London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Agenda

Monday 19 January 2015
5pm
White City Community Centre

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
Tri-borough Director of Public Health

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Date Issued: 9 January 2015

London Borough of Hammersmith & Fulham

Health & Wellbeing Board
Agenda

19 January 2015

Item		Pages
1.	**MINUTES AND ACTIONS**	1 - 9
	(a) To approve as an accurate record and the Chairman to sign the minutes of the meeting of the Health & Wellbeing Board held on 10 November 2014.	
	(b) To note the outstanding actions.	
2.	**APOLOGIES FOR ABSENCE**	
3.	**DECLARATIONS OF INTEREST**	

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

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

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

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

4.	**ST. MUNGO'S BROADWAY: CHARTER FOR HOMELESS HEALTH**	10 - 41
	Rod Cullen, Area Manager for Hammersmith & Fulham, Kensington & Chelsea and Ealing will discuss the charter.	
5.	**CHILD POVERTY**	42 - 48
	This paper provides an update report following the JSNA on child poverty (published in July 2014) and recommends further activity.	

6. CARE ACT IMPLEMENTATION 49 - 54

This report updates on progress in relation to the implementation of the Care Act in the London Borough of Hammersmith and Fulham.

7. BETTER CARE FUND AND WHOLE SYSTEMS INTEGRATION 55 - 63

This paper updates on progress with development of the Better Care Fund Plan.

8. ADULT SAFEGUARDING BOARD 64 - 71

This report asks the Health and Wellbeing Board to consider its joint-working relationship with the Safeguarding Adults Executive Board (SAEB), including agreeing a protocol to describe this relationship and identifying any areas where joint-working might be beneficial to improve health and wellbeing outcomes for residents.

9. WORK PROGRAMME

The Board is requested to consider its work programme.

10. DATES OF NEXT MEETINGS

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

23 March 2015

Agenda Item 1

London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Minutes

Monday 10 November 2014

PRESENT

Committee members: Councillor Vivienne Lukey, Cabinet Member for Health and Adult Social Care (Chair)
Dr Tim Spicer, Chair of H&F CCG (Vice-chair)
Liz Bruce, Executive Director of Adult Social Care
Andrew Christie, Executive Director of Children's Service
Councillor Sue Macmillan, Cabinet Member for Children and Education
Dr Susan McGoldrick, H&F CCG
Trish Pashley, H&F Healthwatch Representative

Other Councillors: Sharon Holder and Rory Vaughan

Officers: Steve Buckerfield (Acting Head of Children's Joint Commisioning), Stuart Lines (Deputy Director of Public Health), Julia Mason (Families and Children's Public Health Commissioner), Sue Perrin (Committee Co-ordinator)

29. MINUTES AND ACTIONS

The minutes of the meeting held on 8 September 2014 were approved and signed as a correct record of the proceedings.

30. APOLOGIES FOR ABSENCE

Apologies were received from Meradin Peachey (Director of Public Health), Denise Chaffer (NHS England), Philippa Jones (H&F CCG) and Jean Daintith, Independent Chair of the Local Safeguarding Children Board.

31. DECLARATIONS OF INTEREST

There were no declarations of interest.

32. CHILDREN, YOUNG PEOPLE AND MENTAL HEALTH TASK AND FINISH GROUP

Steve Buckerfield introduced the report of The Children, Young People and Mental Health (CYPMH) Task and Finish Group, which presented a series of

recommendations, aimed at improving services for children and young people in the short to medium term.

The report also framed the discussion for the HWB around the development of a new long-term vision for how children and young people accessed support for mental illness across the borough.

In addition, following concerns raised about inappropriate care and bed shortages nationally, a CAMHS Taskforce was looking at overhauling the way CAMHS are commissioned. It was expected that the Taskforce would report in Spring 2015.

The experience of users of local Children and Adolescent Mental Health Services had been captured in the report, through the mental health charity Rethink.

The Task and Finish Group had agreed to focus on the following three particular areas, where it was agreed that more could be done to improve the outcomes for children and young people:

- Ensuring early intervention and prevention in relation to children and young peoples' mental health and wellbeing
- Reducing the impact of parental mental health disorders on children and young people
- The transition from Children's to Adult mental health services.

The report set out 12 recommendations.

Mr Buckerfield stated that the key messages were in respect of:

- Access: location of services and how delivered.
- A 'Whole Family' approach being adopted in adult mental services, .
- Parental mental health and the potential impact of any mental health problems on the children for whom they are responsible.

Mr Buckerfield stated that the Rethink project had looked at the experiences of young people from Hammersmith & Fulham of mental health services in the borough, by means of focus groups and surveys, in person and on line. The research had identified a number of key issues.

There were concerns in respect of training for professionals who were not mental health professionals, for example social workers and GPs, and how this could be developed. Hammersmith & Fulham's Looked After Children CAMHS service had collaborated with Rethink's Co-production Project and devised a training package for front line staff. Young people supported by Rethink had successfully delivered a pilot training package for social work staff, which had been well received. It was intended to extend the training to all workers.

The research had found that young people wanted to raise their mental health concerns with professionals that they knew or were close to. This was particularly the case for 'looked after' young people.

Young people would like to self-refer, rather than through A&E and go to a safer place, isolated from A&E.

Co-production brought together young people with commissioners, to work together as equal partners in decision-making around planning, design and the review of mental health services. Champion facilitators and commissioners were trained and empowered to enable them to work effectively together to co-design services.

Members queried the pilot training, how this had been organised, how it could be rolled out, with a consistency of approach and for which other groups it would be relevant. Mr Buckerfield responded that the training had been organised by Rethink and CAMHS for West London Mental Health, but there had been no undertaking to take forward. The training would be relevant for any non-mental health professionals who worked with young people on a regular basis.

Members noted that whilst there were some good practices in respect of eating disorders across the three boroughs, a more co-ordinated approach was needed.

Dr Spicer commented that GPs did not see many young people comparatively, as a GP surgery was not a place where they felt comfortable.
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Mr Buckerfield acknowledged the contribution of the voluntary sector.

Members discussed the configuration of services going forward.

Mr Christie referred to the work with secondary heads groups and suggested the commissioning of these services for pastoral care. However, it was felt that, whilst schools could be used as a reference point, the work was not done in schools. A professional mental health worker was required to pick up the need for a conversation.

Members considered that: a full 24/7 hours service was needed; whilst there were a number of routes into the service, there should be a single reference point; 'family' should be defined and they should know where to get information and how they would be supported; and there should be a seamless service.

Mrs Bruce highlighted the need for improvement in transition from Children's to Adult Mental Health Service and an all age/all disability service. There was a need to improve the whole life journey, and for complex health services to do the same.

Councillor MacMillan commended the establishment of a Taskforce to look at the whole area of CAMHS, and reporting to the HWB. Councillor De'ath was proposed as the Chair.

RESOLVED THAT:

1. The HWB endorsed the recommendations outlined in the report.

2. The HWB recommended the establishment of a councillor led Children and Young People's Mental Health Taskforce.

3. The HWB recommended that the report of the Task and Finish Group be sent to the national Taskforce as evidence.

33. SCHOOL NURSING REVIEW & SERVICE RE-DESIGN

Julia Mason introduced the report on the School Nursing (SN) Review and Service Redesign. The tri-borough review had found that services in Hammersmith & Fulham were effectively delivering the core requirements of the Healthy Child Programme 5 – 19 years (vision and hearing screening and health assessments), the national child measurement programme, immunisations and safeguarding, but had insufficient capacity to provide a comprehensive preventative and early help service to schools. The SN service needed to be part of an integrated school health model to address changing priorities and new technologies.

The report proposed options for a new service model, within the current financial envelope, which made best use of SN resources and skills. Nationally there was only a small pool of registered school nurses, and the workforce would need to be supplemented by staff nurses, nursery nurses and school nurse assistants.

As NHS England was the responsible commissioner for school aged immunisation, additional capacity would be released when the new service was in place (scheduled to be in place by September 2015).

The report set out the components of the service model, together with two workforce options. Option 1 included a number of lead or specialist roles, and option 2 deployed qualified SNs where they were most needed.

Councillor Vaughan queried how the immunisation service would be monitored. Ms Mason responded that NHSE would have access to the Child Health information system for collation of the data. Performance would be monitored and any variances in uptake would be taken seriously. Public Health would work with NHSE when arising. SNs would continue to have a role in promoting immunisation. There would also be a follow up as part of the review of commissioned services.

Stuart Lines stated that the MMR vaccination was of particular concern. Public Health intended to set up a task and finish group of key players across the whole system, including the CCG to encourage uptake.

It was noted that, in respect of Child Protection Conferences, SNs were, by default, asked to attend, and this was a considerable onus.

Dr Susan McGoldrick queried whether the sharing of SN information with other health bodies had been considered. Ms Mason responded that SNs did identify relationships and information sharing. Paediatric hubs had been developed. It worked better where specific issues had been identified and professionals came together in a multi-disciplinary way.

The consultation had indicated that children and young people wanted a wide range of SN services, from confidential advice and support to the provision of health information. They had stated a preference for individual face to face consultations, but also text and web based information.

Councillor Holder queried the equality implications and work with different communities. Ms Mason responded that clearly there were equality implications, and that it would be possible to bring a full report as the model and specification developed. The workforce was not large enough to undertake work with different communities. Equality implications could be addressed through better support and access in schools.

Members considered the two options. Whilst option 1 would spread SNs fairly evenly across schools, option 2 would put the most qualified SNs where most needed, supported by other staff. Where needs were not so high, visits from a SN once/twice a week might be adequate.

Dr Spicer queried whether the option was what SNs were available or where SNs were needed. Ms Mason responded that it was a combination. SNs were deployed to the highest level of need, whilst other staff might have the skills to provide intervention in different settings Mr Christie added that it was not just a question of the number which could be afforded but also the number available. Nationally, there was a small number of SNs.

RESOLVED THAT:

The HWB recommended Option 2, subject to conversations with the School Community.

34. SEXUAL HEALTH AND RELATIONSHIP EDUCATION IN SCHOOLS

The Board received the Healthwatch Central West London Sex and Relationship Education report, which assessed young people's experiences of sex and relationship education, their ideas of how they wanted sex and relationship education to be delivered and their knowledge of sexual health services.

Mr Lines noted that the report contained key information in respect of commissioning decisions.

Ms Pashley noted the ongoing discussions in adult health services with providers and stakeholders in relation to developing procurement plans and the key message that young people were not getting information as readily as was expected. There appeared to be a lack of basic information, no clear pathways and no standard for what was delivered in schools in respect of sex and relationship education.

Mrs Bruce stated that Public Health commissioned services across the three boroughs and some approaches were outdated and not meeting needs. This was being reviewed to modernise the offer. There was a clear message that most young people thought that sex and relationship education should be delivered by their peers, not older people.

Mrs Bruce noted that young people should be involved when procuring services.

Mr Christie stated that the money from the Local Authority to fund this work had been cut back. However, schools were keen to bring in help, and there was an opportunity for re-engineering how the money was spent.

RESOLVED THAT:

1. The HWB supported the recommendations made by Healthwatch.

Action:

Mrs Bruce and Mr Christie to follow up the recommendations.

35. LOCAL SAFEGUARDING CHILDREN BOARD: ANNUAL REPORT

The HWB received the Annual Report of the Independent Chair of the Local Safeguarding Children Board (LSCB) 2013/2014, which: set out the achievements against its four key priorities; evaluated the effectiveness of the LSCB overall, described its activities and future priorities; and commented on the linkage to the HWB.

The report highlighted three priorities:

- Neglect remained a source of concern.
- Child sexual exploitation, gangs, missing young people, suicide risk were linked further high priorities.
- Responding to national issues at a local level such as female genital mutilation (FGM) was also a high priority.

RESOLVED THAT:

The report be noted.

36. HAMMERSMITH & FULHAM CLINICAL COMMISSIONING GROUP CONTRACTING INTENTIONS: PROGRESS UPDATE

Dr Tim Spicer stated that the development of commissioning priorities was a complex area, some of which was based on historical decisions. There was a tension between service needs and commissioning providers of services with constrained finances. The report set out the key points in developing commissioning intentions for 2015/2016 and the move away from an 'annual approach'.

Dr Spicer responded to the query from Mr Christie in respect of the paediatric service for children with special needs that the CCG was not wholly responsible for the service, and that there would need to be a discussion with the other parties involved.

Councillor Lukey queried why NHS 111 and UCCs were shown as services which the CCG had decided to buy for 2015/2016. NHS 111 and the UCCs at Charing Cross and Hammersmith Hospitals were already in place. Dr Spicer responded that it was intended to re-procure the services across North West London, ideally as a bundle.

Dr Spicer confirmed that the CCG would be commissioning services, whilst currently waiting for national guidance in respect of the definition of a local A&E.

Mrs Bruce commented on the services currently being bought, which might need to be reviewed, for example diabetes was very high cost if not managed in the community. Dr Spicer responded that the CCG was engaging with the provider market to review aspects of the services, including quality, equity and value for money.

Councillor Vaughan suggested that there was a key issue for commissioning in respect of the disconnect between where professionals wanted to provide services and where people wanted to access them, such as young people using UCCs instead of the default model of registering with a GP.

Members discussed the stakeholder involvement and the identification of gaps. Mrs Bruce emphasised the importance to modernise the service offer and the use of technology.

Dr Spicer noted the importance of the ability to listen and people feeling that they had been listened to. There should be the ability to change any procedure which was not working. Dr McGoldrick added that a service might not be working because it had an historical base. Money should be used to benefit patients now.

Dr Spicer stated that the aim of the contracting round was to make decisions about services based on co-production with patients and service users, by the beginning of the financial year.

RESOLVED THAT:

The report be noted.

37. THE LONDON HEALTHCARE COMMISSION REPORT

The HWB received a summary of the London Health Commission Report 'Better Health for London', which gave a brief overview of the main recommendations of interest to the Hammersmith & Fulham HWB.

38. HEALTH & WELLBEING BOARD LEARNING & DEVELOPMENT SESSIONS

The HWB received the briefing on the Learning and Development Sessions, which set out for members the benefits of participating in these session.

39. WORK PROGRAMME

RESOLVED THAT:

1. A report of the work of St, Mungo's be added to the agenda for January.
2. An update report on CAMs be added to the agenda for March.
3. The work programme was noted

Action

NHSE to be asked why a representative has not attended for several meetings.

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40. DATES OF NEXT MEETINGS

19 January 2015
23 March 2015

Meeting started: 5.00 pm
Meeting ended: 6.55 pm

Chairman .....

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A Future. Now

Homeless Health Matters: the case for change

October 2014

A Future Now
Demanding action on homelessness

St Mungo's Broadway
Rebuilding lives, day by day

Contents

Executive summary

Homeless Health Matters: the case for change is aimed at Health and Wellbeing Boards and their constituent members. It shows how health and housing services can be better designed to meet the health needs of homeless people.

People who are homeless have worse health than most, yet they find it harder to get help. While there are some services which are effective in addressing the health needs of homeless people, this is not yet consistent across the country. There is an urgent need for change. We are calling on Health and Wellbeing Boards to take action to improve homeless health.

Why?

1. Homelessness hurts:

People who are homeless often have multiple and complex health needs.

- **73%** of homeless people report a physical health problem[1]
- **80%** report a mental health problem[2]
- The average age of people who die while homeless is **47**; for women it is only **43**.[3]

Despite this, people who are homeless often struggle to access healthcare.[4] Changes to how health and housing support is provided can make a significant difference.

2. The financial cost:

The annual cost of hospital treatment for homeless people is at least **£85m a year**.[5] Failure to support homeless people to get the healthcare they need when they need it, before they require urgent hospital treatment, comes at great cost to the health sector, and for homeless people themselves. There is mounting evidence of a number of health interventions that can bring significant financial savings.[6]

3. Health inequalities:

Health and Wellbeing Boards must act to **improve the health** of all local people. Clinical commissioning groups have a **duty to reduce inequalities in health outcomes and access to health services**. These responsibilities will not be met unless action is taken to improve the poor health experienced by people who are homeless.

1 Homeless Link (2014) *The unhealthy state of homelessness: health audit results 2014*
2 As above
3 Based on analysis of CHAIN (Combined Homelessness and Information Network) data, which suggests that between 2009 and 2014, 307 people who had slept rough in London died. The mean average age of death for men was 47, and for women, 43. This aligns with previously published research which used a larger sample: Thomas, B (2011) *Homelessness is a silent killer* Crisis. CHAIN is a multi-agency database recording information about rough sleepers and the wider street population in London, commissioned and funded by the Mayor of London and managed by St Mungo's Broadway
4 McCormick, B, (2010) *Healthcare for single homeless people* Office of the Chief Analyst, Department of Health
5 As above
6 Hendry, C (2009) *Economic Evaluation of the Homeless Intermediate Care Pilot Project*; Hewitt, N (2010) *Evaluation of the London Pathway for Homeless Patients* University College London Hospitals

So how do we change this?

Homelessness is a social determinant of health: it can both cause and exacerbate health problems. Poor health can also make it more difficult to recover from homelessness.

Integrating housing and health commissioning can help ensure people who are homeless get the support they need to improve their health and move on from homelessness.

There are different ways of achieving this integration. Key commissioning principles are ensuring parity of esteem between physical and mental health, training for both health and homelessness staff, cross boundary commissioning, and advocacy.

Summary of recommendations:

Homeless Health Matters: the case for change explores how services can be designed to overcome the many barriers to care experienced by people who are homeless. To achieve this, we are calling on Health and Wellbeing Boards to take the following actions:

1. Identify need:

Knowledge of local health needs is a prerequisite for designing effective services. Health and Wellbeing Boards have a central role in collating this knowledge in Joint Strategic Needs Assessments (JSNAs). Research by St Mungo's Broadway and Homeless Link found that only 36% of JSNAs currently make reference to single homelessness, and only a quarter include detailed information.[7]

- The health needs of single homeless people should be included in each JSNA
- Health and Wellbeing Boards should work with homelessness agencies to collect this data
- People with experience of homelessness should be involved in developing this knowledge.

2. Provide leadership:

Without strong leadership to drive improvements to homeless health and wellbeing, the needs of single homeless people are more likely to be overlooked.

- Directors of Public Health should provide this leadership
- Health and Wellbeing Boards should regularly consider homeless health
- Clinical commissioning groups should ensure they respond to the health needs of local people who are homeless.

This leadership must ensure vulnerable individuals do not fall into the gaps between services.

3. Commission for inclusion:

Commissioners of health and homelessness services should ensure that services meet the health needs of people who are homeless, and that they are welcoming and easily accessible. There is no one size fits all solution, but *Homeless Health Matters: the case for change* sets out a range of approaches for making services more accessible.

We are asking Health and Wellbeing Boards to sign up to the *Charter for Homeless Health*, committing to identify need, provide leadership and ensure inclusive commissioning.

Signing the *Charter for Homeless Health* is the first step towards ensuring a better future for homeless people. Now.

[7] Hutchinson, S, Alcott, L and Albanese, F (2014) *Needs to know: including single homelessness in joint strategic needs assessments* St Mungo's Broadway and Homeless Link

Conclusion

Homelessness has a huge impact on individual health. Homelessness can make it difficult to get help for health problems, which can lead to worse health in the longer term. This has a knock on effect on the NHS, as failure to improve health at an early stage can lead to avoidable emergency admissions, hospital treatment and reliance on long term care.

There is no single solution, but *Homeless Health Matters: the case for change* shows how health commissioners, local authorities, homelessness services and homeless people themselves can work together to improve homeless health.

Homeless health matters:
now is the time for change.

Introduction: homeless health matters

People who are single homeless experience significant health inequalities; they are more likely than the general population to experience multiple physical and mental health problems. Yet they frequently miss out on the healthcare they need. Health problems often go untreated until they become critical, resulting in expensive, and often avoidable, treatment.

The links between housing and health are well known[8] and local areas are increasingly looking at integrated responses. However, the particular health needs associated with single homelessness are often overlooked or misunderstood.[9] This report aims to provide the information that relevant commissioners need to understand and address the impact on health of single homelessness. This will help commissioners demonstrate progress towards achieving their statutory duties on improving health and reducing health inequalities.

Single homeless: what do we mean?

This report is concerned with 'single homeless people', generally understood to be those who are homeless but do not meet the priority need criteria[10] to be housed by their local authority. Many may nevertheless have significant support needs. They may live in supported accommodation, e.g. hostels and semi independent housing projects, or sleep rough, sofa surf[11] or live in squats. Single homeless people may be in a relationship and/or have children who are not currently living with them.

The extent of single homelessness in England

There are single homeless people living in every local authority. In 2014, Homeless Link estimated there were 38,534 supported accommodation bed spaces in England for single homeless people.[12] The Department for Communities and Local Government (DCLG) publishes annual figures on rough sleeping in England, based on snapshot street counts or estimates from local authorities. These suggest there were 2,414 people sleeping rough on a single night during the autumn of 2013.[13] Many more people sleep rough over the course of a year: 6,508 people were seen sleeping rough by outreach workers in London alone in the year up to April 2014.[14]

This report is part of the **St Mungo's Broadway** campaign ***A Future. Now: Homeless Health Matters***. We are calling on local areas to take action to improve the health of homeless people. As a first step, we are asking that Health and Wellbeing Boards sign up to our *Charter for Homeless Health*.

8 Barnes, M, Cullinane, C, Scott, S and Silvester, H (2013) *People living in bad housing – numbers and health impacts 2013*; National Housing Federation (2014) *Connecting Housing and Health series*

9 Hutchinson, S, Alcott, L and Albanese, F (2014) *Needs to know: including single homelessness in joint strategic needs assessments* St Mungo's Broadway and Homeless Link

10 Priority need groups established in the 1996 Housing Act and the Homeless (Priority Need) Order 2002 criteria are intended to protect pregnant women and those with dependent children; those vulnerable as a result of old age, mental illness or disability or other special reason; 16 and 17 year olds and care leavers under 21; victims of domestic violence; people who have been made homeless by a disaster and people who meet certain definitions of vulnerability

11 People who habitually stay with friends, family or acquaintances rather than in accommodation that they themselves own or rent

12 Homeless Link (2014) *Support for single homeless people in England*

13 Department for Communities and Local Government (2014) *Rough sleeping statistics England Autumn 2013 Official Statistics*

14 St Mungo's Broadway (2014) *CHAIN Annual Report 2013/14: Street to Home*

The St Mungo's Broadway *Charter for Homeless Health*

People who are homeless face some of the worst health inequalities in society. They are at much greater risk of mental and physical health problems than the general population and their experiences of homelessness often make it more difficult to access the healthcare they need.

The *[Insert Local Authority name]*

Health and Wellbeing Board is committed to changing this.

We therefore commit to:

Identify need: We will include the health needs of people who are homeless in our Joint Strategic Needs Assessment. This will include people who are sleeping rough, people living in supported accommodation and people who are hidden homeless. We will work with homelessness services and homeless people to achieve this.

Provide leadership: We will provide leadership on addressing homeless health. Our Director of Public Health has a key leadership role to play in tackling health inequalities and will lead in promoting integrated responses and identifying opportunities for cross boundary working.

Commission for inclusion: We will work with the local authority and clinical commissioning groups to ensure that local health services meet the needs of people who are homeless, and that they are welcoming and easily accessible.

Homeless Health Matters: outline

This report aims to assist Health and Wellbeing Boards and their constituent members in delivering the commitments of the *Charter for Homeless Health*.

Section One sets out the case for action, including: the impact of homelessness on health; the barriers to healthcare commonly experienced by people who are homeless; the economic case; and the legal duties which should encourage action.

Section Two makes recommendations to Health and Wellbeing Boards and their constituent members for action. The *Charter for Homeless Health* commitments are explored in order. A number of recommendations are made for each, and examples of existing services that aim to improve homeless health are described.

Homeless Health Matters: now is the time for change.

Inclusion Health

Single homeless people are one of the four groups focused on by the Inclusion Health programme run by the Department of Health. This recognises that homeless people (not only those who are single homeless), Gypsies and Travellers, people involved in prostitution and vulnerable migrants are among those facing the worst health outcomes in society.

While the focus in this report is on the particular heath needs of single homeless people, we recognise that there is an urgent need to ensure the needs of each of these groups is understood and met by the health sector. Many single homeless people may also fall into one or more of the other Inclusion Health groups, and may therefore face additional barriers that must be understood to be overcome. Approaches to improve the health of people who are homeless may be integrated into wider efforts to tackle health inequalities across all these groups.

Section One: the case for change

Section One sets out the case for urgent change in how the health needs of homeless people are addressed. Facing poor health and struggling to get the care that most people take for granted, people who are homeless often find it difficult to take control of their health. This prevents people recovering from homelessness, places significant financial burdens on the health system, and disrupts efforts to reduce health inequalities.

1. What's the impact? Homelessness and ill health

Homelessness is a significant social determinant of health and is associated with premature mortality. **People who are or have been single homeless experience multiple and chronic health problems at a rate that is significantly higher than the general population**.

The 2014 Homeless Link Health Needs Audit found that 73% of homeless people reported a physical health problem. In total, 41% of those surveyed reported a long term problem, compared with 28% of the general population who report a long term physical health condition.[15]

Multiple and co-occurring physical and mental health problems alongside substance use are common. Many single homeless people experience long term and chronic conditions.[16] Infectious diseases such as Tuberculosis, Hepatitis C and HIV disproportionately affect people who are homeless,[17] and at St Mungo's Broadway our experience is that these conditions can be difficult for people living in hostels or on the street to manage.

Among St Mungo's Broadway clients:

70% report a physical health need
47% have a significant medical condition
65% report a mental health problem
27% report simultaneous physical and mental health problems and substance use issues
73% smoke cigarettes/tobacco
52% use alcohol and/or drugs problematically
35% say that drug use was a factor contributing to their homelessness and 33% cited alcohol use[18]

Mental health problems are far more common among homeless people than in the general population.

Homeless Link's Health Needs Audit found that 80% of those surveyed had some sort of mental health problem, with 45% having a mental health diagnosis compared to 25% among the general population.[19] Research published by the **Salvation Army** found that 53% of homeless women, and 34% of homeless men had attempted suicide at least once. [20]

For many people who are homeless, particularly women, mental health issues are rooted in experiences of neglect and abuse in childhood. These are often compounded throughout adult life and by the experience of homelessness itself. [21]

15 Homeless Link (2014) *The unhealthy state of homelessness: health audit results 2014*
16 Deloitte (2013) *Healthcare for the Homeless;* Bines, W (1994) *The health of single homeless people* (Centre for Housing Policy Discussion Paper 9); Homeless Link (2010) *The health and wellbeing of people who are homeless: evidence from a national audit*; Homeless Link (2013) *Survey of Needs and Provision* (SNAP); MacGuire, N, Johnson, R, Vostanis, P, Keats, H, (2009) *Homelessness and Complex Trauma: A Review of the Literature*
17 Beijer U et al (2012) 'Prevalence of tuberculosis, hepatitis C virus, and HIV in homeless people: a systematic review and meta-analysis' *The Lancet Infectious Diseases*; 12: 11, 859–870
18 Figures above taken from St Mungo's Broadway 2014 survey of clients
19 Homeless Link (2014) *The unhealthy state of homelessness: health audit results*
20 Bonner, A and Luscombe, C (2009) *The Seeds of Exclusion 2009* The Salvation Army, University of Cardiff and University of Kent
21 Hutchinson, S, Page, A and Sample, E (2014) *Rebuilding Shattered Lives: the final report* St Mungo's

Drug and alcohol use often develop as a means to cope with the difficulties of homeless life and past trauma; the effects of drug and alcohol use also have a strong and destructive effect on the physical health of homeless people. Homeless people with alcohol dependency are 28 times more likely to have an emergency admission to hospital than the general public.[22]

Ultimately, homelessness can kill. Homelessness is an independent risk factor for premature death.[23] Between 2009 and 2014, 307 deaths were recorded among people who had slept rough in London. The average age of death for men was only 47, for women, only 43.[24] This reflects findings from research based on a much larger sample size, which also found the average age of death of someone who died while homeless (including those in homeless hostels or night shelters) was 47, and for women, 43.[25]

Analysis of data on deaths within our hostels between 2001 and 2012 suggests people living in homeless hostels are 3.5 times more likely than the general population to die at any age between 15 and 64. Women under 45 are 8.5 times more likely to die than their housed counterparts.[26]

Many of these deaths may have been avoided with improved access to healthcare. The Faculty for Homeless and Inclusion Health notes, "when homeless people die they do not commonly die as a result of exposure or other direct effects of homelessness, they die of treatable medical problems, HIV, liver and other gastro-intestinal disease, respiratory disease, acute and chronic consequences of drug and alcohol dependence".[27]

22 Data from Central London CCG 2011
23 Morrison, DS (2009) 'Homelessness as an independent risk factor for mortality: results from a retrospective cohort study' *International Journal of Epidemiology* v.38 pp. 877-883; The Faculty for Homeless and Inclusion Health (2013) *Standards for commissioners and service providers: Version 2.0*
24 (Mean) based on analysis of CHAIN data.
25 Thomas, B (2011) *Homelessness: a silent killer* Crisis
26 Based on analysis of data from hostels run by St Mungo's prior to the merger with Broadway.
27 The Faculty for Homeless and Inclusion Health (2013) *Standards for commissioners and service providers: Version 2.0*

2. The barriers to accessing healthcare

The chronic poor health of many single homeless people is compounded by extensive barriers to accessing healthcare. Understanding how these barriers operate is vital if inequalities in service access are to be addressed.

GPs are the primary point of access to health services. Despite improvements in recent years, many homeless people still **struggle to register with a GP**, often due to being unable to provide a permanent address or the documentation required to register. More work is needed to ensure every homeless person can register with a GP.

Health services are conventionally designed to **treat one condition at a time**. The multiple health problems frequently experienced by homeless people often means support must be accessed from different parts of the health system. This can be difficult to navigate, particularly when people are leading chaotic lifestyles and managing issues relating to mental health and substance use.

Untreated mental health problems can act as a barrier to seeking help. Those with conditions such as depression can find it hard to be proactive about improving their health. **People with complex needs, and, in particular, complex trauma,[28] often find it difficult to manage their emotions in the face of perceived adversity, and can exhibit challenging behaviours and poor compliance with appointments and treatment**. Missed appointments can then lead to people being excluded from services. Negative interactions with, and exclusion from, support services can themselves act as traumatic experiences,[29] meaning engagement can be distressing.

Despite investment in the Improving Access to Psychological Therapies (IAPT) programme, **people who are homeless consistently miss out on mental health care** as services available are often not suitable for those with complex needs. There is a particular **lack of support for people with a dual diagnosis of mental health and substance use**.[30] Many mental health services exclude those who are currently using drugs or alcohol. However, our experience working with clients with dual diagnosis shows they often need to deal with their mental health problems in order to tackle their drug or alcohol use, which can be rooted in the same trauma.

"[I've been trying to get help for my mental health problems] but they won't, because I drink... I said well, I drink because of my issues, she said which way are we doing this? I went through detox, after detox, after detox, then I was thrown back out on the street. Well, what's the first thing I'm going to do? I'm back out on the street having another drink" – St Mungo's Broadway client

Identification of homelessness is key to improving the healthcare that homeless people receive. However, there is evidence that **health staff often remain unaware that a patient is homeless** because the patient has not been asked, or fears admitting their homelessness.[31]

28 Herman, J (1997) *Trauma and recovery: The aftermath of violence – from domestic abuse to political terror* New York: Basic Books

29 Scanlon, C. and Adlam, J (2008) 'Homelessness and disorder: the challenge of the antisocial and the societal response', 27-38, in C. Kaye and M. Howlett (eds) *Mental Health Services Today and Tomorrow: Part 1 Experiences of Providing and Receiving Care* Oxford: Radcliffe; Department of Health (2003) *Personality disorder: no longer a diagnosis of exclusion - policy implementation guidance for the development of services for people with personality disorder;* Anderson, S (2011) *Complex Responses: Understanding poor frontline responses to adults with multiple needs. A review of the literature and analysis of contributing factors* Revolving Doors Agency

30 Brodie, C, Carter, S and Perera, G (2013) *Rough sleepers and health care: 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* Broadway; St Mungo's (2009) *Happiness Matters: homeless people's views about breaking the link between homelessness and mental health*

31 Homeless Link and St Mungo's (March 2012) *Improving hospital admission and discharge for people who are homeless*

A **lack of understanding** on the part of health staff is often a crucial barrier to care. **Many homeless people report experiencing discrimination, which makes them unwilling to seek medical help, or can even result in their being refused treatment**.[32] Staff may lack the skills to work with people who have complex needs, or who exhibit challenging behaviour.

Homeless people may feel they have **more immediate problems** to deal with than their health, and put off seeking treatment until they require urgent care.[33] They may also struggle to engage with their own health needs, and some may find it difficult to comply with advice.

People who are single homeless may also be **more transient** than other populations. This can make it more difficult to maintain engagement with health services, particularly where there are low levels of trust of medical staff.

Low levels of literacy can also deter people from seeking help and can make understanding written advice, such as prescription instructions, challenging. Research by St Mungo's Broadway found that 51% of people who are homeless lack the basic English skills needed for everyday life.[34]

Single homeless people, and especially those with multiple and complex needs, can find it difficult to access health services. Health services are under a duty not only to reduce inequalities in health outcomes, but also in access to health. Commissioners should aim for inclusive commissioning that overcomes these barriers and creates responsive and accessible health services. Approaches to achieve this are set out in Section Two.

32 Homeless Link and St Mungo's (March, 2012) *Improving hospital admission and discharge for people who are homeless*; Brodie, C, Carter, S and Perera, G (2013) *Rough sleepers and health care: 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* Broadway

33 McCormick, B, (2010) *Healthcare for single homeless people* Office of the Chief Analyst, Department of Health

34 Dumoulin, D and Jones, K (2014) *Reading Counts: Why English and maths skills matter in tackling homelessness* St Mungo's Broadway and the Work Foundation

3. The financial cost of homeless ill health

The undeniable moral case for improving the health of homeless people is backed up by a significant financial rationale.

The barriers to health services outlined in the last chapter mean people who are homeless often find it difficult to access primary care and preventative support, only seeking help when their condition has deteriorated to the point at which they need emergency hospital treatment. This results in a tendency to use more expensive emergency services, longer stays in hospital and multiple readmissions.[35] Among St Mungo's Broadway clients, 22% had an ambulance called out for them at least once in the past year and 36% attended A&E at least once.[36] Homeless Link found that homeless people report an average of 1.66 A&E visits a year, compared to 0.38 among the general population.[37]

This has clear cost implications for the NHS and wider services. The Department of Health estimated that the cost of hospital treatment alone for homeless people is at least £85m a year, meaning costs of more than £2,100 compared to £525 per person among the general population.[38]

An increasing body of evidence shows that health interventions targeted at people who are homeless can bring significant financial savings.

- Evaluation of the St Mungo's and Lambeth PCT Intermediate Care pilot, which provided health services within a homelessness hostel, found that during the time the project ran, **A&E visits dropped by half, from 8.4 per month to four per month between 2008 and 2009**. Inpatient admissions fell from 10 a month to 2.33 a month. This suggests savings of about £8,000 for the NHS, while improving mortality and morbidity as a result of improved health.[39]
- Evaluation of the London Pathway, which provides clinical support to homeless people as they prepare for discharge from hospital, estimated the service would lead to net savings of £300,000 a year (based on annual staff costs of £100,000). The programme **reduced the average length of stay by 3.2 days**.[40]
- Research on Tuberculosis screening (provided predominantly but not exclusively to people who are homeless) found that the cost of screening per person was £96.36 in a hospital, £13.17 in a hostel and £1.26 in a GP practice, suggesting that providing this service outside of secondary care can bring considerable cost efficiencies.[41]

35 Brighter Futures (2012) *Better Treatment for Rough Sleepers, reducing A&E attendances*; Homeless Link and St Mungo's (2012) *Improving Hospital Admission and Discharge for people who are homeless*

36 St Mungo's Broadway 2014 client needs survey

37 Homeless Link (2014) *The unhealthy state of homelessness: health audit results 2014*

38 McCormick, B, (2010) *Healthcare for single homeless people* Office of the Chief Analyst, Department of Health. This is based on analysis of service use by patients classed as 'No Fixed Abode' (NFA). However, the limitations of NFA data have been raised, e.g. Aspinall, P J (2014) Hidden Needs - Identifying Key Vulnerable Groups in Data Collections: Vulnerable Migrants, Gypsies and Travellers, Homeless People, and Sex Workers Inclusion Health

39 Hendry, C (2009) *Economic Evaluation of the Homeless Intermediate Care Pilot Project*

40 Hewitt, N (2010) *Evaluation of the London Pathway for Homeless Patients* University College London Hospitals

41 G H Bothamley, J P Rowan, C J Griffiths, M Beeks, M McDonald, E Beasley, C van den Bosch, G Feder (2002) 'Screening for tuberculosis: the port of arrival scheme compared with screening in general practice and the homeless' in *Thorax* v57 pp.45-49

The case for intervening early to address developing health needs is supported by new analysis of data collected for a review of the health needs and health costs of rough sleepers in north west London.[42] This demonstrates the high costs incurred by a small group of homeless people with particularly high health needs. The use of acute hospital services, outpatient and inpatient hospital admissions by 561 people seen sleeping rough in London between January 2010 and December 2011 was examined.

It was found that the **average cost of healthcare for each of the 5% of people seen sleeping rough who needed the most healthcare was £27,000 over two years, compared to under £300 for the 10% who needed the least**.

The existence of such a group of high need patients strengthens the case for improving homeless people's health through access to healthcare at an earlier stage, and for helping people to manage both their health and housing problems to avoid problems worsening.

There are clear costs to both individuals and to the health service of failing to recognise homelessness as a social determinant of health or to get healthcare right for single homeless people. This chapter has illustrated the costs of homeless health, but also shown that where the health needs of homeless people are specifically addressed, significant savings are possible.

42 St Mungo's Broadway and Resolving Chaos (2014) *An analysis of the cost of acute health service use by rough sleepers in London*

4. The health inequalities agenda: the responsibilities of statutory agencies

The Health and Social Care Act 2012 and the *NHS Mandate*[43] further strengthen the case for local action to tackle the significant health inequalities faced by homeless people outlined previously outlined.

The Act introduced duties to improve health and reduce health inequalities. The Secretary of State has clearly stated that "further progress is needed... to tackle inequalities in access and outcomes. Across the system in 2014-15 we now need to build on this early progress, broadening our knowledge and understanding, and supporting effective action across all communities".[44]

Improvement of health

The Act gives responsibility for public health to local authorities, requiring that they take appropriate steps to **improve the health of people in the area**, and provide assistance to individuals to help them **"minimise any risks to health arising from their accommodation or environment"**.[45] As such, the local authority has a duty to improve the health of all, including single homeless people, and to provide assistance to help minimise health risks arising from accommodation.

Local authorities are also required to produce an **assessment of local health needs**, which should identify the needs of all people in the local area. These Joint Strategic Needs Assessments (JSNAs) should identify the health needs of homeless people, including single homeless people, and the gaps in current services. This is underlined in Department of Health Guidance on compiling Joint Strategic Needs Assessments that states "health and wellbeing boards will need to consider…how needs may be harder to meet for those in disadvantaged areas or vulnerable groups who experience inequalities, such as people who find it difficult to access services; and those with complex and multiple needs such as…homeless people".[46]

Health inequalities

The Act places duties on the Secretary of State for Health, NHS England and clinical commissioning groups (CCGs) to **"have regard to the need to reduce health inequalities"**. Local health commissioners (CCGs and NHS England area teams) are, therefore, required to reduce inequalities in both outcomes from health services and access to health services. As shown in earlier sections, single homeless people are disadvantaged in both outcomes and access.

Progress towards reducing health inequalities is measured using a range of indicators set out within NHS, Public Health and Social Care **Outcomes Frameworks**. A number of these indicators are particularly relevant to the health of homeless people. Addressing homeless health will therefore help commissioners to demonstrate that they are improving outcomes against these indicators while reducing fundamental health inequalities.

43 Department of Health (2013) *The Mandate. A mandate from the Government to the NHS Commissioning Board: April 2013 - March 2015*
44 Hunt, J (2014) *Department of Health Annual Assessment of the NHS Commissioning Board (known as NHS England) 2013-14* Department of Health
45 *Health and Social Care Act 2012*, Section 2B, London: The Stationary Office
46 Department of Health (2011) *Joint Strategic Needs Assessment and joint health and wellbeing strategies explained*

Outcomes Frameworks: key indicators

NHS Outcomes Framework	Public Health Outcomes Framework	Social Care Outcomes Framework
• Emergency readmissions within 30 days of discharge from hospital • Patient experience of hospital care and A&E services • Excess under 75 mortality rate in adults with serious mental illness • Cardiovascular disease, respiratory disease and liver disease	• Numbers of households who are statutory homeless • The number of households in temporary accommodation • Levels of domestic abuse • Alcohol related admissions to hospital • Treatment for TB to completion • Smoking prevalence – adults (over 18s) • Successful completion of drug treatment • Suicide rate	• Social care related quality of life • Proportion of adults in contact with secondary mental health services in paid employment • Proportion of adults in contact with secondary mental health services living independently, with or without support • Delayed transfers of care from hospital, and those which are attributable to adult social care

The NHS Outcomes Framework is used to measure progress towards meeting the goals in the NHS Mandate, which sets out the Secretary of State's expectations of NHS England. The Mandate highlights the link between ill health and homelessness, and establishes **"helping people experiencing ill health, whether mental or physical, to remain in or return to work, and avoid homelessness"** as a priority for the organisation.[47]

The importance of addressing the complex needs of single homeless people was underpinned by the Secretary of State's Ministerial Statement in his annual assessment of NHS England. He stated the Government's wish to "see the NHS make further progress in transforming primary care to improve services for…those with the most complex need".[48]

Integration

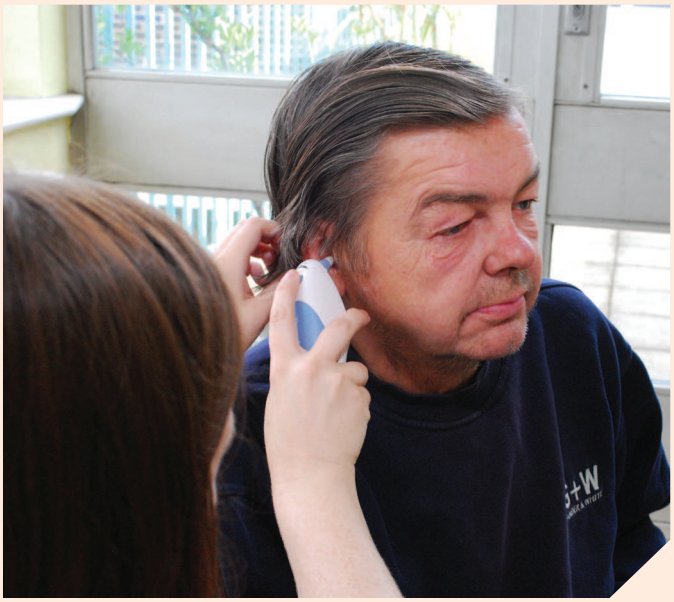
The Act gives Health and Wellbeing Boards and CCGs responsibility to **promote integration between local services, including health, social care or health related services**. Given the complexity of need many homeless people experience, this duty to increase integration is particularly important.

Section One of this report has set out our case that homelessness is a social determinant of health, and that action should be taken to improve homeless health. Efforts to address health inequalities will benefit from recognition of the particular inequalities faced by homeless people. Section Two provides examples of how this can be achieved in practice.

47 Department of Health (2013) *The Mandate. A mandate from the Government to the NHS Commissioning Board: April 2013 - March 2015*

48 Written Ministerial Statement by the Secretary of State for Health Jeremy Hunt, on 'Annual Assessment of NHS England Annual, NHS Mandate and Outcomes Framework' Tuesday 22 July 2014

Section Two: taking action



What can be done to better address the health needs of homeless people? **Section Two** seeks to answer this question. It sets out our recommendations for local commissioners and provides examples of good practice. Each chapter addresses one of the ***Charter for Homeless Health*** commitments to: improve understanding; provide leadership; and ensure inclusive commissioning.

1. Improve understanding

From the *Charter for Homeless Health*

Identify need: We will include the health needs of people who are homeless in our Joint Strategic Needs Assessment. This will include people who are sleeping rough, people living in supported accommodation and people who are hidden homeless. We will work with homelessness services and homeless people to achieve this.

This chapter sets out the central role of Health and Wellbeing Boards in ensuring data is collected on the health needs of homeless people and highlights opportunities to involve other local organisations in this.

Joint Strategic Needs Assessments (JSNAs) underpin every local area's strategy for meeting the health and wellbeing needs of their population. However, despite the health inequalities outlined above, a recent audit[49] of 50 JSNAs carried out by St Mungo's Broadway and Homeless Link found:

- Only 36% of JSNAs referred to single homelessness or rough sleeping
- Only a quarter of JSNAs provided detailed analysis of the needs of single homeless people
- 50% referred only to statutory homelessness, or to non specific 'homelessness' without considering the different health impacts of statutory and single homelessness
- No correlation between the level of homelessness in an area and whether the JSNA included single homelessness.

We are calling on all Health and Wellbeing Boards to use their JSNA to identify the health needs of homeless people in their community, including those of people who are single homeless.

Recommendation 1: Health and Wellbeing Boards should ensure that the health needs of single homeless people are included in their JSNA. See St Mungo's Broadway and Homeless Link's briefing for further information.[50]

The challenge of gathering data on the health needs of people who are homeless and other excluded groups has been evidenced in recent research by the National Inclusion Health Board for the Department of Health.[51] However, these challenges in data collection should not be a reason to omit the health needs of single homeless people from local needs assessments. There is much that can be achieved in local areas alongside the pursuit of an improved national approach over the longer term.

49 Hutchinson, S, Alcott, L and Albanese, F (2014) *Needs to know: including single homeless people in JSNAs* St Mungo's Broadway and Homeless Link. Based on keyword searches of a purposive sample of 50 Health and Wellbeing Boards, including a mix of areas with high, medium and low levels of single homelessness.

50 St Mungo's Broadway and Homeless Link (2014) *Improving the health of the poorest, fastest: including single homeless people in your JSNA*

51 Aspinall, P J (2014) *Hidden Needs – Identifying Key Vulnerable Groups in Data Collections: Vulnerable Migrants, Gypsies and Travellers, Homeless People, and Sex Workers* Inclusion Health

Homelessness agencies are a key source of information about local need. Local authorities already contract homelessness agencies to provide support, and should use this relationship to gather intelligence on local needs and barriers to services. This should include information on those unable to access services, for example, due to waiting lists or exclusions. Homelessness agencies should ensure they are recording information on the health needs of their clients and using this to contribute to local needs assessments and strategies. Cooperation between CCGs and homelessness services will be crucial to ensure this information is comprehensive.

Recommendation 2: Health and Wellbeing Boards should work with local homelessness agencies to collect information on homeless health needs, including access to local services. Local authorities will already be commissioning services such as homelessness hostels and outreach services and will have strong links with local agencies.

Homeless people themselves are also a vital source of information about health needs, and especially about gaps in or obstacles to accessing services. As the consumer champion for health and social care, Healthwatch branches have a key role in representing people who are homeless. An example from Islington shows how this can work in practice.

Healthwatch Islington is working closely with **Islington CCG** to help them better understand why vulnerable groups, including homeless people, were struggling to access GP care. Islington CCG with Healthwatch brought local services working with excluded groups together to identify and better understand issues. The CCG also undertakes regular focus groups and workshops with the local community. This work has led to the introduction of training for GP receptionists. Healthwatch Islington will be organising 'mystery shopping' checks to assess whether improvements are made as a result.

Recommendation 3: Health and Wellbeing Boards should work with client involvement groups to ensure needs assessments, strategies and commissioning decisions are informed by the experience of people who are homeless.

This client involvement may be delivered through local Healthwatch organisations, who should work with client involvement groups or consider ways of facilitating this where there are no existing groups.

Inclusion Healthcare

A specialist GP practice for homeless people in Leicester, Inclusion Healthcare, demonstrates that identification of need is a critical step in commissioning inclusive services.

The service was first commissioned (by the then Primary Care Trust) after a local GP undertook research that revealed a significant need for homeless healthcare. A pilot was funded that showed there was sufficient need for a full specialist GP practice.

The GP practice is now run as a social enterprise, funded by NHS England through a five year Alternative Provider Medical Services (APMS) contract. Other services, for example a full time alcohol specialist nurse, have been added to the contract as areas of unmet need are identified. The social enterprise has expanded and secured additional DAAT (Drug and Alcohol Action Team) and CCG contracts for substance use services in the community and at HMP Leicester. These further improve patient pathways and allow services to be delivered more efficiently as central costs are shared across business units.

Inclusion Healthcare offers primary care, including GP appointments, specialist consultant nurse care, outreach nurses visiting hospitals and hostels and physiotherapy. In addition, it provides access to visiting optician, podiatry and specialist alcohol and substance use services. It works closely with a range of local partners including Probation and the Leicester Partnership Trust with whom they have established a shared care drug treatment service. Now an established training practice, Inclusion Healthcare contributes to GP, undergraduate medical and nursing training.

Inclusion Healthcare also runs a Patient Participation group, offering patients the chance to give their views and feedback on services.

More information: **http://inclusion-healthcare.co.uk/patient_care**

2: Provide leadership to improve homeless health

From the *Charter for Homeless Health*

Provide leadership: We will provide leadership on addressing homeless health. Our Director of Public Health has a key leadership role to play in tackling health inequalities and will lead in promoting integrated responses and identifying opportunities for cross boundary working.

The complex health conditions and range of other support needs presented by people who are homeless require coordination across multiple services. While the provisions of the *Health and Social Care Act 2012* include a welcome increased focus on health inequalities and integration, the split in commissioning between NHS England area teams (which have a direct commissioning function for primary care), CCGs (that commission secondary care) and upper tier local authorities (that commission public health, and social care[52]) presents a real risk of a lack of coordination. This has the potential to be **dangerous** for vulnerable individuals who fall between these services. Strong leadership is needed to ensure consistent efforts are made to address the health inequalities faced by homeless people.

With their role in tackling health inequalities, **Directors of Public Health** should provide this leadership in local areas. All Directors of Public Health should:

- Ensure single homelessness is included in the JSNA
- Ensure Health and Wellbeing Boards receive regular reports on levels of single homelessness, health needs identified and progress in addressing them
- Promote integrated responses to homeless health needs
- Identify and coordinate opportunities for cross boundary or cross borough working on homeless health services.

Considering their broad remit, Directors of Public Health may wish to delegate the above roles to a senior official to act as the **accountable officer for homeless health**. This role may also include a consideration of other socially excluded groups.

Health and Wellbeing Boards as a whole also have a key role to play in holding their Director of Public Health to account for the above.

Recommendation 4: Health and Wellbeing Boards should provide leadership on addressing homeless health. **Directors of Public Health** have a key leadership role to play in tackling health inequalities and should lead in promoting integrated responses and identifying opportunities for cross boundary working.

Recommendation 5: Health and Wellbeing Boards should provide leadership on homeless health by ensuring they are regularly considering homeless health. **Local Healthwatch organisations** should scrutinise JSNAs to ensure they include the health needs of homeless people, including those who are single homeless.

52 Lower tier local authorities are responsible for commissioning housing services, which include housing options/homelessness services

3. Commission for inclusion

From the *Charter for Homeless Health*

Commission for inclusion: We will work with the local authority and clinical commissioning groups to ensure that local health services meet the needs of people who are homeless, and that they are welcoming and easily accessible.

3.1 Commissioning for inclusion

After the health needs of single homeless people have been identified in the Joint Strategic Needs Assessment (JSNA), there will be a choice about how best to respond. There is no one size fits all solution and the most appropriate action will depend on a number of factors, including the level of homelessness in each area and the availability of existing support. However, there are a number of overarching principles that should guide commissioning decisions. This chapter highlights these principles, exploring and providing examples of the different options available.

The **Faculty for Homeless and Health Inclusion Standards for Commissioners**[53] sets out recommendations for commissioners on working with homeless people and other excluded groups. These provide a crucial starting point for any commissioning and should be taken into consideration in all areas. Key principles include:

- Improving collection of data on homelessness and ensuring this is regularly reviewed
- Ensuring staff act as 'gate openers' not 'gatekeepers', so vulnerable people are not turned away due to prejudice or misunderstanding related to their homelessness
- Multi agency working to tackle complex and multiple problems.[54]

3.1.1 Integrate health and housing

The identification of homelessness as a significant social determinant of health makes a clear case for taking an integrated approach to addressing health and housing need. The transfer of public health responsibilities to local authorities and the establishment of Health and Wellbeing Boards has provided clear opportunities to implement this. Arrangements for achieving it range from pooling or aligning budgets to informal agreements between services.

53 The Faculty for Homeless and Inclusion Health (2013) *Standards for commissioners and service providers: Version 2.0*
54 For more information see www.pathway.org.uk

Integrated health, housing and social care in Bradford

Partnership working between the City of Bradford, the clinical commissioning group, Bevan Healthcare CIC and Horton Housing Association, as well as innovative commissioning has led to the creation of integrated health, housing and social care support for homeless people. There are two service delivery models. One is hospital based (Pathway), the other is an accommodation based project (Bradford Respite Intermediate Care and Support Service or BRICSS).

Pathway, based at Bradford Royal Infirmary, is a multidisciplinary assessment and referral team hosted by Bevan Healthcare. The team consists of a practice GP, nurse and a specialist housing worker from Horton Housing Association.

BRICSS is a 14 bed accommodation unit run by Horton Housing that, working with Bevan Healthcare, offers short term, temporary accommodation for homeless clients who are discharged from hospital. It brings together clinical, social care and housing/ homelessness practitioners to work alongside the Pathway team to identify suitable clients, ensure continuity of clinical care and improve health outcomes. The service is short term and is the stepping stone for clients to other appropriate services, which can offer longer term support to the individual.

Neither model was commissioned during the normal commissioning cycle. Pathway is funded by a Department of Health 'Innovation, Excellence and Strategy' development fund through a joint bid by Pathway and Bevan Healthcare, complemented by funding from Horton Housing Association. The capital funding for BRICSS comes from the Department of Health and Horton Housing Association; revenue funding is via the Department of Health, the CCG and Bradford's Public Health team.

A presentation on the service[55] highlights the importance of relationships in providing integrated services – between commissioners and providers, and operational and strategic leaders. Benefits of partnership and integration include improved communications within integrated staff teams; opportunities for joint bidding; higher quality services due to shared knowledge and expertise; reciprocal referrals; and efficiencies resulting from pooled resources.

More information: http://www.hortonhousing.co.uk/service-detail.asp?Service=76&L=0&S=0&C=0

55 Presentation to the Public Health England National Single Homeless Population Health Forum 22 July 2014 'Integrating health, housing and social care' by Gina Rowlands and Liz Barry available at https://www.phe-events.org.uk/HPA/media/uploaded/EVHPA/event_374/Homeless%20-%20Combined.pdf From slide 60. Accessed 3.10.2014

St Mungo's Broadway London Homeless Hospital Discharge Network

The London Homeless Hospital Discharge Network provides an example of health services working in an integrated and innovative way within hostel services for homeless people.

The London Homeless Hospital Discharge Network currently comprises a number of health supported bed spaces across Hackney, Westminster, Camden and Lewisham. The service focuses on homeless people discharged from acute hospitals. It helps them to recuperate from the stay in hospital, but also to learn to manage long term conditions more effectively.

A comprehensive health assessment is undertaken, followed by help to secure mainstream health and social care services, and to become and stay engaged with services. The service can also help clients who make frequent use of emergency services such as A&E in a preventative role.

The core nursing team is available five days a week. The nurses have support from GP services and a part time clinical psychologist and two part time psychotherapists, recognising the levels of mental health problems among our clients.

The health team works closely with hostel staff to jointly plan and deliver support to clients. Clients may remain in the service for a few days, or up to 12 weeks, receiving support to move on to appropriate supported accommodation as appropriate.

"[If I hadn't come here] I probably would have end up dead, because I wouldn't have taken my HIV treatment, I probably would have end up being abused, back on the street work, back on the drugs again, back in hospital… When I came here the amount of support that I got here was unbelievable, you know? Every five minutes they pop in to see if I was alright, make sure I take all my medication, support me when I had to take my IVs, HIV treatment… So I get to come here, because if I didn't come here I'd be back on the street…Since I've come here I've realised I'm somebody" – Hospital Discharge Network resident

This service is funded by the Department of Health, Homeless Hospital Discharge Fund and Camden CCG.

More information: http://homelesshealthcare.org.uk/news/hospital-discharge-network/

Integrating health and housing does not always need special commissioning. Much can be achieved by simple funding solutions using housing investment to target health inequalities, and/or health investment to support housing outcomes.[56] Examples include health professionals working out of homelessness services and outreach workers using treatment rooms in GP practices to change dressings or carry out health checks.

GP in reach at The Old Theatre

The Old Theatre is a St Mungo's Broadway residential service providing support for 12 homeless people with complex needs. Charitable funding has been used to provide a quarterly GP drop in service. This gives clients the opportunity to speak to a GP on site. Clients do not have to be registered with the GP to attend the surgery. The service helps clients who would be unwilling or unsure about registering or visiting the GP the opportunity to get advice and build a relationship with a doctor first. It also enables shared knowledge between the GP and the hostel staff.

At the first in reach session, 60% of all available clients met with the GP, rising to 72% at the second session. Where clients have not engaged with the GP it is generally because they are seeing their own GP.

"Since I started running the three monthly clinics at the hostel I have had an increasingly better communication with allied medical services including the HIV community nurse, the Hepatitis C community team and alcohol services. This allows us to provide a more effective way of working with these clients who are difficult to reach." – Dr Sharon Kaye, a GP providing an in reach service at The Old Theatre

Recommendation 6: Health and housing commissioners should proactively identify opportunities to jointly support services that tackle homeless health. These services should aim to limit the barriers to care, and should be responsive to local need.

3.1.2 Provide training on health and homelessness

People who are homeless tell us that they regularly face a lack of understanding about their complex health needs when trying to access healthcare. Training programmes for non-specialist health staff could help to address this, equipping them to better understand homelessness and how this affects both health and access to healthcare.

Faculty of Homeless and Inclusion Health 'Inclusion Health CPD day'

Pathway has developed a one day Continuing Professional Development (CDP) training course, introducing the concept of inclusion health. The course includes sessions on *Excellence in primary care for excluded groups, Reflective Practice and Latest Developments in Hepatitis C.* The Faculty has applied for Royal College of Physicians CPD approval, and the course is provided in partnership with Brighton and Sussex medical school.

More information: http://www.pathway.org.uk/wp-content/uploads/2014/04/Flyer-20-June-2014-FINAL.pdf

Increasing understanding among staff in homelessness agencies of health conditions and services available locally can help improve the advice and support offered by homelessness services, giving staff the skills to identify health needs at an earlier stage and a better understanding of the health services on offer to their clients.

[56] National Housing Federation (2014) *Connecting housing and health briefing: tackling health inequality through housing*

Hammersmith and Fulham Health and Homelessness Project

Commissioned by Hammersmith and Fulham's Supporting People team and run by St Mungo's Broadway, this project aims help individuals navigate primary and secondary health services, build capacity among hostel staff to help clients to access health services, and focus on early intervention to prevent health problems becoming critical. The service targets the 440 service users and all staff working in Supporting People funded accommodation in the borough.

The service facilitates capacity building training to clients and staff in partnership with health organisations and coordinates complex case conferences. It designs and delivers two health and wellbeing events each year and produces a monthly newsletter. Staff have designed and rolled out a common health assessment tool (CHAT) and collate quarterly submission data to develop analysis of need and engagement in the borough. Bi monthly health action group meetings are held with the health and housing professionals. Three health screening events, the Health MOT, are held each year. The project has also led to the design of a GP appointment card, which clients can use to help them access primary care.

In 2012-13, the project screened 76 clients, trained 118 members of staff across Hammersmith and Fulham, and had 144 people attend a Wellbeing Fair. In total, 133 people attended the health action group.

More information: http://www.mungosbroadway.org.uk/services/recovery_from_homelessness/our_health_specialists

Recommendation 7: Local authority commissioners should support homeless health coordinators to train homelessness agency staff to recognise and understand common health conditions, and to train NHS staff to understand the needs of homeless people.

Recommendation 8: Health services should support the **training** of front of house staff to work with vulnerable patients, including those who are homeless. As outlined on page 19, Islington CCG is training receptionists to work with particularly vulnerable groups of patients, including those who are homeless.

Advocacy services can play a vital role in ensuring homeless people can access the health related services they need. Allocating a member of staff or peer volunteer to help people who are homeless remember and attend appointments, to go along with them, talk to the doctor on their behalf, and help them to understand advice, can help people overcome the fear of seeking help.

"Any hostel, hospital appointment, any doctor's appointment, [the staff] knock on my door and say 'are you ready? Alright, let's go'. They've never sent me anywhere on my own, doesn't matter does it, I can knock that up in stone, they always got time to spare for me… Yeah, I panic, I can't go out on my own, plus this arm, as you see, I got no grip or anything [so it's hard to go to appointments alone]" – Hospital Discharge Network resident.

Groundswell's Homeless Health Peer Advocacy programme demonstrates how effective this personal support can be in improving access to healthcare, and the effectiveness of peer support (see over page).

Groundswell Homeless Health Peer Advocacy

Groundswell is a London based charity that enables homeless and vulnerable people to take more control over their lives, have a greater influence on services and play a more complete role in their community.

Their main work is homeless health peer advocacy. The charity trains people with experience of homelessness – current or past – to volunteer as peer advocates. People needing support are referred by support workers to the charity when they have a health appointment (they can also self refer). They are allocated a peer advocate who ensures they attend the appointment, goes with them, and who can speak to the doctor on their behalf.

Using people with experience of homelessness as advocates is vital to the success of the project. People who have previously found it difficult to engage with support and healthcare staff recognise peer advocates really understand their situations, the daily challenges they face and their fears about going to the doctor.

An evaluation showed a substantial fall in NHS resource usage by participants after leaving the service. Costs to the NHS were reduced by 42% after the intervention was completed.

More information: http://www.groundswell.org.uk/homeless-health-peer-advocacy.html

Recommendation 9: CCGs and local authorities should commission advocacy services, which support homeless people to access health services.

3.2 Commission cross boundary services

In areas where there is a higher density of homelessness over more than one CCG or local authority boundary, joint commissioning of a central specialist GP practice, or a hospital discharge team may be the most effective way to ensure appropriate healthcare is available to all who need it.

The case for such cross boundary services in London is clear. The numbers may be relatively small within some boroughs and the population highly transient, however the overall number of people sleeping rough is significant: 6,508 people were seen sleeping rough in London in 2013/14. This rationale may also apply in other major conurbations.

In areas where the population is less dense, a small number of homeless people who cannot access healthcare can have a substantial impact. Commissioners should explore options for taking a regional approach.

Recommendation 10: Directors of Public Health and **clinical commissioning groups** should explore opportunities for cross boundary/borough commissioning of specialist health services.

Find & Treat service

Find & Treat is a pan London outreach team working with the health sector and with the third sector to tackle Tuberculosis (TB) among homeless people as well as other groups who are at increased risk of TB.

The Find & Treat team is multi disciplinary and includes former TB patients who work as peer advocates, TB nurse specialists, social and outreach workers, radiographers and expert technicians.

The service aims to 'Find' cases by raising awareness among service users and frontline professionals and by screening almost 10,000 high risk people every year using a mobile digital x-ray unit. TB clinics and frontline third sector partners across London, and nationally, refer about 300 complex and socially vulnerable patients each year to the outreach team.

This service is funded by NHS London.

Both the National Institute for Health and Clinical Excellence and the Health Protection Agency have independently evaluated the Find & Treat service and demonstrated that it is cost effective and potentially cost saving.

More information: https://www.uclh.nhs.uk/OURSERVICES/SERVICEA-Z/HTD/Pages/MXU.aspx

3.3 Implement parity of esteem between mental and physical health

"One of the things that would make the biggest difference in tackling homelessness poor health would be a better relationship with mental health services. In the same way, offer a drop in service for the clients, regular contact and the building of a relationship between mental health and both staff and clients would be a huge benefit working with these complex patients." – Dr Sharon Kaye, GP providing an in reach service to a homelessness hostel

The recommendations above all apply to mental health as well as physical health. However, the particular challenge of mental health for people who are homeless necessitates separate attention. As outlined in Section One, people who are homeless not only struggle to get help with their mental health (particularly if they also have problems with drug or alcohol use), but also find it more difficult to get help with their physical conditions because of the impact of mental health problems on their lives and wellbeing.

The situation must be addressed with urgency. The Health and Social Care Act 2012 legislated for parity of esteem between physical and mental health. This should mean everyone has the same access to assessment and treatment of mental health conditions as for physical health problems. However, this goal remains far from realised. While the Improving Access to Psychological Therapies (IAPT) programme has expanded access to NHS counselling and Cognitive Behavioural Therapies, there remains a gap in support for people with more severe and/or complex mental health needs, who often need more than a few weeks of talking therapies. This is a particular problem for single homeless people, who often have more complex and severe mental health problems, as set out in Section One.

Recommendation 11: Clinical commissioning groups should commission for choice, providing a wide range of therapies to meet the needs of their local communities, including people who are homeless and those with complex needs. This should include adequate provision of dual diagnosis services.

City and Hackney Primary Care Psychotherapy Consultation Service (PCPCS)

This innovative service offers support from the Tavistock and Portman NHS Foundation Trust to GPs across the London Boroughs of City and Hackney. It manages patients with complex mental health and other needs that tend to result in high levels of use of health services, but where their needs are difficult to manage through the primary care system. While PCPCS is not directed specifically at people who are homeless, it is available to them and offers intensive support for the types of complex needs experienced by homeless patients.

"This service was commissioned from a direct primary care request. GPs were aware that there were many patients who needed a mental health service, but who either did not fit the criteria for existing services or were reluctant to engage with services. We felt that we needed a service to sit within primary care, to be flexible and holistic in its approach and to be able to work with complex patients, including those with medically unexplained symptoms. Conventional mental health services, using mainly diagnostic assessments, did not offer this complexity focused approach. We wanted very close working with primary care as we recognised that ongoing continuity of care was essential for this group of patients." – Rhiannon England, GP Clinical Lead, City and Hackney CCG

The PCPCS supports GPs in the management of these patients through case discussions and training, and by providing a direct clinical service **within GP practices** to referred patients through assessments and a range of brief psychological interventions.

This service is funded by City and Hackney CCG.

An evaluation of the service found that about 75% of all patients show improvements in their mental health, wellbeing and functioning as a result of treatment. About 55% are shown as having "recovered", meaning an improvement in mental health after treatment.

Compared with the year before referral, the average number of GP attendances per patient seen by the PCPCS fell by 25% in the year after treatment. A typical course of treatment by the PCPCS lasts for 12 or 13 sessions, at an estimated average cost of £1,348 per patient. The subsequent savings from reduced health service use are equivalent to about a third of this cost: a significant offset.

More information: http://mentalhealthpartnerships.com/project/city-and-hackney-primary-care-psychotherapy-consultation-service/

Conclusion

Homelessness has a huge impact on individual health. Homelessness can make it difficult to get help for health problems, which can lead to worse health in the longer term. This has a knock on effect on the NHS, as failure to improve health at an early stage can lead to avoidable emergency admissions, hospital treatment and reliance on long term care.

There is no single solution, but *Homeless Health Matters: the case for change* shows how health commissioners, local authorities, homelessness services and homeless people themselves can work together to improve homeless health.

Signing the *Charter for Homeless Health* is the first step to ensure a better future for homeless people. Now.

Homeless Health Matters: now is the time for change.

Useful resources

St Mungo's Broadway and Homeless Link (2014) *Improving the health of the poorest, fastest: including single homeless people in your JSNA* http://www.mungosbroadway.org.uk/homelessness/publications/latest_publications_and_research/2036_needs-to-know-including-single-homelessness-in-joint-strategic-needs-assessments

Aspinall, P.J (2014) *Hidden Needs: Identifying Key Vulnerable Groups in Data Collections: Vulnerable Migrants, Gypsies and Travellers, Homeless People, and Sex Workers* Inclusion Health https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/287805/vulnerable_groups_data_collections.pdf

Gill, P, Macleod, U, Lester, H and Hegenbarth, A (2013) *Improving access to healthcare for Gypsies and Travellers, homeless people and sex workers* Royal College of General Practitioners http://www.rcgp.org.uk/common-elements/rss/~/media/Files/Policy/A-Z-policy/RCGP-Social-Inclusion-Commissioning-Guide.ashx

HM Government (2010) *Inclusion health: improving the way we meet the primary healthcare needs of socially excluded people* http://webarchive.nationalarchives.gov.uk/+/http:/www.cabinetoffice.gov.uk/media/346571/inclusion-health.pdf

Inclusion Health (2013) *Commissioning Inclusive Services: Practical steps towards inclusive JSNAs, JHWSs and commissioning for Gypsies, Travellers and Roma, homeless people, sex workers and vulnerable migrants* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/287787/JSNA_and_JHWS_guide_-_FINAL.pdf

NHS England (2014) *Avoiding Unplanned Admissions Enhanced Service: Proactive Case Finding and Care Review for Vulnerable People* http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/Enhanced%20Services/201415/Unplanned%20admissions/Avoiding%20Unplanned%20Admissions%20-%20Guidance%20and%20audit%20requirements%20for%202014-15.pdf

The Faculty for Homeless Health (2011) *Standards for commissioners and service providers* http://www.londonpathway.org.uk/uploads/homeless_health_standards.pdf

The Pavement (2014) *The Pavement* http://www.thepavement.org.uk/ (Accessed on 10/09/2014)

The Queen's Nursing Institute (2010) *Improving Healthcare for Homeless People – A learning resource* http://www.qni.org.uk/docs/Section%20B%20Module%205.pdf

A Future Now

Demanding action on homelessness

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Rebuilding lives, day by day

HAMMERSMITH AND FULHAM

HEALTH AND WELLBEING BOARD – 26 JANUARY 2015

REPORT BY THE TRI-BOROUGH EXECUTIVE DIRECTOR OF CHILDREN'S SERVICES

Developing an approach to tacking Child Poverty

This paper provides an update report following the JSNA on child poverty (published in July 2014) and recommends further activity.

FOR DECISION

1. INTRODUCTION

1.1 Child poverty was not explicitly prioritised in the Joint Health and Wellbeing strategy when it was endorsed by the Board in June 2013. Children's services are the main contributor to Priority 3 of the strategy (every child has the best start in life), as the lead agent identified "to lower the proportion of children living in poverty and to ensure that fewer children have poor health, education and welfare outcomes that are known to relate to poverty."

1.2 Since the strategy was drafted, "out of work" child poverty has reduced (attributed to the measure being relative to median income) and "in work" poverty has increased (attributed to the suppression of wages). A joint JSNA has been published and the incoming administration has committed to developing a strategy to promote early intervention and reduce child poverty, via its manifesto of April 2014.

2. BACKGROUND

2.1 The government published its strategy on child poverty in April 2014. The Child Poverty Act 2010 establishes a statutory framework for local partners to cooperate to tackle child poverty. The expectation is that partners ***publish*** a Joint Strategic Needs Assessment and ***prepare*** a Child Poverty strategy. This note provides a short update on needs assessment and strategy and recommends next steps for the Board to consider.

2.2 The Public Health team led a cross departmental 'deep dive' JSNA on child poverty in early 2014, across all three boroughs. The final report was considered for approval by the Health and Wellbeing Board in March 2014 and was published in April 2014. The borough has therefore met its duty with regards to assessment of needs. The Board noted the JSNA, which presented some potential recommendations and proposed a set of priorities. Whilst no specific actions were commissioned by the Board as a result of the JSNA, this report provides a brief update on how services have targeted to meet needs found in the JSNA study.

3. NEED: what the JSNA found and recent activity to support families

3.1 The Health and Wellbeing Strategy carries an objective of "giving every child the best start in life" and a JSNA on child poverty contributed to this priority. The JSNA reinforced what we know about levels of deprivation in some areas of the borough and demonstrated that the drivers of child poverty are complex and multi-faceted. It also demonstrated that the child poverty is intrinsically linked to family income, and that families have been affected by the recent economic downturn and changes to benefits.

3.2 Historically, child poverty affected 'workless' families in London and efforts were focussed on supporting families where no adult was in sustainable employment. However the trend in recent years is for working families to represent an increasing proportion of those living in poverty, because of low pay, employment conditions and high housing costs. For example, unemployment in London has reduced significantly since the start of the recession, yet levels of child poverty have increased.

3.3 Addressing the causes and consequences of child poverty therefore requires attention from a range of agencies, both statutory and voluntary with Children's Services just being one. Schools and wider children's services play a key role in dealing with the consequences of child poverty.

3.4 The JSNA report suggested six priority areas:

- Supporting families to engage with services
- Promoting parental employment
- Access to quality/affordable early years childcare, for all families
- Supporting the role of the school community
- Appropriate healthcare, at the right time
- All families have access to housing of a reasonable standard.

The appendix provides some examples of recent service developments to address the priorities identified.

3.5 The Troubled Families programme, Early Help services and response to welfare reforms by Children's Services all ensure that those most likely to be in poverty are targeted for support. The importance of targeted parental employment support, pay and conditions and housing costs, and the related impact on child health, mean that the causes and consequences of child poverty extend across the whole family and need to be tackled by departments across the council and by the NHS. Child Poverty cannot be reduced and its impact alleviated by Children's Services alone.

4. CONSULTATION

4.1 The JSNA on child poverty was produced via wide consultation with local authority departments, NHS partners, statutory providers and voluntary / community sector partners. An engagement summit was held in November 2013, attended by over 70 representatives from a breadth of organisations. The draft JSNA was considered by the Health and Wellbeing board in March 2014.

5. OPTIONS

5.1 The Health and Wellbeing Board is asked to consider options on *governance* of child poverty policy and *strategy* development to address the needs identified via the JSNA and elsewhere.

5.2 ***With regards to governance***, the Board is asked to consider and decide whether:

A) The Lead member for Children should be identified as the portfolio holder for child poverty policy and strategy development; and
B) The Health and Wellbeing Board should be the body which oversees child poverty policy and strategy in the borough.

5.3 ***With regards to strategy***, some local authorities do not publish a stand-alone child poverty strategy and the borough does not currently have such a strategy. The local authority has few levers over national tax and benefits policy or the austerity measures set out by central government. A child poverty strategy that contains measures to address the *causes* of child poverty (e.g. to increase family income) could be a challenge to achieve on a scale that will affect child poverty statistics across the borough. The local authority and its partners have more leverage in addressing the *consequences* of poverty on the child and ensuring that its major plans and strategies consider their contribution but these are more difficult to measure and quantify. As a result, some local authorities reflect child poverty in all major strategy and commissioning decisions of the council and partners rather than in one single document.

5.4 In LBHF, at present there is no specific strategy dedicated to child poverty. The borough's Children's Plan has been the strategy vehicle used to articulate an approach to alleviate child poverty locally to date, however the statutory duty to produce a children's plan has been removed.

5.5 It is recommended that the Board commissions a standalone child poverty strategy for the borough, working across statutory and voluntary partners and with parents locally. Specifically, a strategy should include contribution from children's services but also from Housing, Health, Regeneration and Economic Development departments which all have a role in alleviating child poverty.

6. RECOMMENDATION(S)

6.1 **It is recommended that:**

a) The Lead member for Children should be identified as the portfolio holder for child poverty policy and strategy development, delegating to the Director for Children's Services on behalf of the Board, working with statutory and voluntary partners.
b) The Health and Wellbeing Board commissions a child poverty strategy, led by Children's services and working across statutory and voluntary partners and with parents locally. It is also recommended that each partner on the Health and Wellbeing Board commits relevant resources as required, to ensure consistent contribution from all agencies.

Andrew Christie
Tri-borough Executive Director of Children's Services

Background papers: Child Poverty JSNA July 2014. Child Poverty Act 2010.

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Appendix A: Examples of recent service developments, contributing to child poverty in Hammersmith and Fulham.

The following provides just a few examples of how existing services and planned investment is meeting the needs identified via the JSNA.

Priority 1- Supporting families to engage with services

1.1 In May 2014, the Public Health Investment Fund invited proposals that could make significant contributions to developing a more co-ordinated and focused approach to improving health and wellbeing.

1.2 Public Health are contributing over £1m during the coming three year period to support the continued provision of targeted activity in children centres ensuring that vulnerable families are able to access a range of health promoting and preventative services.

Priority 2 – Promoting parental employment

2.1 Part of the £1m allocation referred to in paragraph 1.2 will be targeted specifically at initiatives to support parents into employment.

2.2 The Public Health Investment Fund is funding an initiative that will target employers within the Tri-borough area to promote the London Healthy Workplace Charter and engage with businesses to support them to achieve recommended standards. It is intended that one area of focus will be family friendly terms and conditions.

Priority 3 – Access to quality/affordable childcare, for all families

3.1 A task and finish group is in development to review childcare in the borough, including affordability and quality.

3.2 Early years and childcare providers within each borough already provide a mix of sessional and flexible day care in order to meet the needs of local families. Now that the eligibility criteria for the targeted two year old offer has expanded to include more low income families, additional places will be created that suit the needs of these families as demand grows for parents wishing to take up this offer.

Priority 4 – Supporting the role of the school community

4.1 From September 2014 all children in Reception, Year 1 and Year 2 became entitled to a Free School Lunch. Officers have been working with schools within the school meals contract to implement this change. Early indications are that from an already high base, school meals consumption has risen. Officers are currently working on the re-procurement of the school meals service, on behalf of schools. Schools have determined that all school lunches under the new contract will meet the Food for Life Silver or Gold Standards and that new providers will also contribute to local

employability by seeking their workforce from the local area and the provision of workforce training.

4.2 From 1 January 2015, schools across England are legally required to ensure milk is made available during the school day to all pupils (5-18 years) who want it. Schools can make milk available at either mid-morning or afternoon break or at lunchtime. Those infant school pupils who are receiving free school meals will receive it as part of their lunch. Older pupils who are registered for Free School Meals will receive the milk free at whatever time the school makes it available.

4.3 As part of the School Food Plan funding was allocated to Magic Breakfast to pilot and evaluate a number of models of school breakfast club provision. Public Health worked with Magic Breakfast to identify and contact eligible schools. 12 schools with high Free School Meal eligibility across the Tri-borough have taken the opportunity to take part in this 2 year pilot. These include 4 primary schools, 6 secondary schools and 1 Pupil Referral Unit which will significantly expand the number of free breakfasts available to pupils.

4.4 The boroughs' Housing Strategy (draft) includes reference to key worker housing, particularly in relation to priority on the HomeBuy Register.

Priority 5 – Appropriate healthcare, at the right time

5.1 Action is underway to improve the maternal and child health outcomes of the most disadvantaged groups. Maternity champions for Old Oak have been recruited and are currently being trained. This initiative has a particular emphasis on improving access to services and enhancing the support available to BME and other families who find it difficult to access mainstream provision.

5.2 Implementation of the maternity champions initiative is being supported by community midwives, who are also now operating out of children's centres in areas of the highest deprivation across all three borough. This enables earlier and more timely access to maternity services and the provision of a more integrated maternity care pathway.

5.3 The CCGs have recently launched a programme called Connected Care for Children. This model brings paediatricians out of hospitals into GP practice hubs to enhance local clinical knowledge of children's health. There is an opportunity to encourage these hubs to network with local children's centres and seek fresh opportunities for integrated services and support for families.

Priority 6 – All families have access to housing of a reasonable standard

6.1 An award from the Public Health Investment Fund is being used to add capacity to the residential environmental health team to specifically target those residents whose health and wellbeing is vulnerable to poor housing conditions, undertaking home visits to identify and address any housing issues that might compromised their health and wellbeing / put them at risk and developing and implementing an action

plan to address these issues. There is a specific focus in this work on households with young children.

6.2 The Public Health Investment Fund is also funding the expansion of the Housing Department's Occupancy Team role to offer an enhanced 'In-Situ' overcrowding service. This will involve working with overcrowded tenants, giving advice and practical assistance to better use the space that tenants have within their existing property. The project aims to improve living conditions and will be of direct benefit to poor families.

6.3 A Housing Strategy will be issued in draft form for consultation, including findings from a Housing Needs Assessment. Following a consultation period the intention is to bring a final strategy for approval to Cabinet in Spring 2015.

THE LONDON BOROUGH OF HAMMERSMITH AND FULHAM

HEALTH AND WELLBEING BOARD – 21st JANUARY 2015

REPORT BY THE EXECUTIVE DIRECTOR FOR ADULT SOCIAL CARE AND HEALTH

CARE ACT IMPLEMENTATION

The purpose of this report is to inform Health and Wellbeing Board Members about progress in relation to the implementation of the Care Act in the London Borough of Hammersmith and Fulham.

FOR INFORMATION

1. INTRODUCTION

1.1 Governance arrangements to implement the Care Act reforms have been in place since April 2014. This work is overseen by Liz Bruce, Executive Director for Adult Social Care and Health, as programme sponsor.

2. BACKGROUND

2.1 All local authorities are expected to implement the requirements of the Care Act 2014. The programme is focussed on delivery to the milestones below as part of a phased approach.

2.2 Phase 1 key deliverables for compliance by 31 March 2015 include:

- Implementation of an eligibility framework and a single set of criteria for Carers
- All service users in receipt of a personal budget (includes a review of the appropriateness of the resource allocation system)
- Assessment processes in line with Care Act requirements (includes Carers Assessments, assessment of self-funders, and prevention duty)
- Implementation of new safeguarding duties
- Market shaping responsibilities embedded (including Market Position Statement and protocols regarding duty around provider failure)
- Managing transition from children and young people services to adults services which includes a right to an "adults" assessment prior to the 18th Birthday. This right also extends to carers of children and young people.
- Information and advice provision (across operations and commissioned services) and provision of preventative services
- Provision of an advocacy service

- Deferred Payment Agreements
- Workforce trained and developed to meet the new operational requirements

2.3 Phase 2 key deliverables for compliance by 31 March 2016 include:

- Funding Reforms embedded in business (including a care account, cap on care costs)
- Communications and engagement plan fully implemented

2.4 Workstreams are in place to implement the deliverables in Phase 1 and Phase 2 in alignment with the agreed schedule. The work to date has involved the following:

i. **Eligibility and the new National Minimum Threshold** - All three boroughs would already be considered compliant with the national minimum eligibility criteria, based on the existing FACS criteria for 'Critical' and 'Substantial' needs. However, the eligibility policy has been formally updated, and this has been reflected in the Adult Social Care (ASC) standard operating procedures, which will form part of the training modules for roll out to all social care staff. The lead ASC officers in RBKC will also develop options to consider how to retain existing service users that have 'Moderate' needs for care and support under the existing FACS criteria, which will no longer be applicable from April. RBKC is able to do this because local authorities have powers under the Care Act to extend the eligibility criteria beyond the new minimum threshold, if they wish to do so.

ii. **All service users in receipt of personal budget (includes review of appropriateness of RAS) –** personal budgets are already part of the offer to service users with eligible needs in all three boroughs. The Care Act requires that local authorities have a more transparent approach to setting the amount offered to service users. Work is therefore underway to review the existing resource allocation system, with a view to potentially replacing it with something more appropriate. Our objective is to put in place a person-centred, holistic framework for setting personal budgets, linked to focussed outcomes for the service user.

iii. **Assessment processes in line with Care Act requirements (includes Carers Assessments, assessment of self-funders, and prevention duty) –** we have built a revised assessment process into the ASC operating procedures, to be rolled out as part of the training programme in the New Year. This includes a new Carer's assessment process, which is being piloted in December. Early assessment of self-funders will be rolled out from October 2015, inviting 25% of known self funders ahead of the April 2016 deadline, in alignment with Department of Health recommendations. This is because self funders will be entitled to

an assessment once their care costs reach the £72,000 cap, with a view to seeking support via their local authority.

iv. **Implementation of new safeguarding duties –** The London Association of Directors of Adult Social Services (ADASS) is developing a Care Act compliant set of protocols for safeguarding that will be rolled out to all London local authorities. These protocols will be embedded within the ASC standard operating procedures and rolled out to all staff as part of this training.

v. **Market shaping responsibilities embedded (including Market Position Statement and protocols regarding duty around provider failure) –** A Market Position Statement has been drafted to support market shaping through engagement with local providers,. The market position statement will help to inform commissioning of new, innovative services for local residents.

vi. We have developed a draft Provider failure protocol. This will help inform decisions about how to support the transfer and continuity of care for service users in the event the incumbent provider is unable to support them due to business failure.

vii. **Managing transition from children and young people services to adults services -** Project work is underway to build the Education, Health and Care transition pathway, which will be embedded within the ASC Standard Operating Procedures and rolled out to staff in the Learning Disability team. This will ensure a more holistic approach is adopted that supports young people requiring an "adults" assessment prior to their 18th Birthday.

viii. **Information and advice provision (across operations and commissioned services) and provision of preventative services –** The workstream activity to deliver compliance includes development of all information and advice formats, including the People First Website and leaflets. An audit checklist of the full range of the types of information and advice required has been completed. The next stage will refresh the content for each topic area. The work on information and advice also links very closely with new duties to promote prevention, and a mapping exercise is underway to document the existing prevention offer. This includes developing a shared understanding of services provided by the private, voluntary and community sector, health, and universal services that support preventative approaches to underpin health and wellbeing.

ix. **Advocacy Support Services** – A procurement process is underway to develop the service so that the local authority can routinely offer independent advocacy support to anyone who

requests it, as part of the assessment and support planning process.

x. **Deferred Payment Agreements -** Deferred Payments Agreements are offered today. The funding reform workstream is hoping to develop a consistent approach to deferred payment agreements across all three boroughs, including appropriate interest charge rates. This approach will be embedded within the finance operating procedures and rolled out to staff.

xi. **Workforce trained and developed to meet the new operational requirements –** A workforce development programme is being shaped and resourced to be rolled out in the New Year from February onwards. This follows engagement with staff and managers about the workforce implications of the Care Act reforms and the completion of a training needs analysis. Care Act awareness sessions have already been rolled out to ASC staff and this is likely to be extended to other departments across the local authority, externally to health partners including the CCGs, and to the voluntary and private sector.

3. COMMUNICATIONS / CONSULTATION

3.1 Successful 'show and tell' events have been held in the London Borough of Hammersmith and Fulham and Westminster City Hall, to promote the work of the programme and encourage stakeholders to engage in the implementation. A further show and tell event at Kensington Town Hall is scheduled for January 2015.

3.2 A communications plan has been developed to co-ordinate key messages to be communicated to all stakeholders, and a regular update is published in the monthly Triangle newsletter to ASC staff. The communications plan includes the roll out of the Public Health England Campaign to share information with the general public about the Care Act. This is to ensure residents are fully aware of the reforms and the local authority's implementation programme. Care Act briefing sessions have been held with GP's, Housing, Carers Network Hammersmith and Fulham, and care and support providers, and the Public Health Leadership Forum.

4. PARTNERSHIP WORKING

4.1 The Care Act requirements make it clear that Councils are required to co-operate with other organisations including health, housing and employment services to ensure a holistic approach to care and support. Adult Social Care has therefore taken steps to work collaboratively with other parts of the Council, including Housing, Children and Families, Public Health, Environmental Health Leisure, Community Safety, Corporate Voluntary and Community Sector.

External engagement with health colleagues in the CCG's and NHS England is also underway.

4.2 The implementation programme is aligned to other transformation work for Adult Social Care focussed on greater partnership / integration, through the Customer Journey project and the development of the Community Independence Service. This will lead to better coordination of information and advice, assessments, support planning, hospital discharge and help to live at home.

4.3 Mental Health and Housing sub-groups have been meeting regularly to identify key actions that will contribute to compliance with the Care Act. This is specifically in relation to pathways, assessment and support planning, information and advice mapping, alignment of operating procedures, and identifying workforce development activities.

5. RESOURCE IMPLICATIONS

5.1 A number of duties within the Care Act are likely to have financial impacts for the Council that are difficult to quantify at this stage; these are explained below.

5.2 *Financial Modelling.* Conducting accurate financial modelling of the impact of the Care Act and the care cap is challenging due to the large number of variables and unknowns. Our initial model of the costs of self-funders approaching the council indicates that costs in Kensington and Chelsea could rise substantially (this in addition to the costs of additional assessments and deferred payments). Our feedback on funding formulae consultation for the Care Act was that it did not provide assurance that these costs are being fully addressed. This is a major concern, and is compounded by the lack of data about self-funders, which makes it hard to accurately estimate costs for this group. We believe that nationally, we are no further forward in developing robust data to predict self funder impact.

5.3 *Increased demand for needs assessments.* The implementation costs of the Care Act are significantly higher than the Government's current estimation. Needs assessments help self funders keep track of progress towards the cap on their care costs as they become eligible for local authority funding from April 2016. Carer's assessments will also increase from April 2015. The estimated costs for additional assessments for the London Borough of Hammersmith and Fulham, predicted using the Lincolnshire Modelling (the nationally adopted tool) during 2015/16 are £482,026.

5.4 *Deferred Payments.* We have no robust evidence on which to model future demand arising from the implementation of a universal deferred payment scheme. We believe we will see an increase in the number of people wishing to take out a deferred payment. This will

have a financial impact, particularly in managing cash flow, although government funding will be available to support these costs. Based on the Lincolnshire model, cost estimates for deferred payment agreements during financial year 2015/16 are £283,000.

5.5 *Possibility of more people becoming eligible for care and support.* There is likely to be an increased cost to operational delivery within each of the local authorities, to manage the increased demand for information and advice, assessments, and arranging service provision, as more people become eligible for public funding. Based on the Lincolnshire model, the additional costs will potentially come from carers and prison population assessments which are estimated to be £168,000 during 2015/16 for the carers package and service provision and £206,000 for providing social care in prisons.

5.6 *London specific impact.* The impact upon London is likely be significantly different from the impact in other regions, due to its higher cost base; this needs to be fully understood and reflected in funding received from the Department of Health to support implementation of the reforms. For example, the higher costs of care in London will mean that people are likely to reach their cap earlier, so London boroughs will incur costs earlier and face higher costs for these newly eligible people, than will authorities in other parts of the country. These costs have not been quantified as part of the Lincolnshire Model.

5.7 For 2015/16 the costs of implementing the programme will be addressed by the Department of Health via specific funds made available through the Care Act implementation grant or Better Care Fund monies. For LBHF the implementation grant, recently announced, indicates total grant funding available of £839,812. However, we still awaiting confirmation of BCF monies from the Department of Health. We also do not have information about how future costs from 2016/17 onwards will be addressed.

6. RECOMMENDATION(S)

6.1 It is recommended that the Board note the content of this report.

Liz Bruce
Executive Director for Adult Social Care and Health

Background papers: The final regulations and guidance were published for local authorities in October 2014. These can be found at:

https://www.gov.uk/government/publications/care-act-2014-statutory-guidance-for-implementation

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	London Borough of Hammersmith & Fulham **HEALTH & WELLBEING BOARD** **19 January 2015**
TITLE OF REPORT **UPDATE ON BETTER CARE FUND AND WHOLE SYSTEMS INTEGRATION**	
Report of the Cabinet Member for Adult Social Care and Health Councillor Vivienne Lukey	
Open Report	
Classification – For Information **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: Liz Bruce, Executive Director Adult Social Care	
Report Authors: James Cuthbert, Whole Systems Lead for Adult Social Care Jenny Platt, Strategic Lead for Integrated Care and Joint Commissioning, Hammersmith & Fulham CCG	**Contact Details:** E-mail: James.Cuthbert@lbhf.gov.uk Tel: 07792 963830 E-mail: Jenny.Platt@nw.london.nhs.uk Tel: 02033504780

1. EXECUTIVE SUMMARY

1.1. This paper provides an update on progress with development of the Better Care Fund (BCF) Plan. It explains preparations for implementation in 2015/16 of BCF schemes and describes their place in the programme of Whole Systems Integrated Care (WSIC).

1.2. The BCF is a national initiative to improve health and social care outcomes and cost-effectiveness, with an emphasis on more care at and near home.

Every Health and Wellbeing Board is tasked with developing a plan and, following a national review process during the summer and autumn, the Borough's updated BCF Plan is expected to be approved by the national BCF Task Force soon.

1.3. Work is in progress to implement the schemes in the BCF Plan, especially to develop a new integrated Community Independence Service (CIS).

1.4. WSIC is a long-standing programme of change and has a wider purview than BCF. The WSIC programme in Hammersmith & Fulham builds on BCF initiatives. The CIS, for example, is an important short-term service to help people with good care at home at times when they would otherwise need to be in hospital. It has been developed in the Better Care Fund; and it is integral to the aims of Whole Systems. It includes improvements in primary care, acute and mental health services. It aims to bring all these areas of service into partnerships or "alliances" of providers delivering quality, integrated care under a single, capitated budget. Work is in progress to move this programme forward early in 2015.

1. RECOMMENDATION

1.1. The Health and Wellbeing Board is recommended to note progress towards approval of the BCF Plan; preparation for implementation of the BCF schemes; and the link between BCF and WSIC.

2. INTRODUCTION AND BACKGROUND

2.1. The BCF is a single pooled budget for health and social care services to work closer in local areas, based on a plan agreed between the NHS and local authorities. A national fund of at least £3.8bn was announced in the summer of 2013.

2.2. The BCF does not come into full effect until 2015/16, but additional funds were made available to aide planning in 2014/15. A national BCF Task Force working across the Department of Health (DH), the Department of Communities and Local Government (DCLG), NHS England (NHSE) and the Local Government Association (LGA) has been in place since July 2014 to drive and refine BCF planning.

3. BCF PLAN DEVELOPMENT

3.1. The BCF Plan was developed within the existing Whole Systems partnership between the local authority and the NHS, and reflects the shared aims for integrated care.

3.2. The Health and Wellbeing Board approved the first version of the BCF Plan at its meeting on 24th March 2014. In July 2014, the BCF planning guidance was updated and each area was asked to demonstrate how their plans would reduce emergency admissions to hospitals.

3.3. A revised plan reflecting the changes to guidance, based on more detailed analysis of the costs and benefits of the main schemes, was submitted on 19th September 2014, following an update at the Health and Wellbeing Board on 10th September 2014. The revised BCF Plan was then assessed against a common template as part of the BCF Task Force's National Consistent Assurance Review (NCAR), which was used to assess all BCF plans. Some further clarifications were requested and responses were provided in an updated version of the plan on 28th November 2014. As a consequence, the NHSE Area Team has confirmed that the plan will be recommended to the BCF Task Force for approval.

4. BCF IMPLEMENTATION PLANNING

4.1. In anticipation of approval, work has progressed on projects in the plan. The most significant of these a new, integrated CIS serving all three boroughs. It will provide consistent rapid response for people at risk of emergency admission to hospital; in-reach for people getting ready to leave hospital; and rehabilitation and reablement. It will help more people avoid a stay in hospital when they become ill; help those who need hospital care to go home as soon as they are well enough; and ensure everyone who uses the service has time and support recover and return as far as possible to independent life when they leave the service. CCGs and Cabinets agreed a business case for CIS following the BCF resubmission process in September. Preparations to implement the new service beginning in April 2015 are progressing well.

4.2. Community Independence Services in each the three boroughs work in different ways and are provided by numerous organisations. This fragmentation is not efficient and contributes to the reports of confusion that people report when they are asked about their experience of services.

4.3. In 2015/16, the BCF begins to expand and to standardise the CIS, so that it offers services of the same type and quality in all three boroughs; provides enough service to meet the needs of each borough's population; and simplifies the complex organisational structure in each and all of the boroughs. It is not, in this first year, possible to create one organisation to provide the whole of CIS. Instead, in 2015/16, the plan aims to invest in improvements in front-line services by appointing two leads: one for health services and the other for social services. While this does not create a single provider of integrated services, it goes some considerable way to simplify the existing arrangement

4.4. The social care provider is the Adult Social Care service that is shared by the LBHF, RBKC and WCC. The health provider will be chosen through a competition among the NHS providers that work in inner northwest London. The competition culminates in a panel representing, and chaired by, patients and including a mix of health and social care professionals. Once selected, the lead health provider will be expected to work with the social care provider to deliver a service that improves quality and outcomes of care and, by doing so, creates savings by keeping people out of hospitals and residential care. A contractual framework to support this approach is being developed.

4.5. Health and social care commissioners will work together through existing Section 75 Partnership Agreements. Between them the commissioners will oversee the implementation of the new service next year.

4.6. Once selected, the lead health provider is expected to work seamlessly with social care. A contractual framework to support this working arrangement is also being developed in the Better Care Fund programme. They will work together to implement the new service beginning in April 2015.

4.7. From the perspective of patients and people who work in the sector the improvements include a single entry-point that is professionally-led and has a single assessment process; responds in a timely way 7-days, responding to urgent needs in two hours; and has a single, multidisciplinary team working to a common set of standards.

4.8. Alongside CIS, other work is in progress to support increased integration of all the operational services that make up CIS. This includes ensuring an effective interface between CIS and the new homecare service, and enhancements to the social care elements of hospital discharge. This aims to achieve sustainable 7-day social work support in hospitals, from 8am until 8pm, and will help to ensure that sufficient referrals of patients and service users are generated to deliver benefits that were described in the September BCF plan. A pilot before April will test a range of innovations aimed at supporting swift and safe discharge.

4.9. The BCF creates savings by improving the quality of and outcomes from services in the community. With the introduction of these new services, a new monitoring tool help will show whether improvements in care translate into financial benefits, in particular savings from planned reductions in emergency admissions to hospital, and in admissions nursing and residential care homes. Regular data collection will support rigorous evaluation of impact and allow any trends of under-performance to be addressed quickly if detected. The BCF requires CCGs and councils to share the financial consequences if plans do not reduce unplanned admissions to hospital. The revised BCF plan that was submitted to NHS England in September includes the core

principles of risk sharing that will help us prepare new Partnership Agreements between the commissioners and contracts between the commissioners and providers. These include commitment to a shared approach to resolving variances and amending service models and the share of costs if required.

5. BCF IMPLEMENTATION PLANNING – OTHER PROJECTS

5.1. The BCF is not just about changing settings of care and savings. It should improve in people's experience of care. An important group of BCF projects is way to ensure we the programme can routinely report people's satisfaction with their services while we report how many people use the services and the cost of their care.

5.2. BCF also includes plans to improve the joint commissioning of services between health and social care and other things that help with integration such as shared information technology and good information governance.

5.3. In the review of jointly-commissioned services, work is in progress to streamline nursing and care home contracting, helping to focus on both quality and efficiency. This is working towards creating a single team for care home placement contracting, to maximise value for money, ensure that appropriate provision and improve outcomes for people who use residential care services. Detailed review of contracts is also being undertaken to ensure that services commissioned through partnership arrangements between health and social care commissioners give the best value for money.

5.4. The development of all these projects is led by the BCF Board and owned by the executive teams for health and social care, which regularly meet jointly and are supported in between meetings by a BCF steering group of the officers responsible for BCF.

6. WHOLE SYSTEMS PLANNING

6.1. Inner northwest London is in the national vanguard of health and social care integration. The Better Care Fund is part of wider plans to improve community health and care services, including mental health services. It touches all of those plans in some way but it is mostly closely linked with Whole Systems Integrated Care (WSIC).

6.2. In Hammersmith and Fulham WSIC programme builds on initiatives in the BCF. It extends changes to other services that help people live in the community and avoid intensive, bed-based services for as long and as often as possible. Primary care, acute and mental health services all play a part in these wider changes to the health and care system. Just as the BCF brings short-term community nursing, therapy and reablement into an integrated

CIS, WSIC develops partnerships in the wider world of health and care into formal “alliances” of providers that are accountable for the long-term outcomes of care for people who use their services. WSIC does more than develop partnerships that can provide better and integrated health and care services: it plans to change the financial incentives at work in the health and care system. WSIC tests the idea that the providers can be organised to give the providers stronger financial incentives to develop planned services that help people stay well and avoid intensive, institutional services especially in hospitals and care homes. This new method of budgeting and paying for service is called “capitation.” It defines a budget all the services that particular groups of people (“capita”) need to achieve good outcomes from their care. WSIC is working on detailed proposals for capitation, including estimates of costs and benefits across the health and social care system, now.

6.3. The programme team plans a series of design workshops with Hammersmith & Fulham residents and health and social care professionals in Q4 of 14/15. They will be focused on developing a shared understanding of the outcomes programme should help to achieve and use case studies to identify areas where we should strengthen, adapt or transform existing ways of working.

7. CONSULTATION

7.1. The BCF draws on the Joint Health and Wellbeing Strategy and Joint Strategic Needs Assessments across all boroughs, which is informed by feedback from residents who use these services.

7.2. The approach to developing the new services and new ways of working that are described in this paper is characterised by co-design with people who live in the borough and who use the services that will change. Clinicians, provider organisations, neighbouring CCGs and local authorities and national bodies have contributed in relevant ways.

7.3. The Whole Systems programme involves a broad range of clinicians and lay people from across North West London in developing the framework and materials that form the basis of our approach in Hammersmith & Fulham. As we go through the next phase of developing a local approach to implementation we will work closely with local residents, clinicians and stakeholders to co-design the outcomes and model of care we need to deliver care for our population.

8. EQUALITY IMPLICATIONS

8.1. Each relevant workstream within the BCF programme will prepare an Equality Impact Assessment and as the programme develops a programme-wide EIA will be prepared. The programme contributes to the implementation of integrated health and care services across the local area and will improve

services for the most vulnerable adults in the community.

9. LEGAL IMPLICATIONS

9.1. Legal considerations associated with the BCF (including legislation needed to ring-fence NHS contributions to the Fund at national and local levels) were described in the paper for the meeting on 8th September 2014.

10. FINANCIAL AND RESOURCES IMPLICATIONS

10.1. Estimates of 2015/16 costs and savings included in the September BCF submission (and maintained for consistency in the November update) were based on analysis available at the time. As stated in the paper of 8th September 2014, these estimates are being refined as we prepare for implementation. Updated values will be submitted to the BCF Board for review in early 2015. Further updates will also be provided to the Health and Wellbeing Board.

10.2. For 2015-16 the minimum value required of the BCF pooled budget across the three boroughs was £44.531m. In LBHF and Hammersmith and Fulham CCG, this was £13.148m.

10.3. In total across the three boroughs was considerably larger than the minimum. The proposed a budget of £193.092m, which included pooled budgets or jointly commissioned services that existed before the BCF and are incorporated in it.

10.4. The split for LBHF and Hammersmith & Fulham CCG within the BCF submission is as per the table below:

H&F Health & Wellbeing Board	LBHF £'000	H&F CCG £'000	Total £'000
BCF Plan (Sep & Nov)	£48,622	£31,533	£80,155

10.5. The BCF Plan estimates saving around £12.477m across the three boroughs in 2015/16, if targets are fully met.

10.6. Based on the September plan submission (*but subject to updates as per paragraph 10.1 above*) the BCF ensures that LBHF receives funding in 2015/16 for the Care Act (£558k) and the investment costs associated with the new CIS (£870k), and should generate recurrent savings (£1,630k). It also protects social care by continuing to pass through the *Social Care to Benefit Health* funding, currently worth £4.2m in LBHF.

10.7. The individual local authorities will track actual savings and CCGs on an ongoing basis and the Health and Wellbeing Board will be provided with updates during the course of 2015/16.

11. RISK MANAGEMENT

11.1. The BCF Plan includes a section on risks and mitigating actions, and some core principles of risk sharing have been agreed within the BCF Programme. These include organisations taking responsibility for the services that they sign-up to deliver (against agreed specification of service quality, type and volume); and taking responsibility for the benefits that are expected to be realised in their organisation.

12. PROCUREMENT AND IT STRATEGY IMPLICATIONS

12.1. There are no specific procurement and IT strategy implications relating to the BCF Plan except that one of the national conditions is better data sharing between health and social care, based on the NHS number. There is a BCF scheme focused on addressing the requirements of this national condition.

12.2. Procurement and IT Strategy implications relating to individual initiatives within the Better Care Fund Plan will be brought separately to the Cabinet and, where appropriate, to the Health and Wellbeing Board, for consideration.

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
	Triborough Better Care Fund Plan – Part 1 Narrative (updated following NCAR review November 2014)	James Cuthbert / Jenny Platt	As per cover sheet
	CIS Detailed Business Case v5.0	James Cuthbert / Jenny Platt	As per cover sheet

*[**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.

	London Borough of Hammersmith & Fulham **HEALTH AND WELLBEING BOARD** **19th January 2015**
SAFEGUARDING ADULTS EXECUTIVE BOARD	
Report of the Safeguarding Adults Executive Board	
Open Report	
Classification: For Decision **Key Decision:** No	
Wards Affected: All	
Accountable Executive Director: Liz Bruce, Executive Director for Adult Social Care Services and Health	
Report Author: Helen Banham, ASC Strategic Lead for Professional Standards and Safeguarding	**Contact Details:** Tel: 02076414196 E-mail: hbanham@westminster.gov.uk

AUTHORISED BY: .....

.....

DATE: .....

1. EXECUTIVE SUMMARY

1.1. This report asks the Health and Wellbeing Board (HWB) to consider its joint-working relationship with the Safeguarding Adults Executive Board (SAEB), including agreeing a protocol to describe this relationship and identifying any areas where joint-working might be beneficial to improve health and wellbeing outcomes for residents.

2. RECOMMENDATIONS

2.1. That that the Health and Wellbeing Board agree the draft protocol for working with the Safeguarding Adults Executive Board as attached at Appendix A to this report.

2.2. That the Health and Wellbeing Board discuss the areas for potential joint-working with the SAEB as set out in section 6 of this report.

3. REASONS FOR DECISION

3.1. The draft protocol is designed to ensure that safeguarding functions are discharged effectively in the London Borough of Hammersmith and Fulham without duplicating functions or creating additional structures

4. INTRODUCTION AND BACKGROUND

4.1. Leadership of safeguarding adults across the three boroughs[1] is provided by the multi-agency, independently-chaired Safeguarding Adults Executive Board (SAEB).

4.2. The purpose of the SAEB is to ensure that agencies working with adults at risk of abuse or neglect in the three boroughs, and represented on the SAEB, work together to;

- prevent harm and reduce the risk of abuse or neglect, to adults with care and support needs;
- safeguard individuals in a way that supports them in making choices and having control in how they choose to live their lives;
- promote an outcomes approach in safeguarding that works for people resulting in the best experience possible; and
- raise public awareness so that professionals, other staff and communities as a whole play their part in preventing, identifying and responding to abuse and neglect.[2]

4.3. At present, the SAEB is non-statutory body but this will change on 1st April 2015 when the Care Act 2014 is implemented.

4.4. The inaugural Annual Report 2013-14 of SAEB was published in the autumn and is available as a background paper to this report.[3]

4.5. The SAEB is working on its annual plan for 2015/16, which it aims to sign off at its April 2015 meeting. The SAEB draws on issues emerging from case review[4], both locally, and national-reported Serious Case Reviews[5], to inform how its sets its work priorities.

4.6. From 1st April 2015, under the Care Act 2014, the Local Authority is required to conduct a Safeguarding Adults Review (SAR) where an adult has died (or experienced serious harm) and agencies might have worked together more effectively to prevent their death (harm).

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[1] The City of Westminster; the Royal Borough of Kensington and Chelsea; and the London Borough of Hammersmith and Fulham.

[2] Care Act 2014 Guidance S 14 Safeguarding https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf

[3] The SAEB annual report shows the progress has been made in consolidating the governance arrangements of adult safeguarding, that were agreed by all three Cabinets in March 2013, in readiness for the implementation of the Care Act 2014. The report sets out what the SAEB has achieved in its first year, and the priorities it is working on in 2014/15.

[4] This includes findings from audit; peer audit; surveys; as well as formal case reviews.

[5] The Serious Case Reviews that the SAEB have used to inform its thinking and work this year are Winterbourne View; Mid-Staffs Enquiry; Gloria Foster (Surrey); Michael Gilbert (Luton); and the recent events in Rotherham.

4.7. The learning from SARs, and also from regular safeguarding case activity, is captured and disseminated because it often highlights symptoms of an underlying systemic failure that may need focused, joined-up attention to remedy.

4.8. There is value to the two Boards (HWB and SAEB) working together more closely. The learning that is brought to the SAEB is about where things have gone wrong, for a person, or an organisation. This learning can be shared, and can be used to inform the HWB commissioning intentions, to reduce and manage risk. Conversely, the work of the HWB can assist the SAEB in strengthening its work on preventing harm and abuse, and enhancing the quality of people's experience in health and adult social care provision.

5. PROPOSAL AND ISSUES

Joint-working protocol

5.1. **Appendix A** of this report outlines the way in which the HWB and the SAEB might work together, as equal partners, to ensure that safeguarding functions are discharged effectively in the three boroughs, without duplicating functions or creating additional structures.

5.2. The anticipated outcomes of this working together will be:

a.) Ensuring safeguarding is "everyone's business'' and is reflected in the public health agenda;
b.) Any safeguarding issues, or opportunities for the HWB to use its strategic influence over commissioning, are communicated to the HWB by the SAEB;
c.) Equally, if the HWB have concerns about safeguarding issues affecting health outcomes, these are effectively communicated back to the SAEB for consideration;
d.) Cross-Board partnership working embeds safeguarding across the health and wellbeing sector.

Areas for joint working

5.3. There are some themes emerging from adult Safeguarding case activity, and joint work done on 'improving people's experience of care' this year, that the SAEB think require a strategic, joint response, and for this reason may be of interest to the HWB. These are:

a.) Safer recruitment;
b.) Commissioning care for older people with complex care needs;
c.) Understanding and resourcing shared responsibilities for the Deprivation of Liberty Safeguards.

6. OPTIONS AND ANALYSIS OF OPTIONS

a.) Safer Recruitment

6.1. Evidence is emerging from safeguarding case activity, and joint work in improving people's experience of care, that health and care providers in London are increasingly challenged to find suitably qualified staff, with the right experience and qualifications, to carry out essential work. This includes health and social care workers, registered managers, and qualified (Band 7) nurses. There is also the challenge of increasing numbers of illegal workers being attracted to the sector.

6.2. The issue for the SAEB is that risk of abuse and harm is increased when complex tasks are being carried out by unskilled staff, and false identity undermines the need for accountability in care givers.

6.3. The SAEB intend to commission a thematic review of this issue and would welcome the support of the HWB in implementing its findings across all commissioning agencies.

b.) Commissioning care for older people with complex care needs

6.4. A recent case, currently under police investigation, where a Safeguarding Adults Review may be indicated, has highlighted the issue of provision for older people who may, because of dementia or related illnesses, display behaviour that puts themselves, and other people at serious risk of harm.

6.5. The SAEB would value a joint piece of work to identify how many people this applies to, and what new services might be commissioned; or how existing services might be organised differently, or strengthened; to meet this need.

c.) Deprivation of Liberty Safeguards (DOLS): impact of the Supreme Court judgement in March 2014

6.6. Additional safeguards are provided to people who do not have capacity to make decisions about their care and treatment, by the Deprivation of Liberty Safeguards (DOLS). A Supreme Court judgement in March 2014 lowered the threshold for what constitutes a deprivation of liberty, which has led to a significant increase in the number of applications for DOLS authorisations[6].

6.7. The responsibility for processing DOLS applications, and granting authorisations in hospital, nursing and care homes, was given to local authorities from April 2013. However, both health and adult social care retain responsibilities for ensuring any deprivation of liberty is identified and authorised, using the relevant legislation.

[6] A ten-fold increase is indicated

6.8. The response to the Supreme Court judgement from Adult Social Care (ASC) has been robust, despite an additional and unplanned financial burden being placed upon it. In the three boroughs, the same standard of assessment and vigorous scrutiny of each case has been maintained as prior to March 2014, and there continue to be some very good outcomes for people, where restrictions placed on the person have been safely reduced.

6.9. A priority system is being used to manage the increased volumes of application but some risks remain where assessments cannot be completed because of availability of suitably qualified assessors.

6.10. This activity is being closely monitored by the ASC leadership team and the SAEB. The SAEB would like the HWB to consider how the Supreme Court judgement is impacting on the whole health and adult social care system, and to work together to ensure that as far as possible, any risks to persons and organisations are mitigated

7. CONSULTATION

7.1. Between January and March 2015 the SAEB will be consulting member agencies, and the local community with the help of Healthwatch, on the priority areas for adult safeguarding plan for 2015/16. As required by the Care Act 2014, the 2015/16 plan will be published in May 2015.

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.			

Section 14 (Safeguarding) of the Care and Support Statutory Guidance, issued under the Care Act 2014
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf

Cabinet Report 25th February 2013: Consideration of the Findings and Recommendations of the Consultation, and Agreement on the Governance Arrangements for Adult Safeguarding across Tri-borough.
http://democracy.lbhf.gov.uk/documents/s28265/

Safeguarding Adults Executive Board Annual Report 2013-14
http://committees.westminster.gov.uk/documents/s9017/Safeguarding%20Adults%20Executive%20Board%20Annual%20Report%202013-14.pdf

LIST OF APPENDICES:
A: (DRAFT) Protocol to set out governance arrangements between the London Borough of Hammersmith and Fulham Health and Wellbeing Board and the Safeguarding Adults Board

APPENDIX A

(DRAFT) Protocol to set out governance arrangements between the London Borough of Hammersmith and Fulham Health and Wellbeing Board and the Safeguarding Adults Board

Purpose of the Protocol

1. The purpose of this protocol is to:
   - Set out the governance arrangements between the Safeguarding Adults Executive Board (SAEB) and the London Borough of Hammersmith and Fulham Health and Wellbeing Board (HWB);
   - Ensure there is a clear route through by which to refer up partnership issues from the Safeguarding Adults Board to the HWB and to raise any issues which may need to be met through strategic commissioning or delivery; and
   - Ensure that there is a coordinated approach to strategic planning between the HWB and the Safeguarding Adults Board.

Statutory Framework

2. HWB'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.

3. As a committee of the local authority, and a dual-function with the Clinical Commissioning Group (CCG), the HWB reports to the council and, where appropriate, the CCG governing body. HWBs are subject to overview and scrutiny committees of their local authority who are able to review their decisions.

4. The HWB enjoys a reciprocal relationship with other statutory boards operating within the health and wellbeing system, such as the Local Safeguarding Children's Board and the SAEB.

5. The Care Act 2014 replaced a raft of social care legislation and guidance and by April 2015, all local authorities will be required to establish a Safeguarding Adults Board.

6. In March 2013, the Cabinets of the London Borough of Hammersmith and Fulham, the Royal Borough of Kensington and Chelsea and Westminster City Council agreed to establish an independently chaired, multi-agency SAEB to provide robust leadership of adult safeguarding across the three boroughs.

Role and responsibilities

7. The Health and Social Care Act 2012 sets out specific statutory responsibilities which HWBs must fulfil including duties to:
   a.) encourage integrated working between health and social care service commissioners;
   b.) provide advice, assistance or other support for the purpose of encouraging use of flexibilities under NHS Act 2006;
   c.) prepare a Joint Strategic Needs Assessment (JSNA) in relation to local authority needs;
   d.) Prepare Joint Health and Wellbeing Strategies (JHWSs) for meeting needs included in the JSNA for their area; and
   e.) Provide opinions to relevant CCGs and local authorities on whether commissioning plans take proper account of JHWS.

8. Under the Care Act legislation, SAEBs are required to:
   a.) Include the local authority, the NHS and the police, who must meet regularly to discuss and act upon local safeguarding issues;
   b.) Develop shared plans for safeguarding, working with local people to decide how best to protect adults in vulnerable situations; and
   c.) Publish this safeguarding plan and report to the public annually on its progress, so that different organisations can make sure they are working together in the best way.

Working together

9. The relationship between the SAEB and the HWB would be one of equal partners underpinned by this protocol.

10. The HWB and the SAEB will co-ordinate strategic planning across partnerships to secure coherent delivery of business and to avoid duplication and gaps.

11. The HWB will communicate Joint Strategic Needs Assessments to partners on the SAEB to include safeguarding data analysis that helps drive strategic commissioning.

12. The Independent Chair of the SAEB will provide reports when appropriate to the HWB which highlight specific safeguarding areas where support from the HWB is required, such as changes which need to be sought through strategic commissioning and integrated working.

13. The HWB and SAEB will work together to ensure that they include the views of service users in their development of key strategies.

Outcomes of joint working

16. This protocol is designed to ensure that safeguarding functions are discharged effectively in the London Borough of Hammersmith and Fulham 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.) Communicating any issues or opportunities to the HWB in relation to its strategic influence over commissioning.
    c.) Where the HWB has concerns about safeguarding issues affecting health outcomes (such as domestic violence), these are effectively communicated back to SAEB for consideration.
    d.) Cross-Board partnership working to embed safeguarding across the health and wellbeing sector.

Signed

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Chair of the LBHF HWB

Independent Chair of the Safeguarding Adults Board