London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Agenda

Monday 30 June 2014
5pm
Courtyard Room - Hammersmith Town Hall

MEMBERSHIP

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

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http://www.lbhf.gov.uk/Directory/Council_and_Democracy

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Date Issued: 20 June 2014

London Borough of Hammersmith & Fulham

Health & Wellbeing Board
Agenda

30 June 2014

Item		Pages
1.	**MINUTES AND ACTIONS**	
	(a) To approve as an accurate record and the Chairman to sign the minutes of the meeting of the Health & Wellbeing Board held on	
	(b) To note the outstanding actions.	
2.	**APOLOGIES FOR ABSENCE**	
3.	**DECLARATIONS OF INTEREST**	
	If a Member of the Board, or any other member present in the meeting has a disclosable pecuniary interest in a particular item, whether or not it is entered in the Authority's register of interests, or any other significant interest which they consider should be declared in the public interest, they should declare the existence and, unless it is a sensitive interest as defined in the Member Code of Conduct, the nature of the interest at the commencement of the consideration of that item or as soon as it becomes apparent.	
	At meetings where members of the public are allowed to be in attendance and speak, any Member with a disclosable pecuniary interest or other significant interest may also make representations, give evidence or answer questions about the matter. The Member must then withdraw immediately from the meeting before the matter is discussed and any vote taken.	
	Where members of the public are not allowed to be in attendance and speak, then the Member with a disclosable pecuniary interest should withdraw from the meeting whilst the matter is under consideration. Members who have declared other significant interests should also withdraw from the meeting if they consider their continued participation in the matter would not be reasonable in the circumstances and may give rise to a perception of a conflict of interest.	
	Members are not obliged to withdraw from the meeting where a dispensation to that effect has been obtained from the Audit, Pensions and Standards Committee.	
4.	**MEMBERSHIP AND TERMS OF REFERENCE**	1 - 6
	The report sets out the new membership of this Committee and its terms of reference, as agreed at the Annual Council.	
5.	**APPOINTMENT OF VICE-CHAIR**	
	The Board is asked to elect a Vice-chairman from amongst its members for the 2014/2015 municipal year	
6.	**WHOLE SYSTEM INTEGRATED CARE IN HAMMERSMITH &**	7 - 65

FULHAM

This report provides an update on the Whole System Integrated Care (WSIC) programme in Hammersmith and Fulham.

7. JOINT DEMENTIA STRATEGY 2014-2019: DEVELOPMENT SUMMARY 66 - 78

The North West London Mental Health Programme board and the Tri-borough intend to carry out a strategic review of how dementia services are commissioned and provided. This report sets out key areas for the Health & Wellbeing Board.

8. NHS HEALTH CHECKS 79 - 120

This report sets out the progress made in respect of NHS Health Checks.

9. 2013-2014 TRI-BOROUGH PUBLIC HEALTH REPORT 121 - 133

The report provides a snapshot of the health of people who live in the Tri-borough and identifies some of the local public health priorities

10. JOINT STRATEGIC NEEDS ASSESSMENT PROGRAMME 134 - 137

This paper asks for agreement from the Health and Wellbeing Board on which topics should be prioritised for deep-dive JSNAs in the 2014-15 JSNA programme

11. WORK PROGRAMME 138 - 140

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

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

12. DATES AND TIMES OF NEXT MEETINGS

The Board is asked to note that the dates of the meetings scheduled for the municipal year 2014/2015 are as follows:

8 September 2014
10 November 2014
12 January 2015
23 March 2015

London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Minutes

Monday 24 March 2014

PRESENT

Committee members:
Councillor Marcus Ginn, Cabinet Member for Community Care (Chairman)
Dr Tim Spicer, Chair of H&F CCG (Vice-chairman)
Councillor Helen Binmore, Cabinet Member for Children's Services
Liz Bruce, Tri-Borough Executive Director of Adult Social Care
Andrew Christie, Tri—Borough Executive Director of Children's Services
Philippa Jones, Managing Director, H&F CCG
Dr Susan McGoldrick, Vice-Chair, H&F CCG
Trish Pashley, H&F Healthwatch Representative
Meradin Peachey, Tri-borough Director of Public Health

Other Councillors: Georgie Cooney, Cabinet Member for Education

Officers: Cath Attlee (Strategic Lead, Integrated Health & Care Whole Systems Lead, Better Care Funds), Colin Brodie (Public Health Knowledge Manager), Stuart Lines (Deputy Director of Public Health), Holly Manktelow (Senior Policy Officer) and Sue Perrin (Committee Co-ordinator)

Hammersmith Fire Station: Steven Cunningham, Station Manager

H&F CCG: Rachel Stanfield, Head of OD & Governance

43. MINUTES AND ACTIONS

RESOLVED THAT:

(a) The minutes of the Health & Wellbeing Board held on 13 January 2014 be approved and signed as an accurate record of the proceedings.

(b) It was noted that the Council had 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.

44. APOLOGIES FOR ABSENCE

Apologies for absence were received from Dr Susan McGoldrick and Janet Shepherd, NHS England.

45. DECLARATIONS OF INTEREST

There were no declarations of interest.

46. HOME FIRE SAFETY VISITS TO ADULT SOCIAL CARE SERVICES

Steven Cunningham, Station Manager, Hammersmith Fire Station presented an evaluation of home fire safety visits to Adult Social Care Services. The Borough Partnership had originated in 2007/2008, at which time Hammersmith & Fulham had the third highest rate of fires in homes in London. The reduction of fires in homes and the injuries associated with them had been made a priority in the Local Area Agreement.

In the current year, Home Safety Visits had been carried out for 253 people referred by Adult Community Services. All persons had been deemed to be 'high risk individuals'. Firefighters visit people in their homes to provide fire safety advice and fit free smoke alarms. Additional support such as fire retardant bedding could be provided. However, the best way of reducing the potential for fires to occur was to change the behaviour of residents.

Mr Cunningham responded to members' comments. It was suggested that the home visits provided an opportunity for signposting residents to other services and linking with referring GPs.

Mr Cunningham was not aware of the reasons why the statistics indicated that single parents tended to have more fires. Mr Christie commented that there was an established link between fires and areas of concern, such as child neglect. Mr Cunningham stated that where a child had caused a fire, the intervention service would speak to both the child and parent.

RECOMMENDED THAT:

Hammersmith Fire Station be contacted in a year's time and asked to provide a written update.

47. BETTER CARE FUND 2014/2016: FINAL PLAN SUBMISSION

Ms Bruce introduced the 'near-final' version of the Better Care Fund Plan (BCF) which set out the vision for health and social care services, aims and objectives and planned changes encompassing 18 work streams 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 submission date was 4 April.

The report addressed the national conditions: protecting social care services; seven day services to support discharge; data sharing; and joint assessments and accountable lead professional.

It was proposed to bring together existing budgets into a pooled budget, to be held by the local authority on behalf of both the Council and the NHS, to enable the development of integrated health and social care services. Each scheme would be led by the most appropriate commissioner.

The BCF would be used to: help people self-manage and provide peer support; invest in developing personal health and care budgets; implement routine patient satisfaction surveying; invest in re-ablement; and reduce delayed discharges. The report set out the full list of schemes proposed for 2014/2015 and 2015/2016.

Ms Bruce updated on progress in respect of governance. In the medium term, it was intended to develop and strengthen the existing Integrated Partnership Board into a single Tri-borough Health and Wellbeing board, which would oversee large scale integration initiatives that required a single joint approach. It was proposed that one in every three of the HWBs became a single HWB.

In addition, a single Joint Executive Team would be consolidated to act as the single accountable team for the implementation of the BCF programme. The report outlined the proposed Tri-borough governance structure.

Ms Pashley queried the Engagement Plan. Ms Bruce responded that the Whole Systems Programme had been commended for outstanding practise in respect of public involvement. Locally and across the Tri-borough, there had been significant degrees of involvement with Healthwatch and other service user groups. Ms Attlee acknowledged that, because of the tight deadline, public engagement was not currently adequately reflected in the plan.

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RESOLVED THAT:

The Better Care Fund Plan be approved.

48. STRATEGIC & OPERATIONAL PLANNING PROCESS & PROPOSED SUBMISSION 2014/2015 - 2018/19

Philippa Jones introduced the strategic and operational planning report, which set out the improvement trajectories for a range of indicators, required from CCGs as part of the NHS England (NHSE) planning cycle. In some cases, CCGs were asked to detail improvements over a two year period, whilst other indicators were linked to five year trajectories.

Some targets were nationally mandated, whilst others had been developed across the Central West, Hammersmith & Fulham, Hounslow and Ealing Collaborative of CCGs and some had been set locally by the CCG. CCGs had also been asked to identify one local priority for improvement in 2014/2015.

Achievement in some of the trajectories was linked to financial incentives as part of the CCG Quality Premium Fund, which could be invested in improving the quality of local health services. However, a number of targets would be difficult to influence in the short term.

The CCG had sought advice from Public Health in order to ensure the priorities were of an appropriate level of ambition and were supported by public health commissioning priorities. The trajectories and the approach taken to their development was outlined in the report.

An initial submission had been made to NHSE on 14 February 2014, and there was an opportunity for adjustments to be made to the plan before final submission on 4 April 2014.

Of the 2013/2014 targets, those in respect of the X-PERT programme for diabetes and physical health checks for people with severe and enduring mental illness had been exceeded, but the MMR year 2 first dose target of 87% had not been achieved.

The local priority for 2014/2015 was proposed as health checks for people with learning disabilities. This was a three year target. The baseline was 54%. The target in year one was 60% and it was hoped to achieve 80% by 2016/2017.

Ms Jones and Dr Spencer responded to members' queries.

In respect of the emergency admissions indicator, risk stratification was used to profile those people at high risk of unplanned hospital admission and to put in place care plans. Some practices were in their fourth year of using this approach, and there was reasonably strong evidence that this benefited residents by enabling them to remain independent at home. The target of 13% reduction in emergency admissions between 2014/2015 and 2018/2019 was demanding. The target had been derived from 'Shaping a Healthier Future' plans for hospital reconfiguration. The CCG also had strong plans in place for the development of Whole Systems Integrated Care to support this objective.

All GPs would be moved on to one IT system, and sharing of care plans with acute trusts and the community would be negotiated.

Ms Bruce stated that Adult Social Care fully supported this priority.

In respect of patient experience, the CCG considered that it had reached the easy to reach groups, and was looking for ways in which to engage with harder to reach groups and to encourage attendances. Bespoke training for practice nurses was being developed.

The MMR target had not remained a priority. At the beginning of the year, 83% of patients registered with GPs had been achieved and this had temporarily increased to 85%. The CCG was considering other mechanisms for engaging with parents and the Council officers were asked to inform the CCG about any ways in which it could help.

Dr Peachey stated that there was a 95% immunisation target, and this was the responsibility of NHS England. The Local Authority role was to oversee the whole area of health protection.

It was confirmed that the target for potential years of life lost from causes considered amenable to healthcare, would contribute towards closing the health inequalities gap in areas such as coronary heart disease and cancer.

RESOLVED:

1. The report be endorsed.

2. An update report be brought to the next meeting.

49. JOINT HEALTH & WELLBEING STRATEGY: FINAL AGREEMENT

Ms Bruce introduced the revised draft of the Health & Wellbeing Strategy, which set out what success in 2016 would look like and how success would be measured. The high level vision and intent and agreed priorities remained, but were now supported by clear actions.

The eight priority leads had been asked to articulate what success would look like and incorporate three key strategic objectives and three success measures. A summary 'dashboard' had been developed to monitor progress against the objectives on a quarterly basis over the following two years.

A number of the proposed indicators would only be available on an annual basis and further work was required to refine these measures, which would include the development of local indicators, setting of key targets, milestones and process measures.

RESOLVED THAT:

1. The Health and Wellbeing Strategy be agreed.

2. A review of progress against priorities would be brought to the HWB in a year's time.

50. WORK PROGRAMME

Members were asked to identify items for the following year's work programme.

51. JSNA UPDATE

The HWB received a progress update on the JSNA work programme, including the 'deep dive' Physical Activity JSNA and Learning Disabilities JSNA and the initial draft Child Poverty JSNA.

In addition, the report outlined the responsibility of the HWB to prepare a Pharmaceutical Needs Assessment for 1 April 2015 and the proposed approach across the Tri-borough. The data required to produce the assessments was held be a number of organisations, including NHS Engand.

RESOLVED THAT:

The HWB noted the report.

52. DATE OF NEXT MEETING

This is the last meeting of the municipal year.

53. HAMMERSMITH & FULHAM CLINICAL COMMISSIONING GROUP: BRANDING

The HWB received a written presentation of the engagement activity, carried out by H&F CCG to ensure that a wide range of people were involved in the development of the brand and that it reflected the vision of the CCG. The brand would be used alongside the standard NHS logo.

The HWB considered the variations of two brands, which had been selected through the engagement activity. Overall, members expressed a preference for either option 1a or 1b, with one member preferring option 2a.

Meeting started: 4.00 pm
Meeting ended: 5.30 pm

Chairman .....

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	London Borough of Hammersmith & Fulham **HEALTH & WELLBEING BOARD** **30 JUNE 2014**
MEMBERSHIP AND TERMS OF REFERENCE	
Report of the Director of Law	
Open Report	
Classification: For Information **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: Jane West, Executive Director of Finance and Corporate Governance	
Report Author: Sue Perrin, Committee Co-ordinator	**Contact Details:** Tel: 020 8753 2094 E-mail: sue.perrin@lbhf.gov.uk

1. EXECUTIVE SUMMARY

1.1 The report sets out the new membership of this Committee and its terms of reference, as agreed at the Annual Council Meeting held on 16 June 2014.

2. RECOMMENDATIONS

2.1 The Committee is asked to note its membership and terms of reference.

2.2 The Committee is asked to respond to the Council's proposal to make a direction on the entitlement of the Council's non-Councillor representatives to vote.

3. INTRODUCTION

3.1 The Council agreed the membership and terms of reference at the Annual Council Meeting held on 16 June 2013.

4. TERMS OF REFERENCE

4.1 In accordance with the statutory duties and powers given to the HWB by the Health and Social Care Act 2012 it is proposed that the terms of reference of the Board are as follows:

(i) To provide organisational leadership by agreeing the vision and strategic priorities for health and wellbeing in Hammersmith & Fulham, as part of the Joint Health & Wellbeing Strategy.

(ii) To ensure commissioning decisions are based on clear evidence for improving outcomes and integrating services.

(iii) To drive the development and implementation of the Joint Health & Wellbeing Strategy (JHWS) and take joint action to facilitate progress.

(iv) To oversee the development and use of the Joint Strategic Needs Assessment (JSNA) by the Council and H&F CCG.

(v) To oversee the development and maintenance of the Pharmaceutical Needs Assessment (PNA).

(vi) To ensure effective public and patient engagement and involvement in the development and provision of health and wellbeing services.

(vii) Wherever possible, to promote the effective integration of health and social care services across the three boroughs of Hammersmith & Fulham, Kensington & Chelsea and Westminster.

Membership

4.2 The core membership of the HWB, which is set out below, is compliant with the Health & Social Care Act, 2012:

- Cabinet Member for Community Care
- Chair of H&F CCG
- Cabinet Member for Children's Services
- Tri-borough Director of Adult Social Care
- Tri-borough Director of Children's Services
- Director of Public Health
- A Local Healthwatch representative

4.3 The HWB also has the power to appoint additional persons to the Board.

4.4 Each nominating body will be asked to nominate a primary representative and a deputy, both of whom will be permanent appointments and will be expected to understand the business of the

Board and the deputy would have the authority to make decisions in the event that the Board member is unable to attend a meeting.

4.5 The legislation requires that the councillor members of the Board are nominated by the Leader.

Table:

Nominating organisation	Nominee position	Reason for proposal	Nominated deputy
London Borough of Hammersmith & Fulham	Cabinet Member for Health & Adult Social Care	Councillor nomination from the Leader as per Health and Social Care Act 2012	Councillor Rory Vaughan
London Borough of Hammersmith & Fulham	Cabinet Member for Children and Education	Councillor nomination from the Leader as per HSCA 2012	To be confirmed
London Borough of Hammersmith & Fulham	Tri-borough Director for Adult Social Care	Statutory member as per HSCA 2012.	H&F Borough Director
London Borough of Hammersmith & Fulham	Tri-borough Director for Children's Services	Statutory member as per HSCA 2012.	Children's Services Director
London Borough of Hammersmith & Fulham	Tri-borough Director of Public Health	Statutory member as per HSCA 2012.	Deputy Director of Public Health
Healthwatch	Trish Pashley	Statutory member as per HSCA 2012.	To be confirmed
Hammersmith & Fulham Clinical Commissioning Group	Chair	Statutory member as per HSCA 2012.	To be confirmed
Hammersmith & Fulham Clinical Commissioning Group	Vice-Chair	Full Council, 29 January 2014	To be confirmed
Hammersmith & Fulham Clinical	Managing	Full Council, 29 January	To be

Commissioning Group	Directorr	2014	confirmed

4.6 The Chairman shall be appointed by Full Council.

4.7 Members shall elect a Vice-chairman from among the Board's membership.

4.8 The Act provides that the NHS Commissioning Board must appoint a representative for the purpose of participating in the preparations of JSNAs and the development of JHWSs, and to join the HWB when it is considering a matter relating to the exercise, or proposed exercise, of the NHS Commissioning Board's commissioning functions in relation to the area and it is requested to do so by the HWB.

4.9 The HWB will meet five times during the municipal year. During 2014/2015, the HWB will meet on:

30 June 2014
8 September 2014
10 November 2014
19 January 2015
23 March 2015

4.10 The Board's meetings will be subject to the normal access to information rules and therefore, unless exemptions apply which allow for business to be conducted in private, will be held in public.

Other Governance Issues

Quorum

4.11 It is proposed that the quorum for meetings will be three voting members.

Decision-making: consensus and voting

4.12 The Board will seek to work by consensus. Nevertheless, on occasions there may be differences between partner organisations represented on the Board. It is envisaged that where possible these will discussed and resolved in advance of the meeting. Any unresolved difference will, where possible, be noted in the HWB report in question. Furthermore if, at the meeting when the matter has to be determined, consensus cannot be reached, the decision will be made by a vote (in accordance with the provisions in the Council's standing orders).

4.13 Unless the Council directs otherwise following consultation with the Board, officer and non-councillor members of the Board will also be entitled to vote.

Interests

4.14 Members must declare any conflicts of interest at appropriate times. Non-councillor members of the HWB will be subject to the Council's Code of Conduct and the requirements to register and declare disclosable pecuniary interests.

Developing understanding and embedding best practice

4.15 The Board will endeavour to learn and understand the business of other Board members' organisations and build in opportunities to establish roving meetings and site visits where appropriate.

4.16 The Board will ensure all local, regional and national best practices is taken into consideration when developing plans and services for the borough.

Communication

4.17 The Board will endeavour to communicate the aims and business of the Board to all stakeholders, communities and populations, and establish robust two way communication channels for all.

Review

4.18 A review of membership and terms of reference will take place following the set up of the Board, then annually.

Accountability

4.19 Accountability of HWB Members will depend on their relevant parent organisation:

- Accountability of the Council will come through Scrutiny Committees, Local HealthWatch and the democratic process.
- Accountability of the CCGs will come through assessment by the NHSCB, lay people on the CCG Board, and the duties to involve, consult and publish an annual report.
- Accountability of HealthWatch will be to the Council, and to the local community.

Relationships and Intersdependencies

4.20 There are a number of key relationships the Board will need to develop, foster and understand. Locally, the Board will develop effective mechanisms to link to the Scrutiny Committees, the Pharmaceutical Needs Assessment (PNA) Working Group and any JSNA Working Groups, tri borough HWBs, the Commissioning Support Unit (CSU), other local statutory groups, the Voluntary and Community sector and the community itself.

4.21 Regionally and nationally key relationships will be fostered with NHSCB, Public Health England (PHE), and an understanding

developed of the business of the Care Quality Commission (CQC), Monitor, Healthwatch England, and others.

4.22 An understanding of where business is done, and what statutory boards and other decision making bodies exist across the borough, will allow the HWB to function more efficiently and effectivley.

4.23 Regionally and nationally key relationships will be fostered with NHSCB, Public Health England, and an understanding developed of the business of the Care Quality Commission, Monitor, Healthwatch England and others.

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		

	London Borough of Hammersmith & Fulham **HEALTH AND WELLBEING BOARD** **30 June 2014**
WHOLE SYSTEM INTEGRATED CARE IN HAMMERSMITH & FULHAM - UPDATE	
Report of the Divisional Director, ASC and Hammersmith & Fulham CCG	
Open Report	
Classification: For Information **Key Decision:** No	
Wards Affected: All	
Accountable Executive Director: Liz Bruce, Executive Director for Adult Social Care and Health Tim Spicer, Chair H&F CCG	
Report Author: Rob Sainsbury, Deputy Managing Director H&F CCG	**Contact Details:** Tel: 02033504288 E-mail: Robert.sainsbury@nw.london.nhs.uk

AUTHORISED BY: .....

.....

DATE: .....

1. EXECUTIVE SUMMARY

1.1. This report provides an update on the Whole System Integrated Care (WSIC) programme in Hammersmith and Fulham. The WSIC programme is being led by CCGs and Local Authorities from across North West London (NWL) working in partnership with providers, and patients and their carers/families to deliver a person centered vision of integrated care. NWL collectively has been awarded national pioneer status to drive this change programme.

2. RECOMMENDATIONS

2.1. The Health & Wellbeing Board are asked to note progress on the Whole System Integrated Care programme in H&F.

3. REASONS FOR DECISION

3.1. No formal decision is required, the report is provided as an update.

4. INTRODUCTION AND BACKGROUND

4.1 In NWL the Clinical Commissioning Groups have consulted on a large out of hospital investment strategy as part of Shaping a Healthier Future and over the past year they have been doing both the planning and delivery of these changes. Rebalancing the care provided in hospital and the care provided out of hospital to adapt to people's changing needs is just part of a wider vision beyond healthcare - to the whole system of care provided in NWL.

4.2 This update for the Board sets out the progress made in H&F in developing Early Adopter proposals to lead the design and delivery of Whole Systems Integrated Care - resulting in the submission of outline implementation plans in May 2014 and presentation of our ideas to a national and international Review Panel on 12th June 2014.

5. PROPOSAL AND ISSUES

5.1 Across the eight boroughs of NWL, 31 partner organisations across both health and social care, including the local authorities, have agreed to work together in pursuit of a collective person-centred vision of Whole Systems Integrated Care. Integrated care means integrated care teams that are focused on individual people and their needs. Bringing together all the different parts of the health and social care system aiming to provide better communication and sharing of relevant information to reduce duplication and confusion for individuals, carers and staff. This should mean one set of goals agreed by the individual, supported by one team, with one budget, one approach. The fragmented system currently conspires against this.

5.2 In NWL the CCGs and local authorities have collectively been awarded national pioneer status to make these changes real. The CCGs and local authorities have spent six months co-producing with all providers, commissioners and lay partners what integrated care needs to become a reality – a toolkit that answers some of the difficult questions once and for all NWL in order to help all local areas plan their new model.

5.3 Some of the practical steps necessary have already begun with the Better Care Fund. This requires the NHS and local authorities to pool health and care budgets together to commission and deliver more integrated care, enables us to build on existing jointly commissioned services. Next will be to bring the whole provider community together and align them in the interest of the patient with new care models and this in turn means commissioning specific outcomes for particular patient groups and commissioning providers using a capitated budget.

6. OPTIONS AND ANALYSIS OF OPTIONS

6.1. The update is provided for information, no analysis of options is required at this stage

7. CONSULTATION

7.1. The Whole Systems Integrated Care programme has co-produced with lay partners from across NWL the toolkit for integrated care. It has developed shared principles for co-production that will be adopted as Whole Systems Integrated Care is designed and implemented in H&F. The H&F programme will now look to involve lay partners in co-design and co-production of its proposals to produce a full business case by October 2014.

8. EQUALITY IMPLICATIONS

8.1. The update is provided for information, no equalities impact assessment is provided at this stage

9. LEGAL IMPLICATIONS

9.1. No legal implications are presented as part of this update

10. FINANCIAL AND RESOURCES IMPLICATIONS

10.1. No financial implications are presented as part of this update

11. RISK MANAGEMENT

11.1. No risk management implications are presented as part of this update

12. PROCUREMENT AND IT STRATEGY IMPLICATIONS

12.1. No procurement and IT implications are presented as part of this update

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

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	H&F Whole Systems Integrated Care Implementation Plan – Final May 2014		
2.	H&F Whole Systems Integrated Care Expression of Interest		

LIST OF APPENDICES:

Appendix 1: Whole Systems Update presentation

North West London Whole Systems Integrated Care

Update for Hammersmith & Fulham
Health & Wellbeing Board

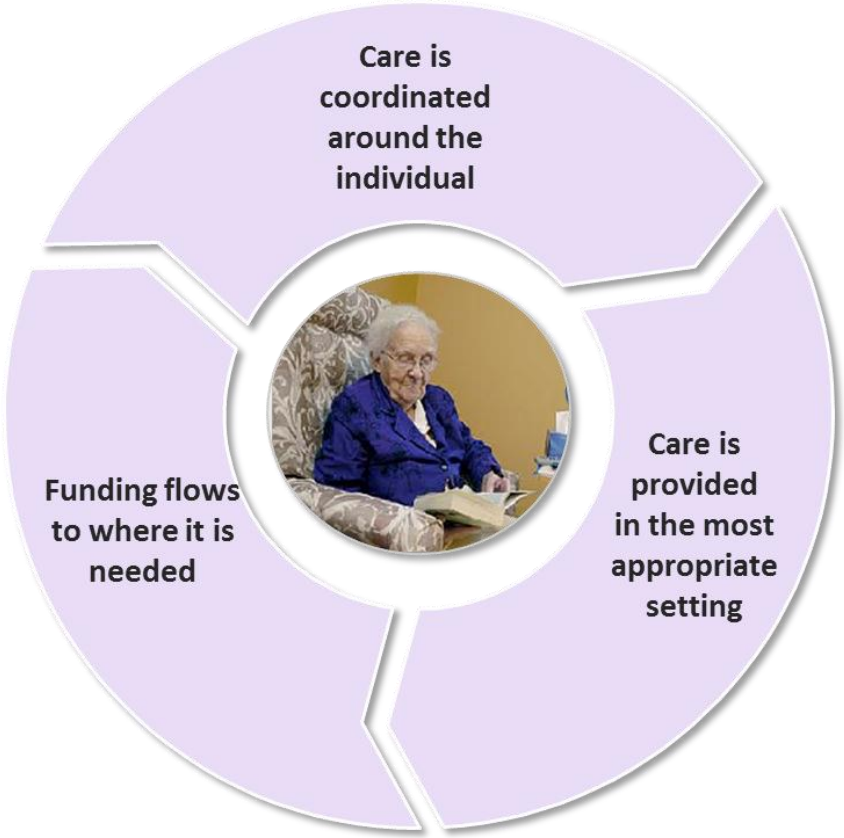
June/July 2014

Living *longer* and living *well*

Whole Systems Integrated Care– Background

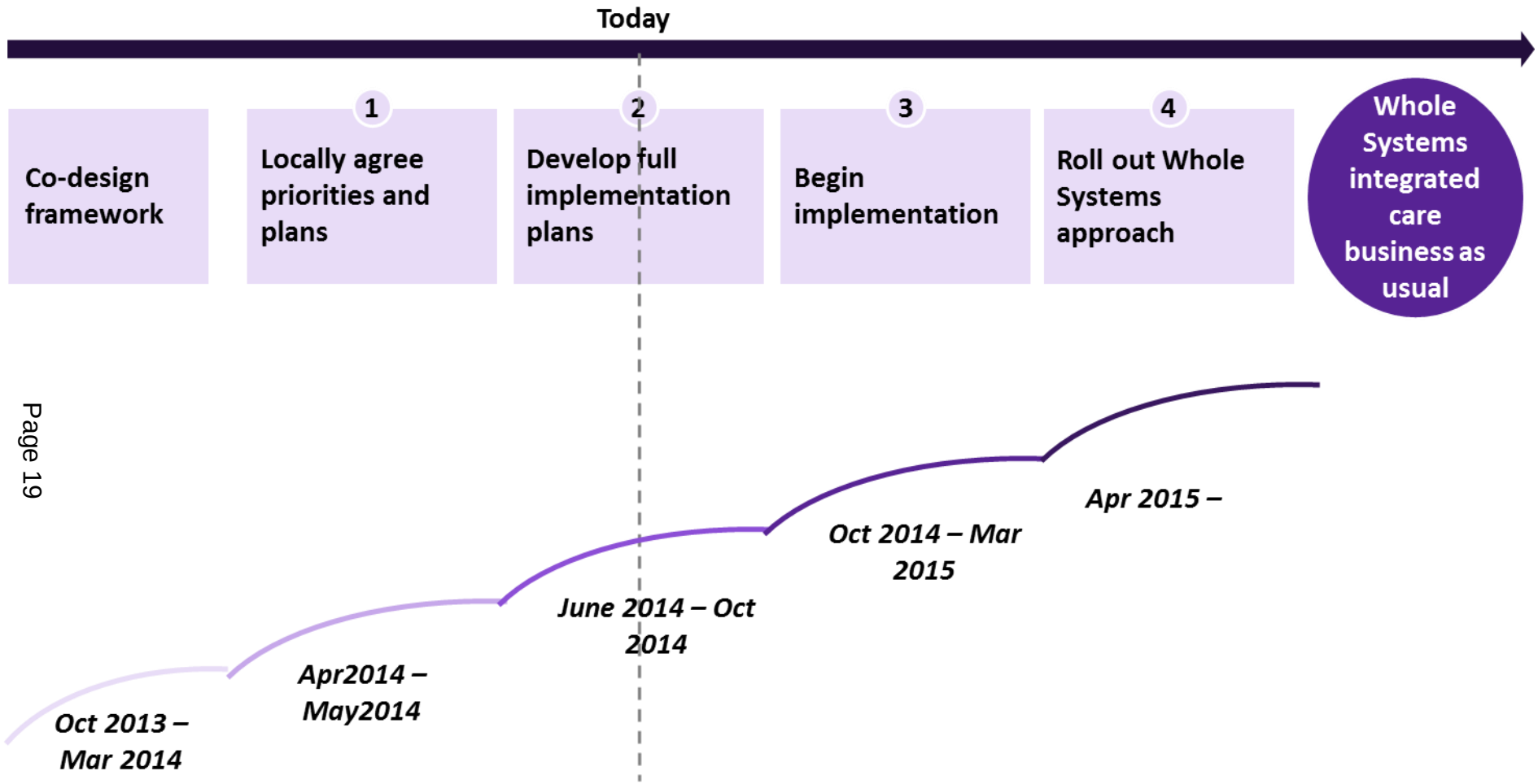
North West London's vision of Whole Systems Integrated Care is underpinned by three principles:

1) People will direct their own 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



Living *longer* and living *well*

Whole Systems Integrated Care– North West London timeline



Living *longer* and living *well*

Whole Systems Integrated Care– Hammersmith & Fulham current position

- Two Early Adopter proposals submitted
  - Hammersmith & Fulham (CCG, Local Authority, Providers)
  - Accountable Care Group (ChelWest, Network 2 GPs, CLCH)

- Outline implementation plans submitted May 2014

- Review panel presentation with international and UK experts held 12th June 2014

- For Hammersmith & Fulham – Out of Hospital Programme Board becomes our delivery board for Whole Systems Integrated Care

- Development of Full Business Case by October 2014

Background papers provided:
- *Hammersmith and Fulham Expression of Interest*
- *Hammersmith and Fulham Outline Implementation Plan*

North West London Whole Systems Integrated Care

Summary of Proposals – Developed for Review Panel
Hammersmith and Fulham
Health and Care Community

Thursday 12th June

Living *longer* and living *well*

Hammersmith & Fulham – Setting the scene…

Small geographical area, large population (202,202)

Population ethnicity: 78% (white) and 22% BME

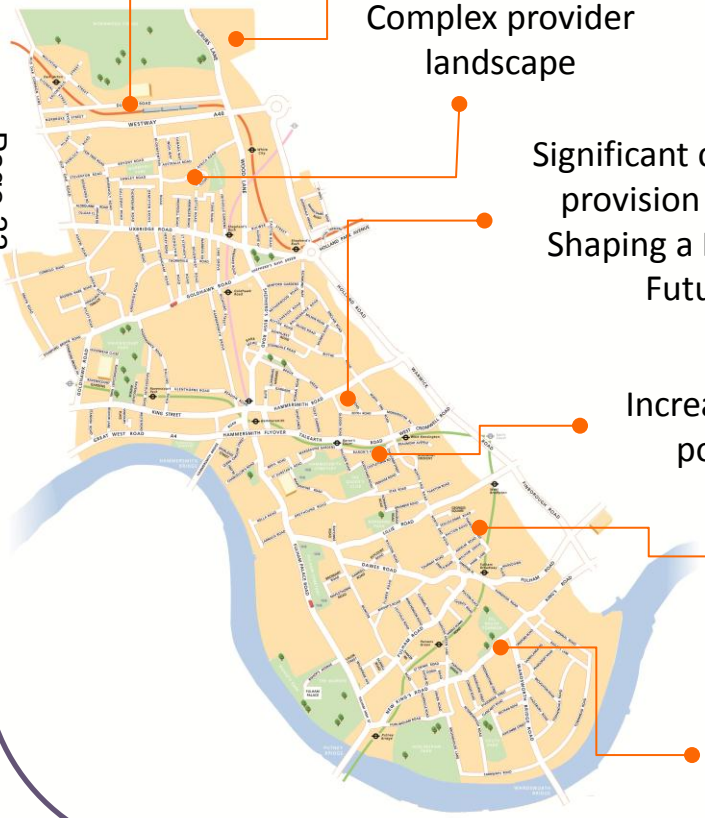
Complex provider landscape

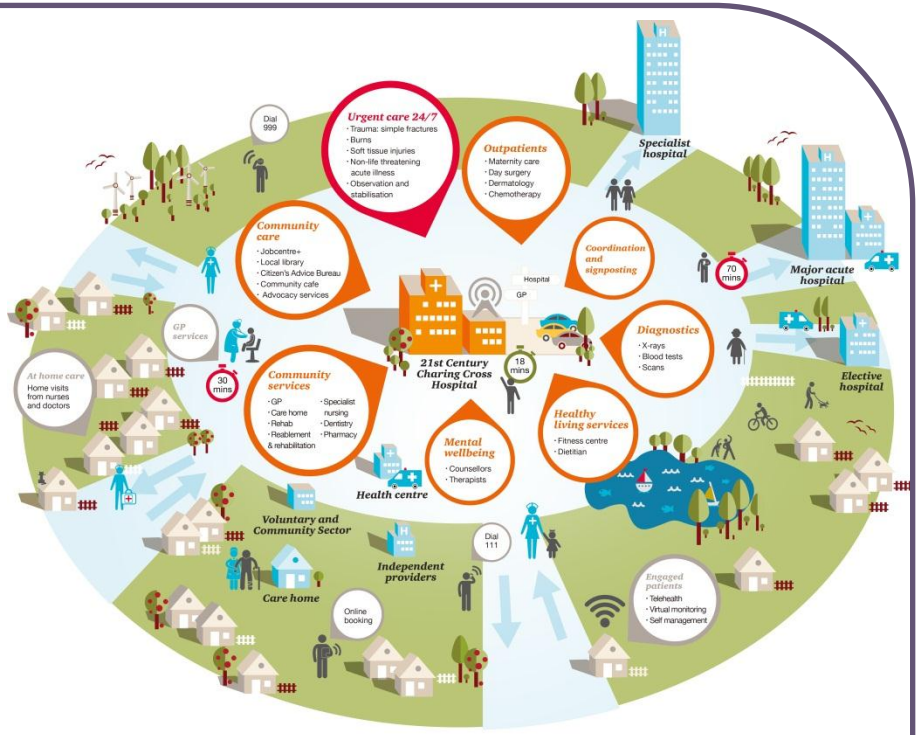
Significant changes in provision through Shaping a Healthier Future

Increasing elderly population

High rates of mental health need and sexually transmitted diseases

Around 11,000 people recorded as providing unpaid care (about 6%)





Hammersmith & Fulham Early Adopter Proposal

Accountable Care Group Early Adopter Proposal

Hammersmith & Fulham - Our journey to date…

- The second area in England to appoint a joint Chief Executive of the Local Authority and PCT in 2009
- Joint integrated care programme 'Continuity of Care' launched in 2011 and co-sponsored by the PCT and LA
- Formation of our five GP Networks in 2011
- Full take up by GP practices of the Integrated Care Pilot for Inner North West London and aligned our networks to multi-disciplinary groups
- Hammersmith and Fulham LA and PCT/CCG were enabling partners in the Tri-borough Community Budgets programme in 2012
- As part of the Shaping a Healthier Future programme we are uniquely positioned to develop a local hospital model intrinsically linked to our out of hospital and community provision
- We have rolled out SystmOne to all our GPs and continue this roll out with our Community Provider enabling information sharing

Hammersmith & Fulham CCG & Local Authority – Early Adopter Proposal

- Two CCG Governing Body Lay members have played a key role in the Embedding Partnership work stream of the Whole Systems Programme – delivering coproduction of the NWL Toolkit
- Our outline Whole Systems plan reflects our journey so far to develop integrated care - being jointly led by CCG and LA as commissioners
- Our models of care have been developed working with our key providers in acute, community, social care and mental health, and who are all represented in our bid
- We have developed our Out of Hospital Board to become our forum to drive our Whole Systems Integrated Care plan – and have representation from commissioners, providers and lay partners

h&f hammersmith & fulham

NHS Hammersmith and Fulham Clinical Commissioning Group

Central London Community Healthcare NHS Trust

Imperial College Healthcare NHS Trust

Chelsea and Westminster Hospital NHS Foundation Trust

Central and North West London NHS Foundation Trust

West London Mental Health NHS Trust

healthwatch Hammersmith and Fulham

Our vision is to deliver whole systems integrated care to all our population groups but we recognise that we need to take a phased approach to implementation. Our bid is therefore focused on adults and older people with one or more Long Term Condition – around 30,000 people in Hammersmith & Fulham

Population size	Population Cost
202,202	£827m

Aged 16-74 who have one or more LTCs:

Population size	Total Group Cost	Average cost per person	Average age
25,693	£64.6m	£2,513	50

Aged >74 who have one or more LTCs:

Population size	Total Group Cost	Average cost per person	Average age
4,110	£20.3m	£4,933	81

Living *longer* and living *well*

Hammersmith & Fulham – Whole Systems Model of Care

1. Delivery of a Virtual Ward model for high risk, complex needs persons as our key admissions avoidance initiative

2. Co-design and development of our primary care provider networks and community services

3. Developing Local hospital services co-designed with our local communities through SaHF programme

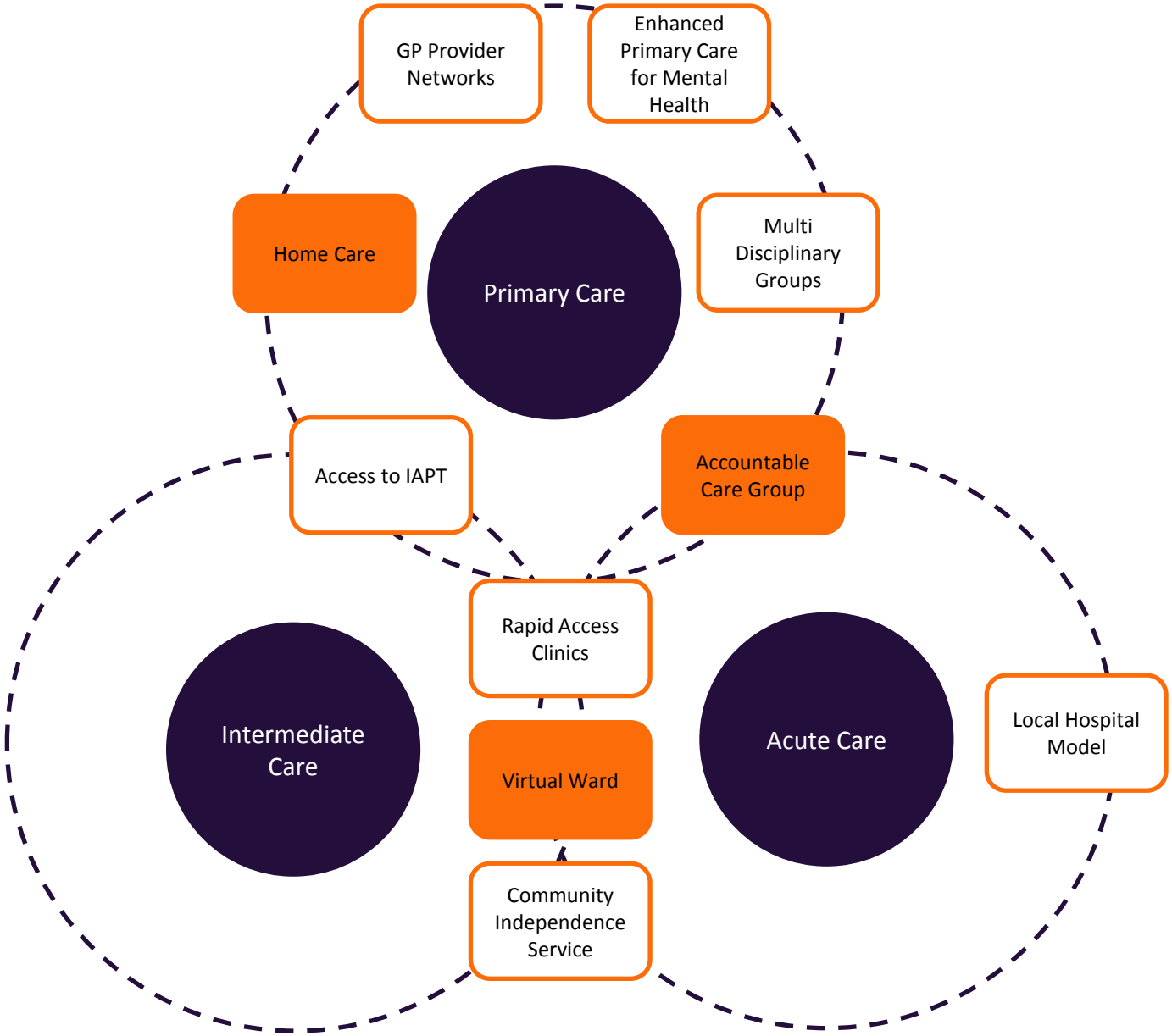
4. Designing streamlined and patient centred acute to community pathways focusing on transitions of care

5. Developing effective integrated care at home provision for older and high risk persons who remain in their own home or a care home that is linked to our GP and provider network function

6. Developing our community assets particularly with a focus on communities and our third sector partners supporting self management, personalisation of care and enabling local responses to peoples' needs

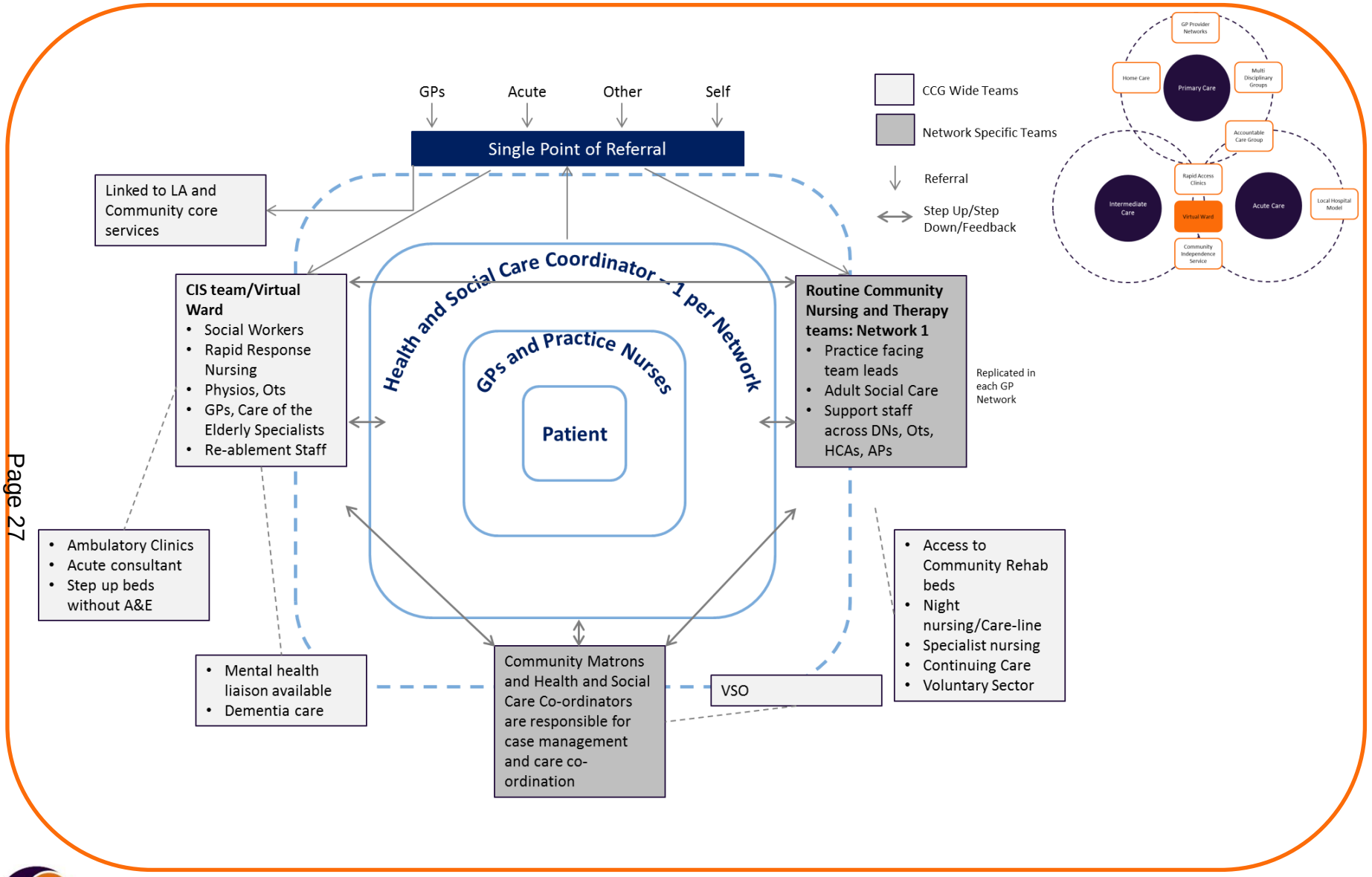
Living *longer* and living *well*

Developing Hammersmith & Fulham's Model of Care



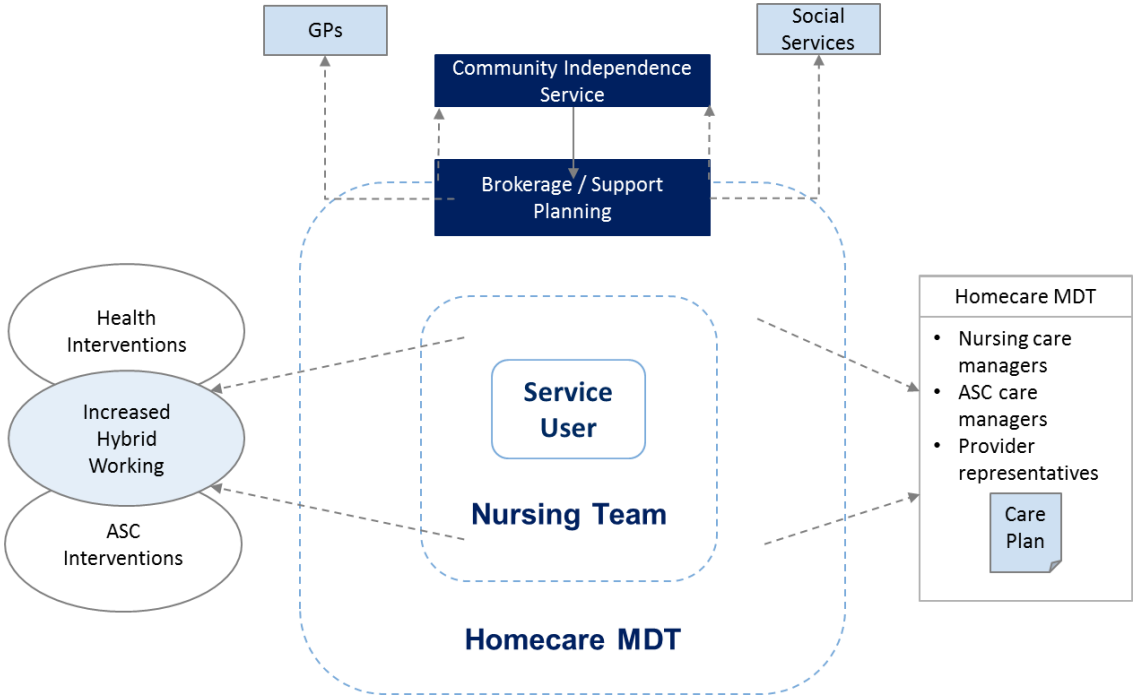
Living *longer* and living *well*

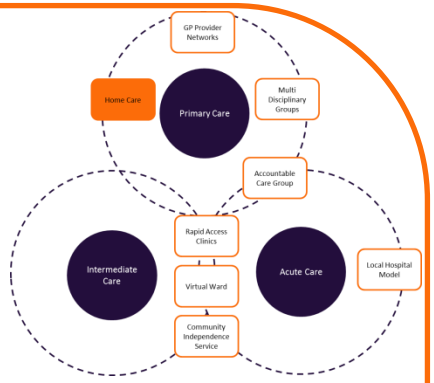
Hammersmith & Fulham – Model of Care (Virtual Ward)



Living *longer* and living *well*

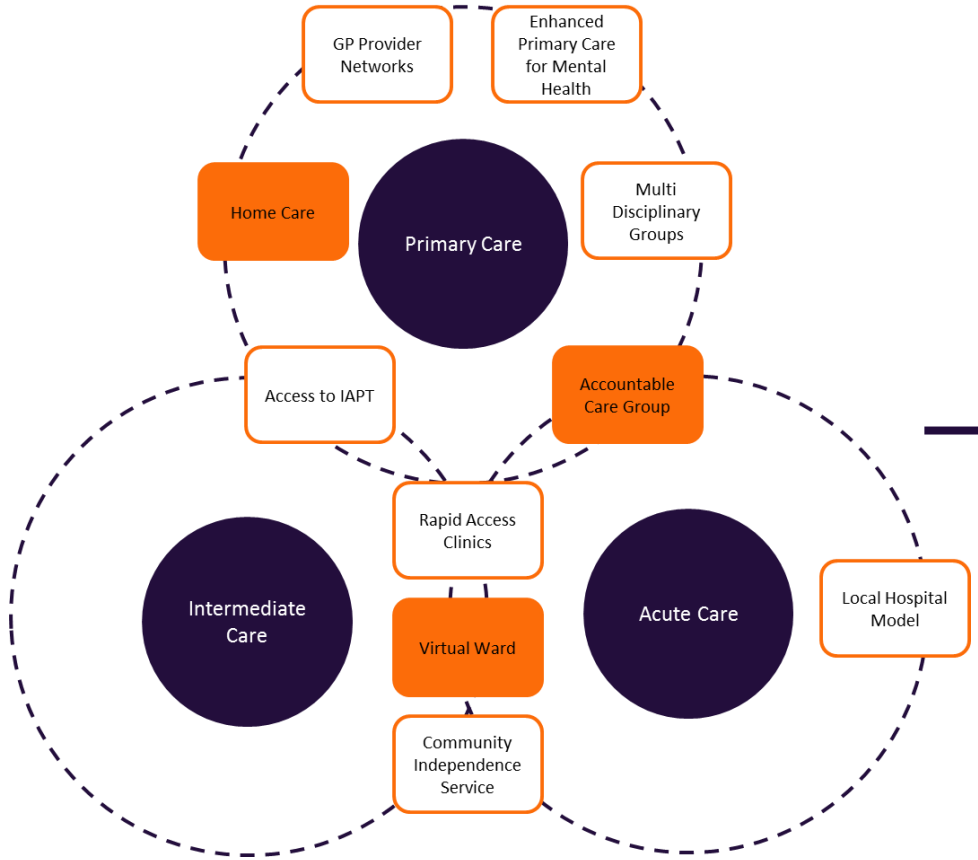
Hammersmith & Fulham – Model of Care (Home Care)

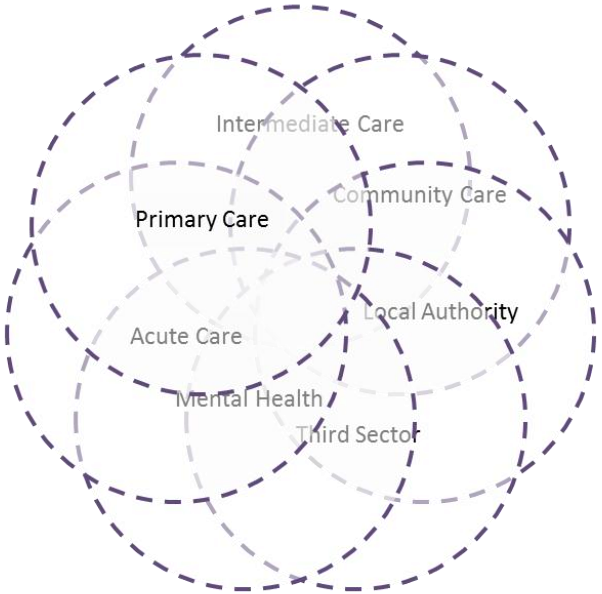




Living *longer* and living *well*

Hammersmith & Fulham – Next steps





Living *longer* and living *well*

Living *longer* and living *well*

Whole Systems Integrated Care

Hammersmith & Fulham Early Adopter

Submitted on behalf of:

h&f hammersmith & fulham

NHS Hammersmith and Fulham Clinical Commissioning Group

Central London Community Healthcare NHS Trust

Imperial College Healthcare NHS Trust

Chelsea and Westminster Hospital NHS Foundation Trust

Central and North West London NHS Foundation Trust

West London Mental Health NHS Trust

healthwatch Hammersmith and Fulham

Last updated: 28st May 2014

Version: 1.0

Executive Summary

As joint commissioners we are committed to delivering radical and innovative change through the Whole Systems Integrated Care programme so that our local residents and patients experience seamless care and support which focuses on their wellness and not their illness. People being in control of their own needs and the care they receive is our primary goal and we recognise that the system needs to change to enable this so that services are commissioned, delivered and paid for differently. For us, the Whole Systems programme offers the opportunity to see real structural and systematic change so that people are at the heart of our health and social care economy.

The North West London Integrated Care Pioneer Programme works towards a shared vision to integrate care across our whole system:

*"We want to improve the **quality of care** for individuals, carers and families, **empowering and supporting** people to maintain independence and to **lead full lives** as active participants in their communities"*

Each locality (health and care) is now to decide how to take forward our local integration work, within the context of the North West London Whole Systems Integrated Care programme and aligned to our local strategic plans and direction. Following a local co-design process in Hammersmith & Fulham, this Outline Whole Systems Plan captures our local vision, initial planning on critical elements such as the outcomes required of our new model of care and a project plan to prepare full business cases and implementation plans going forwards.

We will address six key delivery workstreams as an early adopter, which together represent our shared commitment to taking an ambitious and truly whole systems approach:

- Delivery of a Virtual Ward model for people with complex needs and high risk as our key admissions avoidance initiative
- Co-design and development of our primary care provider networks and community services
- Developing local hospital services co-designed with our local communities through the Shaping a Healthier Future programme
- Designing streamlined and patient centred acute to community pathways focusing on transitions of care
- Developing effective integrated care at home for older and high risk people who remain in their own home or a care home that is linked to our GP and provider network
- Developing our community assets particularly with a focus on communities and our third sector partners supporting self management, personalisation of care and enabling local responses to people's needs

This document lays out the case for change and describes the vision and emerging thinking on the whole systems model of care for adults and older people with one or more Long Term Conditions in Hammersmith & Fulham.

Tim Spicer
Chair
Hammersmith & Fulham CCG

Liz Bruce
Executive Director of Adult Social Care
Tri-borough

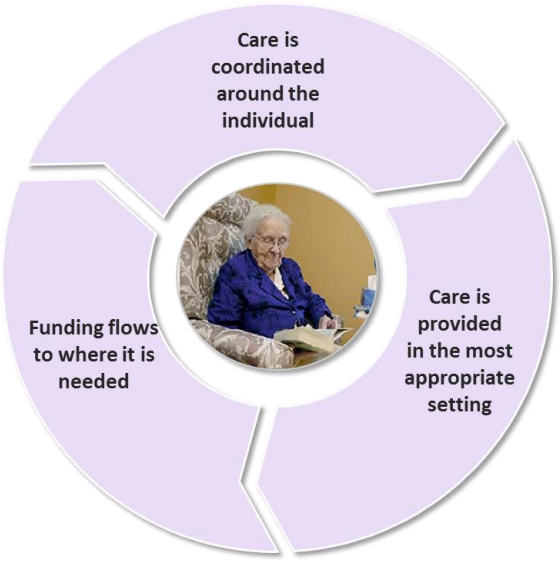
Table of Contents

Section One: Whole Systems Vision

- **What is your vision for improving the care people will receive and how the Whole System will change to support this?**

North West London's vision of Whole Systems Integrated Care is underpinned by three principles:

1) People will be empowered to direct their own 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



We have a clear vision for whole systems transformational change in health and social care for the population of Hammersmith & Fulham, and significant progress has been made in delivering this through partnership working over a number of years.

The Local Authority and Clinical Commissioning Group have worked in close collaboration, and our Commissioning Intentions, for the first time, contain joint intentions for health and social care in Hammersmith & Fulham. Specifically, these intentions include: establishing joint community teams of health and social care professionals to support people remain in their own homes and keep them out of hospital where possible, and aligning better, community based resources such as community nursing, with general practice.

Our ambition is to:

"Enable individuals to be as healthy and independent as possible maintaining and / or regaining their quality of life and well being"

"Support individuals choice to live in the most appropriate place that they want according to their needs and to have control over their lives"

"Ensure that the individuals experience is a positive one by ensuring the service is personalized and seamless within the system"

"Ensure that the treatment, care and support that is provided is right for the individual's needs, in the right setting and respects their individuality and dignity"

"Increase integration and efficiencies across health and social care to ensure strategic investment of funds and resources to maximise value for money"

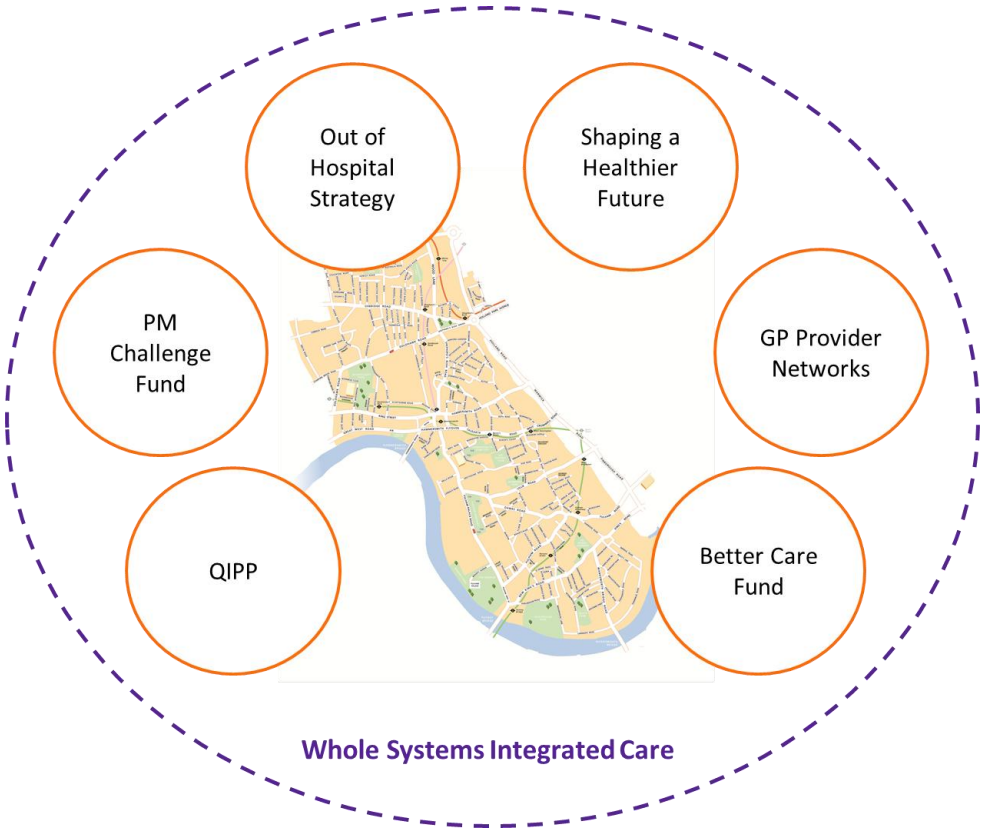
In order to realise our ambition for Whole Systems Integrated Care we have identified six key areas of focus which our Early Adopter work will progress. Put together, these represent our shared commitment to taking an ambitious and truly whole systems approach:

1) Delivery of a Virtual Ward model for people with complex needs and high risk as our key admissions avoidance initiative
2) Co-design and development of our primary care provider networks and community services
3) Developing Local hospital services co-designed with our local communities through SaHF programme
4) Designing streamlined and patient centred acute to community pathways focusing on transitions of care
5) Developing effective integrated care at home provision for older and high risk people who remain in their own home or a care home that is linked to our GP and provider network
6) Developing our community assets particularly with a focus on communities and our third sector partners supporting self management, personalisation of care and enabling local responses to people's needs

■ What will being an Early adopter add above existing strategic initiatives that are already happening in your local area (e.g., Better Care Fund, 7-day working)?

There are a number of existing strategic initiatives already underway within Hammersmith & Fulham:

We are reconfiguring our services to deliver the best care through Shaping a Healthier Future, included in this is our local hospital design work and re-scoping of urgent care. Our Out of Hospital Strategy is building capacity and capability within the community as a vital part of this reconfiguration. Our GP practices are currently exploring mechanisms to drive change through networked provision of care and development of provider networks, and we are improving access to and innovative ways of delivering GP services as part of the Prime Minister's Challenge Fund. The Better Care Fund is enabling us to identify where pooled funding with social care can drive transformation change through, for example, developing integrated services in intermediate care, home care and the commissioning and monitoring of care homes. All of this must be delivered within the financial context of the QIPP gap for Hammersmith & Fulham.



It is vital that health and social care partners work together to integrate at every available opportunity, as integration is necessary to achieving our joint commissioning intentions and to make a step change in service quality. In North West London, health and social care partners are working jointly to progress whole systems integration, and for Hammersmith & Fulham being an early adopter will enable us to test working together differently to manage higher risk cohorts of our population.

For Hammersmith & Fulham being an early adopter will allow us to make the system changes that enable the delivery of our strategic initiatives – without changes to the system we cannot fully realise our ambitions to integrate care and to see the maximum benefit from the existing programmes being delivered in H&F and as part of NWL. These system changes will provide new models for how care is commissioned, delivered and paid for with integration of the supporting infrastructure such as informatics, workforce development and leadership and culture.

Section Two: Involvement of People Who Use Services, Carers and Frontline Staff

- **How have you worked with all the people who will be affected including people who use services, frontline staff, commissioners and providers to co-design our local whole systems plan?**

Hammersmith & Fulham's Whole Systems Expression of Interest was submitted in April 2014 on behalf of:

- NHS Hammersmith & Fulham CCG
- LB Hammersmith & Fulham
- Central London Community Healthcare NHS Trust
- Imperial College Healthcare NHS Trust
- Chelsea & Westminster Hospital NHS Foundation Trust
- West London Mental Health NHS Trust
- Central and North West London NHS Foundation Trust
- Healthwatch Hammersmith & Fulham

Hammersmith & Fulham's Out of Hospital Programme Board, jointly chaired by the CCG and Local Authority, has provided oversight of the development of our Whole Systems Integrated Care Expression of Interest, and at our meeting in May 2014 was confirmed as the forum to deliver our Early Adopter proposal, becoming the Out of Hospital and Whole Systems Integrated Care Programme Board going forwards. This Programme Board includes representation from all providers, patients and carers.

Our first Whole Systems Integrated Care workshop in May 2014, focussed on Outcomes and Model of Care was attended by:

Name	Role
Aglaja Dar	Consultant – Imperial College Healthcare NHS Trust
Ann Stuart	Head of Assessment Social Work – LBHF
Anna Letchworth	Integrated Service Manager - ChelWest
Antoinette Eni	Service Manager - Imperial College Healthcare NHS Trust
Aran Porter	Associate Director, ICP – NWL
Aya Ferguson	PPL Better Care Fund
Caroline Allnutt	NWL Strategy and Transformation
Cath Attlee	Whole Systems Lead – Triborough Adult Social Care
Chris Bench	Senior Clinical Lead - WLMHT
Chris Lambourne	Head of Clinical Transformation – CLCH
Clare Graley	GP – H&F CCG

Darren Jones	Interim Senior Manager – CLCH
David Stacey	Director of Strategy - WLMHT
Dominic Conlin	Director of Strategy & Integration - ChelWest
Gillian McTaggart	Community Independence Service Co-ordinator H&F
Ian Garlington	Director of Strategy – Imperial College Healthcare NHS Trust
Jennifer Allan	Divisional Director - CLCH
Jenny Platt	Deputy Out of Hospital Delivery Manager - CCG
Jessica Simpson	Network Coordinator Primary Care Transformation - H&F CCG
Joe Gale	Network Coordinator – H&F CCG
Julie Scrivens	Lead for Planned Care – H&F CCG
Malika Hamiddou	CE - CITAS
Martin Waddington	Director of Commissioning and Contracting, Adult Social Care - Triborough
Matthew Mead	MDG Manager, ICP – H&F CCG
Neil Snee	Service Transformation - CLCH
Noel Morrow	NWL Joint Commissioning Team
Pauline Mason	Adult Social Care – Triborough
Penny Magud	Head of Community Independence Service - LBHF
Philippa Jones	MD – H&F CCG
Rachel Stanfield	Organisational Development – H&F CCG
Ray Boateng	NWL Joint Commissioning Team
Rebecca Vagi	Standing Together Against Domestic Violence
Rob Sainsbury	Deputy MD Out of Hospital Programme Manager – H&F CCG
Samira Ben Omar	Associate Director Equality & Experience - NWL
Samuel Wallace	Borough Manager - Healthwatch
Sena Shah	IT Lead – H&F CCG
Shad Haibatan	Head of Organisational Development - SOBUS
Sophie Ruiz	Senior Network Coordinator – H&F CCG
Stuart Lines	Public Health - Triborough
Susan McGoldrick	GP – H&F CCG
Vincent Law	Consultant Psychiatrist – WLMHT
Will Jones	NWL Strategy and Transformation
Will Tate	PPL (Homecare)

Recognising co-production with service users as an area for development within our local whole systems integrated care plan we engaged with the Co-Production leads for North West London, and have identified members of the lay partners' advisory group for North West London who will support Hammersmith & Fulham to embed the principles of co-production going forwards.

How are people who use services and front line staff part of your decision making and governance arrangements?

To date we have involved people who use services and front line staff in the development and delivery of our Out of Hospital and Local Hospital programmes in a number of ways:

- Developing with the patient reference group the principles for engagement on our Out of Hospital Programme and sharing progress on our projects
- Attending the Older People's Consultative Forum to share and discuss our Out of Hospital programme and Virtual Ward initiative
- Engaging with the Carers Partnership Board and Learning Disabilities Partnership Board
- Engaging people who use services in the design of the local hospital through workshops and visits to service
- Engaging people who use services in the development of our joint commissioning intentions
- Consultation and engagement with people who use home care services by the Local Authority as part of development of the new specification and model of home care across Tri-borough
- Front line staff – nurses, therapists, consultants, social workers, OTs, GPs – have been actively part of developing our Virtual Ward model of care through workshops and weekly operational group meetings

Hammersmith & Fulham Patient Reference Group meets on a bi-monthly basis, reporting into our Quality Committee. The Patient Reference Group comment on our strategies and plans, feeding into their development.

Hammersmith & Fulham's Stakeholder Engagement Working Group – made up of a GP, Head of OD and Governance, Communication and Engagement Lead, a Practice Manager and the two lay people on the board. Discuss how we engage with our stakeholders and how this can be improved upon (e.g. engagement with our voluntary and community sector).

Hammersmith & Fulham's Out of Hospital/Whole Systems Integrated Care Programme Board, which has two lay representatives, meets on a monthly basis to oversee the co-design and specification of the health & social care system.

From July 2014 a regular paper to the Hammersmith & Fulham CCG Governing Body will be presented on patient engagement, equalities and patient experience. This will include feedback from community group reports, to ensure that we are fully aware of developments across Hammersmith & Fulham.

- **How will you support and train partners to support their participation in co-design?**

Co-design is an inclusive and collaborative process with a breadth of stakeholders who can represent the varied interests of service users, their families, their carers and their communities. Hammersmith & Fulham will use the next phase of the programme to engage lay partners, health and care professionals and voluntary services from across the system to contribute to the future of integrated care for adults and older people with one or more long term conditions.

We will work with lay partners from the North West London Lay Partners Advisory Group to develop co-production locally. We will engage with members of our Programme Board to both agree local principles of co-production and begin to model these behaviours at a strategic level. We will also host shared learning events, selecting one of our integrated care initiatives to co-design in practice, as an opportunity to train partners across Hammersmith & Fulham.

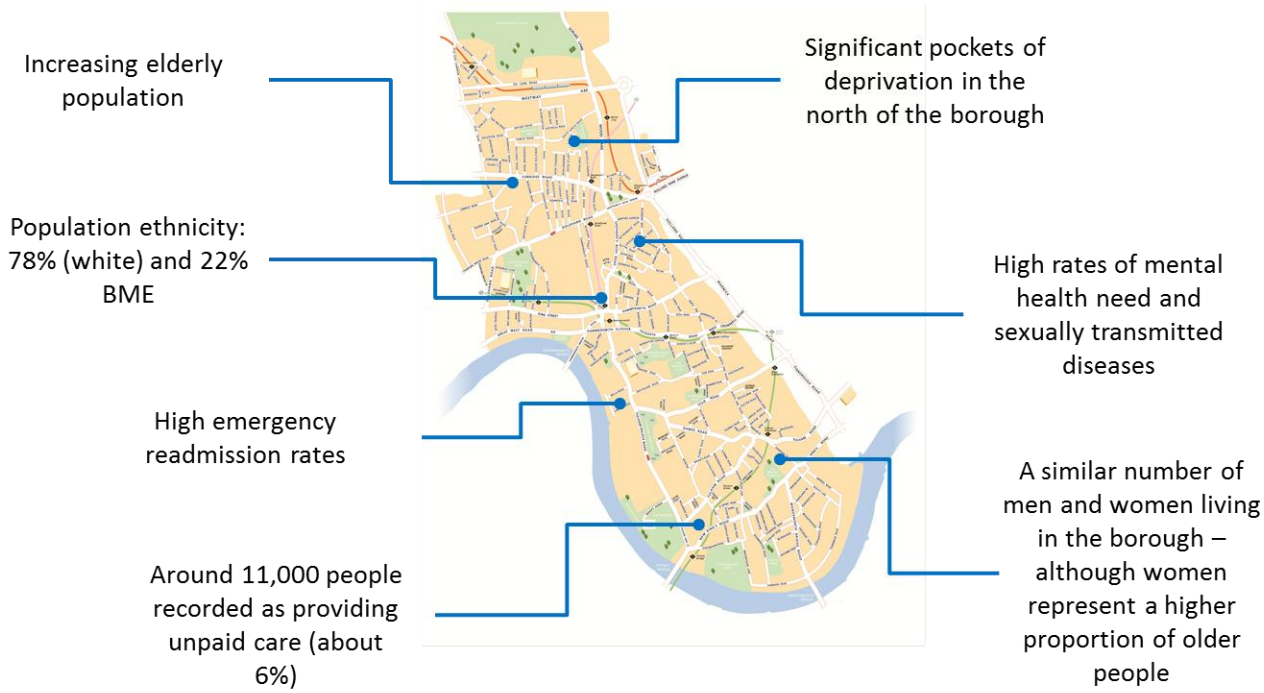
We intend to use the process of co-producing this initiative as a learning exercise in itself, building commitment to co-production and learning lessons in co-production. We would also like to develop a buddying system to provide support to all partners in embedding co-production locally.

At our initial discussion with lay partners we began to talk through our six key delivery workstreams, and it quickly became clear that we need to revisit these to understand the service users affected by these specific initiatives. We will then map out existing community and voluntary groups who would be well placed to represent the varied interests of adults and older people with one or more long term conditions, and will work with these groups to identify opportunities to engage service users, their families and carers in the development of integrated care.

Section Three: Population Grouping

- **Which population group(s) described in the toolkit will you prioritise and what are the local needs?**

Hammersmith & Fulham have a population of approximately 202,202, with a projected increase of to 212,490 over the next five years. The needs of our local population are the starting point for our work, and these are taken from our joint strategic needs assessment (JSNA). The JSNA includes information on the health and wellbeing of our local population which has been analysed to give us an understanding of what people's current and future needs might be, so that this can inform decision making.

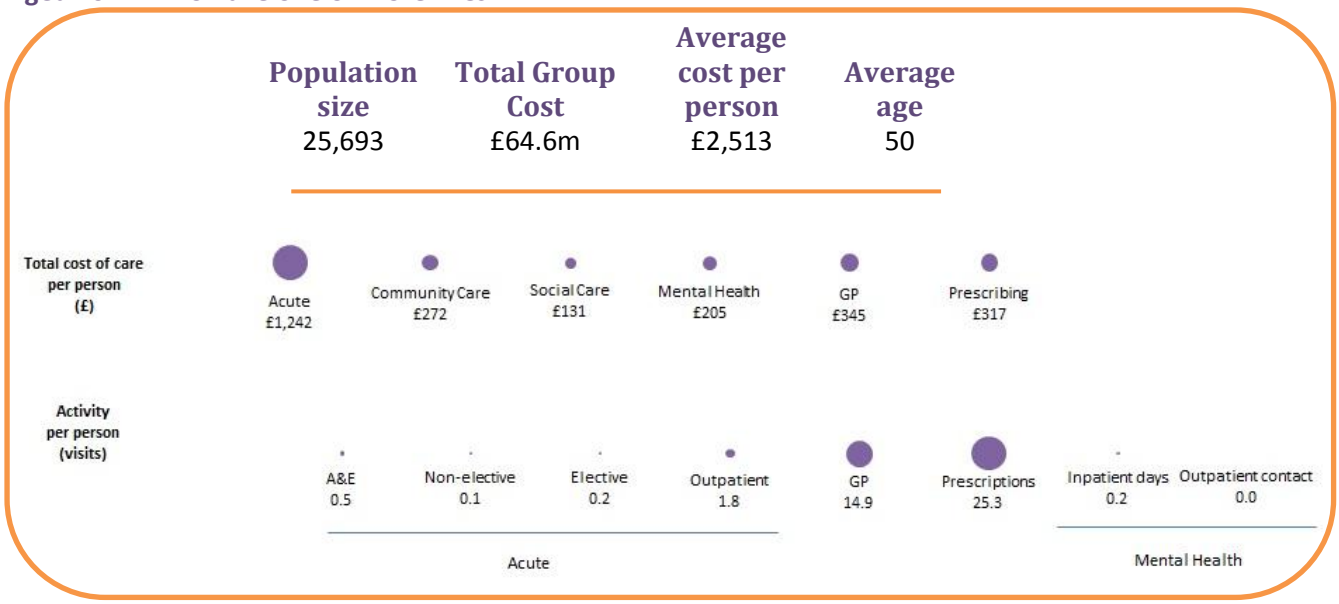


We have chosen to focus our Whole Systems Integrated Care early adopter work on adults and older people with one or more long term conditions, of whom there are approximately 29,802 currently living within Hammersmith & Fulham. These groups are in receipt of a range of services across the health and social care economy, and can often be our most complex in terms of health and social care need. Focussing on these groups will give us an opportunity to build on initiatives, expanding and extending these to provide end to end care for these groups.

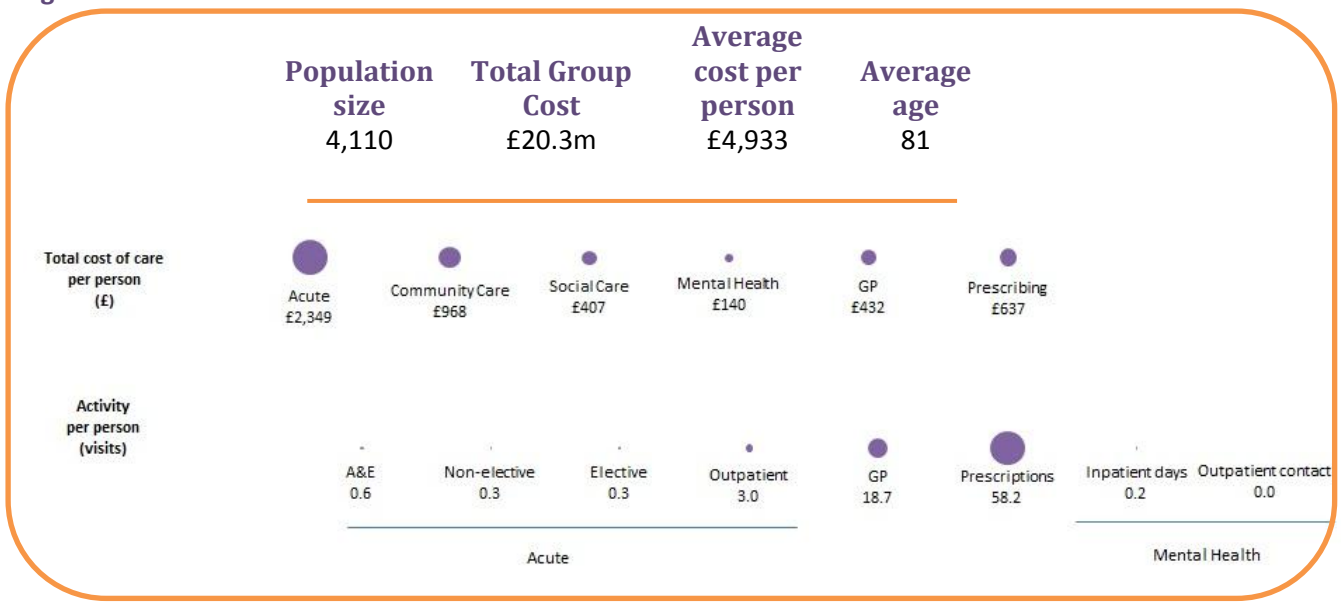
Hammersmith & Fulham CCG and the London Borough of Hammersmith & Fulham have worked closely together to support the development of Whole Systems thinking through enabling a joint data set for Hammersmith and Fulham that has been the basis for developing the population groupings in the North West London Whole System Integrated Care programme.

The population groupings developed from our joint data set identify the holistic needs of individuals who fall into those groupings. The needs of adults and older people with one or more long term conditions in Hammersmith & Fulham can be categorized as follows.

Aged 16-74 who have one or more LTCs:



Aged >74 who have one or more LTCs:



- **What initiatives are planned over the coming year to improve care for this group (e..g, BCF) and how will your plans align with them?**

For our population groups of adults with one of more Long Term Conditions our Whole Systems plan brings together a range of initiatives over the coming year to improve care for these groups and will enable us to deliver this care through an integrated infrastructure to move away from the silo based provision and funding of care that people currently experience:

- Virtual Ward: our Virtual Ward model will be further developed across 2014/15 to offer a multi-disciplinary care response for our most high risk people and extending the groups supported by this model in line with our QIPP plans. We will ensure the resource within the multi-disciplinary team can respond to people's needs and will increase our mental health input and medical cover within the model as well as bringing in third sector and voluntary providers
- Working with acute partners to further develop the rapid access clinics for older people to offer comprehensive diagnostics and assessment within a short timeframe and to link these services to our Virtual Ward
- We are developing care pathways into our Improving Access to Psychological Therapies (IAPT) programme for people with long term conditions and to address anxiety and depression which we recognise are highly prevalent in our population groups
- Developing pathways for smoother and more timely transitions from hospital to community services through our transitions of care and delayed transfers of care projects working with acute, community and social care providers
- Increasing the proportion of planned care that is delivered in community settings by developing new pathways and services for dermatology, respiratory, MSK, diabetes and ophthalmology
- Commissioning an integrated home care service that includes health tasks to reduce duplication and inefficiency caused by people having a number of different health and social care professionals visiting them in their home
- Improving the access and range of primary care services as part of the PM challenge fund with a high number of our practices signed up to deliver this
- Supporting more people with mental illness to be cared for by their GP rather than hospital teams by continuing to increase our enhanced primary care mental health service
- Developing a joint team for commissioning and purchasing of residential and nursing care so that quality of care is monitored and reviewed across the CCG and Local Authority
- Providing proactive enhanced care in care homes to reduce LAS call outs and emergency attendances as well as reducing falls in the home and improving medicines management

Section Four: Outcomes

■ What are the priority outcomes to be achieved by the targeted population group for each of the areas given in the outcomes framework in the Toolkit?

At our first Whole Systems Integrated Care workshop we explored outcomes for adults and older people with one or more long term conditions. Working through each of the five domains of the outcomes framework, as set out in the NWL Integrated Care toolkit, we discussed existing outcomes and explored potential outcomes for development.

A summary of our discussions is below:

	Outcomes and metrics	
	Existing	**Innovative**
Quality of life	• Currently, we have gather patient views on their care in a variety of formats, a have developed some patient reported outcome measures related to quality of life. • Future, we need to give patients the opportunity to shape their care and the goals important to them • Future, we need greater emphasis on psychosocial wellbeing	• An outcome around how people's basic needs are being met and what health conditions make it difficult to fulfil these needs. For example needs such as wellness, having friends and networks, having a suitable house, having enough money • Don't have an outcome that suggests treating the cause of a medical or social problem is the answer to people's needs – look at the person not the condition How do we know that quality of life is improving? a) Is there a care plan b) Has there been a recorded discussion about peoples own goals within that care plan c) At some point an appropriate review, including to what extent those goals have been achieved

	Outcomes and metrics	
	Existing	**Innovative**
Quality of care	• Currently, there are a lot of outcomes collected on quality of care across the system but in isolation for each service/organisation. • Future, we need to have a patient view of quality of care that is across the system not just from each part of it • Future, we need to have a common definition of what good care looks like – that is based on what people tell us	• Communication – how people are communicated with about their care and supported to understand it • Relationships between organisations – how well is this working? With GPs, Social Care, hospitals, voluntary sector • Quality of visits – asking people what they think about the visit they had in their home? People say it's about the quality of the visit – the time spent with them • Qualitative feedback on care – understanding it's impact for patients and outcomes achieved • How empowered do people feel about their own care needs and the care they receive? • A suggestion that we shouldn't talk about 'quality of care' but 'quality of experience' or focus on people's wellness. As care can have a negative focus.

	Outcomes and metrics	
	Existing	**Innovative**
Financial sustainability	• Currently, we rely mainly on activity based finances. • Future, should be focused on measuring outcomes for people against investment made, the focus shouldn't be on inputs delivered against budgets but on health and care outcomes achieved against budgets.	• How shared financial responsibility is being achieved across new provider organisations/networks and how incentives are being used to reward providers for keeping people well • Longer term financial planning –to show sustainability over time • How we are investing in prevention and wellness and what the return on this investment is expected to be • Monitoring the shifts in the financial bubble sizes over time (as per the patient diagrams) – for example seeing that the acute bubble reduces and the OOH bubbles increase • Use of the voluntary sector and community assets – how are statutory providers using these services as part of care plans (not as an 'add on') and what savings we think this delivers • Financial sustainability across organisations – of the whole system and not working against each other

	Outcomes and metrics	
	Existing	**Innovative**
Professional experience	• Currently, individual providers measure their employee's professional experience through staff surveys • Future, we need identify factors that improve professional experience, learning lessons from other healthcare systems, and identify areas where we could improve professional experience	• An outcome measure that ensures focus on professionals receiving feedback on their input to a patient's care e.g. feedback on referrals

Operational performance	• Currently, individual providers measure a number performance factors including:
	  • Sickness rate
	  • Vacancy & turnover
	  • Professional development
	  • Patient facing time
	• Future, we need to move away from individual performance to system wide performance – aligning incentives with delivery across providers
		• An outcome around reducing duplication and how we measure this
		• Measuring access to services and people's understanding of how to access appropriate services could be used to show that settings of care are shifting away from acute

We will continue to develop outcomes for adults and older people with one or more long term conditions across the five domains in the next phase of development, focussing on translating qualitative outcomes to quantitative metrics.

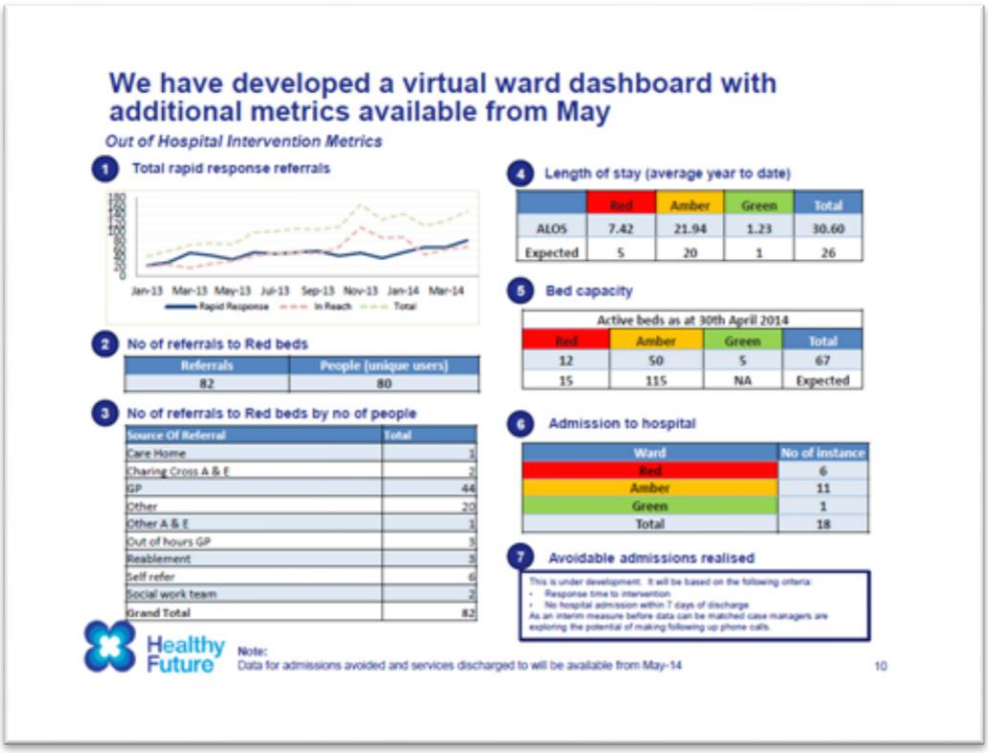
What performance management measures will you adopt?

Once we have established outcomes and metrics, we will build a mechanism for practically measuring and then tracking outcomes. A baseline will be established during the planning phase to enable us to understand the impact of whole systems integrated care on adults and older people with one or more LTC in Hammersmith & Fulham. We will then need to decide how partners will be held to account across the various levels of the system.

We are beginning to develop integrated performance management measures for our integrated intermediate care services and models such as the Virtual Ward. We have identified a range of outcomes and metrics for reporting on the activity and impact of an integrated care model which acknowledge not just the impact on acute services but on social and community services such as:

- A&E attendance avoided
- Non-elective admissions and re-admissions avoided
- Permanent admissions to nursing and residential homes
- People not requiring on-going social or community care
- People remaining in their own home 91 days after discharge
- Impact on community and social care packages following intermediate care intervention
- Number of bed days saved from intermediate care intervention

During 2014/15 we will develop and test our outcomes and metrics for the Virtual Ward using a dashboard like the one below and this will inform how we measure the impact of integrated care in a whole systems model.



We have developed a virtual ward dashboard with additional metrics available from May

Out of Hospital Intervention Metrics

1 Total rapid response referrals

2 No of referrals to Red beds

Referrals	People (unique users)
82	80

3 No of referrals to Red beds by no of people

Source Of Referral	Total
Care Home	1
Charing Cross A & E	2
GP	44
Other	20
Other A & E	1
Out of hours GP	3
Reablement	3
Self refer	6
Social work team	2
Grand Total	82

4 Length of stay (average year to date)

	Red	Amber	Green	Total
ALOS	7.42	21.94	1.23	30.60
Expected	5	20	1	26

5 Bed capacity

Active beds as at 30th April 2014			
Red	Amber	Green	Total
12	50	5	67
15	115	NA	Expected

6 Admission to hospital

Ward	No of instance
Red	6
Amber	11
Green	1
Total	18

7 Avoidable admissions realised

This is under development. It will be based on the following criteria:
- Response time to intervention
- No hospital admission within 7 days of discharge

As an interim measure before data can be matched case managers are exploring the potential of making following up phone calls.

Healthy Future

Note:
Data for admissions avoided and services discharged to will be available from May-14

10

Section Five: Integrated Commissioning

Which organisations want to form integrated commissioning arrangements?

The main commissioners of the proposed Whole Systems Integrated Care model of care are:

- Hammersmith & Fulham Clinical Commissioning Group
- London Borough of Hammersmith & Fulham Adult Social Care

As commissioners, we will also engage with the commissioner of general practice and other family health services, NHS England. Commissioners in Hammersmith & Fulham, covering the same population, residents and patients in the services they purchase, share a case for change around care and also a financial imperative for improving the efficiency and quality of services.

Which budgets do you intend, at this point, to pool to support integrated care? Which contracts will be affected by the pooling of budgets?

As we develop our Whole Systems Integrated Care model of care, we need to undertake detailed work to understand the implications for finance and activity within our current commissioning budgets. We are not at the stage where either commissioner can commit to funding a capitated budget, albeit we are already funding work that will support the development of Whole Systems Integrated Care. We want to get to the stage where we can fully understand what is required, the implications for commissioners and make a formal recommendation to pool a budget to support integrated care.

We expect this work will need the focus of a dedicated working group, which will oversee the work outlined below. This work will also require resource, both within each commissioning organisation and shared.

We expect this work will help us to:

- Undertake a baseline of the areas of spend (within the two identified population groups) helping us to further identify where there is potentially unnecessary spend.
- Agree what to pool / capitate and what not to – working on the premise that the multidisciplinary team will manage the resource regardless of whether a service line is inside or outside of capitation
- Explore the nature of incentives (to include savings and risk apportion)
- Ensure that budgets which are in and out of scope also allow organisations to meet their statutory obligations

Commissioners within Hammersmith & Fulham will work to understand the budgets impacted by the proposed Whole Systems Integrated Care model of care, a potential capitated budget taking into account the population cared for and budgets being pooled and also the contracts that will be affected by the pooling of budgets.

We can make change happen already based on our track-record of integrated working and on current ways of working. In other words, we can and we have worked more collaboratively as commissioners and with our providers. We have made some changes to the contractual arrangements this year to help us deliver the Whole Systems Integrated Care model.

To go further to achieve our ambition for truly whole systems integrated care, we will now work together as commissioners to gain a better understanding of the contracts/budgets to adopt a more collaborative approach and to ensure a better alignment of commissioning and contracting intentions. We know this will require just as much, if not more, organisational development as the proposed model of care.

Section Six: Capitation

- **What is the estimated capitated budget envelope, taking into account the population cared for and the budgets being pooled?**

We have chosen to focus our Whole Systems Integrated Care early adopter work on adults and older people with one or more long term conditions, of whom there are approximately 29,802 currently living within Hammersmith & Fulham.

The North West London Programme Team undertook analysis of a joint data set from Hammersmith & Fulham, attributing total costs and average per capita costs of care across health and social care. Their estimate of the total costs associated with adults and older people with one or more long term conditions is £84.9m, which can be broken down by provider setting as:

Adults with one or more long term conditions:

64.6m – Total cost (includes GP and Prescribing)

31.9m – Acute

5.3m – Mental Health

3.4m – Social Care

7m – Community Care

Elderly with one or more long term conditions:

20.3m – Total cost (includes GP and Prescribing)

9.7m – Acute

0.6m – Mental Health

1.7m – Social Care

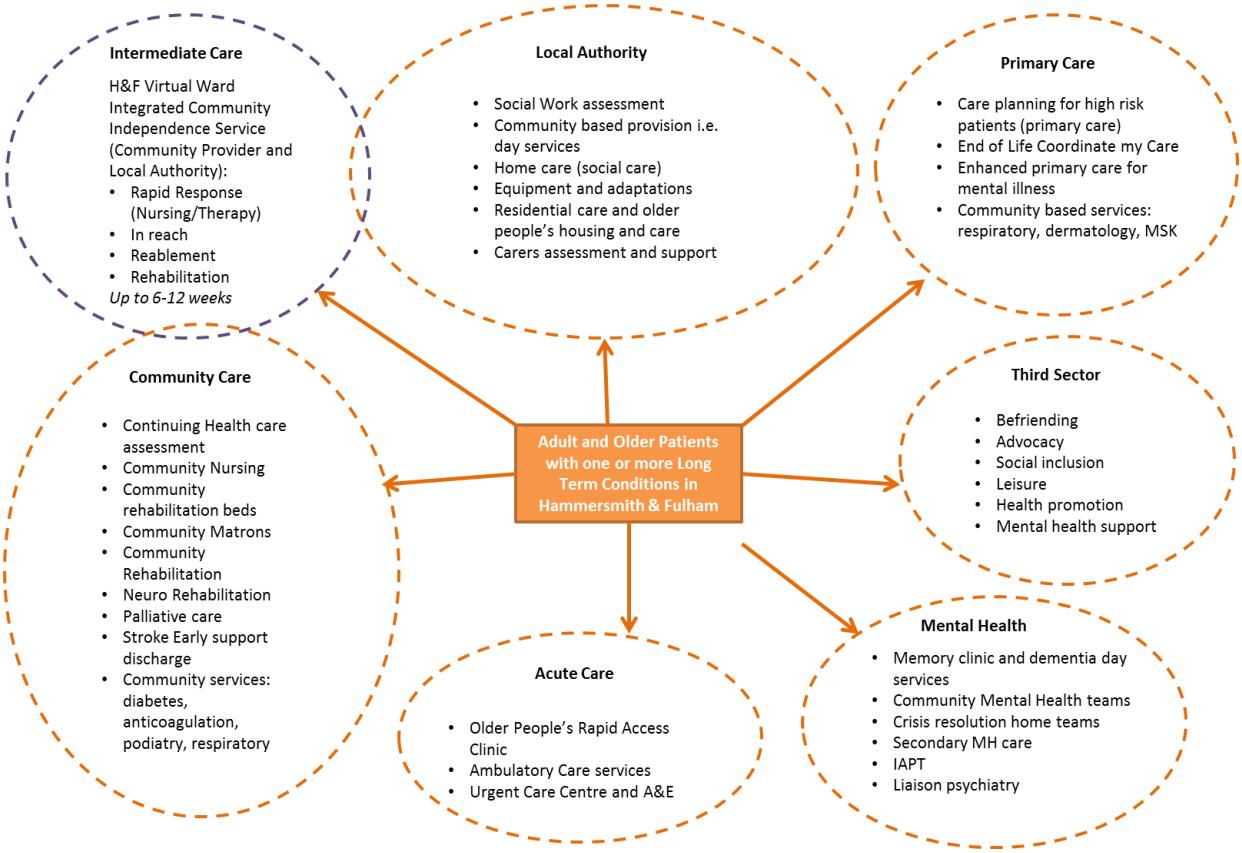
4m – Community Care

We now need to undertake further detailed analysis of the costs attributed to this population, and understand where these are reflected within existing budgets. This will enable us to estimate a capitated budget envelope for adults and older people with one or more long term conditions.

Section Seven: New Models of Care

What is the current model of care for your population group, including the frequency, setting and length of interventions?

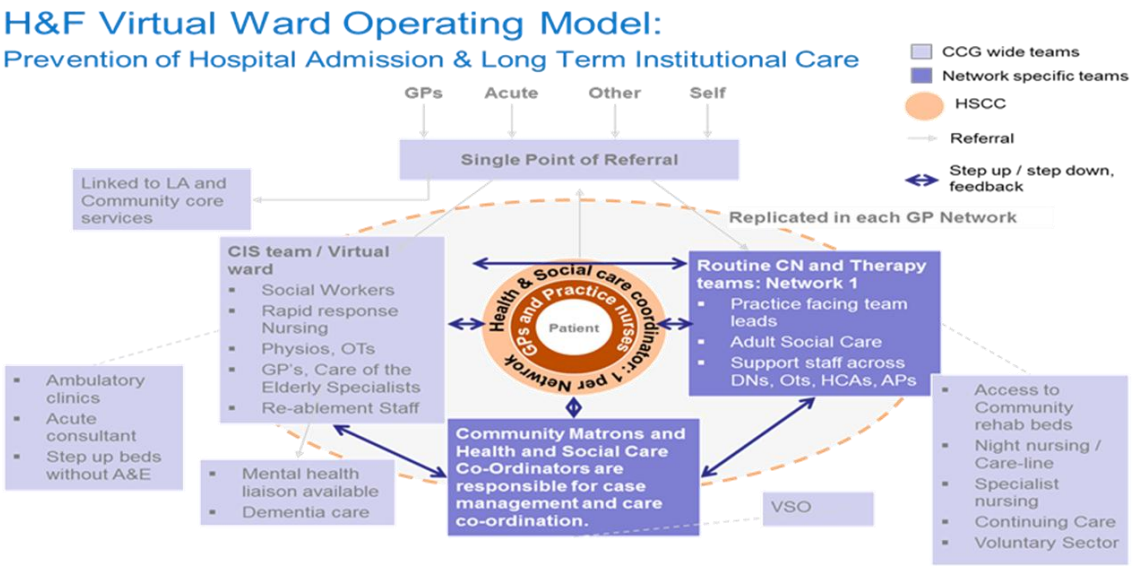
Adults and older people with one or more long term conditions currently access a range of services across Hammersmith & Fulham.



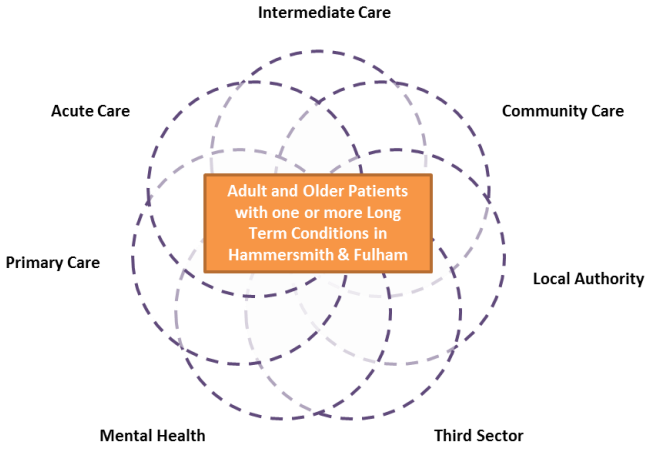
Hammersmith and Fulham have been developing integrated care services for a number of years and launched an integrated Community Independence Service (CIS) in 2012 bringing together the health funded hospital at home and rehabilitation teams with social care reablement. The CIS supports discharge from hospital and aims to prevent unnecessary admissions by providing rapid response nursing and therapy, reablement and rehabilitation and in-reach to acute as part of a multi-disciplinary team. Support from the team continues for up to 12 weeks with a focus on a personalised programme of recovery including reablement and rehabilitation interventions.

The Virtual Ward model builds on this service by providing a wider multi-disciplinary response to people at risk of going into hospital and offering a Red, Amber, Green bed model reflecting people's level of need. The Community Independence Service team is enhanced with dedicated Case Managers and Health & Social Care Coordinators to offer a single point of contact for the patient and their family to coordinate care between the professionals within the team. The team

also includes Community Matrons and Social Workers and medical cover is provided by a consultant geriatrician.



However, outside of these services our core services remain fragmented and can often undo the benefits seen from integrated intermediate care. We have more work ahead to integrate services for adults and older people with one or more long term conditions, and to ensure a holistic response to a person's physical, mental and social needs, rather than an approach focusing on specific diagnoses, services or clinical pathways.

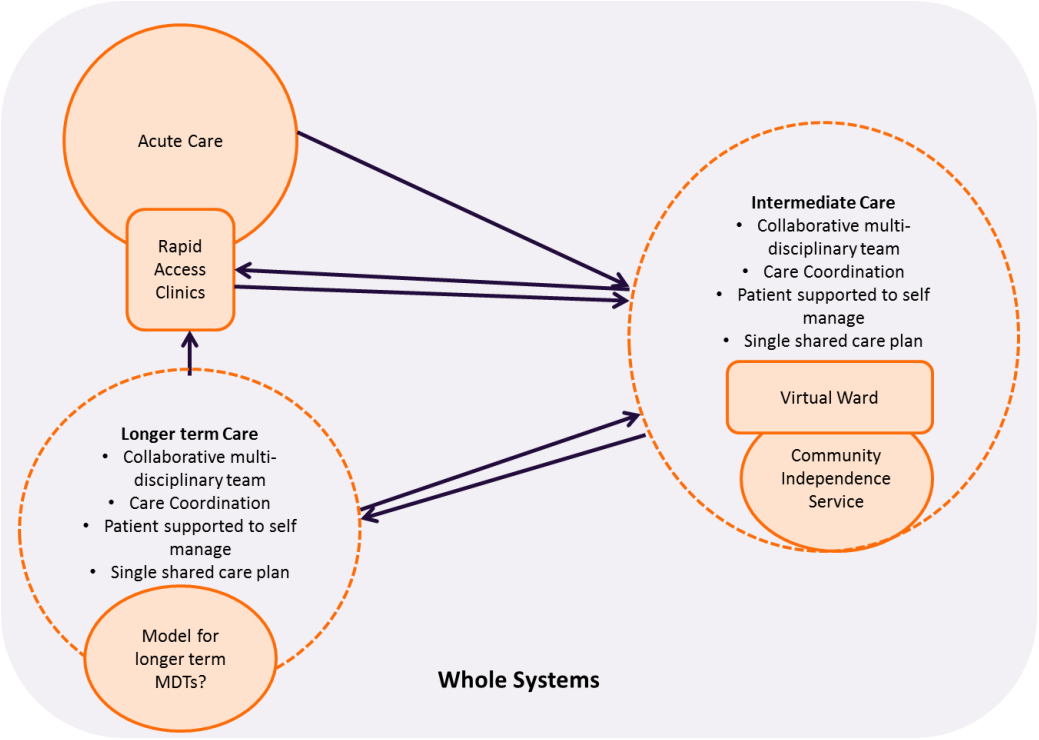


For Hammersmith & Fulham, the Whole Systems programme offers the opportunity to see real structural and systematic change. People being in control of their own needs and the care they receive is our primary goal and we recognise that the system needs to change to enable this so that services are commissioned, delivered and paid for differently.

What is the hypothesis for your model of care, including the frequency, setting and length of interventions?

Our vision for the future model of care is that a network of integrated services will be delivered by a multi-disciplinary team who will work in an integrated way to ensure the patient pathway is seamless, reduces duplication of assessment and ensures the correct outcomes are achieved. The service will utilise the resources of traditional sets of professionals in a more integrated way to create multi-disciplinary teams to enable them to deliver seamless pathways for people. The network will operate as one service, from both a clinical and a patient/service user perspective. Services will maximise patient independence, by supporting and treating individuals in their own home or community thereby preventing and / or delaying admissions into hospital and institutional care placements. We will consider how to maximise support within communities and people themselves, in order to promote social inclusion, prevention and wellbeing – working with other aspects of local provision and community and voluntary groups. Services will deliver tailored packages of support, flexing to people's needs and enabling people to remain at home.

We used our first Whole Systems Integrated Care workshop to explore the four principles of integrated care delivery: One, collaborative multidisciplinary team; Care co-ordination across the MDT; Patient supported to self-manage; and a single shared care plan. To achieve a truly whole systems approach, the new model of care based on these principles should organise care and support around an individual on an continuous basis by establishing a single integrated team that contains the skills/capabilities needed most frequently for the model of care. We set out to understand this in the context of Hammersmith & Fulham, in order to build on and align to existing and planned initiatives across the borough, as in the diagram below:



How do you intend to make full use of social care, self-care, and community capital in your model of care?

We have identified two core principles that will underpin our approach to self-care and empowerment – supporting people to self-manage; and supporting professionals to work in partnership with patients and carers.

"Supporting people to self-manage – using **assets** such as expert patients, community champions to enable people to understand better their condition, and manage it"

"Providing some of the practical tools such as assistive technologies"

"Equally important is that professionals working with patients understand how to work with patients as equals and to work in **partnership** with patients and carers"

"This is a workforce development issue for all professionals about how to work in a way that **empowers** the patients that they are working with. And indeed, working within teams in a more equal way, so for example in teams consisting of qualified and unqualified staff"

"A lot of these things are already happening in Hammersmith & Fulham, but not necessarily across the board"

We are working to understand the capacity of community capital within Hammersmith & Fulham, firstly mapping assets across the borough before moving on to develop mechanisms which harness the potential of community capital to support the delivery of our model of care.

How does your model of care make use of multi-disciplinary teams and care coordination?

We have identified existing multi-disciplinary teams within Hammersmith & Fulham and reflected on the next steps in developing these teams. We identified the need to develop a flexible team membership – designed around people's needs - and began to explore options for provision.

"The members of the team should be based upon the initial assessment and care plan developed – this will determine who is in the team to meet people's needs"

"The team should be based upon how will we meet the outcomes for that person and **design** the team around this"

"It isn't necessarily one team, one employer, one management structure – it is a **matrix** formation"

"We need to develop a different model for care providers"

"People missing from the team diagram – interpreters, housing, wider voluntary sector i.e. leisure, police and community safety, financial support/ benefits"

"Staff should to be **multiskilled**, and we need focus on developing hybrid care providers"

"We need to firstly determine where existing roles overlap, and where there are gaps – so that we can identify the baseline"

We have explored the role of care coordination, the required attributes of these individuals and their core responsibilities.

"A care coordinator should be the person in the team who is **best equipped** to take on that role for that person and their needs"

"Attributes of a care coordinator include: Articulate/Caring/Passionate/Sensible"

"The **ethos** of care coordination as part of professionals roles needs to be developed and embedded so it isn't seen as an 'add on' or an additional task to people's care delivery"

"Care coordination is **continual** not time fixed, as at the moment that is where people begin falling through gaps"

"IT is a key enabler to ensure people are seeing the same information and to ensure the care coordination role is being used efficiently"

"The care coordinator is **responsible** for written and verbal information across the team and with the patient. They also ask the person about their care and what their experience has been"

■ How does your model of care incorporate individual care plans?

We have explored the use of individual care plans within our model of care, and agreed on a number of key requirements. We will incorporate individual care plans into our model of care which are owned by the patient, held within General Practice, accessible to all providers of care, and updated in real time.

*"We need to have an advanced care plan, a crisis plan, which is **accessible** to a range of teams and providers 24/7"*

*"The care plan has to be **owned** by the patient themselves, and has to be contributed to by all of the people within their team"*

"The care plan should be held within General Practice"

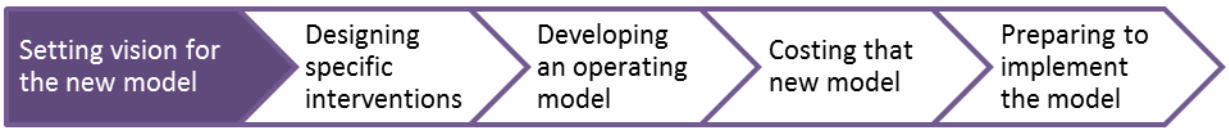
*"Real time access to the care plan is essential, especially as it is **updated** by members of the team"*

"We need to know whether a patient is achieving what was set out in the care plan – we'd monitor and ensure that the plan was delivered by: asking the patients themselves whether their goals were achieved, and monitoring 'failure' of crisis care plans"

*"We don't focus enough on anticipatory planning - understanding based on a patients needs what may lead to exacerbation – we could build the care plan to **divert crisis**"*

Hammersmith & Fulham's partners have articulated their ambition for each of the four principles of integrated care delivery, summarised in the sections above, and we have laid out a vision for the future model of care for adults and older people with one or more long term conditions, moving from separate services for a person's different needs to a single, continuous point of responsibility.

Over the coming months we will convene partners across Hammersmith & Fulham to co-produce the next stages in developing our new model of care:



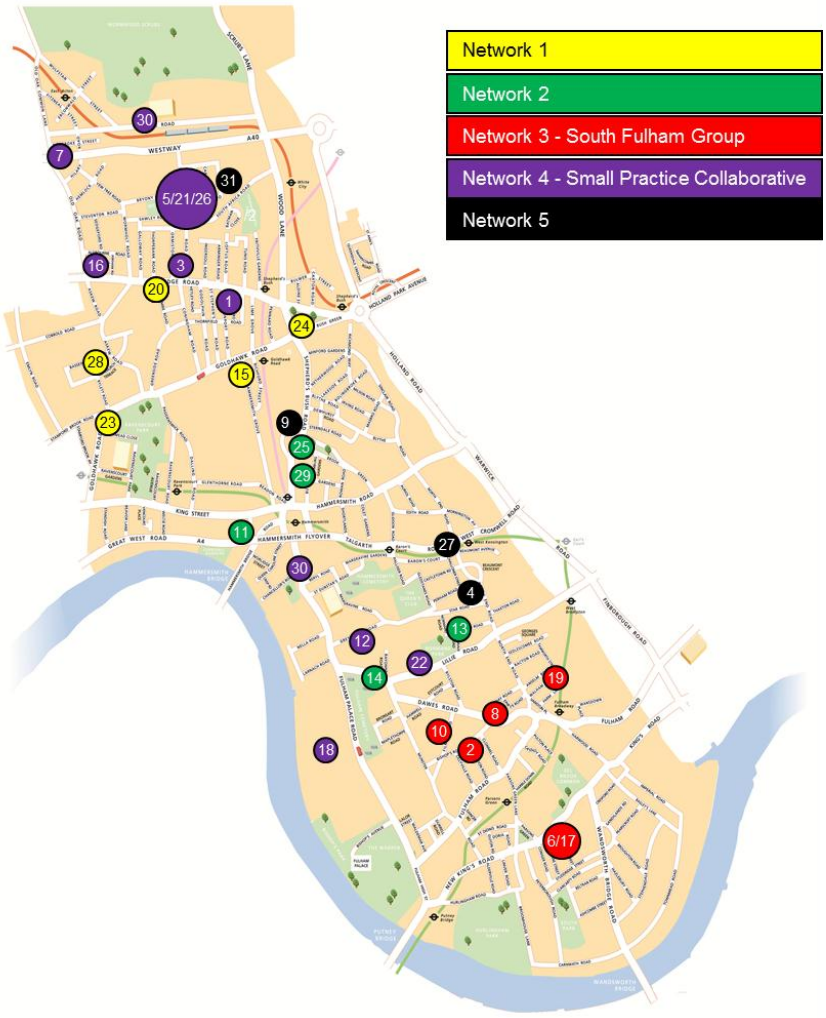
How does your model of care compare in terms of affordability against the capitated budget envelope?

Once we have designed the services, features and specific interventions that will comprise the new model of care, providers and partners across Hammersmith & Fulham will work together to establish the costs of the whole model, establishing the impact on finances that shifting to the new model of care will create.

Section Eight: GP Networks

Which GP Practices will participate in the early adopter partnership?

There are 31 Practices in Hammersmith & Fulham, with a registered population of 190,042. All practices will be participating in the early adopter partnership. GP practices are currently arranged into 5 networks as set out below:



Hammersmith & Fulham CCG are working with member practices to understand preferences for network re-design and reconfiguration. Once a clear vision for networks has been established by the membership, the CCG will support GP Network configurations to successfully form. We anticipate that this network configuration work will be completed by October 2014, and will therefore provide an effective platform for our whole systems integrated approach.

Section Nine: Provider Networks

Which providers will participate in the early adopter partnership?

Hammersmith & Fulham will work with health and social care providers across the borough to deliver our early adopter partnership.

- London Borough Hammersmith & Fulham Adult Social Care
- Central London Community Healthcare NHS Trust
- Imperial College Healthcare NHS Trust
- Chelsea & Westminster Hospital NHS Foundation Trust
- West London Mental Health NHS Trust
- Central and North West London NHS Foundation Trust

We will also seek to engage third sector organisations in provision of our model of care.

Section Ten: Information and Informatics

How will you use the data collected in the data warehouse to support more detailed analytics and planning after May?

We recognise that information is critical to the successful development and implementation of Whole Systems Integrated Care in Hammersmith & Fulham. Data and IT capabilities will be essential in:

- Using metrics to determine if outcomes are being delivered for patients and carers;
- Accessing data on activity and performance of existing contracts to calculate capitation costs; and
- Developing, maintaining and sharing care plans across organisations in real time

Our current understanding of the services that adults and older people with one or more long term condition use is based on a joint data set from 2012-13 for Hammersmith & Fulham, which provides a baseline for our early adopter work. However, we now need to review real time data, validated by health and social care providers in order to further develop our model of care.

How do you plan to share data between providers in your network to support cooperation at a day-to-day and strategic level?

Hammersmith & Fulham's strategy will be to continue to extend the principle of one electronic patient record across all settings of care. This is in alignment with existing and anticipated IT strategies published by the Department of Health and its associated bodies as well as the local IT strategy currently under development for the whole systems implementation within the framework of Shaping a Healthier Future.

The objective is to implement three layers of clinical information exchange where at least one of the following is in place in any setting of care:

Level 1 - There is access to and two way information exchange within a common clinical IT system and a shared record between the GP and the care provider

Level 2 - Where the above is not possible due to technical, operational or financial constraints that as a minimum, the respective IT systems in primary care and elsewhere are interoperable and in full conformance with the current Interoperability Toolkit (ITK) standards (or other common messaging standards) as defined by the Health and Social Care Information Centre (HSCIC)

Level 3 - Where neither of the above is relevant or feasible then the Summary Care Record is enabled, available and accessible particularly where people are receiving care out of area.

We will work towards the sharing of clinical records in different settings of care within robust information governance frameworks and processes across the health and social care community. We will seek to fully implement the recommendations of the Caldicott2 review around the sharing

of patient records to provide integrated and seamless care. Specifically we will ensure that role based access control to electronic patient records in all settings of care is standard. Furthermore, we will facilitate a mechanism and appropriate forum to ensure the management and governance of data controllers is common once common patient records are in place.

Hammersmith & Fulham will continue to have active participation in the NW London IT Forum of commissioning and provider organisations, working collaboratively across the whole health and social care economy to implement an integrated approach to IT systems and information flows across the health and social care community and alignment of commissioning plans with IT solutions and vice versa.

Section Eleven: Planning, Communication and Sharing Learning

- **How have commissioning/provider leadership expressed support for whole system development?**

Hammersmith & Fulham's Out of Hospital/Whole Systems Integrated Care Programme Board provides oversight of the development of our early adopter proposals – and it attended by our commissioning and provider partners:

- Hammersmith & Fulham Clinical Commissioning Group
- Central London Community Healthcare NHS Trust
- London Borough of Hammersmith & Fulham Adult Social Care
- West London Mental Health Trust
- Chelsea & Westminster Hospital NHS Foundation Trust
- Imperial College Healthcare NHS Trust

The Programme Board is co-chaired by Hammersmith & Fulham's Clinical Commissioning Group Chair, and the London Borough of Hammersmith & Fulham's Director of ASC Commissioning.

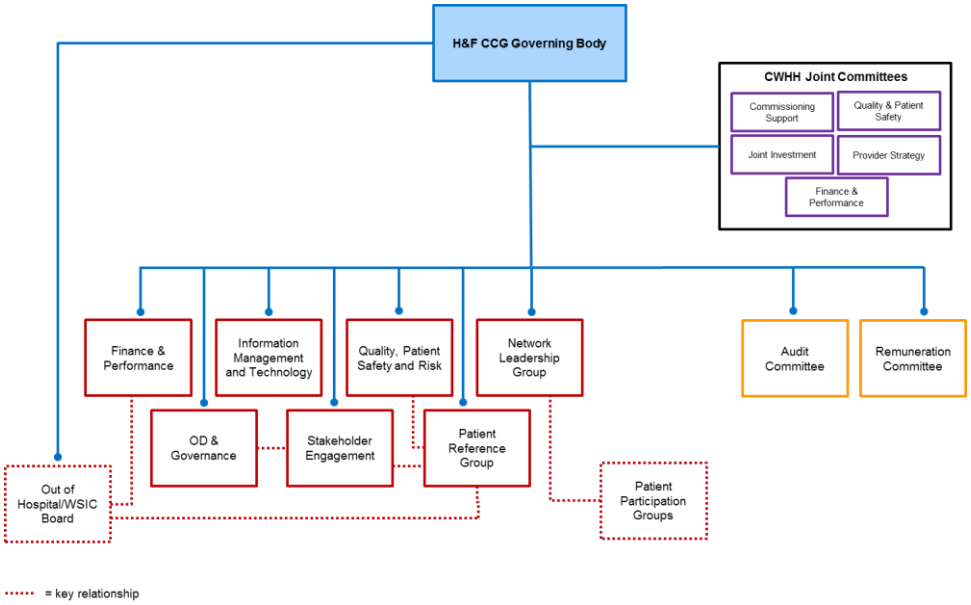
Representatives from across our commissioning and provider partners attended our first Whole Systems Integrated Care workshop to support the development of outcomes and our model of care, a full list of attendees can be found in Section Two of this implementation plan.

Our implementation plan is submitted on behalf of all of our commissioning and provider partners. The implementation plan has received formal sign off from Hammersmith & Fulham Clinical Commissioning Group and the London Borough of Hammersmith & Fulham, with an executive summary reflecting their commitment to whole system development.

- **How will you make decisions together, as commissioners and as providers in the next phase underpinned by your statement of commitment? What are your governance processes? How are people who use services and front-line staff involved?**

Our Out of Hospital/Whole Systems Integrated Care Programme Board, co-chaired by Hammersmith & Fulham's Clinical Commissioning Group Chair and London Borough of Hammersmith & Fulham's Director ofCommissioning, is attended by all of our commissioning and provider partners and in addition by two lay members – and will provide the forum for the delivery of our early adopter proposals.

We will work with our partners to reaffirm how our Programme Board links to the wider governance of our Local Authority Cabinet and H&WB Board, but anticipate that this will continue to take the following form in Hammersmith & Fulham CCG:



We will formalise the Hammersmith & Fulham WSIC working group with core membership from both Hammersmith & Fulham Clinical Commissioning Group and the London Borough of Hammersmith & Fulham. This working group will progress the development of Hammersmith & Fulham's early adopter proposals, reporting to the Out of Hospital/Whole Systems Integrated Care Board.

We will continue to engage all partners through system wide workshops, the content of which is outlined in the programme plan below. We will seek to expand attendance of these workshops to engage service users from across health and social care, voluntary organisations and experts from outside of the health and social care system.

- **What is your Organisational Development plan including: Cultural change, shared leadership, workforce development, estate and resource planning supporting investments?**

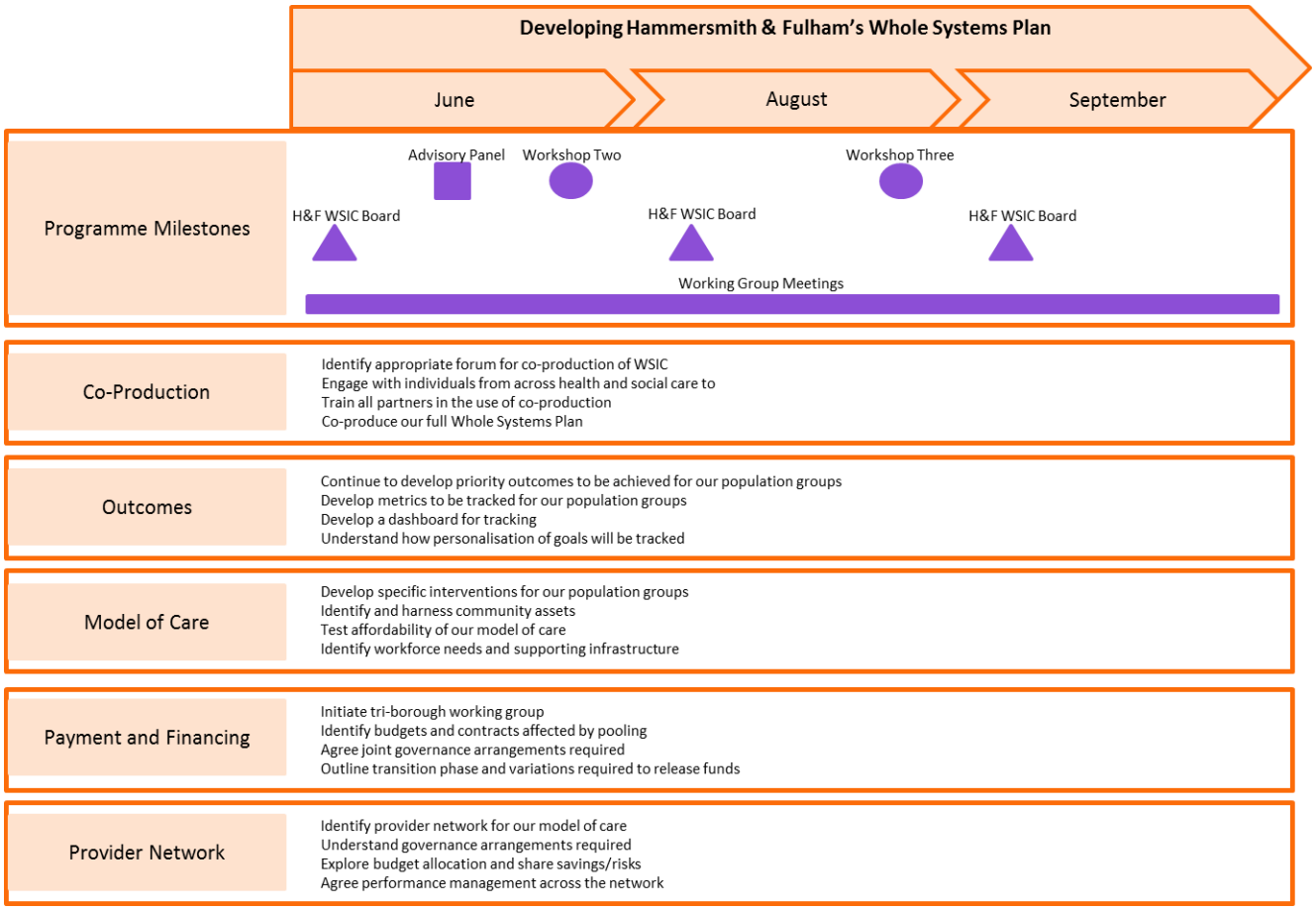
We will initiate an organisational development plan for Hammersmith & Fulham during the next phase of this project that will include:

- Cultural change
- Shared leadership
- Workforce development
- Estate and resource planning
- Supporting investments

This will draw from and link in closely to the work on organisational and cultural change which will be taken across NWL as part of the overall Whole Systems programme.

- **What is your programme plan to develop a full Whole Systems Plan after the June checkpoint?**

We will focus on progressing key elements of the full Whole Systems Plan as follows:



A Shared Vision for Whole Systems Care

Expression of interest by
Hammersmith and Fulham Joint Commissioners (CCG/LA)
and provider partners

Whole Systems Integrated Care Programme

Living ***longer***
and living ***well***

Hammersmith and Fulham Joint Commissioners (CCG/LA) and Provider partners

1. Please specify who the expression of interest is submitted on behalf of:

Following our initial submission, the joint commissioners of H&F CCG and LBHF along with our partner providers are resubmitting our EOI to recognise the alignment with other partners across H&F who are also expressing an interest to be an early adopter of Whole Systems Integrated Care (WSIC). H&F CCG and LBHF as joint commissioners and the providers listed in this bid will work collaboratively with all early adopter proposals across H&F to deliver whole systems integrated care to our identified population groups.

We have considered the process for developing our WSIC model of care and governance to ensure all partners are involved in this. This will be led through our Out of Hospital programme which has been operational since 2012. The Out of Hospital and WSIC Programme Board will address six key delivery work streams to implement our Whole Systems model of integrated care and will provide the necessary co-design forum and joint governance function to progress our early adopter proposals:

- Delivery of a Virtual Ward model for high risk, complex needs persons as our key admissions avoidance initiative
- Co-design and development of our primary care provider networks and community services
- Developing Local hospital services co-designed with our local communities through SaHF programme
- Designing streamlined and patient centered acute to community pathways focusing on transitions of care
- Developing effective integrated care at home provision for older and high risk persons who remain in their own home or a care home that is linked to our GP and provider network function
- Developing our community assets particularly with a focus on communities and our third sector partners supporting self management, personalisation of care and enabling local responses to peoples' needs

This proposal has been developed with all local partners who are supportive of the bid and are represented on our OOH and WS Integrated Care Programme Board including:

- All GP Networks
- Central London Community Healthcare (CLCH)
- LBHF Adult Social Care
- West London Mental Health Trust (WLMHT) and Central North West London Foundation Trust (CNWL)
- Imperial College Healthcare
- Chelsea and Westminster Hospital Foundation Trust
- Public Health
- Third sector organisations

We are developing our plans in partnership with people who use our services and their families and carers. We have written our principles of engagement for our Out of Hospital and WSIC Programme and have representation of patients and carers on our Programme Board. As joint partners we will commit to using co-production to develop our plans. This will include supporting the work being led by the Local Authority to embed personalisation within health and social care.

CONTINUED:

1. Please specify who the expression of interest is submitted on behalf of:

We submit this bid having been at the forefront of integration activity over the last few years which places us in a unique position to take forward WSIC. We are already delivering initiatives built around the key criteria of WSIC and seeing real change as a result of them. As Commissioners we have worked closely together to support the development of Whole Systems thinking through enabling a joint data set for H&F that has been the basis for developing the population groupings in the WSIC programme. Examples of our integrated care progression include;

- Across H&F we had full take up of the Integrated Care Pilot (ICP) from all our GP providers and alignment to multi-disciplinary groups.
- We have tested a number of WSIC features through pilots such as health and social care coordinators and hybrid workers and through the development of our integrated Community Independence Service which has seen almost a three-fold increase in referrals during 2013 from 45 to 130 per month.
- We have supported our GP practices to use the Coordinate My Care tool for End of Life Care and we currently have the highest take up across the CWHHE collaborative with 419 records as of March 2014.
- Presently H&F also have the highest number of patients transferred from our CMHT teams to an enhanced primary care services across the CCGs who work with WLMHT.
- All of our GP practices and our Community Nursing teams are now using our single IT solution, SystmOne.

We are uniquely positioned to work with our acute providers to develop our Local Hospital and Out of Hospital model of WSIC. In working with Imperial to develop the Local Hospital specification and their bid for Foundation Trust status we are able to accelerate the adoption of WSIC thinking. We are already piloting new pathways of care across acute, primary and community by the pilot of our multi provider step-down ward (Ravenscourt), the Older Peoples' Rapid Access Clinic at Imperial, our Virtual Wards, our Community Independence Service and our restructured community nursing teams. The relationships between these services and the ability for them to provide a pathway of high quality out of hospital care that avoids unscheduled admissions is the basis of developing our WSIC model. Furthermore our current initiatives focus on the reduction of unscheduled emergency care for Ambulatory Care Sensitive conditions particularly for people over 75. We are leading the trial of the MCAP system with ICHT to support admission avoidance and improve the number of people being cared for in the most appropriate setting. Linked to this is our joint working between the CCG and the Local Authority to commission placements and packages of care in Nursing and Residential care homes.

As joint leads for this bid, the CCG and Local Authority will seek to involve wider partners in the development of our WSIC model who we see as critical to improving health and wellbeing for our residents. This includes Local Authority Housing and Environment partners and Housing Associations/Providers as we know that providing high quality, accessible and suitable housing for our older and frail populations is a key determinant of improving health outcomes.

We anticipate this scheme will be considered for the Tri-Borough remit to ensure full potential and equity in service delivery.

2. Who you would want to engage with over the next phase to 31st May business case

- **Engagement with our GPs**: We have recently met with all our GP providers through their Network meetings to continue their engagement in our OOH programme with positive feedback. We've held an initial planning event with our GP members in February focused on our Network, Hub and Local Hospital development. Following this we have commissioned support for a network development programme which will bring together our objectives around network configuration for WSIC, PM Challenge fund and network provider delivery based on an inclusive engagement process with all our practices and clinical leadership at the heart of planning and delivery. Working with our GP membership is critical as primary care will be a key enabler of our vision and delivery for WSIC in the future. We would also be very interested to consider with our GP members how we can work with NHSE to jointly commission primary care.

- **Aligning proposals with our partners**: Since our initial proposal we have understood the other early adopter proposals submitted across H&F and our EOI will be taken forward in alignment with all proposals across the borough. All our providers are represented on our Out of Hospital and WSIC Programme Board.

- **Establishing governance for our WSIC development**: We will deliver our early adopter proposals through our jointly chaired Out of Hospital and WSIC Programme Board which has representation from all providers and including patients and carers. We will work with our partners to reaffirm how our Programme Board links to the wider governance of our CCG Governing Body, Local Authority Cabinet and H&WB Board

- **As commissioners**: We have now agreed that the forum in which the CCG and LA will translate the criteria for WSIC into an outline business case and use the co-designed toolkit to put our ideas into implementation proposals will be our Out of Hospital and WSIC Programme Board. This will link to our planning for, and deployment of, the Better Care Fund.

- **With people, patients, carers and families:** We have developed our principles of engagement and co-design for our Out of Hospital programme in conjunction with our Patient Reference Group and will use these to underpin our engagement particularly around the expectations for integrated care

- **With the third sector -** We are engaged in the Community Assets programme being led by the Local Authority and identified in the Better Care Fund and are part of the White City Community Budget initiative

- **With our housing partners, housing providers**

3. Please make a collective statement of commitment to developing plans to implement the features of a fully integrated system (as per slide 4 above)

We believe that our Out of Hospital programme offers the basis from which to develop our WSIC model and will enable us to test and implement the features of a fully integrated system. Our proposed model of care supports the three key principles of WSIC:

People and their families and carers are at the centre of our OOH model of care: Our work on the Local Hospital development is considering what activities should be delivered in a patient's home, at a GP practice and Network level as well as in Hubs so that activity enables improved outcomes through offering improved access to settings that are local to peoples' homes. A key consideration is how the Virtual Ward/Network and Local Hospital are aligned to deliver high quality integrated care and how together they can operate in an Out of Hospital Whole System model, including consideration of the workforce needs to deliver this.

GPs will lead our proactive care planning and delivery: The future development of our GP Networks and Hubs is critical to support this role. Our Governing Body has committed to exploring options for access to primary care services across 7 days involving all elements of primary care delivery to H&F residents which is a key enabler for us to build our Whole Systems proposals on. Our Cassidy Road practice is already trialling a 7 day working model for a 14 week period over the Winter period. GP s will be at the centre of our Virtual Ward model supporting patients with complex high care needs and at high risk of Hospital admission.

The Out of Hospital and WSIC programme is built upon the principles of enabling high quality integrated care through our development of multi disciplinary teams that share common outcomes for people's health and social care and are supporting by shared systems and joint assessments, and a model of care delivery that drives efficiencies and whole system change. Our vision for the Local Hospital will consider how this provision can be a multi provider and multi function to meet the future health and social care needs of our population.

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3. Please make a collective statement of commitment to developing plans to implement the features of a fully integrated system (as per slide 4 above)

Working jointly as commissioners and with our providers we believe being an early adopter site will give us the opportunity to develop and expand our Out of Hospital programme to implement the criteria of Whole Systems:

Embedding Partnerships: Developing a systemic approach to co-production to ensure that people and their carers/families are partners both in the design of services and in the way their individual care packages are designed and delivered. We will continue to support the personalisation of both health and social care services building on the work of the Local Authority and also in considering community assets in our commissioning of services and the use of community capital. The Parkview Centre for Health and Wellbeing will provide a co-located base for health and social care services and are considering how this will include voluntary and third sector organisations.

Population and Outcomes: The Out of Hospital and WSIC model of care provides us with the vehicle for delivering integrated care to a number of the population groupings, in particular groups 3, 4 and older people in groups 5,6 and 8. For a number of our integration initiatives we have identified shared and common objectives relating to improving people's health and wellbeing. Our challenge in WSIC will be to align these to population segments but also to our commissioning and provider framework including pooled and capitated budgets. As an example we are already working with our ICP partners to develop the multi disciplinary groups and function to align with Virtual Wards and provide a key forum for developing pathways for identified population groups

Commissioning Governance & Finance: Our Out of Hospital and WSIC model of care gives us the opportunity to consider how we achieve savings to the system and improved outcomes through pooled budgets as commissioners and to test this in shadow form across a number of settings and within identified population groups. Agreeing our shared outcomes and a shared performance management approach will be critical to this and is enabled by our work already in place developing pathways to reduce unscheduled care for ambulatory conditions with acute, primary and community providers.

Provider Networks: Our Out of Hospital model of care will allow us to test a number of different provider network options incorporating our acute, community, mental health and primary care providers within a number of settings but based around a GP registered population and funding across a care pathway. For example we plan to develop an expanded model of Community Independence Service provision across the Tri-borough CCGs and LAs. We can explore how through commissioning this service we are able to support the governance of different types of provider networks to provide fully integrated care delivery linked to shared outcomes and performance management.

Information: Our roll out of SystemOne across our GPs and Community Services has allowed the flow of information to support care delivery and is the base from which to explore the potential for a common system and information governance across all our providers.

4. Please describe any initial thoughts on which populations you wish to serve and the integrated model of care that could deliver it

The CCG and LA wish to use the existing foundations of our Out of Hospital integration programme as the starting point for Whole Systems working. Through our Out of Hospital and WSIC model we will provide care and support for people who are at risk of admission to hospital or requiring high packages of social care particularly groups 3, 4 and people over 75 within groups 5,6, and 8. In addition we also wish to work with providers for people in group 5 in providing better integrated and quality care for adults and elderly people with cancer. We will also develop our offer for people within the 'Mostly Healthy' population groups to support them to maintain their health and independence for as long as possible through self care and through accessing support services often provided by third sector organisations and building our community assets. In developing our business case a key task will be to understand how we can develop pathways within our Out of Hospital and WSIC model for these different population groups and how this shapes our proposals for pooled and capitated budgets, shared outcomes and provider networks.

Within our Out of Hospital programme there are a range of initiatives which focus on population groups 3,4,5,6 and 8. The Virtual Ward model of care will be our starting point for implementing out of hospital and WSIC care in community provision which we believe will primarily support people in **groups 3, 4 and older people within groups 5,6, and 8**. This will be developed to fully interface with future Local Hospital provision. Our programme enables us to align a number of complementary initiatives under the six key workstreams (reference slide 1) that focus on similar population groups to develop an overall Out of Hospital WSIC model of care:

- We will redesign our multi disciplinary groups to support the Virtual Wards through providing a forum in which primary, community, secondary and social care professionals offer expert advice on our Virtual Ward populations and shape our pathway development for these groups **(groups 3, 4 and older people within groups 5,6, and 8)**
- We will use the learning from our ICP Innovation Pilots to implement the features of Whole Systems care particular around new types of provider networks and how funding flows to where it is needed through new financial models:
  - Proactive Support for Nursing, EMI and Extra Care Homes **(groups 4, and older people in groups 6 and 8**)
  - Supported Self Care through Long Term Condition Information **(groups 3 and 4)**
  - Transitions of Care Project (developed from MDG led audit of electronic discharge summaries)
  - Dementia Recognition and Post Diagnosis Support **(groups 8, and people within other groups who have dementia diagnosis)**
  - Addition of Mental Health Support to the Community Independence Service (Awaiting Recruitment) **(groups 3,4, and 6)**
  - Care Navigation and Support for High Risk Patients (Awaiting Recruitment) **(groups 3,4 and high risk patients within groups 5-9)**

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4. Please describe any initial thoughts on which populations you wish to serve and the integrated model of care that could deliver it

- We will work with our partners at Imperial and Macmillan on pathway development for Cancer with a focus on early diagnosis, care planning and supporting self management, including for cancer survivors, as part of our Out of Hospital model with an aim to improve patient experience and provide better coordinated care for this group. **(Group 5)**
- We will ensure the learning from the best practice in COPD being led by our Academic Health Science Network (Imperial College Health Partners) is embedded into our initiatives to reduce unscheduled care for ambulatory sensitive condition (**Groups 3 and 4**)
- We will develop the pathway for providing rapid response between secondary, primary and community care through initiatives such as the Older Person's Rapid Access Clinic at Imperial and the proposed Rapid Access clinic at Chelsea Westminster Hospital **(Groups 4 and older people in groups 5-9)**
- Working jointly as commissioners we will design and deliver a model of home care that works across our health and social care system in supporting both health and social care outcomes through an enabling model and embedding this within our multi disciplinary teams and as part of the Virtual Ward **(Groups 3, 4 and eligible adults within groups 5-9)**
- We will align our model of care with our Mental Health providers' proposals around WSIC for older adults with SEMI. We believe there is an interdependency between these proposal as to the population groups we will be targeting and therefore we need to ensure Mental Health provision is fully incorporated into our Out of Hospital and WSIC model of care. **(Group 6)**

H and F template

5. Please describe what support you feel is needed between Jan and April to work the expression of interest up into an outline business case?

- Support to use the co-designed toolkit so that we can move from ideas to implementation and understand how our current initiatives can be supported to transition into a WSIC model and to reflect and embed the criteria of WSIC
- Support to develop shared outcomes and SMART measures that can demonstrate change and track progress. We feel the Health and Wellbeing Board have a key role in supporting this
- Support to engage with our GP membership to deliver a programme of Network development and clarify how this development is aligned with WSIC, what the vision is for WSIC Networks and how we can develop Networks which operate with more than one acute provider
- Support for our GP members and wider partners to consider how the strategic initiatives are aligned under our Out of Hospital and WSIC programme such as the development of the Local Hospital , Network development, 7 day access, Better Care Fund and how we develop a shared vision and outcomes for these strategic developments
- Support for commissioners to work jointly between the CCG and LA to consider the appropriate organisational forms and how decisions to adopt these will be taken
- Support to develop our offer to the 'mostly healthy' populations in drawing upon our community capital and resource (family, carers, community groups, third sector including assets)
- Support to ensure people have choice and control in our Out of Hospital WSIC model of care and we are supporting the direction of travel towards personal health budgets within a model of co-production
- Support with obtaining Network level information and analysis in order to develop our proposals
- Support with the writing of the business case and the legal considerations of our proposals
- Alignment of our H&F proposals with wider Tri-borough and North West London vision and direction of travel

	London Borough of Hammersmith & Fulham **Health & Wellbeing Board** **30th June 2014**
JOINT HEALTH AND SOCIAL CARE DEMENTIA STRATEGY	
Report of the Corporate Director	
Open Report Yes	
Classification: For Information (delete as appropriate) **Key Decision:** No	
Wards Affected: All	
Accountable Executive Director: Liz Bruce, Tri-borough Executive Director	
Report Author: Paula Arnell (Senior Joint Commissioning Manager, Triborough)	**Contact Details:** Tel: 0203 350 4361 E-mail: Paula.arnell@nwlcsu.nhs.uk

AUTHORISED BY: .....

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DATE: .....

1. EXECUTIVE SUMMARY

1.1. The North West London Mental Health Programme board and the Tri-borough intend to carry out a strategic review of how dementia services are commissioned and provided.

1.2. The Mental Health Programme Board consists of clinical leads from all NWL CCGs, Social Services and Providers, and the aim of the board is to work collaboratively to review the current pathways and services and to plan future services that meet the needs of the population.

1.3. The key areas for the Board to consider are:

- Scope of the strategy

- Stakeholder involvement
- Length of time of review
- Desired outcomes and timescales including national mandatory target achievement

2. RECOMMENDATIONS

2.1. It is recommended that the Board consider the approach and note the intention to develop a Joint Dementia Strategy across the five Clinical Commissioning Groups, and Tri-borough, Hounslow and Ealing boroughs.

3. REASONS FOR DECISION

3.1. The National Dementia Strategy 2009 and the government's dementia challenge has driven the need to consider changes to the dementia pathway to enable more streamlined and integrated dementia services, better information and advice for families and a response to the increasing incidence of dementia due to demographic and epidemiological changes in the national population.

4. INTRODUCTION AND BACKGROUND

4.1. The Cabinet/Committee is requested to consider the intention to produce a joint dementia strategy across NW London that will build on previous strategies and consolidate ongoing developments for each locality. Strategic planning will be overseen by the wider Mental Health Programme Board dementia programme across NW London for improving dementia services, and ensuring future local provision builds on the ethos of collaboration for social care as well as health care services.

4.2. The programme board has scoped the approach to a joint dementia strategy across the boroughs covered by the Central, West London, Hammersmith, Hounslow and Ealing collaborative of Clinical Commissioning Groups, including the Tri-borough. There is an expectation that the over-arching approach will support the strategic developments required in each sovereign borough to ensure it meets local needs.

5. PROPOSAL AND ISSUES

5.1. Dementia is an umbrella term for symptoms of diseases of the brain that will affect a third of people over 65. There are more than 40 different types of dementia illness. Dementia can affect memory, the ability to use language (some people are no longer able to remember their second language), facial recognition, perception (dark contrast areas in flooring such as entrance mats may be viewed as holes; some people may hear voices), changes to orientation in time and space and understanding of current abilities, as well as personality changes.

5.2. Recently, medication to slow the progress of Alzheimer's type dementia was made available, and new treatments are being trialled.

5.3. There are still gaps in provision post-diagnosis. People with dementia and their carers are generally pleased with the overall changes in the diagnosis and treatment pathway, but are still saying there is not much support available to them before they become eligible for care home or nursing care services, especially at crisis points when carers can feel overwhelmed; nor when the person needs acute healthcare services. They also feel that there is a lack of training of professionals in health and social care to adequately meet their needs (source: Central West London Healthwatch report June 2014).

6. OPTIONS AND ANALYSIS OF OPTIONS

6.1 Strategic planning should dovetail with the wider programme across NW London for improving dementia services, but ensure local services build on the ethos of collaboration for social care as well as health services.

7. CONSULTATION

7.1. Consultation on the strategic work and the dementia JSNA will take place throughout the development with all stakeholders at an appropriate level of involvement.

8. EQUALITY IMPLICATIONS

8.1. None required at this stage

9. LEGAL IMPLICATIONS

9.1. None at present

10. FINANCIAL AND RESOURCES IMPLICATIONS

10.1. None at present

11. RISK MANAGEMENT

11.1. None at present

12. PROCUREMENT AND IT STRATEGY IMPLICATIONS

12.1. None at present

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.			

LIST OF APPENDICES:

Appendix 1: Joint Dementia Strategy 2014 – 2019 Development Summary
Appendix 2: Dementia Healthwatch presentation

Joint Dementia Strategy 2014 – 2019 Development Summary

Health and Social Care

Briefing to Health and Well-Being Board

Joint Commissioning

Central London CCG, West London CCG, Hammersmith and Fulham CCG, Triborough LAs

Dementia

Dementia is an umbrella term for symptoms of **diseases of the brain** that will affect a third of people over 65

- There are more than 40 different **types of dementia illness**
- Alzheimer's Disease accounts for 50%; Vascular related dementia accounts for 30%

National Dementia Strategy: Living Well with Dementia 2009 recommends:

- **Diagnosis** - needs to be timely, in specialist services
- **Treatment** includes suitable dementia medications and personalised activity to help with health and well-being
- **Reduction** in the use of mental health medications if these are not needed
- **Integrated approach** to care in the community – dementia is a **progressive long term condition** that requires support to 'live well'
- Access to **information** about dementia
- Better **Public awareness** – Dementia Alliances, Dementia Champions
- The National Dementia Strategy recommends a range of post-diagnostic provision for health and well-being

Dedicated Dementia care in Hammersmith and Fulham

Dementia Services

- Memory Assessment Service WLMHT
- Dementia Day Resources ((Alzheimer's Society - including health funding for Nubian Life and BCH Safer Homes)
- Outreach service (Housing 21)
- Carers respite services
- Admiral Nursing and other dementia clinical support (WLMHT)
- Memory Café (Alzheimer's Society)
- Dementia Outreach worker (Alzheimer's Society)
- Cognitive Stimulation therapy (WLMHT)
- Peer support for carers and people with dementia (Alzheimer's Society)
- Triborough Dementia Service User and Carer Group – Healthwatch

Achievements to date

- Chelsea and Westminster Hospital Foundation Trust and Imperial College Hospital Trust appointed Dementia Nurses (2013) – awareness training commenced for all staff
- GPs in K&C and Westminster receive training in dementia from the Memory Services as requested. Training programme for H&F GPs started 2014 – delivered by WLMHT.
- Dementia Friends briefings delivered to 12 Triborough Older People Day Services managers (2014)
- Admiral Nursing pilot commenced in May 2014

- Compassion in Care leadership training rolled out to commissioners, service managers and homecare and care home managers across Triborough (2014)
- Planning a local Dementia Action Alliance from July 2014

Dementia Trajectory - population

The national prevalence of people with dementia stands at approximately 800,000 in the UK – this number is expected to rise to 1.7m by 2051. The current and future population of people with dementia (NDPR) in H&F, K&C and Westminster is shown in the following tables:

H&F 2013/14 The % of people with dementia diagnosed out of total expected is **52.7%**

H&F Total Expected numbers of people with dementia* (additional average 25 cases per year)					Projected **
2011	2012	2013	2014	2015	2019
1,118	1,143	1,169	1,193	1,217	1,317

K&C (not QPP) 2012/13 The % of people with dementia diagnosed out of total expected is **51.1%**

K&C (not incl. QPP) Total Expected numbers of people with dementia* (additional average 27 cases per annum)					Projected **
2011	2012	2013	2014	2015	2019
1,192	1,220	1,247	1,273	1,299	1,407

W'stmstr (inc. QPP) 2012/13 The % of people with dementia diagnosed out of total expected is **54.3 %**

W'smstr (incl. QPP) Total Expected numbers of people with dementia* (additional average 32 cases per annum)					Projected **
2011	2012	2013	2014	2015	2019
1,463	1,497	1530	1561	1593	1725

***National Dementia Prevalence Rate [NDPR] – NHS England Prevalence calculator**

****Projected Dementia Prevalence Rate based on additional average cases per annum**

NHS England has set a mandate for local diagnosis of dementia to reach 67% of the total expected by 2015 (Nat. av. 44.6%)

Triborough Dementia strategic aims

Aim	Determine the current need via Joint Strategic Needs Assessment and review the dementia care pathway to deliver a strategy for the Triborough. The strategy will need to fit with the CCG Collaborative dementia strategy and the Triborough Customer Journey. Overarching themes include:
1	Determining need – mapping epidemiology and populations
2	Engaging all stakeholders
3	Dementia Pathway design – the Customer Journey
4	Integrated approach to commissioning dementia services as well as capturing local differences
5	Timely diagnosis
6	Integrated action-plan across organisations

healthwatch
Central West London

Healthwatch: Dementia
Patient / Customer Experience

Briefing to Health and Well-Being Board

Trish Pashley
Healthwatch Hammersmith and Fulham

Patient/Customer experience

Evidence collected through 'enter & view' visits to hospitals and care homes, patient stories, outreach, Dementia Project Group, Day centre(50+ stories):

Day centre

- ***'…the people here are lovely, we sing and dance together'*** *(SU)*
- ***'… the workers here really care they find out all about us and they are kind'*** *(SU)*
- ***'.. Transportation does become a problem for people as the illness develops'*** *(worker)*

Diagnosis

- ***'diagnosis took a long time'*** *GP and hospital*
- ***'hospitals should test all new patients because some of the people here (ward CXH) may need extra assistance'***

Care homes and hospitals (observed on dignity champions visits)

- ***'…there are a lot of staff but (on the whole) they don't seem to interact with the residents'***
- ***'…nursing staff were not differentiating between someone who has dementia and someone who did not, unclear if hospital staff have extra training to learn about the illness?'***
- ***'The residents are not taken out in to the wider community'*** *(carer)*
- ***'families are not involved in care until something goes wrong'*** *(family carer)*

Patient/Customer experience

healthwatch Central West London

Areas for improvement (to date):

- Confidence in GP ability to effectively screen for dementia
- Regularity of care reviews – GP and social services every year/15 months?
- Integration of health and care services
- Staff training (inc. GPs, support staff, hospital staff)
- Information on how to access services especially for self funders
- Inpatient care including discharge planning
- Respite and support for carers,
- Quality and confidence in care homes and home care, particularly staff,

	London Borough of Hammersmith & Fulham **Health & Wellbeing Board** **30th June 2014**
NHS HEALTH CHECKS	
Report of Director of Public Health	
Open Report Yes	
Classification: For Information (delete as appropriate) **Key Decision:** No	
Wards Affected: All	
Accountable Executive Director: Meradin Peachey, Tri-borough Director of Public Health	
Report Author: Christine Mead, Behaviour Change Commissioner, Public Health	**Contact Details:** 020 7641 4662 cmead@westminster.gov.uk

AUTHORISED BY: .....

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DATE: .....

1. EXECUTIVE SUMMARY

1.1 NHS Health Checks are a mandatory Public Health Service.

1.2 The NHS Health Check is a national risk assessment and prevention programme that identifies people between the ages of 40 and 74 at risk of developing heart disease, stroke, diabetes, kidney disease and certain types of dementia, and helps them take action to avoid, reduce or manage their risk of developing these health problems.

1.3 The Department of Health has set targets for 20% of the eligible population to be invited for health checks each year, on the basis that the entire eligible population would then have a health check every five years.

1.4 Between 50-75% of those invited are expected to attend a health check each year.

1.5 The health check calculates the risk of developing cardiovascular disease in the next 10 years, based on checking BMI, blood glucose, cholesterol, blood pressure, physical activity, alcohol, smoking, age and ethnicity.

1.6 Local authorities are required to commission the risk assessment, to monitor the offers made and the take up of offers, to increase take up, to promote health checks, to make sure people receive information about their identified risks and are signposted to services and receive clinical or lifestyle interventions when necessary, and to commission lifestyle services which reduce risk.

1.7 In LBHF the eligible population for health checks is 40,050.

1.8 From April 2013 – March 2014, 8,582 health checks were offered (21.5% of eligible population, against a target of 20%)

1.9 From April 2013-March 2014, 2,336 health checks have been delivered (5.9% of eligible population, against a target of 10%)

2. RECOMMENDATIONS

2.1 The Health and Wellbeing Board are invited to:

- Consider the progress made
- Review the gaps and improvements in provision

3. BACKGROUND

Data Analysis

3.1 A review of the data from April – December 2013 was conducted to evaluate whether health checks are reaching the right people, whether they are identifying people at risk or only seeing the 'worried well', and what is happening following a health check.

3.2 We have unreliable ethnicity data for last year, due to an error in the software system which has now been corrected.

3.3 49.7% of health checks were delivered to people in the 40-50 age group. Risk of cardiovascular disease increases with age, so prioritising older people would find those who are at highest risk.

3.4 7.6% of those receiving checks were identified as a high risk (a risk of 20% or above of developing cardiovascular disease in the next 10 years) and 24.3% were identified as having moderate risk,(a risk of 15-19% of developing cardiovascular disease in the next 10 years).

3.5 Nationally, 7% of women and 14% of men in the eligible population would be expected to be at high risk.

3.6 Single Risk factors:

- 52.6% identified as overweight or obese
- 33% have high cholesterol according to their cholesterol ratio
- 20% have high blood glucose
- 18.7% are smokers
- 14.4% have high blood pressure

3.7 For every risk factor identified, patients have been given information about services they can access to reduce their risk, and direct referrals top those services have been made where the patient has accepted them. Patients can see visually what happens to their overall risk if they modify one or more of their risk factors.

3.8 Where a risk factor requires treatment from the GP, an appointment is then booked so that the right treatment can be prescribed.

3.9 Referrals and signposting are made to services where a need has been identified. The following referrals were accepted:

- 17.7% of stop smoking referrals
- 26.9% of physical activity referrals
- 3.1% of core alcohol service referrals
- 43.4% of referrals for MyAction – (Westminster only intensive intervention for people identified as at high risk. This programme will be put out to tender to provide a service for Hammersmith and RBKC from April 2013)

Current Delivery

3.10 NHS health checks are offered by GP practices using a system of pods or software which collects all the data into one database, and allows for a systematic approach to health check delivery.

3.11 Over the past year this system was introduced into Hammersmith and Fulham, mostly following the change to the SystmOne IT system which took place between September – October 2013.

3.12 This delay in using the new pod system, combined with a series of software implementation problems experienced by surgeries at the start of using pods, largely accounts for the underperformance in numbers of health checks delivered.

3.13 Some practices are still experiencing problems with using the pods, and this has become a demotivating factor for those practices.

3.14 From December 2013, Health Trainers were commissioned to deliver health checks in community settings, to increase uptake of health checks in areas of deprivation.

3.15 From April 2014, 9 pharmacies in LBHF have been commissioned to deliver health checks, concentrating on areas of deprivation and areas where practices are not delivering health checks.

Improvement Plan

3.16 The Improvement Plan is based on best practice guidance from Public Health England, shared at the national conference in February 2014, and best practice guidance from our local GP practices who are championing health checks.

3.17 Public Health will visit all practices with remaining issues and seek to resolve any outstanding problems with the software providers.

3.18 Public Health will explore with the CCG SystmOne team whether it is possible to rewrite the software used on the pods within SystmOne.

3.19 Uptake of offers is currently running at 28%. The following steps have been taken:

- The invitation letter has been redrafted following national best practice
- Residents will be offered a check at their own surgery, as well as given information about the pharmacies and health trainer options so that they have a choice.
- New marketing materials have been designed and will be ready at the end of June, for display in surgeries and pharmacies and community settings.
- Presentations on health checks are being given at all network meetings, at the network coordinators meeting, and at the CCG Quality and Safety meeting to engage in a discussion across the CCG about improving health checks.
- Surgeries who have been successful in delivering large numbers of health checks have recommended the following:
    - text invitations, with good response rates.
    - Telephone invitations to people aged 60 and above
    - Text reminders of appointments, to reduce cancellations
    - GPs and practice nurses recommending booking in for a health check during a routine appointment

3.20 Practices will be encouraged to invite older patients, smokers, men and populations known to be at higher risk of cardiovascular disease as a priority.

3.21 Health trainers have been commissioned to deliver more health checks in areas of deprivation, where there is higher prevalence of cardiovascular disease, and in homeless hostels.

3.22 Pharmacies have been commissioned to deliver health checks in areas of deprivation.

3.23 Each practice will receive a detailed report on their data for the past year, which will support the practice to have a discussion about the outcomes of health checks; follow up on high risk patients; and how to increase the uptake of both health checks and of referrals.

3.24 An evaluation of health checks nationally is being conducted and will be ready in April 2015, including our reports for each area.

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

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	Public Health England NHS Health Check and Implementation Review and Action Plan		

LIST OF APPENDICES:

Appendix 1: Annual Performance Report 2013/14
Appendix 2: Comparison of Offered and Received by borough

Public Health England

Supported by: Local Government Association

NHS England

NHS Health Check implementation review and action plan

July 2013

Public Health England

Executive summary

Context

Findings – issues and actions

Next steps

Public Health England

Executive summary

The NHS Health Check programme offers a fantastic opportunity to tackle avoidable deaths, disability and reduce health inequalities in England. Public Health England (PHE), the Local Government Association (LGA) and NHS England are working closely together to provide consistent, strong support for this important programme.

Key to the review has been talking to people involved in commissioning and delivering local programmes. Qualitative research to understand how the NHS Health Check programme has been implemented since 2009, was combined with a series of stakeholder and expert meetings to explore, in detail, best practice, barriers to implementation, emergent issues and possible actions.

Through the review process and in discussion with our partners in the Local Government Association, NHS England and others, we have identified ten key areas which will be the focus of PHE support.

The review has been an opportunity to take stock of what we have achieved, share what we have learned and start to understand what makes a successful programme. We stand united in our shared ambition to work together for successful implementation and scale-up of the NHS Health Check programme. Colleagues working across health and social care all play a critical role in now making this programme happen. This will help achieve the reductions in avoidable deaths and ill-health across our communities: the people we serve, our neighbours, friends and within our own families.

Professor Kevin Fenton
Director, Health and Wellbeing
Public Health England

Councillor Zoe Patrick
Chair, Community Wellbeing Board
Local Government Association

Professor Sir Mike Richards
Director for Reducing Premature Mortality
NHS England

Public Health England

Local Government Association

NHS England

	Issues	Actions
1	Leadership	PHE fully supports the NHS Health Check programme at all levels. It will lead the development of collaborative national leadership through a clear programme governance structure including an advisory committee, comprising the key stakeholders (NHS England, NHS Improving Quality (NHS IQ), Department of Health (DH), LGA and others) and an expert clinical and scientific advisory panel. PHE will provide timely and authoritative advice on emerging issues and will empower public health leaders locally with the evidence and rationale for the programme.
2	Improving uptake	PHE will work with local authority NHS Health Check teams to test the potential impact of behavioural insight and marketing interventions on uptake. This will include developing options for improving the NHS Health Check brand, establishing the effectiveness of different approaches to recruitment and testing marketing campaigns to support uptake locally and nationally.
3	Providing the Health Check	A. PHE will thoroughly review and collate previous approaches to commissioning and delivering the NHS Health Check programme and so learn from and share promising practice and experience. B. PHE will collaborate with the Centre for Public Scrutiny to work with several test bed sites to explore approaches to effective commissioning the programme.
4	Information governance	PHE will explore long term solutions to free up the system to enable the flow of data, including to and from GP practices, for the best possible delivery of the NHS Health Check programme. It will explore the use of innovation and IT technologies to allow the seamless flow of NHS Health Check data across the health and social care system. This will create an environment that supports local teams to commission and evaluate programmes which aspire for excellence and improved outcomes.
5	Supporting delivery	PHE will build upon and give continued support to established national, regional and local implementation support networks, ensuring equitable access to all organisations across England. PHE will work with the LGA to advance NHS Health Checks through the sector led improvement agenda.
6	Programme governance	PHE will set up clear programme governance arrangements, including an Expert Clinical and Scientific advisory panel to assure that any additional elements of the programme are evidence based. It will keep the programme under review and advise the DH and Ministers accordingly.
7	Provider competency	A. PHE will work with Health Education England (HEE) to build upon existing competency frameworks for use by providers and commissioners to ensure high quality training for those delivering the NHS Health Check. B. PHE will work with local commissioners, training providers and professional bodies to develop a professional development programme of work on NHS Health Checks to enhance the focus on behaviour change for better health outcomes.
8	Consistency	PHE will release and review on a regular basis best practice guidance describing all the elements and standards it would expect of a quality programme such as quality of delivery and robustness of data capture and reporting. It will raise awareness, promote adoption and explore opportunities for quality assurance programmes in local authorities.
9	Proving the case	PHE will work with system partners to facilitate future research and evaluation of the NHS Health Check programme at a national and local level. This will provide the implementation evidence required to ensure effective roll-out and improvement.
10	Expected roll-out	PHE will support those LAs taking on challenging programmes. It will work with local authorities to achieve offers to 20% of the target population annually with a vision to realise at least 75% uptake per year. This will support local authorities to achieve offers to 100% of their eligible population over five years.

Public Health England

Executive summary

Context

Findings – issues and actions

Next steps

Public Health England

Purpose and scope of the implementation review

This review has determined how PHE will support local authorities in commissioning the NHS Health Check programme

The Secretary of State for Health has prioritised reducing premature mortality and has a focus on improving prevention and early diagnosis; the NHS Health Check programme will be a key deliverable in supporting this ambition.

The Department of Health published *Living well for longer:* a *call to action on avoiding premature mortality* and the *Cardiovascular disease (CVD) outcomes strategy* on 5 March 2013. Both identify the NHS Health Check programme as a vehicle for delivering ambitions.

The *Global burden of disease* report (2013) highlighted the need to reverse the growing trend in the number of people dying prematurely from non-communicable diseases. Since 1990, the number of people dying from ischemic heart disease and diabetes has risen by 30% and a high body-mass has been attributed as the most important cause of premature mortality and disability.

Therefore it is imperative that PHE supports local authorities to commission successful NHS Health Check programmes.

- *The Global burden of disease: Generating evidence, guiding policy* – The Global Burden of Disease (GBD) approach is a systematic, scientific effort to quantify the comparative magnitude of health loss due to diseases, injuries, and risk factors by age, sex and geography for specific points in time [Ref 1]

- Living well for longer: a call to action on avoiding premature mortality – the Government's ambition is for England to have the lowest rates of premature mortality amongst European peers
- CVD outcomes strategy – provides advice to local authority and NHS commissioners and providers about actions to improve cardiovascular disease outcomes. It sets out outcomes for people with or at risk of cardiovascular disease (CVD) [Ref 2, 3]

In winter 2012/2013, PHE led an implementation review with a range of stakeholders to determine how they can best support local authorities to commission the NHS Health Check programme successfully.

The implementation review:

1. reviewed the public health leadership position in support of the implementation of the programme
2. reviewed implementation and uptake across England
3. identified examples of effective practice and lessons learned
4. considered national and local support mechanisms
5. identified awareness and attitudes in key clinical communities
6. considered how local engagement could be strengthened to support future local authority commissioning and DH policy
7. considered NHS Health Check delivery expectations for 2013/14 – 2014/15
8. considered the support PHE will provide
9. identified any difficult issues which require further work

Link to Methodology – Annex A

Public Health England

NHS Health Check: explained

The NHS Health Check programme is a national risk assessment and management programme for those aged 40-74 years

NHS Health Check is a national risk assessment and management programme for those aged 40 to 74 living in England, who do not have an existing vascular disease, and who are not currently being treated for certain risk factors. It is aimed at preventing heart disease, stroke, diabetes and kidney disease and raising awareness of dementia for those aged 65-74 and includes an alcohol risk assessment. An NHS Health Check should be offered every five years.

The programme systematically targets the top seven causes of premature mortality. It incorporates current NICE recommended public health guidance, ensuring it has a robust evidence base. Economic modelling suggests the programme is clinically and cost effective. [Ref 4]

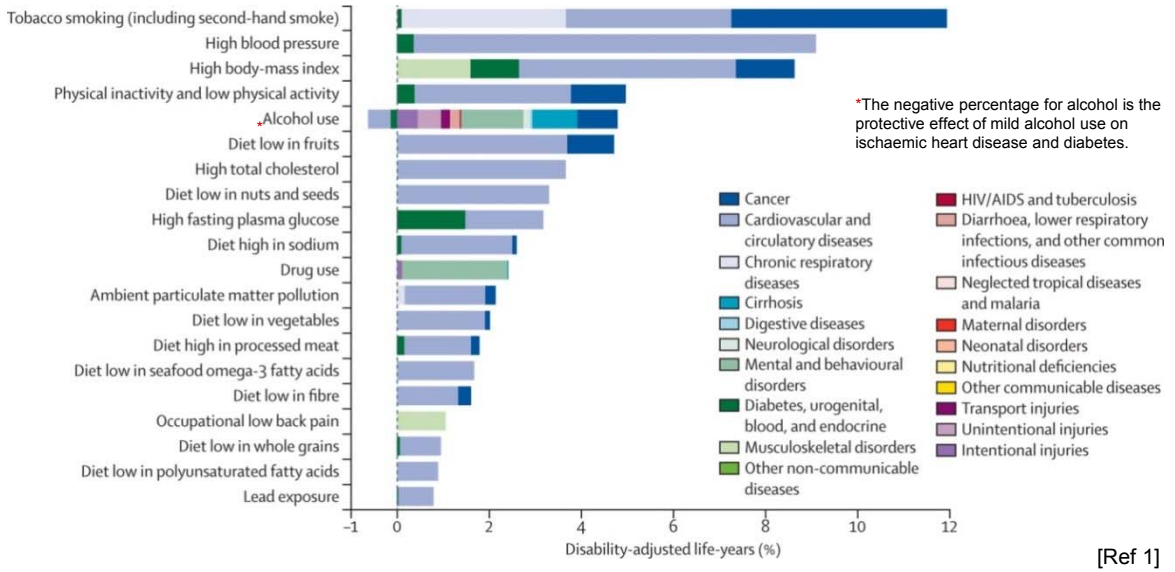
Top seven causes of preventable mortality: high blood pressure, smoking, cholesterol, obesity, poor diet, physical inactivity and alcohol consumption.

Each year NHS Health Check can on average:

- prevent 1,600 heart attacks and save 650 lives
- prevent 4,000 people from developing diabetes
- detect at least 20,000 cases of diabetes or kidney disease earlier

[Ref 5]

Burden of disease attributable to 20 leading risk factors for both sexes in 2010, expressed as a percentage of UK disability-adjusted life-years



[Ref 1]

Public Health England

NHS Health Check: benefits to health

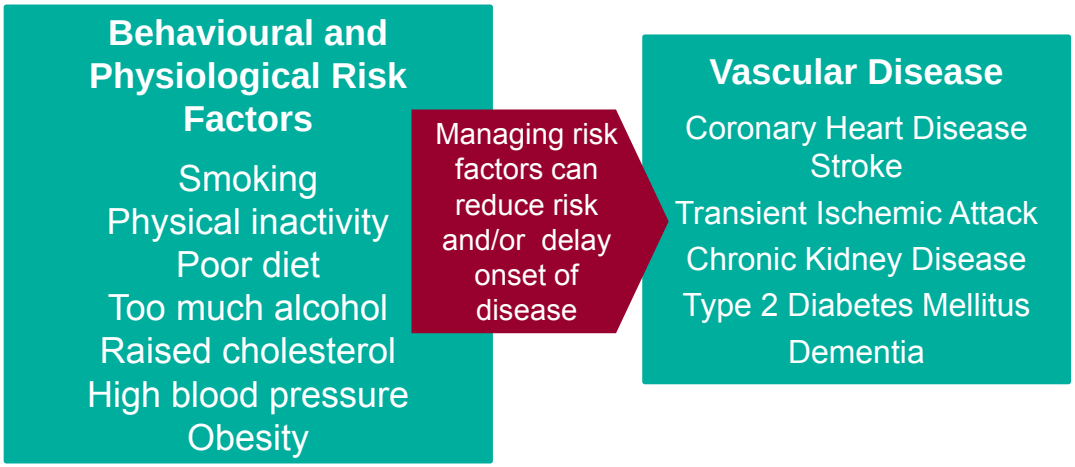
Reducing and managing risk factors will reduce prevalence and effects of disease

Vascular disease: over four million people in England are estimated to have vascular disease, which is recognised as the largest single cause of long term ill-health, disability and death. Vascular diseases are responsible for over a third of deaths and a fifth of hospital admissions in England each year.

Dementia: more common in people as they get older, it is estimated that 670,000 people are living with dementia in England. Over half have Alzheimer's disease and up to a third vascular dementia. In many cases however these conditions coexist and are thus likely to be subject to delay in symptoms if we manage the common risk factors that predispose to them.

Alcohol consumption: over 10 million people in England are drinking at levels which increase their risk of ill-health. [Ref 5-7]

The NHS Health Check programme helps to prevent the onset of vascular disease and vascular dementia by supporting changes to and management of behavioural and physiological risk factors.



- it is estimated that around 850,000 people are unaware that they have type 2 diabetes; half of all people diagnosed have serious complications [Ref 8]
- in more than 90% of cases the first heart attack is related to preventable risk factors [Ref 9]

Public Health England

NHS Health Check: the economic case

Economic modelling suggests the programme is clinically and cost effective

The economic case [Ref 4]

DH established that the NHS Health Check policy was likely to be cost effective, before implementation began.

The cost calculations include two components:

- the cost of the actual assessments plus any follow-on tests or monitoring that are required in terms of staff time and lab costs
- the cost impact of the interventions that are provided as a result of the NHS Health Checks

The estimated savings to the NHS budget nationally are around £57 million over four years, rising to £176 million over a fifteen-year period. It is estimated that the programme will pay for itself after 20 years as well as having delivered substantial health benefits.

The programme is underpinned by cost benefit modelling which considers cost in relation to quality adjusted life year (QALY) and shows that it is extremely cost effective.

Further analysis showed that of all the options considered, the optimal is a starting age of 40 with an NHS Health Check offered every five years.

Further work will be undertaken to:

- refresh the economic modelling for this programme, given the addition of the two new components: alcohol and dementia awareness
- establish the potential savings for local local authority services, including social care and benefits

Quality Adjusted Life Years (QALYs) – gives an idea of how many extra months or years of life of a reasonable quality a person might gain as a result of treatment.

The ready reckoner [Ref 10]

An **interactive ready-reckoner** on the NHS Health Check website identifies the potential service implications, health benefits and cost savings resulting from implementing health checks at council level. It is likely that there will be significant additional social care savings as a result of ill-health prevention, with a reduction in people accessing social care with conditions such as dementia, stroke and heart failures.

Example area results from ready reckoner
local authority: Macclesfield

- Total cost of providing NHS health check for one year based on national estimates - £216,842
- Workforce requirements to undertake NHS health check in this year - 2,234 hours of time to invite people to Health Check and arrange appointments, 2,688 hours of contact time for the health check and 1,862 hours of contact time for feedback of results
- Total lifetime gains for the cohort of people invited for an NHS Health Check this year 879 QALYs at a cost of £1,941 per QALY

Public Health England

NHS Health Check: responsibilities

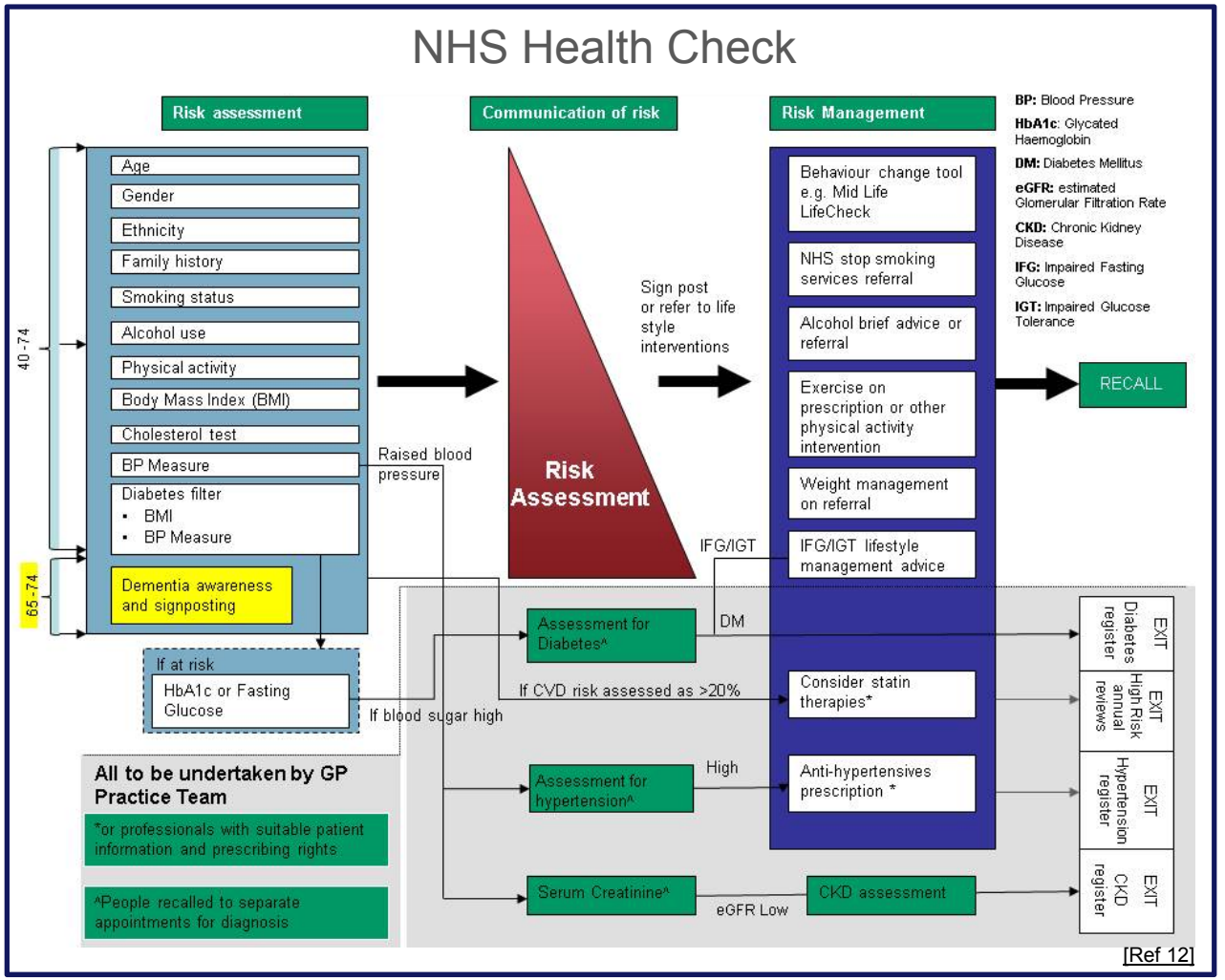
Local authorities are mandated to commission the NHS Health Check and are encouraged to work with the HWBs to commission local interventions

From April 2013 local authorities are mandated to provide the NHS Health Check programme. Money has been allocated as part of the public health ring fence to provide NHS Health Checks for 20% of the eligible population per year.

For benefits to be secured, local authorities will need to ensure the programme is seen as part of a strategic approach to tackling morbidity and mortality from vascular disease and have a clear sense of how it impacts on local priorities.

They will need to provide:

- strong leadership at the health and wellbeing boards (HWBs) and work closely with the clinical commissioning groups (CCGs) to ensure a co-ordinated response
- risk assessment and follow-up interventions, with clear links to commissioned staying healthy initiatives and community development programmes [Ref 11]



[Ref 12]

Public Health England

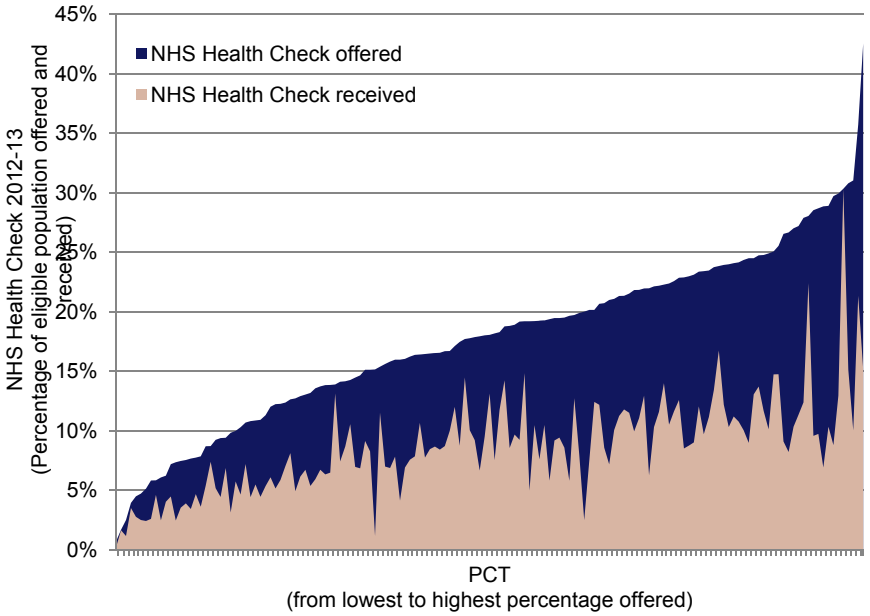
NHS Health Check: varying implementation

Local authorities will be taking on programmes at varying stages of implementation and performance

Before April 2013, primary care trusts (PCTs) had responsibility for commissioning the programme. Phased implementation began in 2009. The number of NHS Health Checks offered and received has varied significantly across England. Therefore local authorities will be taking on programmes in varying stages of implementation and with widely varying performance.

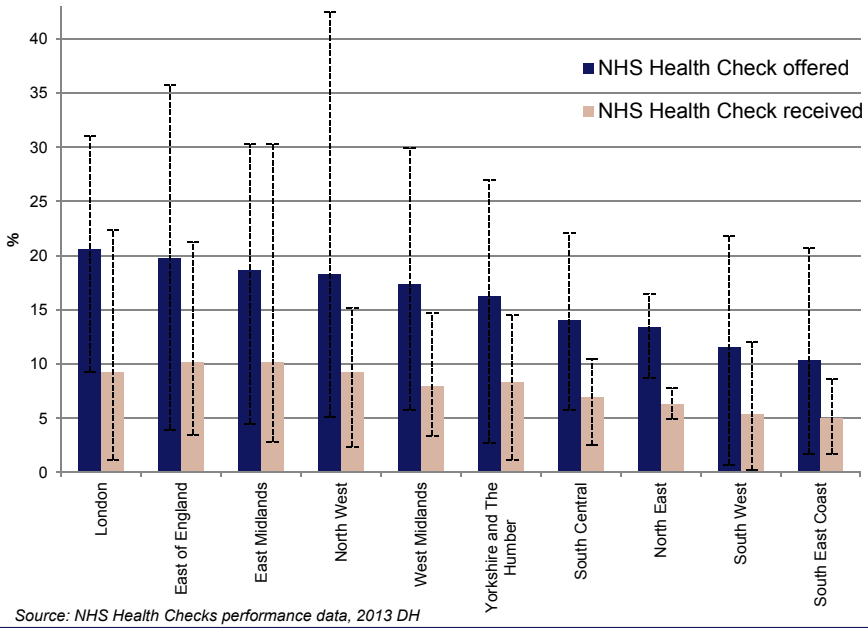
Learning from similar programmes has demonstrated that it takes time to increase uptake rates and with the programme still in its early stages, it is encouraging that the national take-up rate in 2011/2012 was 52% and that during transition, in 2012/13 it was 49%.

A comparison of offered and received NHS Health Checks by PCT (2012/2013)



Source: NHS Health Checks performance data, 2013 DH

Variation in NHS Health Check offers and take-up rates across SHAs (covers all 2012/2013; each year 20% of eligible population should be offered an NHS Health Check)



Source: NHS Health Checks performance data, 2013 DH

Public Health England

Making the case: the rising costs of social care

Current trends suggests that the cost of social care and continuing healthcare will continue to rise

As the number of older people living in England increases and public expenditure becomes more constrained, meeting the need for social care will become more challenging.

The Office for National Statistics (ONS) 2010-based principal population projections for England project that between 2010 and 2022 the number of people aged 65 or over will rise by 27% and the number aged 85 or over will rise by 44%.

Eighty percent of those aged 65 and over will need care in their later years of their life.

Current trends suggest that the cost of social care and continuing healthcare will continue to rise; reasons include:

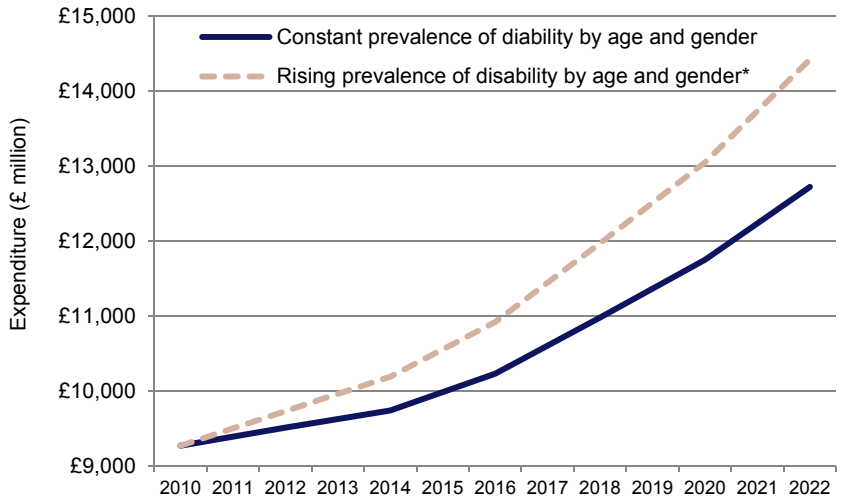
- 2% yearly increase in obesity, increasing prevalence of arthritis, stroke, CHD and vascular dementia
- emergence of minority ethnic groups in significant numbers within the older population adds to prevalence of stroke and CHD
- 2% bi-yearly increase in prevalence of arthritis, stroke, CHD and mild dementia from 2012 (moderate/severe dementia from 2016)
- 10% increase in disabling effects of arthritis, stroke and CHD from 2012 and a reduction in mortality of 5% from mild dementia, stroke and CHD from 2016

The NHS Health Check programme offers us an opportunity to stall some of these trends, and reduce current cost predictions.

[Ref 13]

Personal social services net and continuing health expenditure on over-65s in England under base case (BC) and continued trends assumption (CTA), 2012-2022 [Ref 13]

Scenario	BC	CTA
Rise in number ≥ 65 years with a moderate or severe disability by 2022	32%	54%
Cost of social and continuing healthcare by 2022	£12.7 billion	£14.4 billion



*The rising prevalence of rates of disability reflects continuation of recent trends in prevalence rates of chronic conditions.

Public Health England

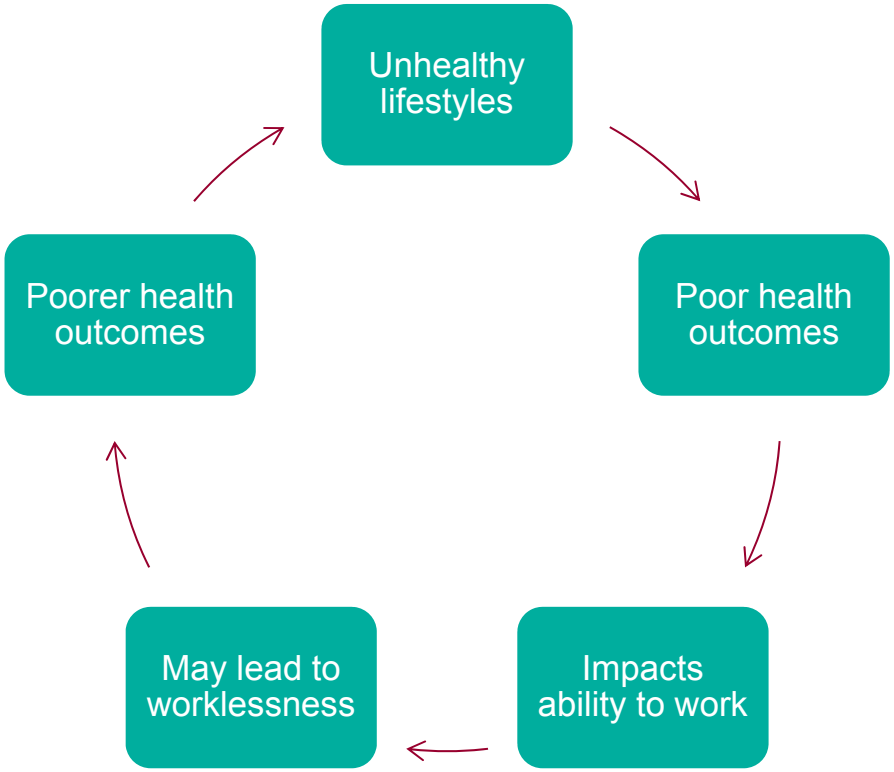
Making the case: keeping the working population healthy

The impact of poor health on the working age population affects everyone: individuals, employers and society

Good health improves an individual's chances of finding and staying in work and enjoying the consequential financial and social advantages. Being in work has a beneficial impact on health. Conversely poor health may impact on an individual's ability to work and lead to poorer health outcomes.

The health of the working age population is important for everyone:

- **individuals and families:** impacts quality and length of life, affects capacity to work and provide for family
- **employers:** a healthier workforce is more productive and inspires greater investment from employers
- **society:** consequences of ill-health include social exclusion, lower output and reduced tax revenues and higher healthcare and social security costs



- 175 million working days were lost in sickness absence in 2006 (7 days per working person)
- 7% of the working age population are workless and receiving benefits [Ref 14]

The NHS Health Check programme is well placed to support people to remain in and return to work and consequently benefit from it.

Public Health England

Making the case: the cost of poor health

There is an economic and social case to act decisively to improve the health of the working age population

The annual costs of sickness absence and worklessness associated with working age ill-health are estimated to be over £100 billion.

The NHS Health Check programme offers an opportunity to target those in work, aged 40 and over to support a reduction in sickness absence and worklessness.

Individuals	Employers	NHS	Government	Whole economy
• loss of income if poor health leads to worklessness • emotional cost of ill-health to themselves and their families • loss of years of life spent in state of poor health • cost of informal care by friends and family (£25-45 billion per year)	• cost of health related productivity losses • associated costs of staff turnover, loss of skill base, downtime, recruitment and re-training	• cost of treating working age people who are sick and out of work, which includes GP consultation through to secondary care (£5-11 billion per year)	• cost to the NHS • cost of benefits related to working age ill-health (£29 billion a year) • increased burden on the tax payer (£30-34 billion per year) • loss of income tax due to loss in productivity (£28-36 billion per year)	• includes forgone taxes (£70 billion per year) and healthcare costs (formal and informal) to Government (~£30 billion per year)

[Ref 14]

Public Health England

Making the case: targeting deprived communities

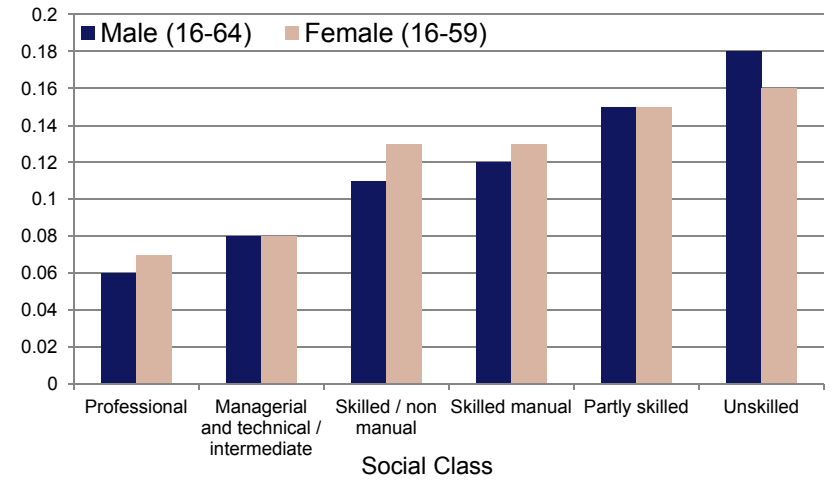
Supporting people in deprived communities to improve their health, will give them the greatest chance to stay in work and remain healthy

Socio-economic status influences health outcomes.

Having a higher income is likely to improve a person's health status, while being in good health increases earnings potential. Conversely a lower income is linked to poorer health outcomes.

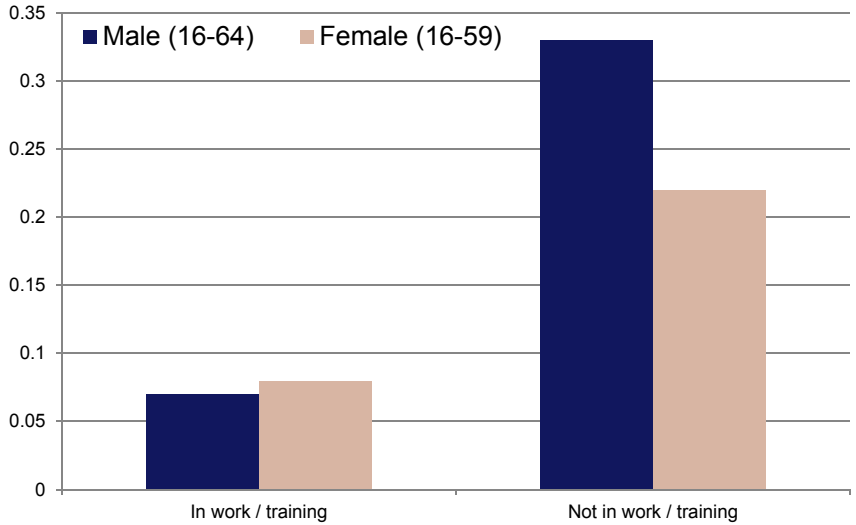
Tackling the risks and managing poor health will lead to lower incidence of health inequalities and a higher number of people staying in work.

Proportion of deviation from perfect health by social class



Note: Based on QALY measure of self-reported health. Does not cover Scotland and Wales
Source: Health Survey for England 2005, age adjusted, analysis by Department of Health

Proportion of deviation from perfect health by work status



Note: Based on QALY measure of self-reported health. Does not cover Scotland and Wales
Source: Health Survey for England 2005, age adjusted, analysis by Department of Health

- a child of a lone parent who does not work is eight times more likely to live in poverty than that of a lone parent who works full time
- children have higher incidence of recurrent health conditions if parents have a low income

[Ref 14]

Public Health England

Making the case: targeting BME groups

There is a strong association between ethnicity and health

General health outcomes

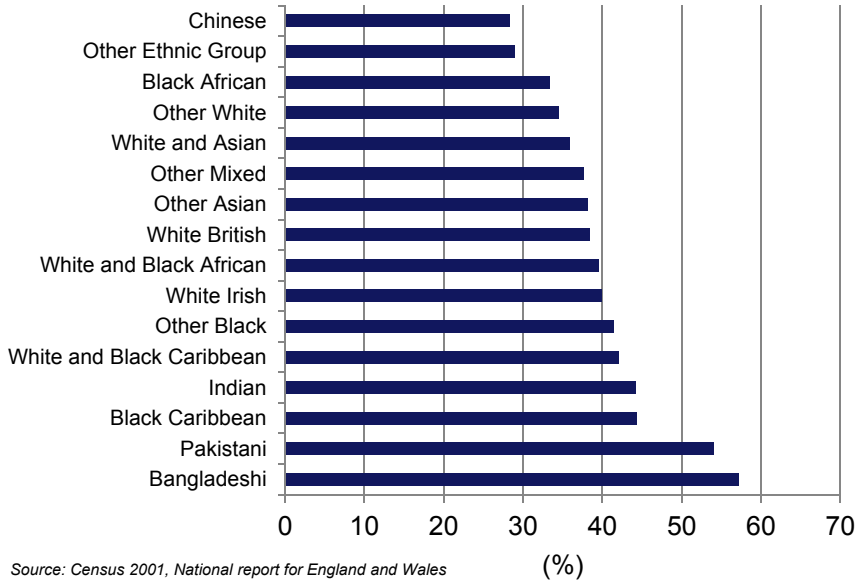
Black British people are 30% more likely to rate their health as fair, poor or very poor.

Pakistani and Bangladeshi people have the worst health of all the ethnic groups and are 50% more likely than white people to report fair, poor or very poor health. [Ref 15]

Diabetes

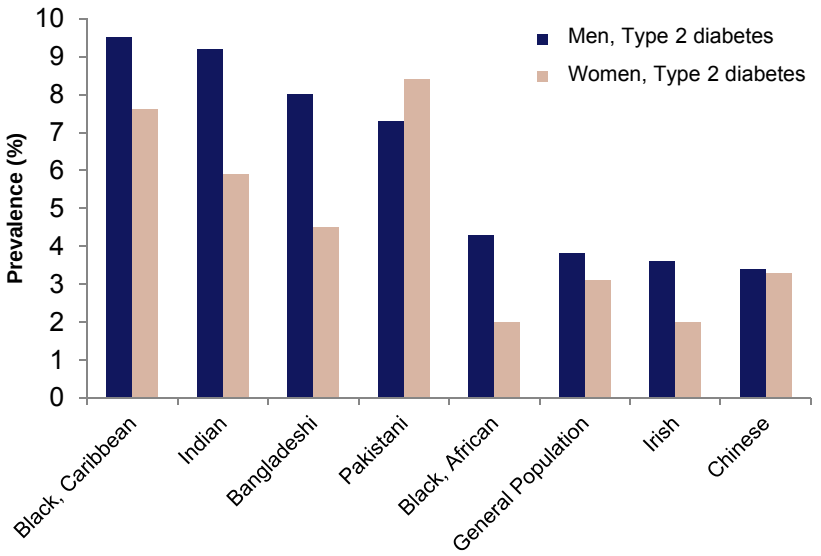
South Asian people who live in the UK are up to six times more likely to have diabetes than the white population. With the prevalence predicted to increase by 47% by 2025 (in England), the condition will continue to have a considerable impact on South Asian communities across the UK. [Ref 16]

All people over 50 years with limiting long-term illness, by ethnic group, 2004, England and Wales



Source: Census 2001, National report for England and Wales

Prevalence of doctor diagnosed diabetes (type 2) by sex and ethnic group, 2004, England



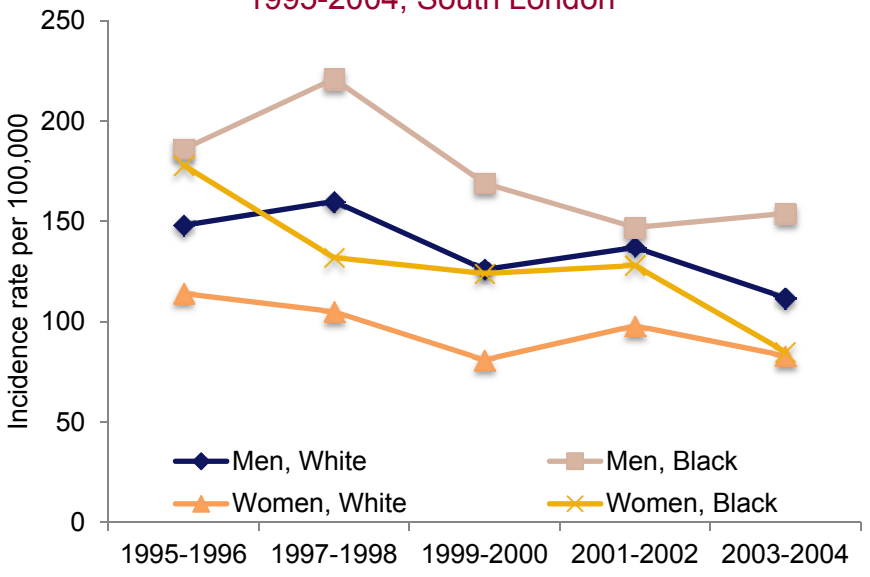
Source: Health Services Unit (2005), Health Survey for England (2004). The health of minority ethnic groups, DH, London.

Public Health England

Making the case: targeting BME groups

Premature mortality rates for CVD are higher in some populations

Incidence of stroke in men and women by ethnic group, 1995-2004, South London



Source: Health Survey for England (2004)

Stroke

The premature mortality rate for stroke in England is higher for those born outside the UK than for those born within. Furthermore stroke mortality rates are falling more slowly in minority ethnic groups than the rest of the population, widening inequality.

[Ref 17]

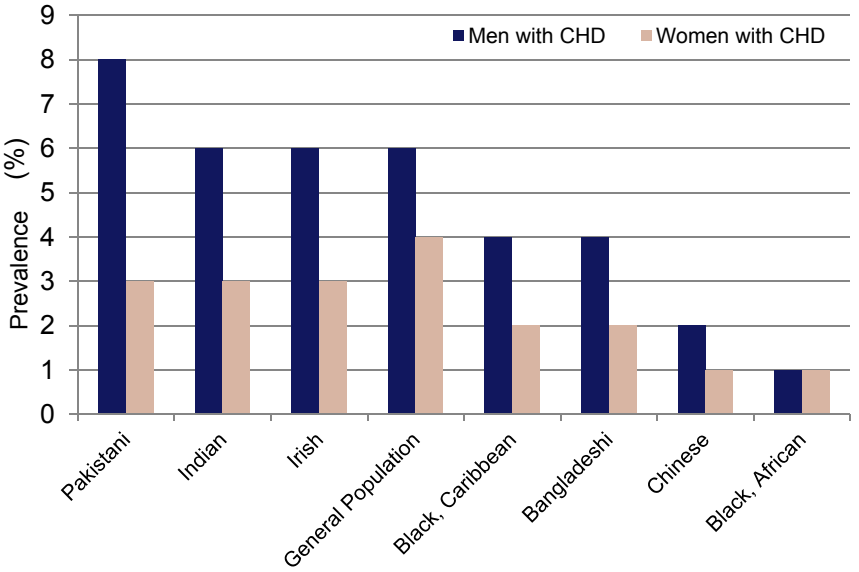
Coronary heart disease (CHD)

South Asian people born in India, Bangladesh, Pakistan and Sri Lanka are approximately 50% more likely to die prematurely from CHD than the general population.

The prevalence of CHD in England is highest in Indian (6%), Irish (6%) and Pakistani (8%) men.

[Ref 18]

Prevalence of CHD in men and women by ethnic group, 2004, England



Source: Health Services Unit (2005), Health Survey for England (2004). The health of minority ethnic groups, DH, London.

Public Health England

Executive summary

Context

Findings – issues and actions

Next steps

Public Health England

Issue 1: leadership

Disagreement in the public health community has led to inconsistent support for the NHS Health Check programme

The NHS Health Check programme offers a fantastic opportunity to reduce premature mortality and health inequalities in England; PHE is fully supportive of its roll-out.

PHE's role is to lead the public health community in promoting the programme's value. The key to its success lies in collaboration with key partners from all sectors (local authorities/LGA, NHS England, clinical commissioning groups, Health Education England, wider government, other healthcare providers, pharmacists, voluntary organisations).

PHE acknowledges that there are some significant issues to be addressed and reservations from national and local leaders to be overcome in making NHS Health Check a world class public health programme.

The comment boxes on this and following slides illustrate some of the concerns expressed to us [Ref 19].

personal level you're not sure if you've 100% bought into the programme either" (Commissioner)

Action 1

PHE fully supports the NHS Health Check programme at all levels. It will lead the development of collaborative national leadership through a clear programme governance structure including an advisory committee, comprising the key stakeholders (LGA, NHS England, NHS IQ, DH and others) and an expert clinical and scientific advisory panel. PHE will provide timely and authoritative advice on emerging issues and will empower public health leaders locally with the evidence and rationale for the programme.

Public Health England

Issue 2: improving uptake

Low public awareness and engagement are major barriers to the success of the programme

To drive uptake, PHE recognises the need to improve both awareness of the NHS Health Check programme and engagement of those invited so they are willing to take up the offer of an NHS Health Check.

While there have been concerns that local authorities may not want to promote and lead on an 'NHS' product, the LGA is supportive of the continued use of the NHS Health Check brand complemented by local authority joint branding.

Research has shown that adapting invitations to support improved uptake from local population groups is pivotal to success. PHE will work with local authorities to develop a repository of local case studies to support local implementation.

PHE will work with and support its partners (local authorities, LGA, NHS and DH) to co-produce and share advice and good practice to ensure consistency across the programme.

"The biggest thing in being able to increase our uptake. We've had a very big communications campaign" (Commissioner)

Action 2

PHE will work with local authority NHS Health Check teams to test the potential impact of behavioural insight and marketing interventions on uptake. This will include developing options for improving the NHS Health Check brand, establishing the effectiveness of different approaches to recruitment and testing marketing campaigns to support uptake locally and nationally.

Public Health England

Issue 3: providing the NHS Health Check

The landscape is complex and local authorities have different options to choose from; we cannot say yet, the best way to commission the service

PCTs have used different invitation processes; case studies have shown us that using a call-recall system is effective, but that opportunistic approaches also have benefits. We are not yet certain of the best approach to use.

PCTs commissioned the programme from a range of providers (GPs, pharmacists, third sector etc). Case studies suggest that programmes using a mix of providers are most successful at reaching out to local population groups but more evaluation is needed before we can say for certain which approach is best.

NHS Health Checks can and have been provided by a range of health professionals (GPs, nurses, healthcare assistants, volunteers etc). Further work needs to be undertaken to understand the value of using different types of professionals for different populations.

"There's a risk that the GPs will throw their hands up and say 'this is too much work, we're not going to do it,' and then we'll have to commission private providers who are more expensive, then we risk it becoming very expensive programme which will not be cost effective"
(Commissioner)

Action 3a

PHE will thoroughly review and collate previous approaches to commissioning and delivering the NHS Health Check programme and so learn from and share promising practice and experience.

Action 3b

PHE will collaborate with the Centre for Public Scrutiny to work with several test bed sites to explore approaches to effective commissioning of the programme.

Issue 4: information governance

Some commissioners are unclear about NHS Health Check information governance

Public Health England

The transfer of responsibilities brings with it a requirement to continue to meet the highest possible data protection requirements for services users, combined with reaching all eligible residents in the most appropriate manner. Local commissioning arrangements and procedures for identifying and inviting eligible people to their NHS Health Check are extremely varied and it is therefore not possible to provide national guidance to cover every eventuality. Local areas should be familiar with legal requirements for handling sensitive personal data.

In March 2013 a guidance note from PHE and DH was shared with local authorities and other key partners setting out a number of general approaches that local commissioners could consider: a) NHS Health Checks are conducted by GPs only b) invitations are sent by GPs, but health checks are issued by a third party provider or both a GP and a third party provider c) an opportunistic element of the programme is offered, in conjunction with GP delivery d) invitations are sent via the National Health Authority Information System (NHAIS), where people can opt out.

"Recording community practice data on practice systems has been a challenge – this has to be done, in order to count towards targets" (Commissioner)

"It's about understanding the challenges we face and where possible coming up with national solutions, particularly data solutions" (Commissioner)

Action 4

PHE will explore long term solutions to free up the system to enable the flow of data, including to and from GP practices, for the best possible delivery of the NHS Health Check programme. It will explore the use of innovation and IT technologies to allow the seamless flow of NHS Health Check data across the health and social care system. This will create an environment that supports local teams to commission and evaluate programmes which aspire for excellence and improved outcomes.

Public Health England

Issue 5: supporting delivery

There is uncertainty about the future of regional and national networks

National and regional networks play a vital role in supporting roll-out and improving the quality of NHS Health Check programmes across England.

Since April 2010, NHS Diabetes and Kidney Care (NHS DAKC), with the Department of Health supported commissioners and providers to improve NHS Health Check programmes through provision of a national network and targeted local support. Strategic Health Authorities supported improved performance, disseminating national messages through regional networking events to PCT commissioners and encouraging local teams to share their knowledge and work together.

Now that those organisations who provided support have been abolished or integrated into other organisations, some commissioners are worried that networks will no longer be supported. PHE will take on the role of providing support to both clinical and non clinical commissioners of the risk assessment and follow-up services.

"You get an idea of the issues other people are going through. It's good to know it's not just you" (Commissioner)

"I would hope it would be PHE who would provide networking and support. That's the role they should have, combined with the local area teams and Commissioning Boards" (Commissioner)

Action 5

PHE will build upon and give continued support to established national, regional and local implementation support networks, ensuring equitable access to all organisations across England. PHE will work with the LGA to advance NHS Health Checks through the sector led improvement agenda.

Issue 6: programme governance

The NHS Health Check community is concerned that new elements are added without due concern for the evidence base

Public Health England

Before introducing the policy DH undertook a comprehensive analysis of the evidence and the economic case for the NHS Health Check programme. This suggested that the programme is both clinically and cost effective.

Mindful of transition, PHE will allow the system time to stabilise, while continuing to review existing and potential new elements for the programme, ensuring they are evidence based.

PHE will also ensure governance is in place to review any future proposed changes. Decision makers will be cognisant of concerns raised by commissioners and providers, including the time pressures and practicalities of introducing new elements and their affect on the effectiveness of the NHS Health Check.

NHS Health Check: risk assessment measurements

Age
Gender
Ethnicity
Family history
Smoking status
Alcohol use
Physical activity
Body-mass index
Cholesterol test
Blood pressure measure
Dementia awareness*
Diabetes filter (BMI and BP measure)
If at risk: HbA1c/Fasting Glucose tests

* Awareness and signposting only for those aged 65-74

Action 6

PHE will set up clear programme governance arrangements, including an expert clinical and scientific advisory panel to assure that any additional elements of the programme are evidence based. It will keep the programme under review and advise the DH and ministers accordingly. See Appendix B for programme governance structure.

Public Health England

Issue 7: provider competency

Some commissioners are worried that providers are not appropriately skilled to deliver behaviour change interventions

PHE recognises that the success of NHS Health Check lies in part with the ability of the chosen provider to inspire behaviour change in those attending.

Through this review, PHE has identified that risk assessment delivery varies nationally, from those that focus on prevention through lifestyle advice to those focusing on early detection of disease and other clinical elements. Some practitioners have suggested that they do not feel equipped to undertake lifestyle discussions. There is therefore a risk that the programme's impact is not fully realised.

PHE has a role in supporting local authorities in commissioning local programmes focused on behaviour change using and building on NICE guidance[ref 20] and in working with its partners (professional bodies and training providers) to support enhanced delivery.

"The health check consultation is perceived as a series of clinical tests by attendees; lifestyle discussions are seen as secondary to testing" (Commissioner)

Action 7a

PHE will work with Health Education England (HEE) to build upon existing competency frameworks for use by providers and commissioners to ensure high quality training for those delivering the NHS Health Check.

Action 7b

PHE will work with local commissioners, training providers and professional bodies to develop a professional development programme of work on NHS Health Checks to enhance the focus on behaviour change for better health outcomes.

Public Health England

Issue 8: consistency

There is a lack of consistent, quality driven roll-out

Every person eligible for an NHS Health Check should be offered a good quality, consistent risk assessment interview and follow-up, irrespective of where they live, or the provider commissioned to deliver it.

This review has highlighted a desire in some for a national quality assurance process. While PHE may consider this in the future, supporting delivery of a consistent offer is considered the priority at present. The programme is a mandated service in order to help to drive this.

Commissioning and management of the programme has been the responsibility of PCTs and through this review PHE has identified a disparity in approaches and investment.

PHE accepts that some local authorities may wish to add elements to their local NHS Health Check services to reflect local need, but stresses that additional elements should not compromise the quality of the standard offer.

Encouraging consistency will support and further develop local and national evaluation of the NHS Health Check programme.

"The major problem is that there just isn't a QA programme in place, either centrally or regionally, that you see for other programmes" (Commissioner)

Action 8

PHE will release and review on a regular basis best practice guidance describing all the elements and standards it would expect of a quality programme such as quality of delivery and robustness of data capture and reporting. It will raise awareness, promote adoption and explore opportunities for quality assurance programmes in local authorities.

Public Health England

Issue 9: proving the case

Some of the public health and clinical communities are concerned about the evidence base for the NHS Health Check intervention

Each of the individual elements contained within the NHS Health Check are evidenced by NICE guidance [ref 12] and have a strong economic case, supporting their inclusion in the NHS Health Check programme. However some leading pubic health professionals and clinical providers continue to have questions about the evidence base.

The case for the programme is clear and research is currently underway to provide an early assessment of programme outcomes since phased implementation began in 2009. This work will also highlight a range of implementation and delivery issues for future consideration. See February's e-bulletin for more details.

PHE will work with its partners to develop data collection techniques and research proposals to support evaluation of the NHS Health Check programme.

"I would like PHE to highlight the benefits of the programme, as the critical national voice. This will encourage GPs and other organisations to buy into it. There is a debate about the evidence for health checks. PHE should provide clear evidence of their value"
(Commissioner)

Action 9

PHE will work with system partners to facilitate future research and evaluation of the NHS Health Check programme at a national and local level. This will provide the implementation evidence required to ensure effective roll-out and improvement.

Public Health England

Issue 10: expected roll-out

Some local authorities are worried that they will not meet expected delivery targets

NHS Health Check is a mandated service and the regulations state that local authorities must achieve a 100% offer rate in their eligible populations after five years.

Ideally local authorities will offer the NHS Health Check to 20% of their eligible population each year, reaching 100% over five years. Enabling them to commission a programme in steady state and supporting the development of clinical and lifestyle follow-on services.

Funding has been allocated to support this scenario and is modelled on an uptake rate of 75%. Ideally local authorities will want to show annual improvement in uptake rates aiming for and beyond 75%.

PHE is aware that local authorities are taking on programmes in varying stages of implementation and with widely varying performance. Reporting by PHE of delivery and take-up by local authorities will be cognisant of this being a five year rolling programme.

"We'll be lucky if we get anywhere near 10%... Some GPs have really gone for it and smashed their targets, but those with low engagement are bringing the average down." (Commissioner)

"The massive thing is the sheer variability in delivery. You get some star performers and some people just don't engage with it" (Commissioner)

Action 10

PHE will support those local authorities taking on challenging programmes. It will work with LAs to achieve offers to 20% of the target population annually with a vision to realise at least 75% uptake per year. This will support local authorities to achieve offers to 100% of their eligible population over five years.

Public Health England

Executive summary

Context

Findings – issues and actions

Next steps

Public Health England

Next steps

2012-13, the first full year of the NHS Health Check programme, saw 2.7 million offers made and 1.26 million NHS Health Check appointments received, during a time of so much transformation across the health system. This provides a solid base on which to build.

Over the coming year and beyond, PHE will work with our key partners to:

- support effective implementation and monitoring
- facilitate the sharing of best practices
- support evaluation and research
- make sure that any new strategic developments are based on the best evidence
- support strong, challenging and robust governance

Our challenge now is to increase national coverage so that all areas are offering access to this mandated public health programme. We must also strive to increase further levels of uptake and referral to appropriate risk management services, particularly in those communities at greatest risk.

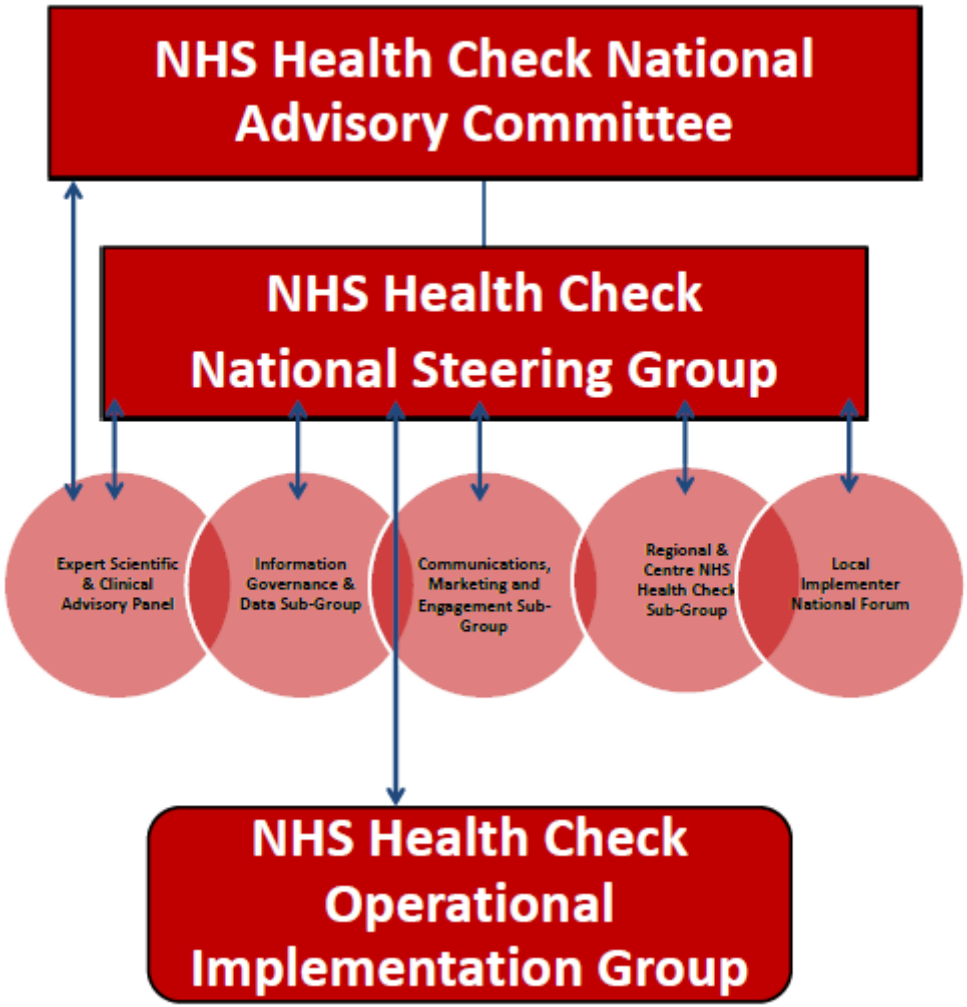
Public Health England

Annex A: methodology

Stage	Information	Dates of Completion
1. Research Works qualitative research: 'Understanding the implementation of NHS Health Checks'	Commissioned by the Public Health England Transition Team to: • assess the experiences of commissioners and providers in delivering the NHS Health Check programme • gain an understanding of the engagement of public health professionals with NHS Health Check and the process of implementing the programme	February 2013
2. Workshops help to establish the views of senior stakeholders	Two workshops held. Stakeholders represented the following organisations: DH, local government (Birmingham, Cheshire & Merseyside, North Lincolnshire, West Midlands, Worcestershire, York), LGA, NHS England, NHS IQ, PHE, Research Works, UK National Screening Committee	January 2013 & February 2013
3. Comments sought via the PHE's engagement mailbox	Comments sought from PHE's National Executive, the project working group and wider stakeholders, with an interest in the NHS Health Check programme: a) after the second stakeholder meeting in February 2013 b) after the launch of our initial findings at the NHS Health Check Learning Network Event in April 2013. • 17 sets of comments were received.	May 2013
4. Meetings held with 'opinion leaders' from across England	Engagement meetings held with: • Members of the Delivering Transition Steering Group (DTSG) • PHE Centre directors • Leading GPs • Association of Directors of Public Health [June 2013]	May 2013
5. Analysis agreed with the PHE Programme Board chaired by the Director General of DH	Final report agreed with the PHE National Executive and Felicity Harvey (Director General – Public Health Directorate, DH)	June 2013

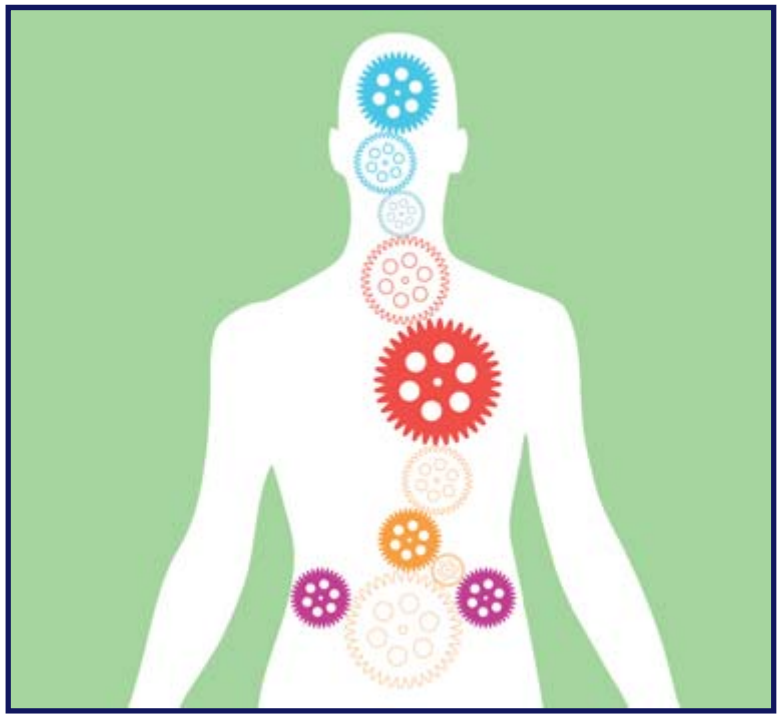
Public Health England

Annex B: NHS Health Check governance



Public Health England

Acronym list



Acronym	Full title
CCG	Clinical Commissioning Group
CHD	Coronary Heart Disease
CVD	Cardiovascular disease
DTSG	Delivering Transition Steering Group
HEE	Health Education England
HWB	Health and Wellbeing Board
LA	Local Authority
LGA	Local Government Association
NHAIS	National Health Authority Information System
NHS CB	NHS Commissioning Board
NHS DAKC	NHS Diabetes and Kidney Care
NHS IQ	NHS Improving Quality
NICE	National Institute for Health and Care Excellence
PCT	Primary Care Trust
PHE	Public Health England
QALY	Quality Adjusted Life Year
RCGP	Royal College of General Practitioners
SHA	Strategic Health Authority

Public Health England

Useful documents

Local Government Association (2013)
NHS Health Check frequently asked questions

Centre for Public Scrutiny (2013)
NHS Health Check – what council scrutiny needs to know

Public Health England

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20. The most appropriate means of generic and specific interventions to support attitude and behaviour change at population and community levels [link to http://guidance.nice.org.uk/PH6}

Public Health Outcomes Framework indicators include:

- The percentage of people eligible for the NHS Health check programme who have been offered an NHS Health Check and
- The percentage of people eligible for the programme who have received an NHS Health Check

What does the data tell us?

Offers for 2013/14

- In 2013/14 21.1% of the eligible London population were offered a health check. This demonstrates an increase from 2012/13 when 20.6% were offered a health check.
- This 2013/14 target to offer a Health Check to 20% of the eligible population aged between 40 and 74 years has been exceeded in London.
- The proportion of the eligible population offered an NHS Health Check in London (21.1%) is also higher than the England average (18.5%).
- 19 boroughs met the 20% target for offers. 14 boroughs didn't reach the 20% target, and of these 9 were more than 10% behind target.
- There is considerable variation across London.

Uptake for 2013/14

- The total for London at the end of 2013/14 was 10.0% of the eligible population - behind the aim to achieve 13.2%. Only 5 boroughs met this aim. The other 28 boroughs did not meet this aim, and of these 23 were more than 10% behind the aim.
- London provided health checks for 10% of the eligible population which was more than the England average (9%).
- In the Midlands and East of England region, the number of Health Checks received represents 51.3% of offers made.
- The number of Health Checks received in 2013/14 represents 47.3% of offers made.

Comparison of Offered and Received by Borough

This table shows colour coded progress in respect of target. This shows that 19 boroughs met the 20% target for offers. 14 boroughs didn't reach the 20% target, and of these 9 were more than 10% behind target.

Name	% of people who were ***offered*** a NHS Health Check
Kingston	44.4
Lambeth	38.2
Westminster	35.3
Southwark	33.1
Lewisham	28.3
Islington	26.5
Hackney	25.9
Bromley	25.9
Richmond & Twickenham	25.4
Barking and Dagenham	25.1
Wandsworth	24.0
Merton	23.2
Greenwich	23.0
Kensington & Chelsea	22.7
Ealing	22.1
Hammersmith & Fulham	21.5
Enfield	21.5
Havering	20.2
Sutton	20.0
Camden	19.8
Bexley	19.6
Haringey	19.3
Newham	18.1
Hounslow	18.1
Tower Hamlets	17.2
Brent	16.6
Barnet	16.1
Waltham Forest	14.4
Redbridge	12.9
Harrow	11.8
Hillingdon	11.2
City of London	9.9
Croydon	0.8
LONDON	**21.1**

Met Target	20.0
10% or more behind schedule	18.0

Name	% of people that ***received*** a NHS Health Check
Kingston	18.2
Wandsworth	18.0
Ealing	16.7
Islington	15.5
Merton	13.4
Newham	13.1
Hackney	12.8
Greenwich	12.5
Lambeth	12.4
Tower Hamlets	12.2
Barking and Dagenham	11.4
Richmond & Twickenham	11.2
Southwark	10.9
Lewisham	10.7
Redbridge	10.1
Westminster	10.0
Bromley	9.8
Havering	9.1
Camden	8.9
Haringey	8.7
Brent	8.6
Waltham Forest	8.5
Hounslow	8.5
Sutton	8.1
Hillingdon	8.1
Kensington & Chelsea	7.7
Enfield	7.5
Bexley	7.5
Harrow	6.6
Barnet	6.0
Hammersmith & Fulham	5.9
City of London	5.9
Croydon	2.0
LONDON	**10.0**

Met Target	13.2
10% or more behind schedule	11.9

	London Borough of Hammersmith & Fulham **Health and Wellbeing Board** **30 June 2014**
2013-2014 TRI-BOROUGH PUBLIC HEALTH REPORT	
Report of the Corporate Director	
Open Report	
Classification: For Information	
Wards Affected: All	
Accountable Executive Director: Meradin Peachey, Director of Public Health	
Report Author: Kate May, Senior Public Health Officer	**Contact Details:** Tel: 020 7641 4652 E-mail: kmay@westminster.gov.uk

AUTHORISED BY: .....

.....

DATE: .....

1. EXECUTIVE SUMMARY

1.1. The 2013-14 Tri-borough Public Health Report is the first to be published since local councils took back responsibility for public health after 40 years in the NHS. The report provides a snapshot of the health of people who live in our boroughs and identifies some of the local public health priorities

2. RECOMMENDATIONS

2.1. The annual public health report is an independent report but we are keen that the reach and appeal of the report is broad. We therefore ask for your support in identifying the priorities for next year's report.

3. INTRODUCTION AND BACKGROUND

3.1. There is a statutory requirement for the Director of Public Health to produce an independent public health report. This paper provides the Health and Wellbeing Board with key messages from the 2013-14 Tri-

Borough Public Health Report. It offers a snapshot of the health of people who live in our boroughs, identifies some of the local public health priorities and describes some of the current projects designed to improve the health and wellbeing of local people.

3.2. This 2013-14 report is aimed at residents as well as council officers and members. It is the first report to be published since local councils took back responsibility for public health after 40 years in the NHS.

4. PROPOSAL AND ISSUES

Local Health Overview

4.1. There is no significant difference in life expectancy for men and women living in Hammersmith and Fulham compared to the rest of London and England (PHOF 2010-12). Whilst many residents are affluent, there are significant areas of poorer health in the more deprived parts of the borough and therefore large health inequalities between rich and poor.

4.2. We need to make sure people are supported to make healthy choices, protected against risks to their health and, through working with the NHS, ensure equal access to health care services.

4.3. The major causes of death and disease locally are the same as those across the country. The biggest killers in our area are cancer, heart disease, and respiratory disease. Liver disease is also a significant cause of death locally.

4.4. Other causes of death and disease that are bigger problems here than in other parts of the country include poor air quality, tuberculosis and HIV/AIDs.

Our areas of focus for public health for the next year

4.5. People living in more deprived areas suffer more health problems and die earlier than the rest of our residents. These health inequalities can only be reduced if there is a focused effort across all services that affect health and wellbeing. These include council services such as leisure, education, employment, housing and planning and social care.

4.6. Giving every child the best start in life is crucial to reducing health inequalities. Children who live in poverty are at greater risk of poor nutrition, physical and mental health problems, social problems and lower education achievement. Later in their lives these children will be at greater risk of heart disease, mental illness and unemployment.

4.7. Unhealthy lifestyle choices tend to cluster together so people who smoke are more likely to drink too much alcohol or to use drugs and are also more likely to have poor diets and live inactive lives. We need to consider how we can help people address multiple, rather than individual, unhealthy behaviours.

4.8. The number of 10 and 11 year old children who are obese in our schools is almost 40%. This matters, as they have a much higher risk of growing

up to be overweight or obese as adults and getting diabetes, heart disease, stroke and some cancers as they get older.

4.9. Our population is aging and this means we will need to support growing numbers of people living with multiple conditions including dementia, cardiovascular disease, and respiratory disease. These conditions are often linked to factors like social isolation and poor housing which can make care more complicated.

4.10. We believe that we can make a difference to improve the health and wellbeing of people who live work and visit Hammersmith and Fulham by focusing on these priorities and working with partners, including residents, council departments, NHS commissioners and providers, community and voluntary organisations, and businesses.

Next steps

4.11. There are a number of specific steps that Triborough Public Health will be taking over the next year to support innovative public health initiatives. These actions include:

1) Building on the current JSNAs to make sure appropriate actions are implemented by public health services and our partners.

2) Identifying what further JSNAs or related data and intelligence gathering needs to happen to inform commissioning and service delivery (both within the local authorities, and within CCGs and local voluntary and community providers).

3) Reviewing and re-commissioning public health services delivered across the three local authorities to ensure we use public health resources to best effect.

4) Supporting partners across the health, social care and community and voluntary sectors to deliver cost effective and evidence based interventions that are accessible and acceptable to all in need.

4.13 These actions will help ensure that the Council is demonstrating the leadership, initiative and innovation required to deliver improvements in health and wellbeing for local residents.

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.			

LIST OF APPENDICES:

Appendix 1: APHR Presentation

h&f hammersmith & fulham

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

City of Westminster

London Borough of Hammersmith & Fulham | The Royal Borough of Kensington and Chelsea | Westminster City Council

TRI-BOROUGH PUBLIC HEALTH REPORT

2013-14

The Areas of Focus

•Reducing health inequalities through a focused effort across all services that effect Health and Wellbeing,

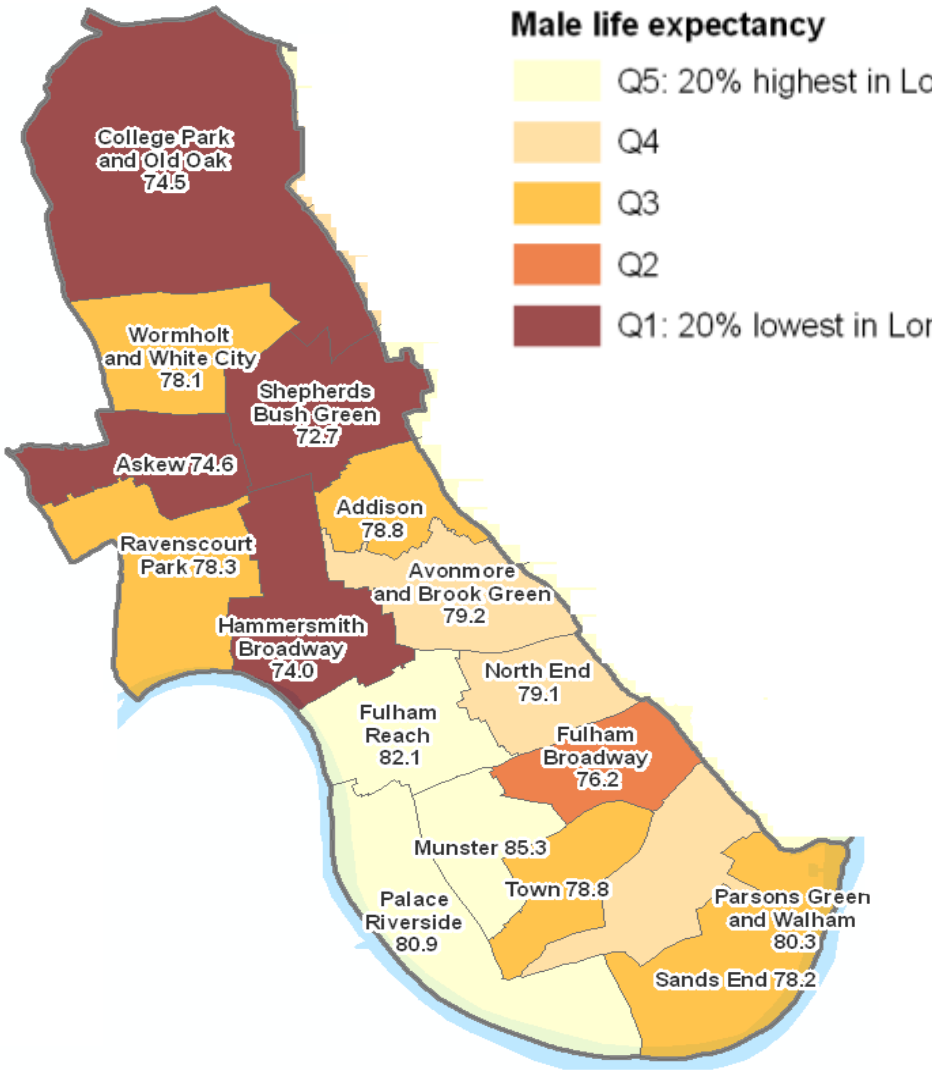
•Giving Every Child the Best Start in life,

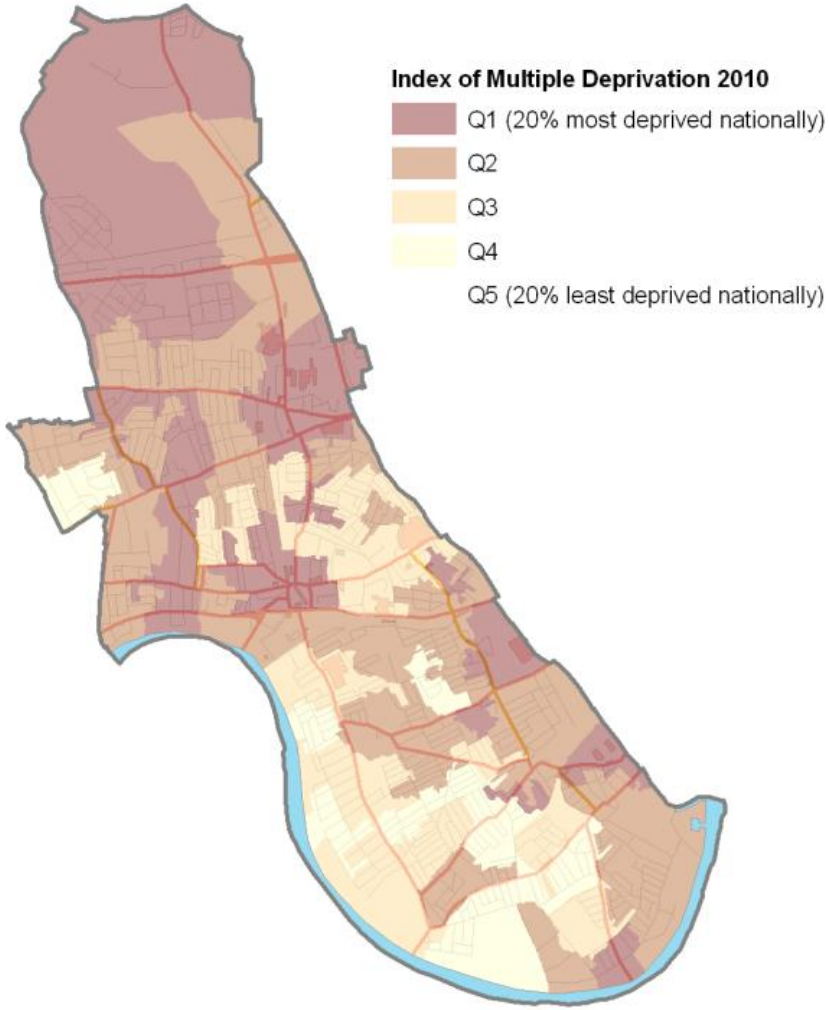
•The clustering of unhealthy lifestyle choices,

•Childhood Obesity,

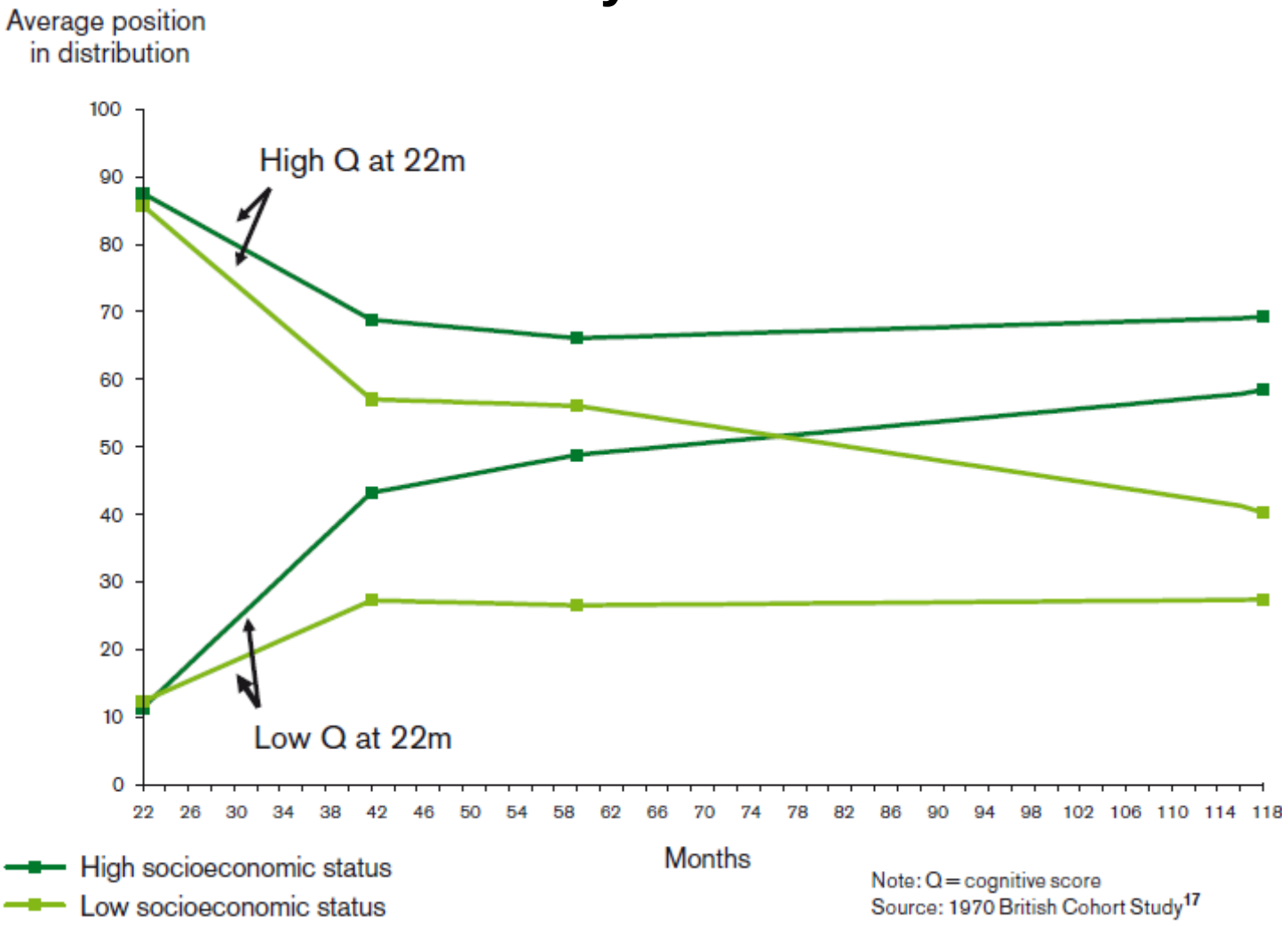
•The Ageing Population,

Life expectancy and deprivation in Hammersmith and Fulham

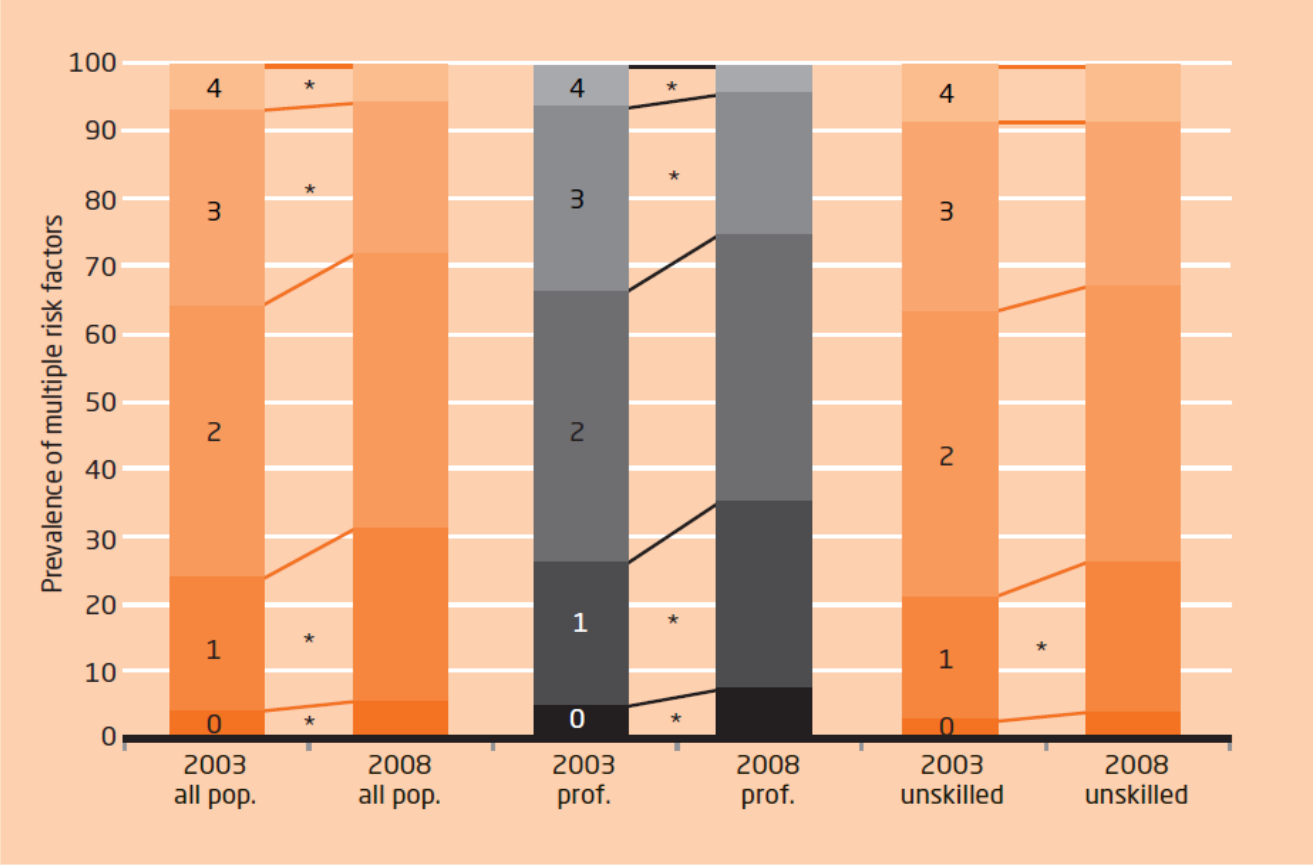




Give every child the best start in life

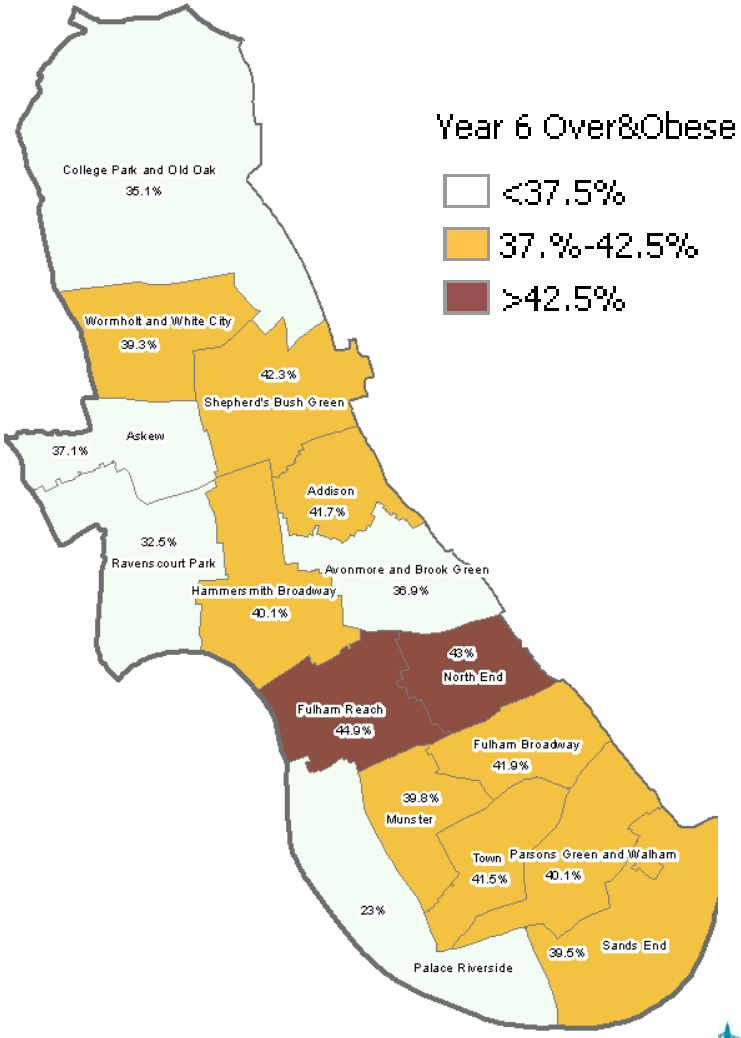


Change in Prevalence of Multiple Lifestyle Risk Factors Between 2003 and 2008 for Men in Professional and Unskilled Manual Households

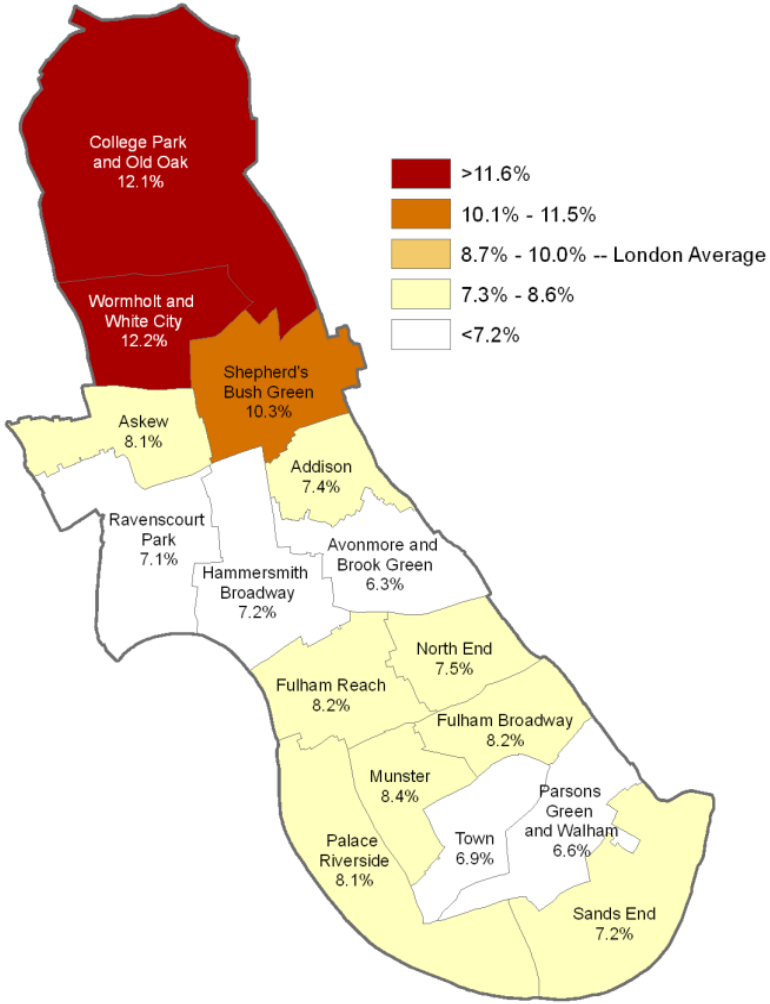


Note: *, Significant difference ($p<0.05$) between the years
Source: Authors' analysis of the Health Survey for England 2003 and 2008 (NHS Information Centre 2012)

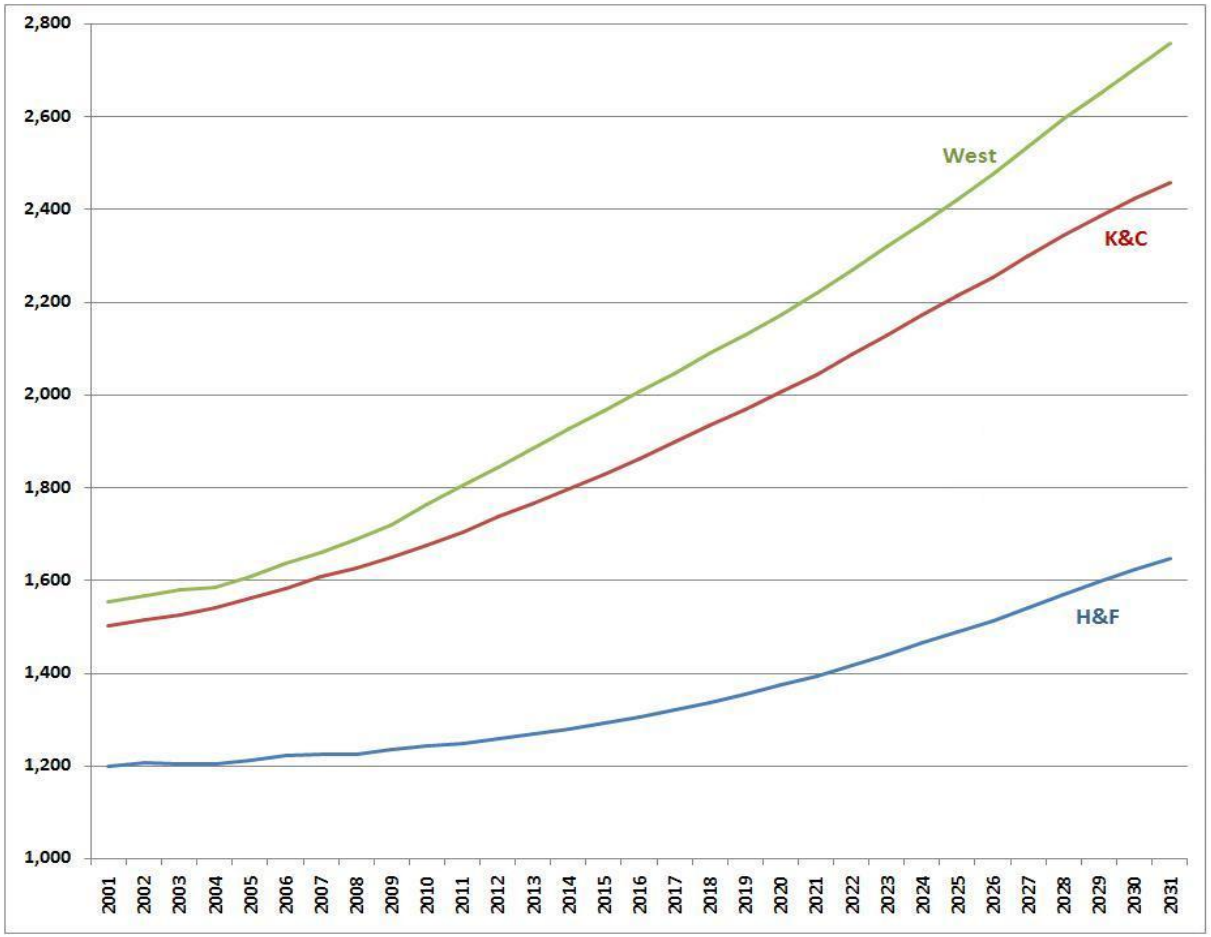
Percentage of childhood Obesity and overweight by ward (average of 2007-08 to 2012-13 for year 6 pupils)



Adult obesity prevalence in H&F (GP reported QOF prevalence 2012/13)



Expected Prevalence of Dementia



Number of people with dementia across INWL expected to be 6,800+ by 2031

Expected **sharp rise** in the number of cases of dementia in the next 20 years compared to last 10 years

By 2027, there will be 50% more cases in INWL compared with 2001

Rise is expected as a result of increasing Life Expectancy and the large numbers of people reaching old age from 10 years' time as a result of the 'baby boom'

https://www.westminster.gov.uk/one-year-what-have-we-achieved-public-health

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Hammersmith & Fulham

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lbhf.gov.uk

The Royal Borough of
Kensington and Chelsea

The Town Hall
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London W8 7NX

rbkc.gov.uk

Westminster City Council

Westminster City Hall
64 Victoria Street
London SW1E 6QP

westminster.gov.uk

	London Borough of Hammersmith & Fulham **HEALTH AND WELLBEING BOARD** **30 June 2014**
Joint Strategic Needs Assessment (JSNA) programme	
Report of the Director of Public Health	
Open Report	
Classification: For Decision **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: Meradin Peachey, Director of Public Health	
Report Author: Dan Lewer, JSNA Manager, Public Health (or Colin Brodie, Knowledge Manager)	**Contact Details:** Tel: 020 641 6406 E-mail: dlewer@westminster.gov.uk

AUTHORISED BY: .....

.....

DATE: .....

1. EXECUTIVE SUMMARY

1.1. Local authorities and CCGs have a joint responsibility, exercised through the Health and Wellbeing Board, to produce Joint Strategic Needs Assessments (JSNAs). JSNAs look at the current and future health, care and wellbeing needs of local populations. JSNAs are a key tool used to inform and guide the development of local strategy and the planning and commissioning of health, well-being and social care services within a local authority area.

1.2. The JSNA programme is agreed by the Health and Wellbeing Board annually. The JSNA programme always includes a borough-specific JSNA highlight report which gives a snapshot of local need. However, the central part of the JSNA programme is 'deep-dive' JSNAs that look at specific aspects of the population's health. This paper asks for agreement from the

Health and Wellbeing Board on which topics should be prioritised for deep-dive JSNAs in the 2014-15 JSNA programme.

2. RECOMMENDATIONS

2.1. It is recommended that the London Borough of Hammersmith and Fulham Health and Wellbeing Board approve the JSNA Steering Group's recommendation to conduct JSNA 'deep-dives' into:
(i) childhood obesity,
(ii) older people's housing needs; and
(iii) dementia.

3. REASONS FOR DECISION

3.1. Partners from across Children's Services, Adult Social Care, the Hammersmith & Fulham Clinical Commissioning Group, Housing, Public Health and other local authority departments were asked to put forward suggestions for potential areas which could benefit from inclusion in the 2014-15 Joint Strategic Needs Assessment programme. A long-list of the topics put forward by partners is attached in appendix A

3.2. The JSNA Steering Group considered this long-list of topics and asked for three to be developed into formal applications: childhood obesity, older people and housing, and dementia. On the basis of these applications, these three areas are now being recommended to the Health and Wellbeing Board as priority areas for JSNA deep-dives in the 2014-15 JSNA work programme.

3.3. This recommendation reflects the fact that the childhood obesity, dementia and older people's housing needs are areas which affect large populations. They also link directly to areas identified as commissioning priorities for the council and the clinical commissioning groups over this year and the next. The Health and Wellbeing Board are asked to note that these JSNA deep-dives would be undertaken across the tri-borough geography, but will provide an understanding of the need within the individual boroughs.

3.4. Other topics may be included in 2014-15 JSNA work programme later in the year, or addressed in other ways

4. INTRODUCTION AND BACKGROUND

4.1. JSNAs are developed jointly by local health and social care partners. Joint Strategic Needs Assessments provide a detailed picture of the health needs of the local population, usually focusing on a specific topic. They are developed jointly by local health and care partners and identify actions that local agencies will need to take to improve the well-being of individuals and communities. Local authorities and Clinical Commissioning Groups (CCGs), through the Health and Wellbeing Board, are responsible for the production of JSNAs. Many other partners are also involved in the process, including service providers, voluntary organisations and bodies representing patients and service users.

4.2. The London Borough of Hammersmith and Fulham Health and Wellbeing Board has delegated the day-to-day management of the Joint Strategic Needs Assessment programme to a sub-group of the Health and Wellbeing Board. This sub-group, “the JSNA Steering Group”, is shared with neighbouring Health and Wellbeing Boards in the Royal Borough of Kensington and Chelsea and Westminster. This arrangement reflects the fact that health and care organisations commonly work across this geographical boundary and often jointly plan and commission services together.

4.3. The JSNA Steering Group manages the process of receiving and reviewing applications for Joint Strategic Needs Assessments and the day-to-day production of assessments and other products. However, the individual Health and Wellbeing Boards retain overall responsibility for agreeing the JSNA programme, including making decisions about the content of the work programme and signing off the final products.

4.4. Deep-dive JSNAs address commissioning priorities; focus on specific populations, risk factors, diseases or interventions; address knowledge gaps and provide tangible recommendations for commissioners. Recent deep-dive JSNAs have looked at learning disabilities, physical activity, tuberculosis and child poverty.

4.5. In addition to deep-dive JSNAs, highlight JSNA reports for each borough are produced, which summarise the population’s general health needs.

4.6. The output of a JSNA project is a public report. All local JSNAs are available at www.jsna.info, which is a dedicated to JSNAs for the Triborough.

5. FINANCIAL AND RESOURCES IMPLICATIONS

5.1. There is no direct financial implication of the deep-dive JSNA programme.

5.2. Resources available to undertake deep-dive JSNA’s usually exceeds the number of topics which are suggested by partners. The JSNA Steering Group manages this by making recommendations to the Health and Wellbeing Board, like those included in this paper, on which topics should be considered as a priority by the Health and Wellbeing Board.

APPENDIX A

Topics raised as possible JSNA deep-dives

1. Childhood obesity
2. Dementia
3. Victims of crime
4. 'Harmful practices'
5. Anti-social behaviour and mental health
6. Offender health
7. Older people and housing
8. Disability
9. LGBT health
10. Shisha smoking
11. Workplace health
12. Betting shops
13. Church Street
14. Child sexual exploitation
15. Female genital mutilation
16. Intermediate care and rehab
17. Therapy services for children
18. Climate change adaptation
19. Village-based JSNAs

	London Borough of Hammersmith & Fulham **HEALTH & WELLBEING BOARD** **30 June 2014**
WORK PROGRAMME AND FORWARD PLAN 2014-2015	
Report of the Director of Law	
Open Report	
Classification - For Scrutiny Review & Comment **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: Jane West, Executive Director of Finance and Corporate Governance	
Report Author: Sue Perrin, Committee Co-ordinator	**Contact Details:** Tel: 020 8753 2094 E-mail: sue.perrin@lbhf.gov.uk

1. EXECUTIVE SUMMARY

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

2. RECOMMENDATIONS

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

3. INTRODUCTION AND BACKGROUND

3.1 The purpose of this report is to enable the Committee to determine its work programme for this municipal year 2014/15.

4. PROPOSAL AND ISSUES

4.1 A draft work programme is set out at Appendix 1, which has been drawn up, having regard to actions and suggestions arising from previous meetings.

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

5. OPTIONS AND ANALYSIS OF OPTIONS

5.1. As set out above.

6. CONSULTATION

6.1. Not applicable.

7. EQUALITY IMPLICATIONS

7.1. Not applicable.

8. LEGAL IMPLICATIONS

8.1. Not applicable.

9. FINANCIAL AND RESOURCES IMPLICATIONS

9.1. Not applicable.

10. RISK MANAGEMENT

10.1. Not applicable.

11. PROCUREMENT AND IT STRATEGY IMPLICATIONS

11.1. Not applicable.

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

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

LIST OF APPENDICES:

Appendix 1 - List of work programme items

Appendix 1

Hammersmith & Fulham Health & Wellbeing Board
Work Programme 2014/15

Agenda Item	
Meeting Date: 30 June 2014	
Whole System Integrated Care in Hammersmith & Fulham Joint Dementia Strategy 2014-2019: Development Summary NHS Health Checks 2013-2014 Tri-borough Public Health Report Joint Strategic Needs Assessment Programme	
Meeting Date: 8 September 2014	
Developing an approach to tacking Child Poverty Improving Immunisation Rates in Hammersmith & Fulham	
Meeting Date: 23 March 2015	
Joint Health & Wellbeing Strategy: Progress Review	