London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Agenda

Monday 8 September 2014
4pm
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 (Vice-chair)
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: 29 August 2014

London Borough of Hammersmith & Fulham

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8 September 2014

and future local need.

This report also includes information on the quality of primary care within the London Borough of Hammersmith and Fulham

6. MENTAL HEALTH TRANSFORMATION PROGRAMME

This report will follow.

7. CCG COMMISSIONING INTENTIONS 2015/2016 49 - 63

This presentation gives an overview of the West London CCG Contracting Intentions for 2015/16.

8. CHILDHOOD IMMUNISATION

This report will follow.

9. PHARMACEUTICAL NEEDS ASSESSMENT 64 - 74

This report sets out the progress being made by the Pharmaceutical Needs Assessment (PNA) Task and Finish Group to prepare a new PNA for the London Borough of Hammersmith and Fulham.

The report also seeks agreement from the Health and Wellbeing Board to undertake the statutorily required 60 day consultation on a draft PNA in the autumn.

ITEMS FOR INFORMATION

10. TRI-BOROUGH LEARNING DISABILITY ACTION PLAN 75 - 112

This Action Plan identifies the key priorities across the three Boroughs within this financial climate for improving the quality, quantity and choice of support for people with learning disabilities, and how this will be improved across the three boroughs in the following years.

11. JOINT STRATEGIC NEEDS ASSESSMENT 12 MONTH REVIEW 113 - 134

This report sets our progress being made against evidence set out in deep dive JSNAs published in early 2013.

12. HEALTH AND WELLBEING BOARD PLAN 135 - 154

This report sets out:

- A proposed approach for the Health and Wellbeing Board in relation to undertaken engagement in relation to its statutory functions; and
- Options for how the Health and Wellbeing Board could develop more effective engagement and communications across its areas of responsibility.

13. PROTOCOL FOR GOVERNING THE RELATIONSHIP BETWEEN THE LOCAL SAFEGUARDING CHILDREN BOARD AND THE HEALTH AND WELLBEING BOARD 155 - 163

This report provides the Hammersmith & Fulham Health and Wellbeing Board (H&WB) with an overview of the role and responsibilities of the Local Safeguarding Children Board (LSCB) for Hammersmith & Fulham, Kensington and Chelsea, and Westminster, and its priorities for 2014/15.

The report proposes that the H&WB agrees to a formal working

agreement between the Hammersmith and Fulham H&WB and the LSCB, as set out in the protocol included in Appendix A, to maximise opportunities to safeguarding children in the local area.

14. WORK PROGRAMME 164 - 168

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.

15. DATES OF NEXT MEETINGS

The Board is asked to:

(i) note that the dates of the meetings scheduled for the municipal year 2014/2015 are as follows:

10 November 2014
19 January 2015
23 March 2015

(ii) agree that future meetings will commence at 5pm
(iii) propose external venues for meetings.

London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Minutes

Monday 30 June 2014

PRESENT

Committee members:
Councillors Vivienne Lukey (Cabinet Member for Health and Adult Social Care (Chair) and Sue Macmillan (Cabinet Member for Children and Education)
Dr Tim Spicer, Chair of H&F CCG (Vice-chair)
Liz Bruce, Tri-Borough Executive Director of Adult Social Care
Andrew Christie, Tri—Borough Executive Director of Children's Services
Stuart Lines (Deputy Director of Public Health)
Jo Murfild, NHS England
Trish Pashley, H&F Healthwatch Representative

Other Councillors: Rory Vaughan

Officers: Paula Arnell (Senior Joint Commissioning Manager, Tri-borough), Colin Brodie (Public Health Knowledge Manager), Christine Mead, Holly Manktelow (Senior Policy Officer) and Sue Perrin (Committee Co-ordinator)

H&F CCG: Daniel Elkeles

1. MINUTES AND ACTIONS

RESOLVED THAT:

The minutes of the meeting held on 24 March 2014 be approved and signed as an accurate record of the proceedings.

2. APOLOGIES FOR ABSENCE

Apologies for absence were received from Ms Philippa Jones, Dr Susan McGoldrick and Dr Meradin Peachey.

3. DECLARATIONS OF INTEREST

Dr Tim Spicer declared an interest in respect of item 6, in that his GP practice was involved with Whole System Integrated Care in Hammersmith & Fulham.

4. MEMBERSHIP AND TERMS OF REFERENCE

RESOLVED THAT:

The Committee noted its membership and terms of reference.

5. APPOINTMENT OF VICE-CHAIR

RESOLVED THAT:

Dr Tim Spicer be appointed as Vice-Chair.

6. WHOLE SYSTEM INTEGRATED CARE IN HAMMERSMITH & FULHAM

Mrs Liz Bruce introduced the report, which provided an update on the Whole System Integrated Care (WSIC) programme in Hammersmith & Fulham. The WSIC programme was 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 centred vision of integrated care. NWL collectively had been awarded national pioneer status to drive this change programme.

The WSIC programme had co-produced with lay partners from across NWL the toolkit for integrated care. It had developed shared principles for co-production that would be adopted as WSIC was designed and implemented in Hammersmith & Fulham.

NWL's vision of WSIC was underpinned by three principles:

- people would direct their own care and support and receive the care they needed in their homes or local community;
- GPs would be at the centre of organising and co-ordinating people's care; and
- Systems would enable and not hinder the provision of integrated care.

Some of the practical steps necessary had already begun with the Better Care Fund, which required NHS and local authorities to pool health and care budgets together to commission and deliver more integrated care, to build on existing jointly commissioned services.

In developing Early Adopter proposals, outline implementation plans had been submitted in May 2014, with a presentation to a national and international Review Panel on 12 June 2014. The full business case would be developed by October 2014.

The presentation set out the overall profile of Hammersmith & Fulham and the type of population being targeted.

Dr Spicer drew attention to the importance of unpaid carers and the increasingly elderly population with long term conditions. The report outlined the work to combine health and adult social care, including: the formation of five GP networks in 2011; full take up by GP practices of the Integrated Care Pilot for Inner NWL and alignment of networks to multi-disciplinary groups; participation in the Shaping a Healthier Future programme and the

development of a local hospital model intrinsically linked to out of hospital and community provision; and the rolling out of System One to all GPs and the continued rolling out with Community Providers enabling information sharing.

Dr Spicer highlighted the Model of Care (Virtual Ward) set out graphically in the report, with the patient at the centre. Councillor Rory Vaughan noted the importance of service user involvement in developing proposals and the predominance of health care professionals at the first WISC workshop.

Dr Spicer responded by giving mental health development over the previous six months as an example of service user involvement. There were five major work streams, all with lay members and co-chairs. The report set out a number of ways in which people who use services had been involved in the development and delivery of the Out of Hospital and Local Hospital programmes. Mrs Bruce added that there were some 150 established lay partners in addition to engagement with Healthwatch and the Partnership Boards. This would bring about a change in the culture of commissioning services.

Councillor Vaughan queried how this diagram could be explained so that the public could understand why the service would work in that way. Mrs Bruce responded that the model was difficult to represent on paper. At a recent tri-borough workshop, reliance had been placed on a simple shared narrative of support for people in the community in a respectful and dignified way. However, in order to create a robust service, parts of adult social care and the NHS would be redesigned to transform health care provision, including GP provision.

Mrs Bruce noted the importance of commissioners and providers and GPs keeping messages simple and the need to articulate this message through people's journey through the system.

Members considered how people could be enabled to look after themselves by for example: medicine compliance; a health professional who co-ordinated a person's care; and a full session, maybe one hour with a GP, rather than just ten minutes.

The way in which health and care services worked needed to be redesigned into non-hospital, multi-organisation, multiple structures which incentivised all those different groups to work together with the patient at the centre.

The Chair concluded the discussion by noting the current objectives of providing the best Out of Hospital care and the significant challenges of a virtual ward.

RESOLVED THAT:

The Board noted the progress on the Whole System Integrated Care Programme in Hammersmith & Fulham.

7. JOINT DEMENTIA STRATEGY 2014-2019: DEVELOPMENT SUMMARY

Ms Paula Arnell introduced the report, which set out the intention to produce a joint dementia strategy across NWL.

Ms Arnell stated that dementia was an umbrella term for symptoms of diseases of the brain and that there were more than 40 different types of dementia illness. The National Dementia Strategy sought to address the impact on a person. It recommended that treatment should include suitable dementia medications and personal activity to help with health and well-being.

Hammersmith & Fulham provided dedicated dementia care, including Carers' respite services, Admiral Nursing and other dementia clinical support and a Memory Café.

Training programmes in dementia for Hammersmith & Fulham GPs had commenced in 2014 (delivered by West London Mental Health Trust).

The report set out the Tri-borough Dementia Strategic Aims.

The Chair queried the constraints to further improvements in diagnosis rates. Ms Arnell responded that there was very little understanding of what was available post diagnosis. A lot of support was required. There were issues in respect of staff training to recognise dementia and early investigation. Dr Spicer considered that there were missed opportunities: a lack of confidence in GPs, time delays and lack of understanding in respect of what the diagnosis meant. In addition, GPs were not always first point of contact.

The Chair queried how the strategy addressed these issues. Ms Arnell responded that the strategy included the provision of information such as dementia guides in GP surgeries and other places and on websites, including links from health to social care websites, and linked to other forms of communication.

The requirement for an Equalities Impact Assessment was noted.

The Chair queried how the discussion would be continued with residents. Ms Arnell responded that Dementia Services would continue to work with Healthwatch and other forums across the tri-borough. Consultation on the strategic work and the dementia JSNA would take place throughout the development with all stakeholders.

Dr Spicer stated that dementia was a long term condition and must be brought into normal business, not separated, for example vascular related dementia could be identified through blood pressure checks.

Stuart Lines noted the importance of NHS health checks in screening out risk.

RESOLVED THAT:

The report be noted.

8. NHS HEALTH CHECKS

Ms Christine Mead introduced the report on NHS Health Checks, a mandatory Public Health Service.

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

The Department of Health had set targets for 20% of the eligible population to be invited for health checks each year. From April 2013 to March 2014, 2336 health checks had been delivered (6% of eligible population against a target of 10%).

Uptake of offers was currently running at 28%. An Improvement Plan based on best practice guidance from Public Health England and from local GP practices, which were championing health checks, had been put in place to increase take up.

7.6% of those receiving checks had been identified as a high risk and 24.3% as having a moderate risk.

Practices would be encouraged to invite older patients, smokers, men and populations known to be at higher risk of cardiovascular disease as a priority. Health trainers had been commissioned to deliver more health checks in areas of deprivation, where there was a higher prevalence of cardiovascular disease and in homeless hostels. Pharmacies had been commissioned to deliver health checks in areas of deprivation.

For every risk factor identified, patients had been given information about services they could access to reduce their risk, and direct referrals to services where the patient takes up the referral.

Officers suggested different ways of communication and access to improve uptake and helping people to make lifestyle changes, for example a health bus outside the supermarket which would offer tests on the spot.

An analysis of reaching certain ethnic groups was suggested and also that the third sector had contacts with some of the groups about which there was most concern.

RESOLVED THAT:

(1) The Board noted the report.

(2) An update report be brought to a future meeting.

9. 2013-2014 TRI-BOROUGH PUBLIC HEALTH REPORT

Mr Stuart Lines introduced the report which provided a snapshot of the health of people who lived in tri-borough, identified some of the local public health priorities and described some of the current projects designed to improve the health and wellbeing of local people.

There was no significant difference in life expectancy for men and women living in Hammersmith & Fulham compared to the rest of London and England. Whilst many residents were affluent, there were significant areas of poorer health in the more deprived parts of the borough and therefore large health inequalities between rich and poor.

The major causes of death and diseases locally were the same as those across the country, the biggest killer being cancer, heart disease and respiratory disease, with liver cancer being a significant cause of death. There were a number of causes of death and disease which were bigger problems in tri-borough than in other parts of the country, including poor air quality, tuberculosis and HIV/AIDs.

The report set out the areas of focus for public health for the following year and a number of specific steps that Tri-borough Public Health would be taking over the next year to support innovative public health initiatives.

RESOLVED THAT:

The Board noted the report.

10. JOINT STRATEGIC NEEDS ASSESSMENT PROGRAMME

Mr Colin Brodie introduced the report, which asked the HWB to agree which topics should be prioritised for deep-dive JSNAs in the 2014-2015 JSNA programme. The central part of the programme was 'deep-dive' JSNAs which looked at specific aspects of the population's health.

RESOLVED THAT:

(1) The Board approved the JSNA Steering Group's recommendation to conduct JSNA 'deep-dives' into:

- childhood obesity
- older people's housing needs
- dementia

(2) The Board recommended that a variety of stakeholders with responsibility for implementing the recommendations be identified.

11. WORK PROGRAMME

RESOLVED THAT:

(1) A more detailed work programme would be brought to the next meeting.

(2) Reports should be supplemented by 'patients stories'.

(3) Different meeting venues should be considered.

12. DATES AND TIMES OF NEXT MEETINGS

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

Meeting started: 5.00 pm
Meeting ended: 6.30 pm

Chairman .....

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	London Borough of Hammersmith & Fulham **HEALTH AND WELLBEING BOARD** **8th September**
PRIMARY CARE COMMISSIONING IN LONDON BOROUGH OF HAMMERSMITH AND FULHAM	
Report of NHS England	
Open Report	
Classification: For Discussion **Key Decision:** No	
Wards Affected: All	
Accountable Executive Director: N/A	
Report Author: Karen Clinton, Head of Primary Care North West London, NHS England (London Region)	**Contact Details:** Tel: n/a E-mail: karen.clinton@nhs.net

1. EXECUTIVE SUMMARY

1.1. This report sets out the role and responsibilities of NHS England (NHSE) and others in primary care commissioning and asks the Health and Wellbeing Board to consider how they should seek to support and influence primary care commissioning to ensure that it reflects current and future local need.

1.2. This report also includes information on the quality of primary care within the London Borough of Hammersmith and Fulham

2. RECOMMENDATIONS

2.1. It is recommended that the Health and Wellbeing Board review and consider the three attachments to this paper relating to the commissioning, and quality, of local primary care services and consider:

a.) how the Health and Wellbeing Board should seek to support and influence primary care commissioning to ensure it reflects local need, when exercising their role in providing local system leadership.

b.) Whether the Health and Wellbeing Board can work with NHSE and CCGs to monitor and improve the quality of primary care

c.) how to maximise the opportunities that might be available through the introduction of co-commissioning of primary care services between NHSE and CCGs

3. REASONS FOR DECISION

3.1. The Health and Social Care Information Centre suggests that around 90% of patient interaction is with primary care services. As such, access to good quality, primary care is absolutely central to improving the health outcomes for our local population and to the deliverability of our key local system change programmes such as Shaping a Healthier Future, whole systems integration and the Better Care Fund Plan.

4. INTRODUCTION AND BACKGROUND

4.1. Primary care services are many people's first point of contact with the NHS. The main source of primary health care is general practice, but primary care also includes dental practice, community pharmacy and high street optometrists.

4.2. The Health and Social Care Act 2012 made a number of changes to the way that primary care is commissioned. Since April 2013, NHSE has been solely responsible for the commissioning of primary care services. Clinical Commissioning Groups have a responsibility to help improve the quality of primary care services

5. PROPOSAL AND ISSUES

5.1. The PowerPoint presentation attached at Appendix 1 to this report set out more information about how primary care commissioning is undertaken by NHSE and what future changes might look like. It also considers how NHSE engages with the local health and care system and what work will be underway in 2014/15.

5.2. The reports attached Appendices 2 and 3 provide information on the current quality of primary care services in Hammersmith and Fulham

6. OPTIONS AND ANALYSIS OF OPTIONS

6.1. Health and Wellbeing Boards, as local system leaders, should develop strong relationships with NHSE to help ensure that primary care services within their area align with the needs of residents and local system change. The report attached at Appendix 1 will provide an opportunity for the Health and Wellbeing Board to consider how it may support NHSE better to ensure that the provision and quality of local primary care is aligned with the need of the local population and that it reflects local system change.

7. CONSULTATION

7.1. N/A

8. EQUALITY IMPLICATIONS

8.1. N/A

9. LEGAL IMPLICATIONS

9.1. N/A

10. FINANCIAL AND RESOURCES IMPLICATIONS

10.1. N/A

11. RISK MANAGEMENT

11.1. N/A

12. PROCUREMENT AND IT STRATEGY IMPLICATIONS

12.1. N/A

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: A PowerPoint Presentation from NHS England: London Primary Care Commissioning

Appendix 2: A PowerPoint presentation report from NHS England on the quality of primary care in the London Borough of Kensington and Chelsea

Appendix 3: A report from Tri-borough Adult Social Care Business Intelligence on acute and GP services within the London Borough of Hammersmith and Fulham

London Primary Care Commissioning

THE NHS CONSTITUTION
the NHS belongs to us all

Plan on a page 2014/15 onwards

NHS England

Vision

Primary care services that consistently provide excellent health outcomes to meet the individual needs of Londoners

Form

Objective One
Co-ordinated Care

Objective Two
Proactive Care

Objective Three
Accessible Care

Function

Objective Four
Collaborative models of delivery

Quality Standards and Outcomes
- Ensuring consistency of service across London
- Performance management

Premises
- Making best use of the assets available
- Borough based strategic planning to inform investment decisions

Workforce
- Ensure the services we commission maintain a diverse workforce that supports collaborative 24/7 working

Technology
- Joined up working that meets the needs of patients
- Integrated systems and better data sharing

Commissioning and contracting
- Managing the provider landscape
- Redesigning incentives
- Primary care contract that delivers national consistency which enables programme of change in local context

Stakeholder engagement
- Ensuring ongoing engagement of patients, healthcare providers and other key stakeholders in service design and programme of change

Change management
- Organisation design
- Clinicians and organisations collaborating to deliver integrated care for patients

Governance arrangements
- Overseen by the Primary Care Programme Board
- Borough based accountability – via the SPGs?

Success criteria
- Enables effective delivery of out of hospital care
- Demonstrable improvement in:
  - Outcome standards across all London CCGs
  - Public confidence in NHS England's ability to address and act upon poor quality (premises, clinicians, systems)
- Ensuring fast, responsive access to care and preventing avoidable emergency admissions and A&E attendances.
- Primary care system that prevents ill health and supports healthy lifestyle choices
- Patients and stakeholders are at the heart of commissioning decisions

High level risks to be mitigated
- Information governance – linking IT systems across different organisations involved in the pathway.
- Engagement with key stakeholders will be crucial to ensuring the success of this strategy
- Finance – investment required to support the transformational change over the next 5-7 years

Six High-Level National Objectives

General practice will play a much stronger role, as part of a more integrated system of out-of-hospital care. It will need to work on a more systematic, collaborative basis with community health services, social care, voluntary/community organisations, community pharmacy and other partners.

Six underlying objectives for general practice:

1. **Proactive co-ordination of care** (or anticipatory care), particularly for people with long term conditions and more complex health and care problems.
2. **Holistic care**: addressing people's physical health needs, mental health needs and social care needs in the round.
3. Ensuring **fast, responsive access to care** and preventing avoidable emergency admissions and A&E attendances.
4. Promoting health and wellbeing, **reducing inequalities and preventing ill-health** and illness progression at individual and community level.
5. **Personalising care** by involving and supporting patients and carers more fully in managing their own health and care.
6. Ensuring consistently **high quality and value of care**: effectiveness, safety and patient experience.

Commissioning Primary care for the local systems in London

- Currently NHS England (NHSE) is solely responsible for commissioning primary care services. However we don't do this in isolation and we have an agreed process of consultation which takes into account local stakeholders.

- NHSE London primary care does not work to a single strategy for primary care commissioning. We have an agreed framework for improving primary care performance and for decision making around commissioning and decommissioning of services but the final decisions about commissioning are made within the context of the local health economy. For North West London (NWL) this means taking account of Shaping a Healthier Future (SaHF) and NHSE officers work closely with CCGs to ensure commissioning decisions support the SaHF ambitions.

- Co-commissioning with CCGs will formalise this arrangement and ensure primary care commissioning has a cohesive and transparent framework from which to make commissioning decisions. The development of co commissioning sits with the CCGs as they must decide what level of responsibility they wish to take on. NHSE will work with CCGs to develop the governance around their chosen model.

Model for decision making when a practice closes.

Over recent years on average the number of practices that close their contracts in NWL has been 4-5 each year (less than 1 per borough). With the current emphasis on improving the quality of primary care and the significant shift in demand that primary care providers are dealing with it is possible that this number could increase. Funding from practices that close is always recycled back into primary care but this can be done in one of two ways either of which can be right for a specific practice population.

1. Dispersal of the list
2. Procurement

A range of factors is taken into account when making the final recommendation, these include

- The views of all stakeholders (patients, OSC, health-watch, CCGs and others as identified, although the patient views are always paramount)
- Local out of hospital strategy, including the ned to co-locate services etc (for NWL this is SaHF)
- Condition and quality of available estate
- Quality and capacity of provision nearby
- Any unique needs of the local population
- Any other specific local issues, for example the impact of the decision on other local practices.

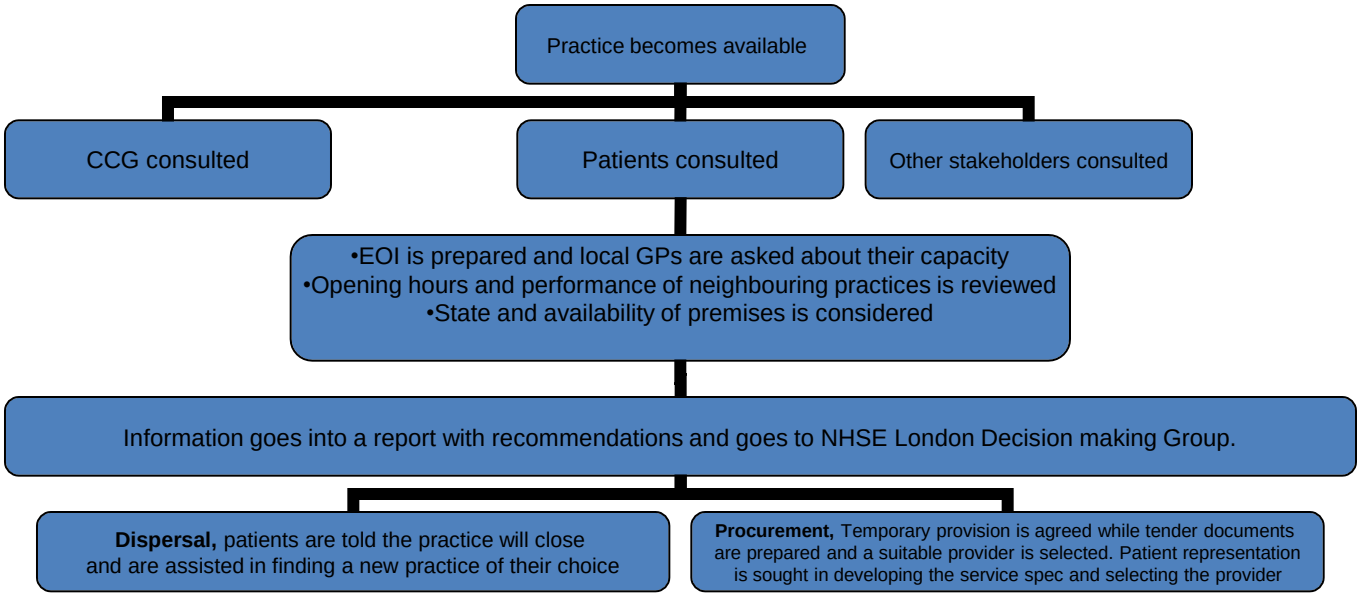
There is a nationally agreed standard around the time given to consult after which a paper is presented to the London Primary Care Decision Making Group (DMG) with recommendations.

Commissioning a GP Practice.

New contacts can only be let when a current practice contract becomes available. There are two options when this happens, to disperse the list or procure a new contract. There are benefits to both and both options are considered within the context of other available provision and local need.

Dispersal: Often small practices are not able to offer patients the full range of services that are available in larger practices and opening hours are less flexible. By dispersing the list neighbouring practices are able to expand and the extra funding that follows the patient can support the development of more comprehensive services in these practices.

Procurement: This would be the option of choice when the list is too large to safely disperse, the neighbouring practices have no capacity to expand or there are unique needs of a specific population that need addressing.



Payment mechanisms for GPs

There are three contract types available for the provision of GP services:

1. GMS: this is the national contract and is predominantly funded by the patient list, practices are paid a fixed price for the number of patients they have on their list (circa £66). This is nationally agreed each year. In addition practices are reimbursed for certain infrastructure such as IT and premises. Finally practices can increase their income by providing extra services usually called 'enhanced' services such as minor surgery. GMS contracts have no end date and only become vacant if the partner/s retires or relinquishes their contract. The contract holder must be a GP.
2. PMS: this contract is locally negotiated and again the main source of funding is the patient list. However the price per patient is agreed based on local factors to recognise the particular needs of the population. In NWL this price ranges from £65 to £135. PMS contracts usually have additional KPIs to recognise local need. These contracts have the opportunity for additional funding as above. Again there is no end date to these contracts but NHSE is able to give notice to terminate or vary these contracts if required. The contract holder does not need to be a GP although GPs must be employed in the practice.
3. APMS: this contract is also locally negotiated and has similarities to the PMS contract in terms of how they are funded. However infrastructure costs are normally wrapped up into the price. APMS contracts are tendered with an end date (normally 5-10 years depending on the service) and also frequently have additional services that would be offered to the wider population. An example would be a practice that also had a walk in centre. The contract holder does not need to be a GP although GPs must be employed in the practice.

Personal Medical Services (PMS) reviews (currently on hold awaiting national decision)

Nationally we said…	**1. NHS England will seek to align PMS contracts with local emerging primary care strategies arising from discussions informed by 'a call to action' to achieve better access and better outcomes for patients, and offering best value for money** **2. NHS England will be engaging with PMS practices and their representatives to seek to agree the best way forward for PMS contracts, taking into account the results of the desktop review and contract disaggregation exercise undertaken by area teams in August 2013**
In London this means:	1. Review of all PMS contracts for size and volume to align to national process. The preferred model is for larger / federated PMS contractors to bring benefit and economies of scale 2. Once reviewed, PMS contracts should be aligned to ensure consistency of service and access. The premium will be aligned to the London 'standards'.

Locally in North West London this means… **Ensuring any premium is also offered to GMS practices to create parity.** **Ensuring any premium deducted from higher rate practices is reinvested into primary care in NWL.**	
Inner – Central, West London, Hammersmith & Fulham, Hounslow, Ealing	60 PMS contracts Average £95.29 per weighted patient Previous reviews: Hounslow in 2010 – a range core requirements and optional premium services introduced KCW reviewed premium enhanced services introduced

Alernative Provider Medical Services (APMS)

Nationally we said…	**1. NHS England will be engaging with APMS practices and their representatives to seek to agree the best way forward for APMS contracts, whilst understanding the impact of closures of these centres on patients and on choice and competition.**
In London this means:	1. London Region is systematically reviewing its time limited APMS contract portfolio which includes 73 primary medical services and 24 GP Led Health Centres. 2. The review is being undertaken with CCGs in the case of GP Led Health Centres, in recognition of the shared commissioning responsibility and London Region intends uncouple the unscheduled care element of these contracts. 3. The result of these reviews is that contracts will either continue, or be re-procured, renegotiated or terminated, as appropriate. 4. London, in collaboration with NHS England National Primary care Support Team, is developing a standard APMS contract. This will include a standard specification, price per weighted patient and KPIs for London. Once complete, this will be used to ensure consistency across new APMS contracts within London – both in terms of quality and access to services. 5. Any significant changes to services , both in terms of access and services provided will be subject to appropriate consultation and engagement of key local stakeholders and Equality Impact Assessments
Locally in NWL this means:	The re commissioning of APMS contracts in NWL must be aligned with the SaHF programme. We have a schedule of when contracts are due for renewal and work closely with the CCGs to decide what is required before going out to the market.

Improving performance

- There is a rolling programme to tackle the bottom 10% of practices in London as defined by the quality Outcome Framework (QOF), High Level Indicators (HLI) and the GP Outcome Standards (GPOS)
- Under these measures 39 practices across NWL have been identified for review.
- The Primary care performance team are working with practices to develop improvement plans.
- Exit strategies will be developed for those practices not able to improve
- Close liaison with CCGs to ensure any market opportunities this creates reflects SaHF strategic and transformation plans
- There is a London wide quality and governance system to ensure consistent approach across London
- There is a 5 year aspiration to raise the number of achieving and higher achieving practices in line with or better than the national average.

Premises

Nationally we said…	**1. We are developing a strategic framework to support joint work with healthcare providers, CCGs, local authorities and other community partners to ensure that local strategies for out-of-hospital care include appropriate strategies for premises development.** **1. NHS England will work with other commissioners and with healthcare providers and premises providers (including NHS Property Services Ltd, Community Health Partnerships and LIFT companies) to promote more effective use of current primary care estate, including ways to improve utilisation of current properties. NHS England will seek to develop an abatement policy to ensure that payments made under the GP rent and rates scheme appropriately support primary medical services; understanding the range of non-core services currently reimbursed under the Premises Directions and how these should be managed in the future.**
Locally in London this means:	1. NHS England will need to work with partners, including healthcare providers, CCGs, Local Authorities and community partners to develop the premises required to deliver the primary care element of out of hospital strategies 2. In 14/15, this will require scoping around the needs for premises across the London region, taking into account the future changes planned for primary care and the out of hospital agenda. This will include an assessment of the space required, in what location and with what equipment to deliver the strategy. It should also link to facilities requirements and potential IT solutions, to provide a single premises strategy for the future of primary care 3. Additional consideration will need to be given to the best way to procure space, both within an expensive property market in London and the long term risks associated with building and maintaining property.
For NWL this means:	For NWL our proposal is to work with CCGs and NHSPS to agree a 5 year premises estates strategy which will be managed via a steering group acting as a gateway for schemes going to FIPA.

The benefits of working with H&WBB

The Health and Wellbeing Board, may like to consider:

1. How the Health and Wellbeing Board should seek to support and influence primary care commissioning to ensure it reflects local need, when exercising their role in providing local system leadership

1. How the Health and Wellbeing Board can work with NHSE and CCGs to monitor and improve the quality of primary care

2. How to maximise the opportunities that might be available through the introduction of co-commissioning of primary care services between NHSE and CCGs

NHS Hammersmith & Fulham CCG Primary Care Data Analysis

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gary.williams3@nhs.net

18th August 2014

Purpose of this report

- To present Hammersmith & Fulham H&WBB with an overview of Primary Medical Services:

1. General Practice Outcome Standards (GPOS) and General Practice High Level Indicators (GPHLI)
2. National GP Patient Survey (GPPS)
3. Quality and Outcomes Framework (QOF)

GLOSSARY OF TERMS

The General Practice Outcome Standards (GPOS) and General Practice High Level Indicators (GPHLI) represent the minimum patients can expect to receive from general practice and form part of a suite of products designed to support and improve primary care in London, covering areas such as screening, diagnosis and patient experience.

The GP Patient Survey is an independent survey run by Ipsos MORI on behalf of NHS England. The survey is sent out to over a million people across the UK. The results show how people feel about their GP practice.

The Quality and Outcomes Framework (QOF) is the annual reward and incentive programme detailing GP practice achievement results. QOF was introduced as part of the GP contract in 2004.QOF awards surgeries achievement points for managing some of the most common chronic diseases e.g. asthma, diabetes; how well the practice is organised; how patients view their experience at the surgery; the amount of extra services offered such as child health and maternity service

GPOS and GPHLI

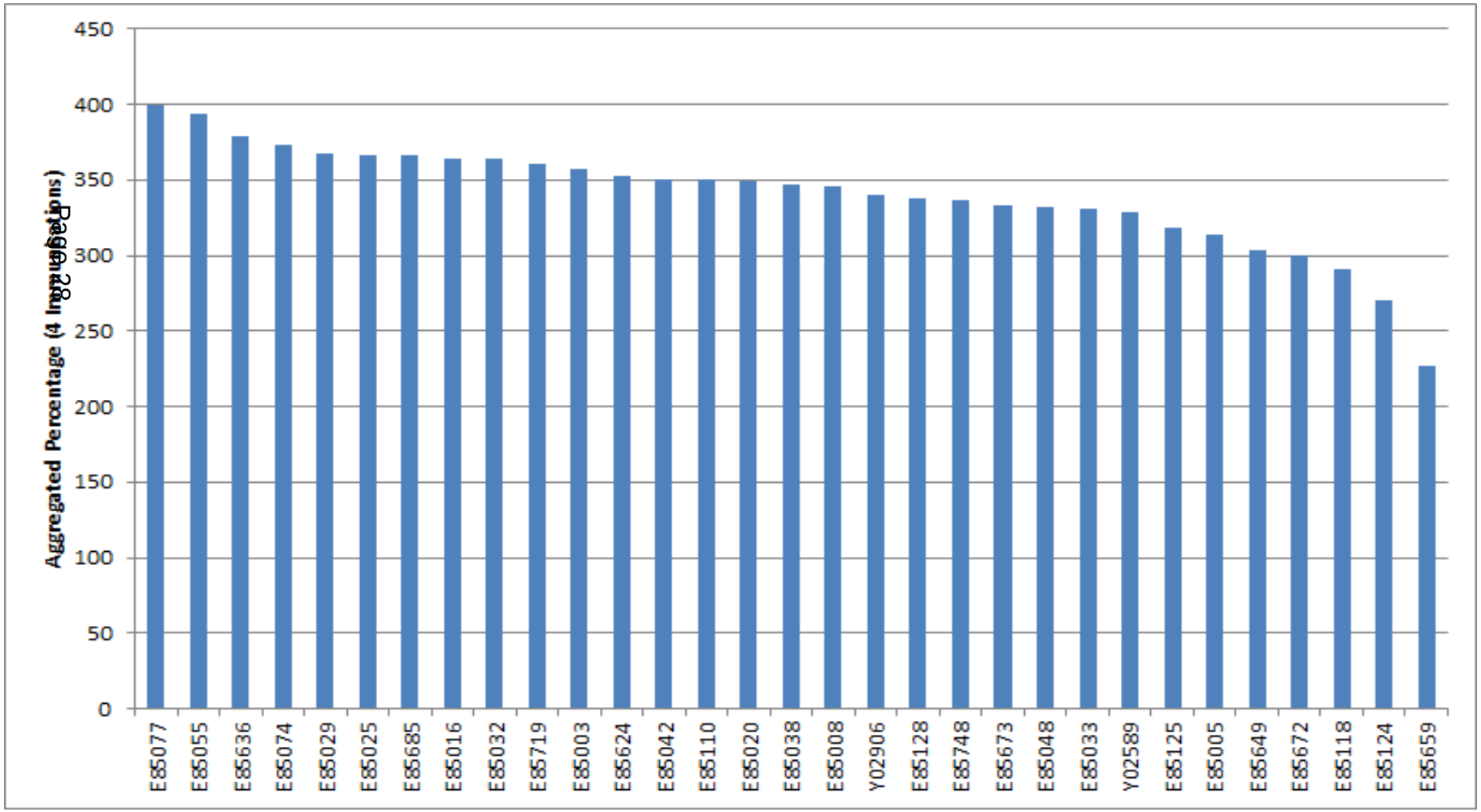
- General Practice Outcomes Standards (GPOS) Headlines for Hammersmith and Fulham
- Indicator Specific Practice level charts

GPOS headlines for NHS Hammersmith & Fulham CCG: Percentage of GP practices in each achievement category

- **August 2014:**
  - 31 Practices
  - 0 practices higher achieving (0%)
  - 5 practices achieving (16%)
  - 14 practices approaching review (45%)
  - 12 practices review identified (39%)
- **December 2013:**
  - 31 Practices
  - 0 practices higher achieving (0%)
  - 4 practices achieving (13%),
  - 19 practices approaching review (61%)
  - 8 practices review identified (26%)
- **Significant changes:**
  - The proportion of achieving practices has **increased** from December 2013 (13%) to August 2014 (16%)
  - Review Identified practices has increased from 26% to 39%.

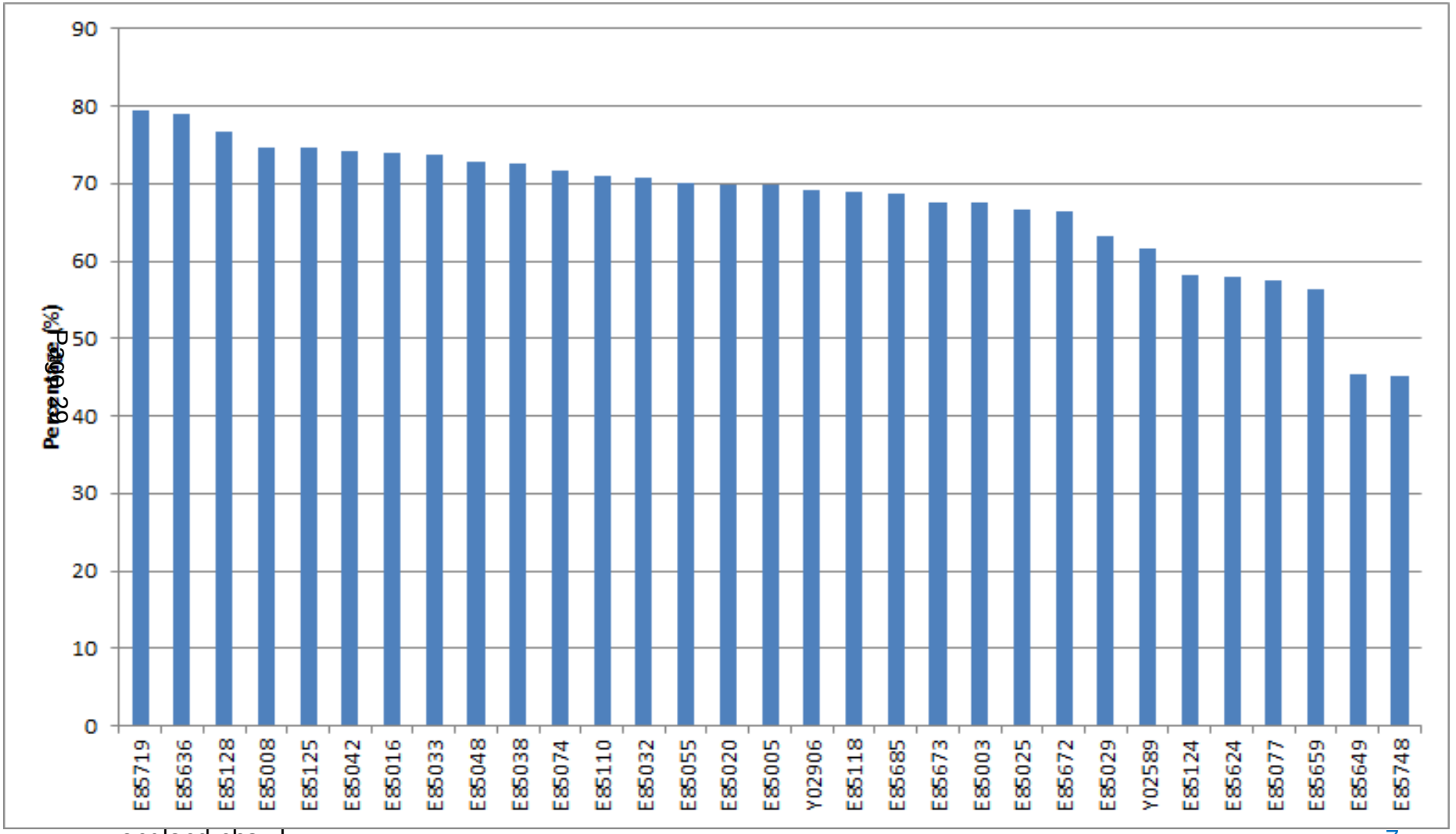
GPOS: Childhood Immunisation Practice Level, NHS Hammersmith & Fulham CCG Practices, Q4 2011/12

The aggregated percentages of a range of completion rates of immunisations for children by ages 1 and 2.



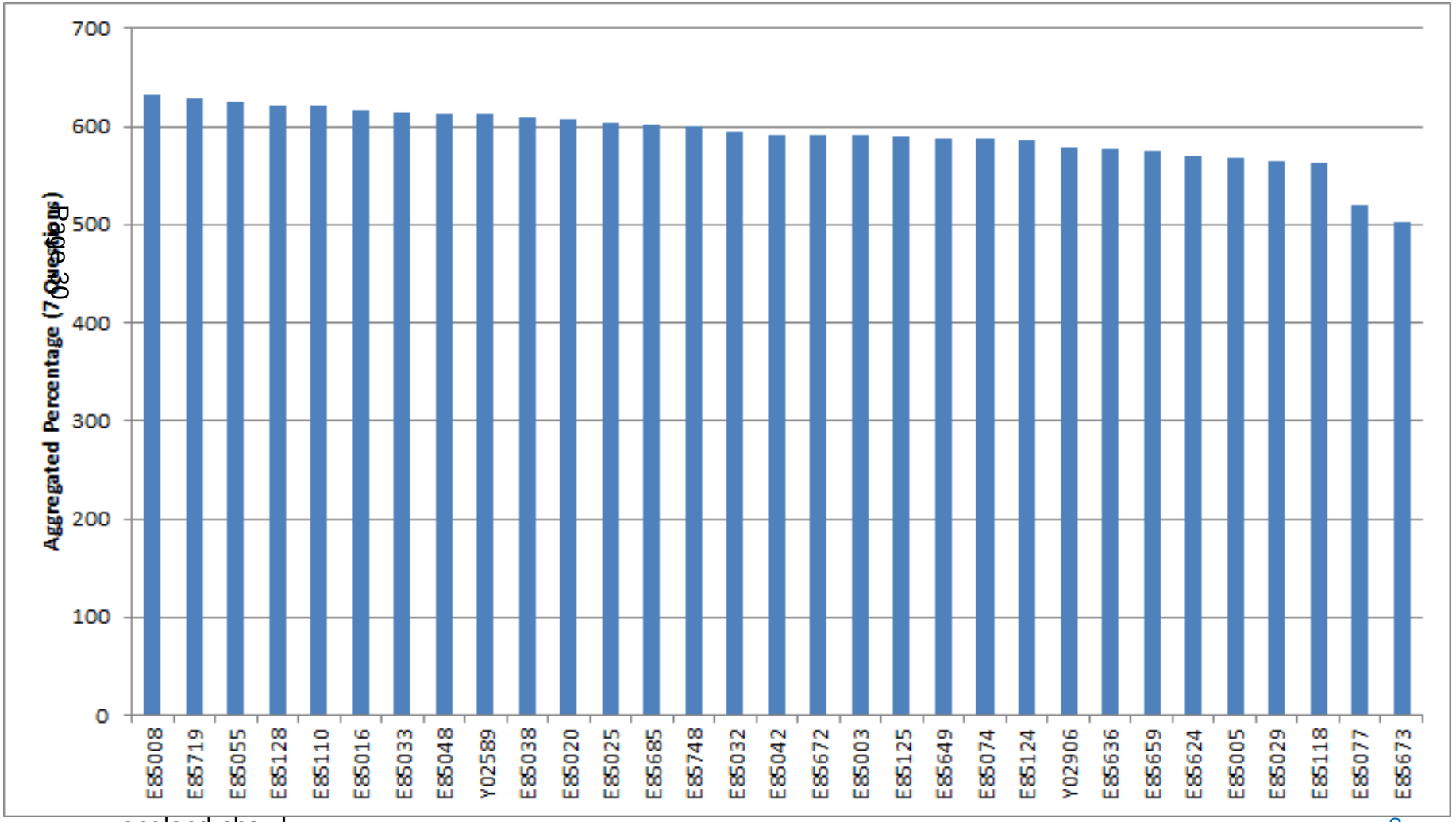
GPOS: Cervical Cytology Practice Level, NHS Hammersmith & Fulham CCG Practices, Q2 2013/14

The percentage of women aged from 25 to 64 whose notes record that a cervical smear has been performed in the past five years.



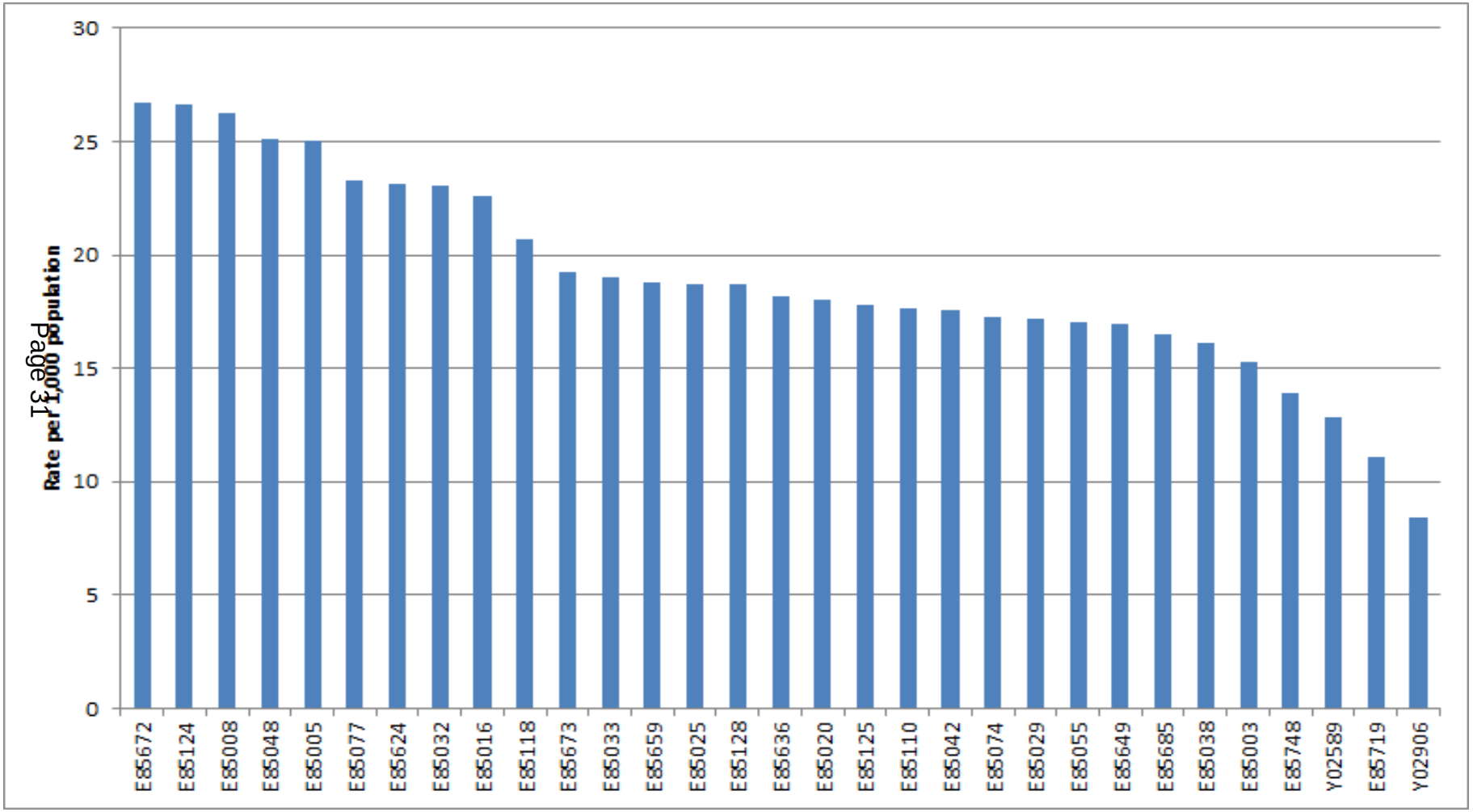
GPOS: Patient Satisfaction (Quality) Practice Level, NHS Hammersmith & Fulham CCG Practices, Q4 2013/14

The aggregated percentage of patients gave positive answers to selected questions in the GP survey about their satisfaction with overall care received.



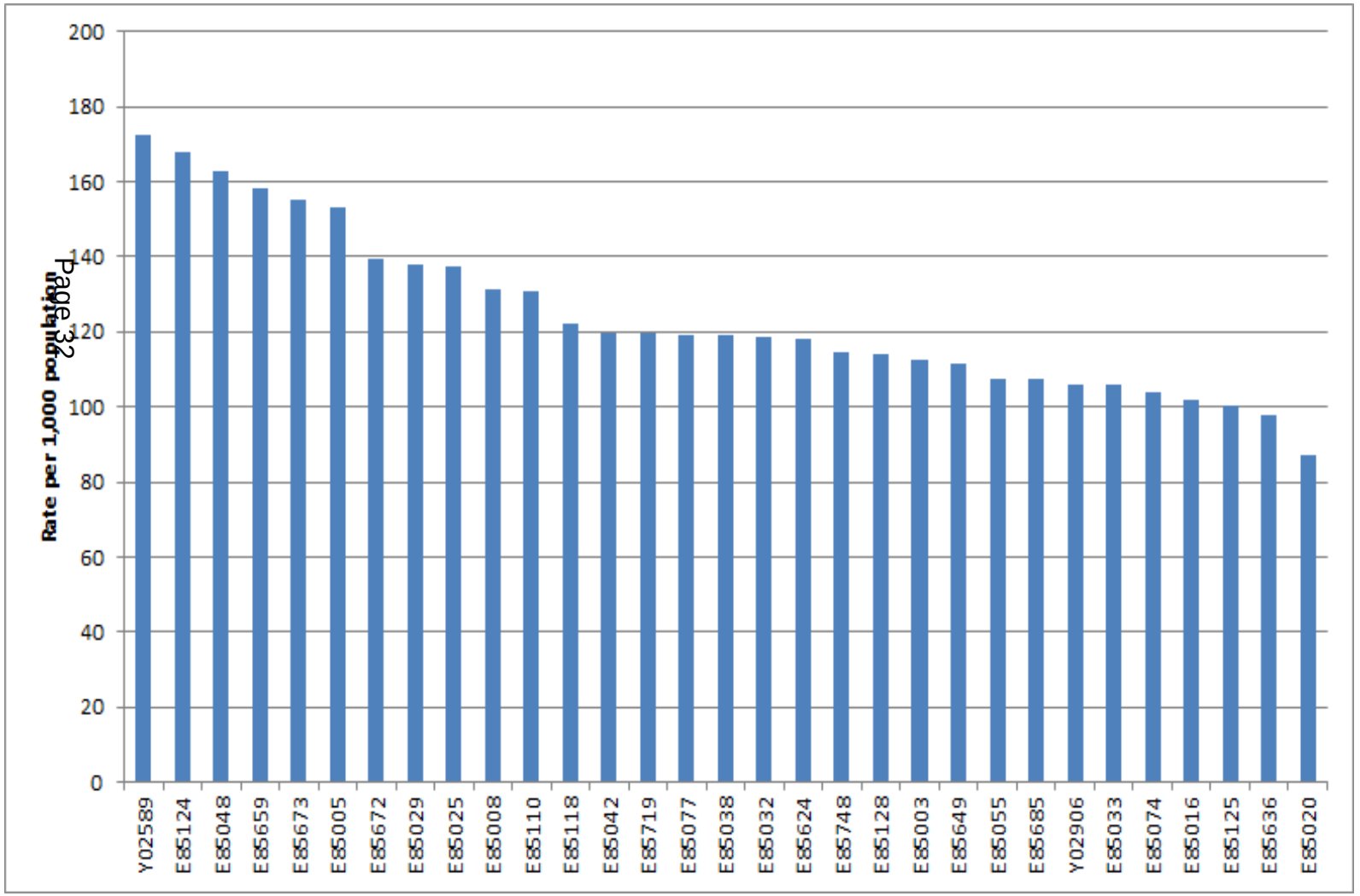
GPOS: Emergency Admissions Practice Level, NHS Hammersmith & Fulham CCG Practices, Q3 2013/14

Rate of emergency hospital admissions for selected long term conditions as a proportion of total number of patients per GP practice.



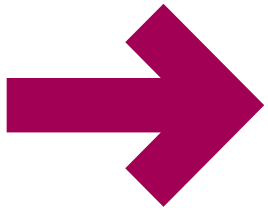
GPOS: A&E Attendances Practice Level, NHS Hammersmith & Fulham CCG Practices, Q3 2013/14

The rate of A&E attendances per 1000 patients on GP practice register

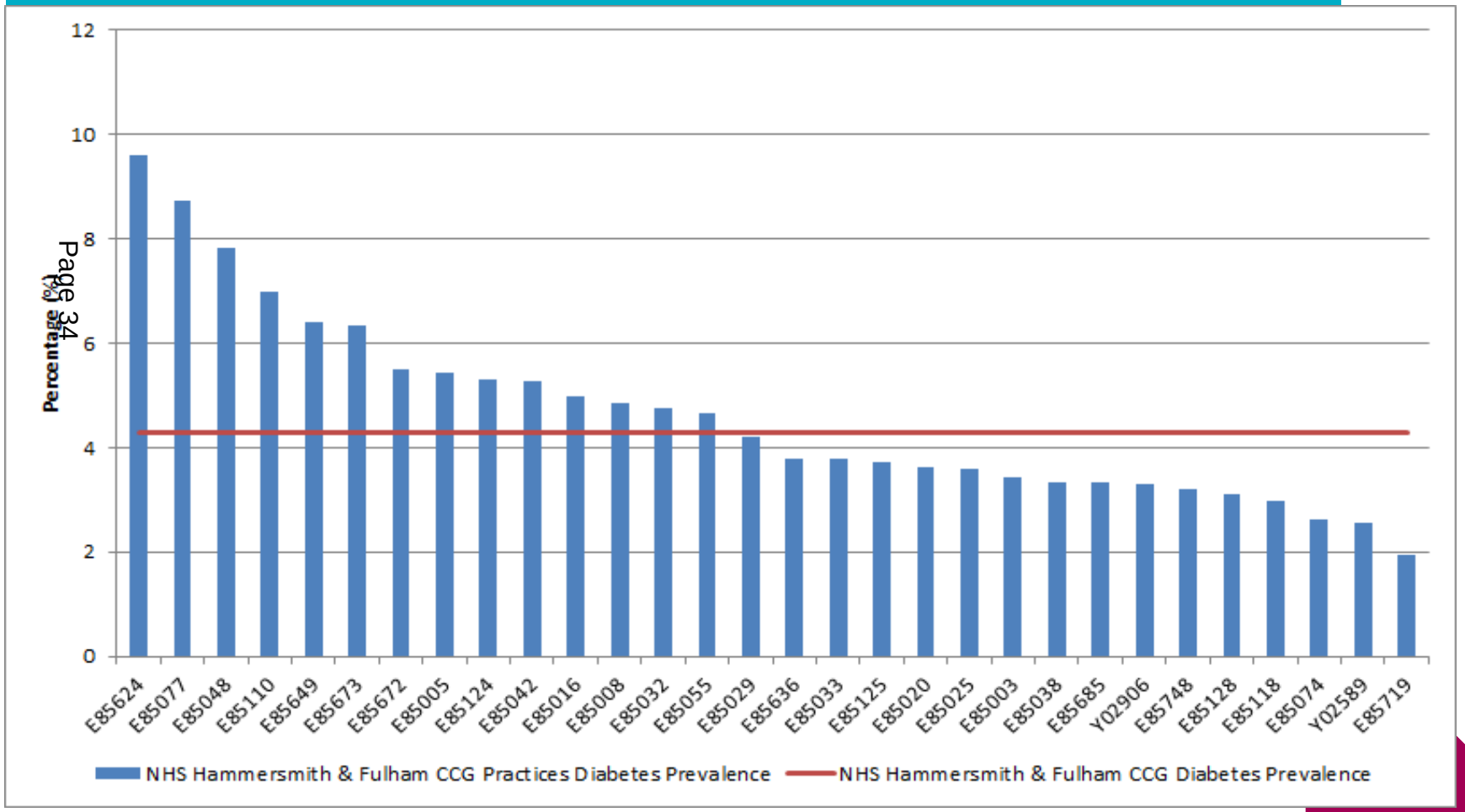


Diabetes in NHS Hammersmith & Fulham CCG

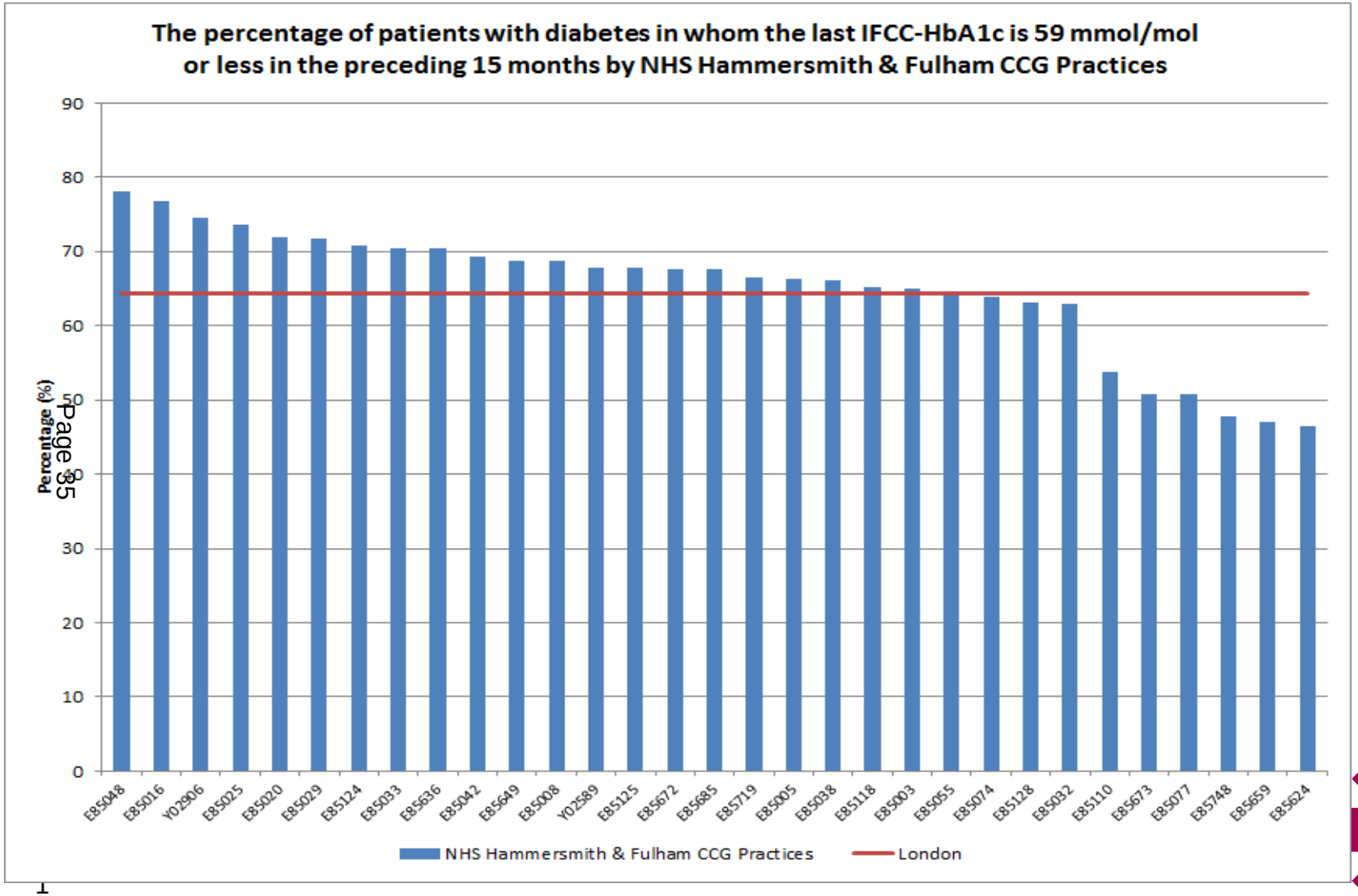
- Prevalence of Diabetes
- Diabetes Care Processes



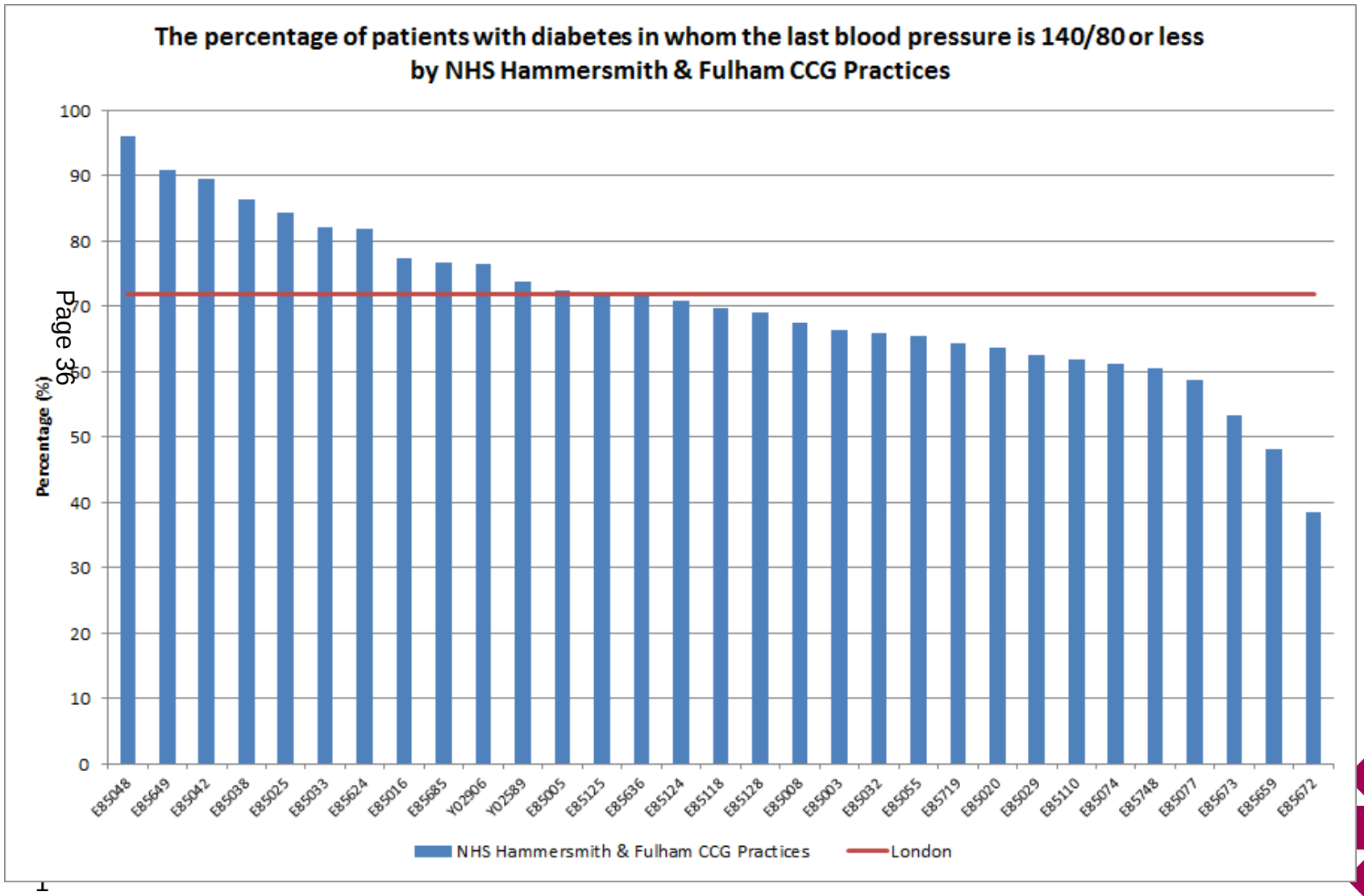
Diabetes Prevalence (17+) Practice level, NHS Hammersmith & Fulham CCG Practices, QOF 2012/13



Diabetes Care Processes – Cholesterol Measurement



Diabetes Care Processes – Blood Pressure Measurement



GP Patient Survey

- Summary
- NHS Hammersmith and Fulham CCG Comparison with London & England
- Survey question breakdown by NHS Hammersmith and Fulham CCG practices

GP Patient Survey July 2013-March 2014: Headlines for NHS Hammersmith and Fulham CCG

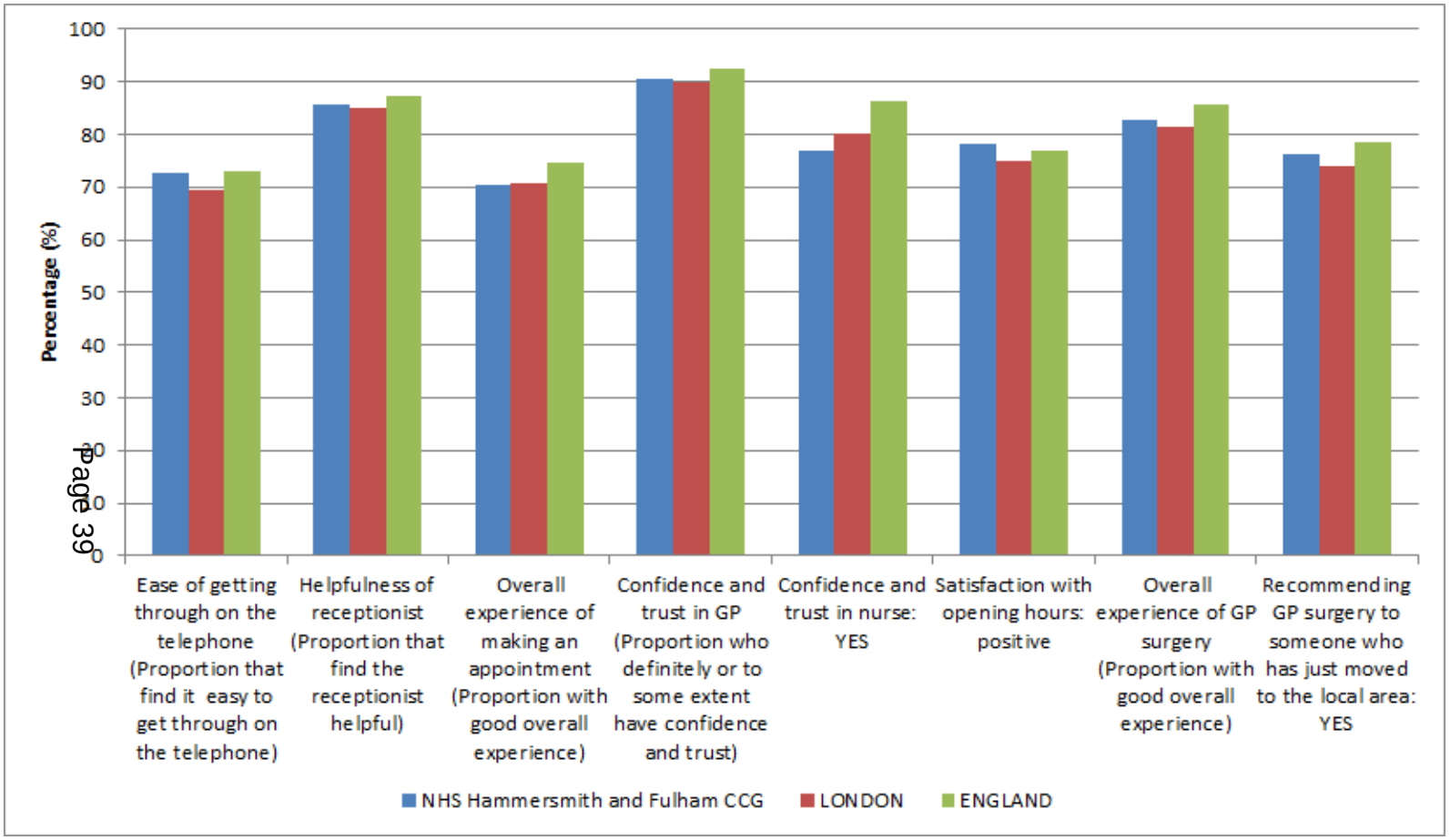
- Across 8 selected questions which were analysed, NHS Hammersmith and Fulham CCG response was **higher** than both the London and England average for the % of patients who were satisfied with the opening times of their surgery. The % of patients in NHS Hammersmith and Fulham CCG (78.1%) who were satisfied with their surgery opening hours was higher than in London (74.9%) and England (76.9%).

- The largest variation between NHS Hammersmith & Fulham CCG and London occurred for the % of patients who found it easy to get through on the telephone (72.6% in NHS Hammersmith and Fulham CCG compared with 69.3 % in London)

- The largest variation between NHS Hammersmith & Fulham CCG and England occurred for the % of patients who had trust in their Nurse (77% in NHS Hammersmith and Fulham CCG compared with 86.2 % in England)

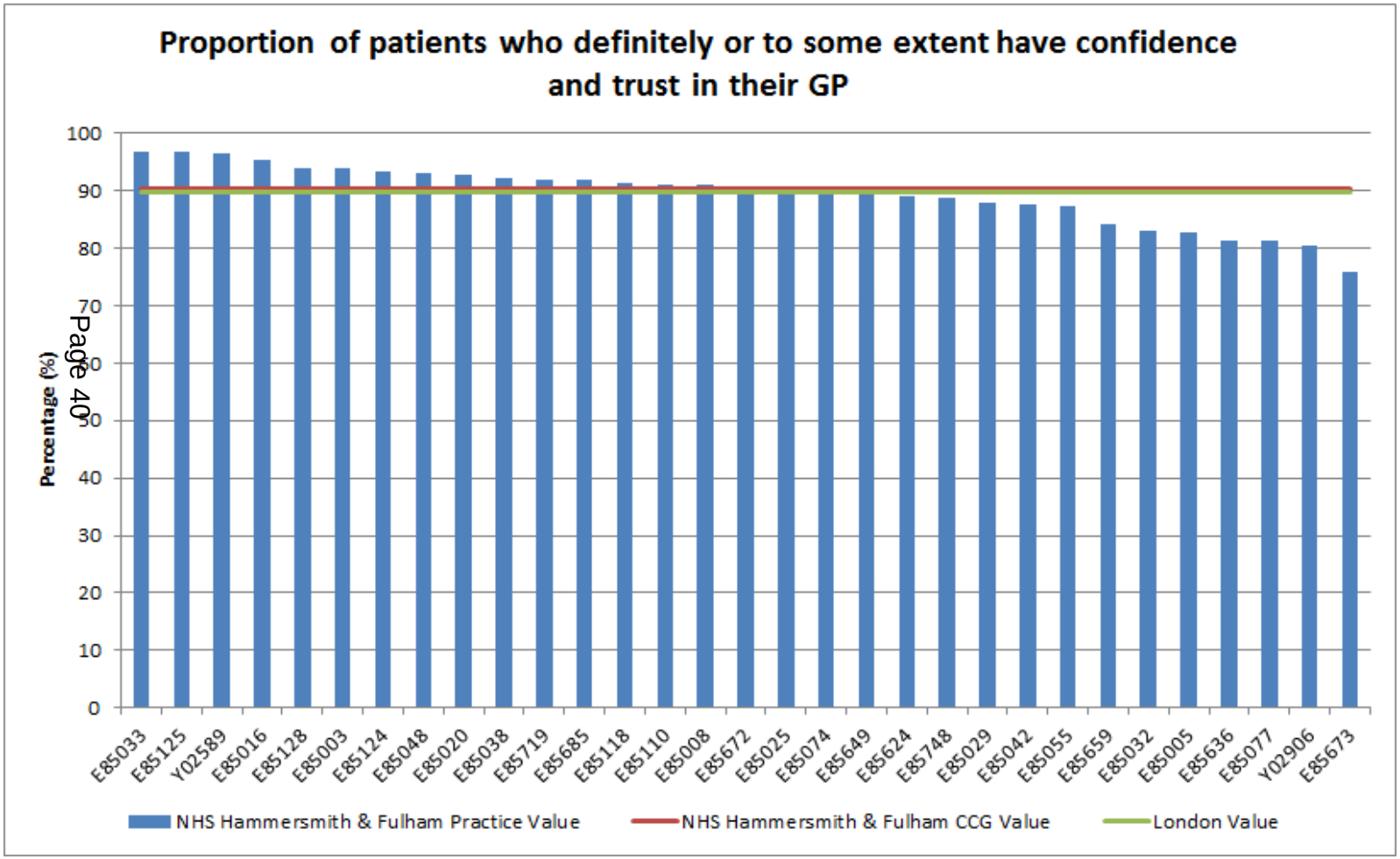
- The % of patients who had trust in their nurse varied from 34.7% to 92.7% in NHS Hammersmith and Fulham CCG.

GP Patient Survey Confidence and Trust in GP, NHS Hammersmith & Fulham CCG Practices, July 2013-March 2014



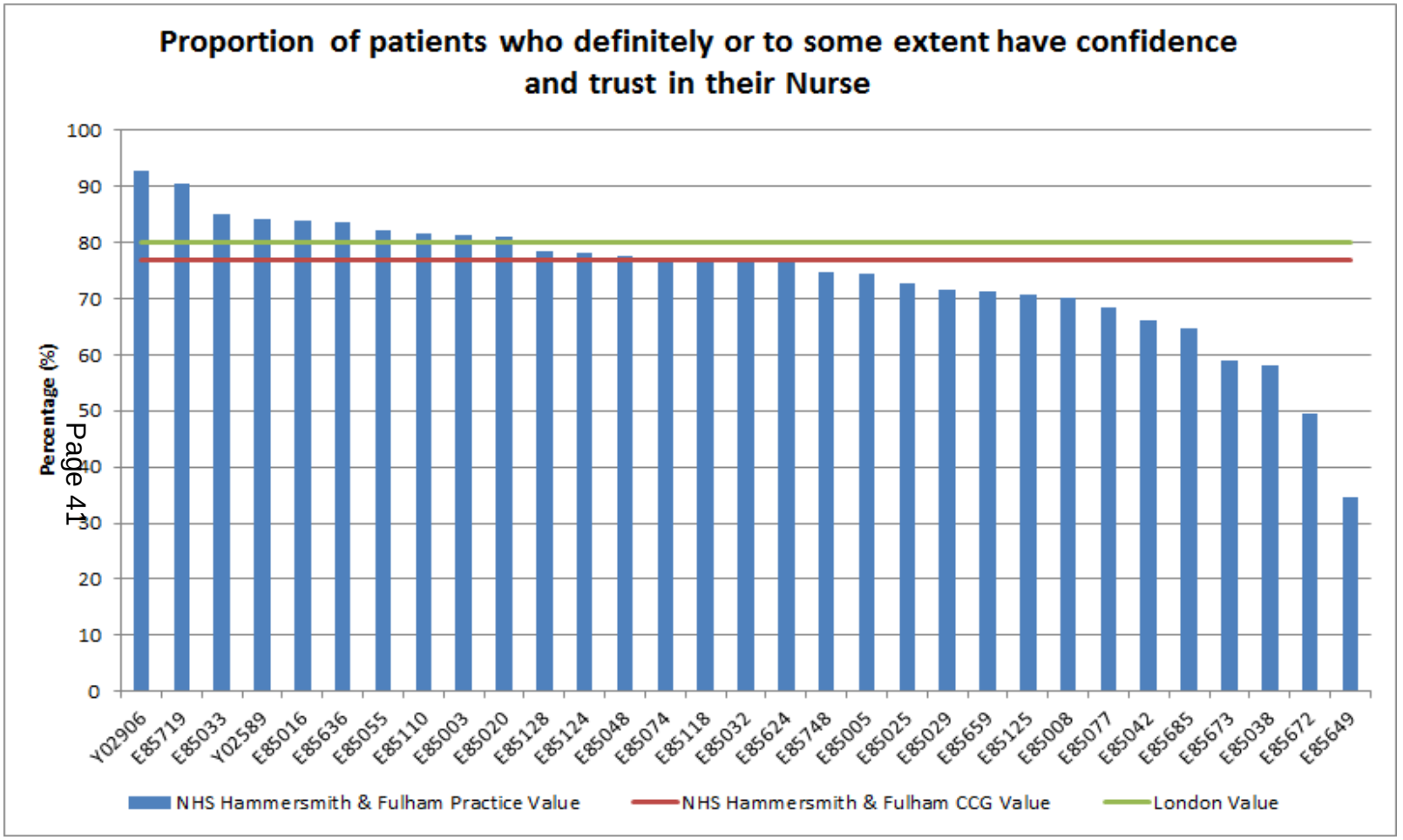
- The % of patients in NHS Hammersmith & Fulham CCG who had confidence and trust in their nurse (77%) was lower than in London (80%) and England (86.2%).
- The % of patients in NHS Hammersmith and Fulham CCG (78.1%) who were satisfied with their surgery opening hours was higher than in London (74.9%) and England (76.9%).

GP Patient Survey Confidence and Trust in GP, NHS Hammersmith & Fulham CCG Practices, July 2013-March 2014



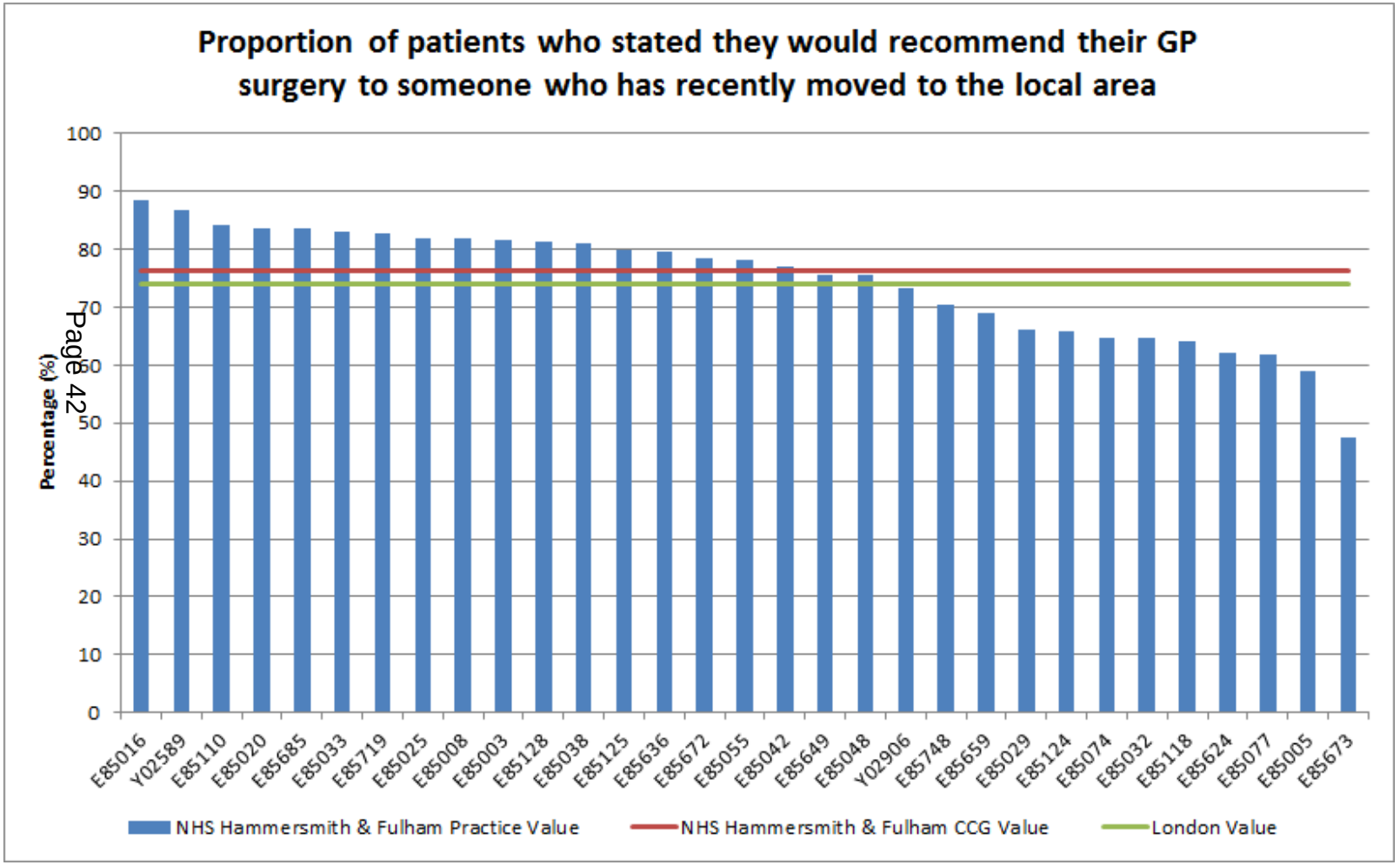
- 13 Practices had scores below the NHS Hammersmith & Fulham CCG average of (90.4%)

GP Patient Survey Confidence and Trust in Nurse, NHS Hammersmith & Fulham CCG Practices, July 2013-March 2014



- 17 Practices had scores below the NHS Hammersmith & Fulham CCG average of (77%)

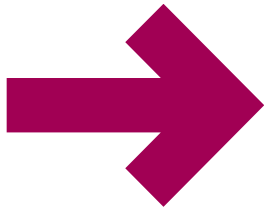
Recommending GP Surgery to someone who has just moved to the local area, NHS Hammersmith & Fulham CCG Practices, July 2013-March 2014



- 14 Practices had scores below the NHS Hammersmith & Fulham CCG average of (76.4%)

QOF

- Regional / National Summary
- Hammersmith & Fulham CCG Practice Summary



QOF – Regional Summary

Quality and Outcomes Framework 2012/13	High Level Summary						
		Domain					
	No. of Practices	Clinical (%)	Organisational (%)	Patient Experience (%)	Additional Services (%)	QOF Points Total (%)	Exception Rate (%)
National	8,020	95.4	97.3	98.7	97.0	96.1	4.1
NORTH OF ENGLAND	2,421	95.6	98.1	98.9	97.4	96.4	4.1
MIDLANDS AND EAST OF ENGLAND	2,358	95.2	97.5	99.1	97.5	96.0	4.1
LONDON	1,447	94.0	95.2	96.8	93.9	94.4	3.6
SOUTH OF ENGLAND	1,794	96.6	97.8	99.6	98.1	97.1	4.4

QOF – H&F CCG Practice Summary

	No. of Practices	Practice List Size	Domain				QOF Points Total (%)	Exception Rate (%)
			Clinical (%)	Organisational (%)	Patient Experience (%)	Additional Services (%)		
National	8,020	-	95.4	97.3	98.7	97.0	96.1	4.1
LONDON	1,447		94.0	95.2	96.8	93.9	94.4	3.6
HAMMERSMITH AND FULHAM	31		90.7	88.8	87.1	82.3	89.7	4.0
BROOK GREEN MEDICAL CENTRE		12,174	90.6	100.0	100.0	95.9	94.1	5.1
CANBERRA CENTRE FOR HEALTH		3,046	95.5	100.0	100.0	100.0	99.1	5.1
CASSIDY MEDICAL CENTRE		4,310	99.3	96.9	100.0	95.5	98.8	5.4
DR B DAS		2,398	92.7	23.6	0.0	30.6	70.0	2.6
DR B MANGWANA		4,711	98.2	92.1	100.0	99.7	97.1	2.2
DR C ELLIOTT		5,029	98.6	100.0	100.0	93.6	99.3	6.5
DR D O'GALLAGHER		8,440	99.6	100.0	100.0	100.0	99.8	6.4
DR GC LAWLEY		7,901	97.9	97.2	100.0	100.0	97.9	3.3
DR GS UPPAL		6,589	95.9	100.0	100.0	80.8	-	.
DR J HARROP-GRIFFITHS		7,815	96.9	100.0	100.0	99.8	98.5	4.5
DR J JOLLY		4,955	96.9	100.0	100.0	93.3	97.6	3.3
DR K WINAYAK		5,826	89.3	96.9	100.0	91.5	91.9	3.6
DR L SLATER		4,408	88.0	94.1	100.0	100.0	91.3	3.0
DR MAL EVANS		8,198	90.6	100.0	100.0	86.1	93.1	2.2
DR PFR FERNANDES		9,777	96.0	100.0	100.0	96.9	97.8	3.0
DR R DANDAPAT		3,613	99.1	100.0	100.0	79.9	99.1	6.9
DR RK & DR R KUKAR		1,706	54.5	100.0	100.0	59.5	69.6	1.8
DR RK KUKAR		6,826	78.6	100.0	100.0	68.8	84.8	1.8
DR RN MUTHIAH		1,480	78.1	23.6	0.0	24.2	59.8	3.3
DR S DASGUPTA		3,445	97.2	100.0	100.0	95.6	98.8	4.3
DR SAMJI & PARTNERS		12,162	94.1	100.0	100.0	90.4	95.7	2.6
DR SF ARAS		10,883	96.4	23.6	0.0	47.7	72.6	4.0
DR SM JEFFERIES		14,845	99.0	100.0	100.0	90.8	98.9	5.2
FULHAM CROSS MEDICAL CENTRE		2,147	81.9	98.0	100.0	75.0	88.9	1.7
HAMMERSMITH & FULHAM CENTRE FOR HEALTH		5,681	97.1	95.3	100.0	91.8	96.8	5.3
LILLIE ROAD PRACTICE		3,397	97.9	100.0	100.0	86.2	98.3	8.4
NORTH END MEDICAL CENTRE		16,791	92.9	97.2	100.0	85.4	94.5	5.5
RICHFORD GATE MEDICAL PRACTICE		10,258	90.4	94.1	100.0	96.5	92.5	4.0
SHEPHERDS BUSH MEDICAL CENTRE		3,542	76.3	98.0	100.0	76.3	83.4	2.6
THE FULHAM MEDICAL CENTRE		7,361	99.2	100.0	100.0	100.0	99.5	2.4
THE OLD OAK SURGERY		3,860	53.3	23.6	0.0	19.0	43.4	3.3

Acute Health Care and General Practice

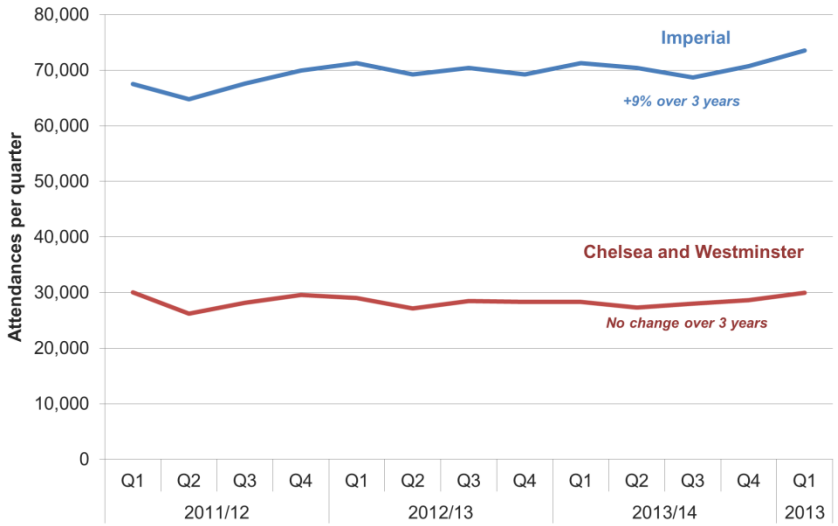
Performance Summary - Hammersmith and Fulham

Tri-Borough Adult Social Care Business Analysis Team
james.hebblethwaite@lbhf.gov.uk

18th July 2014

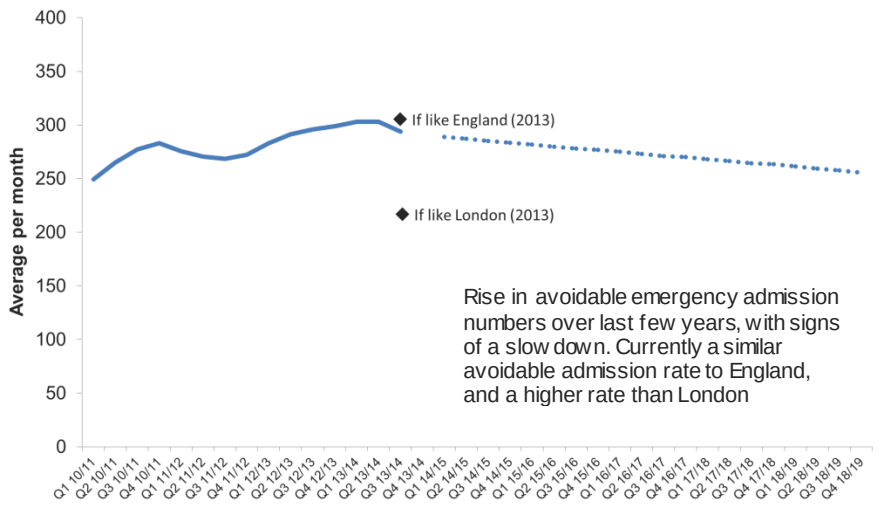
ACUTE HEALTH CARE SUMMARY – HAMMERSMITH AND FULHAM

Total A&E and Minor Injuries Unit attendances, number by Trust by quarter

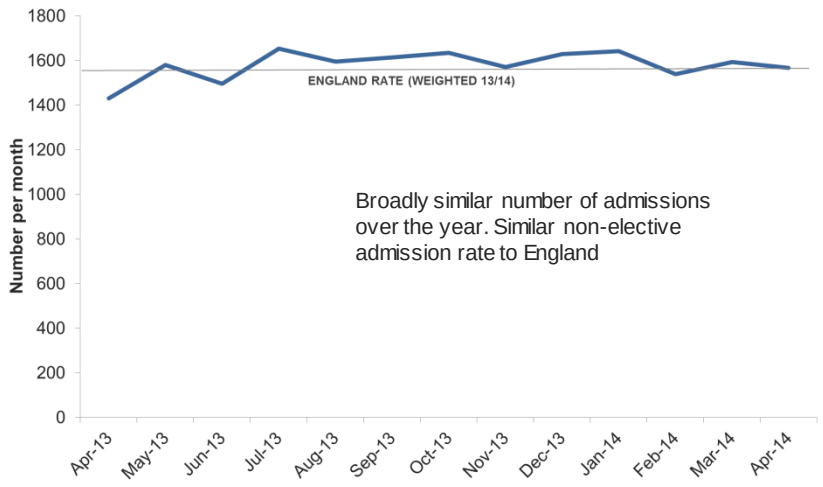


Avoidable emergency admissions (average number per month)

annual data rolling forward quarterly – with Better Care Fund 5 year indicative target

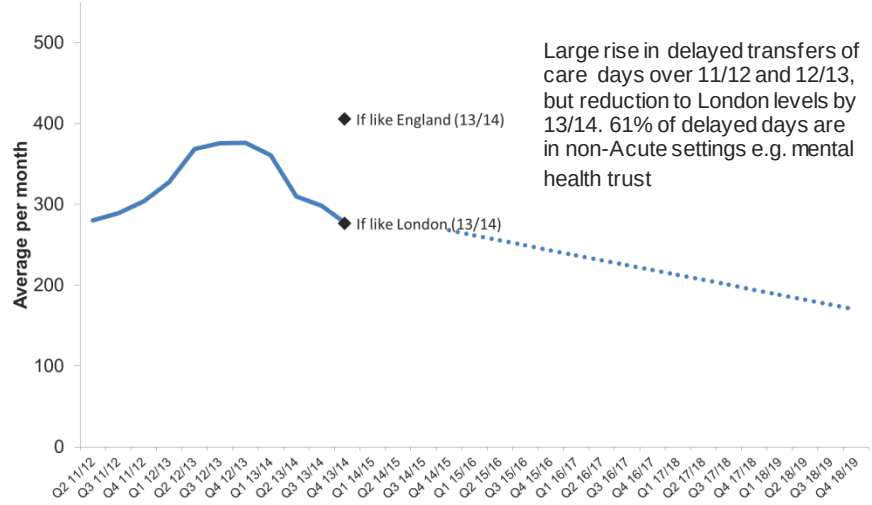


Non-elective admissions for H&F CCG, number by month (FFCEs)



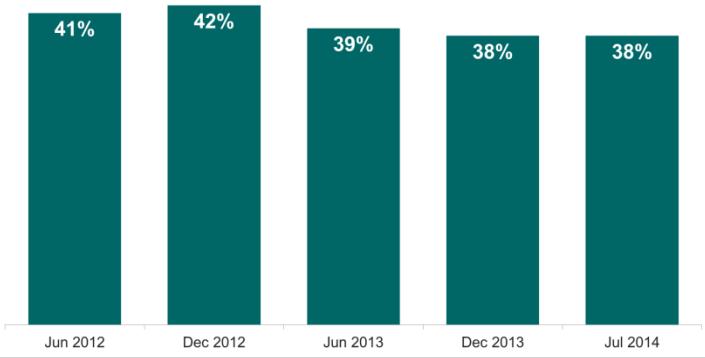
Delayed transfers of care (average days per month)

annual data rolling forward quarterly – with Better Care Fund 5 year indicative target



GP ACCESS AND QUALITY SUMMARY – HAMMERSMITH AND FULHAM

GP Patient Survey – **Very satisfied** with GP surgery/health centre, over time



There has been a drop over time in the proportion of patients in the **CCG area** who are very satisfied with their GP surgery

Summary of GP Access and Quality

In the period to March 2013, Hammersmith and Fulham (H&F) patients reported good access to the practice by phone and higher satisfaction with opening hours than typical for London. However, they were less able to get an appointment 2 days in advance than London or England.

Local patients were more satisfied with their practice than typical of London, and were also more likely to recommend it to a friend. However, patients felt less happy with the quality of consultation than London and England averages, and they felt they were less likely to see their preferred doctor.

The proportion of people feeling supported in managing their long-term condition and reporting a good experience with GP out-of-hours services was lower than London and England. Practice clinical achievement was lower than average in 2012/13.

Find more information here:
Selected GP Patient Survey data, as presented on the **My Health London** website: http://www.myhealth.london.nhs.uk/
GP Patient Survey data used in NHS Outcomes Framework, on the **NHS IC Indicator Portal**: https://indicators.ic.nhs.uk/webview/
Quality and Outcomes Framework data on GP clinical points achieved on Health & Social Care Information Centre website: http://www.hscic.gov.uk/qof

Summary GP Access and Quality Indicators

GP Survey - Access Source: My Health London website (March 2013 data)	**H&F**	**London**	**England**
Found it easy to get through on the **telephone**	**78.6%**	74.9%	77.7%
Able to get an appointment with a doctor more than **two full weekdays** in advance	**85.7%**	87.0%	90.4%
Satisfied with GP practice **opening hours**	**80.3%**	79.4%	82.7%
GP Survey - Satisfaction Source: My Health London website (March 2013 data)	**H&F**	**London**	**England**
Level of satisfaction with the **quality of consultation** at the GP practice (composite measure)	**592**	602	628
Able to see a **preferred** doctor	**52.5%**	54.4%	60.7%
Would **recommend** the GP surgery or health centre to someone who has just moved to your local area	**78.5%**	76.7%	81.3%
Overall satisfaction with the care at the GP surgery or health centre	**83.0%**	82.1%	86.7%
GP Survey - Support Source: NHS IC Indicator Portal (2012/13 data)	**H&F CCG**	**London**	**England**
% of people feeling supported to **manage their long term condition**	**57.0%**	59.4%	65.6%
% reporting a good experience with **GP out-of-hours service**	**60.1%**	62.9%	70.2%
QOF GP quality of care Source: HSCIC website (2012/13 data)	**H&F CCG**	**London**	**England**
% of total points achieved for **clinical domain** - Quality and Outcomes Framework (QOF)	**90.7%**	94.0%	95.4%

Better than London and England
Between London and England
Worse than London and England

	London Borough of Hammersmith & Fulham **HEALTH & WELLBEING BOARD** **08 September 2014**
HAMMERSMITH & FULHAM CCG COMMISSIONING INTENTIONS 2015/16 DEVELOPMENT PROCESS AND EMERGING INTENTIONS	
Report from Hammersmith & Fulham CCG	
Open Report	
Classification - For Information & Comment (delete as appropriate) **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: Dr Tim Spicer	
Report Author: Philippa Jones, Managing Director, H&F CCG	**Contact Details:** Tel: 02033504368 E-mail: Philippa.jones@nw.london.nhs.uk

1. INTRODUCTION

1.1 The Health and Wellbeing Board is requested to review and comment on the attached overview of the West London CCG Contracting Intentions for 2015/16.

1.2 The CCG has consulted with staff, the Governing Body, joint commissioning colleagues, and the CCG membership. Patient and public engagement is also undertaken consistently throughout the year as part of development of all projects and is fed into the development of the document.

1.3 The CCGs are currently developing their commissioning plans for 2015/16. This year, two documents will be produced:

- A document known as Contracting Intentions, for which the specific audience is provider organisations. This will be circulated to providers in early October 2014.
- A public and stakeholder facing document, which will be made available by December 2014.

1.4 The 2015/16 Contracting Intentions will have two main angles:

- The delivery of the key NWL strategic priorities, including patient empowerment, primary care transformation, Whole Systems Integration and service reconfiguration.
- Responding to local issues, gaps and priorities.

1.5 At present, the CCG is using the attached slide pack as an overview of the key strategic themes and the local priorities within them. In September, the commissioning Intentions will be drafted and signed off by the Governing Body, prior to circulation to providers in early October.

1.6 The CCG's commissioning intentions for 2015/16 build on the 2014/15 Commissioning Intentions and the CCG's Out of Hospital Strategy and aim to address JSNA priorities. These include mental health, heart disease, respiratory disease and patients living longer with more long-term conditions.

1.1. The HWB is asked to:

- Review and comment on the attached slide pack

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

- Do our emerging plans adequately reflect Health and Well Being Board priorities?
- How should we specifically work with the Health and Well Being Board over the next year to deliver and monitor our plans?

Healthy Future

NHS
Hammersmith and Fulham
Clinical Commissioning Group

Developing Commissioning Intentions 2015-16

Health & Wellbeing Board Discussion

Tim Spicer

5 August 2014

Healthy Future

NHS
Hammersmith and Fulham
Clinical Commissioning Group

Developing Commissioning Intentions

Discussion today

Today we will …

- **Share the headlines for this year**
- **Have a discussion and gather some feedback on some aspects of our emerging commissioning intentions**
- **Set out the next steps & timescales**

Healthy Future

NHS
Hammersmith and Fulham
Clinical Commissioning Group

Developing Commissioning Intentions

Headlines for this year

Key points about developing the intentions this year

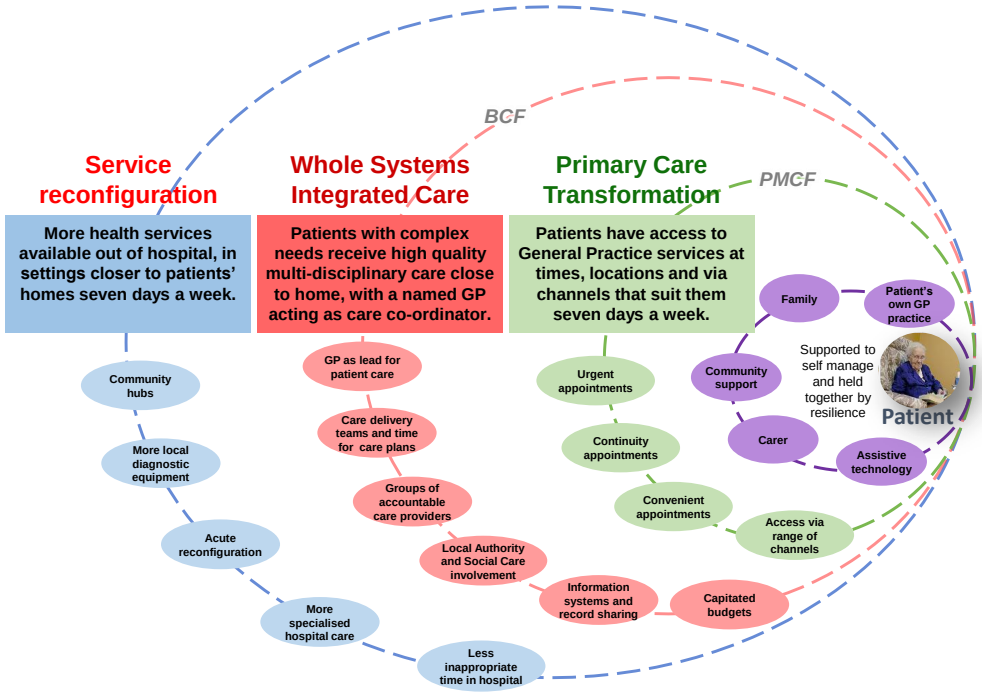
- **A move away from the 'annual' approach to intentions – we will engage with staff and patients but will draw on the all the work we have done through the year**
- **Providers are the specific audience in the first instance - more 'contracting intentions' than 'commissioning intentions' – by September**
- **Two angles: what do we need to do this year to:**
  - Progress the delivery of our 'big ticket' strategic plans?
  - Respond to local issues?
- **A separate public facing document will be produced for the end of the year**

Healthy Future

NHS
Hammersmith and Fulham
Clinical Commissioning Group

‘Big ticket’ items

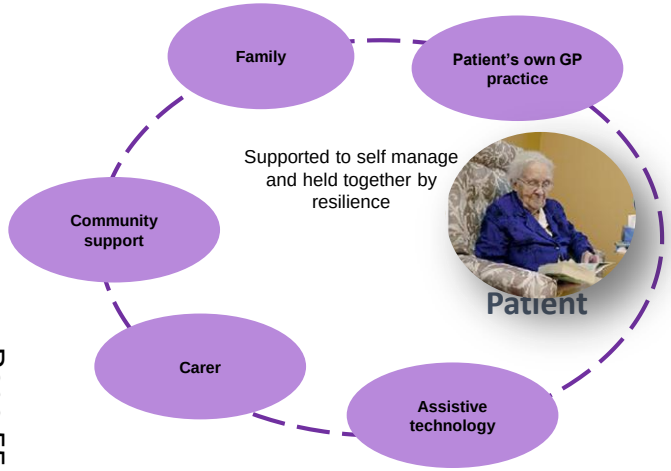
- Framework developed by Strategy & Transformation colleagues
- Allows us to consider the key planks of our strategy in turn and the actions needed to deliver
- For each one, we can look at:
  - What’s been achieved?
  - What’s needed next year?
  - Other enablers?



Healthy Future

NHS
Hammersmith and Fulham
Clinical Commissioning Group

Patient empowerment (1)



Enablers

- Lay person group established
- Co-design and co-production – ensure these are built into all our plans
- Develop ways of recognising that not every patient is the same
- Ensure the right links with local authority/public health

Deliverables 2014/15

- Patient experience strategy
- Personal budgets for adults & children
- Re-commissioned Expert Patient Programme
- Self-management incorporated as part of model of care in WSIC plan
- Work with carers, especially young carers
- Work on LD health checks

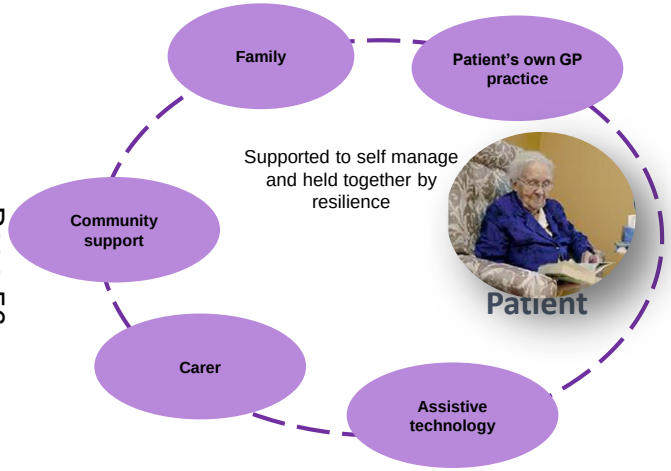
Deliverables 2015/16

- New diabetes education programme
- Develop VCS signposting of services, especially how to access GP/primary care services
- Develop work with community organisations to increase our capability & capacity to engage and share messages with community
- Commission providers to act in line with the National Voices statements
- Ensure functioning Patient Participation Groups in every H&F practice (working with NHSE where appropriate)
- Recommissioning of mental health involvement forum

Healthy Future

NHS
Hammersmith and Fulham
Clinical Commissioning Group

Patient empowerment (2)



Enablers

- Feedback from the cohort of patients that have been care planned to see how it has empowered them, e.g. roll out of patient questionnaires; learning from ICP survey of patients/users which got a low response rate
- Use different methods of getting feedback, e.g. carers
- Learn from practices for care planning, e.g. Network 2 pilot
- Learn from Central London Wellbeing plans
- Link to any BCF deliverables

Deliverables 2015/16

- Care planning: communications to patients, f/u checks with practices, DES for care planning 3%?
- Meet specific requirements of the Care Bill, e.g. paid holidays
- LD and Friends and Family Test – need to build on this

Healthy Future

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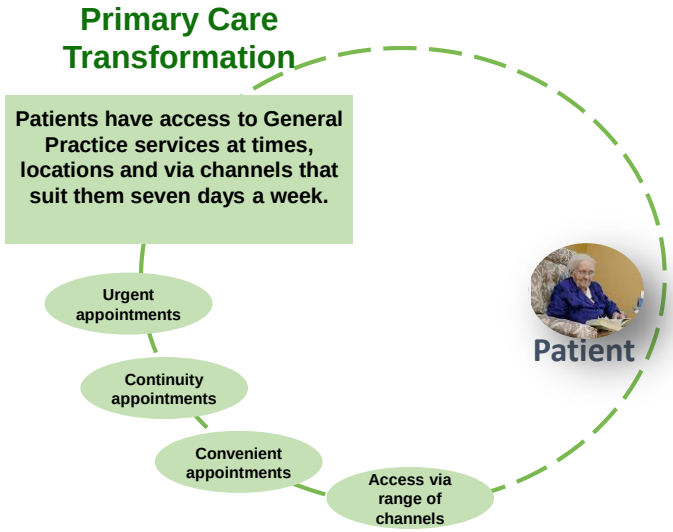
Hammersmith and Fulham
Clinical Commissioning Group

Primary Care Transformation (1)



Enablers

- PM Challenge Fund
- Federation development/ new legal entity
- 7-day working
- OOH contracts
- Affordable workforce model – include recruitment of practice nurses, HCAs
- Communicate more widely about the role of the practice nurse
- HENWL training and development funding

Deliverables 2014/15

- Commission OOH services from the Federation
- Federation/practices have agreed their delivery plan for 2014/15 (including OD requirements)
- Initial business change in place in primary care (e.g. online appointment booking / email consultations etc)
- Models of Federation service delivery agreed

Deliverables 2015/16

- 7 day/ week primary care services in operation at practices within networks
- A range of consultation methods available to patients (telephone/email/Skype)
- Primary care appointments tailored to patients needs (e.g. urgent, continuity and convenience appointment standards met)
- Deliver range of OOH services
- Link Federation into WSIC – being part of a provider network for whole systems

Healthy Future

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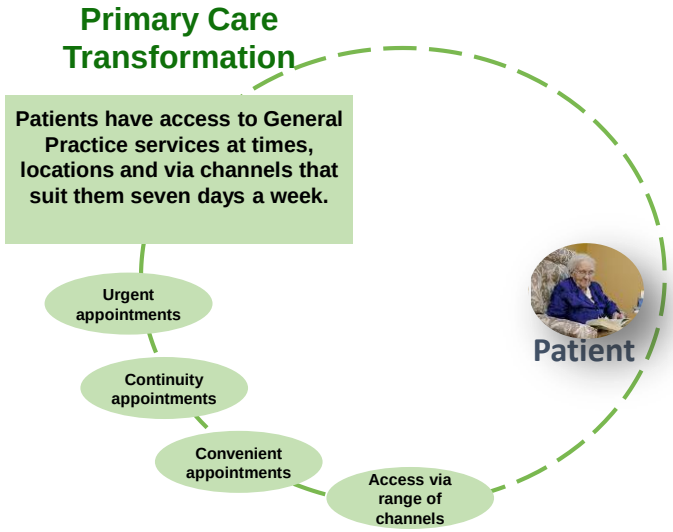
Primary Care Transformation (2)



Deliverables 2015/16

- Commission the Federation to deliver communications to patients (ready-made database)
- Use of expert patients in practices?
- Address the needs of transient population – ensuring patients are registered with practices (link to UCC specification/redirection)

Healthy Future

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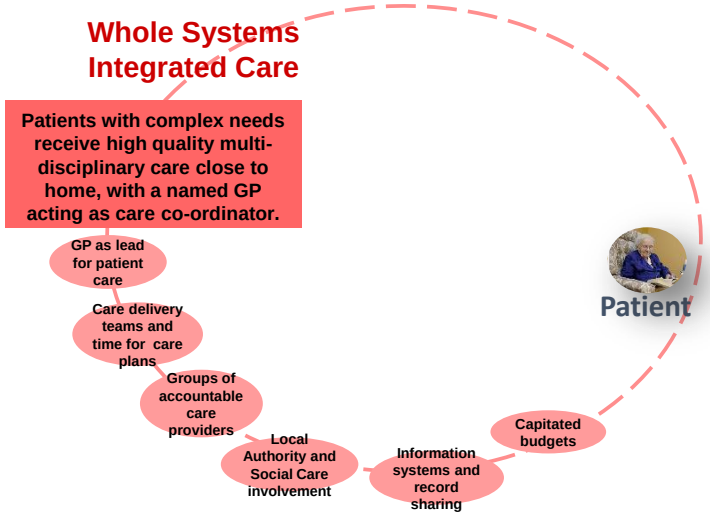
Whole Systems Integrated Care



Enablers

- Better Care Fund
- Joint governance arrangements
- Pooled budgets
- Integrated community recovery services
- Joint homecare tenders
- QIPP
- Workforce
- WSIC enabling infrastructure OOH hubs (Parson's Green)
- IT – further SystmOne roll out esp. acute trusts
- Mental health

Deliverables 2014/15

- CIS 'plus' gone live with medical cover and an enhanced multidisciplinary team
- Develop full implementation plans for WSIC Early Adopter that inform commissioning intentions & develop longer term aspects of a WS model of care
- Trial new ways of working and organisational development
- Provide linked dataset with local capitation values and analysis
- Create provider and commissioner dashboards
- Agree NWL-frameworks for new commissioning and provider vehicles
- Provide costing tool for new models of care
- Embed co-production in local WSIC plan

Deliverables 2015/16

- New models of care in place
- 7-day services in operation
- Health and social care commissioners holding multi-provider 'accountable care partnerships' to account for delivery of population health outcomes
- Federation and provider vehicles working to new Whole Systems specification
- End Planned care pathways, e.g. MSK, gynaecology
- Medical model for nursing homes recommissioned
- Incorporate mental health into the Community Independence Service

Healthy Future

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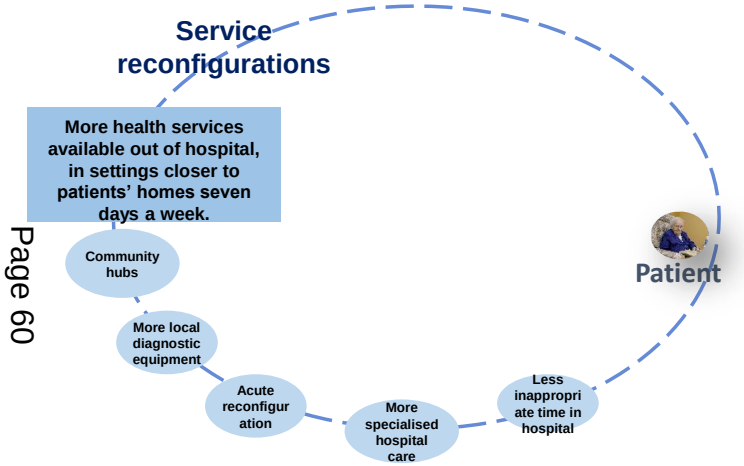
Service Reconfigurations



Enablers

- 7 day working
- Mental health transformation
- Local Hospital Business Cases
- Major Hospital Business Cases
- Out of Hospital Strategies
- Clinical standards
- QIPP

Deliverables 2014/15

- Complete baseline self-assessment against 10 clinical standards for 7-day services (all acute Trusts with partners)
- Agree priorities and sequence for implementation of standards across the non-elective pathway/develop action plan
- Achieve priority standards for 14/15 (including as per 7-day CQUINs)
- Integrated mental health emergency pathway in place
- New service specification & business case agreed for integrated crisis response service x-Triborough; providers working to new model of care
- Homecare contracts in place, including low level health tasks
- Urgent Care on the Hammersmith site reconfigured

Deliverables 2015/16

- 7-day services
- Achieve agreed priority 7-day clinical standards for 15/16, including those included within the national acute contracts
- Mental health and wellbeing strategy
- Full business case for Charing Cross Hospital (local hospital)
- Longer term commissioning/procurement of integrated crisis response service x- Triborough
- Homecare model aligned with Whole Systems network provider vehicle

Healthy Future

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Hammersmith and Fulham
Clinical Commissioning Group

What are our key local issues? (1)

We are identifying the specific quality/performance issues we want to address next year with each of our providers

- CLCH
- Imperial
- WLMHT
- ChelWest
- Nursing & residential
- Primary care

Healthy Future

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Clinical Commissioning Group

What are our key local issues? (2)

We are also identifying the gaps in service/local pathway priorities we want to address. Our 'long list' so far includes:

- Paediatric continence
- Tissue viability
- Ophthalmology
- Diabetes
- MSK
- CKD
- End of Life Care
- TB
- Podiatry
- Heart failure
- Community ENT
- Retinal screening
- Community gastro
- Foot care (linked to diabetes)
- District/community nursing

Healthy Future

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Hammersmith and Fulham
Clinical Commissioning Group

Next steps

The key next steps and timescales are:

Timescale	Action
August	Draft intentions developed through work with stakeholders
Early September	Governing Body approves direction of travel/outline content
September	Draft document refined; circulated to Governing Body members and other stakeholders for input
	Draft contracting intentions share with the public at AGM
End September	Sign-off final version in line with delegated authority from the Governing Body
October	Contracting intentions shared with providers
October – December	Develop public facing document describing our intentions

	London Borough of Hammersmith & Fulham **HEALTH AND WELLBEING BOARD** **8th September**
PHARMACEUTICAL NEEDS ASSESSMENT	
Report of the Pharmaceutical Needs Assessment Task and Finish Group	
Open Report	
Classification: For Decision **Key Decision:** No	
Wards Affected: All	
Accountable Executive Director: Liz Bruce, Tri-borough Executive Director of Adults and Health	
Report Author: Holly Manktelow, Senior Policy and Strategy Officer	**Contact Details:** Tel: 020 7641 2757 E-mail: hmanktelow@westminster.gov.uk

1. EXECUTIVE SUMMARY

1.1. This report sets out the progress being made by the Pharmaceutical Needs Assessment (PNA) Task and Finish Group to prepare a new PNA for the London Borough of Hammersmith and Fulham.

1.2. The report also seeks agreement from the Health and Wellbeing Board to undertake the statutorily required 60 day consultation on a draft PNA in the autumn.

2. RECOMMENDATIONS

2.1. The Health and Wellbeing Board is asked to

a.) Note the progress in preparing the draft PNA for publication (as outlined in Appendix 1); and

b.) Agree that the PNA Task and Finish Group should commence with the 60 day statutory consultation once the draft PNA is ready. A statutory consultation plan is attached at Appendix 2.

3. REASONS FOR DECISION

3.1. Health and Wellbeing Boards are required to publish and maintain a Pharmaceutical Needs Assessment by virtue of section 128A of the National Health Service Act 2006 (pharmaceutical needs assessments) and the Health and Social Care Act 2012.

3.2. The London Borough of Hammersmith and Fulham Health and Wellbeing Board is required to publish a new Pharmaceutical Needs Assessment by 1st April 2015.

3.3. As part of the process for preparing a new Pharmaceutical Needs Assessment, the Health and Wellbeing Board are required to undertake a 60 day consultation with a set of statutory consultees.

3.4. To ensure that the Health and Wellbeing Board is in a position to publish a new Pharmaceutical Needs Assessment by 1st April 2015, the 60 day consultation will need to take place before the end of 2014. The current proposal is to begin the consultation on a draft PNA in October 2014.

3.5. A draft of the PNA will be circulated to the Health and Wellbeing Board by email for comments two weeks before publication to provide time for members to provide comment and steer.

4. INTRODUCTION AND BACKGROUND

4.1. Pharmaceutical Needs Assessments are a statement of the need for pharmaceutical services of the population in a defined geographical area.

4.2. Pharmaceutical Needs Assessments are used primarily by NHS England to inform market entry decisions in response to applications from businesses, including independent owners and large pharmacy companies. A Pharmaceutical Needs Assessment may also be used by commissioners to make decisions on which funded services need to be provided by local community pharmacies.

4.3. The responsibility for producing and managing the content and update of Pharmaceutical Needs Assessments transferred from Primary Care Trusts to Health and Wellbeing Boards on 1st April 2013.

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

- The Local Pharmaceutical Committee;
- The Local Medical Committee;
- Any persons on pharmaceutical lists and any dispensing doctors;

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

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

5. PROPOSAL AND ISSUES

5.1. The PNA Task and Finish Group are developing the draft PNA for the London Borough of Hammersmith and Fulham. This requires the collection and analysis of data from a variety of sources. In particular, it has required the collection of information from pharmacies within the London Borough of Hammersmith and Fulham via a questionnaire.

Pharmacy response rate

5.2. In the London Borough of Hammersmith and Fulham, the response rate from local pharmacies was 87%. All efforts were made to maximise this response rate, including through joint work with the Local Pharmaceutical Committee. However, the response rate was a little lower than expected. This most likely reflects the change of responsibilities for PNAs from primary care trusts to Health and Wellbeing Boards which have less of a profile and relationships with the local pharmaceutical sector. The PNA Task and Finish Group have approached NHS England for advice as to whether this response rate is acceptable so that we can provide assurance to the Health and Wellbeing Board on this point.

Missing Data

5.3. The PNA Task and Finish Group are still awaiting two sets of data from partners which are required to complete the draft Pharmaceutical Needs Assessment. This data is required as soon as possible. These are:

- Comparison data on prescribing and dispensing trends to London and England. This data has been requested from North West London Commissioning Support Unit.
- A list of pharmacies from neighbouring boroughs which is required to complete some of the maps required to underpin the Pharmaceutical Needs Assessment. This has been requested from NHS England.

6. OPTIONS AND ANALYSIS OF OPTIONS

6.1. The PNA is a technical and factual document, which provides a statement of pharmaceutical need in the area (following strict regulatory guidelines) for use by NHS England. It is not a description of policy or intent, or a document which proposes changes to pharmaceutical services in the area.

6.2. The PNA is unlikely to be of interest to the wider public and the PNA Task and Finish Group advise that the cost of a public consultation would be disproportionate to the likely response received. Therefore, the PNA Task and Finish Group do not recommend undertaking a full consultation with members of the public.

6.3. However, it is important that the views of patients and service users are gathered as part of the consultation process. As such, consultation will be undertaken with patient and consumer groups to ensure that the user's perspective is referenced where appropriate within the PNA. The draft PNA will also be available on-line (with a hard copy on request) for members of the public who may have a particular interest. This approach aligns with the relevant regulations and guidance.

6.4. The PNA Task and Finish Group will be ready to begin the consultation, on behalf of the Health and Wellbeing Board, in October. This represents a slight delay from the original deadline of September, agreed by the London Borough of Hammersmith and Fulham Health and Wellbeing Board in March 2013. This delay has been caused by the difficulty in obtaining data sets from partners, as outlined in paragraph 5.3

6.5. While the delay is unfortunate, it should have no impact on the ability of the Health and Wellbeing Board to publish a new Pharmaceutical Needs Assessment 1st April 2015.

7. CONSULTATION

7.1. As set out above, a 60 day statutory consultation must be undertaken with a list of statutory consulted. Appendix 2 provides an overview of the consultation plan for the draft Pharmaceutical Needs Assessment which the Health and Wellbeing Board may wish to review.

8. EQUALITY IMPLICATIONS

8.1. The regulations governing the development of a Pharmaceutical Needs Assessment require the Health and Wellbeing Board to have regard (as far as is practicable) to compliance with the duties under the Equality Act 2010, specifically relating the following protected characteristics:

a.) Age
b.) Disability
c.) Gender Reassignment
d.) Marriage and Civil Partnership
e.) Pregnancy and maternity
f.) Race
g.) Religion or belief
h.) Sex
i.) Sexual orientation

8.2 The regulations also require the Health and Wellbeing Board to take account of future needs such as changes in demographics with regards to people who share a protected characteristic and the risks to health or

wellbeing of people in its area, particularly to those who share a protected characteristic.

9. LEGAL IMPLICATIONS

9.1. The Health and Wellbeing Board is required to publish and maintain a Pharmaceutical Needs Assessment by virtue of section 128A of the National Health Service Act 2006 (pharmaceutical needs assessments) and the Health and Social Care Act 2012.

10. FINANCIAL AND RESOURCES IMPLICATIONS

10.1. None

11. RISK MANAGEMENT

11.1. N/a

12. PROCUREMENT AND IT STRATEGY IMPLICATIONS

12.1. None

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.	London Borough of Hammersmith and Fulham Pharmaceutical Needs Assessment		

LIST OF APPENDICES:

Appendix 1: Skeleton Pharmaceutical Needs Assessment with progress update

Appendix 2: Pharmaceutical Needs Assessment Statutory Consultation plan

Appendix 1

London Borough of Hammersmith and Fulham Pharmaceutical Needs Assessment outline and progress update

Chapter	Description	Current state	Any further data required?	If yes, source
1 - Background	PNA definition and purpose, policy background, methodology (defining localities, demographic sources, needs), consultation process	Almost complete – compilation of previous PNA and DH PNA guidelines		
2 - Demographic & Health Needs	Mostly data and content based on the JSNA, including maps	Almost complete – Public Health Analysts completing data		
3 - Location of current health services	Maps with data from the pharmacy survey	Base map created. Awaiting list of neighbouring pharmacies to complete	List of pharmacies from neighbouring boroughs.	Requested from NHS England
4 - Prescribing and dispensing trends	Maps and graphs of prescribing within the borough	Data received from NWL CSU (ePACT) – ready for mapping	Comparison data to London/England	Requested from NWL CSU
5 - Access to pharmaceutical services	Pharmacy choice within each ward, opening hours, languages spoken	Ready for mapping	List of pharmacies from neighbouring boroughs.	Requested from NHS England
6 - Premises characteristics	Features such as private consultation rooms, handwashing, wheelchair access etc	Ready for mapping		
7 - Relationships, opportunities and skills	Relationships with GPs, LA, NHS – from survey	Ready for mapping and graphs		

8 - Services provided by pharmacies	Categorisation of services: necessary services: current provision, necessary services: gaps in provision, Other relevant services: current provision, Improvements or better access: gaps in provision	Text to be updated	Categorisation of services – currently assuming this has not changed since previous PNA	
Appendix A - Needs mapping: existing enhanced services	Table with list of pharmacies which provide enhanced services Maps and tables comparing need and current supply of services deemed necessary	Ready for mapping		
Appendix B - Needs mapping: potential new services	Maps and tables of services considered to secure improvement or better access	Ready for mapping		

Appendix 2

London Borough of Hammersmith and Fulham Health and Wellbeing Board Pharmaceutical Need Assessment Statutory Consultation Plan

Holly Manktelow
Senior Policy and Strategy Officer
20th August 2014

Revision History

Date of this revision: 20th August 2014
Date of next revision: TBC

Revision Date	Previous revision date	Summary of Changes	Changes marked
20th August 2014	First version	First versions	First Version

1. OBJECTIVES OF THE CONSULTATION

The high-level objective of the London Borough of Hammersmith and Fulham Pharmaceutical Needs Assessment (PNA) statutory consultation is to ensure that statutory consultees are provided with a 60 day period between October 2014 and January 2014 in which to consider the draft PNA for Hammersmith and Fulham and provide their views to the PNA Task and Finish Group. The list of statutory consultees are:

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

2. KEY AUDIENCES

Audience	Approach	Responsibility
Local Pharmaceutical Committee	§ Letter and Email (on behalf of the Health and Wellbeing Board) § LPC are represented on the PNA Task and Finish Group	HWB Chair PNA Task and Finish Group
Local Medical Committee	§ Letter and Email (on behalf of the Health and Wellbeing Board) § Offer of a meeting if required	HWB Chair PNA Task and Finish Group
Individual Pharmacies	§ Email and link to the online PNA § Support from the Local Pharmaceutical Committee if required (through their membership on the PNA Task and Finish Group)	PNA Task and Finish Group
Dispensing GPs	§ Email and link to the online PNA § Work with WLCCG to put out information through their channels of communication with GPs	PNA Task and Finish Group HFCCG
Healthwatch	§ Letter and Email sent to the Chair and support team § Offer to attend meetings or public events if required	HWB Chair PNA Task and Finish Group
HFCCG User Panel	§ Information provided to the user panel through WLCCG channels § Offer to attend meetings if required	PNA Task and Finish Group
Other patient or consumer group	§ Healthwatch to support the provision of information to their organisation or institutional members	Healthwatch
Sobus (Community	§ Letter and Email sent to the Chair	HWB Chair

Development Agency)	§ Offer to attend meetings or public events if required	PNA Task and Finish Group
Chelsea and Westminster NHS Trust	§ Letter and Email sent to the Chief Executive and Chair, and communications team § Offer to attend meetings if required § Request that the information is shared with the trusts patient user groups	HWB Chair PNA Task and Finish Group
Imperial NHS Trust	§ Letter and Email sent to the Chief Executive and Chair, and communications team § Offer to attend meetings if required § Request that the information is shared with the trusts patient user groups	HWB Chair PNA Task and Finish Group
Ealing NHS Trust	§ Letter and Email sent to the Chief Executive and Chair, and communications team § Offer to attend meetings if required § Request that the information is shared with the trusts patient user groups	HWB Chair PNA Task and Finish Group
West Middlesex Hospital Trust	§ Letter and Email sent to the Chief Executive and Chair, and communications team § Offer to attend meetings if required § Request that the information is shared with the trusts patient user groups	HWB Chair PNA Task and Finish Group
Central London Community Healthcare	§ Letter and Email sent to the Chief Executive and Chair, and communications team § Offer to attend meetings if required § Request that the information is shared with the trusts patient user groups	HWB Chair PNA Task and Finish Group
West London Mental Health Trust	§ Letter and Email sent to the Chief Executive and Chair, and communications team § Offer to attend meetings if required § Request that the information is shared with the trusts patient user groups	HWB Chair PNA Task and Finish Group
Wandsworth Health and Wellbeing Board	§ Letter and Email sent to the Chair and support team	Chair of the Health and Wellbeing Board
Brent Health and Wellbeing Board	§ Letter and Email sent to the Chair and support team	Chair of the Health and Wellbeing Board
Ealing Health and Wellbeing Board	§ Letter and Email sent to the Chair and support team	Chair of the Health and Wellbeing Board
Hounslow Health and Wellbeing Board	§ Letter and Email sent to the Chair and support team	Chair of the Health and Wellbeing Board

Richmond Health and Wellbeing Board	§ Letter and Email sent to the Chair and support team	Chair of the Health and Wellbeing Board
RBKC Health and Wellbeing Board	§ Email sent to the Chair and support team (Shared support team RBKC, LBHF and Westminster HWBs)	Chair of the Health and Wellbeing Board
NHS England	§ Letter and Email sent to NHS England London Region	Chair of the Health and Wellbeing Board
Relevant Scrutiny Committee (not required by legislation but good practice)	§ Letter and Email sent to the Chair and support team	Chair of the Health and Wellbeing Board

4. COMMUNICATORS	
Communicator	**Responsibilities**
London Borough of Hammersmith and Fulham Health and Wellbeing Board	All communications to statutory consultees will be delivered in the name of the LBHF Health and Wellbeing Board
Healthwatch	Support communication with wider patient and consumer groups
NHS Trusts	Support communication with their patient and consumer groups
Hammersmith & Fulham Clinical Commissioning Group	Support communication with individual dispensing GPs Support communication with their patient and consumer groups
Local Pharmaceutical Committee	Support communications with individual pharmacies
Sobus	Support communications with relevant community groups

6. METHODS OF COMMUNICATION	
Email and Letters	Emails and letters will be the primary form of communication to statutory consultees
Presentation	May be used occasionally to support communications with patient and consumer groups (if required)
Website	The draft PNA, details on the scope of the consultation and how to provide feedback will be place on the LBHF council website, and the www.jsna.info website
Reports	Available on request (for example by NHS Trusts, Healthwatch and CCG governing body) A report will be presented to neighbouring Health and Wellbeing Boards for information
Stakeholder Group Meetings	Available on request.
Other meetings	Available on request
One-to-One meetings	Available if required due to concerns

NHS West London Clinical Commissioning Group

NHS Central London Clinical Commissioning Group

NHS Hammersmith and Fulham Clinical Commissioning Group

Learning Disability Action Plan

2014 – 2017

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

h&f hammersmith & fulham

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

City of Westminster

1. BACKGROUND

1.1 Outcomes experienced by those with learning disabilities are poorer than in the general population. For example, the average age of death of someone with a moderate learning disability is 20 years less. Yet, although many people with learning disabilities have complex health needs, they often suffer from potentially preventable conditions, also common to the general population. These conditions are often left untreated due to barriers accessing services in a timely and effective way and insufficient support to enable lifestyle change.

1.2 Wider aspects of living which many people take for granted, such as housing, employment, material wealth and social inclusion, often create challenges for those with learning disabilities, and result in substantial health inequalities for this group.

1.3 Because the impacts reach so far into all aspects of life, making progress towards improving outcomes relies on a wide-ranging and strong partnership approach, where working together on key strategic issues and projects can make a real difference to the lives of people with learning disabilities.

1.4 Working in partnership with key agencies such as Housing, Health, Education and Regeneration will be the critical success factor in achieving real progress and ensuring that people with learning disabilities have access to mainstream community facilities and housing opportunities the same as other citizens.

1.5 The Council's face serious financial challenges in the next three years. This Plan therefore needs to be set within the context of needing to take difficult financial decisions based on agreed priorities, focusing limited resources to achieve value for money and maximise benefits for people with learning disability and their family.

1.6 This Action Plan therefore identifies what the key priorities are across the three Boroughs within this financial climate for improving the quality, quantity and choice of support for people with learning disabilities, and how this will be improved across the three boroughs in the following years. This will include provision that is funded by both health and social care.

1.7 The Learning Disability Action Plan has been based on resource, performance and service mapping information, needs assessment of those with learning disabilities (provided in the JSNA), consultation with carers and customers through the Learning Disability Partnership Board, and a range of other partners and stakeholders.

1.8 The development of this Plan has also been based on links to other plans listed below.

Links to other plans

- **Learning Disabilities Joint Strategic Needs Assessment (JSNA)** Available on www.jsna.info
- **Learning Disability Housing and Support Plans**
- **Learning Disabilities Health Self-Assessment (SAF)**
- **Winterbourne View Action Plan**
- **Autism Strategy**

- **Carers Strategy**
- **Market Position Statement for Learning Disability Service Requirements and Provision in London, 2013**

Please see the councils websites for more information

Strategic Reviews

The following service reviews are currently taking place and will inform the future re modelling and commissioning plans across the following areas.[1]

Strategic Reviews, Tri-borough 2013/14 and 2014/15:		**Day services- complex needs**
Short breaks	**Transport**	**Preventive day provision**
Advocacy	**Employment**	**Transitions process**

2. KEY PRIORITIES

2.1 The key priorities are around ensuring that people with learning disabilities (including those with complex health and social care needs) are supported to be able to live in the borough, close to families and friends, rather than have to be placed in out-of-borough residential care.

- **Accommodation and support –** New supported housing developments and a programme of remodelling of existing accommodation will be required in order to meet the ambition of greater numbers of people with learning disabilities living in-borough, as well as expected future demand. Providing access to a range of quality local housing provision will avoid the need for expensive out of borough residential care provision. The development of outreach support and skilled local providers are key considerations along with the development of quality local housing provision. This will involve working with health and housing colleagues to look at a range of housing options within the public and private sector. To deliver on the Winterbourne View actions will mean the joint commissioning of services, pooling of resources as well as identification of capital funding for the refurbishment of existing buildings or new build.

- **Supporting people with complex needs** – As more people with learning disabilities move from children's to adults services and remain in-borough 'settled' accommodation rather than residential care, there needs to be adequate support for them, particularly for those with complex needs , as well as for those who care for them. There needs to be a range of day, work, community and short breaks support available for individuals and their families.

- **Accessing mainstream services and market development** – There needs to be wider access to mainstream community provision and a greater range and choice of services available to people via their personal budgets. This should include ways to develop small local 'non-commissioned' services providing work and community support which could be accessed through the development of local micro social enterprises.

[1] To find out more information on these reviews, please contact mdalton@westminster.gov.uk

- **Good transition planning** – Young people from age 14 onwards will be supported through the transition process to ensure that they have a single person centred plan when they move through to adulthood.

- **Reasonable adjustments** - Equality law recognises that bringing about equality for disabled people may mean changing the way in which services are provided to people with learning disabilities, and there is therefore a duty to make reasonable adjustments. This requirement cuts across many aspects of service provision, including GPs, hospitals, community health services and other leisure and community services.

3. VISION

3.1 Our vision and key aims are based on improving five key outcomes for people with learning disabilities. These are summarised below. Under each outcome we explain the key actions we will take to achieve that vision and who the key partners are who will need to work together to make it happen.

3.2. The Action Plan in this document gives a lot more detail on the actions that will be needed, when they will be done, and the key measures of success that will be used to monitor how well we are doing.

Outcome	Key Area of Action	Main Partners
Having choice & control	More control through access to personal budgets, advocacy, and seamless well planned transitions service.	• Children's /Adult Services • Education • Voluntary sector organisations
Working in partnership with families	Carers will have a stronger voice and access to quality, flexible support	• Family carers • Adults/Children's Services • Voluntary sector orgs
Having a home I can call my own	People access an increased range of local housing options as an alternative to residential care, including those with complex needs.	• Housing departments • Clinical Commissioning Groups (Cages) • Registered Social Landlords
Being part of my Community	People will be supported to live safely in their community and have access to a broader range of day, work and leisure opportunities. Day provision will be reviewed to ensure the growth of local community and work opportunities.	• Leisure services • Regeneration • Voluntary sector organisations • Partnerships with local business
Better Health	People will have access to Health checks and Action Plans, reasonable adjustments. Also IT flagging of patients to help support reasonable adjustments	• CCGs • GP's • Acute hospitals • Mental health trusts

4. MONITORING THE SUCCESS OF THE PLAN

This plan runs from 2014 to 2017. However, it will be formally reviewed on an **annual basis** to ensure that it remains relevant and up to date.

We will know whether the plan is **making a difference** through a range of quantitative and qualitative information, such as evidence collected for the annual learning disability health self-assessment framework and the annual service user survey. The main quantitative measures of our success against each of the five desired outcomes are shown under each section of action plan.

Measures will be reported on a regular basis to two main tri-borough learning disability groups:

Tri-borough Learning Disability Partnership Board	**Tri-borough Learning Disability Executive Group**
Made up of people with learning disabilities, family carers, provider organisations and health and social professionals, with responsibility for overseeing the implementation of the learning disability plan	Made up of health and social care officers of adult social care tri-borough and the North West London Commissioning Support Unit

For further information about this plan, please contact Mary Dalton on:
mdalton@westminster.gov.uk

London Borough of Hammersmith & Fulham, Royal Borough of Kensington and Chelsea and Westminster City Council. Learning Disability Action Plan

Outcome 1. Having real choice and control in our lives

People will have control over how they live their lives through access to advocacy, self-directed support and robust person centred planning, ensuring a smooth transition from Children's to Adult Services.

Key Owners of this Outcome: *Children's Services, Adult's Services, Education, Voluntary Sector Organisations*

Case for change

The improvements in life expectancy for those with learning disabilities will almost certainly drive up **numbers of people with learning disabilities in transition** into adult services over future years, as well as the numbers living into old age. The migratory nature of the local population has always created challenges around **identification** of those in need of support. The **transition process** from children's to adult's services therefore provides an opportunity to accurately identify families in need of support in adult services and improve the process for them, particularly because many families find this a challenging time.

Alongside the improvement of identification and experiences of transition, there is an opportunity to understand the effectiveness of local **advocacy services** through the current review being carried out in Tri borough. Performance against local indicators also identifies that work needs to be carried out to improve the number of **clients receiving a review** locally (except in Kensington and Chelsea, where rates are already high), to ensure those locally have control over their lives.

What we are going to do	How we are going to do it	When it will be done	Who Will Lead
Ensure that cross-organisational systems are in place to identify young people with learning disabilities who are transitioning to adult services	As part of the Customer Journey, review the operational structure across the Boroughs for working with people in transition	April 2014	Rohan Wardena Customer Journey Project Lead Gill Vickers Operational Director (ASC)
	Identification of young people from age 14+ to ensure that Adults division has the information to undertake an assessment of need (if appropriate) from age 16 +	October 2014	LD Operational leads/ Berni Jennings Transition Commissioning lead

Ensure that young people and their carers experience a seamless transitions service	Children with special needs have a single Education, Health and Care plan when leaving school	September 2014	Tri B Director of Schools Commissioning/Asst Director SEN
Improve local provision to meet the needs of young people coming into adult services	Work with families to identify the current and future needs of young people and ensure that there are plans in place to meet any gaps in service provision	April 2014	Berni Jennings, Commissioning Lead Transition /Operational Leads
Ensure that all learning disabilities clients are offered an annual review or re assessment	Monitor performance through a Service Level Agreement with Care management to ensure improvements in this area of work.	On going	LD Operational leads /Commissioning lead
Provide a joined up professional advocacy service across the three Boroughs	Review of current 1 to 1 advocacy provision across Tri Borough. Commission new framework for advocacy services across the Tri Borough.	Feb 2014	LD Commissioning Lead Pete McDonnell
Develop user involvement	Review current arrangements for customer involvement in the planning and monitoring of services and agree a new procurement strategy.	In place during 2014/15	Toby Dickenson Linda Burke Commissioning leads
Put in place flexible purchasing and contract arrangements with providers that enable individual choice.	Review the current Procurement Plan /Strategy with existing contracts to ensure that there is an agreed approach for all future purchasing arrangements	July 2014	Commissioning and contracts leads

Measures of success

- More people supported at home will have a personal budget
- More people will receive their personal budget as a direct payment
- More people will have a review in the year
- More survey respondents will say 'I make all the choices I want' / 'I make some choices, not all, but that is OK' (Annual survey)
- More young people will have a seamless experience from children to adults services

Outcome 2. Partnership with families

Family carers will be expert partners in care, have a strong voice, and be supported better as carers and as individuals

Key Owners of this Outcome: *Family Carers, Children's Services, Adult's Services, Voluntary Sector Organisations*

Case for change

Caring for someone with learning disabilities can be demanding and has impacts on mental and physical health. Caring can also have a big economic impact on carer's working lives. Like elsewhere in the country, local carers of people with learning disabilities can struggle to maintain sufficient **social contact** and **control** in their lives, and eight out of ten locally say they do not do enough of the things they **value or enjoy**.

Ongoing **employment, leisure and short break-related support** for carers is likely to prevent more costly and less suitable interventions from statutory services when crises occur.

Although local carers find **information and advice** useful, surveys suggest not all say it is easy to find. There is scope to make information and advice more accessible using a range of approaches.

In two of the boroughs, the number of carers receiving an **assessment or review** has been less than in previous years (rates remain high in Kensington and Chelsea). Although rates now appear to be improving, ensuring high levels of assessment and review is necessary as part of providing the support needed to carers and facilitates ongoing 'signposting' to services that might support them.

What we are going to do	How we are going to do it	When it will be done	Who Will Lead
Provide timely , flexible support to carers	Strategic review of short breaks provision across the boroughs with options for improving the range and choice of services available	April 2014	Commissioning Lead Derry Pitcaithly
	Re commissioning of Home Care provision across the boroughs to improve the quality of service.	Implementation April 2015	Commissioning Lead Sara Newton
	Offer a Carer's Assessment to all carers to ensure they are aware of the support, advice and information available	On-going	LD Operational Leads
	Identify and support older carers to plan for the	On going	LD Operational Leads

	future care of their family member Work in partnership with Carer Support Services to review and establish specialist support for LD carers Review, improve and promote existing carers' information and advice literature, including websites, to raise awareness amongst carers and stakeholders of the support available Undertake a mapping exercise of employment, training and volunteering opportunities for carers prior to developing a comprehensive guide	 March 2014 April 2014 June 2014	 Carer Commissioning Lead Communications Team/People First Carer Commissioning Lead
To ensure that the views of carers are taken into account when planning services	To review the current framework and forums for carer feedback and engagement including the LD and Carers' Partnership Board, and Carers' Forum	March 2014	LD and Carer Commissioning Leads
Provide support to those people with a learning disability who are also carers	Identify the people who are carers and ensure they are offered a proper Carer's Assessment and additional training and support where required	June 2014	LD Operational Leads

Measures of success

- More people supported at home will have a personal budget
- More carers will have an assessment or review in the year
- More carers will have a carer's personal budget
- All staff within the learning disability team, service providers, and relevant external partners will complete the new carers e-learning module
- More carers will say they are extremely or very satisfied with the support or services that they and the person they support receive (Statutory carers survey)

Outcome 3. Having a home I can call my own

People with learning disabilities experience more choice and control in the range, quality and supply of local supported housing available as an alternative to out of borough residential care

Key Owners of this Outcome: *Housing Departments and Regeneration, Clinical Commissioning Groups (Cages), Registered Social Landlords (RSLs)*

Case for change

Outcomes for clients in **residential care** settings are generally considered to be poorer than in 'settled accommodation', but movement to other in-borough housing options is only possible with an available range of suitable housing stock.

The proportion of clients with learning disabilities in Westminster who are living in **'settled accommodation'** (secure tenancy) has risen to beyond London levels. However, the other two boroughs remain below, with a particularly high proportion of clients in Hammersmith and Fulham living in residential care and many clients living outside the borough in both cases. Hammersmith and Fulham spend a large proportion of the budget on residential and nursing care.

The situation and **demand for suitable housing** is likely to become increasingly challenging. The current and predicted future rise in numbers **transitioning** in to adult services, and the increasing complexity suggests more 'bespoke' housing solution may be needed. This is exacerbated by the improving life expectancy for **older people** with learning disabilities, many of whom may outlive their parents and have disabling conditions such as dementia.

What we are going to do	How we are going to do it	When it will be done	Who Will Lead
Develop more housing with support options locally to minimise the need for people to live in residential care out of the borough	Consider the business case for a shared lives scheme across the Tri borough, with a focus on the provision of short breaks as well as longer term accommodation.	April 2014	Christian Markandu Commissioning Lead
	Consider the options and arrangements for the potential leasing of properties from the Private Rented Sector market	September 2014	Accommodation and Support Commissioning Lead Hannah Carmichael
Pathways into housing	Consider the Business Case for a framework	December 2014	Operational

	for mapping and utilising supported housing voids across the Tri Borough.		Leads/Accommodation and Support Commissioning lead
Improve accommodation and support locally for people with complex needs	Continue the implementation of Westminster's Housing Strategy 27 New build units of specialist supported housing for people with autism and high support mobility needs in Harrow Road /Elmfield Way Capital investment projects to refurbish properties for people with complex needs. Re modelling of the Westminster Society contract from residential care to supported living. Implementation of LBHF Accommodation and Support Strategy Review in house provision at Coverdale Road. Review Community Support Service. Re model Yarrow services into Supported Housing Identify possible sites for new build supported housing for people with complex needs Identify avenues for potential capital	In place 2016/17 Completed April 2016-April 2017 2014-15 Re registration completed by December 2014. 2014-17 March 2014 April 2015 December 2014	LD Accommodation Manager Cindy Maula Cath Atlee. Project Sponsor LD Accommodation Manager Cindy Maula LD Accommodation Manager Cindy Maula Accommodation and Support Commissioning Lead . Hannah Carmichael Commissioning/ Operational/Contracts Housing/Regeneration/Planning Accommodation and Support Commissioning Lead . Hannah Carmichael

	investment to adapt and refurbish existing property for people with mobility/complex needs.		
Improve the support available for people to live in their own homes	To review the current provision of outreach and community support to people in their own homes to ensure that it can support people with more complex needs. (With a focus on LBHF provision) To review and re commission the Supporting People funded housing support in RBKC	Completed April 2015 New contract from 1st Feb 2014	Accommodation and Support Commissioning Lead . Hannah Carmichael Hannah Carmichael Accommodation and Support Commissioning Lead
That people have more choice and control over their housing options and the support that they receive	Review existing contracts with providers to move towards a core and flexi model of support. Models of supported housing will be delivered increasingly through the use of personal budgets to enable choice of support from a range of providers	Ongoing	Personalisation Lead /Contracts Team

Measures of success

- More people will live in their own home (a home with a secure tenancy) or with their family
- Fewer people will live in residential care
- More survey respondents will say, 'I can do everything I need in my home' / 'I can do most of what I need in my home, it's OK.' (Annual survey)

Outcome 4. Being part of my community

People with a learning disability will be supported to be active and independent citizens, living and working in their communities in the same way as non-disabled residents

Key Owners of this Outcome: *Leisure Services, Economic Development and Regeneration, Voluntary Sector Organisations, Partnership with Local Businesses*

Case for change

People with learning disabilities locally generally state in surveys they have adequate **social contact** with other people (similar to nationally), and that they can **get to places** in the local area (better than nationally). However, given the inequalities that those with learning disabilities face every day, particularly around employment, safeguarding and accessibility of services, there is still considerable scope for further improvement

Increasingly, the incidence of hate crime for people with learning disabilities and their families is being raised as a local issue, and nationally

Uptake of **personal budgets** has been lower than nationally. Levels of **paid employment** for those with learning disabilities are lower than London and England averages.

What we are going to do	How we are going to do it	When it will be done	Who Will Lead
Develop the range of local non-commissioned services that can be accessed via personal budgets	Consider developing the market through supporting local micro social enterprises and community development initiatives. Explore the use of Social Impact Bonds	2014 - 2015	Pete McDonnell LD Commissioning Lead
	Look at the possibilities for developing the role of People First to provide information on Community activities and support that can be individually purchased. To ensure that this information feeds into care planning.	2014 - 2015	Nick Merchant/Pete Mc Donnell LD Commissioning Lead
To provide access to community activities which	Review the range of preventative day activities that can provide people with meaningful	2014 – 2016	Pete McDonnell/Derry Pitcaithly Commissioning Lead

increase integration and reduce social isolation	leisure, work and education opportunities. To identify support networks that can help people to pool their personal budgets to increase access to a range of social as well as individual community activities during the evenings and weekends	2014 - 2016	Pete McDonnell/Derry Pitcaithly Commissioning Lead
Work to identify and prevent hate crime	Collate information across the boroughs on areas of hate crime and work with service users, advocates and the police on an awareness raising and preventative plan. Widely distribute the accessible 'Keeping safe' pack across Tri-borough so people and their families know how to report abuse, are listened to and feel safer as a result of safeguarding activity.	Ongoing 2014-2016 Ongoing 2014-2016	Safeguarding Lead Commissioning Linda Burke Mary Wynne and SARG members Louise Butler
Improve transport and community facilities	To work with planners across the boroughs regarding the building of more accessible changing places / toileting facilities: Review the current transport arrangements to provide a more flexible, personal service. Pilot Tri B Travel Support Plan Roll-out Travel Support Plan New Tri B Transport Framework of buses and Taxis and internal Transport Commissioning Office Review Travel Mentoring and Buddying	2014-2016 2014 - 2015 Nov 13 – Feb 14 April 2014 April 2014 Winter 2014	Hannah Carmichael/Linda Burke LD Commissioning Leads Pete McDonnell/Rachel Hargreave Mawson Pete McDonnell/Laxmi Jamdagni Cath Atlee/Pete McDonnell/Rachel Hargreave Mawson Steven Falvey/Barry Keenan

Ensure local day activities support people with complex needs	Review of day activities across the three boroughs to ensure that the Council's buildings and staff are being used in the most flexible way to support people in the community. New service offer to include combined LBHF and RBKC day provision. To outsource all in-house complex need day services	2015/16 2015/16	Stella Baillie/Mary Dalton Stella Baillie/Mary Dalton
Support more people to understand how they can 'have a say' through voting	Work with Electoral Services and communications sections across tri-borough and also advocacy organisations and support staff to promote awareness of and encourage participation in local and national elections	2014 to 2018	LD Commissioning Lead
Employment and Volunteering Opportunities	Tender RBKC and WCC Supported Employment Services Pump prime a social enterprise to offer a very supported employment environment (WCC/KC) Develop an offer from the Economic Development Team in LBHF in job and work experience opportunities for ASC customers. Develop better employment opportunities from the Councils Continue to develop successful Volunteer	July 2014 May 2014 On-going from November 2013 2014 onwards	Mary Dalton/Pete McDonnell/Charles Stephens/ Commissioning Leads /Economic Development Team Mary Dalton/Pete McDonnell/Charles Stephens/Michael Gray Mary Dalton/Pete McDonnell/Michael Gray/Julia Copeland/LBHF Economic Dev. Team Pete McDonnell/WCC Economic Development Team

	schemes with a work experience focus and investigate Tri-borough options leading to an ASC and NHS volunteering strategy and procurement. Link to the wider voluntary offer in London. Put employment at the forefront of day opportunities and care management through senior management endorsement and targeted staff training	 2014 onwards	Linda Burke/Pete McDonnell RBKC Economic Development Team Pete McDonnell/Linda Burke Pete McDonnell/Lara Hogan

Measures of success

- More people of working age have a paid job in the year
- More people will do voluntary work in the year
- More survey respondents will say, 'I spend my time as I want' / 'it's OK' (Annual survey)
- More survey respondents will say, 'I see my friends / family as much as I want' / 'It's OK' (Annual survey)
- More survey respondents will say, 'I can get to all the places I want' / 'Sometimes it's difficult' (Annual Survey) (Also 3.4)
- More survey respondents will say 'I feel very safe' (Annual Survey)
- Number of safeguarding alerts which are followed up under safeguarding policies and procedures
- In the great majority of concluded safeguarding cases, the risk of harm or abuse will have been removed or reduced
- Number and nature of complaints (and compliments) received by the Tri-borough Customer Feedback Team

Outcome 5. Better health

People will have improved access to mainstream health services and health promotion and more people will receive a health action plan and an annual health check

Key Owners of this Outcome: *Clinical Commissioning Groups (Cages), GPs, Hospitals, Mental Health Trusts*

Case for change

People with learning disabilities have **poorer health outcomes** than the general population. Some of this can be accounted for by conditions common to the general population, which are not identified early enough or are not managed properly because the system doesn't cater for needs specific to people with learning disabilities. In some cases, high levels of obesity, typical to some with learning disabilities, can lead to health complications such as high blood pressure and heart disease.

Identifying conditions early through **annual health checks** with GPs is critical. Previously, Westminster and Kensington and Chelsea performed well in relation to London but performance slipped in 2012/13. Hammersmith remains similar to the London average, suggesting further progress can be made.

Community and hospital-based health services are not set up in a fashion that allows people with learning disabilities to be supported in receiving health care, and **reasonable adjustments** need to be considered by law. Local people with learning disabilities and their families want a range of things, including longer appointments, appropriate waiting areas and IT systems that can identify specific needs.

The **Winterbourne View Concordat** has also required that patients in hospital placements are, where appropriate, discharged into the community with action plans in place.

What we are going to do	How we are going to do it	When will it be done	Who Will Lead
Improve and maintain uptake of health checks, action plans, and prevention services	To work with LD Community Teams and GPs to increase the numbers of health checks and audit the quality of health checks and action plans To address data quality issues around numbers attending cervical and breast screening: - establish baseline data for breast, bowel and	Current to March 2014.	NHS NW London Community Support Unit

	cervical screening - develop actions to improve uptake in mainstream screening where necessary		
Make reasonable adjustments to services to make them more accessible and easier to use	Implement a I.T. system to identify the learning disability status of patients in primary care Work with acute leads to ensure that an approach is made to embed reasonable adjustments into mainstream provision Provide staff in acute settings with access to training To work with community services (e.g. CLCH community care, dentists, pharmacies, optometrists, maternity services, offender services and other services) to make further adjustments to enable service users with complex and challenging behaviour to access the services easily - This may include aspects such as designated slots when there are fewer patients, and reductions in waiting times for clients with LD	September 2014 Ongoing Ongoing Ongoing	Senior Commissioning Officer LD & Carers Health/Nurse lead in community LD team Health/Nurse lead in community LD team Health/Nurse lead in community LD team
To improve opportunities to take part on health and leisure opportunities	To work with housing, leisure services and care providers around issues relating to the promotion of leisure facilities and the tackling of obesity for people with learning disabilities This will include reasonable adjustments to ensure that those with learning disabilities or autism are able to access mainstream services (e.g. leisure	September 2014	Health/Nurse lead in community LD team

	services), to maintain positive outcomes		
Ensure people in specialist hospitals have access to local housing and support	Review all people in inpatient Assessment and Treatment Provision and ensure that completed reviews and discharge plans are in place to use community-based services, to avoid the inappropriate use of inpatient assessment and treatment placements. Ensure that all people are moved from assessment and treatment provision if deemed no longer appropriate Work with Children and Families Services to identify those individuals likely to use inpatient assessment and treatment provision *in the future* and plan to implement community services to avoid this, where appropriate and possible	April 2013 and ongoing June 2014 2014-2016	LD Community Teams LD Community Teams LD Lead
Supporting good mental health	To improve access and experience of treatment for those with learning disabilities who have mental health needs	April 2015	LD Lead and Service Managers
Prevent unnecessary death from conditions related to learning disabilities	To report causes of death of those with learning disabilities, to give indications of possible preventability, risk factors and causes Link findings to the health checks and health action plans process to improve outcomes via reducing the risks. Track performance over time	September 2014	Service Managers

Measures of success

- More people will have an annual health check
- More people will have a health action plan
- More survey respondents 'My life is really great' / Mostly good' (Annual Survey)
- More survey respondents will say 'I am very healthy' / 'I am quite healthy' (Annual survey)
- Number of deaths of people under 60 years of age
- More survey respondents will say 'I am very happy with the way staff help me, it's really good' / 'I am quite happy' (Annual survey)
- Fewer respondents will say 'the way I'm helped and treated makes me feel a bit bad' / 'Very bad about myself (Annual survey)'

NHS West London Clinical Commissioning Group

NHS Central London Clinical Commissioning Group

NHS Hammersmith and Fulham Clinical Commissioning Group

Our Big Plan for Learning Disability Services 2014 to 2017

h&f hammersmith & fulham

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

City of Westminster

Why have a Big Plan?

The Big Plan says what we are going to do to make things better so that :

I have more choice and control

I have a home of my own

I am part of my community

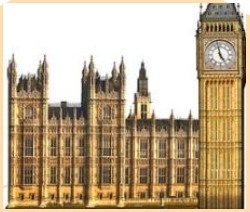
Why have a Big Plan?

I am supported to get a job

Have better health

My family is supported

We have lots of information



Government Policy/Best Practice

Big Plan

Health Self-Assessment and Partnership Board Report

User and Carer Voice

Performance

Joint Strategic Needs Assessment

About People

Number receiving a service (in year):

h&f hammersmith & fulham **490**

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA **285**

City of Westminster **520**

By 2020 we think there will be more people

About 10% more

Increase in support needs

For example, young people moving to adults services: 36 this year; 52 next year (one in three with autism)

About Money and Services

City of Westminster

Westminster Gross Budget for Services 2013/14: £27,790,000
(excluding assessment and care management and overheads)

Little money

Big money

Jobs:0.6%

Advocacy (TAP) : 0.5%

Learning Disability Development Fund : 0.8%

Home care: 3%

Short breaks: 6%

Direct Payments: 5%

People in hospital : 4.6%

Day Care: 12.5%

Care homes: 43.%

Supported Living : 24.%

About Money and Services

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

Kensington and Chelsea Gross Budget for Services 2013/14: £16,530,799

(excluding assessment and care management and overheads)

Little money

Big money

Learning Disability Development Fund : 1%

Jobs:1%

Advocacy (TAP) : 1%

Home care: 3%

People in hospital : 1%

Short breaks: 4%

Other: 5%

Day Care: 11%

Direct Payments: 9%

Care homes: 43%

Supported Living : 21%

About Money and Services

Hammersmith & Fulham Gross Budget for Services 2013/14: £20,081,000

(excluding assessment and care management and overheads)

h&f hammersmith & fulham

Little money

Big money

Jobs:0.5%

Advocacy (TAP) : 0.5%

Learning Disability Development Fund : 1%

Short breaks: 2%

People in hospital: 4%

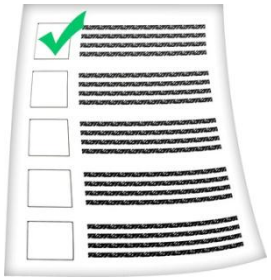
Day Care: 4%

Supported Living : 4%

Home care: 6%

Direct Payments: 5%

Care homes: 73%

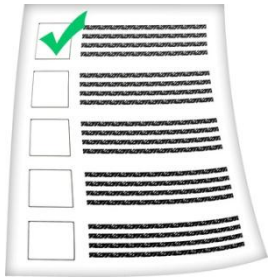


Big Things to Do

In all the 3 boroughs we will work on a joint Plan for:

Better housing that supports people with more complex needs to live locally in their own home rather than in residential care.

Making sure young people have a joint person centered plan for when they become an adult.



Big Things to Do

More people have better access to health services, a health action plan and annual health check.

People feel safe and supported to make friends and access community activities the same as other citizens.

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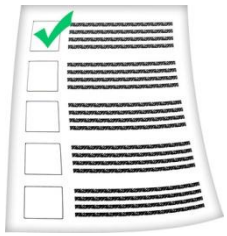


Big Things to Do

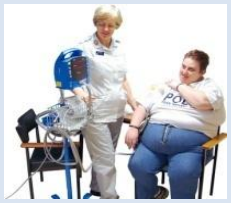
Work with other Council Departments to get funding and support for paid and unpaid work

Ensure that carers have a voice and have flexible support when they need it

Provide more local choices of day, work and community activities , that I can buy with my Personal Budget

Better Health

What we plan to do



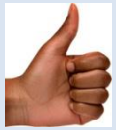
Audit health checks and action plans for quality and work with Gp's to identify and increase numbers

Make sure health services are accessible and easier to use

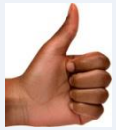
Make sure people in specialist hospitals are reviewed and have access to local housing and support.

Home of my own

What we plan to do



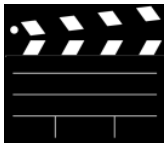
Identify money for new and better housing across the boroughs for people with complex needs



Work with more housing providers, such as Private and Social landlords to increase the quality and choice of local housing

Develop more supported housing so people can have their own home and do not have to live in residential care out of the borough

Working with Families



What we plan to do

Review the short breaks offered to carers to ensure access to quality, flexible support.

Work in partnership with families and ensure that carers have a stronger voice.
Regualy review the care provided to people living with their families

Every young person with complex needs will have a joint Plan before they leave school, identifying the support they need when an adult

Being part of my community

What we plan to do

Give people more choice and control by offering everyone a personal budget by 2015 and a bigger choice of support services people can buy.

Review day opportunities to ensure that our buildings and staff are being used in the most flexible way to offer a broader range of work, leisure and community activities.

Review advocacy and the support people need to have a voice and feel safe and active in the community.

Getting a job

What we plan to do

Develop more opportunities for volunteering and work experience, such as micro social enterprises.

Work with people in other Council departments such as Regeneration to identify schemes that could be funded by the government

Review current employment services to ensure that they are joined up across the 3 boroughs

How will we know how well we are doing ?

We will see if the Plan is making a difference through customer surveys and other information on how we are meeting our targets

People with Learning Disabilities and their families be will part of monitoring the Big Plan through the Partnership Board and other meetings set up to monitor progress.

	London Borough of Hammersmith & Fulham **HEALTH AND WELLBEING BOARD** **8th September 2014**
JOINT STRATEGIC NEEDS ASSESSMENT – 12 MONTH REVIEW	
Report of the JSNA Steering Group	
Open Report	
Classification: For Information **Key Decision:** No	
Wards Affected: All	
Accountable Executive Director: Liz Bruce, Tri-borough Executive Director of Adults and Health	
Report Author: Colin Brodie, Public Health Knowledge Manager	**Contact Details:** Tel: 020 7641 4632 E-mail: cbrodie@westminster.gov.uk

1. EXECUTIVE SUMMARY

1.1. This report sets our progress being made against evidence set out in deep dive JSNAs published in early 2013.

2. RECOMMENDATIONS

2.1. The London Borough of Hammersmith and Fulham Health and Wellbeing Board are asked to note the report attached at Appendix 1 which provides a 12 month update on Joint Strategy Needs Assessment Deep Dive projects undertaken in 2013.

3. REASONS FOR DECISION

3.1. This is for information only

4. INTRODUCTION AND BACKGROUND

4.1. 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, “the JSNA Steering Group”.

4.3. The report attached at Appendix 1 has been provided by the JSNA Steering Group and provides a summary of progress on the deep dive JSNAs published a year ago. These were Suicide Prevention; Rough Sleepers; Carers; Child and Adolescent Mental Health (CAMHS); Sexual Health; Tobacco Control and Prison Healthcare. The report includes an evaluation on progress made against the recommendations (where this is relevant)

4.4. The JSNA programme team are currently developing a framework to ensure there is a robust process in place for future reviews on the impact of JSNA deep dives, primarily focussing on the recommendations which are now included in the deep dive JSNAs.

5. PROPOSAL AND ISSUES

5.1. Please see attached report at Appendix 1.

6. OPTIONS AND ANALYSIS OF OPTIONS

6.1. N/A

7. CONSULTATION

7.1. N/A

8. EQUALITY IMPLICATIONS

8.1. N/A

9. LEGAL IMPLICATIONS

9.1. N/A

10. FINANCIAL AND RESOURCES IMPLICATIONS

10.1. N/A

11. RISK MANAGEMENT

11.1. N/A

12. PROCUREMENT AND IT STRATEGY IMPLICATIONS

12.1. N/A

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: Joint Strategic Needs Assessments 2013 – 12 month progress report

Appendix A: JSNA Deep Dive Update and Progress Review July 2014

COMPLETED JSNA DEEP DIVES PRODUCTS 2012/13 – Update on Progress

The following deep-dive JSNAs were completed and published in 2012/13. Below is a reminder of the summary of the key findings for each JSNA and an update on progress since they were published.

Suicide Prevention JSNA	

Summary	Rates of deaths by suicide in Inner North West London are higher than in most London Boroughs.
	
	Suicides are most prevalent in men aged 40-49 years old and the majority of all people completing suicide are born in the UK.
	
	There is strong evidence that the following interventions help prevent suicides:-
	• For the general population
	  ○ Restricting access to means of suicide
	  ○ Policies to reduce harmful use of alcohol
	  ○ Responsible reporting of suicide in the media
	• For at risk groups
	  ○ Gatekeeper training for family and community members and health and social care professionals to recognise those at risk
	  ○ Mobilising communities
	  ○ Postvention for suicide survivors
	• For individuals
	  ○ Identification and treatment of mental disorders
	  ○ Management of persons who have attempted suicide or identified as at risk
	
	There needs to be improved access to local data relative to suicide from coroners.
	Feedback from local service providers and families of people who have completed suicides indicate that there is an urgent need to:
	• Strengthen and co-ordinate postvention for the friends and family bereaved by suicide
	• More joined up working between services, including information sharing
	• Increased gatekeeper training for family and community members as well as health and social care professionals to help recognise those

	that might be at risk, question them openly, persuade them to seek help and refer them to appropriate health professionals. • Improve the knowledge about mental illness and the risk of suicide for family members
Purpose	To inform the development of a Triborough suicide prevention strategy
Recommendations	No
Lead responsibility	Triborough Suicide Prevention Working Group
Progress to date	A tri-borough suicide prevention strategy was developed based on the findings of the JSNA and which sets out five priorities: • Timely communication and information sharing between agencies on identification of at risk individuals and care pathways. • Public education and awareness on suicide and/or mental health promotion – through community outreach, anti-stigma campaigns, etc. • Promotion of existing suicide prevention resources, interventions or support services (e.g. Maytree respite or telephone help-lines like Samaritans/CALM). • Training for frontline workers (GPs, A&E, and concerned others) through programmes like mental health first aid training or applied suicide intervention skills training. • Targeted interventions for at risk groups (bereaved families, people from BME background, people with mental health issues, people known to mental health services, etc. One issue highlighted in the JSNA was improved access to coroner's files and data. Permission was received from Fulham coroners to access case files. An audit of the coroner's files was recently completed and this information is now being analysed. In response to feedback from local providers and families of people who have completed suicide the following action has been taken: • A resource pack for families bereaved by suicide has been developed. This has information to help people navigate the bereavement process from death notification, coroner's inquest and afterwards. • A multi-agency suicide prevention working group continues to meet quarterly. Membership is drawn from a range of agencies in operating in the area that have a strategic interest in promoting mental wellbeing. These include local mental health trusts, London underground, acute trusts, local authority, public health, police (British transport and metropolitan), clinical commissioning groups, academic institutions, community providers and service users. The group seeks to promote effective inter-agency working in communicating, managing and preventing suicide incidents in the tri-borough area. One of the key themes the group is exploring is developing an information sharing protocol. • A business case for suicide prevention training for gatekeepers is currently being developed
Future delivery	As above

Risks and issues	None identified
Actions for Health and Wellbeing Board	• Ensuring that suicide prevention and mental health promotion receives equal priority to other health and wellbeing issues. • To nominate a named board member as a lead for mental health. This person can be trained as a mental health champion. • Explore opportunities for investment in prevention, promotion and early intervention

Rough Sleepers: health and healthcare	
Summary	In 2012 INWL PCT was given funding by NHS London to undertake a review of the health needs and healthcare costs of rough sleepers in the London Boroughs of Hammersmith and Fulham, Kensington and Chelsea and Westminster. The INWL Boroughs were chosen because they have amongst the highest rough sleeper populations in London. This work consisted of a literature review, a qualitative piece of research talking to current and ex rough sleepers and service providers and a quantitative piece of research to identify the secondary care health costs of rough sleepers across the three boroughs. The quantitative data analysis has never been done in London before and provides very useful healthcare usage and costing data of rough sleepers and shows that rough sleepers use emergency health care significantly more than the general resident populations and therefore cost more per head than the general population. **Key findings from the report are:** • **Rough sleepers use more secondary health services, and therefore cost more.** National estimates show that the homeless population consumes about four times more acute hospital services than the general population, costing at least £85m per year. The 933 rough sleepers analysed in inner North West London used secondary care at a cost of £2.4 million. Rough sleepers access A&E seven times more than the general population, and are more likely to be admitted to hospital as emergencies, who cost four times more than elective inpatients. • **Rough sleepers have more health needs.** When rough sleepers attend hospital, they average seven A&E attendances per patient, nearly 10 appointments per patient for outpatients, and nearly three inpatient admissions per patient. They also present with more co-morbidity – one in five who had contact with hospitals had three or more diseases. • **There are specific barriers to accessing services for rough sleepers.** Rough sleepers face a number of attitudinal and structural barriers to accessing healthcare. These include discrimination by health professionals, not being allowed to register with a GP, a lack of knowledge of services, a lack of continuity of care, and cost. Fear of stigmatisation and health as a low priority are also significant

	barriers. • **But there are things that can be done.** Interventions and models of care have been developed, and are being used, to provide a better system of care for rough sleepers.
Purpose	To inform future decision-making by contributing to the evidence base for rough sleepers in inner London. The JSNA describes rough sleepers health needs and usage, evaluates the cost of healthcare, identifies existing models of service delivery, and summarises the evidence for interventions targeting rough sleepers.
Recommendations	No
Lead responsibility	Peter Beard; Senior Commissioning Officer Learning Disabilities and Carers; North West London Commissioning Support Unit; Tri-borough Joint Commissioning Team Adults
Progress to date	In response to the findings from the JSNA the following information has been provided **Rough sleepers use more secondary health services, and therefore cost more.** • A peripatetic nurse role has been established in West London and funded by WL CCG **Rough sleepers have more health needs.** • There is an identified clinical lead for Homeless Health which includes rough sleepers • A Homeless Health Local Enhanced Service **There are specific barriers to accessing services for rough sleepers.** • Homeless health peer advocacy service provided by Groundswell which has been shown to reduce Did Not Attend (DNA) rates among rough sleepers • A workshop was held on 21st May bringing together CCGs, health providers and patients to develop a pathway to ensure that the health services for rough sleepers and the homeless are based on need and not location • A pathway has been developed. This will now be formally agreed during June and the impact on commissioning determined by the CCG
Future delivery	As above
Risks and issues	None identified
Actions for Health and Wellbeing Board	None identified

Carers Evidence Pack for Hammersmith and Fulham	
Summary	This evidence pack was designed to provide the analytical underpinning that justifies why the Borough Carers Action Plan gives priority to the areas chosen. It used data and evidence from a range of national and local sources. In some cases, available data was relatively old. Early in 2013, new data will be made available from the 2011 Census and National Carers Survey, which will add to the existing knowledge base around carers' needs and inform future action plans. **Key points from the evidence pack** • The way information is recorded and shared could be improved and new data from the 2011 Census and National Carers Survey could alter understanding of the pattern of caring locally, • There is a need to work closely and in a coordinated way with a wide range of stakeholders to improve identification of carers, particularly new carers • The drop in numbers of carers known to the council in 2010/11 needs to be addressed (although recent data shows a rise). • The expected rise in those needing care may result in more carers and hence more support needed for them in their caring role. • Although the numbers taking up carers' assessments and receiving direct payments are high compared to elsewhere, there is scope to improve this uptake. • There has been a drop in numbers receiving information and advice compared to previous years • More information and advice is needed for carers, not only in a range of formats but also a range of settings, including GP practices, pharmacies, libraries and job centres. • Involvement of carers in decisions about care appears to be slightly better in the borough than nationally, but with scope for further improvement, particularly in hospital settings (e.g. through link workers and hospital discharge planning) • A range of interventions that help reinforce and build well-being may tackle issues of low well-being and low life satisfaction reported among some carers locally. • There needs to be increased awareness of the factors that increase the risk of carers being involved in harm. • Although the borough is relatively successful at identifying young carers compared to elsewhere, there is still likely to be significant unmet need. • There is a recognised 'gap' for carers who have reached the age of 18 , and are therefore too old for the young carers service, but too young for the range of services offered to predominantly older adult carers.
Purpose	Provide the evidence base to inform the Carers Action Plan

Recommendations	No
Lead responsibility	Peter Beard, Senior Commissioning Officer Learning Disabilities and Carers; North West London Commissioning Support Unit; Tri-borough Joint Commissioning Team Adults
Progress to date	The following is an update against specific findings of the JSNA: **Need to work closely and in a coordinated way with a range of stakeholders to improve identification of carers, particularly new carers** • Carer Primary Care Navigator project initiated with practices • GP practices better connected to the local carer support service • GP practices better connected to the young carers service **The drop in numbers of carers known to the council in 2010/11 needs to be addressed (although recent data shows a rise).** • There has been an increase in number of carers identified by GP practices involved in the carer primary care navigator service; following data cleanse of their carer register: **The expected rise in those needing care may result in more carers and hence more support needed for them in their caring role**. • Current carer support services Funded by CCGs are establishing level of need and developing exit strategies that are sustainable and efficient in supporting existing carers and new carers **Although the numbers taking up carers' assessments and receiving direct payments are high, there is scope to improve this.** • There is a focus on increasing the number of carers personal budgets via improved identification **There has been a drop in numbers receiving information and advice compared to previous years.** **More information and advice is needed for carers, not only in a range of formats but also a range of settings, including GP practices, pharmacies, libraries and job centres**. • We have seen an increase in the numbers of carers identified and referred to the local carers support service through primary care services • No work has yet started in relation to pharmacies, however the local carer support service have run information points within other community based locations including libraries and churches

	Involvement of carers in decisions about care appears to be slightly better in the borough than nationally, but with scope for further improvement, particularly in hospital settings (e.g. through link workers and hospital discharge planning) • There is a Tri-Borough carer hospital discharge project in place covering Imperial and CWFT • This is provided by a local third sector carers organisation working with key senior managers in the relevant hospital sites and frontline staff and carers **Interventions that reinforce and build well-being may tackle issues of low well-being / life satisfaction among carers locally.** • There has been ongoing funding and management support provided by the CCG to Third Sector organisations to promote and further develop the wellbeing services for carers **There needs to be increased awareness of the factors that increase the risk of carers being involved in harm.** • Carers e-learning package procured through CCG funding Due to launch in July/August • This will be rolled out to staff in Social care, Housing, Universal services, Primary and acute care etc **Although the borough is relatively successful at identifying young carers, there is still likely to be significant unmet need.** **There is a recognised 'gap' for carers who have reached the age of 18 , and are therefore too old for the young carers service, but too young for the range of services offered to predominantly older adult carers.** • Work is required in this area • Transition pathway needs to be established • Detailed needs analysis to be completed • Identification of where there are specific gaps
Future delivery	• Implementation and launch of Carer roadmap in partnership with CCGs and RCGP, modelled on Dementia roadmap • Further practices to be engaged through the carer primary care navigator project • Further extension to the Carer primary Care Navigator service for a further 12 months; working with 24 more practices • Commencement of procurement of a young carer family support service commissioned by CLCCG
Risks and issues	Lack of procurement capacity in Local Authority procurement team could result in services not being delivered as planned through S.75
Actions for Health and Wellbeing Board	Assist in increasing capacity to procure services already agreed in Section 75 for 2014/15

Child and Adolescent Mental Health (CAMHS)

Summary

Main findings

It is estimated that the prevalence of mental health disorders for children and young people across the tri-borough are as follows:

	Boys		Girls		Estimated total number across the tri-borough
	5-10	11-15	5-10	11-15	
Conduct Disorder	3.75%	4.8%	1.75%	2.1%	**Between 1281-1764**
Hyperkinetic Disorder	1.0%	0.4%	0.1%	0.1%	Between 175-229
Emotional Disorder	2.2%	3.5%	2.8%	5.2%	Between 1336-1736
Co-Morbid Disorder	2.1%	2.9%	0.6%	1.3%	Between 714-963
Neurotic Disorders (16-19 year olds)					2688
Autistic Spectrum Disorder					406

Based on population projections the number of children presenting with mental health conditions will increase as a total number and as a percentage of the population for the next 15 years.

Children and Young People who are particularly vulnerable to mental health conditions are:

- BAME children
- Looked After Children
- Care Leavers
- Young Offenders
- Children with learning Disabilities
- Unaccompanied Asylum Seekers
- Homeless young people
- Those who self harm and are at risk of Suicide

The number of children and young people who may experience mental health problems appropriate to a response from CAMHS at Tiers 1, 2, 3 and 4 have been estimated using national research. The following table shows the estimates for the population aged 17 and under across the tri-borough area:-

		Tier 1	Tier 2	Tier 3	Tier 4
	Hammersmith & Fulham	4926	2299	608	25
	Kensington & Chelsea	4080	1904	503	20
	Westminster	5550	2590	685	28

Main issues

- The service data collected from across the tri-borough is not consistent across all the services and there is a wide variation in the data and information that they can provide. This means that it is difficult to know if the services that provide the different tiers of service are doing so effectively.
- Currently prevalence of mental health conditions in children and young people is an estimation based on national research. It is not possible to get local prevalence data currently as the data is not consistently collected across the services.

Purpose	On 1st April 2012 the Children's Joint Commissioning Team became responsible for commissioning Council and CCG funded CAMH Services for Hammersmith and Fulham, Kensington and Chelsea and Westminster. The team requested a JSNA to inform their review of funding and provision across the three boroughs. This was to ensure that a comprehensive range of accessible services from universal to highly specialist that; a. are commissioned and delivered in line with best practice guidance b. effectively meet the needs of patients, families and stakeholders c. are high quality d. represent good value for money
Recommendations	No
Lead responsibility	Jacqui Wilson; Commissioning Manager ; Children's Joint Commissioning Team North West London Commissioning Support Unit
Progress to date	Progress update provided by lead commissioner • Service specifications and reporting systems have been tightened up in the last contract round. This will help us to better understand demand and supply for CAMHS services. • Work is underway across the Triborough to think about how services for Looked After Children (LAC), including those with mental health issues, are best managed

	• A CAMHS network has been established. These meetings provide a forum for services working with children and young people to thir about how services function, and ensure consultation opportunities around service changes. This is also an opportunity for those working with children and young people to raise issues and think about how they can work together to resolve them. • Commissioners are engaged in Early Help work to again ensure joined up working
Future delivery	As above
Risks and issues	None identified by Commissioner
Actions for Health and Wellbeing Board	None identified

Sexual Health JSNA	
Summary	The consequences of poor sexual health can be serious. Many sexual infections have long-term impacts on health such as: • Pelvic inflammatory disease (which can cause ectopic pregnancies and infertility); • Cervical and other genital cancers; • Hepatitis, chronic liver disease and liver cancer; • Recurrent genital herpes; • Bacterial vaginosis and premature delivery; • Psychological consequences of sexual coercion and abuse; • Poor educational, social and economic opportunities for teenage mothers; • Requirement for lifelong adherence to Highly Active Anti-Retroviral Therapy (HAART) for HIV; • Earlier onset of conditions normally seen in older age amongst people living with HIV. **Limitations and potential data requirements** • Estimates indicate a significant Lesbian, Gay, Bisexual and Transgender people who live, work and visit the tri-borough. However, accurate population size remains unknown. In addition, more understanding is required of the needs of these communities to ensure that accessible and appropriate services are available. • Estimates indicate a significant number of sex workers living or working in the tri-borough area. Work is required to understand the

	size and demographics of this population. Further understanding of the complex needs of this population needs to be gained over time.
Purpose of JSNA	The purpose of the sexual health needs assessment was to inform the development of the Tri-borough Sexual Health and HIV Strategy, ensuring continuity and integrity of sexual health commissioning following NHS reforms. It describes the picture of sexual health across the Triborough, service provision, identifies gaps in services, and key prevention groups
Recommendations	No
Lead responsibility	Ewan Jenkins, Sexual Health Commissioner, Triborough Public Health Service The CCGs also have responsibility for commissioning certain sexual health services, NHS England commission all HIV treatment
Progress to date	A draft Sexual Health Strategy and Action Plan has been presented to stakeholders. Feedback indicates that further work is required to ensure that the strategy will coherently drive improved sexual health outcomes. The following progress has been made: • Work is underway to identify how we can improve prevention work across tri-borough • A review of Sexual and Reproductive Health services delivered in the community has been initiated. This will recommend ways to improve the uptake of contraception including in Primary Care settings. New services are scheduled to be in place from 1 April 2015 • A review of HIV services (including prevention, testing and psychosocial support) has been initiated. New services are scheduled to be in place from 1 April 2015.
Future delivery	Prevention is key to reducing the high rates of acute sexually transmitted infections across Westminster. Significantly increasing the number of people practising 'safe sex' has the potential to reduce suffering and reduce costs. This will require joint working between the local authority and CCGs. To better understand the needs of the Lesbian, Gay, Bisexual and Transgender (LGBT) people Public Health are scoping out an application for a deep-dive JSNA on this community which is likely to involve an element of primary research.
Risks and issues	None identified
Actions for Health and Wellbeing Board	None

Tobacco Control	
Summary	Smoking is the biggest single preventable cause of disease and premature death in the UK and across the tri-borough.Generally, smoking attributable mortality is low in Westminster and Kensington and Chelsea. However, smoking attributable deaths are significantly high in Hammersmith and Fulham compared with other two boroughs and higher than London and England. For Westminster and Kensington and Chelsea, average smoking attributable mortality masks the high mortality rates in the more deprived parts of the boroughs. Deaths due to lung cancer and COPD are significantly higher in H&F compared with Westminster and K&C. Hospital admissions due to smoking were also observed to be high in Hammersmith and Fulham compared with other two Inner North West London boroughs. Health costs due to smoking across the tri-borough are £25.8 million per year with similar amounts for loss of productivity due to smoking. High prevalence of smoking in the most deprived parts of Inner North West London. These areas have a high proportion of social housing, ethnic minority groups and routine and manual workers. These deprived parts of Inner North West London have the highest rates of premature mortality including cardiovascular diseases and cancer. National evidence suggests that over the last 60 years, male smoking prevalence is decreasing faster than female smoking prevalence and as of 2010 male smoking prevalence is slightly higher than females. Certain ethnic groups including Black African and Caribbean males and any other ethnic group (Middle Eastern community) groups, Irish men and Eastern Europeans and Bangladeshi men have high prevalence of smoking compared with other ethnic groups. Routine and manual groups in Westminster and Kensington and Chelsea have high rates of smoking prevalence, while routine and manual groups living in Hammersmith and Fulham have low rates those compared with their respective general population. All Inner North West London boroughs have low rates of current smokers who are pregnant compared with England and London. Generally, rates of quitting smoking across the tri-boroughs are either similar of better compared with London and England. The highest rates of smoking quitters were observed in Hammersmith and Fulham compared with other two boroughs.

	Low rates of smoking quitters in certain deprived parts of the tri-borough According to a recent self assessment looking at current performance with regards Tobacco Control with stakeholders and an additional review of the functioning of the Inner North West London Tobacco Control Alliance across the tri-borough:- • There is good work with young people in Hammersmith and Fulham • Communication is largely reactive with no communications strategy. • No strong leadership • Attendance and membership of the alliance is patchy and unequal • No lead for Tobacco Control • No local Tobacco Control Strategy or vision • Commissioning of services is not joined up with wider strategic plans • There are no governance or reporting arrangements in place. **Data Limitations** There are limitations in terms of data availability for this needs assessment. For example, data on the prevalence of other tobacco products such as shisha is unknown in Inner North West London. There are a high proportion of shisha bars and Middle Eastern community groups smoke shisha in these bars. Furthermore, data availability is limited for Paan use amongst certain ethnic community groups such as Bangladeshi groups. An additional gap in information is for second-hand smoking for those residents in tri-boroughs.
Purpose	The aim of this report was to describe the size of the smoking problem in the three Inner North West London Boroughs (Hammersmith and Fulham, Kensington and Chelsea and Westminster), to analyse the public health impact and disease burden due to smoking and to analyse the local stop smoking services to date. The JSNA has informed the re-commissioning of Stop Smoking Services
Recommendations	No
Lead responsibility	Andrew Burnett, Deputy Director for Public Health, Triborough Public Health Service Christine Mead, Behaviour Change Commissioner, Triborough Public Health Service
Progress to date	Progress to date: • An ineffective Stop Smoking service was decommissioned and a new service commissioned on a Triborough basis, using the

	evidence from the JSNA to develop the service specification. • The new service is incentivised with targets to deliver in areas of highest smoking prevalence, both geographically and amongst communities with higher prevalence eg mental health service users and certain ethnic communities • A draft Triborough Smokefree strategy has been developed • Three local campaigns and local implementation of the three national campaigns have been commissioned to improve communication. The three local campaigns include Busting the Myths about Smoking and Stopping Smoking; a shisha campaign/CntrlZ launch focusing on students; and a campaign on preventing young people from starting smoking. • Work has been commissioned to take the message not to start smoking in schools, using Operation Smokestorm game • Questions were added to the schools survey to collect information on the prevalence of smoking amongst 15 yr olds, as well as information about where young people get their cigarettes from.. • The Smokefree Alliance (formerly Tobacco Control Alliance) has supported innovation projects in mental health hospitals, Chelsea and Westminster Hospital, trading standards testing of shisha, trading standards using sniffer dogs to find illicit tobacco sellers together with HMRC, a paan chewing research project amongst Bangladeshi communities, and hospital referral systems to stop smoking services. • The Smokefree Alliance reviews KPIs of the stop smoking services, trading standards and environmental health on tobacco control elements • The Smokefree Alliance has received briefings from HMRC, ASH, and the Fire Brigade on tobacco control evidence and best practice to link local work with wider strategic working.
Risks and issues	None identified
Actions for Health and Wellbeing Board	None identified

Prison JSNA – HMP Wormwood Scrubs	
Summary	This document highlights the current range of services that are available for prisoners in HMP Wormwood Scrubs. These include primary and secondary care services for physical health, mental health and substance misuse. Local data accessed indicates that the actual numbers of prisoners diagnosed with specific health conditions (including Asthma, Diabetes, Epilepsy and Learning Disabilities) is above that of the local population in the adjacent areas in the local community. However, the rates picked up are below estimated prevalence figures highlighted in national research projects. This may indicate that health conditions are not being picked up at reception and may lead to health and health concerns worsening while in prison. In addition, there are higher levels of mental health disorder, smoking, and worse dental health than in the general population.
Purpose	This JSNA was produced to identify the health needs of prisoners in HMP Wormwood Scrubs so that appropriate and effective services can be commissioned for the prison population.
Recommendations	The following findings and recommendations were made in the JSNA **Overarching principle for healthcare delivery** Prisoners should be cared for by a health service that comprehensively assesses and meets their health needs while in prison and which promotes continuity of health and social care on release. The standard of health service provided is equivalent to that which prisoners could expect to receive in the community. **Recommendations** 1. Introduction of effective communication protocols and action plans between healthcare providers, specialist services and prison staff to ensure clinic DNA (Did Not Attend) rates reduce. Healthcare providers to ensure continued implementation of the induction scheme. Scheme will also look at implementing a reserve list of patients. 2. The healthcare provider to ensure the induction procedure focuses on identifying on-going health issues amongst the prison population. 3. The healthcare providers to ensure all staff are well equipped through appropriate training to guarantee robust data recording and data management from the existing clinical systems. Good data recording will show an increase in the accuracy of data collection, the creation of historical disease / condition registers (including multiple prescribing and comorbidity), and the planning of regular interrogation of intelligence data on patterns of service use and epidemiology within the prison to inform

Prison JSNA – HMP Wormwood Scrubs	
	service delivery. 4. The healthcare providers to introduce the concept of active self-management to prisoners through modular or incremental health and learning programmes to enable short-term prisoners to engage in easily replicable techniques for managing their own healthcare issues. This has potential to improve the health inequalities seen in the offender cohort for the future. 5. The healthcare provider to ensure the investment in the X-ray room can reap on-going and broad health benefits for TB monitoring and minor injuries (fractures and MSK issues) 6. Healthcare services in HMP Wormwood Scrubs will conduct regular assessment and analysis of prisoner health needs and service trends and comparisons in the future in light of the prevailing changes in the wider healthcare landscape. This assessment and analysis will be done in partnership with the prison establishment staff, commissioner and other stakeholders as required. 7. To build stronger links with the education department in order to provide health promotion material to a wider audience, capitalising on the capability of the education department to reach more prisoners.
Lead responsibility	Patricia Cadden Senior Commissioning Manager, Health in the Justice System Team, NHS England 105 Victoria Street, London, SW1E 6QT
Progress to date	The following progress has been made against the recommendations listed above: 1. The DNA rates have been part of a continuing improvement programme led by the primary care provider. The data on DNAs is scrutinised by the commissioner at quarterly contract reviews and remedial solutions out in place. An example of this is the DNA rates for the dental service. Additional investment was given to the dental provider (Tooth and Mouth) to re-triage the list and cleanse their data to reflect new rates of access and any resulting DNAs. The highest rate in 2013 was running at 49%. This was reduced by the end of March 2014 to 20%. Changes in prison officer staffing due to cuts has proved challenging for all healthcare interventions. The National Offender Management Service (NOMS) has introduced a model of “New ways of working” which

reduces staffing levels by approximately 25%. This has seen a sharp rise in Q1 2014-15 of DNAs that is outside of the control of the healthcare provider. NHS England has raised this issue with NOMS on the understanding that healthcare is fully "enabled" where possible to ensure access to healthcare as equivalent to that available in the community.

2. New induction processes have been in place all year 2013-14 and on-going to help prisoners understand their rights to healthcare; what is on offer and how to access treatment and care. These communications have been developed with consideration for the foreign national population as well as prisoners with learning difficulties/learning disabilities. Induction has now widened to be able to take place as prisoner's access other services such as the gym and education.

3. The quality and consistency of data has been managed through a specific project where the data infrastructure lead has developed a guidance document for all healthcare staff to ensure there is consistent use of read codes for conditions and interventions. Additional training by the provider was introduced to support this new work and all partner and sub-contracted providers have access to SystemOne in order to facilitate better communication. This will continue to be amended following the roll out of a new key performance indicator set from NHS England this year.

4. Additional investment was injected to change the existing Seacole Centre (a previously under-used area in the prison) into a health and well-being centre to help demonstrate and support self management techniques. There is yoga, managing musculoskeletal issues sessions and primary care mental health group interventions to promote well-being. Special sessions are also structured for those with long-term conditions to better manage their condition, as well as health checks for the targeted population pre-release.

5. On-going problems with the X-ray machine calibration have frustrated both the provider and commissioner. The x-ray pathway has been established through an audit and resulting protocol set out by NHS England; the staff have been trained; the room specification is complete; the team await the final calibration to be completed by the end of July with a fully "go-live" date on 1st September 2014

6. The prime provider has continued to conduct service audits throughout the year and review their internal and external pathways. There is a proposal to build a "segmented" health needs assessment this year to prepare for the re-procurement next year. This new way of addressing health needs assessments will offer "deeper dives" into the health pathways, interventions and where

Prison JSNA – HMP Wormwood Scrubs	
	possible outcomes. Scoping work starts on this in the next month with roll-out of data and analysis in September 2014-January 2015 7. As noted above better structures are in place with all other providers in the prison including education to maximise understanding of health available and the health promotion programme.
Future delivery	NHS England has negotiated a new set of CQUINs (Commissioning for quality and innovation) targets with the provider (these are consistent across all of our prisons) to address Hepatitis B; Tuberculosis (x-ray); access times to mental health interventions and staffing vacancies no greater than 15% (for all WTE/Bank staff). The new national performance indicators will allow consistency and standardisation of data as well as allowing comparisons to be run for key health deliverables/outcomes. As part of our procurement programme, NHS England will go out to re-procure this service in 2015-16 for a new contract in April 2016
Risks and issues	i. NOMS needs to decide the agreed staffing profile for public sector prisons that supports the "enabling" of healthcare continues problems with regime changes that negatively impact on healthcare will reduce the ability to offer good access health benefits to the patient. ii. Reduction in prison staff can mean a reduction in access to outpatient appointments. Healthcare providers need to ensure they maximise "in-reach" services from the community. A risk is the reluctance/priorities of these community services to offer services in the prison iii. Build the "offender health" pathway as an attractive career opportunity for nurses and GPs. NHS England is working with the Royal College of Nursing on this matter iv. Continuity of care is not available from community services, therefore reducing the health benefits made whilst in prison
Actions for Health and Wellbeing Board	i. To ensure offender health is part of the community services' considerations when building their intervention pathways. That is, how best to link with prison services to maintain continuity of care ii. To make links with the Transforming Rehabilitation agenda in order to support the Community Rehabilitation Companies iii. To make links with local integrated offender management structures to maximise health's contribution to reducing risk and re-offending

Prison JSNA – HMP Wormwood Scrubs		
	iv.	To maintain funding levels for local drug and alcohol services and for those service contracts to highlight robust pathways with the local prison to ensure continuity of treatment pathways
	v.	To build pathways with IAPT and other primary mental health interventions to improve the treatment options for primary mental health needs within the prison services
	vi.	To consider the use of the Social Care Act with borough adult social care services to support health and well-being in the prison and pathways on release
	vii.	In addition to this JSNA make considerations for the management of young offenders released to the tri-borough from HMYOI Feltham in Hounslow.

	London Borough of Hammersmith & Fulham **HEALTH & WELLBEING BOARD** **08 September 2014**
Health and Wellbeing Board Engagement Plan	
Report of the Health and Wellbeing Board Office and Healthwatch	
Open Report	
Classification - For Information **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: N/A	
Report Author: Chris Swoffer, Policy Officer, Westminster City Council	**Contact Details:** Tel: 020 7641 5146 E-mail: cswoffer@westminster.gov.uk

1. EXECUTIVE SUMMARY

1.1 The London Borough of Hammersmith and Fulham (LBHF) Health and Wellbeing Board has a statutory duty engage with residents and stakeholders in the performance of some of its functions. There are also wider opportunities for the Health and Wellbeing Board to improving resident and stakeholder engagement and interest in the the work of the Board.

1.2 This paper sets out a:

- A proposed approach for the Health and Wellbeing Board in relation to undertaken engagement in relation to its statutory functions; and
- Options for how the Health and Wellbeing Board could develop more effective engagement and communications across its areas of responsibility.

2. RECOMMENDATIONS

2.1 The London Borough of Hammersmith and Fulham Health and Wellbeing Board are asked to note, for information, the draft engagement plan attached at Appendix A

which sets out a proposed approach for the Board to meets its statutory responsibilities in relation to the engagement of residents.

2.2 The Board is particularly asked to note the following principles on which this engagement strategy is founded. Namely, that:

- the Board's role is primarily one of co-ordination across the health and wellbeing system, to promote engagement standards and to support the co-ordination of key communications and engagement activity which ensures consistent messaging across partners, reduces duplication and reduces the risk of consultation fatigue;
- where possible, existing networks and channels should be used to undertaken engagement, rather than the development of new networks.
- the Joint Health and Wellbeing Strategy priority leads should be responsible for supporting the LBHF Health and Wellbeing Board to meet its legislative duties by ensuring engagement is undertaken on the actions and commissioning responsibilities which align to their priorities;
- the Tri-borough Joint Strategic Needs Assessment Steering Group should be responsible for supporting the Health and Wellbeing Boards to meet their legislative duties by producing and delivering an engagement plan in relation to the development of highlight JSNA and deep-dive JSNAs as well as the dissemination of final products; and
- the Tri-borough Pharmaceutical Needs Assessment Task and Finish Group should be responsible for support the Health and Wellbeing Boards to meet there legislative duties by producing a clear consultation plan for the statutory 60 day consultation of the draft PNA and managing this consultation process.

2.3 The Board is also asked to note that the proposed engagement plan includes a few direct engagement activities to be undertaken by the Health and Wellbeing Board support team on behalf of the Board, including:

- making improvements to the London Borough of Hammersmith and Fulham Health and Wellbeing Board pages on the LBHF website to improve the information provided;
- introducing an e-newsletter to London Borough of Hammersmith and Fulham Health and Wellbeing Board stakeholders as well as filtering information through existing networks and channels
- introducing a series of engagement/networking sessions with providers, stakeholders, patients, service users and the public; and

2.4 The Health and Wellbeing Board has previously shown an interest in increasing its engagement with residents and stakeholders. Some best practice in this area has been outlined in this report for the Board to note.

3. REASONS FOR DECISION

3.1 This paper is for information.

4. INTRODUCTION AND BACKGROUND

4.1 Health and Wellbeing Boards have a statutory duty to engage and consult on a number of key deliverables:

Under s192 and s193 of the Health and Social Care Act, when developing the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy, the Health and Wellbeing Board has a duty to involve the Local Healthwatch organisation for the area of the responsibility local authority; and involve the people who live or work in that area.

4.2 By virtue of section 128A of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012, the Health and Wellbeing Board is responsible for developing a Pharmaceutical Needs Assessment for its area, including undertaking a consultation with a list of statutory consultees for a minimum period of 60 days.

4.3 More generally, Health and Wellbeing Boards can be a vehicle through which communities have a greater say in understanding and addressing their local health and social care needs.

4.4 For example, local Healthwatch have a seat on the Health and Wellbeing Board and bring with them expertise and tools through which to support the Board and its partners to engage and communicate with patients, service users and the wider public. They also act as the “voice” for patients and service users on the Health and Wellbeing Board, feeding in evidence and contributing to the Boards functions on behalf of their members.

4.5 The Health and Wellbeing Board may wish to take a more cohesive approach to engagement and communications to strengthen the patient, service user and public voice in the operation of the Board and across the health and wellbeing system.

5. PROPOSAL AND ISSUES

5.1 A draft engagement plan has been prepared to support the Health and Wellbeing Board in meeting their statutory responsibilities in relation to engagement. This engagement plan is attached as Appendix A to this report.

5.2 Healthwatch has been involved in developing this engagement strategy and should be a key player in promoting effective engagement across the Board and its partners.

6. OPTIONS AND ANALYSIS OF OPTIONS

6.1 The Health and Wellbeing Board may, however, wish to do more over and beyond their statutory responsibilities to embed residents, partners and stakeholders in the work of the Board and improve co-ordination across the health and wellbeing system.

No decision about me without me

6.2 During the development of this engagement plan, colleagues from Healthwatch have emphasised the importance of the principle "no decision about me, without me". This is an approach to shared decision making, in which patients are fully involved in their care, with decisions made in partnership with clinicians, rather than by clinicians alone. Usually this is applied to care planning by encouraging the development of new relationships between patients, carers and clinicians to work together in equal partnership to agree care planning. However, Shared Decision Making can also be applied at a strategic and commissioning level, with patients involved in the co-design, co-commissioning and co-production of health and wellbeing services. A range of tools and resources are available on the NHS website to enable organisations to achieve this objective.

6.3 If the Health and Wellbeing Board wanted to adopt this doctrine and champion it across the local system, the members of the Board would need to take it upon themselves to embed this culture within their individual areas of responsibility.

Best practice from Health and Wellbeing Boards around the country

Giving the public a say at Health and Wellbeing Board meetings

6.4 The Richmond Upon Thames Health and Wellbeing Board Community Engagement and Involvement Framework outlines plans for the Board to engage with the Public by allowing them to ask questions at meetings.[1] It also outlines the use of seminar sessions to explore issues and share information and views. A range of stakeholders, including providers and voluntary sector organisations are invited to seminars depending on the topic.

6.5 At the Sheffield Health and Wellbeing Board, members of the public are also allowed to ask questions to the Board. There is a 'Public Questions' item on the agenda and if it is not possible for the questions to be answered at the meeting, they will receive a written reply within 14 days. Questions have to be submitted to Democratic Services prior to the meeting.[2]

[1] Richmond Upon Thames Community Engagement Framework 2013, http://www.richmond.gov.uk/hwb_community_engagement_framework.pdf
[2] http://sheffielddemocracy.moderngov.co.uk/ieListMeetings.aspx?CommitteeId=366

Using technology during meetings to increase engagement

6.6 At the Leeds Health and Wellbeing Board, there are Tweets throughout the meeting providing live interaction and engagement, and the Health and Wellbeing Team engage with public attendees asking them where they're from, what is their interest in Health and Wellbeing Board and how would they like to be involved in future work.[3]

6.7 The Health and Wellbeing System Improvement Programme, funded by the Department of Health and delivered by the Local Government Association (LGA), is currently working with public sector social media experts comms2point0 to consider how health and wellbeing boards can improve the way they engage digitally with their local residents. Potential options include live streaming of meetings over the internet and giving members of the public opportunity to ask questions via a social channel too, such as Twitter.

Holding Board meetings at various locations

6.8 The London Borough of Hammersmith and Fulham Health and Wellbeing Board has already expressed an interest in holding meetings at different locations to increase engagement and involvement with residents in the work of the Board. Feedback from residents attending the first meeting at a different location will be important in evaluating whether this is something that should taken forward on a regular basis.

6.9 The Sheffield Health and Wellbeing Board welcome suggestions from the public for other events, themes and locations.[4] This may be an also be an effective way for the London Borough of Hammersmith and Fulham Health and Wellbeing Board to engage with key stakeholders in the community through being hosted at different locations.

6.10 The Health and Wellbeing Board may wish to note that undertaking some of the proposals above could require additional resources to be invested in the supporting framework around the Health and Wellbeing Board.

7. CONSULTATION

7.1 Healthwatch has been involved in developing this engagement strategy.

8. EQUALITY IMPLICATIONS

[3] Leeds Health and Wellbeing Communications and Engagement Framework, http://democracy.leeds.gov.uk/documents/s105369/14.2%20-%20HWB%20Comms%20and%20engagement%20framework%20FINAL.pdf

[4] https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/meetings.html

8.1. The London Borough of Hammersmith and Fulham Health and Wellbeing Board should carry out its statutory level of engagement in line with the Equality Act 2010. If the Board wishes to increase the level of engagement beyond its statutory duty, it would be sensible to consider doing this in close consultation and involvement with the BME community.

9. LEGAL IMPLICATIONS

9.1 N/A

10. FINANCIAL AND RESOURCES IMPLICATIONS

10.1 N/A

11. RISK MANAGEMENT

11.1 N/A

12. PROCUREMENT AND IT STRATEGY IMPLICATIONS

12.1 N/A

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.			

*[**Note:** Please list only those that are not already in the public domain, i.e. you do not need to include Government publications, previous public reports etc.] Do not list exempt documents. Background Papers must be retained for public inspection for four years after the date of the meeting.*

LIST OF APPENDICES:

(Please submit appendices with the main report. Appendices should be numbered clearly and consecutively on the top right hand corner of the page, i.e. Appendix 1, Appendix 2, etc. There needs to be a clear reference to the appendix in the body of the report.)

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APPENDIX A: DRAFT LBHF Health and Wellbeing Board Engagement Plan (v2.0)
Version control:

Version	Date	Comments
1.0	26th June 2014	First draft
1.1	3rd July 2014	Changes following Healthwatch input
1.2	7th July 2014	Changes following discussion with health communications lead
2.0	27th August 2014	As submitted to the LBHF Health and Wellbeing Board

1. Background

1.1 Health and Wellbeing Boards have a statutory duty to engage and consult on a number of key deliverables.Under s192 and s193 of the Health and Social Care Act, when developing the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy, the Health and Wellbeing Board (through the responsible local authority and partner Clinical Commissioning Group) has a duty to involve the Local Healthwatch organization for the area as well as involve the people who live or work in that area.

1.2 By virtue of section 128A of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012, the Health and Wellbeing Board is responsible for developing a Pharmaceutical Needs Assessment for its area, including undertaking a consultation with a list of statutory consultees for a minimum period of 60 days.

1.3 Health and Wellbeing Boards also formed a key part of the Government's health and social care reforms, including as a vehicle through which communities could have a greater say in understanding and addressing their local health and social care needs.

1.4 Local Healthwatch have a seat on the Health and Wellbeing Board and bring with them expertise and tools through which to support the Board and its partners to engage and communicate with patients service users and the wider public. They also act as the "voice" for patients and service users on the Health and Wellbeing Board, feeding in evidence and contributing to decision making on behalf of their members. Healthwatch have been involved in developing this engagement strategy and should be a key player in promoting effective engagement.

2. Aim

2.1 This Communications and Engagement plan aims to provide a framework and a set of tools and methods through which the Health and Wellbeing Board and its

partners can strengthen the patient, service user and public voice in the operation of the Board and across the health and wellbeing system.

3. Objectives

3.1 The three main objectives for the Health and Wellbeing Board are set out below, to:

1. undertake a co-coordinating role in setting minimum engagement standards for health and care partners, driving improved engagement with communities and working across partners to streamline communications activity to ensure consistent messaging, reduce duplication and reduce consultation fatigue;
2. carry out its statutory duties to engage during the development of the Joint Strategic Needs Assessment, Joint Health and Wellbeing Strategy and the Pharmaceutical Needs Assessment; and
3. increase awareness of the work of the Health and Wellbeing Board to the public and key stakeholders, encouraging involvement across all sectors.

4. Key audiences

4.1 The health and wellbeing system is relevant to a very wide range of audiences. As such, key audiences have been identified under each objective. However across all engagement activity key stakeholders to engage will include:

- statutory partner organisations;
- commissioners of services;
- providers of services;
- staff and professionals within the health, care and wellbeing environment as well as those linked to the wider social determinants of health;
- the community and voluntary sector;
- service users and patients;
- specialist groups; and
- the general public.

4.2 Appendix B provides a key audience and stakeholder engagement plan broken down by each objective.

5. Strategy and Approach

5.1 The Health and Wellbeing Board has no formal decision-making authority, does not hold a direct budget and only has a small support team. Therefore, there is a limit to the direct communications and engagement activity that the Board can undertake itself.

5.2 Instead, the Health and Wellbeing Board needs to rely on its relationships and influence across the health and care system to deliver its engagement objectives.

In some cases it will be the responsibility of the individual Health and Wellbeing Board member organisations to undertake engagement, whilst in others the Health and Wellbeing Board will need to work in partnership with organisations outside of its influence to deliver these objectives.

5.3 A range of tools has been provided to support this activity and Healthwatch has offered its expertise to help colleagues when undertaking engagement within the health and care system.

5.4 The strategy and approach to achieve the Health and Wellbeing Board's main objectives are set out below.

Objective 1 - Co-ordination and consistency

To undertake a co-coordinating role in setting minimum engagement standards for health and care partners, driving improved engagement with communities and working across partners to streamline communications activity to ensure consistent messaging, reduce duplication and reduce consultation fatigue

5.5 The Health and Wellbeing Board should play a co-ordination role in ensuring minimum engagement standards are met across all key communication and engagement activity undertaken by Clinical Commissioning Group's, the Commissioning Support Unit, local authorities, the acute sector and NHS England where appropriate. This co-ordination role should also be used to help ensure consistent messages are delivered across the health system to front-line professionals, patients and service users and the wider public. There will, of course, be instances where one organisation needs to act alone or take a different approach or message to partners. Each organisation reserves this right, but where possible organisations should be aware of each other's activity.

5.6 A meeting will be undertaken over the summer between communications leads from across the local authority, clinical commissioning groups, wider health partners and healthwatch to discuss how we can better work together to plan and co-ordinate joint communications activity. In particular, this meeting will focus on co-ordinating messaging across the system and ensuring oversight of consultation activity to join-up where possible and reduce the risk of consultation fatigue. If it is deemed necessary, this could include the setting up of a health and local authority communications group. An update on the outcome of this meeting will be provided to the Board at their next meeting.

5.7 Key activity should be fed into a communications grid to provide oversight to Health and Wellbeing Board members of engagement activity underway across the system.

Objective 2 - Statutory duties

To carry out its statutory duties to engage during the development of the Joint Strategic Needs Assessment, Joint Health and Wellbeing Strategy and the Pharmaceutical Needs Assessment; and

5.8 The Health and Being Board is accountable under legislation for:

- involving Healthwatch and people who live or work in the area in the development of the Joint Strategic Needs Assessment;
- involving Healthwatch and people who live or work in the area in the development of the Joint Health and Wellbeing Strategy; and
- delivering a 60 day formal consultation with a range of statutory partners when developing its Pharmaceutical Needs Assessment.

The Joint Strategic Needs Assessment

5.9 The Health and Wellbeing Board has delegated the management of the Joint Strategic Needs Assessment Programme to the Tri-borough Joint Strategic Needs Assessment Steering Group. It is proposed that this group should also be responsible for ensuring effective engagement is undertaken when:

- identifying and agreeing the JSNA work programme;
- developing the highlight JSNA or individual deep-dive JSNAs; and
- when disseminating the results of individual assessments.

5.10 Healthwatch is represented on this group and will be an important partner through which to feed in patient and service user views to inform assessments,

5.11 Appendix C sets out how the JSNA Steering Group will ensure engagement in their programme of work.

Joint Health and Wellbeing Strategy

5.12 The Joint Health and Wellbeing Strategy has been developed and is now being delivered by the Board with a set of priority leads responsible for co-ordinating delivery. During development, there was engagement with partners, patients and service users, providers, commissioners and the public.

5.13 Now that the strategy has moved into the delivery stage, it is proposed that individual priority leads should be responsible for ensuring engagement is undertaken when delivering actions detailed in the strategy or when undertaking commissioning influenced by the strategy. The priority leads should also be responsible for undertaking any further necessary engagement for their priorities

5.14 As appropriate, each Joint Health and Wellbeing Strategy priority lead should undertake a stakeholder mapping exercise to identify and prioritise stakeholder engagement activity and key audience groups. Each of these priorities will have a unique list of stakeholders who will need to be engaged in developing and

shaping the work of the theme, to monitor the work and feedback on performance and outcomes. In most cases, such as the dual diagnosis and hospital discharge themes it is clear that this engagement is taking place. However, to provide the Board with assurance, each priority lead should consider developing their own engagement plan and the Board should receive updates on engagement activity as part of the planned six-monthly updates from priority leads.

5.15 In order to help facilitate priority leads to develop effective engagement plans, an engagement plan checklist has been provided at Appendix D.

5.16 Priority leads will wish to use existing informal networks and Boards to support engagement. For example, the Tri-borough Children's Board (which supports delivery of the children priorities within the strategy) includes a range of wider stakeholders such as schools, the police and jobcentre plus and would provide a useful forum for engagement with these stakeholders.

Pharmaceutical Needs Assessment

5.17 The Health and Wellbeing Board has delegated the development of a new Pharmaceutical Needs Assessment to a Tri-borough Pharmaceutical Needs Assessment Task and Finish Group.

5.18 The Health and Social Care Act 2012 requires a formal 60 day consultation to be undertaken with a list of statutory consultees on the development of the pharmaceutical needs assessment. The statutory consultees are as follows:

- Local pharmaceutical committee.
- Local medical committee.
- Any persons on pharmaceutical lists and any dispensing doctors.
- Any LPS chemist in its area with whom the NHSCB has made arrangements for the provision of any local pharmaceutical services.
- Any local Healthwatch or any other patient, consumer and community group which (in the opinion of the HWB) has an interest.
- Any NHS trust or Foundation Trust.
- NHSCB.
- Any neighbouring HWB.

5.19 A plan for undertaking this consultation has been developed and will be considered by the Board in September. This will be managed by the Pharmaceutical Needs Assessment Task and Finish Group.

Objective 3 – Stakeholder awareness and engagement

To increase awareness of the work of the Health and Wellbeing Board to the public and key stakeholders and encourage involvement across all sectors.

5.20 In order to meet the third objective around increasing awareness and engagement, it is proposed that the following channels are used to communicate with stakeholders and the general public as well as highlight the key milestones and successes of the Health and Wellbeing Board:

1. The Health and Wellbeing Board page on the local authority website will be improved to better communicate information about upcoming agenda items and ongoing pieces of work. The website will also include other information as appropriate.

2. A quarterly newsletter will be produced to be sent to all key stakeholders and will also be uploaded to the existing Health and Wellbeing Board webpage.

3. Thought leadership pieces from Board members could be pitched to professional networks and trade press on key priorities for the Board to communicate and promote the work of the Health and Wellbeing Board.

4. Proactive Media activity will be undertaken in the lead up to the launch of work by the Health and Wellbeing Board which has improved the health and wellbeing of the local population.

5. A series of networking events will be held with providers and stakeholders from the across the sector to promote the work of the Health and Wellbeing Board and increase levels of awareness. These events could also be used by priority leads to undertake workshops with stakeholders to support their engagement plans.

6. A set of engagement sessions will be held each year with patients, service users and members of the public. These sessions will be themed around the particular priority areas of the Board and will be used both to inform the public as to the work of the Health and Wellbeing Board and also enable them to feed into current work underway. These would be held in an informal setting to encourage engagement from a wide range of people across the local community. Healthwatch will be a key partner in helping to drive attendance at these sessions.

7. Consideration could also be given to holding some Health and Wellbeing Board meetings in more informal locations as appropriate. For example, the Health and Wellbeing Board could agree to have a Children and Young People focused meeting which could be held at a school to encourage students and parents to attend and engage with the meeting.

5.21 The decision to inform, consult, engage and co-produce should be proportionate in all cases and the impact that service user and non-users have had through engagement should be assessed. The Ladder of Participation set out in Appendix E illustrates how effective engagement can be achieved.

6. Timescale

6.1 Effective engagement and communication takes time and resources if it is to be delivered properly. Projects and themes will develop their own timescales identifying who should be engaged, and for what purpose. Regular communication activities will take place on number of levels, and planning will need to take place to ensure information is prepared and suitable for target audiences. Where possible, the Board should not look to create new arrangements for engagement and communications but instead should focus on promoting minimum standards, best practice and co-ordinating activity over the health and wellbeing system.

6.2 Appendix F provides a draft timetable for engagement and communication over the next year.

APPENDIX B: Stakeholder map with communications and engagement channels

Lead	Key audience	Communication and engagement required	Method
Objective 1: Co-ordination and consistency To set out a co-coordinating role for the Health and Wellbeing Board in setting minimum standards and driving engagement within communities in decisions which affect health and wellbeing locally.			
Communications leads within the organisations represented on the Board	• General Public • Patients & Service Users • Providers • Commissioners • Practitioners • Frontline Professionals	Ensuring that key communications and engagement activity across the local authority and health systems are joined up to ensure consistent messaging, reduce duplication and avoid consultation fatigue	• Improve communications between local authority and health communications leads, potentially requiring the development of a communications group to oversee activity. • Grid of activity for oversight for review by the Health and Wellbeing Board at every Board meeting to ensure consistency of messages and coordinated engagement across all partners. • Front sheet on the agenda of Board meetings will continue to include a section on engagement/consultation. Paper authors will be encouraged to include detail in this section where it is appropriate
Objective 2: Statutory Duties To ensure the Health and Wellbeing Board carries out its statutory duties to engage through the Joint Health and Wellbeing Strategy, Joint			

Strategic Needs Assessment and Pharmaceutical Needs Assessment.			
Joint Health and Wellbeing Strategy			
Health and Wellbeing Strategy Priority Leads Directors and Senior managers within the organizations represented on the Board.	• Wider staff across Local Authority and Health sector. • Health and Wellbeing Strategy Priority Leads • Schools • Police • Fire Service • Health partners • Voluntary and Community Sector Local Councillors • General Public	Communication and engagement plans delivered by the priority leads to ensure: • Awareness of what the Health and Wellbeing Strategy is. • Awareness of how to feed into the health and wellbeing strategy. • Evidence of how engagement influences the Health and Wellbeing Strategy, 'closing the loop'.	• Development of a set of tools for priority leads. (An engagement checklist and Patient and Public Engagement tool kit are already attached to this strategy) • A set of networking and engagement sessions to be delivered across the year, themed around the Board's priorities. • Improving engagement through existing channels, networks and boards.
Joint Strategic Needs Assessment			
JSNA Steering Group	• General Public • Patients & Service Users • Providers • Commissioners • Practitioners • Frontline Professionals	• Involvement in the prioritization of JSNAs • Involvement in the development of JSNAs • Dissemination of JSNA findings to frontline professionals, external organizations, general public.	• The JSNA Steering Group will be given responsibility for ensuring engagement with the JSNA prioritization process and on each individual JSNA. • Improved engagement through the JSNA and partner websites • Improve use of existing channels, networks and boards.
Pharmaceutical Needs Assessment			
Pharmaceutical Needs Assessment Task and Finish	• Local pharmaceutical committee. • Local medical committee. • Pharmaceutical lists and	Undertaking a 60 day consultation as required by statute, with the list of statutory consultees	The PNA TFG will be given responsibility for undertaking this consultation. The Board will sign-off the consultation plan in September

Group	dispensing doctors. • Chemists • Healthwatch • NHS trusts or Foundation Trust. • NHS England • Neighbouring HWB.		
Objective 3: Stakeholder awareness and engagement To increase awareness of the work of the Health and Wellbeing Board to the public and key stakeholders and encourage involvement across all sectors.			
Health and Wellbeing Board support team Directors and Senior managers within the organizations represented on the Board	• General Public • Patients and Service Users • Schools • Police • Fire Service • Health partners • Voluntary and Community Sector • Local Councillors • MP's and national policy makers	• Key messages from Health and Wellbeing Board meetings. • Information on how to engage locally through priority leads. • Key messages from Health and Wellbeing Board meetings. • Engagement around the Health and Wellbeing Strategy/JSNA • Upcoming agendas and minutes • The role and purpose of Health and Wellbeing Boards. • Health and Wellbeing achievements and forward plan	• Update of HWB web pages • Quarterly circulation of e-newsletter to key stakeholders for dissemination and key audiences. • A series of networking and engagement sessions • Quarterly email to leads for key networks and partnership boards • Annual member induction refresher sessions • Include HWB updates in through regular member communication channels. • Thought leadership pieces and speaking opportunities where appropriate

APPENDIX C: JSNA Steering Group – Engagement Plan

Local authorities and CCGs have a duty to develop JSNAs, and to consult with service users, patients and local partners.

The JSNA programme in the Tri-borough is focused on 'deep-dive' projects that provide insight on the health needs related to specific groups (e.g. rough sleepers), conditions (e.g. TB), behaviours (e.g. physical activity) or services (e.g. young people's mental health).

Engagement happens at two levels: the overall JSNA programme, and individual JSNA deep-dive projects.

At the programme level, local partners are represented on the JSNA Steering Group, which includes Healthwatch and local voluntary organisations. The main purpose of engagement at this level is to gain stakeholders' input on which JSNAs are undertaken.

At the project level, patients, service users and local partners are engaged by 'Task and Finish' groups that are set up to deliver each project. The consultees and methods of consultation are determined for each project. The Task and Finish groups include or consult with patient representative bodies, service providers and other local stakeholders. In many cases, Task and Finish groups engage directly with service users through surveys or qualitative research. The purpose of engagement at this level is to ensure that stakeholders' views are included in each JSNA, and therefore fed into commissioning plans.

APPENDIX D: Three Stage Process for Engagement and Communication

Check list for priority leads:

Planning:

 Be clear about why we are undertaking a consultation and engagement activity.

 Ensure that existing consultation and engagement results are used where applicable.

 Have a clear idea of who needs to take part.

 Identify appropriate resources.

 Identify opportunities for joint working at the planning stage.

Doing:

 Be clear about how people can be involved.

 Ensure the consultation and engagement methods and language used are suitable for the audience.

 Provide clear information about what we are consulting on.

 Be clear about what the results will be used for.

 Ensure all affected stakeholders have the opportunity to be involved.

Decision Making, Review and Feedback:

 Ensure results of consultation and engagement activity are considered when making decisions.

 Share the results (where appropriate) with as wide an audience as possible.

 Effectively feedback the outcome to participants e.g. summary of results.

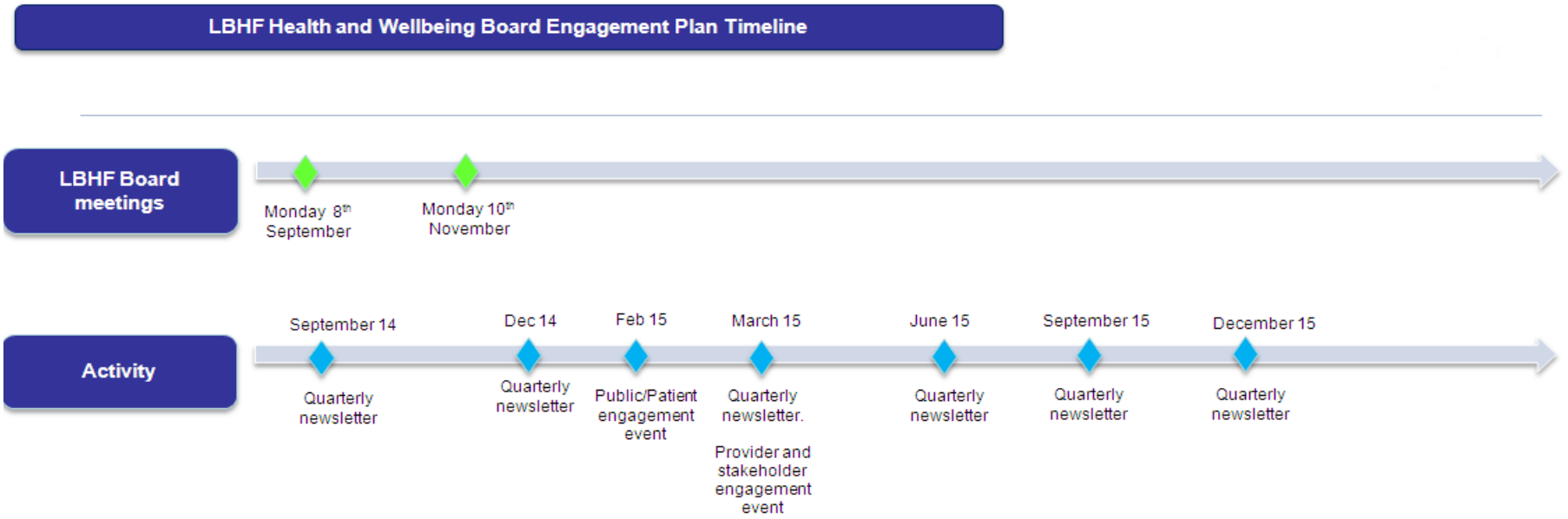
 Promote the outcomes of key consultation and engagement activity both internally and externally.

APPENDIX E: Healthwatch Ladder of Participation

A ladder of Participation

Citizenship	•Control & choice •Co-design •Partnerships & alliances
Tokenism	•Placation •Consultation •Informing
Non-participation	•Imposed models •Expertise lies with the professional •Imbalance in power and responsibility

APPENDIX F: TIMELINE



Highlights for this next period (2014/15)	Requirements from HWB members
• A patient and public event to inform and promote the work of the London Borough of Hammersmith and Fulham Health and Wellbeing Board (February 2015) • One provider and stakeholder event to inform and promote the work of the London Borough of Hammersmith and Fulham Health and Wellbeing Board (March2015) • A quarterly e-newsletter sent to all relevant stakeholders (September 2014) • Ad-hoc representation at relevant engagement events throughout the year.	• To promote stakeholder events through appropriate communication channels and attend where appropriate. • To contribute to quarterly newsletters and distribute through appropriate communication channels.

	London Borough of Hammersmith & Fulham **HEALTH & WELLBEING BOARD** **08 September 2014**
TITLE OF REPORT **Working agreement between the local safeguarding children board and health and wellbeing board**	
Report of the Independent Chair of the Local Safeguarding Children Board	
Open Report	
Classification - For Decision & Comment **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: Andrew Christie, Executive Director for Tri-borough Children's Services	
Report Author: Tim Deacon, LSCB Manager	**Contact Details:** Tel: 0208 753 5140 E-mail: tim.deacon@lbhf.gov.uk

1. EXECUTIVE SUMMARY

1.1 This report provides the Hammersmith & Fulham Health and Wellbeing Board (H&WB) with an overview of the role and responsibilities of the Local Safeguarding Children Board (LSCB) for Hammersmith & Fulham, Kensington and Chelsea, and Westminster, and its priorities for 2014/15.

1.2 The report proposes that the H&WB agree to a formal working agreement between the Hammersmith and Fulham H&WB and the LSCB, as set out in the protocol included in Appendix A, to maximise opportunities to safeguarding children in the local area.

2. RECOMMENDATIONS

2.1 The Board is asked to consider:

a) The complementary but distinct roles the Health and Wellbeing Board (H&WB) and the Local Safeguarding Children Board (LSCB) have in safeguarding and promoting the welfare of children and young people in Hammersmith and Fulham.

b) The LSCB's current priority areas for focus during 2013/14-2014/15.

c) The proposed protocol for joint working between the Hammersmith & Fulham H&WB and the LSCB.

d) How else the two Boards might work together to promote 'safeguarding is everyone's business' and to ensure that there is a coordinated approach to strategic planning between the three H&WB's and the LSCB.

3. REASONS FOR DECISION

3.1 The Board is asked to agree to a formal working agreement with the Local Safeguarding Children Board to ensure that opportunities to strengthen local safeguarding practice are identified and secured.

4. BACKGROUND

Statutory requirements of Local Safeguarding Children Board (LSCB)

4.1 Section 13 of the Children Act 2004 requires that every area establish a Local Safeguarding Children's Board (LSCB). The LSCB has a range of roles and statutory functions including developing local safeguarding policy and procedures and scrutinising local arrangements. The statutory responsibilities of the LSCB are:

a) to coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and

b) to ensure the effectiveness of what is done by each such person or body for those purposes

4.2 The LSCB must include at least one representative of the local authority and include representation of: the Police; Local Probation Trust; Youth Offending Team; the NHS Commissioning Board and clinical commissioning groups; NHS Trusts and NHS Foundation Trusts all or most of whose hospitals, establishments and facilities are situated in the local authority area; CAFFCASS; and the governor or director of any secure training centre or prison in the area of the authority.

4.3 Members of an LSCB should be people with a strategic role in relation to safeguarding and promoting the welfare of children within their organisation. They should be able to: speak for their organisation with authority; commit their organisation on policy and practice matters; and hold their own organisation to account and hold others to account.

4.4 The role of the LSCB is to scrutinise and challenge the work of agencies both individually and collectively. The LSCB does not commission services and is not operationally responsible for managers and staff in the constituent agencies.

Tri-borough Local Safeguarding Children Board

4.5 A Tri-borough Local Safeguarding Children Board for Hammersmith & Fulham, Kensington and Chelsea and Westminster, replaced the previous three LSCBs in April 2012. The LSCB is chaired by an independent chair, Jean Daintith, and is supported by a single team, with an agreed set of subgroups and activities.

4.6 As a Tri-borough board there has been increased opportunity for challenge and comparison of key safeguarding activity and practice; better use of training opportunities; shared learning through audits, Serious Case Reviews and projects; and a streamlining of meetings and administration.

4.7 There are a number of LSCB subgroups which meet at least quarterly where much of the business of the Board is taken forward. These include:

- **Quality Assurance** - this group has been working on the development of a new multi-agency quality assurance framework for the LSCB which will capture key performance data, audit and survey findings and support the Board in its scrutiny and challenge role. Chair: Clare Chamberlain – Director of Family Services RBKC
- **Learning and Development** - this group oversees the existing tri-borough LSCB multi-agency training programme ensuring that the local children's workforce is equipped to deliver sound safeguarding practice whilst responding to local priorities and national developments and learning. Chair: Liz Royle - CLCH Head of Safeguarding, CLCH
- **Case Review** - this group considers how local agencies can learn from national and local case review findings and oversees the implementation of local action plans arising from case reviews. Chair: Steve Miley - Director of Family Service Hammersmith and Fulham
- **Child Death Overview Panel** - this group has been operating as a tri-borough initiative for some time and considers the circumstances relating to the deaths of children from the three boroughs and relevant practice implications. Chair: Nicky Brownjohn - Associate Director for Safeguarding (CWHH)
- **Chairs Group** - this group oversees the work of the subgroups, short life working groups and partnership groups of the Board and effectively steers the direction and progress of the Board's work, responding to key issues arising. Chair: Jean Daintith.

4.8 In addition to the standing subgroups the LSCB create short-life improvement groups which consider specific issues of concern to agencies; in 2013/14 the LSCB managed two groups on children missing from home and care and prevention of suicide amongst young people. In 2014/15 short-life improvement groups have been established to consider domestic violence, e-safety, and female genital mutilation.

4.9 In order to secure the effective engagement of and communication with local partners, a multi-agency Partnership Group has been maintained in each of the three local authorities. The focus of these partnership groups is primarily early help/prevention of harm. In the past year Hammersmith and Fulham's partnership group has developed a local strategy to reduce female genital mutilation.

LSCB priority areas for 2014/15

4.10 The Tri-borough LSCB has four priority areas for focus during 2014/15:

i) Early help and prevention of harm

ii) Better outcomes for children subject to child protection plans and those looked after

iii) Practice areas to compare, contrast and improve together

iv) Continuous improvement in a changing landscape

4.11 Going forward into 2014/15 the Board has agreed that neglect is a cross-cutting theme that needs to be highlighted across all the other priorities. Responding to national issues at a local level, such as female genital mutilation, will also be high on the LSCB's agenda as will getting the local multi-agency response right regarding child sexual exploitation, gangs, missing young people, and suicide risk.

4.12 There are many opportunities for the H&WB to add value to the work of the LSCB; in particular on areas of national focus and where the contribution of services outside of the membership of the LSCB – such as Adult Services - is critical to ensuring progress in priority areas of work. Examples include priority areas such as child sexual exploitation, female genital mutilation, and missing children; and services for adults who are parents and dealing with issues such as poor mental health and domestic violence.

5. JOINT WORKING AND GOVERNANCE ARRANGEMENTS BETWEEN THE HEALTH AND WELLBEING BOARD AND TRI-BOROUGH LOCAL SAFEGUARDING CHILDREN BOARD

5.1. Health and Wellbeing Boards have a unique role in providing a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. H&WBs are the executive body responsible for agreeing what the needs of the local population are, promoting integration, and supporting alignment and joint commissioning.

5.2. Working Together to Safeguard Children 2013 does not outline in detail how the relationship between LSCBs and H&WBs, and other key partnership bodies, should be secured; this is for local determination. The

two partnerships are separate and there are no requirements for the boards to report to each other. However, given the important role that both Boards have to help, protect and care for children and young people this relationship should be clearly articulated.

5.3. A draft protocol outlining a proposed joint working arrangement between the two boards is included in Appendix A. The aim of this protocol is to promote 'safeguarding is everyone's business' and to ensure that there is a coordinated approach to strategic planning between the three H&WBs and the LSCB.

5.4. The protocol also sets out the proposed governance arrangements which will enable the three boroughs' Health and Wellbeing Boards (H&WB), and the Tri-borough Local Safeguarding Children Board (LSCB), to assess whether they are fulfilling their statutory responsibilities to help (including early help), protect and care for children and young people.

5.5. As part of the new Ofsted inspection framework, a review of the effectiveness of the LSCB will be undertaken at the same time as the inspection of the local authority. Such an inspection can be announced at any time and it is anticipated that Ofsted will carry out a simultaneous inspection of Hammersmith & Fulham and the other two Tri-borough authorities. This protocol will help explain to Ofsted Inspectors the relationship between the two boards and be used to judge how well the LSCB uses its scrutiny role and statutory powers to influence priority setting across other local strategic partnerships.

5.6. In order to deliver the draft protocol, it is proposed that the following arrangements would be put in place to ensure effective co-ordination and coherence in the work of the H&WBs and the LSCB:

a) Between September and November each year, the Independent Chair of the LSCB would present to the H&WB its Annual Report outlining performance against business plan objectives in the previous financial year. This would be supplemented by a position statement on the Board's performance in the current financial year. This would provide the opportunity for the Health and Wellbeing Boards to understand where it may be able to support the performance of the LSCB, to draw across data to be included in the JSNA and to reflect on key issues that may need to be incorporated in the refresh of the Health and Wellbeing Strategies.

b) Between October and February the Health and Wellbeing Boards to present to the LSCB the review of the Health and Wellbeing Strategies, updates on the JSNA with the proposed priorities and objectives to enable the LSCB to consider whether it may be able to support the Health and Wellbeing Board drive delivery of the Health and Wellbeing Strategy.

c) Between March and May, the LSCB will share their proposed business plans with the HWBBs to identify areas for partnership working across the year.

6. CONSULTATION

6.1. Consultation is not relevant to this report

7. EQUALITY IMPLICATIONS

8.1 Health and Wellbeing Boards have a unique role in improving the health and wellbeing of their local population and reduce health inequalities. *The LSCB has a statutory requirement to* coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area. Together, the two boards are well placed to promote the health and wellbeing of children and reduce inequalities.

8. LEGAL IMPLICATIONS

8.1. No legal implications identified through this report.

9. FINANCIAL AND RESOURCES IMPLICATIONS

9.1. No financial and resources implications identified through this report.

10. RISK MANAGEMENT

10.1. Risk of reputational damage if the H&WB and LSCB are seen to not work together to promote the wellbeing and safety of children in the borough.

11. PROCUREMENT AND IT STRATEGY IMPLICATIONS

11.1. No procurement and IT strategy implications identified.

JEAN DAINTITH
INDEPENDENT CHAIR OF THE TRI-BOROUGH LOCAL SAFEGUARDING CHILDREN BOARD

ANDREW CHRISTIE
EXECUTIVE DIRECTOR OF TRI-BOROUGH CHILDREN'S SERVICES

Contact officer: Tim Deacon, LSCB Manager **Tel:** 020 8753 5140 **E-mail:** tim.deacon@lbhf.gov.uk

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

None that are not in the public domain.

APPENDIX A

Protocol to set out governance arrangements between the Health and Wellbeing Board and the Tri-borough Local Safeguarding Children Board

Purpose of the Protocol

1. The purpose of this protocol is to set out the governance arrangements which will enable the three borough's Health and Wellbeing Boards (H&WB), and the Tri-borough Local Safeguarding Children Board (LSCB), to assess whether they are fulfilling their statutory responsibilities to help (including early help), protect and care for children and young people.

2. The aim of this protocol is to promote 'safeguarding is everyone's business' and to ensure that there is a coordinated approach to strategic planning between the three H&WB's and the LSCB.

Statutory framework

3. H&WB's were established by the Health and Social Care Act 2012. They are intended to be a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities.

4. The Children Act 2004 required each local authority to establish a Local Safeguarding Children Board (LSCB). It is the key statutory mechanism for agreeing how the relevant organisations in each local area will co-operate to safeguard and promote the welfare of children and to ensure that these agencies are effective.

5. Working Together to Safeguard Children 2013 does not outline in detail how the relationship between LSCB's and H&WB's, and other key partnership bodies, should be secured; this is for local determination. However, given the LSCB's scrutiny and challenge role, and the fact that they do not commission or directly delivery services, there is a strong case that the relationship between them is clearly articulated.

Role and responsibilities

6. The three borough's H&WBs have strategic influence over commissioning decisions across health, public health and social care through their Joint Strategic Needs Assessment (JSNA) and the development of their Health and Wellbeing strategies.

7. The H&WB Board is the executive body responsible for agreeing what the needs of the local population are, promoting integration, and supporting alignment of and joint commissioning. The purpose of the Board is to provide strong and effective leadership across the local authority and NHS partners to improve the health and wellbeing of local residents and reduce inequalities in outcomes. The Board sets a clear direction, across

traditional boundaries, to deliver change and fresh thinking in the provision of health, adult and children's services social care and housing services.

8. The LSCB is required to: a) coordinate what is done by each person or body represented on the board for the purposes of safeguarding and promoting the welfare of children in the area; and b) to ensure the effectiveness of what is done by each such person or body for these purposes.

Working together

9. The H&WB and the LSCB agree that strategic planning across partnerships will be coordinated to secure coherent delivery of business, to avoid duplication and gaps.

10. The H&WB and LSCB will take an integrated approach to the JSNA and ensure comprehensive safeguarding data analysis is included. The JSNA will drive the formulation of the Health and Wellbeing Strategies and the LSCB's Business Plan.

11. The Independent Chair of the LSCB will present an annual report, on the effectiveness of child safeguarding and promoting the welfare of children across the three boroughs, to the Chair of the H&WB. The report will provide the H&WB with an assessment of the performance and effectiveness of local services. This assessment will be clearly reflected in, and will form part of, the H&WB strategy in respect of services for children and families.

12. The H&WBs will formally share with the Tri-borough LSCB the JSNA, the Health and Wellbeing Strategy, the commissioning intentions and progress against these. The LSCB will provide relevant feedback on any key aspect of the H&WB plans as set out above, in respect of safeguarding and promoting the welfare of children.

13. This process will provide opportunity for sharing learning and expertise and to enable Boards to feed any improvement and development needs into the planning process for future years' strategies and plans.

14. In addition to the above the Tri-borough LSCB and H&WB will have members in common who can ensure that key information in relation to trends, concerns and action plans are communicated to relevant Boards in a coordinated way. The LSCB Chair will also, at any time necessary, bring to the H&WB or its members, any matters which require their attention outside of the opportunities outlined above.

15. The H&WB and LSCB will work together to ensure that they include the views of young people in their development of key strategies.

Outcomes of joint working

16. The role of the LSCB in relation to the HWBB would be one of equal partners underpinned by this protocol. The LSCB has a statutory responsibility to challenge and hold agencies to account for the safety of local children and young people. This protocol is designed to ensure these functions are discharged effectively in the three boroughs without duplicating functions or creating additional structures. Other outcomes include:
    a. Ensuring safeguarding is ‘’everyone’s business’’ and is reflected in the public health agenda;
    b. Supporting the Health and Wellbeing Board to drive delivery of safeguarding outcomes through the Health and Wellbeing Strategy, and of safeguarding on wider determinants of health outcomes (such as domestic abuse);
    c. Cross-Board partnership working to embed safeguarding across the health and wellbeing sector.

Signed

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Chair of Hammersmith & Fulham Health and Wellbeing Board

Independent Chair of the Tri-borough Local Safeguarding Children Board

	London Borough of Hammersmith & Fulham **HEALTH & WELLBEING BOARD** **9 September 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: Liz Bruce, Tri-borough Executive Director of Adult Social Care and Health	
Report Author: Holly Manktelow	**Contact Details:** Tel: 020 7641 2757 Email: hmanktelow@westminster.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

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

Agenda Item	Issue and/or decision	Theme Lead
Meeting date: 30th June 2014		
WHOLE SYSTEM INTEGRATED CARE IN HAMMERSMITH & FULHAM	This report provides an update on the Whole System Integrated Care (WSIC) programme in Hammersmith and Fulham.	CCG
JOINT DEMENTIA STRATEGY 2014-2019: DEVELOPMENT SUMMARY	Joint Health and Care strategic review of how dementia services are commissioned and provided. This report sets out key areas for the Health & Wellbeing Board.	CCGs and Adult Services
NHS HEALTH CHECKS	This report sets out the progress made in respect of NHS Health Checks.	Public Health
TRI-BOROUGH ANNUAL PUBLIC HEALTH REPORT	Key messages from the tri-borough annual public health report of particular importance to the Board	Public Health
JOINT STRATEGIC NEEDS ASSESSMENT PROGRAMME	Which topics should be prioritised for deep-dive JSNAs in the 2014-15 JSNA programme	JSNA Steering Group
Meeting Date 8th September 2014		
PROVISION AND QUALITY OF PRIMARY CARE	Report setting out commissioning landscape, current provision and quality and future strategy	NHS England CCG
BETTER CARE FUND	Discussion on potential impact of recent government changes to the locally – agreed Better Care Fund Plan	Adult services CCGs
MENTAL HEALTH TRANSFORMATION PROGRAMME	Update on the development and implementation of the programme	NWL CSU
CHILDHOOD IMMUNISATION	Report on current uptake and plans to improve uptake within LBHF	NHS England Public Health
PHARMACEUTICAL NEEDS ASSESSMENT	Endorse the PNA Consultation draft and plan	PNA Task and Finish Group
Meeting Date 10th November 2014		

CHILD POVERTY	Development of a strategy to tackle Child Poverty which will meet the need identified in the recent JSNA deep dive	Executive Director of Children's Services
CHILDREN AND YOUNG PEOPLE MENTAL HEALTH AND WELLBEING	Discussion and endorsement of Final Report and recommendations from the Task and Finish Group	Task and Finish Group
COMMISSIONING INTENTIONS AND BUSINESS PLANNING	Discussion of draft 2015/16 H&F CCG commissioning intentions. These will be reviewed alongside reports from other areas outlining their 2015/16 business plans	CCG (Input from Adults, Children's, Public Health and NHSE)
LOCAL SAFEGUARDING CHILDREN BOARD ANNUAL REPORT	The LSCB would like to present on their annual report and highlight areas where the HWB might need to take action	LSCB (and Children's)
SEXUAL HEALTH AND EDUCATION	Findings of a Healthwatch report with young people and views from the commissioners	Healthwatch Public Health
EQUALITIES	*Healthwatch would like to report on the demographics of LBHF and discrimination through the lens of equalities*	*Healthwatch*
Meeting Date 12th January 2015		
OUT OF HOSPITAL STRATEGY	Consider progress in delivering Out of Hospital Strategy	CCG
HEALTH AND WELLBEING STRATEGY	Report on progress and further development	All Board Sponsors
CCG COMMISSIONING INTENTIONS	Review and endorse final version of the CCG Commissioning intentions	CCG
SOCIAL INCLUSION	*Consider current work underway to promote social inclusion and identify areas for improvement*	*tbc*
Meeting Date 23rd March 2015		
PHARMACEUTICAL NEEDS ASSESSMENT	Endorse final Pharmaceutical Needs Assessment for publication	PNA Task and Finish Group
H&F JSNA Highlight report 2014/15	Consider key messages from the highlight report and endorse for publication	Public Health

CHILDRENS 0 – 5 YEARS PUBLIC HEALTH	Consider arrangements underway for the transfer of children 0 – 5 years public health responsibilities from NHSE to the local authorities and the opportunities that may arise from the transfer	Public Health Children's NHS England