital readmissions and admissions to residential and nursing home care.

b) 7-day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy)

North West London was awarded “Early Adopter” status by the NHS England/NHSIQ Seven Day Services Improvement Programme, meaning that we have a responsibility to progress the seven day services agenda at scale and pace.

The joint strategic needs assessments and Joint Health and Wellbeing Strategies (JHWS) have helped us to identify the main areas where integration and joint working will improve outcomes and informed our commitment to drive forward 7 day services.

The 7 Day Services programme is an overarching programme which includes a number of projects, many of which will be delivered through existing work streams. The work streams closely linked with the BCF programme relate to social care and primary care providers.

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

Additional funding has been identified within the Tri-borough area during the winter period of 2013/14 to facilitate 7 day services in health and social care. This will enable partners to assess what additional capacity is required to develop an ongoing 7 day service offer and to evaluate how successful the approach is to facilitating discharges and avoiding un-necessary admissions

Further work is also being undertaken to understand the Adult Social Care Customer Journey, including interfaces with health providers to enable timely assessment and transfer, and 7 day services in social care will be considered as part of this work.

A costed plan for 7 day services will be developed in 2014 for implementation in advance of the 2014/15 Winter period.

c) Data-sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

All health services use the NHS number as the primary identifier in correspondence.

Social services are in the process of adopting this, and we are committed to ensuring this adoption is universal across the 3 local authorities of the Tri-borough.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by.

Number to be the primary identifier across all 3 localities by April 2015.

Please confirm that you are committed to adopting systems that are based upon Open APIs and Open Standards (i.e. secure email standards, interoperability standards (ITK))

We are committed to adopting systems based upon Open APIs and Open Standards. We already use:

- System One, a clinical computer system that allows service users and clinicians to view information and add data to their records;

- Emis Web, a tool that allows primary, secondary and community healthcare practitioners to view and contribute to a service user's cradle to grave healthcare record;

- Carefirst 6, a software solution to provide a range of services and content to social care, while allowing the involvement of health care partners.

To enable cross-boundary working, we will improve interfaces between systems. Further, we are creating a data warehouse that will aggregate data from different sources into a consistent format. This will provide one view over the whole systems of health and social care, and allow queries and analyses to take place across multiple, separate systems. Also, it will improve data quality by identifying gaps or inconsistent records.

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 BCF will help ensure this happens by joining up Health and Social Care data across the Tri-borough, linked as above via the NHS number.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott2.

All of this will take place within our Information Governance framework, and we are committed to maintaining five rules in health and social care to ensure than patient and service user confidentiality is maintained. The rules are:

- Confidential information about service users or patients should be treated confidentially and respectfully

- Members of a care team should share confidential information when it is needed for the safe and effective care of an individual

- Information that is shared for the benefit of the community should be anonymised

- An individual's right to object to the sharing of confidential information about them should be respected

- Organisations should put policies, procedures and systems in place to ensure the confidentiality rules are followed

d) Joint-assessments and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional.

Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

North West London has been implementing an Integrated Care Programme across local CCG areas that involves risk stratification of practice populations and review by multi-disciplinary groups, followed by implementation of care planning and case management as appropriate.

In Hammersmith and Fulham and West London CCGs the ICP risk stratification tool, modified from the Combined Predictive Mechanism (CPM), has identified 4% of the population at high risk of hospital admission. Central London CCG uses WellWatch who are planning to transition from an approach which selects patients on the basis of pathways, to one based on selecting patients on the basis of their relative risk score. WellWatch may begin to use the ICP risk stratification tool.

Each CCG has set different targets around care planning:

- In Hammersmith and Fulham, they are working towards the 4% having a joint care plan and accountable professional
- In West London, all patients with a risk score of 20 or over will be care planned, and those with a risk score of 65 or over will be case-managed
- In Central London, WellWatch Case Management Services will care plan for those in the 61-91 centile risk stratified cohort.

Our integrated plan envisages GPs taking a lead in coordinating care as the agreed accountable lead professionals for people at high risk of hospital admission.

Under the Integrated Care Programme, around 2% of patients and service users have a care plan, and this will increase to 4% to account for the population that has been identified as high risk. The CPM algorithms are used to predict emergency hospital admission in the next year. The algorithm draws on information from primary and acute care, as well as patients' ages, to make its predictions.

Further, we stratify segments of our population based on risk. The segments identified as high risk are (a) diabetes; (b) chronic obstruction pulmonary disorder (COPD); (c) coronary heart disease (CHD); or (d) if they are over 75. The multi-disciplinary groups within each borough also use these segments as a bsis for focussing their discussions. Based on these four indicators, approximately 4% of our population is at high risk of hospital admission.

Based on the algorithm and our stratification, we then closely monitor those classified as at high risk of hospital admission within the next year.

The Early Adopter pilots being proposed by the CCGs as part of the Whole Systems Integrated Care programme reflect a commitment by GP networks to undertake systematic risk stratification and care planning for their high risk populations and to develop an integrated response to providing treatment and care.

4) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers.

The table below provides an overview of some of the key risks identified through the co-design process to-date. A full risks and mitigations log is being produced in support of our final BCF submission.

Ref	Risk	Risk Rating	Mitigating Actions
1	Shifting of resources to fund new joint interventions and schemes will destabilise current service providers, both in the acute and community sector	High	• Our current plans are based on the agreed strategy for North West London, as outlined in "Shaping a Healthier Future". • The development of our plans for 2014/15 and 2015/16 will be conducted within the framework of our Whole System Integrated Care programme, allowing for a holistic view of impact across the provider landscape and putting co-design of the end point and transition at the heart of this process. • We will establish strong mechanisms for involving service providers, both statutory and independent, in our programme.
2	A lack of detailed baseline data and the need to rely on current assumptions means that our finance and performance targets for 2015/16 onwards are unachievable.	High	• The Whole Systems Integrated Care programme is undertaking a detailed mapping and consolidation of opportunities and costs which will be used to validate our plans. • We are investing specifically in areas such as customer satisfaction surveying and data management to ensure that we have up-to-date information around which we will adapt and tailor our plans throughout the next 2 years.
3	Operational pressures will restrict the ability of our workforce to deliver the required investment and associated projects to make the vision of care outlined in our BCF submission a reality.	High	• Our 2014/15 schemes include specific non-recurrent investments in the infrastructure and capacity to support overall organisational development. • We will build on existing arrangements such as the Whole Systems Integrated Care Programme which have already established some of the infrastructure and mechanisms for engagement, data gathering and analysis, and work closely with public health and the academic community to add value to our own capacity.

Ref	Risk	Risk Rating	Mitigating Actions
4	Improvements in the quality of care and in preventative services will fail to translate into the required reductions in acute and nursing / care home activity by 2015/16, impacting the overall funding available to support core services and future schemes.	High	• We have modelled our assumptions using a range of available data, including metrics from other localities and support from the National Collaborative. • 2014/15 will be used to test and refine these assumptions, with a focus on developing detailed business cases and service specifications. • We will rigorously evaluate the impact of our workstreams and, where these do not appear to be contributing to the required outcomes, we will bring them to an end and look to alternative approaches.
5	The introduction of the Care Bill, currently going through Parliament and expected to receive Royal Assent in 2014, will result in a significant increase in the cost of care provision from April 2016 onwards that is not fully quantifiable currently and will impact the sustainability of current social care funding and plans.	High	• We have undertaken an initial impact assessment of the effects of the Care Bill and will continue to refine our assumptions around this as we develop our final BCF response, and begin to deliver upon the associated schemes. • We believe there will be potential benefits that come out of this process, as well as potential risks. • We will work with other local authorities across the country to monitor closely the anticipated impact of the Care Bill.
6	Risks associated with pooled budgets	Medium	• The three local authorities and CCGs have established Health and Wellbeing Partnership Agreements which contain the necessary legal and financial framework to protect local sovereignty while facilitating partnership and collaboration. • During 2014-15 the terms of the new pooled budgets will be developed, consulted up on and agreed to provide all authorities with the confidence and trust they need to go forward.

Ref	Risk	Risk Rating	Mitigating Actions
7	Risk of failing to achieve targets	Medium	• Performance against the national metrics is already strong locally, so the setting of additional stretches is challenging and there is a risk of double counting. • The programme office will ensure that we monitor carefully, understanding the attribution of outcomes between workstreams both within the BCF programme and externally, and take steps to address slow performance as soon as a problem is identified.
8	Cultural change and workforce development	Medium	• Changing organisational structure is not necessary or sufficient to achieve integration. We will work with local education and training institutions and with service providers to develop integrated ways of working and behaviours to transform the quality of health and social care as well as the efficiency and effectiveness of delivery.

Tri-borough Better Care Fund

Part 2 Outcomes and Finances

The development of our outcomes framework and financial plans is now underway.

This has commenced with a baseline of current joint spending and national performance measures across health and care in the 3 localities which make up the Tri-borough, followed by development of high-level estimates for the priority interventions, over the next 2 years, which will help to make our overall vision a reality.

In addition to the identified savings we will be constructing a financial model which enables NHS revenue to flow into out of hospital services delivered by social care, and reimburses the local authority against agreed targets. This will reflect an agreed portion of the savings which will accrue to the NHS by preventing admissions and facilitating timely discharge from hospital.

The current joint commissioning arrangements under s75 partnership agreements are now fully reflected in the 2014-15 figures. The established partnership agreements provide a framework for the development of a new pooled budget(s) for the Better Care Fund.

We are in parallel looking at a local “person-centred” outcomes framework which will help us define our and our communities’ expectation of what good looks like, for future providers of integrated care within the Tri-borough; and allow us to evaluate at a more detailed level our progress over the next 5 years. In doing so we will work with partners including NHS England, the LGA and other localities to ensure that our measures are consistent, achievable and represent genuine improvement on the ground for the populations we serve.

At present the options we are considering for a Local Metric are contained in Appendix A.

Please see the attached BCF Part 2 Excel file for details of current baseline performance and metrics for our areas, and estimates of our BCF costs and benefits.

The assumptions upon which our costs and benefits are based are set out in Appendix B attached.

Appendix A – Options for a Local Metric

Indicator	Relevance to BCF Projects	RAG	Accuracy/ benchmarking	RAG	Feasibility of measurement	RAG
Rate (per 1000) of avoidable admissions for persons aged 75 and over supported in the community with social care	It is a joint health and social care indicator, therefore embodying the principles of the BCF. It targets the cohort most likely to be impacted by BCF projects. It is therefore a very strong indicator.		Locally defined indicator, so not possible to benchmark with other areas outside Tri-borough. Could be monitored quarterly, but admissions will probably need to be on a rolling 12 month basis to ensure sufficient numbers to detect change. May have to focus on those social care clients registered with a Tri-borough GP to ensure there is associated hospital activity		It is a NEW indicator which is reliant on data linkage being carried out by the CSU DMIC Team at regular (probably quarterly) intervals by linkage to NHS number. This poses a risk, as a process to facilitate this linkage does not appear to currently be in place between social care and the DMIC. Data linkage would need to take place before the end of Q1 2014/15 so that a baseline can be provided and a target set.	
Number of persons aged 65 and over supported with long term social care	This indicator would ensure that we have a 'whole system' view and that demand is not 'shunted' from different settings. If people can be better supported to manage long term conditions, avoid hospital admissions and when crisis occurs receive rehab/reablement, then fewer people should require long term social care.		May be possible to benchmark with other areas. But may be challenging to achieve targets given the 'other noise'.		This information is not currently reported but the data is available from the social care case management system to establish it as an indicator.	
Weighted percentage of people who feel supported to manage their long-term condition	This is a measure of the level of support patients in primary care feel they receive from their GP. It embodies some of the principles of BCF but does not give a full picture across both health and social care		Will be possible to benchmark against other areas, as this is calculated using a national definition. However, the response rate to the survey is relatively low (46%) and the numbers are therefore prone to fluctuate due to chance.		This is a routinely collected indicator, used for the NHS Outcomes Framework (2.1) and comes from the GP Patient Survey, which is collected routinely. It has been suggested as a potential local indicator in the Better Care Fund Technical Guidance. As of Dec 2013 the HSCIC states that the method of calculating the indicator is 'under review', but a consistent back series of data will be provided	

Appendix B – Tri-borough BCF Costs and Benefits Assumptions

BCF Investment	Costing Assumptions	Savings Assumptions
BCF01/11 - Strengthen 7 Day Social Care Provision in Hospitals	Costs based on 5 months of winter pressures funding with additional 7 months at 45% intensity of the winter months.	N/A
BCF02/06/12 - Developing Self-Management and Peer Support/Patient Satisfaction	Costs as per the scheme PID	N/A
BCF03/09 - Transforming Nursing and Care Home Contracting/Existing Joint Commissioning (CCG Joint Commissioning Team spend only - LA included within BCF07b)	Costs reflect the CCG contribution to the joint commissioning team plus project costs from the scheme PID.	Initial work done by PPL suggested an opportunity in spot placements alone of £1.2m from bringing 25% of the higher cost placements into line with the lower cost placements. Savings have been pro-rated by spend with £0.82m in LA spend and £0.38m in CCG spend.
BCF04 - Better Care Fund Programme Management	Costs from scheme PID	N/A
BCF05 - IT Integration	Costs from scheme PID	N/A
BCF07a - Review Existing Section 75 services	Costs reflect existing Section 75 agreements	Assumes that 50% of Section 75 agreements would be reviewed and 2% savings could be achieved. £867k in LA, £561k in CCG
BCF07b - Existing Section 256 pass through funds (including LA Joint Commissioning team spend)	Costs reflect the existing Section 256 Social Care to benefit health spend and includes the LA contribution to the joint commissioning team.	N/A
BCF07c - Existing Community Services (unless included in other schemes)	Costs reflect the community services commissioned from CLCH which align with an integrated service target operating model	Assume 2% savings on Community Services review
BCF07d - Carers	Costs reflect current Carers Section 75 agreements	N/A
BCF07e - Reablement Section 256	Costs reflect current reablement Section 256 agreements	N/A
BCF08 - Community Independence Service	Costs taken from the draft CIS business case which includes £11.1m of existing spend plus £6.1m of new investment	Savings based on high-level benchmarking done by PPL as part of the CIS business case with some triangulation against the LGA Value Cases toolkit. Savings are a combination of reduced demand for Nursing and Care homes and reductions in emergency admissions. Current split is £8.89m CCG and £3.2m LA. Savings are indicative and subject to further validation and assessment as the CIS business case is developed.

Appendix B – Tri-borough BCF Costs and Benefits Assumptions

BCF Investment	Costing Assumptions	Savings Assumptions
BCF09 - Integrated Commissioning		N/A
BCF10 - Rehabilitation and Reablement Services	Costs based on estimated requirement of 18 new neuro-rehabilitation beds	N/A
BCF13 - Psychiatric Liaison	Costs reflect existing investment in Psychiatric Liaison plus an additional 0.5m investment by H&F CCG in Hammersmith and Charing Cross Hospitals.	N/A
BCF15 - GP 7-Day Access	Costs based on 2 practices per locality open 8 hours a day Sat and Sun	Assumes that 10% of the additional capacity is used by people diverting from UCC where providers are reimbursed on a cost per case.
BCF16 - Developing Personal Health and Care Budgets	Costs as per PID	N/A
BCF17 - Whole System Integration		N/A
BCF18 - Implementation of Care Bill	Costs as per PID	N/A
BCF14/19 - Developing integrated services for people with Long Term Conditions		N/A
Disabled Facilities Grants	As per notified allocations	N/A
Community Capacity Grant	As per notified allocations	N/A

Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
Westminster City Council	Y	28,761,068	1,379,000	26,252,068
Royal Borough of Kensington and Chelsea	Y	22,942,850	874,000	22,003,850
London Borough of Hammersmith and Fulham	Y	49,715,999	1,052,000	47,781,199
Central London CCG	N	27,137,037	13,553,000	43,754,621
West London CCG	N	15,923,613	17,830,000	39,745,502
Hammersmith and Fulham CCG	N	12,629,786	13,148,000	31,923,371
BCF Total		**157,110,353**	**47,836,000**	**211,460,612**

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

Our aim is to ensure that we have the strong governance in place around delivery of our BCF plans, aligned to a benefits realisation framework with regular monitoring of early warning indicators. This will allow early intervention where plans are not on target and should ensure that the risk of failing to achieve the planned savings is minimised. In the event that the savings aren't delivered in full, planning contingencies could be used to ensure that services are maintained in the short-term while delivery of the savings is brought back on target.

Contingency plan:		2015/16	Ongoing
Reduction in admissions to residential and nursing homes	Planned savings (if targets fully achieved)	7,647,192	7,647,192
	Maximum support needed for other services (if targets not achieved)	2,676,517	0
Reduction in Emergency Admissions	Planned savings (if targets fully achieved)	5,017,896	5,017,896
	Maximum support needed for other services (if targets not achieved)	4,014,317	0
Reduction in costs through joint commissioning of nursing and residential care	Planned savings (if targets fully achieved)	1,200,000	1,200,000
	Maximum support needed for other services (if targets not achieved)	0	0
Better VFM on jointly commissioned services	Planned savings (if targets fully achieved)	1,841,949	1,841,949
	Maximum support needed for other services (if targets not achieved)	0	0

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
BCF01/11 - Strengthen 7 Day Social Care Provision in Hospitals	ASC/Home Care	*1,303,760*	*0*	*0*	*0*	*1,303,760*	*0*	*0*	*0*
BCF02/06/12 - Developing Self-Management and Peer Support/Patient Satisfaction	TBD	*227,047*	*0*	*0*	*0*	*289,555*	*0*	*0*	*0*
BCF03/09 - Transforming Nursing and Care Home Contracting/Existing Joint Commissioning (CCG Joint Commissioning Team spend only - LA included within BCF07b)		*600,000*	*160,000*		*0*	*600,000*	*111,000*	*1,200,000*	*0*
BCF04 - Better Care Fund Programme Management		*0*	*272,800*	*0*	*0*	*307,800*	*0*	*0*	*0*
BCF05 - IT Integration		*150,678*	*100,000*	*0*	*0*	*150,678*	*659,881*	*0*	*0*
BCF07a - Review Existing Section 75 services		*138,774,943*	*0*	*0*	*0*	*138,774,943*	*0*	*1,387,749*	*0*
BCF07b - Existing Section 256 pass through funds (including LA Joint Commissioning team spend)		*11,126,000*	*0*	*0*	*0*	*11,126,000*	*0*	*0*	*0*
BCF07c - Existing Community Services (unless included in other schemes)		*0*				*22,710,000*		*454,200*	
BCF07d - Carers		*1,931,875*				*1,931,875*			
BCF07e - Reablement Section 256		*2,076,000*				*2,076,000*			
BCF08 - Community Independence Service		*0*	*0*	*0*	*0*	*17,223,400*	*0*	*12,096,000*	*0*
BCF09 - Integrated Commissioning		*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
BCF10 - Rehabilitation and Reablement Services		*0*	*0*	*0*	*0*	*2,700,270*	*0*	*0*	*0*
BCF13 - Psychiatric Liaison		*0*	*0*	*0*	*0*	*4,119,000*	*0*	*0*	*0*
BCF15 - GP 7-Day Access		*0*	*0*	*0*	*0*	*2,432,600*	*0*	*569,088*	*0*
BCF16 - Developing Personal Health and Care Budgets		*100,000*	*0*	*0*	*0*	*100,000*	*0*	*0*	*0*
BCF17 - Whole System Integration		*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
BCF18 - Implementation of Care Bill		*0*	*287,250*	*0*	*0*	*1,400,000*	*138,850*	*0*	*0*
BCF14/19 - Developing integrated services for people with Long Term Conditions		*0*	*0*	*0*	*0*	*0*	*0*		*0*
Disabled Facilities Grants		*0*	*0*	*0*	*0*	*1,574,000*	*0*	*0*	*0*
Community Capacity Grant		*0*	*0*	*0*	*0*	*1,731,000*	*0*	*0*	*0*
Total		***156,290,303***	***820,050***	***0***	***0***	***210,550,881***	***909,731***	***15,707,037***	***0***

Outcomes and metrics LBHF

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

Details on outcome trajectories and technical specifications have been given below. Expected outcomes and benefits of the scheme have been detailed in other documentation

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please

It is suggested that the national patient experience measure be used, to ensure consistency with other areas and hence the ability to benchmark against them

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

We are establishing robust programme governance across health and social care, with a joint programme board than can monitor the improvements that the schemes will deliver.

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and

This covers Hammersmith and Fulham, which is part of the Tri-borough (alongside Kensington and Chelsea and Westminster)

Metrics		Current Baseline (as at….)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment	Notes
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	Metric Value	**618.2**	N/A	**584.6** (Apr 14-Mar 15)	**Trajectory:** to hit the average of the top quartile nationally by 2018/19 (27% improvement) at time when the Care Bill and demographic change means upward pressure . 14/15 figure represents one fifth of this straight line 5 year improvement. **Technical notes:** actual number of admissions given as opposed to 'rounded to the nearest 5' nationally reported figure.
	Numerator	105			
	Denominator	16,985			
		(April 2012 - March 2013)			
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Metric Value	**88.6**	N/A	**89.2** (Apr 14-Mar 15)	**Trajectory:** to hit the average of the top quartile nationally by 2018/19 (3.3% proportionate improvement - H&F is already in top quartile). 14/15 figure represents one fifth of this straight line 5 year improvement. **Technical notes:** caveat re methodology which is based on exclusions, therefore any improvements / refinements to the methodology will reduce outcome performance. Furthermore calculation of the 91 day reablement/ rehab measure has previously been carried out by using data linkage between hospital admission, community rehab, local authority reablement and deaths data. Given changes in the law around identifiable data and data linkage, it is no longer possible to calculate this measure using this approach. Any changes made to the methodology for calculating this data may impact on the outcomes/ targets in the future, so baselines may need to be recalculated.
	Numerator	140			
	Denominator	160			
		(April 2012 - March 2013)			
Delayed transfers of care from hospital per 100,000 population (average per month)	Metric Value	**200**	**187.0** (Apr - Dec 2014)	**176.1** (Jan-Jun 2015)	**Trajectory** to hit the average of the top quartile nationally by 2018/19 (43% reduction). Figures represent points in time within this straight line 5 year improvement. **Technical notes:** ONS 2013 used for trajectories due to unreliability of ONS on Tri-borough populations.
	Numerator	298			
	Denominator	148,931			
		(April 2012 - March 2013)			
Avoidable emergency admissions (composite measure)	Metric Value	**1933.9**	**1908.1** (Apr -Sep 2014)	**1858.4** (Oct 2014-Mar 2015)	**Trajectory:** these targets represent the same drop as the CCG 'Everyone Counts - Planning for Patients' submission with the following proportionate drops on baseline: 2.6% in 14/15, 5.2% in 15/16, 7.8% in 16/17, 10.4% in 17/18, and 13.0% in 18/19. CCG figures are based around the 'Shaping a Healthier Future' assumptions. ONS 2013 used for trajectories due to unreliability of ONS on Tri-borough populations. **Technical notes:** figure provided is actual number of avoidable admissions divided by ONS MYE 2013 and expressed as rate per 100,000. For April 2015 and October 2015, it is the 6 month figure multiplied by 2 to get an annualised rate. ONS 2013 used for trajectories due to unreliability of ONS on Tri-borough populations.
	Numerator	3539			
	Denominator	182,995			
		(Dec 2012 - Nov 2013)			
Patient/ service user experience - Recommedation to use national measure		**Recommendation to use national measure**			Recommendation to use national measure, to ensure benchmarking against other areas
Local measure: *Options around suggested local measures have been presented in a paper which discusses relevance, accuracy, and feasibility. Options include:* 1. Rate (per 1000) of avoidable admissions for persons aged 75 and over supported in the community with social care 2. Number of persons aged 65 and over supported with long term social care 3. Weighted percentage of people who feel supported to manage their long-term condition					Several options for local indicators have been discussed in a separate paper

Outcomes and metrics RBKC

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

Details on outcome trajectories and technical specifications have been given below. Expected outcomes and benefits of the scheme have been detailed in other

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015

It is suggested that the national patient experience measure be used, to ensure consistency with other areas and hence the ability to benchmark against them

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

We are establishing robust programme governance across health and social care, with a joint programme board than can monitor the improvements that the schemes

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for

This covers Kensington and Chelsea, which is part of the Tri-borough (alongside Hammersmith and Fulham and Westminster)

Metrics		Current Baseline (as at....)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment	Notes
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	Metric Value	**138.3**	N/A	**138.3** (Apr 14-Mar 15)	**Trajectory:** to maintain the very low rate of admission - currently the lowest (best) in the country - at time when the Care Bill and demographic change means upward pressure. **Technical notes:** actual number of admissions given as opposed to 'rounded to the nearest 5' nationally reported figure. **NEED TO RECALCULATE BASELINE**
	Numerator	28			
	Denominator	20,240			
		(April 2012 - March 2013)			
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Metric Value	**84.7**	N/A	**86.1** (Apr 14-Mar 15)	**Trajectory:** to hit the average of the top quartile nationally by 2018/19 (8.0% proportionate improvement). 14/15 figure represents one fifth of this straight line 5 year improvement. **Technical notes:** caveat re methodology which is based on exclusions, therefore any improvements / refinements to the methodology will reduce outcome performance. Furthermore calculation of the 91 day reablement/ rehab measure has previously been carried out by using data linkage between hospital admission, community rehab, local authority reablement and deaths data. Given changes in the law around identifiable data and data linkage, it is no longer possible to calculate this measure using this approach. Any changes made to the methodology for calculating this data may impact on the outcomes/ targets in the future, so baselines may need to be recalculated.
	Numerator	110			
	Denominator	130			
		(April 2012 - March 2013)			
Delayed transfers of care from hospital per 100,000 population (average per month)	Metric Value	**267.7**	**244.1** (Apr - Dec 2014)	**224.6** (Jan-Jun 2015)	**Trajectory** to hit the average of the top quartile nationally by 2018/19 (57% reduction). Figures represent points in time within this straight line 5 year improvement. **Technical notes:** ONS 2013 used for trajectories due to unreliability of ONS on Tri-borough populations.
	Numerator	350			
	Denominator	130,761			
		(April 2012 - March 2013)			
Avoidable emergency admissions (composite measure)	Metric Value	**1477.3**	**1458.1** (Apr - Sep 2014)	**1419.7** (Oct 2014-Mar 2015)	**Trajectory:** these targets represent the same drop as the CCG 'Everyone Counts - Planning for Patients' submission with the following proportionate drops on baseline: 2.6% in 14/15, 5.2% in 15/16, 7.8% in 16/17, 10.4% in 17/18, and 13.0% in 18/19. CCG figures are based around the 'Shaping a Healthier Future' assumptions. ONS 2013 used for trajectories due to unreliability of ONS on Tri-borough populations. **Technical notes:** figure provided is actual number of avoidable admissions divided by ONS MYE 2013 and expressed as rate per 100,000. For April 2015 and October 2015, it is the 6 month figure multiplied by 2 to get an annualised rate. ONS 2013 used for trajectories due to unreliability of ONS on Tri-borough populations.
	Numerator	2349			
	Denominator	159011			
		(Dec 2012 - Nov 2013)			
Patient/ service user experience - Recommedation to use national measure		**Recommendation to use national measure**			Recommendation to use national measure, to ensure benchmarking against other areas
Local measure: *Options around suggested local measures have been presented in a paper which discusses relevance, accuracy, and feasibility. Options include:* 1. Rate (per 1000) of avoidable admissions for persons aged 75 and over supported in the community with social care 2. Number of persons aged 65 and over supported with long term social care 3. Weighted percentage of people who feel supported to manage their long-term condition					Several options for local indicators have been discussed in a separate paper

Outcomes and metrics WCC

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

Details on outcome trajectories and technical specifications have been given below. Expected outcomes and benefits of the scheme have been detailed in other

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015

It is suggested that the national patient experience measure be used, to ensure consistency with other areas and hence the ability to benchmark against them

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

We are establishing robust programme governance across health and social care, with a joint programme board than can monitor the improvements that the schemes will

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each

This covers Westminster, which is part of the Tri-borough (alongside Hammersmith and Fulham and Kensington and Chelsea)

Metrics		Current Baseline (as at….)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment	Notes
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	Metric Value	**472.7**	N/A	**468.2** (Apr 14-Mar 15)	**Trajectory:** to hit the average of the top quartile nationally by 2018/19 (4% improvement - Westminster is already 17th highest in country) at time when the Care Bill and demographic change means upward pressure . 14/15 figure represents one fifth of this straight line 5 year improvement. **Technical notes:** actual number of admissions given as opposed to 'rounded to the nearest 5' nationally reported figure.
	Numerator	120			
	Denominator	25,385			
		(April 2012 - March 2013)			
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Metric Value	**86.1**	N/A	**87.2** (Apr 14-Mar 15)	**Trajectory:** to hit the average of the top quartile nationally by 2018/19 (6.3% proportionate improvement). 14/15 figure represents one fifth of this straight line 5 year improvement. **Technical notes:** caveat re methodology which is based on exclusions, therefore any improvements / refinements to the methodology will reduce outcome performance. Furthermore calculation of the 91 day reablement/ rehab measure has previously been carried out by using data linkage between hospital admission, community rehab, local authority reablement and deaths data. Given changes in the law around identifiable data and data linkage, it is no longer possible to calculate this measure using this approach. Any changes made to the methodology for calculating this data may impact on the outcomes/ targets in the future, so baselines may need to be recalculated.
	Numerator	180			
	Denominator	210			
		(April 2012 - March 2013)			
Delayed transfers of care from hospital per 100,000 population (average per month)	Metric Value	**225.2**	**208.1** (Apr - Dec 2014)	**194.0** (Jan-Jun 2015)	**Trajectory** to hit the average of the top quartile nationally by 2018/19 (49% reduction). Figures represent points in time within this straight line 5 year improvement. **Technical notes:** ONS 2013 used for trajectories due to unreliability of ONS on Tri-borough populations.
	Numerator	436			
	Denominator	193,621			
		(April 2012 - March 2013)			
Avoidable emergency admissions (composite measure)	Metric Value	**1440.3**	**1421.6** (Apr - Sep 2014)	**1384.1** (Oct 2014-Mar 2015)	**Trajectory:** these targets represent the same drop as the CCG 'Everyone Counts - Planning for Patients' submission with the following proportionate drops on baseline: 2.6% in 14/15, 5.2% in 15/16, 7.8% in 16/17, 10.4% in 17/18, and 13.0% in 18/19. CCG figures are based around the 'Shaping a Healthier Future' assumptions. ONS 2013 used for trajectories due to unreliability of ONS on Tri-borough populations. **Technical notes:** figure provided is actual number of avoidable admissions divided by ONS MYE 2013 and expressed as rate per 100,000. For April 2015 and October 2015, it is the 6 month figure multiplied by 2 to get an annualised rate. ONS 2013 used for trajectories due to unreliability of ONS on Tri-borough populations.
	Numerator	3317			
	Denominator	230,302			
		(Dec 2012 - Nov 2013)			
Patient/ service user experience - Recommedation to use national measure		**Recommendation to use national measure**			Recommendation to use national measure, to ensure benchmarking against other areas
Local measure: *Options around suggested local measures have been presented in a paper which discusses relevance, accuracy, and feasibility. Options include:* 1. Rate (per 1000) of avoidable admissions for persons aged 75 and over supported in the community with social care 2. Number of persons aged 65 and over supported with long term social care 3. Weighted percentage of people who feel supported to manage their long-term condition					Several options for local indicators have been discussed in a separate paper

h&f the low tax borough	**London Borough of Hammersmith & Fulham** **HEALTH & WELLBEING BOARD** **24 March 2014**
Hammersmith & Fulham CCG strategic and operational planning 2014/15-2018/19	
Report from Hammersmith & Fulham CCG	
Open Report	
Classification - For Information/For Scrutiny Review & Comment (delete as appropriate) **Key Decision: NO**	
Wards Affected: All	
Accountable Executive Director: Philippa Jones, MD, H&F CCG	
Report Author: Rachel Stanfield, Head of OD & Governance, H&F CCG	**Contact Details:** Tel: 02033504559 E-mail: rachel.stanfield2@nw.london.nhs.uk

1. SUMMARY

1.1. Background

As part of the NHS England planning cycle, Clinical Commissioning Groups (CCGs) are required to submit improvement trajectories for a range of indicators, which are detailed below. In some cases, CCGs are asked to detail improvements over a two year period, while other indicators are linked to five year trajectories.

This paper outlines the indicators in question and NHS Hammersmith & Fulham CCG's approach to setting improvement trajectories. Some targets are nationally mandated, while others have been developed across the CWHHE (Central, West, Hammersmith & Fulham, Hounslow and Ealing) Collaborative of CCGs, and some have been set locally by the CCG. CCGs have also been asked to identify one local priority for improvement in 2014/15.

1.2. Key content areas

The nationally mandated improvement areas are described, along with the proposed trajectories. The improvement areas are:

- Potential years of life lost from causes considered amendable to healthcare
- Health-related quality of life for people with long-term conditions
- Emergency admissions
- Positive experience of hospital care, in general practice and the community
- Specific targets for Improving Access to Psychological Therapies and dementia
- Medication error reporting
- Friends and Family Test (FTT)
- Healthcare acquired infections.

In addition, the CCGs are required to select one local priority for specific improvement in 2014/15. NHS Hammersmith & Fulham CCG has selected the number of patients recorded on GP systems as having a learning disability who receive an annual health check.

1.3. The HWBB is asked to:

- Consider and endorse the trajectories outlined in the paper (pp. 2-3)
- Comment on and endorse the list of providers and the proposed targets that have been set for medication error reporting
- Comment on and endorse the selected local priority

NHS Hammersmith & Fulham Clinical Commissioning Group (CCG)
Operational Plans 2014/15-2018/19

Hammersmith & Fulham Health and Wellbeing Board

24 March 2014

1. Executive summary

As part of the NHS England planning cycle, Clinical Commissioning Groups (CCGs) are required to submit improvement trajectories for a range of indicators, which are detailed below. In some cases, CCGs are asked to detail improvements over a two year period, while other indicators are linked to five year trajectories.

This paper outlines the indicators in question and NHS Hammersmith & Fulham CCG's approach to setting improvement trajectories. Some targets are nationally mandated, while others have been developed across the CWHHE (Central, West, Hammersmith & Fulham, Hounslow and Ealing) Collaborative of CCGs, and some have been set locally by the CCG.

CCGs have also been asked to identify one local priority for improvement in 2014/15.

Hammersmith & Fulham CCG has selected health checks for people with learning disabilities (LD) for this indicator. Further detail explaining the rationale for this choice and how the indicator will be measured is provided below.

Achievement in some of the trajectories is linked to financial incentives as part of the CCG Quality Premium. Funds awarded under the Quality Premium can be invested in improving the quality of local health services for the CCG's populations.

An initial submission to NHS England (NHSE) was made on 14 February 2014, and this was discussed in an Assurance meeting on 28 February 2014. The feedback from this meeting was very positive and required no changes from the CCG. The final submission will be made to NHSE on 4 April 2014.

2. Key matters for the Board's consideration

The CCG has sought advice from public health in order to ensure the priorities are of an appropriate level of ambition and are supported by public health commissioning priorities.

The trajectories and the approach taken to their development are outlined in the table below.

CCGs in England have been categorised into quintiles according to their current performance, and these quintiles have been used to set plans for improvement. In all cases, the first quintile indicates the best comparative performance, and the fifth indicates the poorest comparative performance.

The Board is asked to consider and endorse the trajectories outlined in the table below.

Indicator	Proposed target	Rationale
Potential years of life lost (PYLL) from causes considered amenable to healthcare (adults and children)	3.2% improvement year on year between 2014/15 and 2018/19.	The CCG is currently at the top of the second quintile for performance, so has a strong starting point. 3.2% is a nationally mandated minimum annual improvement target. The CCG understands from public health colleagues that this will be a stretch target and as such the CCG does not propose to set a more ambitious target.
Health-related quality of life for people with long-term conditions Measure derived by asking patients with a long-term condition a series of 5 questions, which include how they rate their mobility, ability to self-care, ability to carry out usual activities, pain and anxiety/depression.	Movement from a score of 74.6 to 76.1 (out of possible 100) between 2014/15 and 2018/19. This constitutes movement from the second to the top quintile.	The CCG is currently in the second quintile for this indicator. As such, the CCG proposes to set a target which would move the CCG to the top quintile over 5 years.
Composite measure on emergency admissions, including: § Rates for unplanned hospitalisation for chronic ambulatory care sensitive conditions; § Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s; § Emergency admissions for acute conditions that should not usually require hospital admission; § Emergency admissions for children with lower respiratory tract infections.	13% improvement between 2014/15 and 2018/19.	The CCGs in the CWHHE Collaborative are all applying a 13% reduction in emergency admissions. The target is derived from Shaping a Healthier Future plans for hospital reconfiguration. The CCG also has strong plans in place for the development of Whole Systems Integrated Care to support this objective.

Indicator	Proposed target	Rationale
Positive patient experience of hospital care Measure derived by counting the number of 'poor' responses to experience of hospital care per 100 patients.	4% improvement in CCG's score between 2014/15 and 2018/19.	The CCG is currently in the fourth quintile. This constitutes movement from the third quintile.
Positive patient experience of out of hospital care, in general practice and the community Measure derived by counting the number of 'poor' responses to experience of GP practice and GP out of hours services.	11% improvement in CCG's score between 2014/15 and 2018/19.	The CCG is currently in the fifth quintile. This constitutes movement from the fifth quintile to the fourth quintile.
Improving Access to Psychological Therapies roll out	Nationally mandated target of 15%, which the CCG proposes to achieve in 2014/15 and maintain in 2015/16.	The CCG plans to achieve a minimum of 15% in the next two financial years in line with the national mandate. The current forecast for 2013/14 year end performance is 13.1%
Improving Access to Psychological Therapies recovery rate	Nationally mandated target of 50%, which the CCG proposes to achieve in 2014/15 and maintain in 2015/16.	The CCG plans to achieve 50% in the next two financial years in line with the national mandate.
Dementia diagnosis rate	Nationally mandated target of 67% diagnosis rate by March 2015, which the CCG proposes to achieve in 2014/15 and maintain in 2015/16.	The CCG plans to achieve 67% in the next two financial years in line with the national mandate. The current forecast for 2013/14 year end performance is 54%

Self-certifications

The CCGs are submitting a joint response in respect of confirmations that they will comply with nationally mandated plans for improving the reporting of medication-related safety incidents, improving performance in the Friends and Family Test, and healthcare acquired infections.

Medication error reporting

Targets have been identified on an individual basis for local providers based on their current performance and their ability to demonstrate an increase in incidents related to medication errors.

The CWHHE Collaborative has analysed the National Reporting and Learning System (NRLS) data in order to identify current performance and benchmark improvement targets (see Appendix 1).

Where a Trust is already achieving higher than the national average for a Trust of similar size and demographic, the expectation will be for the Trust to demonstrate an ability to consistently maintain reporting at this level.

NB. This is in the process of being agreed with providers so still draft.

The Board is asked to comment on and endorse the list of providers and the proposed targets that have been set.

Friends and Family Test (FFT)

CCGs working with providers will be required to produce a quarterly integrated patient experience report which would include FFT data. A meeting with providers will take place to agree a collaborative approach to take this forward.

CCGs are working closely with Trusts to address areas where people are reporting poor experience of care as well as where the response rate is below the national target of 15%.

CCGs are currently supporting an FFT pilot for people with Learning Disabilities in partnership with CLCH and the Learning Disabilities Team.

Health Care Acquired Infections

NHS England are introducing a revised approach to setting clostridium difficile objectives for 2014/15 that requires continued improvement but recognises the great strides that have been made in recent years.

On-going monitoring of Trusts' compliance with MRSA targets will be through Clinical Quality Group meetings.

CCG Local Priority

In 2013/14, the CCG was required to select three local priorities, which were:

- Increase MMR year 2 first dose to 87%
- X-PERT programme for diabetes: increase the number of patients with diabetes enrolled on to a disease education programme to 18%
- Physical health checks for people with severe and enduring mental illness

In 2014/15, the CCG is required to select **one local priority** tied to the Quality Premium – this needs to be something which is both achievable and measurable.

It is proposed that this is:

The number of patients recorded on GP systems as having a learning disability, as of 1st April 2014, who receive an annual health check between 1st April 2014 and 31st March 2015

Rationale for selection

This is being proposed as the CCG's local priority for the following key reasons:

- H&F published Equality Objective that we are committed to achieving
- DES (Directed Enhanced Services) scheme continued into 14/15
- Local authority colleagues are particularly supportive of this as a priority area given local interest in the area and this priority provides an opportunity for collaboration
- Support to people with learning disabilities in H&F is known to be a development area for the Borough.

Local authority colleagues and the joint commissioning team were both involved in making the decision to propose this as the CCG's local priority.

Description of the target

Component	Description
Target	60%
Baseline	54% (actual performance for 2012/13)
Denominator	No of patients with learning disability registered with a Hammersmith & Fulham GP as at 1st April 2014
Numerator	No of people with learning disability registered with a Hammersmith & Fulham GP who receive an annual health check
Measured	On a monthly basis using SystmOne
Reported	Quarterly using SystmOne

Approach to delivery

We will do the following things in order to deliver the target:

- Encourage take up of the DES from GP Practices

- Work with GPs, Practice nurse and the LA teams to understand what additional training could support delivery of this target
- Work with service users and carers to determine what the current blocks are to having an annual health check
- Work with the Health and Wellbeing Board to unblock any issues that arise from understanding the issues better.

The Board is asked to comment on and endorse the selected local priority.

3. Conclusion

The Board is asked to comment on and endorse the approach outlined above, and in particular the local priority proposed by the CCG.

There is opportunity for adjustments to be made to the plan before final submission on 4th April 2014. If there is further feedback on the trajectories, the CCGs ask that this be provided by close of play on 26 March 2014, as there will not be an opportunity to present this information again before the final submission.

The CCGs in North West London are also completing a 5 year Strategic Plan, which is due for submission in June. The Health and Wellbeing Board will be consulted on the contents of this in due course.

APPENDIX 1:

Operational Plan Submission

Domain 5 – improved reporting medication-related safety incidents

The Operational Plan requires CCGs to agree a specified increased level of reporting of medication errors from specified local providers for the period between Q4, 2013/14 and Q4, 2014/15. The measure should be agreed by the CCG with its local Health and Wellbeing Board and the NHS England area team.

Across the CWHHE Collaborative the local providers who will be asked to achieve the specified increase are:

- Central London Community Healthcare NHS Trust (CLCH)
- Chelsea and Westminster NHS Foundation Trust
- Central and North West London NHS Foundation Trust (CNWL)
- Imperial College Healthcare NHS Trust
- West London Mental Health NHS Trust

The Operational Plan requires commissioners to consider this improvement for all providers who deliver 10% or more of the total CCG activity. Further work is on-going to confirm which providers this includes and the following methodology will be discussed with their lead CCG.

Progress and Proposal

The current position and proposal is shown in the table overleaf.

Targets have been identified on an individual basis for local providers based on their current performance and their ability to demonstrate an increase in incidents related to medication errors.

The CWHHE Collaborative has analysed the NRLS data to identify current performance. The proposal uses the nationally benchmarked 'comparable organisation' performance percentage as the target for local providers to achieve.

Where performance at a Trust is already achieving higher than the national average for a Trust of similar size and demographic, the expectation will be for the Trust to demonstrate an ability to consistently maintain reporting at this level.

Organisation	NRLS Uploads in last 6 months	Overall Reporting culture	Medication related incidents	NRLS Comparable organisation	Difference between performance and national average	Interpretation	Target
Imperial	6 of 6	Middle 50%	13.60%	11.70%	1.90%	Good overall reporters and higher than NRLS comparators for medication related incidents. Would be difficult for Trust to achieve gross increase.	**Trust to sustain current performance to match or exceed the 11.7% achieved by comparable organisations.**
Chelsea and Westminster	6 of 6	Middle 50%	10.10%	11.70%	-1.60%	Good overall reporters to NRLS but lower than NRLS comparator in relation to medication incidents.	**Increase current reporting levels to match 11.7% requiring an increase of 1.60%**
West Mid	6 of 6	**Lowest 25%**	5.70%	10%	-4.30%	Low reporting generally and low reports against NRLS comparator Highly relevant and large scope for improvement	**Increase current reporting levels to match 10% requiring an increase of 4.3%**
CLCH	6 of 6	Middle 50%	10.10%	9.40%	0.70%	Good reporters to NRLS and in line with comparator. Trust may find it difficult to achieve gross increase.	**Trust to sustain current performance to match or exceed the 9.4% achieved by comparable organisations.**
CNWL	6 of 6	Middle 50%	7%	8.40%	-1.40%	Good reporters to NRLS but lower numbers of medication related incidents against NRLS comparator. Scope to raise reporting rates against comparable organisations.	**Increase current reporting levels to match 8.4% requiring an increase of 1.4%**
West London Mental Health	6 of 6	**Lowest 25%**	10.90%	8.40%	2.50%	Low reporters to NRLS but positive against NRLS comparator for medication incidents. Might be difficult, Medication related incidents are higher meaning that addressing the overall reporting culture could actually see a decrease in the proportion of these incidents. May respond to a focused push on these types of incidents.	**Trust to sustain current performance to match or exceed the 8.4% achieved by comparable organisations. Commissioners would welcome an overall increase in reporting of all incidents.**

h&f the low tax borough	**London Borough of Hammersmith & Fulham** **HEALTH & WELLBEING BOARD** **24 March 2014**
HEALTH & WELL-BEING STRATEGY	
Report of the Executive Director Tri-borough Adult Social Care	
Open Report	
Classification - For Decision **Key Decision: No**	
Wards Affected: All wards	
Accountable Executive Director: Liz Bruce, Tri-borough Executive Director for Adult Social Care	
Report Author: David Evans, Business Manager, Tri-borough Adult Social Care	**Contact Details:** Tel: 020 8753 2154 E-mail: david.evans@lbhf.gov.uk

1. EXECUTIVE SUMMARY

1.1. On 13 January 2014, the Board agreed that a revised draft of the Health & Well-being Strategy (Appendix 1), setting out what success in 2016 would look like and how we will measure success, would be brought back to the Board for sign off.

1.2. The existing high level vision and intent remains, as does the agreed priorities but they are now supported by clear actions.

1.3 A dashboard in Table 1 will inform a quarterly highlight report to the Board throughout 2014/15. An example of the detailed template which will support the implementation is attached as Appendix 2.

2. RECOMMENDATIONS

2.1. Board Members are asked to comment and agree the Draft Health & Well-being Strategy as set out in Appendix 1.

2.2 Board Members are asked to delegate the target setting to named officers for each of the indicators for 2016.

3. REASON FOR DECISION

3.1. The Health & Social Care Act 2012 requires the Health &Well-being Board to agree a Joint Health & Well-being Strategy.

4. INTRODUCTION AND BACKGROUND

4.1. Following consultation on the Health & Well-being Strategy at the end of 2013, it was clear that further work was required to articulate what success would look like and how it would be measured.

4.2. Since the January Board meeting further work has been undertaken to achieve this and the latest draft is included as Appendix 1.

5. REVISIONS TO THE HEALTH & WELL-BEING STRATEGY

5.1. The original strategy document has been revised to set out more clearly what success will look like for each of the priorities.

5.2. Since the original strategy document was written the Better Care Fund has been developed and this has been reflected in the strategic objectives set out in Priority 1: Integrated Health and Social Care Services.

5.3. Priorities 3 and 5 regarding children and young people's health and well-being have also been revised to be more focussed and specific and are now worded as:

- Priority 3: Integrated services across all relevant agencies which support prevention and early intervention to reduce illness, neglect and abuse for children.

- Priority 5: Integrated services across all relevant agencies which support prevention and early intervention to reduce avoidable demand for services by adolescents.

6. HEALTH & WELL-BEING STRATEGY DASHBOARD

6.1. Each of the eight priority leads has been asked to articulate what success will look like and incorporate three key strategic objectives and three success measures. A summary "dashboard" (Table 1) has been developed to monitor progress against the objectives on a quarterly basis over the next two years.

6.2. A number of the proposed indicators will only be available on an annual basis and further work is required to refine these measures. These refinements will include the development of local indicators, setting of key targets, milestones and process measures. Appendix 2 is an example of the template to be used to set out the detail of how each priority will be achieved.

Table 1: Hammersmith & Fulham Health & Well-being Strategy Dashboard 2014 – 2016

	Priority	Strategic Objectives	Success Measures
1	Integrated health and social care services which support prevention, early intervention and reduce hospital admissions	Reduction in unnecessary avoidable hospital admissions Reduction in unplanned hospital admissions for chronic ambulatory care Increased numbers of people over 75 enabled to live in their own homes	Number of unnecessary avoidable hospital admissions: Number of unplanned hospital admissions; Number of people over 75 enabled to live in their own homes:
2	Delivering the Park View Centre for Health & Well-being to improve care for residents and regenerate the White City Estate.	Improved access to GPs in White City Increased access or referrals to lifestyle/behaviour/prevention services More Health Checks taken up	Increased numbers of White City Residents on GP rolls Number of referrals and take up of lifestyle/behaviour/prevention services Number of Health Checks undertaken
3	Integrated services across all relevant agencies which support prevention and early intervention to reduce illness, neglect and abuse for children.	Reduction in smoking, drinking, drug taking and domestic violence during pregnancy and early years and increase in breastfeeding and regular pre and postnatal check-ups/visits. More children are protected from preventable communicable diseases Reduction in hospital admissions for tooth decay in children under 5years	Number of pregnant women seen by Maternity Services before 12 weeks+6days Number of children with low birth weights. Number of children born suffering with conditions due to the effects of smoking, alcohol, and drug addiction. Immunisation rates Number of hospital admissions for tooth decay in children aged 5 years.
4	Tackling childhood obesity	More children entering primary school are of a healthy weight More children of primary and secondary school age in the borough are of a healthy weight	Excess weight in 4-5 year olds Excess weight in 10-11 year olds

	Priority	Strategic Objectives	Success Measures
5	Integrated services across all relevant agencies which support prevention and early intervention to reduce avoidable demand for services by adolescents.	More young people have a good level of social and emotional development Reduction in the number of young people requiring mental health services or admitted to hospital with an injury (self-inflicted, assault or accident). Reduction in number of underage/teenage/Looked After Children (LAC)/Care Leaver pregnancies	Response to emotional well-being questions in the Children & Young People's Survey Number of CAMHS appointments/services required and reduction in hospital admissions due to mental health concerns, assault or accidents. Number of underage, teenage pregnancies. Number of LAC/Care Leaver pregnancies.
6	Improving mental health services for service users and carers to promote independence and develop effective preventative services	People have a better experience of mental health services People are supported to be independent People, including adolescents, LAC and Care Leavers, can access preventative mental health services	Reduced referrals into secondary care community services, increased step down to primary care services and good outcomes for these patients Good move on rates from inpatient rehabilitation services into more independent settings such as supported housing Development of action plans for interventions which promote early identification, mental well-being and resilience.
7	Better access for vulnerable people to Sheltered Housing.	More appropriate accommodation is available to vulnerable groups More older people are able to live at home for longer Fewer admissions to residential and nursing homes	Delivery of 105 units of extra care and 24 units of accommodation for people with Learning Disabilities Proportion of older people who were still at home 91 days after hospital discharge Number of permanent admissions to residential and nursing care homes

	Priority	Strategic Objectives	Success Measures
8	Better sexual health across Triborough with a focus on those communities most at risk of poor sexual health.	Reduce the transmission rate and prevalence of undiagnosed HIV and STIs Increase access to all contraceptive methods including barrier methods, Long Acting Reversible Contraception (LARC) and Emergency Hormonal Contraception (EHC) Improve health and social care for people living with HIV and reduce associated stigma End Female Genital Mutilation (FGM) in H&F and support those already affected by it.	Rates of acute STIs Number of new HIV diagnoses Uptake of LARC in Sexual and Reproductive Health Services Under 18 Conceptions People presenting with HIV at a late stage of infection All agencies have appropriate procedures in place. All instances recorded by maternity services. Number of women and girls requiring sexual health services due to FGM.

7. CONCLUSION AND NEXT STEPS

7.1. The Board is asked to agree this strategy and associated plans and support further work to set baselines and targets for the indicators which will be presented to the next meeting of the Board.

7.2. The priorities will need to be reviewed and evaluated, at least annually.

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: DRAFT Hammersmith and Fulham Health and Wellbeing Strategy 2014 – 2016
Appendix 2: Example Template for illustrative purposes

Appendix 1

DRAFT

Stronger Communities, Healthier Lives

Hammersmith and Fulham

Health and Wellbeing Strategy

2014 - 2016

Contents

Forward – UPDATE DRAFT

Cllr Marcus Ginn
Cabinet Member for Community Care
Chairman of the Hammersmith & Fulham Health &Well-being Board

Dr Tim Spicer,
Chair of Hammersmith & Fulham CCG
Vice Chair of the Hammersmith & Fulham Health & Well-being Board

Stronger Communities, Healthier Lives

1. Introduction

Stronger Communities, Healthier Lives sets out the vision and priorities for the Hammersmith & Fulham Health & Well-being Board and is the culmination of a process over the last twelve months. It sets out the key issues where we need to have an impact to improve the health and well-being of local people so that they can live full, independent and active lives in communities which are prosperous and vibrant.

This document capture not just our vision and commitment, but the practical steps we are taking to work with local people support them to benefit their health and live, independent and active lives.

2. The Need for Change

Hammersmith & Fulham faces major challenges over the next decade, including significant health inequalities and increasing pressure upon financial resources. We need to work with local communities to make sure that they have services which support them to be independent and to make sure that, whatever their conditions, they can live a full and active life and receive services in their own homes or as close to where they live as possible.

The scale of the challenge is illustrated by the significant variation in life expectancy between the most and least deprived areas in the Borough. This difference in life expectancy is a 7.9 year gap for men and a 5.4 year gap for women. This gap has widened over the last five years and increases in life expectancy have been driven primarily by improvements in the more affluent areas, with life expectancy in the more deprived areas remaining almost the same.

Looking to the future there are a number of areas where health needs will change and increase.

- A rise in the number of older people over the next two decades combined with a relatively low number of unpaid carers is expected to have a dramatic impact on demand for services.

- Illnesses such as dementia, more prevalent among older populations, will become increasingly common. Currently, there are likely to be around 1,250 patients in Hammersmith and Fulham with dementia and by 2025, this is likely to be in the region of 1,500 patients. Other public health concerns for the older population, such as social isolation, may become more common as may physical and sensory disability and reduced mobility.

- Unless behaviour and services change, people may experience longer periods of time living with disability, resulting from improved survival rates from major diseases such as stroke, heart disease and cancer.

- Changes in the environment, behaviour and social norms mean it is very likely we will see an increase in obesity and diseases associated with it, as well as an increase in alcohol related harm.

- Medical and social care advances have been leading to significant increases in the life expectancy of children with complex needs. This vulnerable population group may therefore need support over longer periods.

The reforms to promote integration and partnership working at the local level are tools to help us tackle some of these challenges and build on the joint working between the NHS and other key partners in the borough.

Building on this legacy, the Health and Wellbeing Board (HWB) brings together the Council and NHS with the aim of achieving integrated services across the health and social care sector in order to improve the health and wellbeing of our local population.

Public health has also changed, with the Council taking on new responsibilities for public health services.

3. The Vision: Stronger Communities, Healthier Lives

Our 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

4. Our Priorities and what success will look like

At the end of last year the Board consulted with local community groups on the priorities it had identified for the next two years and one of the key messages which came back from that process was that we need to more clearly define what success will look like at the end of the strategy in April 2016.

Each of the priorities is set out below with a description of the Board's view of what success will look like in April 2016:

- **Integrated health and social care services which support prevention, early intervention and reduce hospital admissions.**

Our aim is to provide care and support to the people of Hammersmith & Fulham 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.

- **Delivering the Park View Centre for Health & Well-being to improve care for residents and regenerate the White City Estate.**

  Our aim is to provide care and support to the people of White City in their homes and in their communities, with the Park View Centre for Health & Well-being by:

  - Increasing access to GP services by delivering co-ordinated high quality, modern health and social care services which also inform and support individuals, carers and their families so that they can be proactive in managing their own care.
  - Achieving local residents expectations of receiving a good experience of health and social care services and choosing to use the Centre as an alternative to A&E services.
  - Offering planned care for patients with long term conditions which prevent and avoid unscheduled hospital admissions.
  - Improving access to patient education initiatives and wellbeing activities through the delivery of the Expert Patient Programme, an information hub, a carers clinic, medicines management group, community cafe and a patient peer/mentors group.

- **Integrated services across all relevant agencies which support prevention and early intervention to reduce illness, neglect and abuse for children.**

Our aim is to provide care and support to the children of Hammersmith & Fulham and their families in their homes and in their communities:

- More pregnant women from all sections of the community being seen at an early stage in their pregnancy to ensure they have a healthy and safe pregnancy and good birth experience. Vulnerable women will be more effectively identified and given the appropriate support to ensure their child has the best start in life.
- More children will be brought up in smoke-free homes.
- More under 5s will be immunised against serious, preventative diseases, such as Measles, Mumps and Rubella.
- As children reach the age of 2, they will have received a developmental check to identify any particular needs which will be met through a range of agencies and the most vulnerable children will have access to high quality day care opportunities.
- Children under 5 will have better oral health, fewer attendances at A&E, they will ready to start school as their needs have been identified earlier

and appropriate support measures put in place. Income deprived families will benefit from a range of coordinated strategies to alleviate the impact of poverty on their children.
    - Families whose children experience disabilities will spend less time being assessed, and will be supported so their children can live at home wherever possible.

- **Tackling childhood obesity**

Our aim is to provide care and support to the children of Hammersmith & Fulham and their families in their homes and in their communities:

    - We will have developed a preventative approach to childhood obesity to effectively support children, families, and local communities to encourage behaviour which promotes healthy eating and physical activity.
    - We will have engaged with children, young people and their families, their schools, sports and leisure services, planning and housing, children and family services to support a healthy start in life and learnt from the obesity whole place intervention pilot in Kensington & Chelsea.
    - We will have in place effective universal and targeted programme for children and families and clear pathways to services.
    - By 2016 we are unlikely to achieve our objective of halting or even reversing the current upward trend in childhood obesity, however, we will have in place services to help us achieve it over a longer time period.

- **Integrated services across all relevant agencies which support prevention and early intervention to reduce avoidable demand for services by adolescents.**

Our aim is to provide care and support to the children and young people of Hammersmith & Fulham and their families in their homes and in their communities, through:

    - More schools engaged in the Healthy Schools Partnership, ensuring pupils have improved social and emotional development, lead healthier lifestyles and a healthier school environment.
    - Strategies to keep young people in education, employment or training will continuing to be effective.
    - Looked after children having access to the health support they need regardless of where they are placed,
    - Fewer troubled families who continue to reoffend, engage in anti-social behaviour, are unemployed and whose children miss school and/or are involved in crime.

- **Improving mental health services for service users and carers to promote independence and develop effective preventative services.**

Our aim is to provide care and support to the people of Hammersmith & Fulham in their homes and in their communities:

- Services will have been redesigned, improved and delivered in community settings so that patients can be discharged in a timely manner, their length of hospital stay will have been reduced and there are fewer readmissions and a reduced need for hospital beds.
- Service users will report good experience and have good outcomes from using these services and report that they know how to access a range of interventions.
- Service users and carers will report positive experiences of being offered and using personal budgets from health and/or social care to purchase a range of packages of care and administering such budgets are simple and quick.

- **Better access for vulnerable people to Sheltered Housing.**

Our aim is to provide care and support to the people of Hammersmith & Fulham in their homes and in their communities.

- We will see 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.
- There will be an additional 105 units of extra care accommodation and 24 units of accommodation for people with Learning Disabilities.
- More older people will be discharged from hospital to live at home with the right support.

- **Better sexual health across Triborough with a focus on those communities most at risk of poor sexual health.**

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

- Support people to make informed choices about their sexual behaviour to reduce the transmission and prevalence sexually transmitted diseases.
- Ease of access to services which enable early diagnosis and treatment of HIV and sexually transmitted infections.
- Increase access to all contraceptive methods including barrier methods, Long Acting Reversible Contraception (LARC) and Emergency Hormonal Contraception (EHC).
- Improve health and social care for people living with HIV and reduce associated stigma

It is expected that the pace of change over the next two years is unlikely to slacken, therefore there is a need to ensure that there is sufficient flexibility to keep pace with that change and the Board is keen to provide an opportunity to regularly review these priorities for going forward.

4. Role of the Health & Well-being Board

The Hammersmith and Fulham Health and Wellbeing Board will be inclusive and collaborative, working together to add value and develop a whole system approach to

commissioning and the delivery of high quality, cost effective services for the borough. The Board will be focussed and decisive, being driven by the aim to have a positive impact on the lives of the residents of Hammersmith and Fulham and improve their health and wellbeing.

The new arrangements provide an opportunity for system wide leadership, to achieve more together than individual agencies could achieve alone. It will create a distinct and new identity, carrying new functions with the potential to deliver transformational change across the health, care and wellbeing landscape.

The emerging models for the Better Care Fund and Community Budgets will be vehicles for the Board to achieve its ambitions and further consideration will need to be made of how that might be realised over the next 2 years.

6. The Strategy

The Strategy provides a baseline against which we will measure success in developing integrated services which deliver real outcomes for residents. The next two years will continue to be a period of change when new relationships between the new structures and emerging organisations begin to mature. The Strategy will therefore need to be dynamic and flexible to accommodate these growing pains.

The Strategy will act as the framework to guide commissioning across health, public health and social care for both adults and children. The Council, the CCG and the NHS England will hold each other to account for commissioning in line with our shared priorities and values as expressed in this Strategy.

The Strategy will provide a framework and guide for the development of other plans which will address specific health and wellbeing issues.

The strategy is a two year strategy covering 2014 to 2016 to accord with the Kensington and Chelsea and Westminster Health and Well-being Strategies, since the three councils share a number of services including adult social care, family and children's services and public health. Bearing this in mind it will probably be opportune to review the strategy regularly to take account of developments.

The Joint Strategic Needs Assessment (JSNA) has also been an important part of shaping the priorities of both the Council and CCG locally and are reflected in the Health & Well-being Strategy, a summary which demonstrates the links between the two is included as Appendix 1.

7. Our Approach

The combination of the HWBs, local democratic accountability and the new architecture for public health offer real opportunities for mutual influence on commissioning strategies, and allow for whole system plans and service models to be embedded into day to day operating practices and mechanisms.

Building on existing successful partnerships, developing trusting relationships across organisations, and engaging and communicating will be essential in order for the Board to be successful in delivering the aims and objectives of this strategy.

Consideration must be given to partnership arrangements such as lead commissioning, integrated provision and pooled budgets, with attention also being given to operational integration health and social care services.

8. Delivering Outcomes and Measuring Success

The Board has focused on improving those outcomes that matter most to the population. Table 1 sets out the strategic objectives against each of the priorities and the success measures to judge the impact of what partners around the table at the Health & Well-being Board are achieving.

The Board will monitor progress on a quarterly basis and will produce an annual report to demonstrate our progress against the each of the priorities and engage with stakeholders and the wider audience to ensure that work is focussed, targeted and addressing the greatest current need.

The outcomes are in line with national outcomes frameworks (public health, adult social care, NHS outcomes frameworks, and children's and young people's strategy) which allows the use of readily available data.

Where necessary, local indicators are also being developed to enable us to effectively monitor local needs and the impact we are having to address them.

Table 1: Hammersmith & Fulham Health &Well-being Strategy Dashboard 2014 - 2016

Hammersmith & Fulham Health &Well-being Strategy Dashboard 2014 - 2016

	Priority	Strategic Objectives	Success Measures
1	Integrated health and social care services which support prevention, early intervention and reduce hospital admissions	Reduction in unnecessary avoidable hospital admissions Reduction in unplanned hospital admissions for chronic ambulatory care Increased numbers of people over 75 enabled to live in their own homes	Number of unnecessary avoidable hospital admissions: Number of unplanned hospital admissions; Number of people over 75 enabled to live in their own homes:
2	Delivering the Park View Centre for Health & Well-being to improve care for residents and regenerate the White City Estate.	Improved access to GPs in White City Increased access or referrals to lifestyle/behaviour/prevention services More Health Checks taken up	Increased numbers of White City Residents on GP rolls Number of referrals and take up of lifestyle/behaviour/prevention services Number of Health Checks undertaken

	Priority	Strategic Objectives	Success Measures
3	Integrated services across all relevant agencies which support prevention and early intervention to reduce illness, neglect and abuse for children.	Reduction in smoking, drinking, drug taking and domestic violence during pregnancy and early years and increase in breastfeeding and regular pre and postnatal check-ups/visits. More children are protected from preventable communicable diseases Reduction in hospital admissions for tooth decay in children under 5years	Number of pregnant women seen by Maternity Services before 12 weeks+6days Number of children with low birth weights. Number of children born suffering with conditions due to the effects of smoking, alcohol, and drug addiction. Immunisation rates Number of hospital admissions for tooth decay in children aged 5 years.
4	Tackling childhood obesity	More children entering primary school are of a healthy weight More children of primary and secondary school age in the borough are of a healthy weight	Excess weight in 4-5 year olds Excess weight in 10-11 year olds
5	Integrated services across all relevant agencies which support prevention and early intervention to reduce avoidable demand for services by adolescents.	More young people have a good level of social and emotional development Reduction in the number of young people requiring mental health services or admitted to hospital with an injury (self-inflicted, assault or accident). Reduction in number of underage/teenage/Looked After Children (LAC)/Care Leaver pregnancies	Response to emotional well-being questions in the Children & Young People's Survey Number of CAMHS appointments/services required and reduction in hospital admissions due to mental health concerns, assault or accidents. Number of underage, teenage pregnancies. Number of LAC/Care Leaver pregnancies.

	Priority	Strategic Objectives	Success Measures
6	Improving mental health services for service users and carers to promote independence and develop effective preventative services	People have a better experience of mental health services People are supported to be independent People, including adolescents, LAC and Care Leavers, can access preventative mental health services	Reduced referrals into secondary care community services, increased step down to primary care services and good outcomes for these patients Good move on rates from inpatient rehabilitation services into more independent settings such as supported housing Development of action plans for interventions which promote early identification, mental well-being and resilience.
7	Better access for vulnerable people to Sheltered Housing.	More appropriate accommodation is available to vulnerable groups More older people are able to live at home for longer Fewer admissions to residential and nursing homes	Delivery of 105 units of extra care and 24 units of accommodation for people with Learning Disabilities Proportion of older people who were still at home 91 days after hospital discharge Number of permanent admissions to residential and nursing care homes
8	Better sexual health across Triborough with a focus on those communities most at risk of poor sexual health.	Reduce the transmission rate and prevalence of undiagnosed HIV and STIs Increase access to all contraceptive methods including barrier methods, Long Acting Reversible Contraception (LARC) and Emergency Hormonal Contraception (EHC) Improve health and social care for people living with HIV and reduce associated stigma End Female Genital Mutilation (FGM) in H&F and support those already affected by it.	Rates of acute STIs Number of new HIV diagnoses Uptake of LARC in Sexual and Reproductive Health Services Under 18 Conceptions People presenting with HIV at a late stage of infection All agencies have appropriate procedures in place. All instances recorded by maternity services. Number of women and girls requiring sexual health services due to FGM.

9. Next Steps

The Joint Health & Well-being Strategy has been developed to reflect local needs and sets out the priorities for the next two years. The Health & Well-being Board will regularly review progress and ensure that the priorities are still the right ones to address locally.

Appendix 1

Table 1: Linkages between the JSNA and Health & Well-being Priorities

JSNA	Causes of Early Death		Causes of Disability				Outliers												
HWS Priorities	Cancer	CVD	Mental ill-health	Sense organ disease	Respiratory disease	MSK	Smoking	Alcohol related and specific	STDs	Poor dental health	Premature death (under 75)	Breast and cervical screening	Looked after children	Under 18 conceptions	HIV	Prison population	Severe and enduring mental illness	Welfare reform	Problem drug users
Integrated health and social care services which support prevention, early intervention and reduce hospital admissions.																			
Delivering the Park View Centre for Health & Well-being to improve care for residents and regenerate the White City Estate.																			
Every child has the best start in life																			
Tackling childhood obesity																			

JSNA	Causes of Early Death		Causes of Disability				Outliers												
HWS Priorities	Cancer	CVD	Mental ill-health	Sense organ disease	Respiratory disease	MSK	Smoking	Alcohol related and specific	STDs	Poor dental health	Premature death (under 75)	Breast and cervical screening	Looked after children	Under 18 conceptions	HIV	Prison population	Severe and enduring mental illness	Welfare reform	Problem drug users
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.																			

JSNA						
HWS Priorities				Integrated health and social care services which support prevention, early intervention and reduce hospital admissions.	Delivering the Park View Centre for Health & Well-being to improve care for residents and regenerate the White City Estate.	Every child has the best
Emerging public health issues	Obesity					
	Child obesity					
	Alcohol related harm					
	Alcohol related crime					
	Growth in the older population					
	Living with disability					
	Dementia					
	Improved life expectancy for children with complex needs					
Prioritising social determinants of health	Giving every child the best start in life	Enabling children and adults to maximise their capabilities and have control over their lives	5 or more GCSEs at Grade A* to C			
			NEET			
		Creating fair and good employment for all	Unemployment rate			
			IB for mental health reasons			
		Ensuring a healthy standard of living for all	Household income			
			Children living and income			
		Creating sustainable communities and places that foster health and well-being	Improve the physical and social infrastructure			
			% of land which is Open Space			
		Strengthening the role and impact of prevention	Obesity			
			Physical activity			
			Breastfeeding			
			Smoking during pregnancy			
			Child immunisation			
			Infant mortality rate			
			Good level of development at age 5			

JSNA	Emerging public health issues								Prioritising social determinants of health															
HWS Priorities	Obesity	Child obesity	Alcohol related harm	Alcohol related crime	Growth in the older population	Living with disability	Dementia	Improved life expectancy for children with complex needs	Giving every child the best start in life					Enabling children and adults to maximise their capabilities and have control over their lives		Creating fair and good employment for all		Ensuring a healthy standard of living for all		Creating sustainable communities and places that foster health and well-being		Strengthening the role and impact of prevention	
									Good level of development at age 5	Infant mortality rate	Breastfeeding	Smoking during pregnancy	Child immunisation	5 or more GCSEs at Grade A* to C	NEET	Unemployment rate	IB for mental health reasons	Household income	Children living and income	Improve the physical and social infrastructure	% of land which is Open Space	Obesity	Physical activity
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.																								

JSNA	Emerging public health issues								Prioritising social determinants of health													
HWS Priorities	Obesity	Child obesity	Alcohol related harm	Alcohol related crime	Growth in the older population	Living with disability	Dementia	Improved life expectancy for children with complex needs	Giving every child the best start in life					Enabling children and adults to maximise their capabilities and have control over their lives		Creating fair and good employment for all		Ensuring a healthy standard of living for all		Creating sustainable communities and places that foster health and well-being		Strengthening the role and impact of prevention	
									Good level of development at age 5	Infant mortality rate	Breastfeeding	Smoking during pregnancy	Child immunisation	5 or more GCSEs at Grade A* to C	NEET	Unemployment rate	IB for mental health reasons	Household income	Children living and income	Improve the physical and social infrastructure	% of land which is Open Space	Obesity	Physical activity
Better sexual health across Triborough with a focus on those communities most at risk of poor sexual health.																						

Appendix 2

Example Template for illustrative purposes

PRIORITY 1: INTEGRATED HEALTH AND SOCIAL CARE SERVICES WHICH SUPPORT PREVENTION AND REDUCE HOSPITAL ADMISSIONS

Lead : Dr John Smith

Governance/Forums: Integrated Partnership Board					
Strategic Objective	**Population**	**Success Measures**	**Action**	**Timescale**	**Lead**
Extended 7 Day access to Social Care and GPs	Universal	The proportion of persons aged 75 and over receiving ongoing social care in the community who are admitted hospital as an emergency Unplanned hospital admissions for chronic ambulatory care aged 75 and over People over 75 enabled to live in their own homes <u>NHS Outcomes Framework</u> 2.1 Proportion of people feeling supported to manage their (long term) condition (ref:P01627) 2.6i Estimated diagnosis rate for people with dementia 3.5 Proportion of patients with fragility fractures recovering to their previous levels of mobility / walking ability at 30 (ref: p01541)/ 120 (ref: P01542) days	As part of the NWL Early Adopter for 7 Day Services, extend social care to provide 7 day access particularly to facilitate early discharge; and extend primary care offer to prevent unnecessary attendances at A&E	Apr-May 2014 June- July 2014 October 2014	Peter Andrews
Establish step up and step down Community Independence Services	Vulnerable people		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.	Apr-June 2014 July – Dec 2014 April 2015	David Jones
Extend community rehabilitation and re-ablement services	People with long term conditions		Increase investment in additional community and bed based capacity, particularly for neuro-rehabilitation; streamline process Extend community rehabilitation period up to 12 weeks in the community including home care	Apr- June 2014 July-Dec 2014 April 2015	Masood Khan
Integrated Services early intervention and prevention services for People with Long Term Conditions to include housing and homecare	People with long term conditions		Develop integrated approach to prevention and early intervention for people with, or likely to have, long term conditions including housing interventions and home care – Links to Whole Systems Early	Feb-Apr 2014 Apr 2014 – March 2015 April 2015	Patricia Lott

interventions		4.9 Improving people's experience of integrated care (under development) <u>Adult Social Care Outcomes Framework</u> 1A Social care-related quality of life (ref: P01507) 1H Proportion of adults in contact with secondary mental health services in stable accommodation (ref: P01513) 1D Carer-reported quality of life (ref: P01631) <u>Public Health Outcomes Framework</u> 1.18i Proportion of adult social care users who have as much social contact as they would like 2.13ii Proportion of adults classified as "inactive" 2.24i Injuries due to falls in people aged 65 and over	Adopters (BCF17)		
Develop psychiatric liaison services in line with NWL wide review	Mental Health Service Users		Develop psychiatric liaison services in line with the NWL wide review, delivering a common specification and contracting of services to ensure equity of access, improve performance and consistent standards assurance	Apr-June 2014 October 2014	Simon Simmons
Work with individuals to develop Self-Management and Peer Support	All social service clients		Working with individuals and community groups to co-design, co-develop and co-produce improved health and care outcomes, maximising service user capacity within the system	Feb-May 2014	Sue Hughes
Developing Personal Health and Care Budgets	All social service clients		Extend our current arrangements for personal health budgets, working with patients, service users and front line professionals to empower people with long term conditions to make informed decisions around their care; link to BCF02	April 2014 April-Dec 2014 April 2015	Justin Barber
Transforming Nursing and Care Home Contracting	People using residential care		Create a single care home placement contracting team across health and social care; develop outcomes based specifications, maximise value and ensure appropriate and timely provision reduces pressure on hospitals	Jan-March 2014 April – June 2014 October 2014	

h&f the low tax borough	**London Borough of Hammersmith & Fulham** **HEALTH & WELLBEING BOARD** **24 March 2014**
TITLE OF REPORT Joint Strategic Needs Assessment (JSNA) and Pharmaceutical Needs Assessment (PNA) 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. This report provides an update on progress with the 2013/14 JSNA work programme and describes the next steps for developing the 2014/15 work programme.

1.2. This report presents the 'deep dive' Physical Activity JSNA and Learning Disabilities JSNA for consideration and approval, and an initial draft of the Child Poverty JSNA for comment and feedback

1.3. This report outlines the responsibility of the Health and Wellbeing Board to prepare a Pharmaceutical Needs Assessment for 1 April 2015 and describes the proposed approach to be taken across the Tri-borough.

2. RECOMMENDATIONS

2.1. The Health and Wellbeing Board are requested to consider the progress being made against the 2013/14 JSNA programme and the approach to developing the 2014/15 work programme

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

2.3. Review and agree to publish the Learning Disabilities JSNA

2.4. Agree the arrangements and timescales for the development of the Pharmaceutical Needs Assessment (PNA) for Hammersmith and Fulham by April 2015;

2.5. Note, and agree where necessary to, the provision of information required to support the development of the Pharmaceutical Needs Assessment

3. CURRENT JSNA WORK PROGRAMME

3.1 The JSNA Hammersmith and Fulham Highlights Report has now been completed and published on the JSNA website: http://www.jsna.info/download/get/hammersmith-and-fulham-jsna-highlights-report-2013-14/15.html

3.2 The following deep dive JSNAs are complete and are presented for consideration and approval

- Physical activity JSNA
- Learning disabilities JSNA

3.3 An initial draft of the Child Poverty JSNA is presented here for consideration and comment

4. 2014/15 WORK PROGRAMME

4.1 The JSNA Steering Group met on the 21st January 2014 to review progress on the current work programme and proceed with planning for the year ahead.

4.2 The Steering Group discussed a number of areas of further development for the JSNA work programme, including the dissemination of JSNA findings and recommendations; identifying individuals and agencies

responsible for implementation of recommendations; follow-up and evaluation; and inclusion of economic analysis

4.3 The Group agreed to incorporate the Pharmaceutical Needs Assessment into the JSNA work programme.

4.4 An application for a JSNA on the 'Impact of Parental Mental Health on Children' was presented. The Group recommended that this links in with work currently being undertaken for the Westminster Health and Wellbeing Board, through a task and finish group.

4.5 The JSNA Steering Group also discussed the work programme for 2014/15. Currently the following work has been identified for 2014/15:

- JSNA Highlights reports and continued work to add supporting detail
- Pharmaceutical Needs Assessment
- Development work (including follow-up on JSNA findings and recommendations, review of JSNA website)

4.6 New applications currently being scoped for 'deep dive' JSNAs are:

- Impact of parental mental health on children
- Older peoples accommodation needs
- Dementia

4.7 The JSNA Steering Group is in the process of engaging commissioners to identify priority areas and information needs in order to inform the 2014/15 work programme. It is hoped that this will allow for a full outline of the 2014/15 work programme to be presented to the Hammersmith and Fulham Health and Wellbeing Board at their next meeting in May 2014.

4.8 Dan Lewer, the newly required Tri-Borough JSNA Programme Manager, will start on 7th April 2014.

5. PHYSICAL ACTIVITY JSNA

5.1 The Physical Activity 'deep dive' will inform local strategies and pathways designed to promote physical activity across the tri-borough area.

5.2 Overall, the findings highlight:

- the many benefits of physical activity for promoting physical and mental health and wellbeing as well as combating social isolation;

- that any amount or type of physical activity is better than none;

- the range of barriers which prevent uptake (but there are also some promising interventions).

5.3 The “deep dive” indicates that although the percentage of people meeting the DH recommended levels of physical activity are higher in the tri-borough compared to England and London, there is evidence of inequalities in physical activity levels. In particular, BME groups, women, people with long term conditions and those living in the most deprived areas have low participation rates. Nearly 250 premature deaths and 3000 new cases of diabetes could be prevented if all the tri-borough population met the recommended levels of physical activity. This would have represented a saving of over £5m for healthcare costs in 2010/11.

5.4 The “deep dive” makes the following recommendations:

- **Recommendation One: An asset mapping exercise should be undertaken in each of the boroughs to address specific or targeted needs** - In order to identify how existing community assets can be best utilised to improve participation in physical activity.
- **Recommendation Two: Consistent messaging is needed to promote physical activity promotion** - including the definition of physical activity, recommended levels and the promotion of physical activity as a part of everyday life.
- **Recommendation Three: Local authorities, the NHS, and the third sector should take a lead in promoting participation in physical activity across the tri-borough** - Physical activity messages should be embedded in all local statutory and voluntary sector strategies and policies that relate to health and wellbeing.
- **Recommendation Four: All Health and Social Care workers should be offered training on giving advice on physical activity** - to ensure consistency of messaging and to improve participation levels
- **Recommendation Five: A process should be established to capture data on levels of physical activity and physical education in schools in order to inform strategy development, target and evaluate interventions**.

- **Recommendation Six: Specific groups should be targeted around the promotion of physical activity, and access to opportunities for physical activity.**
- **Recommendation Seven: The implementation of the Lets Get Moving Physical Activity Care Pathway should be facilitated across the tri-borough.**

6. LEARNING DISABILITIES JSNA

6.1 The JSNA examines the current and future needs of the local population with learning disabilities, and highlights how local services are responding to these needs.

6.2 This report will be used to assess and develop local strategy around support for people with learning disabilities, alongside a range of other information, such as other specific needs assessments, strategies, action plans and routine monitoring.

6.3 The findings of the JSNA indicate that the poor outcomes, high health needs, and diagnostic 'overshadowing' compared to the general population reinforces the need for universal health checks among the population with learning disabilities to improve identification of conditions.

7. DRAFT CHILD POVERTY JSNA

7.1. Children who grow up in poverty face serious disadvantage and consequently struggle to thrive, learn and achieve, meaning the following generation may also live in poverty. Evidence has shown that the foundations for virtually every aspect of human development are laid in early childhood, and that this has a lifelong impact on health and wellbeing, from obesity, heart disease and mental health through to educational achievement and economic status.

7.2. The Child Poverty Act 2010 established a framework for local partners to cooperate to tackle child poverty, by publishing a JSNA and prepare a Child Poverty Strategy.

7.3. In 2013 the three Health and Wellbeing Boards agreed to commission a Tri-borough 'deep dive' JSNA on child poverty. Work has been led by the Tri-borough Public Health team and a Task and Finish Group

established, with input from Children's and other Council services and partners such as voluntary organisations.

7.4. The JSNA will:

- describe child poverty and the effect it has on children and families
- describe the level of child poverty across Tri-borough
- outline the drivers of child poverty
- identify examples of what is being done locally to alleviate the effects of child poverty
- provide recommendations for further action.

7.5. The priority areas for action and the recommendations are based on local engagement and supported by the evidence base.

7.6. Work on completing the JSNA has experienced some delay and although work is progressing and the draft is near completion some additional input is required from stakeholders. Further alterations may also be required following the Government's consultation on its' child poverty strategy https://www.gov.uk/government/consultations/child-poverty-a-draft-strategy

8. PHARMACEUTICAL NEEDS ASSESSMENT

8.1 Pharmaceutical Needs Assessments (PNAs) are a statement of the needs for pharmaceutical services of the population in a defined geographical area. PNAs are used by commissioners to make decisions on which funded services need to be provided by local community pharmacies. They are also an important tool in market entry decisions, in response to applications from businesses, including independent owners and large pharmacy companies. Applications can be keenly contested by applicants and existing contractors and so can be open to legal challenge. As such, it is important that the local PNA is robust.

8.2 The responsibility for producing and managing the content and update of PNAs transferred from PCTs to Health and Wellbeing Boards on 1st April 2013. Health and Wellbeing Boards are required to maintain and revise their PNA as necessary, either by issuing supplementary statements for minor changes and adjustments, or by carrying out a complete revision of the PNA if there are major changes locally. A new

PNA must be developed by the Health and Wellbeing Boards every 3 years.

8.3 Following this transfer of responsibilities, supplementary statements were published for Westminster, Hammersmith & Fulham and Kensington and Chelsea's PNA in September 2013 to ensure that the PNAs published online reflected current local circumstances.

8.4 All HWBs are required to publish a fully revised PNA by 1st April 2015.

8.5 When producing a full PNA, Health and Wellbeing Boards are required by law to consult a specified list of bodies at least once during the process of developing the PNA. These bodies are:

- The Local Pharmaceutical Committee;
- The Local Medical Committee;
- Any persons on pharmaceutical lists and any dispensing doctors;
- Any Local Pharmaceutical Services chemist in the area with whom the NHS Commissioning Board has made arrangements for the provision of any local pharmaceutical services;
- Any local Healthwatch or any other patient, consumer and community group which (in the opinion of the Health and Wellbeing Board) has an interest;
- Any NHS trust or Foundation Trust;
- The NHS Commissioning Board; and
- Any neighbouring Health and Wellbeing Boards.

8.6 There is a minimum period of 60 days for consultation.

Proposed arrangements

8.7 Overall responsibility and accountability for the pharmaceutical needs assessment rests with individual Health and Wellbeing Boards. However, the process and key partners involved are very similar across the tri-borough area (London Borough of Hammersmith & Fulham; Royal Borough of Kensington and Chelsea; and Westminster City Council). We believe that it would be sensible for the three Health and Wellbeing Boards across this area to produce their individual PNAs through a jointly-agreed and combined approach.

8.8 To provide assurance to the three Health and Wellbeing Boards in Westminster, Hammersmith & Fulham and Kensington and Chelsea, it is proposed that:

- The Tri-borough JSNA Programme Manager should be responsible for the day to day management of the production of Pharmaceutical Needs Assessments for Westminster, Hammersmith & Fulham and Kensington and Chelsea. Until the JSNA programme manager starts in April, the Tri-borough Senior Policy Officer for Health and Wellbeing and the Tri-borough Health and Wellbeing Programme Manager will take responsibility for agreeing the process, timetable and roles/responsibilities with the Health and Wellbeing Boards.
- The Tri-borough JSNA Steering Group should retain overall accountability to the three Health and Wellbeing Boards for the production of the PNAs and should provide assurance to the Boards on progress and quality. However, a smaller PNA Task and Finish Group will be put in place to steer the work.

8.9 A draft timetable for producing the PNAs is attached at Appendix A.

8.10 The data required to produce the assessments is held by a number of organisations including:

- Local Authorities – Public Health department; Planning departments
- the Commissioning Support Unit – prescribing teams
- the Clinical Commissioning Groups
- NHS Choices
- NHE England
- Local Pharmacies (to be collected through a pharmacy questionnaire)

8.11 A full list of the data and information required, including the source organisation, is attached at Appendix B.

8.12 Health and Wellbeing Board member organisations are asked to agree to provide any data on this list where they are the named source organisation.

8.13 NHS England has provided each Health and Wellbeing Board with a “heat map” which provides an analysis of the current PNA held by the Board. The heat maps are not meant to be a definitive analysis of where the PNA is not fit for purpose, simply a guide to how they meet new legislative and regulatory requirements following the Health and Social Care Act 2012. The heat maps across the tri-borough area show that the Kensington and Chelsea PNA is more aligned with new legislative and regulatory requirements and, as such, this will be used as the base model. The PNA task and finish group will be responsible

for ensuring that all the legislative and regulatory requirements are fully met by the revised PNAs

8.14 The combined heat map for Westminster, Hammersmith and Fulham and Kensington and Chelsea is attached as Appendix C.

9. CONSULTATION

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

10. EQUALITY IMPLICATIONS

10.1. 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.

10.2. 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

10.3. 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.)

11. LEGAL IMPLICATIONS

11.1. Each HWB is required to publish a PNA by virtue of section 128A of the National Health Service Act 2006 (pharmaceutical needs assessments) and the Health and Social Care Act 2012.

11.2. Failure to produce and maintain a robust pharmaceutical needs assessment could potentially lead to legal challenge, for example if a pharmacies application for a new pharmacy in an area is refused on the basis of need set out in an out of date or not fit for purpose PNA.

12. FINANCIAL AND RESOURCES IMPLICATION

12.1. Dependent on the findings of individual JSNA reports

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

13. RISK MANAGEMENT

13.1. Dependent on the findings of individual JSNA reports

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

14. PROCUREMENT AND IT STRATEGY IMPLICATIONS

14.1. Dependent on the findings of individual JSNA reports

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

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

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	Physical Activity JSNA	Colin Brodie, Tel: 02076414632	Tri-Borough Public Health
2.	Physical Activity JSNA Summary and Recommendations	Colin Brodie, Tel: 02076414632	Tri-Borough Public Health
3.	Learning disabilities JSNA	Colin Brodie, Tel: 02076414632	Tri-Borough Public Health
4.	Draft Child Poverty JSNA	Colin Brodie, Tel: 02076414632	Tri-Borough Public Health

LIST OF APPENDICES:

Appendix A – PNA draft timetable

Appendix B – PNA Data Requirements

Appendix C – PNA Heat Maps for Triborough

THEME	TASK	OWNER	2014																																																2015											
			January				February				March				April				May				June				July				August				September				October				November				December				January				February				March			
			1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Preparation	Discuss process, timeline and governance at JSNA steering group	HWB Programme Manager																																																										
	Set-up PNA T&F group (reporting to JSNA steering group)	JSNA Steering Group Manager																																																										
	Provide assurance to HWBs	Director of Public Health / ASC								WCC				RBKC / H&F																																																
Health Needs and Priorities	Obtain reference documentation, eg JNSA / PNA / Heat Maps	HWB Programme Manager																																																										
	Confirm localities to be used	PH Intelligence																																																										
	Obtain relevant public health data set at locality level	PH Intelligence																																																										
	Obtain any additional data (if required)	PH Intelligence																																																										
	Identify potential changes which could impact need over next three years (business plans,	PH Intelligence / Strategy Unit																																																										
	Produce initial maps for the PNA	PH Intelligence																																																										
	Analysis	PH Intelligence																																																										
Current pharmaceutical services provision	Obtain existing pharmaceutical services data	???																																																										
	Identify other relevant	????																																																										
	Data cleaning and preparation	PH Intelligence																																																										
	Pharmaceutical provider questionnaire designed	PH Intelligence																																																										
	Pharmaceutical provider questionnaire - live	LPCs																																																										
	Chase	LPCs																																																										
	Data entry	PH Intelligence																																																										
	Analysis of data	PH Intelligence																																																										
Patients, Public and Stakeholders	Develop engagement strategy	HWB Programme Manager / LPC																																																										
	Engagement pre-draft	HWB Programme Manager / LPC																																																										
	Analysis of Engagement pre-draft	PH Intelligence																																																										
Synthesis and Drafting	Develop PNA structure and framework	PNA Task & Finish Group																																																										
	Drafting	PNA Task & Finish Group																																																										
	Review consultation draft at steering group	JSNA Steering Group																																																										
	Agree final consultation draft with HWBs	Health and Wellbeing Boards																																		RBKC	WCC																									
Consultation	Consultation	HWB Programme Manager / LPC																																																										
	Analysis of feedback	PH Intelligence																																																										
	Draft Final PNA	PNA Task and Finish Group																																																										
	Review final PNA at steering group	JSNA Steering Group																																																										
	Sign-off of PNA by HWBs	Health and Wellbeing Boards																																																								RBKC	WCC	HF
	Publication	Public Health																																																										

Appendix B

Data required for 2014 Pharmaceutical Needs Assessments

Based on 2010-13 Kensington and Chelsea PNA

Aspect	Detail	Team/ data source
Population profiling		
Demographic information describing the local population	Age, gender, ethnicity, deprivation, health & wellbeing, lifestyles, vulnerable groups	Tri-borough Public Health
Changing population and new development areas which might change the need for pharmaceutical services	Regeneration sites planned across Tri-borough and expected population change Population projections	Planning teams? Tri-borough Public Health
Location of services		
Locations of pharmacies (including dispensing and appliance contractors)	Postcodes, names and ID codes of pharmacies collected in routine data submissions to CSU pharmacy team (and NHS England?)	CSU Prescribing Team (Gavin Boyter), NHS Choices *Data from 1 year ago has been provided, verified and mapped by PH for the supplementary statements*
Locations of GPs	Names, practice codes, locations	Tri-borough Public Health and CSU, NHS Choices
Locations of other services	Names and locations of opticians, dentists, acuter providers, community providers, mental health providers etc	Tri-borough Public Health and CSU NHS England?
Prescribing and dispensing trends		
Prescribing volumes	Prescribing volumes by borough and GP practice	On HSCIC website and available from CSU Prescribing team at a small area level (EPACT) (Ash Khan)
Dispensing volumes	Dispensing volumes by borough and pharmacy, and by internet	On HSCIC website and available from NHS England at a small area level (MIS dispensing data)
Access to pharmaceutical services		
Pharmacy choice/ distance	Straight line distance between pharmacies and different postcodes in the boroughs, from X and Y coordinates	From postcode data above, and postcode grid reference data (Tri-borough Public Health)
Opening times		From pharmacy questionnaires
Language		From pharmacy questionnaires and historic Exeter data on country of birth by ward
Premises characteristics		
Physical characteristics (consulting rooms etc)	Questionnaire ratings	From pharmacy questionnaires
IT	Questionnaire ratings	From pharmacy questionnaires
Relationships, opportunities and skills		
Utilisation of clinical skills, relationship with GPs, relationship with commissioners	Ratings from pharmacy questionnaires	From pharmacy questionnaires

Improvements, opportunities and challenges	Learning points from pharmacy questionnaires and discussions	From pharmacy questionnaires and from consultation with pharmacies at a community pharmacy development event
Services provided by pharmacists		
Essential, appliances and advanced services	List of pharmacies supplying essential services, appliances and advanced services. E.g. medicines usage reviews, stoma appliance customisation service, and appliance use review	From pharmacy questionnaires but cross-checked with NHS England's contract monitoring data (e.g. number of MURs carried out). Gavin Boyter from CSU prescribing team may also have
Local enhanced services or similar	List of pharmacies supplying services under local 'enhanced' schemes or similar, such as stop smoking, health checks, supervised administration etc *There are likely to have been considerable changes since April 2014, and these changes may be an important aspect of the new PNA*	This data is likely to be in a range of locations, with some falling under Local Authority Public Health Team responsibility (including substance misuse services), and others services falling under NHS England responsibility, and CCGs (Ash Khan in CSU is main contact) Enhanced Services with the CCGs (moving to NHS England in next few months): **H&F CCG** H Pylori breath testing **West London CCG** Minor ailments service Palliative care drugs Monitored dosage service **Central London CCG** Minor ailments service
Needs profiling data mapped to service provision	Health and demographic geographical trends relating to each of the provided services (e.g. location of problem drug users, end of life care patients, smokers etc)	Tri-borough Public Health

	Description	Requirement	Hammersmith and Fulham PCT	Kensington and Chelsea PCT	Westminster PCT
3A (2) a	Relates to pharmaceutical services with persons on the pharmaceutical list	PNA makes assessment for all the services which are commissioned by the PCT	Partially	Yes	Partially
3A (2) b	Relates to local pharmaceutical services under an LPS scheme	LPS services to be included in the assessment	Yes	Yes	Yes
3A (2) c	Relates to dispensing of drugs and appliances to patients on a dispensing doctor's list	*If required,* ensures the dispensing service element is taken into account	N/A	N/A	N/A
4 (1)	Relates to information to be contained within the pharmaceutical needs assessment	PNA contains the information in Schedule 1. Detailed analysis provided under schedule 1 requirements below	Partially	Partially	Partially
Schedule 1	Relates to **necessary services** - **current provision**	PNA documents necessary services which are provided			
(1) a		a. **Within** the PCT area	Partially	Yes	Yes
(1) b		b. **Outside of the PCT** , if necessary to meet pharmaceutical needs *(if it has*)	Partially	Partially	Partially
Schedule 1	Relates to n**ecessary** services - **gaps in provision**	Expects the PCT (if it has) to include a statement setting out necessary services which are not provided but:			
(2) a		a. Are **currently required** to meet a pharmaceutical need; or specified service type	Partially	Yes	Yes
(2) b		b. Will need to be provided, in **specified future circumstances** to meet a **future need** for pharmaceutical services; or a specified pharmaceutical service type	Partially	Yes	Partially
Schedule 1	Relates to other **relevant services - current provision**	Requires the PCT to include a statement of the current pharmaceutical services (*if it has*):			
(3) a		a. That have secured improvements to, or better access to, pharmaceutical services **within** the PCT area	Partially	Yes	Yes
(3) b		b. That have secured improvements to, or better access to, pharmaceutical services, **outside** the area of the PCT	Partially	Yes	Yes
(3) c		c. For **all other services, within or outside of the area of the PCT**, which affect the need for pharmaceutical services in its area [other than those described in Schedule 1 (1) and (3)a and b]	Partially	Yes	Partially
Schedule 1	Relates to **other relevant services - current gaps** in provision of which would secure improvements to or better access	Requires the PCT (if it has) to include a statement setting out **relevant services** which are **not currently provided** in the area of the PCT but which			
(4) a		a. Would secure improvements to, or better access to pharmaceutical services; or a pharmaceutical service of a specified type	Partially	Yes	Yes
(4) b		b. **In future specified circumstances**, would secure improvements in, or better access to, pharmaceutical services; or a pharmaceutical service of a specified type	Partially	Yes	Partially
Schedule 1	Relates to Other NHS Services	Requires the PCT to include a statement of **any NHS services** provided by the PCT, another PCT, an NHS Trust or an NHS FT which affects:			
(5) a		a. The **need for pharmaceutical services**, or pharmaceutical services of a specified type	Yes	Yes	Yes
(5) b		b. Whether **further provision** of pharmaceutical services in its area would **secure improvements to, or better access to**, pharmaceutical services or pharmaceutical services of a specified type	Partially	Yes	Yes
Schedule 1 (6) a	Relates to how the assessment was carried out	Requires the PCT to:			
		a. Describe how the localities were determined	Partially	Yes	Yes
		b. Describe, *If applicable* , How the PCT has accounted for:			
		i. Different needs of the different localities	Partially	Yes	Partially

(6) b		ii. Different needs of people who share protected characteristics			
(6) c		c. Requires the PCT to include [within the PNA] a report on the consultation that was undertaken	Yes	Yes	No
Schedule 1 (7)	Relates to a map of provision	Requires the PCT to provide a map which identifies the premises at which pharmaceutical services and dispensing services are provided in the area of the PCT	Yes	Yes	Yes
4 (2)	Relates to keeping the map up to date	Requires the PCT, *as far as is practicable* , to keep up to date the map identifying the premises at which pharmaceutical and dispensing services are provided (*without needing to republish the assessment or publish a supplementary statement*)	Not assessed	Not assessed	Not assessed
5	Relates to the publication of the first PNA for PCTs	Each PCT established, on or after the appointed day; or on a day that is less than 10 months before the appointed day must publish its first PNA within 10 months of the date on which its PCT order comes into force	Not assessed	Not assessed	Not assessed
6 (1)	Relates to subsequent PNAs	PCTs are required to publish a statement of its revised assessment: a. Within 10 months of any order varying the area of the PCT b. Within **3 years** of its previous publication of a PNA	N/A	N/A	N/A
6 (2)	Relates to the requirement to revise the PNA following the identification of changes which are relevant to the granting of applications	Requires PCT to revise its PNA, as soon as is practicable, after identifying changes since publication which are relevant to the granting of applications ***unless this would be disproportionate to the changes in pharmaceutical services***	Not assessed	Not assessed	Not assessed
6 (3)	Relates to the publication of supplementary statements (which become part of the published PNA)	PCT may publish a supplementary statement explaining changes to the availability of pharmaceutical services where: a. The changes are relevant to the granting of an application; and b. The PCT is: i. Satisfied that revising the PNA would be disproportionate; OR ii. In the process of revising its PNA **and** is satisfied that modification of its PNA is essential to prevent detriment to the provision of pharmaceutical services	Not assessed	Not assessed	Not assessed
7	Relates to the temporary extension of PNAs	Allows for a temporary extension of a PNA if: a. A locality changes from one PCT to another ; and a PNA has not been published by the [new] PCT which relates to that locality b. A PNA (and any supplementary statements) was published by the [former] PCT before the change The extension applies pending publication of a PNA by the new PCT	N/A	N/A	N/A
8 (1)	Relates to stakeholder consultation	Requires consultation with: a. LPC b. LMC c. Persons on the pharmaceutical list (include dispensing doctors, DACs) d. Any LPS chemist e. Any relevant LiNK; and any patient, consumer group in its area which has an interest in the provision of pharmaceutical services f. Any LA with which the PCT is or has been a partner g. NHS Trusts or NHS FTs in its area h. Any neighbouring PCT	Yes	Yes	No
8 (2)	Relates to consultation frequency	Requires the PCT to consult with all persons mentioned in 3F (1) at least ONCE on a draft of the proposed PNA	Yes	Yes	No
8 (3)	Relates to consultation with a neighbouring PCT	Where a PCT is consulted under 8 (2) and there is a different LPC and/or LMC for its area, the PCT must: a. Consult these Committee(s) before making a response to the consultation	Nor assessed	Nor assessed	Not assessed

		b. Have regard for representations received from the Committee(s) when making its response to the consultation			
8 (4)	Relates to consultation duration	Requires a minimum of 60 days consultation starting from the day that all persons under 8 (1) have been served with the draft	No	Yes	No
8 (5)	Relates to method of serving the consultation	For the purposes of 8 (4) a person may be regarded as being served with a draft if they are notified of the website address on which the draft is available providing the draft is to remain there for the duration of the consultation	N/A	N/A	N/A
8 (6)	Relates to the provision of hard copy of a draft PNA	If a person has been served with a PNA draft either by web address or an electronic form but requests a hard copy, then the PCT must provide a hard copy (free of charge) as soon as is practicable or within 14 days	N/A	N/A	N/A
9 (1)		Requires the PCT to have regard (*in so far as is practicable*) to the following:			
9 (1) a		a. The JSNA where: i. The PCT was a partner OR the JSNA relates to the PCT's area; AND ii. This has not been superseded by a further assessment	Yes	Yes	No
9 (1) b	Relates to matters to consider when making assessments	b. Requires the PCT to have regard (in so far as is practicable) to the outcome of its assessment of compliance with its duties under Chapter 1 of Part 11 of the Equality Act 2010(a) specifically the following protected characteristics i. Age ii. Disability iii. Gender reassignment iv. Marriage and civil partnership v. Pregnancy and maternity vi. Race vii. Religion or belief viii Sex ix Sexual orientation	Partially	Partially	Partially
9 (1) c		c. Demography	Yes	Yes	Yes
9 (1) d		d. Benefits of reasonable choice	Partially	Yes	No
9 (1) e		e. Different needs of different localities	Partially	Yes	Partially
9 (1) f		f. Pharmaceutical services provided under arrangement with neighbouring PCTs which affect: i. The need for pharmaceutical services within its area ii. Whether further provision of services in its area would secure improvements to or better access to pharmaceutical services	Yes	Partially	Partially
9 (1) g		g. Any other NHS services provided in or out of area (& not covered by 9 (1) f) which affect: i. The need for pharmaceutical services within its area ii. Whether further provision of services in its area would secure improvements to or better access to pharmaceutical services	Partially	partially	Partially
9 (2)		Requires the PCT to take account of future needs:			
9 (2) a		a. Must be sufficient to account for Schedule 1 (2) and (4) i.e. gaps in necessary services; and gaps which would secure improvements or better access to pharmaceutical services	Partially	Yes	Partially
9 (2) b	Relates to matters to consider when making assessments	b. Have regard to changes in: i. Population size ii. Demography with regard to people who share a protected characteristic iii. The risks to the health or wellbeing of people in its area, particularly to those who share a protected characteristic	Partially	Partially	No