London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Agenda

Monday 22 June 2015
6pm
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
Vanessa Andreae, H&F CCG
Liz Bruce, Executive Director of Adult Social Care
Andrew Christie, Director of Children's Services
Janet Cree, H&F CCG
Trish Pashley, Local Healthwatch representative
Director of Public Health

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Date Issued: 02 September 2015

London Borough of Hammersmith & Fulham

Health & Wellbeing Board
Agenda

22 June 2015

This is the first public health strategy for the three councils since public health functions transferred from the NHS in 2013.

7. EXCESS WINTER DEATHS 59 - 66

This paper presents the 12 recommendations set out in the National Institute for Health and Care Excellence guidance in order to support the Board to consider an appropriate response in the context of Hammersmith and Fulham's Housing Strategy, *Delivering the Change We Need in Housing* and the Public Health Strategy, *Improving our Public's Health*.

8. PREVENTATIVE HEALTH

This item will be an oral update.

9. EARLY YEARS 67 - 72

This report updates on transition for the transfer of commissioning responsibilities for Public Health Services for 0-5 year olds, Health Visiting and the Family Nurse Partnership, from NHS England to the London Borough of Hammersmith and Fulham.

10. JSNA 2015/2016 73 - 79

This report provides a short update on the current stage of delivery of the Joint Strategic Needs Assessment (JSNA) products agreed by the Health and Wellbeing Board for the 2014/15 work programme. It also reports on two subsequent proposals received from partners for the 2015/2016 work programme.

11. 2015-2016 OPERATING PLAN, QUALITY PREMIUM - OPERATIONAL PLAN 80 - 143

This report updates on the Operating Plan and Quality Premium measures and targets.

12. NATIONAL HEATWAVE PLAN 144 - 186

The Heatwave plan for England is a plan intended to protect the population from heat-related harm to health. It aims to prepare for, alert people to, and prevent, the major avoidable effects on health during periods of severe heat in England.

Dr Tim Spicer will present this item.

13. DATES OF NEXT MEETINGS

The Board is asked to note that the dates of the meetings scheduled for the municipal year 2015/2016 are as follows:

1 September 2015
9 November 2015
9 February 2016
21 March 2016

London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Minutes

Monday 23 March 2015

PRESENT

Committee members: Councillors Vivienne Lukey (Chair)
Liz Bruce, Executive Director of Adult Social Care
Janet Cree, Managing Director, H&F CCG
Stuart Lines, Deputy Director of Public Health
Keith Mallinson, Healthwatch Representative
Dr Susan McGoldrick, H&F CCG
Rachel Wright-Turner, Director for Commissioning

Other Councillors: Rory Vaughan

NHS North West London: Dr Beverley McDonald (GP and Mental Health Lead) and Thirza Sawtell (Director of Strategy and Transformation Team)

NHS England (London Region): Jo Murfitt (Head of Public Health, Health in the Justice System and Military Health)

Officers: Sue Perrin (Committee co-ordinator)

51. MINUTES AND ACTIONS

The minutes of the meeting held on 19 January 2015 were approved as an accurate record of the meeting and signed by the Chair.

52. APOLOGIES FOR ABSENCE

Apologies were received from Councillors Sue Macmillan and Sharon Holder, Dr Tim Spicer, Andrew Christie and Trish Pashley.

53. DECLARATIONS OF INTEREST

Declarations of interest were received from Councillor Vivienne Lukey as a trustee of H&F Mind and Keith Mallinson as an advisor for H&F Mind.

54. NORTH WEST LONDON WHOLE SYSTEMS MENTAL HEALTH & WELLBEING STRATEGIC PLAN: BRIEFING PAPER

Dr Beverley McDonald and Thirza Sawtell introduced the North West London Whole Systems Mental Health & Wellbeing Strategic Plan, which encompassed all population groups, including children and young adults. The strategic plan looked at services in a more holistic way, supporting people to maintain mental health.

The report set out the strategic context, the vison for mental health services and the objectives and expected benefits.

Dr McDonald noted the essential role of local authorities in commissioning health and wellbeing services and the importance of their commitment and involvement in the programme.

Dr McDonald emphasised the importance of 'shifting settings of care' and good joint working, with all local stakeholders.

Mr Mallinson queried whether learning disabilities had been encapsulated within the mental health strategy. Dr McDonald responded that learning disabilities would be one of a number of strands within the whole work programme, concentrating on how the needs of the group could be best met.

Mr Mallinson stated that Healthwatch would be happy to support the programme and represent the interests of patients.

Dr McDonald responded to comments about the involvement of local authorities, that they sat on the North West London Transformation Board. Mrs Bruce commented that the Board had a lack of locality focus and there tended to be limited local authority attendance through lack of capacity. There was a need for local authorities to be represented at all levels.

Mrs Wright-Turner commented that the Children's Trust Board considered the CAMHs service to be a key priority and would be keen to influence the programme outcomes.

Councillor Lukey referred to the aspirations of 'Shifting settings of care' and noted the lack of a recovery house locally to meet mid-stage needs. In addition, facilities did not meet the aspirations of women who did not want to be in mixed communities and it appeared that the carers of people with mental health problems had not been given prominence. Dr McDonald responded that there had been engagement with service users and carers and this would continue. It was recognised that carers of people with mental health problems were at risk because they were in stressful situations.

Councillor Vaughan considered that the Council would expect to be formally consulted.

Mr Mallinson stated that Healthwatch had three areas of concern with West London Mental Health Trust (WLMHT): the quality of services for patients in the Claybrook Centre; the transfer of services from Hammersmith & Fulham to Ealing; and the apparent reluctance of the trust to participate in wider patient engagement.

Dr McGoldrick stated that the CCG shared the concerns in respect of Claybrook Centre and potential risk. It was believed that WLMHT was aware of the issues and was reviewing its strategies.

Mrs Bruce noted the concerns in respect of Approved Mental Health Professionals leaving because of the workload and environment.

Mrs Bruce referred to the 'Shifting settings of care' and the role of the joint commissioning board. The Local Authority was the lead in respect of the learning disabilities service. Some of the pressures on providers in respect of the shift from secondary to primary care were understandable. There needed to be a locality focus. Should there be a change to or removal of a service, the Council would expect to be consulted and would like to work closely with health services in respect of the pathway and supporting people early, in a preventative way.

Mr Lines noted the importance of the relationship between physical and mental health, and supporting people to maintain physical health through a holistic approach, particularly for people with long term conditions.

Councillor Lukey concluded the discussion, stating that it had been helpful to receive the strategic plan at an early stage and that the Council would want to be involved at various levels. It was suggested that NHS North West London should work with the Health, Adult Social Care & Social Inclusion PAC to consider how to take forward the strategic plan.

RESOLVED THAT:

The Health & Wellbeing Board noted the North West London Whole Systems Mental Health & Wellbeing Strategic Plan.

55. PHARMACEUTICAL NEEDS ASSESSMENT

The Board received the Pharmaceutical Needs Assessment (PNA) 2015-2018.

Mr Lines stated that the responsibility for producing and managing the update of PNAs had transferred from Primary Care Trusts to HWBs on 1 April 2013. Local Authorities have a statutory duty to publish a fully revised PNA by 1 April 2015.

PNAs are a statement of the need for pharmaceutical services of the population in a defined geographical area. They are used in the main by NHSE as a market entry tool. There had been statutory consultation and it was believed that all comments and concerns raised by the respondents had been addressed. The PNA would be updated in three years' time.

Having assessed the local needs and the current provision of necessary services, there had not been any necessary pharmaceutical services identified, which were not provided within Hammersmith & Fulham.

The PNA could be used as a springboard for a wider review of capacity and capability of community pharmacies in Hammersmith & Fulham. In addition, they could be used in more strategic ways, for example by achieving accreditation as a Healthy Living Pharmacy, and providing sign posting and information.

Councillor Lukey commented on the lack of information in respect of immunisation (flu vaccinations were mentioned briefly). Ms Murfitt responded that commissioning through pharmacies had to be evaluated in terms of value for money, as well as access.

Councillor Vaughan commented on the importance of information in respect of pharmacy availability, opening times and services and this needed to be communicated better, for example on the Council website. Councillor Vaughan queried whether pharmacies provided the flu vaccination for children. Ms Murfitt responded that pharmacies were not licensed for the flu vaccination for children. This had to be administered by a health professional.

Mr Mallinson referred to the private provision of sexual health services by pharmacies, and queried whether there were any proposals to commission these services. Mr Lines responded that it was not planned to use pharmacies as a source of primary care in the community, as an alternative to GPs, but rather as an addition to improve access for health advice. Dr McGoldrick added that, in respect of chronic disease management whilst it was possible for pharmacists to identify these conditions, it was not possible for GPs to commission this service.

Councillor Lukey considered that there should be a dialogue with local pharmacies in respect of utilisation of their services in a more effective way. Mr Lines responded that Public Health could help with the role of a community pharmacy and accreditation as a Healthy Living Pharmacy, in addition to looking at the work streams within the PNA.

RESOLVED THAT:

The Health & Wellbeing Board approved the PNA for the London Borough of Hammersmith & Fulham.

56. HAMMERSMITH & FULHAM CLINICAL COMMISSIONING GROUP: LOCAL PRIORITY 2015/16: UPDATE AND NEXT STEPS

The Board received Hammersmith & Fulham CCG's 'Local Priority 2015/2016: Update and Next Steps'. Dr McGoldrick stated the CCG was awaiting further guidance from NHS England on the number of local priorities

to select and the timetable. Ms Murfitt undertook to find out when the guidance would be available.

Initial information from the consultation on the short list indicated the following two priorities: Childhood Immunisation – MMR2 and Identification of Young Carers, followed by Tackling childhood obesity – signposting to weight management services and diabetes.

Mr Mallinson noted that there was evidence of the success of expert patient support in respect of diabetes.

Councillor Vaughan queried the meaning of 'priority'. Dr McGoldrick responded that a financial bonus was received from NHS England in respect of achievement of targets in the two priority areas. Whilst this impacted on the CCG's focus, the other areas remained priorities.

Mr Lines suggested that Public Health would be keen to assist in helping to develop an objective prioritisation process in order to assist in selecting from the long list, providing analysis and quantifying outcomes.

Councillor Lukey noted that the local priorities were a work in progress. Whilst the priorities of the CCG were not necessarily identical to those of the HWB, there needed to be some core synergies.

RESOLVED THAT:

The Health & Wellbeing Board noted the Local Priority 2015/2016: Update and Next Steps.

57. WORK PROGRAMME

The work programme for 2015/2016 was approved subject to the addition of the development of commissioning intentions to the June agenda and Community Independence Service, a joined up approach to the work programme.

58. DATE OF NEXT MEETING

This was the last meeting of the municipal year.

Meeting started: 6.00 pm
Meeting ended: 7.00 pm

Chairman .....

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	London Borough of Hammersmith & Fulham **HEALTH & WELLBEING BOARD** **22 June 2015**
TITLE OF REPORT **UPDATE ON ADULT SOCIAL CARE AND HEALTH INTEGRATION VIA THE BETTER CARE FUND**	
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: Stella Baillie, Director of Integrated Care for Adult Social Care and Health Janet Cree, MD of Hammersmith and Fulham Clinical Commissioning Group	**Contact Details:** E-mail: stella.baillie@rbkc.gov.uk Tel: 020 7361 2398 E-mail: janet.cree@nw.london.nhs.uk Tel: 020 3350 4273

1. INTRODUCTION

1.1. This paper is an update for the Health & Wellbeing Board on progress with development of the Better Care Fund (BCF). After a reminder of the national context for the BCF, a brief progress update on BCF schemes in the three boroughs of Hammersmith & Fulham, Kensington & Chelsea and Westminster is provided. The progress update starts with the most significant scheme, the new integrated Community Independence Service (CIS). There is also a specific update on the pilot that has now commenced to test a new approach to hospital discharge. Following these, there is a broader update on the other schemes that form the BCF plan for the three boroughs.

2. RECOMMENDATION

2.1. The Health and Wellbeing Board is asked to note the progress made with the BCF schemes.

3. BACKGROUND

3.1. 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. 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 has been tasked with developing a plan, and the Hammersmith & Fulham BCF plan has been approved by NHS England. The BCF did not come into full effect until 2015/16, but a significant amount of planning and preparatory work was required in 2014/15. Regular updates on the progress to date have been provided to the Health and Wellbeing Board.

4. PROGRESS UPDATE – COMMUNITY INDEPENDENCE SERVICE

4.1. The new, integrated CIS will provide consistent rapid response, hospital in-reach, and rehabilitation and reablement services. This is the most significant scheme in terms of anticipated benefits. Each borough currently has a CIS, but the services in each of the three boroughs work in different ways and are provided by a range of different organisations. In autumn 2014, the three CCGs and local authority Cabinets agreed a business case for investment in a single, integrated CIS, serving all three boroughs. It is not possible in 2015/16 to create one organisation to provide the whole of CIS. Instead, the BCF plan aims to invest in improvements in front-line services through two lead provider roles, one for health services and the other for social services. This goes a considerable way to simplifying existing arrangements.

4.2. Following selection of Imperial College Healthcare Trust (ICHT) and partners as lead health provider, joint working has been established with the Adult Social Care teams in the three boroughs to develop and implement the service changes needed. Joint mobilisation, investment and communication plans have been developed, and at the end of March, health and social care commissioners reviewed and approved the plans against a set of pre-agreed requirements.

4.3. The new service led by ICHT and the three Adult Social Care teams therefore commenced as planned at the beginning of April 2015. Contractual arrangements, including performance indicators and measures, have been developed and agreed to monitor and manage the new service. A joint governance structure across health and social care has also been developed, which includes a clinical reference group to review and approve detailed service design. Patients and residents will be involved in design and scrutiny through this governance structure.

4.4. Lead providers are working together to plan and deliver communications to increase awareness, firstly amongst health and social care professionals and then the wider public. This includes briefings for GPs to build their confidence in the CIS changes and additional capacity, encouraging more referrals from them into the service. In-depth patient communications are scheduled for July.

5. PROGRESS UPDATE – PILOTING ENHANCEMENTS TO HOSPITAL DISCHARGE PROCESSES

5.1. Plans were developed in 2014/15 for hospital social work teams to pilot improvements in the support for people leaving hospital. The pilot started in March and will evaluate process changes against a range of criteria, including patient and carer experience, reductions in length of stay in hospital, and the interface with CIS.

5.2. In the pilot, assigned social workers are responsible for all residents from the three boroughs on selected wards across Imperial and Chelsea and Westminster hospitals. The pilot social workers have started at Charing Cross Hospital (8 West and 8 South wards) and Hammersmith Hospital (Fraser Gamble and Christopher Booth wards). The pilot workers are making good progress on the Charing Cross wards, identifying people with social care needs earlier on; and in Hammersmith, the LBHF adult social care team has worked with hospital consultants to increase integration on the pilot wards.

5.3. The pilot will be evaluated to provide recommendations and options for wider roll-out. A briefing paper with further information on the pilot is provided at Appendix 1.

6. PROGRESS UPDATE – OTHER SCHEMES

6.1. Work is also continuing to improve other operational services as part of the BCF plan. These include commissioning of the new homecare service to help more people remain independent in their own homes. Providers for the new service are being procured, and more ways to support joint working between health and social care are being established. Work is also progressing on the business case to increase capacity for neuro rehabilitation in the three boroughs, helping to reduce Delayed Transfers of Care in acute hospitals.

6.2. In the BCF schemes focusing on patient and customer experience, a model of care for self-management has been developed through public engagement workshops in each borough and a review of national best practice. An approach to testing the model is now being developed with Whole Systems leads. A review of personal budgets for patients with Continuing Healthcare needs has informed development of a business case, now approved, to increase CCG investment in support provided by Adult Social Care teams in the three boroughs.

6.3. In the schemes focusing on integrated commissioning and contracting, finance and commissioning leads across health and adult social care are meeting regularly to review opportunities for greater effectiveness and efficiency in services included in existing pooled budgets; and a business case has been developed to assess the benefits of establishing a joint health and social care placements and review team for nursing and residential care.

6.4. In the schemes supporting programme delivery, work is continuing to enable consistent use of the NHS number as the primary identifier of individuals across health and social care. Complementary work on information governance has led to accreditation against the Department of Health's self-assessment toolkit, which measures compliance with legal requirements and central government guidance on information governance. BCF investment is also continuing to support a range of tasks to support Care Act implementation.

7. BCF OWNERSHIP

7.1. The BCF plan is owned by the Health and Wellbeing Board and overseen by the BCF Board. Delivery is led by the executive teams for health and social care, which regularly meet jointly and are supported in between meetings by a steering group of the officers responsible for BCF schemes.

Appendix 1: Update on Hospital Discharge Pilot

1. Purpose of Paper

1.1 This paper provides an update on the hospital discharge scheme that is part of BCF Group A.

2. Background

What is the objective of the pilot?

2.1 The pilot is about testing a new approach to hospital discharge. The Better Care Fund Programme and Customer Journey Programme are supporting the three ASC borough hospital teams to prepare a pilot that will test a new approach to Adult Social Care hospital discharge, and alignment to hospital discharge and in-reach functions. The new approach will enhance the timeliness and quality of hospital discharge, and prepare the ground for reform of the wider hospital discharge process (including the CIS and discharge services of the acute trusts).

2.2 The pilot will test (and evaluate) the following areas:

- **Improving multi-disciplinary teams and integrated working** – are staff members more satisfied working together and sharing information/knowledge – and more effective?
- **Patient and carer experience** – is this really improving outcomes for people? Or impacting on patient safety and quality?
- **Improving discharge process** – are we finding a reduction in length of stay and more effective transfer into CIS?
- **Improving quality of post-discharge** – are their less re-admissions due to holistic care planning? Is there less usage of long-term care arrangements, and specifically placements directly from hospitals?
- **What care needs are not being met currently** – how are we addressing these needs differently?
- **Staffing and skills** – what is the best way to deliver an integrated discharge?
- **Wider recommendations** – what staff resources are needed? What is the business case (quality, finance) based on the activity/outcomes of the pilot wards?
- **Reciprocal arrangements between authorities** – what are the operational requirements on the ground?

What is in scope?

2.3 The pilot is running across the three borough footprint in Imperial and Chelsea & Westminster hospitals.

2.4 The pilot will only affect the three borough residents that are being discharged from the following 8 wards:

- Imperial – Hammersmith Hospital: Fraser Gamble and Christopher Booth
- Imperial – Charing Cross Hospital: 8 West and 8 South.
- Imperial – St Mary's Hospital: Witherow and Manvers
- Chelsea & Westminster: Edgar Horne and David Erskine

2.5 The primary aim of the pilot is to test redesign of social care and in-reach discharge related functions and workforce – and will directly affect:

- H&F, RKBC and WCC ASC hospital teams
- CLCH in-reach assessment functions across the patch.

2.6 The secondary aim of the pilot is to engage and align to the following services – to ensure improved integration between health and social care:

- Imperial and Chelsea & Westminster medical, nursing, therapy and discharge teams
- The pilot will measure the effect of these changes on demand for other services and make recommendations to optimise the service pathway. Specifically it will look at the referral volumes and demand for the following services:
    - Current CIS and other service provision teams delivering short term care
    - ASC long term assessment teams and provision across the three boroughs
    - Information and advice – potentially access teams and voluntary sector.

What are the desired outcomes?

2.7 The pilot seeks to demonstrate a new approach that will enhance the timeliness and quality of hospital discharge, and provide increased alignment between CIS and the discharge services of the acute trusts; and contribute to the MTFP savings in the Customer Journey programme.

2.8 It will produce evidence-based recommendations and options for wider roll-out across the three boroughs (and potentially with neighbouring authorities across NW London) and inform a business case for integrated 7 day working across the health and social care discharge model.

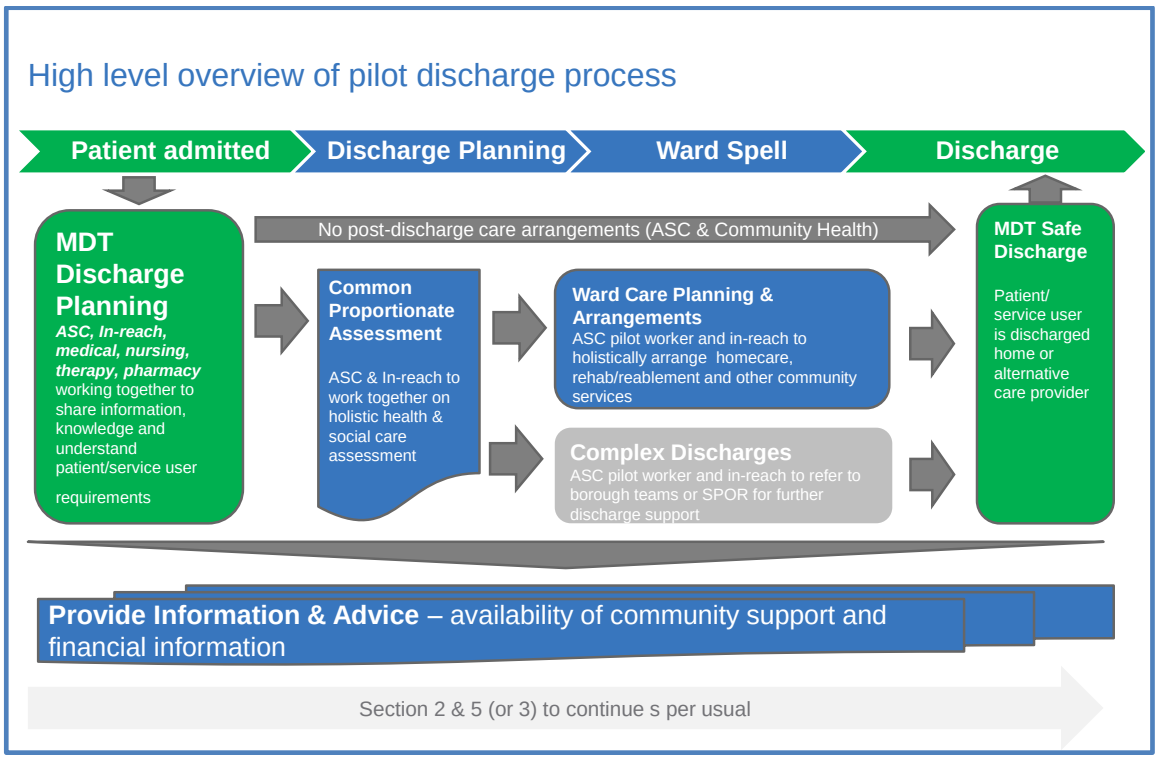
How does it work?

2.9 An assigned ward social worker is responsible for all patients/residents from LBHF, RBKC and WCC on selected wards (8 altogether) across Imperial and Chelsea & Westminster hospitals. They are working as one team with the CIS in-reach assessors.

2.10 They will be attending the multi-disciplinary meetings and board rounds, and be available to provide information and advice for and about patients, carers, hospital discharge, nursing, medical and therapy staff. They are also trialling a common proportionate assessment between social care and in-reach, which will help reduce any duplication and delays in discharge planning.

2.11 Figure 1 depicts the overall process of the pilot.

Figure 1: Overview of hospital discharge pilot process for all patients from the three boroughs:



What are the key features of the discharge process?

2.12 Immediate benefits of the pilot include:

- Information and advice for patients and carers in the ward, to improve transition of care to community services
- Named social care and in-reach staff working with one MDT on the wards
- One access point to social care and in-reach for H and F, K and C and Westminster, with common assessment across both teams for all three boroughs
- Access to information from social care records (Frameworki) as part of MDT meetings and board rounds
- More integrated working between Hospital Discharge and Hospital Adult Social Care

- Easy access to knowledgeable professionals and resources around social care and community health provision including CIS (Rapid Response, Reablement, Rehabilitation), voluntary sector and long-term care options
- Streamlined referral processes for CIS and community services
- Reduced duplication and delays between current ward teams and adult social care
- Managed as part of BCF Group A to ensure consistency with development of the new CIS.

Method: co-production

2.13 Taking a pilot approach has been highly beneficial as we can develop and test a different model. The staff who deliver the service, and who know what does and doesn't work on the ground. We have been able to engage with staff, managers and wider stakeholders to shape the approach and gain real buy-in from staff in ASC, in the acute and community NHS trusts.

2.14 A co-production and "test and implement" approach has been taken to designing, developing and implementing this pilot. The co-production consists of:

- Running a weekly working group involving front-line managers and staff across ASC, in-reach and hospitals, to inform design and day-to-day management
- Monthly pilot staff development workshops to listen to and engage with staff
- Direct input and support from:
  - The wider ASC hospital team, including support functions
  - ASC teams including extended hours, long-term care, Frameworki and performance teams
  - Acute medical, nursing, therapy, performance and IT teams
  - CIS project implementation team
- Survey and other feedback from a wide range of customers, patients and ward hospital staff to inform the design of the pilot, and for planning evaluation.

2.15 This approach has been very well received. Operational staff and managers are feeling engaged and working in a safe environment to provide both feedback and develop their own solutions – and they know what works best.

How is this being funded?

2.16 This pilot is being funded by the BCF programme. The staffing costs have been funded through current staffing budgets in addition to Winter Resilience funding which will continue to give us operational capacity to continue with this pilot and keep the service running during such a busy period for the acute system.

3. Progress to Date

What are the key achievements to date?

Pre Go-Live

3.1 Managers and front-line staff from ASC hospital and in-reach teams have developed and agreed a joint assessment and support planning process that is streamlined across the three boroughs.

3.2 A joint health and social care assessment has been developed, and is to be tested by both ASC and in-reach staff during the pilot. The pilot design and process has been very well received by the Imperial medical team: “It’s great that we are removing silos and bringing the right staff together to manage discharges”.

3.3 There has been excellent buy-in and contribution from acute teams, including a successful push for Wifi access on pilot wards for ASC and in-reach staff members. This is allowing MDT teams to access Frameworki information live on the ward for the first time. Overall, there is good enthusiasm and momentum from both managers and staff. Induction and training have been completed and well received.

Post Go-Live

3.4 The pilot went live on 16th March, with all pilot workers (including ASC and In-Reach), management and support teams. Since then, there has been a robust issue-resolution process in-place. It has been possible to resolve 90% of issues, with emphasis on front-line support by operational managers across ASC, CLCH, Imperial and Chelsea & Westminster hospitals and the project team.

3.5 Work is continuing to embed new processes, and refine based on staff, support and managerial feedback. This is contributing to continual improvement of the hospital discharge process across the three boroughs, taking good practice from each borough.

3.6 An evaluation approach and plan has been developed by the working group, and there will be further exploration of how the approach could be scaled across hospitals in the three boroughs. This includes “front-door” acute units and out-of-borough hospitals (e.g. UCLH/St. Thomas etc).

What is the early feedback so far?

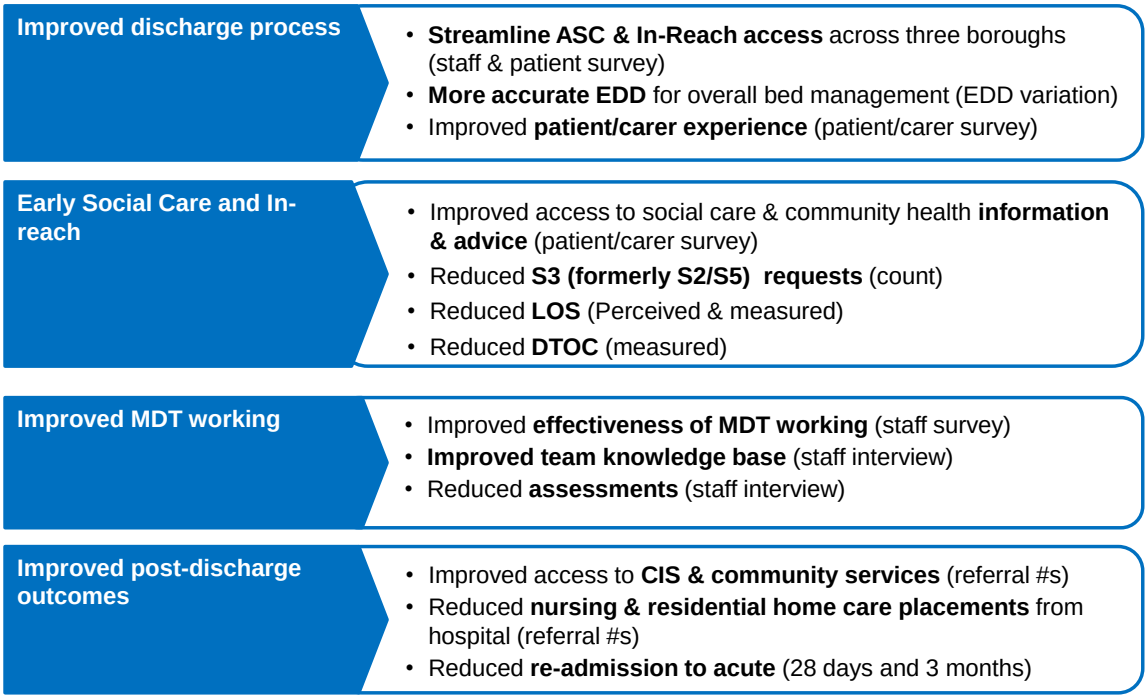
3.7 Over the first 3 weeks of the pilot, early feedback has been obtained from carers, ASC, CIS In-Reach and hospital staff on how the pilot is shaping:

*Early **successes** to date…* • Ability to assess **holistic needs** of patients and in particular for carers – early wins of identifying alternative and cost-effective options • Staff involved have highlighted is **reduced duplication** between different professionals – e.g. assessments, administration, referrals • **'One-stop' access** for patients, carers and professionals on community assessment, service planning and information and advice • Building relationship and **breaking down traditional cultural barriers** between health and social care and acute and community care • **Locally tailored** pilot discharge design to different ward and patient-population type • Ward Consultants feedback **"Why have you not done this before?"**	*Key **issues/challenges** to date…* • **Information governance** between multiple organisations (LA, CLCH, Imperial, Chelsea & Westminster) – having to develop "workarounds" (e.g. joint assessments – storage issue of information) • Effective discharge may potentially **increase demand on 'downstream' services** – long-term ASC, CIS, home care – this is being measured as part of the evaluation to better understand impact for wider recommendations and to ensure appropriate resourcing. Demand for CIS is high and increasing, so resourcing is needed to meet this demand. Clinical support will be crucial in order to satisfactorily change the practices of supporting people at home. • Running a **hybrid environment** of pilot vs. non-pilot wards – we have developed operational processes to enable this and reviewed on a weekly basis
***Opportunities** to further explore…* • Further develop **whole team' approach** - Front-line management and staff have recognised that different teams (i.e. hospital discharge, therapist, CIS, in-reach, ASC hospital teams) using this pilot as an opportunity to test an integrated discharge model • Pilot should expand to **7 day MDT approach** on emergency and acute wards (e.g. AAU and medical units) – where pilot approach and 'turn-around' outcomes • Enhance current **care coordination/arrangement** processes – e.g. enhanced carer support in tandem with CHC packages • **Reduce duplication and handover** between hospital and community teams for both social care and health – e.g. looking at in-reach assessment as a function of CIS rather than a separate team. A discharge role, encompassing both aspects could reduce duplication and provide economies of scale.	***Risks and barriers** to mitigate/ overcome…* • Further explore **clinical responsibility** – who is accountable for what decisions – and what functions can be shared between professionals (e.g. joint assessments to inform **workforce recommendations)** • Continue to develop and implement **CIS** service to enable smooth discharge and transition into community

4. Next Steps

Focus on evaluation and data collection

4.1 An evaluation framework has been developed (with an associated data collection process) based on the original pilot objectives and areas we want to test:



4.2 Next steps and considerations will include how to:

- Further 'operationalise' and embed pilot processes across pilot, hospital and wider ASC borough hospital and in-reach teams
- Develop recommendations and an options paper for wider implementation, informed by evaluation and stakeholder input/feedback
- Implement automated data collection across adult social care in the three boroughs, and in Imperial and Chelsea & Westminster performance teams.

4.3 After the completion of the pilot, an evaluation report will be produced, including feedback from staff, patients and carers.

	London Borough of Hammersmith & Fulham **BRIEFING TO HEALTH AND WELLBEING BOARD** **22 June 2015**
IMPROVING OUR PUBLIC'S HEALTH – THE PUBLIC HEALTH STRATEGY FOR THE LONDON BOROUGH OF HAMMERSMITH AND FULHAM, THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA AND THE CITY OF WESTMINSTER 2015-2025I	
Report of the Executive Director of Adult Social Care and Health	
Open Report	
Classification: For Information **Key Decision:** No	
Wards Affected: All	
Accountable Executive Director: Liz Bruce, Executive Director of Adult Social Care and Health	
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1. EXECUTIVE SUMMARY

1.1 *Improving our public's health* is a ten-year strategy for the City of Westminster, the Royal Borough of Kensington and Chelsea and the London Borough of Hammersmith and Fulham. It includes six shared public health priorities as well as one specific priority for each borough. The LBHF specific priority is "reducing the health inequalities associated with childhood poverty".

1.2 Annual updates on progress and thorough reviews every three years will ensure that the priorities remain relevant and focused. The strategy will be used as an internal resource, which public health professionals and wider council departments can use to work together and embed public health priorities into day to day working. The full strategy will be shared with health (CCG) colleagues as key partners in its delivery, and a shorter, public facing document will be made available to residents and other partners.

1.3 Much of the success of this strategy will be dependent on the positive engagement from council services and wider partners. Achievement of these large scale public health outcomes will be delivered most effectively by different services and organisations working together and sharing aims.

2. RECOMMENDATION

2.1 HWBB members are asked to consider how the strategy's priorities can be aligned to the work of their organisations and how these efforts can be coordinated with Public Health and other relevant stakeholders.

3. INTRODUCTION AND BACKGROUND

3.1 This is the first public health strategy for the three councils to be developed by since public health functions transferred from the NHS in 2013. It seeks to support a step change in the integration of public health priorities into all relevant services by providing a clear focus on the priorities that will help make our boroughs places where everyone starts their life well, lives well and ages well.

3.2 A single page summary of the strategy, including the six shared priorities and one LBHF specific priority, is included on page 5 of the full report attached as appendix 1.

4. PROPOSAL

4.1 Through the development and delivery of the ten year public health strategy, we intend to help create sustained and focused action on the key areas that we believe will improve public health and reduce health inequalities in our three boroughs.

5. OPTIONS AND ANALYSIS OF OPTIONS

5.1 HWBB Board Members are asked to review the priorities below and consider:

5.2 Whether they cut across or complement priorities for their organisations and/or the Health and Wellbeing Board and, if so, what new opportunities does this strategy afford for collaboration to achieve shared priorities and,

5.3 Whether any of the priorities represent a strategic opportunity to introduce new activities into their service and/or the Health and Wellbeing Board that can improve public health outcomes.

6. CONSULTATION

6.1 This Strategy has incorporated feedback from the Cabinet Member for Adults and Public Health, Shared Services Board, Public Health Integration and Transformation Board and Public Health England, London

7. EQUALITY IMPLICATIONS

7.1 An overriding ambition of this strategy is to address the wider determinants of health and reduce health inequalities. We believe a sustained focus on these priorities will make a tangible difference to health inequalities in our boroughs.

7.2 Any significant changes in service delivery as a result of this strategy will be subject to Equality Impact Assessments as part of the decision making process.

8. LEGAL IMPLICATIONS

8.1 There have not yet been any proposals that impact on services and therefore there has not been the need to seek legal advice.

8.2 Implications verified/completed by: N/A

9. FINANCIAL AND RESOURCES IMPLICATIONS

9.1 In the future, the public health budget will be more closely aligned to the identified priorities within the strategy. This alignment will be subject to normal governance processes and will require consideration of financial implications on a case by case basis.

9.2 Implications verified/completed by: N/A

10. RISK MANAGEMENT

10.1 RISK – Lack of engagement from all stakeholders may undermine successful action to address priorities. ACTION TO MITIGATE RISK – the strategy is being presented to all key stakeholders within the Councils and CCGs. A public facing document is being produced to share with wider stakeholders. Task and Finish Groups will be established to coordinate activities on priorities where there is currently a lack of joint action (for example, a Task and Finish Group is not required for reducing smoking rates because the Smokefree Alliance is already well-established.

10.2 RISK – The strategy fails to focus action on the key priorities and becomes irrelevant. ACTION TO MITIGATE RISK – every year we will review and provide an update on how we are performing against each of the priorities. The Annual Public Health Report will also comment on our progress in these priorities.

10.3 RISK – The public health priorities in the borough change during the ten year lifetime of the strategy. ACTION TO MITIGATE RISK – every three years we will review progress and strategic direction of the overall strategy to ensure that it remains relevant.

10.4 Implications verified/completed by: Stuart Lines, Interim Director of Public Health for LBHF

11. PROCUREMENT AND IT STRATEGY IMPLICATIONS

11.1 Public Health is currently in the process of conducting comprehensive reviews of all our commissioned public health services. This strategy will help guide these reviews which will ultimately have implications on procurement activity

11.2 Implications verified/completed by: N/A

LIST OF APPENDICES:

Appendix 1 – Full report – Improving our Public's Health – the public health strategy for the London Borough of Hammersmith and Fulham, the Royal Borough of Kensington and Chelsea and the City of Westminster

IMPROVING OUR PUBLIC'S HEALTH

The public health strategy for the
London Borough of Hammersmith and Fulham,
the Royal Borough of Kensington and Chelsea and
the City of Westminster

2015 – 2025

INTERNAL DOCUMENT

For sharing with internal council directorates and the three CCGs only

ANNUAL UPDATES:

THREE YEARLY REVIEWS:

PUBLICATION DATE:

Foreword

Two years on from the transfer of public health responsibilities from the NHS to local government we have made great progress in taking on and developing our approach to the improvement of health and wellbeing in our communities and in reducing health inequalities.

There is an overwhelming consensus on the importance of prevention in limiting levels of ill-health and early death. This is not only important at an individual and a family level, where living with a long term condition such as diabetes or heart disease can present daily challenges, but it is also true for whole communities and wider society. We want to help create environments where people prosper and achieve their full potential, avoid preventable illness and live longer and more fulfilling lives.

The importance of prevention in helping achieve long term sustainability of the health and care system has been echoed in a range of national documents, from the Wanless Review in 2002, the Marmot review in 2010 to the NHS Five Year Forward Plan in 2014. Local authorities, with their new leadership role in improving health and wellbeing through public health services play a fundamental part in helping achieve this.

Since April 2013 public health functions have been embedded into the working of the three councils, making connections with other services, developing key programmes such as tackling rising rates of childhood obesity and providing seed funding across the councils to help deliver the improved public health outcomes we want to see. A structural review of how our public health capacity and capabilities work is currently in progress. This is expected to help deliver further efficiencies and focus in achieving our priorities.

This 10-year Public Health Strategy is designed to create sustained focus and action on the key areas that we believe will make a tangible difference to the lives of residents in our three boroughs. Our six shared priorities reflect the challenges that are common across all three boroughs and our individual priorities direct attention to those issues which are most important to each individual borough. Improving outcomes at this scale takes time and concerted effort across a range of partners and stakeholders. This strategy will serve to galvanise our collaborative efforts and deliver positive changes to the health and wellbeing of our residents.

As the public health lead cabinet members for the London Borough of Hammersmith & Fulham, the Royal Borough of Kensington & Chelsea and Westminster City Council, we endorse this strategy and encourage services across all three councils, and wider partners, to work together to help achieve these ambitions for our residents.

		
Cllr Vivienne Lukey Cabinet Member for Health and Adult Social Care	**Cllr Mary Weale** Cabinet Member for Adult Social Care and Public Health	**Cllr Rachael Robathan** Cabinet Member for Adult Social Care and Public Health

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

Transferring responsibility for the public's health back to local authorities is the biggest shift this area has seen for decades.

It's an exciting challenge and represents a huge opportunity for our three boroughs to work together and improve wellbeing, reduce health inequalities and enable the delivery of higher quality care.

This strategy sets out our priorities for the next ten years and while improvements won't be apparent overnight I believe we can lay the foundations to help our residents live long, healthy and fulfilling lives.

Our three councils cannot achieve this alone and we are committed to sharing learning and experience between council departments, clinical commissioning groups, GPs, third sector organisations and local people.

This strategy is ultimately about enabling council services to work together to deliver our public health priorities. It will be kept on track through annual updates and three-yearly reviews, which will link strongly to the three health and wellbeing strategies.

Liz Bruce
Executive Director of Adult Social Care and Health
London Borough of Hammersmith & Fulham,
the Royal Borough of Kensington & Chelsea and
Westminster City Council

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OUR PUBLIC HEALTH STRATEGY AT A GLANCE

OUR VISION

By 2025 Hammersmith & Fulham, Kensington & Chelsea and Westminster will be places where everyone starts life well, lives well and ages well

OUR MISSION

- To use our expertise and resources effectively and holistically
- To work across all council services and with partners across the whole system
- To tackle the health challenges within our boroughs
- To address the wider determinants of health and health inequalities
- To create opportunities for our residents to enjoy good health and wellbeing

SHARED PRIORITIES

The councils will work together, sharing services and approaches as appropriate to tackle our common health challenges and shared priorities:

PRIORITY 1	PRIORITY 2	PRIORITY 3	PRIORITY 4	PRIORITY 5	PRIORITY 6
Reducing levels of obesity in children	Reducing smoking rates	Improving sexual health	Reducing levels of substance misuse	Improving mental wellbeing	Improving preventative services

BOROUGH SPECIFIC PRIORITIES

We will also drive work individually to meet the challenges of particular importance to our boroughs:

HAMMERSMITH & FULHAM	KENSINGTON & CHELSEA	WESTMINSTER
Reducing the health inequalities associated with childhood poverty	Encouraging more people to be physically active	Overcoming barriers to employment

MEASURING IMPACT

A series of high level outcomes will be monitored annually and reviewed every three years to monitor our progress towards achieving our 2025 vision

OUR UNDERPINNING PRINCIPLES

USING THE EVIDENCE	WORKING IN PARTNERSHIP	INVESTING IN PREVENTION	A LIFE STAGE APPROACH

1 INTRODUCTION

1.1 The Health & Social Care Act 2012 placed local leadership for public health within councils in order to benefit from their central role in providing and shaping many of the things that influence people's lives such as education, housing, employment, the built environment, social care and regulation.

1.2 Councils now have a statutory duty to improve the health of their residents, tackle health inequalities and ensure that robust plans are in place to protect the health of their local population.

1.3 The communities we serve experience marked inequalities in health caused by a range of factors[1]:

- the wider determinants of health, including employment, environment, education and housing;
- the lives people lead, including tobacco and alcohol use, being overweight, levels of physical activity and social connectedness;
- the health services people use, including the accessibility and of primary care (i.e. GPs), secondary care (i.e. hospitals) and preventative care (e.g. measures taken to prevent diabetes).

1.4 These affect many aspects of people's lives, including quality of life, health experienced and how long a person may live. We recognise that, in order to address these effectively, we need to work in different ways, work closely with our partners and work to reduce, and ultimately close the health inequalities gap experienced by many of our residents.

1.5 Our aim is to use the full range of council influence and functions to achieve this and to provide a clear focus on the priorities that will help make our boroughs places where everyone starts their life well, lives well and ages well.

1.6 This strategy will be reviewed every three years, with annual updates, in order to monitor our progress towards achieving our aims and to help ensure that our priorities remain relevant and focused.

Our Mission

1.7 By 2025 Hammersmith & Fulham, Kensington & Chelsea and Westminster will be places where everyone starts life well, lives well and ages well.

[1] DH (2010) Tackling inequalities in life expectancy in areas with the worst health and deprivation. http://www.nao.org.uk/wp-content/uploads/2010/07/1011186es.pdf

1.8 We will use our public health expertise and resources effectively, working across the councils and with partners to tackle the health challenges within our boroughs and to create opportunities for our residents to enjoy good health and improved wellbeing.

1.9 In doing this, we will work closely with our partners across the system and draw on the evidence of what works, including giving full consideration to what interventions and services are shown to be cost-effective, in order to invest in prevention across throughout a person's life.

1.10 In particular, we will enable all council services to contribute to the achievement of our public health priorities through work to address inequalities in health that result from the wider determinants.

What this strategy will do

1.11 In order to ensure that we achieve our vision this strategy helps to begin the conversation with our residents and communities. It will help our residents to understand what we are currently spending our public health budget on and what this is achieving. This will enable us to set out how we will address the needs of our residents and communities and align our actions with both the councils' priorities and the Department of Health's Public Health Outcomes Framework (PHOF)[2]. Some of these priorities are shared priorities which we will deliver across the three councils. However, as populations and needs differ across the three boroughs, specific priorities have been identified for each council.

1.12 The strategy identifies where priorities may be addressed through the use of public health resources to develop new, or re-commissioned, services for our residents. We are currently in the process of conducting comprehensive reviews of all our public health services. This will identify where there may be opportunities for improved ways of working across council departments and with our partners to help improve the wider factors that influence health, such as housing, environment, employment and education.

1.13 Much of the success of this strategy will be dependent on the positive engagement from services and wider partners. Achievement of these priorities will be delivered most effectively by different services working together and sharing aims. For example, action on effective tobacco control and encouraging cycling require coordinated effort across several council services. A key indicator of success therefore is the degree to which stakeholders are

[2] http://www.phoutcomes.info/

engaged and influenced to shape services that positively contribute towards addressing these priorities.

1.14 This strategy therefore prioritises:

- action in areas where there is the greatest evidenced need;
- where it is lacking building evidence through innovation, such as piloting initiatives, and evaluation;
- investment in services that support prevention and early intervention through promoting healthier behaviours and improve the wider determinants;
- reducing demand that results from preventable ill-health;
- delivery of sustainable outcomes;
- identification and use of local assets where possible; and
- building resilience at both the individual and community level.

2 BACKGROUND

What is public health?

2.1 Public health is about helping people to stay healthy, and protecting them from threats to their health. Rather than treating each case of disease or health condition as it occurs in an individual public health focuses on understanding and addressing the key patterns and causes of disease in a whole population.

2.2 This is done by using information to assess what people's health needs are now and what they are likely to be in the future, and then responding to these by using scientific evidence, data and other information to help create strategies, policies, environments and services which improve health, prevent illness and reduce health inequalities.

2.3 Public health's primary purpose is to prevent avoidable disease and to increase both quality and quantity of life (i.e. adding years to life and life to years) by working to protect and improve health and wellbeing for everyone throughout the course of their life. The underlying principle therefore is that prevention is better than cure.

Our statutory responsibilities

2.4 Section 12 of the Health & Social Care Act 2012[3,4], places a duty on local authorities to improve the health of the public, including ensuring the provision of:

- information and advice (for example giving information to the public about healthy eating and exercise) and important contributions to joint strategic needs assessments (JSNAs); and
- services for the management of health risk factors such as such smoking, and overweight and obesity.

2.5 Regulations[5] made under Section 6c of the NHS Act 2006 require local authorities to ensure the provision of:

- the weighing and measuring of children in reception class and Year 6 (the National Child Measurement Programme, NCMP);
- health checks for people aged 40-74 years;
- open access sexual health services;
- a public health advice service to clinical commissioning groups (CCGs) in their area; and
- information and advice on the preparation for and the management of threats to people's health such as infectious diseases, environmental hazards and extreme weather conditions.

2.6 The Health & Social Care Act 2012 also requires councils to have regard to the Department of Health's Public Health Outcome Framework (PHOF) which includes a range of measures across two key outcomes and four domains [see appendix].

Improving the public's health is everyone's responsibility

2.7 In helping councils undertake public health responsibilities, and in recognition of the cross-cutting nature of many health issues, public health professionals now provide a shared service across the three boroughs and work closely with many council departments. These public health professionals are led by the Director of Public Health (DPH) who has legally defined responsibilities for advocating and leading for the health and wellbeing of residents.

[3] http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted/data.htm
[4] Local authorities' public health responsibilities http://www.parliament.uk/business/publications/research/briefing-papers/SN06844/local-authorities-public-health-responsibilities-england
[5] http://www.legislation.gov.uk/ukdsi/2012/9780111531679

2.8 An important function of the DPH is to use a range of information and evidence to help understand local health needs in order to inform work with residents and local communities, so that council and local NHS services are designed to meet those needs. Much of this information will be presented in JSNAs and will be used by the health and wellbeing boards.

2.9 The cross-cutting nature of this strategy aligns with aspects of the councils' corporate strategies and will help achieve their commitments, particularly through its focus on achieving population level improvements in health, wellbeing and prevention. This strategy is also influenced by, and supports delivery of, each borough's health and wellbeing strategy. Each health and wellbeing board will be able to consider these priorities when reviewing their strategies[6,7,8,9].

2.10 The strategy will provide the framework and context for considering how relevant national, London-wide and partner[10] strategies align with our priorities and will be reviewed every three years, with annual updates, to ensure that it remains relevant and focused.

2.11 Borough-specific public health business plans will be developed to ensure the delivery of our public health priorities. These will be further informed by detailed information provided by the JSNAs for each borough, and which provide a strategic overview of population health challenges over the coming years.

Using our public health budget effectively

2.12 Each council has a public health grant, currently ring-fenced, which allows us to commission and fund a range of services that contribute to achieving our aims.

2.13 In future the public health budget will be aligned to the identified priorities within this strategy and its use will be consistent with the key underpinning principles of using the evidence base and investing in prevention.

[6] https://www.westminster.gov.uk/sites/default/files/uploads/workspace/assets/publications/Westminster-Joint-Health-and-Well-1364920681.pdf
[7] http://www.kcsc.org.uk/sites/kcsc.org.uk/files/documents/RBKC_docs/Kensington%20and%20Chelsea%20JointHealth%20and%20Wellbeing%20Strategy%202013_2016%20Print%20docx.pdf
[8] http://www.lbhf.gov.uk/Images/131104%20FINAL%2010_16jcw_health_and_wellbeing_strategy_2013_rev2_tcm21-184369.pdf
[9] http://transact.westminster.gov.uk/docstores/publications_store/city_for_all/city_for_all_booklet.pdf
[10] Including the NHS, HealthWatch, and the Voluntary and Charitable sector

2.14 Across the three councils the current public health budget stands at £73 million per annum. The individual borough allocations are:

Hammersmith and Fulham	£21 million
Kensington and Chelsea	£21 million
Westminster	£31 million

[convert table to infographic]

2.15 A further £11 million per annum will be transferred from the NHS to the three councils in autumn 2015 to cover additional responsibilities for child health programmes (principally health visitor services) for the 0 to 5 year age group.

2.16 During the lifetime of this 10-year strategy, it is expected that the ring-fence will be removed and that the grant allocation may be reduced. Over this time it is also expected that wider council funding from central government will continue to reduce.

2.17 It is therefore vital that we all use our resources wisely and effectively in order to encourage and embed the achievement of our priorities over the coming years. This will include reviewing all of our contracts, re-commissioning strategically relevant services in line with best value principles and using evidence wherever possible.

3 OUR HEALTH CHARACTERISTICS

3.1 Whilst each of our boroughs is a unique and distinct area, our residents share some common health characteristics and needs. These shared issues may best be addressed by working in partnership and providing joined up services across the boroughs so as to help improve value for money and outcomes for our residents.

Common features across the three boroughs

[use infographics**]**

3.2 All three boroughs show socioeconomic contrasts, with wide variations in affluence and deprivation within them. This is an important feature, with consequent impacts on health inequalities and health outcomes as less

affluent population groups generally tend to experience poorer health and shorter life expectancy.

3.3 The main causes of death in our three boroughs, as elsewhere in London and England, are cancer, heart disease, stroke and respiratory disease. However, improved health generally, reductions on the prevalence of smoking, and advances in healthcare and earlier diagnosis often mean that individuals live longer with long-term disease than would have been the case in previous generations. Lifestyles and external influences are significant factors for all of these causes of death and disease, with smoking, insufficient physical activity and inappropriate diet, as well as poor housing and unemployment, making significant contributions.

3.4 The three boroughs have a larger proportion of black and minority ethnic (BME) groups than the national average. Some people in BME groups have a higher incidence of some long-term conditions, such as diabetes and heart disease, than others. This has implications for the prevention services we commission as well as for the local provision of health and social care services.

3.5 There are some very positive health outcomes for children and young people across the three boroughs. For example, a comparatively low number of women smoke during pregnancy, there are low numbers of babies born that are underweight and breastfeeding levels at 6-8 weeks after birth are relatively high. These factors all help to give children a good start in life.

3.6 However, there are other outcomes where we are not doing as well as we could. For example, tooth decay and childhood obesity are higher than London and England averages and childhood immunisation rates are generally lower than London and England.

3.7 A significant number of our children and young people live in deprived areas, with ten wards across the three boroughs having over 40% of children classified as living in poverty. These children and families are more likely to experience poorer health and social outcomes. For example, whilst the number of under-18 year olds giving birth across the three boroughs is relatively low, the majority live within the same small, often deprived, areas. Many of our young people that are out of work and not in education also tend to live in the more deprived areas and households, and live in the poorest housing conditions.

3.8 The three boroughs all experience high levels of obesity in school year 6 children. This reflects national trends and indicates the scale of likely future

impact through increasing demand and ill-health associated with diabetes and cardiovascular disease (heart disease and stroke).

3.9 A key feature of the three boroughs is the larger than average proportion of the population of working age, with the consequent health related issues and behaviours associated with this age group. For example, the smoking rate in Hammersmith and Fulham is 22%, compared to the London average of 19%. Rates can often be more than double this in the more deprived areas within our boroughs and amongst particular groups.

3.10 All three of our councils have characteristics associated with urban environments, deprivation, mobile populations and changing social behaviours:

- all are in the top 12 of boroughs in England for the incidence of sexually transmitted infections (STIs) and for the prevalence of HIV infection;
- the estimated prevalence of drug and alcohol use across the three boroughs is high;
- although the number of people with learning disabilities is low in each of the three boroughs, and employment rates are on a par with London levels, people with learning disabilities tend to have worse employment prospects than other disability groups;
- sickness absence is estimated to cost the economy of the three boroughs around £84 million per annum in employer costs, health and social care costs and welfare[11], with mental ill-health being the main cause of long-term sickness absence, closely followed by musculoskeletal problems;
- the prevalence of mental health problems is estimated to be high across the boroughs;
- hotspots of very poor air quality are found across the three boroughs, which are likely to have a greater impact on more vulnerable residents such as those living with cardiovascular or respiratory disease;
- we have a large homeless population who tend to have much poorer health and a markedly different pattern of service use than the general population;
- incidence of tuberculosis (TB) in all three boroughs is significantly higher than England.

3.11 All three boroughs also attract a large number of daytime visitors and workers. This has an impact on health outcomes for our residents as well as leading to higher demand for some services which serve the working age population in particular, such as sexual health services.

[11] http://www.jsna.info/sites/default/files/Employment%20Support%20JSNA.pdf

3.12 Whilst all three boroughs have a smaller proportion of residents aged over 65 years compared to England, both Westminster and Kensington & Chelsea have a larger proportion than the London average, and Hammersmith & Fulham is only just below this level. With an ageing population it is estimated that the over-65 age group will increase by around 50% across the three boroughs over the next 20 years, with the most growth expected to be in the over-85s. Although such predictions cannot be completely accurate due to the effects of other factors such as migration, a substantial increase in demand for older people's care is expected.

3.13 The challenge of an ageing population therefore is to ensure that people are supported to maintain their health and independence for as long as possible. Many of the risk factors that can cause older people to lose their independence require collective action across a number of council services, the NHS and community and voluntary services. Vulnerable older people are likely to experience a number of risk factors or conditions including fuel poverty, social isolation, falls, malnutrition and dementia. Many of these issues are inextricably linked to the priorities set out in this strategy, for example, social isolation is a risk factor for poor mental wellbeing.

3.14 Alongside these common issues, each borough has individual challenges which require particular attention.

Hammersmith and Fulham

3.15 Thirty per cent of children in Hammersmith and Fulham are estimated to live in poverty. This is a slightly higher rate than the London average but a much higher rate than nationally. The areas with the highest rates of child poverty tend to be areas of social housing, which also tend to be the areas with the highest concentration of children. Wards with a particularly high proportion of children living in poverty include, College Park and Old Oak, Wormholt and White City.

3.16 Since the beginning of the 2008 recession the national and local profile of families in poverty has changed significantly. Previously, as workless families formed the majority of those living in poverty, measures to address this focused on reducing worklessness[12]. However, those in poverty are now more likely to be in work, and with low wages being the main contributory factor to

[12] The term *worklessness* includes people who are unemployed and people who are economically inactive, such as people who are sick, disabled, students, carers and retired people. It is therefore a wider definition than those people classified as 'unemployed' and includes those people that may want to find employment but may be unable to because of caring responsibilities or other barriers.

child poverty rather than worklessness. Therefore fresh approaches are likely to be needed to address child poverty and its health impacts locally.

Kensington and Chelsea

3.17 Overall, residents in Kensington and Chelsea tend to have a higher than average life expectancy. However, there are some areas, predominantly in the north of the borough, where health outcomes are much poorer and where residents may need more support. Forty-seven per cent of the households in the borough are single person households. This is the highest in the country and almost half of older people live alone. This carries a significant risk of social isolation and poorer mental wellbeing, and means that older people may need more support to remain independent in their homes.

3.18 Estimates indicate that around 20% of people in Kensington and Chelsea undertake the recommended level of physical activity. Although similar to the England average, increasing levels of participation in physical activity, particularly in those groups and individuals that are the most inactive, are expected to contribute to improving many of these characteristics. Examples of such activities include healthy walks for older people which encourage both physical activity and social connectedness.

Westminster

3.19 With a resident population of around 240,000, and with a four-fold daily increase due to visitors and commuters, Westminster's local economy is vibrant and diverse. However, there are wide socioeconomic differences across the borough, including high levels of children living in poverty in areas such as Church Street, Westbourne[13], Queen's Park[14] and Churchill and Harrow Road. These differences are also reflected in high local rates of mental ill-health. Westminster also has the largest concentration of rough sleepers in the country, accounting for three quarters of the rough sleeping population in London. These issues have associated impacts on physical health and wellbeing.

3.20 There is strong evidence to support the link between economic prosperity and better health and wellbeing. A key contributor to improving the health outcomes in some of these areas is through supporting vulnerable groups into employment and safe housing. Enabling the most vulnerable members of society into work, and helping people overcome some of the barriers to

[13] Ranked 1st and 2nd highest proportion in London
[14] Ranked 9th highest proportion in London

employment, such as parental responsibilities, is expected to lead to improved health and wellbeing outcomes.

4 WHAT WE WILL DO

4.1 We will work together, as councils and with our partners, to share services and approaches to tackle both our common and individual health challenges. In many cases, we will need to do this by investing our resources more effectively so that they are focussed on prevention in the areas of greatest need.

4.2 This 10-year strategy aims to maintain strong focus on the key areas that will produce tangible improvements in our residents' health and wellbeing.

4.3 We have six shared priorities. Of these, two are considered to fundamentally underpin achievement of the others and are therefore identified as 'underpinning priorities':

- Reduce childhood obesity by increasing the number of children that leave school with a healthy weight
- Reduce smoking rates by reducing the proportion of people who smoke and who start to smoke, particularly children
- Improve sexual health by reducing the rates of sexually transmitted infections and unplanned teenage pregnancy
- Reduce levels of substance misuse by improving the health and wellbeing of people at risk of becoming substance misusers and improving treatments services
- Improve mental wellbeing by promoting and sign-posting to preventative and joined up services [*an underpinning priority*]
- Improve preventative services, by helping design and deliver services that have the capacity to have the biggest impact on prevention, early intervention and positive health promotion [*an underpinning priority*]

4.4 Alongside our shared priorities each council has identified individual priorities based on local needs and challenges:

- **Hammersmith and Fulham**
  To reduce the health inequalities associated with childhood poverty

- **Kensington and Chelsea**
  To increase the number of people being physically active

- **Westminster**
  To overcome barriers to employment

5 OUR SHARED PRIORITIES

- **Reduce childhood obesity by increasing the number of children that leave school with a healthy weight**

To improve quality of life and reduce the future prevalence of diabetes

5.1 Childhood obesity is associated with a wide range of health problems in childhood including respiratory illness, interrupted breathing during sleep and high blood pressure. If obesity persists into adulthood there are also increased risks of developing diabetes, some cancers and cardiovascular disease.

5.2 We need to do much more to support children and families to eat well, move more and maintain a healthy weight. For example, by supporting parents and children to make positive behaviour changes through promoting participation in physical activity and encouraging healthy eating from an early age it helps embed positive lifestyle habits for life.

5.3 As behaviour is also affected by our physical environment we will also support approaches that help make the built environment less obesogenic and provide more opportunities for making healthy choices easy choices.

By 2025 there will be

- **a higher proportion of children leaving primary school with a healthy weight**

5.4 We will do this by:

- investing around £2.5 million per year in healthy weight services for children and families;
- investing in frontline staff in social care, education and health to ensure that those in most need are offered appropriate advice, support and services when in contact with professionals;
- working with relevant departments across the councils, and with our partners, to identify how we can make changes to the physical environment to enable healthier choices;
- working with children and families to design tools that will help them make healthier choices in their everyday lives;
- evaluating our actions and interventions rigorously to understand what works and how so we can share our learning widely.

- **Reduce smoking rates by reducing the proportion of people who smoke and who start to smoke, particularly children**

To reduce long term respiratory illness and early mortality

5.5 Although rates continue to fall, smoking remains the single largest contributor to preventable illness and premature death. Smoking is also costly, estimated at around £110m[15] a year to the local economy. Although around 25% of these costs fall to the NHS through hospital admissions, GP consultations and prescriptions, the Government also pays for sickness/invalidity benefits, widow's pensions and other social security benefits for dependants and the economy as a whole pays in days lost to work.

5.6 Our councils already do a lot to help residents to stop smoking. In 2013, we invested £2.6 million in stop smoking services, including working with premises providing shisha, and in a service aimed at helping prevent young people from starting to smoke. Reducing smoking rates continues to be a key preventative public health priority for each of our boroughs so that we can support our residents to live longer, healthier lives.

[15] Modelled estimates indicate that smoking related healthcare costs are around £25.8 million, with a similar cost due to loss of productivity (£22.8 million). Output loss due to early deaths was greater that hospital costs at £31.4 million.

By 2025 we will have

- ***reduced smoking prevalence in adults and children by a further 2% on the 2014 baseline***
- ***implemented initiatives that focus on harm reduction with people who are still smoking as part of individual plans to quit***
- ***reduced the proportion of people who start to smoke, especially children***

5.7 We will do this by:

- continuing to invest in high quality stop smoking services;
- working more closely with our service providers and health partners, such as GPs, pharmacies and hospitals, to target specific groups who may find it more difficult to stop smoking;
- using the wider powers that we have as councils to stop the illegal sale of tobacco to children and the sale of illicit cigarettes;
- working more closely with schools and young peoples' groups to support anti-smoking campaigns;
- support the Smoke Free Alliance to integrate the work on tobacco control across fire services, trading standards, licensing, environmental health, hospital and mental health trusts, community organisations and stop smoking services;
- prioritise the areas with the highest rates of smoking prevalence for the take up of stop smoking services;
- encourage referrals to stop smoking services through delivering the NHS health checks programme.

- **Improve sexual health by reducing the rates of sexually transmitted infections and halting the rise of unplanned teenage pregnancy**

To support personal resilience, self-esteem and promote healthy choices

5.8 All three councils are in the top 12 in England for the incidence of sexually transmitted infections (STIs) and for the prevalence of HIV infection. These diseases cause unpleasant short-term symptoms, are highly infectious and can lead to longer term health problems such as infertility, cancer and HIV.

5.9 Jointly, the three boroughs currently spend almost £13 million per year on testing and treatment services for STIs as well as £3.4 million on contraceptive services and £3.2 million on related services. This investment is among the highest in both London and England.

5.10 Despite this level of spending we still need to shift focus further to prevention. The money needed to support these services will continue to rise unless we halt the growing prevalence of STIs through unsafe sex.

5.11 It is therefore clear that a new approach is needed, which is based on an assessment of need, and that has a greater emphasis on prevention and early diagnosis, improved access to services, and that maximises the improvements that we can achieve through our investment.

By 2025 we will have

- ***halted the year-on-year rise in sexually-transmitted infections***
- ***transformed our delivery systems to ensure that best outcomes are achieved through sustainable and cost effective services***

5.12 We will do this by:

- developing a stronger and more whole-system strategic approach, following assessment of health and behaviour needs;
- investing in prevention services to encourage and enable people in all age, ethnic, cultural, faith and socio-economic groups to be better informed and better skilled at practising safer sex and reducing teenage pregnancy rates;
- supporting work in schools and other settings to help educate children and young people about healthy relationships and choices using the most effective interventions;
- encouraging and enabling earlier diagnosis of STIs to increase treatment effectiveness and reduce the risk of transmission;
- increasing the availability of appropriate sexual health prevention and treatment services in the community;
- working in collaboration with other London boroughs and acute trusts to develop affordable and sustainable genito-urinary medicine (GUM) treatment services and pathways.

- **Reduce levels of substance misuse by improving the health and wellbeing of people at risk of becoming substance misusers and improving treatment services**

  To support healthy choices and improve life chances

5.13 There is significant evidence that investing in the prevention and treatment of drug and alcohol misuse improves an individual's socioeconomic status and physical and mental wellbeing. Improved levels of mental wellbeing are generally also likely to reduce the prevalence of substance misuse.

5.14 A wide range of services are commissioned to deliver substance misuse treatment, including needle exchanges, psycho-social interventions, specialist prescribing, inpatient detoxification and residential rehabilitation. The provision of such treatment is generally cost-effective and delivers a range of benefits for the individual and wider society. As individuals recover from their addiction or problem use they increase their ability to access education, training and employment, sustain appropriate housing, commit fewer offences and improve relationships, often reconnecting with their families and gaining positive social networks.

5.15 In addition to those who are already dependent, it is important that services provide information and advice that enables people to make informed choices about responsible drinking and gives harm reduction messages to those who choose to use substances.

5.16 Being able to accurately identify the prevalence of misuse and dependence is difficult. Those who misuse can often remain hidden within the population until the use escalates to a level where the consequences may result in significant physical or mental health issues or criminality. The estimated number of adults misusing substances across the three boroughs is:

	Hammersmith & Fulham	**Kensington & Chelsea**	**Westminster**
Dependent drug users	4,353	3,595	5,626
Dependent drinkers	7,667	6,332	9,966

Source: Projecting Adult Needs and Service Information System October 2014

5.17 There is a clear need to address the gaps in current service provision, particularly in relation to preventing harm from new and emerging drugs and in the different groups that may misuse alcohol. These people typically do not access services. We therefore intend to transform drug and alcohol services and to work collaboratively to build an inclusive, sustainable and flexible model of service that maximises value for money and quality.

5.18 The 'toxic triangle' of poor mental health, substance misuse and domestic violence can have profound impacts on the safety, health and wellbeing of children. We will support work in a variety of settings, including schools, to

help prevent children and young people starting to use harmful substances, working closely with the Children's Services team. It is clearly important that we work across the council to ensure safeguarding principles are followed.

By 2025 we will have

- ***improved the health and wellbeing of drug and alcohol misusers, including their families and communities***
- ***ensured that those people in need of services have access to the full range of prevention, treatment and recovery opportunities***
- ***reduced costs and improved service effectiveness***

5.19 To achieve this we will:

- commission services to improve effectiveness and ensure resources are deployed effectively and efficiently to achieve value for money, and to reduce costs whilst delivering improved outcomes;
- jointly commission services and share resources to achieve best outcomes;
- collaborate effectively with key partners across the statutory and voluntary sector;
- fully embed a recovery-oriented whole system approach from first point of access through to successful completion;
- innovate to respond to changing patterns of substance misuse;
- develop a stronger and more whole-system strategic approach, following assessment of health and behaviour needs;
- invest in prevention services to encourage and enable people in all age, ethnic, cultural, faith and socio-economic groups to be better informed and equipped to not misuse drugs and alcohol;
- support work in schools and other settings to help educate children and young people about substance misuse.

- **Improve mental wellbeing by promoting and sign-posting to preventative and joined up services**

To support positive states of mind and body

<u>This is an underpinning priority</u>

5.20 Good mental wellbeing involves having a positive state of mind and body, feeling safe and able to cope, and having a sense of connection with people,

communities and the wider environment. It may fluctuate through a person's life and will be influenced by many of the factors considered to be the wider determinants of health, such as good jobs, homes and friends. Mental wellbeing is linked to better physical health; people with higher levels of wellbeing are less likely to smoke, tend to eat more healthily and have lower rates of substance misuse and poor sexual health. Equally, more healthy behaviours tend to promote better mental wellbeing.

5.21 Good mental wellbeing is crucial to enabling us to make positive life choices and achieve our aspirations in life. It is important that we invest in the promotion, prevention and early intervention of mental illness and increase opportunities for good mental wellbeing for people across all ages.

5.22 On average, mental illness will affect 1 in 4 of us in our lifetimes. All three of our boroughs have higher than national average rates of reported mental health problems and a higher than average burden of severe and enduring mental illness compared to London. Unfortunately, they are often undiagnosed or inadequately treated, leading to poorer health outcomes and sometimes premature death. It is crucial that we work with partners in the health system to improve diagnosis and treatment rates locally.

5.23 Although many mental health problems start in early life others may develop later in life, such as dementia. The severity of such conditions is often linked to the availability and quality of social support networks and level of connectedness people feel. It is therefore important that the broad range of services provided for older people adequately address this need.

By 2025 we will have improved the mental health and wellbeing of our residents by

- **helping people with mental health problems to have the same opportunities as everyone else**
- **improving access and awareness to support and advice services to help maintain mental wellbeing**

5.24 We will do this by developing a comprehensive mental health programme which:

- invests in the promotion of mental wellbeing, prevention of mental ill-health, early intervention, and prevention of suicides across all population groups;
- improves access to primary mental health services with a clear focus on prevention, early identification and self-management;

- invests in initiatives that strengthen individual and community resilience as well as reducing structural barriers to mental health, such as increasing opportunities and reducing barriers to employment;
- conducts equality impact assessments to ensure all at risk population are targeted equitably;
- enables us to work better with partners to improve the design of mental health diagnosis and treatment services for children and adults (including whole system approaches to address problems at points of transition, such as from child to adult services and lack of whole family approaches when parents have poor mental health);
- considers how to both reduce the onset of dementia and how to mitigate its impact once diagnosed;
- works across all parts of the councils to identify and sign-post to appropriate services.

- **Improve preventative services, by helping design and deliver services that have the capacity to have the biggest impact on prevention, early intervention and positive health promotion**

To deliver upstream interventions to reduce levels of ill-health and demand

<u>This is an underpinning priority</u>

5.25 Prevention is better than cure. Many diseases and causes of ill-health and early death are preventable. This is true of many strokes, heart attacks and new diagnoses of diabetes, but it is also true of fractured hips, depression, measles and a large number of other health problems.

5.26 Services for preventative care include immunisations against infectious diseases, screening for cancer, and risk assessments for cardiovascular disease. These important preventative interventions are often delivered through primary care services but are also offered in a range of settings by different providers to encourage and support uptake amongst different groups. An example is the NHS Health Checks programme, which helps address health inequalities in higher risk groups.

5.27 Although commissioning responsibility may be split (for example, immunisations and screening are currently commissioned by NHS England and cardiovascular risk assessments are commissioned by councils) preventative services are an extremely cost-effective way of reducing health inequalities and reducing both morbidity and mortality, and so need to be promoted throughout the system.

5.28 Current levels of immunisation coverage for children in all three boroughs are low and may be insufficient to prevent isolated outbreaks of avoidable infections. For example, the proportion of children aged less than one year that had all three doses of the 'five-in-one' vaccine[16] has been reported as being lower than 80% across the three boroughs. To provide adequate herd immunity against outbreaks, immunisation coverage needs to be in the order of 95%. There is also insufficient coverage for measles, mumps, German measles, flu and pneumococcal disease. During 2015 we plan to undertake a detailed assurance process to ascertain what the true immunisation coverage rates are amongst local children to enable better targeting of activities to increase immunisation rates.

5.29 Similarly, we have poor recorded levels of people taking part in cancer screening programmes. For example, the of breast screening coverage in 2012 was 77% in England, but 65% in Hammersmith & Fulham, 62% in Westminster and only 59% in Kensington & Chelsea. However, we have an especially low incidence of cancers overall. Our national ranking out of 150 local authorities is Hammersmith & Fulham 103, Kensington & Chelsea 150, and Westminster 148. In addition, our age-standardised mortality rate from cancers is also good. Our national ranking out of 150 local authorities for this is Hammersmith & Fulham 87, Kensington & Chelsea 149, and Westminster 150. Whilst we will seek to improve the detection of cancers by screening and to contribute to reduce cancer mortality, there are other health improvement areas, highlighted in this strategy, which we consider to be of higher priority at the moment.

5.30 Prevention also includes a wider range of interventions which link strongly with and underpin many of the other priorities in this strategy. The wider preventative agenda includes support and focus in many diverse areas and throughout life, such as helping reduce social isolation in older age groups through the use of assistive technology, and helping improve life opportunities for young people through good parenting and education.

5.31 Our overarching aim of preventing ill-health therefore links to a wide range of areas, such as those covered in the Care Act 2014 and the Children and Families Act 2014 which have this principle embedded within them.

5.32 The effective embedding of this preventative approach requires the identification of priority areas, which are often those with the biggest health and financial impact, such as the cost of a fall in a frail elderly person. Public

[16] Protecting against diphtheria, tetanus, whooping cough, polio and haemophilus influenzae type b (which can cause a number of different infections in babies and children such as meningitis, pneumonia, septicaemia, osteomyelitis).

health seeks to provide insight into such costs to enable the commissioning of effective and cost-effective preventative services.

By 2025 we will have

- **provided leadership, via our health & wellbeing boards, to enable the NHS to achieve immunisation and screening uptake to levels sufficient to meet national recommendations**
- **delivered coordinated and joined up preventative initiatives throughout life that help reduce long term health and economic consequences, especially for cardiovascular disease by significantly increasing the uptake of health checks.**

5.33 To achieve this we will:

- work with the NHS (including NHS England, CCGs and GPs) to establish ways to improve immunisation and screening uptake, such as GP capturing accurate practice data;
- work with our partners to encourage more people to take advantage of free immunisation and screening services to reduce the incidence of avoidable diseases;
- deliver the NHS health check programme effectively to the eligible population, focusing on those at greatest risk, and refer them to services which help reduce their risks by stopping smoking, losing weight, becoming more active, reducing alcohol use, and treating high blood pressure, cholesterol and diabetes;
- encourage community based prevention campaigns which help spread messages through peer and social networks, such as the community champions;
- work with the council communications teams, local communities, libraries and the *People First* website to improve health promotion messages through social media to increase uptake of screening programmes and other preventative initiatives;
- work with commissioners to help design services that address prevention and that are effective and cost-effective, and that reduce health inequalities;
- work across all parts of the councils to identify and sign-post to appropriate preventative services.

OUR INDIVIDUAL PRIORITIES

5.34 Alongside these six shared priorities, there are challenges unique to each of our individual boroughs which must also be addressed. Each council has selected a specific priority which will be driven forward and championed within our individual boroughs.

a. Hammersmith and Fulham
Reducing the health inequalities associated with childhood poverty

5.35 A key priority in Hammersmith and Fulham is addressing child poverty. Child poverty, both its causes and its effects, are closely linked with many of the priorities outlined in this strategy. Whilst there are drivers of child poverty that cannot be addressed locally, there is scope for significant impact through local intervention to help reduce its impact on health and wellbeing.

5.36 The determinants of health, for example parental employment and adequate housing are opportunities for local action to both reduce child poverty in the long term and reduce its impact in the short term.

5.37 The health inequalities associated with childhood poverty require focus and a coordinated response across council services, and with our partners, to help give children the best start in life.

By 2025 Hammersmith and Fulham will have

- **improved key health and wellbeing outcomes of the most disadvantaged children in the borough, ensuring that all strategies and policies contribute towards a reduction in child poverty**

5.38 We will do this by working across the council and with partners on the issue of child poverty, contributing to the priorities outlined in the Child Poverty JSNA.[17] This will include helping:

- develop a joint approach to engaging and supporting hard to reach families;
- assist with coordinated local commissioning of employability support and employment advice and assessment;
- ensure that childcare provision is appropriate, tailored and targeted to meet the needs of low income families;

[17] http://www.jsna.info/sites/default/files/Child%20Poverty%20JSNA%20-%20April%202014_0.pdf

- encourage joint planning to ensure that council services such as planning and housing contribute effectively to reducing the effects of child poverty;
- influence to ensure appropriate healthcare is delivered at the right time;
- support employment programmes targeted at parents;
- work across all parts of the council to identify and sign-post to appropriate services.

b. Kensington and Chelsea
Encouraging more people to be physically active

5.39 There is good evidence that being more physically active both promotes greater independence in later life and reduces the risk of developing obesity and a number of long term conditions, including cardiovascular disease, diabetes, cancer, musculoskeletal conditions and mental health problems. Being physically active also reduces the likelihood of falls in later life and increases the chances of an individual remaining independent as they get older.

5.40 A recent JSNA on physical activity[18] highlighted a number of key messages:

- that any amount or type of physical activity is better than none;
- significant health gains can be made by getting the physically inactive to become active;
- physical activity helps promote physical and mental health and wellbeing and helps reduce social isolation;
- there are a range of barriers, real and perceived, which can block uptake;
- the importance of incorporating physical activity into everyday life, such as through active travel;
- work across all parts of the council to identify and sign-post to appropriate services.

5.41 We will enable more people to increase their levels of physical activity by supporting and enabling people to incorporate physical activity into daily life, such as by making short trips by bicycle or on foot, walking up stairs instead of taking a lift, as well as enabling people to do whatever they enjoy that encourages more activity, e.g. sport, exercise or dance.

[18] http://www.jsna.info/document/physical-activity-0

By 2025 Kensington & Chelsea will have

- **worked with partners and key stakeholders to have become frontrunners in the promotion of the participation in physical activity**
- **ensured that physical activity messages are embedded within all strategies and policies related to health and wellbeing**

5.42 We will do this by:

- encouraging more people, particularly the most inactive, to be more physically active as part of their everyday lives;
- as part of promoting workplace health and wellbeing, working with employers to help them encourage and enable their staff to be more physically active;
- working with schools and other organisations to encourage and enable more children and young people to be more physically active;
- support local activity champions and community champions to promote getting people moving;
- encouraging the uptake of NHS health checks which refer people to services that support behaviour change around physical activity;
- working with local parks and leisure services to increase activity in our community;
- promoting active transport schemes.

c. Westminster
Overcoming barriers to employment

5.43 Worklessness is associated with poorer physical and mental wellbeing. The health and social impacts of long periods of worklessness may last for years, with consequent impacts on individuals, families and communities. Insecure and poor quality employment may also have adverse effects on health[19]. Amongst groups identified as experiencing higher unemployment rates are people with disabilities, people experiencing mental ill-health and people with substance misuse problems.

5.44 Estimates indicate that 7.8% of Westminster adult residents with a learning disability were in paid employment during 2013/14,[20] which is lower than for London (8.8%). Around 87% of residents attending an initial assessment with

[19] Marmot M (2010) Fair Society, Healthy Lives
[20] Adult Social Care Outcomes Framework (ASCOF) data

substance misuse services in 2013/14 in Westminster were not employed. It is also known that many people in these groups would like to work and that participation in work can play an important role in recovery in relation to mental health and substance misuse[21,22].

5.45 Supporting local people into sustained and good quality employment is a shared objective across council departments and contributes to the aims around health improvement and economic development. The Employment Support JSNA[23] highlighted the evidence that specialist employment support, tailored to the needs of clients with mental illness or disabilities, can support individuals into work and that these approaches can deliver:

- improved individual health and wellbeing;
- increased personal income;
- reduced use of health and social care services;
- reduced levels of child poverty.

By 2025 Westminster will have

- **reduced the barriers to employment for many people, particularly those with learning disabilities, who have caring responsibilities and who are vulnerable**
- **improved the health and wellbeing of our residents who find it difficult to access employment by facilitating improved access to local integrated employment support and volunteering opportunities**

5.46 We will do this by:

1. helping commissioners use local intelligence and evidence to ensure that locally commissioned employment support is designed and targeted to address the needs of those experiencing difficulties accessing and sustaining work opportunities, including parents;
2. implementing joint planning, commissioning and integrated service design;
3. developing a coordinated and integrated support pathway;
4. adopting models with a focus on early intervention and prevention;
5. leading by example through the council offering supported employment and volunteering opportunities for priority groups;
6. identifying and addressing employment barriers associated with parental responsibilities including child care;
7. supporting volunteering as a pathway into employment;

[21] *http://www.centreformentalhealth.org.uk/pdfs/briefing37_Doing_what_works.pdf*
[22] *HM Government (2010) Drug Strategy 2010: Reducing Demand, Restricting Supply, Building Recovery: Supporting people to live a drug free life. London: TSO*
[23] http://www.jsna.info/document/employment-support

8. working across all parts of the council to identify and sign-post to appropriate services.

6 MEASURING IMPACT

6.1 It is important that our residents are able to hold us to account for the delivery of the actions and targets set out in this 10-year strategy. To help do this, we have identified how we will measure the impact of the actions we have set out.

6.2 Every year we will provide an update on how we are performing against each of our priorities and pledges. Every three years we will review progress and strategic direction of the overall strategy to ensure that it remains relevant, focused and outcome-orientated. The annual public health report (APHR), produced by the Director of Public Health, will also comment on our progress in these priority areas.

6.3 Lead officers from across the councils will be held to account by our residents, our council leadership, our scrutiny committees and our health and wellbeing boards for progress made in delivering improvements in these important public health priorities.

6.4 We will report annually against progress in improving the relevant outcomes listed in the Department of Health's Public Health Outcome Framework. This information will provided and benchmarked against our statistical neighbours and national data, and will allow us to continually review our progress in achieving our priorities.

7 SUMMARY

Borough	Priority	Pledge	Indicators
All	Reduce childhood obesity by increasing the number of children that leave school with a healthy weight	By 2025 there will be a higher proportion of children leaving primary school with a healthy weight	• Increased proportion of school children leaving with a healthy weight; • Joint working processes established that make positive changes to the physical environment; • Tools designed and rolled out that assist families to make healthier choices in their everyday lives; • Clear recommendations from the evaluation to inform how public health expertise can be embedded across all council areas to reduce childhood obesity.
	Reduce smoking rates by reducing the proportion of people who smoke and who start to smoke, particularly children	By 2025 we will have • reduced smoking prevalence in adults and children by a further 2% on the 2014 baseline • implemented initiatives that focus on harm reduction with people who are still smoking as part of individual plans to quit • reduced the proportion of people who start to smoke, especially children	• Sustained lower smoking prevalence rates in each borough • Sustained lower prevalence rates amongst 15-18 year olds
	Improve sexual health by reducing the rates of	By 2025 we will have • halted the year-on-year rise in sexually-transmitted	• Improved outcomes evidenced through reduced prevalence of STIs and reduced teenage pregnancy rates

	sexually transmitted infections and unplanned teenage pregnancy	infections • transformed our delivery systems to ensure that best outcomes are achieved through sustainable and cost effective services	• System redesign implemented and efficiencies achieved • Decommissioned ineffective services
	Reduce levels of substance misuse by improving the health and wellbeing of people at risk of becoming substance misusers and improving treatments services	By 2025 we will have • improved the health and wellbeing of drug and alcohol misusers, including their families and communities • ensured that those people in need of services have access to the full range of prevention, treatment and recovery opportunities • reduced costs and improved service effectiveness	• Communication strategy implemented • Service redesign implemented • Increase in successful completion rates • Reduced drug related crime and reoffending rates • Reduced infection and transmission rates of blood borne viruses (BBVs) • Increased proportion of people with substance misuse successfully completing drug treatment • Increased proportion of people with substance misuse entering the workforce or participating in meaningful activities and less dependent on benefits
	Improve mental wellbeing by promoting and sign-posting to preventative and joined up services **[an underpinning priority]**	By 2025 we will have improved the mental health and wellbeing of our residents by • helping people with mental health problems to have the same opportunities as everyone else • improving access and awareness to support and advice services to help maintain mental wellbeing	• Promotion of mental wellbeing, prevention of mental ill-health, early intervention across all population groups; • A completed equality impact assessment, ensuring all at risk populations are equitably considered; • Improved whole system design of mental health early diagnosis and treatment services for children and adults; • reduced levels of dementia and a mitigation plan in place once diagnosed.

	Improve preventative services, by helping design and deliver services that have the capacity to have the biggest impact on prevention, early intervention and positive health promotion **[an underpinning priority]**	By 2025 we will have • provided leadership, via our health & wellbeing boards, to enable the NHS to achieve immunisation and screening uptake to levels sufficient to meet national recommendations • delivered coordinated and joined up preventative initiatives throughout life that help reduce long term health and economic consequences, especially for cardiovascular disease by significantly increasing the uptake of health checks	• An established mechanism that captures GP practice data on immunisation and screening rates; • A developed programme with GPs, hospital providers and community services that encourages more people to take advantage of both free immunisation and screening services; • Improved immunisation rates; • Improved screening rates; • Improved NHS health check programme uptake; • Delivery of community based prevention campaigns; • Better designed services that address prevention and that are effective and cost-effective, and that reduce health inequalities.
Hammersmith and Fulham	To reduce the health inequalities associated with childhood poverty	By 2025 Hammersmith and Fulham will have improved key health and wellbeing outcomes of the most disadvantaged children in the borough, ensuring that all strategies and policies contribute towards a reduction in child poverty	• Improved parental employment rates; • Improved rates for school readiness amongst those with the highest proportion of children from families with low income; • Improved take up of the early years childcare offer for low income families; • An adopted approach implemented to continue and develop programmes which engage and support hard to engage/reach families; • Joint commissioning in place to support local commissioning of employability support; • Established joint working protocols with key council departments and partners to inform the reduction of the effects of child poverty.

Kensington and Chelsea	To increase the number of people being physically active	By 2025 Kensington & Chelsea will have • worked with partners and key stakeholders to have become frontrunners in the promotion of the participation in physical activity • ensured that physical activity messages are embedded within all strategies and policies related to health and wellbeing	• Increased levels of people participating in physical activities for more than 30 minutes a day; • Employers engaged in helping staff to be more physically active; • More children and young people physically active; • Delivery of health promotion initiatives promoting positive behaviour change.
Westminster	To overcome barriers to employment	By 2025 Westminster will have • reduced the barriers to employment for many people, particularly those with learning disabilities, who have caring responsibilities and who are vulnerable • improved the health and wellbeing of our residents who find it difficult to access employment by facilitating improved access to local integrated employment support and volunteering opportunities	• Increased successful treatment outcomes; • Reduced drug related crime and reoffending rates; • Improvement in literacy, numeracy and computer skills; • Increased proportion accessing and sustaining work opportunities and/or participating in meaningful activities; • Increased proportion of local businesses/organisations participating in London Healthy Workplace Charter or similar.

Public Health Outcomes Framework (PHOF)[24]

Outcome 1: Increased healthy life expectancy

Taking account of the health quality as well as the length of life

(Note: This measure uses a self-reported health assessment, applied to life expectancy.)

Outcome 2: Reduced differences in life expectancy and healthy life expectancy between communities

Through greater improvements in more disadvantaged communities

(Note: These two measures would work as a package covering both morbidity and mortality, addressing within-area differences and between area differences)

DOMAINS

DOMAIN 1:	DOMAIN 2:	DOMAIN 3:	DOMAIN 4:
Improving the Wider Determinants of Health	Health Improvement	Health Protection	Healthcare public health & preventing premature mortality
Objective: Improvements against wider factors which affect health and wellbeing and health inequalities	**Objective**: People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities	**Objective**: The population's health is protected from major incidents and other threats, whilst reducing health inequalities	**Objective**: Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities.

1 Improving the wider determinants of health

Objective

Improvements against wider factors that affect health and wellbeing and health inequalities

Indicators

- Children in poverty
- School readiness
- Pupil absence
- First-time entrants to the youth justice system
- 16-18 year olds not in education, employment or training
- Adults with a learning disability / in contact with secondary mental health services who live in stable and appropriate accommodation
- People in prison who have a mental illness or a significant mental illness
- Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services
- Sickness absence rate
- Killed and seriously injured casualties on England's roads
- Domestic abuse
- Violent crime (including sexual violence)
- Re-offending levels
- The percentage of the population affected by noise
- Statutory homelessness
- Utilisation of green space for exercise/health reasons
- Fuel poverty
- Social isolation
- Older people's perception of community safety

[24] http://www.phoutcomes.info/ 2015

2 Health improvement

Objective

People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

Indicators

- Low birth weight of term babies
- Breastfeeding
- Smoking status at time of delivery
- Under 18 conceptions*
- *Child development at 2-2½ years (under development)*
- Excess weight in 4-5 and 10-11 year olds*
- Hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14 and 15-24 years
- Emotional well-being of looked after children
- *Smoking prevalence – 15 year olds (placeholder)*
- Self-harm
- Diet
- Excess weight in adults
- Proportion of physically active and inactive adults
- Smoking prevalence – adult (over 18s)
- Successful completion of drug treatment
- People entering prison with substance dependence issues who are previously not known to community treatment
- Recorded diabetes
- Alcohol-related admissions to hospital
- Cancer diagnosed at stage 1 and 2
- Cancer screening coverage
- Access to non-cancer screening programmes
- Take up of the NHS Health Check Programme – by those eligible*
- Self-reported wellbeing
- Falls and injuries in people aged 65 and over

3 Health protection

Objective

The population's health is protected from major incidents and other threats, while reducing health inequalities

Indicators

- Fraction of mortality attributable to particulate air pollution
- Chlamydia diagnoses (15-24 year olds)*
- Population vaccination coverage
- People presenting with HIV at a late stage of infection
- Treatment completion for Tuberculosis (TB)
- Public sector organisations with board-approved sustainable development management plan
- Comprehensive, agreed inter-agency plans for responding to health protection incidents and emergencies*

4 Healthcare public health and preventing premature mortality

Objective

Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities.

Indicators

- Infant mortality
- Tooth decay in children aged 5
- Mortality from causes considered preventable
- Mortality from all cardiovascular diseases (including heart disease and stroke)
- Mortality from cancer
- Mortality from liver disease
- Mortality from respiratory diseases
- Mortality from communicable diseases
- Excess under 75 mortality in adults with serious mental illness
- Suicide rate
- Emergency readmissions within 30 days of discharge from hospital
- Preventable sight loss
- Health-related quality of life for older people
- Hip fractures in people aged 65 and over
- Excess winter deaths
- Estimated diagnosis rate for people with dementia

	**London Borough of Hammersmith & Fulham** **BRIEFING TO HEALTH AND WELLBEING BOARD** **22 June 2015**
National Institute for Health and Care Excellence (NICE) guideline 'Excess winter deaths and morbidity and the health risks associated with cold homes'	
Report of the Executive Director of Adult Social Care and Health	
Open Report	
Classification: For Information **Key Decision:** No	
Wards Affected: All	
Accountable Executive Director: Liz Bruce, Executive Director of Adult Social Care and Health	
Report Author: Stuart Lines, Public Health Consultant, Interim Director of Public Health for LBHF	**Contact Details:** Tel: 020 7641 4690 E-mail: slines@westminster.gov.uk

1. EXECUTIVE SUMMARY

1.1 In March 2015 the National Institute for Health and Care Excellence (NICE) published guideline 'Excess winter deaths and morbidity and the health risks associated with cold homes'. This sets out 12 recommendations as to how local authorities through their Health and Wellbeing Boards (HWBs) and key delivery partners should mitigate and reduce the risk of death and ill health associated with living in a cold home. The aim is to help meet a range of outcomes.

1.2 This paper presents the 12 recommendations set out in the guidance in order to support the HWB to consider an appropriate response in the context of Hammersmith and Fulham's Housing Strategy, *Delivering the Change We Need in Housing* and the Public Health Strategy, *Improving our Public's Health*.

2. RECOMMENDATION

2.1 HWBB members are asked to consider:

- the extent to which current activity adequately addresses the 12 recommendations of the guidance,
- what further action might be required in order to reduce the risk of death and ill health associated with living in a cold home and
- how best this might be taken forward in partnership.

3. INTRODUCTION AND BACKGROUND

3.1 There is mounting evidence that living in a cold home has severe and wide ranging adverse health impacts, resulting in cost and increased activity to the NHS and other services. The health problems associated with cold homes are experienced during 'normal' winter temperatures, not just during extremely cold weather; an increase in death rates due to a drop in temperature can happen when temperatures drop below about 6°C.

3.2 A wide range of people are vulnerable to the cold. This is either because of a long term condition, a disability that, for instance, stops people moving around to keep warm, or makes them more likely to develop chest infections; or personal circumstances, such as being unable to afford to keep warm enough.

3.3 The NICE guideline aims to help meet a range of public health and other goals, including:

- Reducing preventable excess winter death
- Improving health and wellbeing among vulnerable groups
- Reducing pressure on health and social care services
- Reducing 'fuel poverty' and the risk of fuel debt

Improvements to the home may also reduce absences from work and school that result from illnesses caused by living in a cold home.

3.4 The guideline sets out 12 recommendations as to how local authorities through their HWBs and key delivery partners should mitigate and reduce the risk of death and ill health associated with living in a cold home.

Table one: NICE Guideline Recommendations, related activity and identified gaps

NICE Recommendation	Action to date	Gaps
<u>Recommendation 1</u> Health and wellbeing boards should include the health consequences of living in a cold home in the joint strategic needs assessment process and develop a strategy to address the health consequences of cold homes.	*Improving our Public's Health* includes the following two priorities ➢ 'Improve preventative services, by helping design and deliver services that have the capacity to have the biggest impact on prevention, early intervention and positive health promotion'. ➢ 'To reduce the health inequalities associated with childhood poverty' The Child Poverty JSNA (2014) makes the following recommendations: ➢ Ensure that … primary healthcare works closely with children's centres, early help and other family services to identify and address the family's wider socio-economic issues more effectively. ➢ Develop greater integration between Residential Environmental Health Services (REHS) and other front line services, particularly health and social care, to ensure that poor housing conditions are addressed regardless of tenure. Hammersmith and Fulham's Housing Strategy, *Delivering the Change We Need in Housing* includes emphasis on improving housing standards in the private rented sector.	The Public Health Annual Report 2013-14 does not present local data regarding the proportion of the population living in cold homes or the number of excess winter deaths. There has been no specific consideration of excess winter deaths or morbidity due to cold homes, or the reasons for them in the London Borough of Hammersmith and Fulham JSNAs. A formal borough strategic approach to tackling excess winter deaths is lacking.
<u>Recommendation 2</u> Health and wellbeing boards should ensure there is a single-point-of-contact health and housing referral service for people living in cold homes, ensuring anyone who comes into contact with vulnerable groups is able to refer people to the referral service and that the referral service links with relevant national and local services that can provide a range of solutions. <u>Recommendation 3</u>	A food and fuel poverty multi-agency working group is exploring how a range of front line professionals supporting vulnerable people in their own home might work to better effect, making every contact count. It is reviewing local care pathways and the information and advice available to both front line professionals and residents regarding the services available locally. The 'Healthier homes, healthier people initiative', funded by Public Health, provides a residential environmental health service to residents whose health and wellbeing is compromised by poor housing conditions. Particular emphasis is given to those living in fuel poverty. Specific objectives include	As yet this work could not be said to be systematic or comprehensive as it is at an early stage of development.

NICE Recommendation	Action to date	Gaps
Health and wellbeing boards and their partners should ensure the local single-point-of-contact health and housing referral service provides access to tailored solutions to address identified needs, rather than an off-the-shelf approach.	➢ To facilitate the development and implementation of a whole person approach to addressing the needs of vulnerable households, which enables front line professionals across the system to identify a range of potential health and wellbeing issues and make the appropriate referral(s). ➢ To develop effective working relationships with health and social care professionals and other front line providers. ➢ To support partner agencies in developing their understanding and use of the service, enabling them to make timely and appropriate referrals.	
<u>Recommendation 4</u> Primary health and home care practitioners should identify people at risk of ill health from living in a cold home.		Local health services are not currently systematically assessing or referring vulnerable residents to available assistance programmes.
<u>Recommendation 5</u> Primary health and home care practitioners make every contact count by assessing the heating needs of people who use primary health and home care services		
<u>Recommendation 6</u> Non-health and social care workers who visit people at home should assess their heating needs, providing information and onward referral.		
<u>Recommendation 7</u> Those responsible for someone's discharge from a health or social care setting should ensure the arrangements are in place for vulnerable people to be discharged to a warm home.		Discharge planning could be further developed to ensure that housing considerations are systematically incorporated at the appropriate stage.
<u>Recommendation 8</u> Training providers for health and social care practitioners should ensure training to support continuing professional development incorporates the impact of living in a cold home on health and wellbeing and how to help people whose homes may be too cold.	The 'Healthier homes, healthier people initiative', referred to above incorporates two specific outputs which relate: ➢ The creation and provision of marketing and training sessions / learning opportunities for staff of partner agencies. ➢ In conjunction with partner agencies, the provision of staff training sessions / learning opportunities for REHS staff regarding the identification of potential health and wellbeing	

NICE Recommendation	Action to date	Gaps
Recommendation 9 Training providers for housing professionals and for people working in the faith and voluntary sector should ensure housing professionals and faith and voluntary sector workers are trained to identify and help people whose homes may be too cold for their health and wellbeing.	issues and appropriate referral routes.	
Recommendation 10 Employers who install and maintain heating systems, electricity and gas meters and building insulation and those involved in employee training should train heating engineers, meter installers and those providing building insulation to identify and help appropriately vulnerable people at home.	This recommendation is being explored with housing colleagues with respect to council owned stock.	
Recommendation 11 Health and wellbeing boards, Public Health England and the Department of Energy and Climate Change should raise awareness among practitioners and the public about how to keep warm at home.	The 'Healthier homes, healthier people initiative', referred to above incorporates a specific output which relates: ➢ The provision of awareness events and initiatives (e.g. web page on councils' websites for residents. Three public events were specifically organised around cold homes week in February 2015.	
Recommendation 12 Building control officers, housing officers, environmental health and trading standards officers should ensure buildings meet ventilation and other building and trading standards.	This recommendation is being explored with the relevant council departments.	

4. PROPOSAL

4.1 Several key elements of the NICE recommendations are already being addressed in Hammersmith and Fulham. However there do remain some gaps, notably in our knowledge of the extent to which excess winter deaths and morbidity associated with cold homes are an issue in the borough.

4.2 Reference was made in the Annual Public Health Report 2014 to the importance of a healthy home environment but this did not incorporate assessment of current housing conditions. Similarly, while there is reference to excess winter deaths and the impact of cold homes in the JSNA Highlights report for 2013/14, there is no analysis of the geographical spread across the borough, the residents affected / at risk, or the type of housing stock presenting the greatest challenge. Neither document provides an analysis of the assets we have to address the issues or the gaps. JSNA reports prior to 2013/14 also did not address this area of public health.

Further research on available data, possibly through the JSNA process, that specifically looks at this area in depth could provide a more accurate picture of the impact of cold homes, which could then be used to inform a programme of action, supported by cost benefit analysis, which might achieve a tangible difference to health inequalities.

4.3 HWB Board Members are asked to consider how they wish to respond to the NICE guideline.

5. EQUALITY IMPLICATIONS

5.1 Excess winter deaths and the health and wellbeing impact of cold homes have a strong correlation with deprivation. Activity to address the recommendations in the NICE guidance will enhance the Council's ability to reduce health inequalities.

5.2 Any significant changes in service delivery as a result of this strategy will be subject to Equality Impact Assessments as part of the decision making process.

6. LEGAL IMPLICATIONS

6.1 There have not yet been any proposals that impact on services and therefore there has not been the need to seek legal advice.

6.2 Implications verified/completed by: N/A

7. FINANCIAL AND RESOURCES IMPLICATIONS

7.1 Any request for further research into data and information through the JSNA process would need to be considered by the JSNA Steering Committee.

7.2 Implications verified/completed by: N/A

8. RISK MANAGEMENT

8.1 RISK – Should a JSNA be requested, there may be capacity issues due to the current workplan.

8.2 RISK – Age UK and the National Right to Fuel Campaign (NRFC) have written to the Chair of the HWB. Age UK expressed a desire that the Board 'implement the guidance as a matter of urgency…[and] review your Joint Strategic Needs Assessment and Health and Wellbeing Strategy to incorporate the proposals from NICE'. The NRFC asked that the HWB 'review the guideline with a view to adopting the … recommendations locally'. A response has been provided to both Age UK and the NRFC to the effect that the guideline will be discussed at the HWB and they will be awaiting feedback.

8.3 Implications verified/completed by: Stuart Lines, Interim Director of Public Health for LBHF.

9. PROCUREMENT AND IT STRATEGY IMPLICATIONS

9.1 There are none.

9.2 Implications verified/completed by: N/A

	**London Borough of Hammersmith & Fulham** **HEALTH AND WELL BEING BOARD** **22nd June 2015**
UPDATE ON THE TRANSITION ARRANGEMENTS FOR THE TRANSFER OF HEALTH VISTING AND FAMILY NURSE PARTNERSHIP SERVICES	
Report of the Executive Director of Adult Social Care and Health	
Open Report	
Classification: For Information and discussion **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: Liz Bruce, Executive Director of Adult Social Care and Health	
Report Author: Julia Mason, Families & Children's Public Health Commissioner	**Contact Details:** Tel: 020 7641 4653 E-mail: jmason@westminster.gov.uk

1. EXECUTIVE SUMMARY

1.1. This report provides a progress update on transition for the transfer of commissioning responsibilities for Public Health Services for 0-5 year olds, Health Visiting (HV) and the Family Nurse Partnership (FNP), from NHS England to the London Borough of Hammersmith and Fulham (LBHF). It includes:

- a summary of the background to the commissioning changes
- the scope of the transfer
- mandated elements of the services
- the agreed annual baseline budget and additional commissioning resource for LBHF HV and FNP services
- the contract transfer process
- information governance & performance
- strategic intentions for a new integrated early years' service

2. RECOMMENDATIONS

2.1. HWBB Members are asked to note the progress update and to consider the opportunities provided by the transfer of these services to support the Council's 'Best Start in Life' strategic ambitions.

3. INTRODUCTION AND BACKGROUND

3.1. In January 2014 the Government confirmed that the Healthy Child Programme (HCP) for 0-5 year olds, which includes the commissioning of health visitors and family nurses, would transfer to local government on the 1 October 2015. These services are now referred to as Public Health Children's Services for 0-5 year olds.

3.2. It is only the commissioning that will transfer and not the workforce. Health Visitors and Family Nurses will continue to be employed by the same provider organisation, which for LBHF is Central London Community Healthcare NHS Trust (CLCH).

3.3. The transfer marks the final part of the overall public health transfer and will join up commissioning for 0 to 19 year olds to improve service continuity for children and their families.

3.4. It also presents a unique opportunity to support delivery of LBHF's Health Well Being Board's 'Best Start in Life' priority to transform and integrate early years' services to improve outcomes for pregnant women, children and families

4. THE SAFE TRANSFER OF SERVICES

4.1. Scope of the Transfer

4.1.1 The following commissioning responsibilities will be retained by NHS England:

- Child Health Information Systems (CHIS) in order to improve systems nationally. The CHIS ensures that each child in England has an active health care record and supports the delivery of national screening and immunisation programmes as well as the Healthy Child Programme. This will be reassessed in 2020.
- The six to eight week GP check (also known as the Child Health Surveillance) because of its complex commissioning arrangements.

4.1.2 The Department of Health has mandated local authorities to provide the following five universal elements of the Healthy Child Programme (HCP) to ensure a national, standard format for universal coverage of these elements is delivered

- antenatal health promoting visits
- new baby review
- six to eight week maternal mood assessment
- one year assessment
- two to two and a half year review

4.1.3 These requirements will be subject to a 'sunset clause' at 18 months. A review involving Public Health England will be undertaken in October 2016 to inform future arrangements relating to these mandatory elements.

4.2. Governance: managing and overseeing the transfer

4.2.1 A national Health Visitor Transition task and finish group has been established to develop and lead the transfer arrangements. The Executive Director of Children Services has been part of this group since its establishment. Within London, the NHS England London Area Team and London Councils recruited a transition lead to support the process.

4.2.2 Locally, a multi-agency Health Visitor Partnership Group of PCTs/Clinical Commissioning Groups, NHS England London Area Team, LA Public Health and Children Services, was established to implement the local HV service development plans and to have oversight of performance. This group has been now been reconvened to oversee the safe transfer of the service and to contribute to the development of commissioning intentions for a new integrated service model.

4.2.3 Meanwhile, a small local transition team consisting of combined Public Health and Family and Children's Senior Managers and Commissioners has worked with the London Area Team lead since July 2014 to establish the local transition processes and outcomes. The team is continuing to work with NHSE and CLCH on the contract transfer arrangements.

4.2.4 NHSE issued contract transfer guidance in February 2015 and based on legal and contractual advice it was agreed that NHSE will put in place its own contract from April to September 2015 and assist us with putting together a new local authority contract for LBHF from 1st October 2015.

4.3. Performance management

4.3.1 In 2013 a Memorandum of Understanding was agreed between NHSE, Central London CCG and local Public Health to provide a framework for information sharing and performance management for the three boroughs' services during 2013-2015.

4.3.2 The regulations make it clear that there is no expectation of an uplift in performance at the point of transfer, and that councils will only be expected to take a reasonably practicable approach to delivering the mandated elements of the Healthy Child Programme 0-5 years and to continuous improvement over time.

4.3.3 Information governance arrangements are in place so that our provider CLCH is able to share information and data submitted to the NHS England about the current level of performance, so that LBHF can know their pre-transfer baseline.

4.4.4. The performance data is currently provided on a CCG basis, but from October 1st the requirement is that it will be reported on a local authority basis. Initial analysis of the Q4 data shows that the LBHF health visiting service is performing well against the mandated elements of the HCP.

4.4.5 The Family Nurse Partnership reports directly to the National FNP Unit and their performance data is made available and reviewed quarterly through the local multi-agency FNP Advisory Board. The FNP has demonstrated significantly improved outcomes for vulnerable young mothers and their children and performance is good.

5. Developing Future Commissioning Intentions

5.1 From the 1st October both HV and FNP will be commissioned to deliver against the standard national service specification, which include clear outcome measures and KPIs, until a new service is re-commissioned during 2016-17.

5.2 LBHF's HWBB's Best Start in Life and Early Help Strategy are informing the development of an integrated early years' service model for future 0-5 services with a shared outcomes framework. This is being developed jointly with CCGs, Local Authority Public Health and Children's and Families' Services, service providers and other key stakeholders.

5.3 The proposed model will bring together a universal, targeted and enhanced offer into a single pathway, with an emphasis on identifying need, in families and individuals, much earlier and more systematically across all early years' services.

5.4 It is proposed that a range of targeted services will be part of the Children's Centre core offer, providing a resource to the universal early years' service, and be an integral part of the early years' pathway. An enhanced pathway will also be developed for families under pressure.

5.5 An integrated early years' service will include working closely with maternity and primary care services and continue to provide a named link and regular liaison with each GP.

5.6 Benefits of this approach will include an integrated approach to supporting families from an early stage, a team of staff wrapped around GP practices that can provide extra support, and improved outcomes for maternal well-being and child development with fewer consultations on non-medical issues and less pressure on A&E and out-patient appointments.

5.7 The Best Start in Life Programme Board is overseeing the strategic development of this work and the LBHF Best Start in Life Work Group is reviewing current customer journeys and good practice, to develop a local multiagency service offer with shared aims and outcomes.

5.8 A series of Best Start in Life Partner Workshops, facilitated by the Early Intervention Foundation, have been arranged to support engagement of all partners in developing an integrated model and pathways.

6. CONSULTATION

6.1. The Department of Health undertook extensive consultation with service users, providers, commissioners, and other partners in the development of the national health visiting specification and mandation requirements.

6.2. Local service user and stakeholder consultation will be undertaken for the service review and development of an integrated early years' pathway.

7. EQUALITY IMPLICATIONS

7.1. Health visiting and FNP services are designed to influence and improve child health and family outcomes and address inequalities. Prior to transfer, the DH undertook an Equality Assessment of the mandated elements of the Healthy Child Programme/ 0-5 years and concluded that mandation will in general have a neutral or slightly positive impact.

7.2. Any proposed significant changes in local service delivery will be subject to Equality Impact Assessments as part of the decision making process.

8. LEGAL IMPLICATIONS

8.1. Whilst the financial and workforce analysis is not a transfer agreement, and is not binding on local government or NHS England, it will inform the level of funding that the Council will receive as part of the Public Health Grant to support the new commissioning functions.

9. FINANCIAL AND RESOURCES IMPLICATIONS

9.1 In December 2014 the Department of Health published the proposed half year funding allocations for HV and FNP services on transfer to LAs in October 2015. The final LBHF HV annual funding allocation of £3,992M was published and signed off in February 2015.

9.2 The contract value matches expectations and is considered sufficient to deliver the mandated elements of the service. It includes a growth element for increased HV workforce for 2014 -15 as part of the Government's Agenda for Change. A recurrent commissioning resource of £30K PA per borough is also included in the allocations, proportionately 15K for LBHF in 2015-16.

9.3 Additionally, the total funding allocation of £350K PA for the three borough West Central London FNP service is being apportioned to reflect each local authority's level of need, based on a three year average of the number of births to teenage mothers in each local authority. It will be adjusted annually where there is a significant change in proportion. For LBHF the annual contribution to this shared service is £150,606.

10. RISK MANAGEMENT

10.1 Local Authority Officers negotiated with NHSE to ensure that the budget allocation on transfer would be sufficient to deliver the mandated elements of the LBHF services and ensure service continuity. The budget allocation was agreed and signed off in February 2015.

11. PROCUREMENT AND IT STRATEGY IMPLICATIONS

11.1 The NHSE contract for these services will end on 30th September 2015 when commissioning responsibilities and the budget for health visiting and FNP transfers to the Local Authority. A new Local Authority contract will be directly awarded to the current provider from 1st October 2015 for 24 months. This will allow sufficient time to undertake a service review, develop commissioning intentions and re-procure the new service.

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

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

	**London Borough of Hammersmith & Fulham** **HEALTH AND WELLBEING BOARD** **22 June 2015**
JSNA WORK PROGRAMME AND PRIORITIES 2015/16	
Report of the Acting Director of Public Health	
Open Report	
Classification - For Information (delete as appropriate) **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: Liz Bruce, Executive Director of Adult Social Care	
Report Author: Jessica Nyman, JSNA Manager Colin Brodie, Public Health Knowledge Manager	**Contact Details:** Tel: 020 7641 8461 E-mail: jnyman@westminster.gov.uk

1. EXECUTIVE SUMMARY

1.1. This paper provides a short update on the current stage of delivery of the Joint Strategic Needs Assessment (JSNA) products agreed by the Health and Wellbeing Board for the 2014/15 work programme. It also reports on two subsequent proposals received from partners for the 2015/2016 work programme.

2. RECOMMENDATIONS

2.1. The Health and Wellbeing Board are invited to consider progress on the 4 deep dive JSNAs in the current work programme (Dementia JSNA, Childhood Obesity JSNA, End of Life Care JSNA and Housing JSNA).

2.2. The Health and Wellbeing Board are invited to consider how they may wish to get involved in the development of specific JSNAs in the current work programme

2.3. The Health and Wellbeing Board are asked to consider how they may wish to inform the scope and development of the Evidence Hub.

3. REASONS FOR DECISION

3.1. The Health and Wellbeing Board are invited to comment on progress with the JSNA work programme.

4. INTRODUCTION AND BACKGROUND

4.1. There are currently 4 JSNA projects underway which are at different stages of delivery. These were approved by the Health and Wellbeing Board in 2014 for the JSNA work programme.

4.2. Two new proposals for JSNA products are also currently being considered for the 2015/16 work programme. These proposals are at different stages of development and are currently being scoped in further detail.

5. CURRENT JSNA WORK PROGRAMME

Dementia JSNA

5.1. The purpose of this JSNA is to provide a comprehensive evidence base and information about the local population to inform the development of commissioning intentions and support the strategic approach taken across

North West London, that takes account of national and local policy, strategy, and guidance.

5.2. Information has been collected from a variety of sources including audit, relevant policy and research as well as local data provided by stakeholders, providers and service users. This evidence has been analysed to identify gaps and solutions and forms the basis of the recommendations.

5.3. In the care of people with dementia and their carers there is an emphasis on sustainability through better community care, living as well as possible with dementia, keeping people out of hospital and reducing length of hospital stays. In the course of writing the JSNA, several priority themes have been highlighted. These are:

- The numbers of people with dementia are increasing and we need **adequate resource** to deal with this challenge and we need to provide services **efficiently** and **sustainably**

- **Dementia diagnosis rates** have been **rising** in each of the three boroughs. This has to be followed by an equal input into **post-diagnostic care** to ensure people are not left on a 'cliff edge' once diagnosed

- Most of the cost of supporting those with dementia falls on **unpaid carers** and **adult social care.** We need to **support, advise and empower carers** to fulfil this enhanced role without a detriment to their own quality of life

- Whilst it is important to maintain independence for longer, there needs to be **appropriate escalation of care** when needed. There may be a need for **increased training** for paid and unpaid carers and residential care staff to recognise when this escalation is required.

- Dementia services are provided by a **range of agencies** - acute and primary care, mental health services, social care and third sector. Better **cohesion and collaboration** is needed via well-coordinated information, advice & signposting, advocacy and outreach services

- People with dementia do not always receive fair access to services which support their **mental and physical** health needs. People with dementia need to receive **parity of access** across mental and physical health

5.4. A draft report is now complete and was circulated to a range of stakeholders for consultation, including Local Authority colleagues, CCGs, Community and Voluntary Sector, and Healthwatch. Response to the consultation was good and a large number of comments received. The

Task and Finish Group are currently working through this feedback to update the document as appropriate, and will brief senior colleagues within the Local Authority and Clinical Commissioning Groups on the development of the final report.

5.5. The final JSNA report will be disseminated to the Health and Wellbeing Board for consideration and final sign-off.

Childhood Obesity JSNA

5.6. This JSNA will look at the prevalence of childhood obesity in Westminster, Hammersmith and Fulham, and Kensington and Chelsea. The report will examine the factors which are known to influence levels of obesity in our population, analysing the available data for the local area.

5.7. Some of the wider implications of obesity for local services and society more generally will be described, relating these to the available data.

5.8. This analysis of data and other sources of information is underway, and the first draft will be sent to stakeholders in June 2015 for comment and feedback. A final draft is expected to be ready for consideration by the Health and Wellbeing Board in September 2015

5.9. The Childhood Obesity JSNA will inform and support the next phase of the Childhood Obesity Programme.

End of Life Care JSNA

5.10. This JSNA will assist in identifying the future capacity requirements to meet the increasing End of Life Care needs of residents in Hammersmith and Fulham, Westminster and Kensington and Chelsea.

5.11. This work draws together information from key partners to provide a local evidence base for future integrated commissioning. It is an opportunity to understand the whole landscape for people approaching end of life, and their carers' and to highlight areas of improvement to be addressed in joint strategic planning.

5.12. Data analysis and evidence review is currently underway by Public Health. In June 2015 a first draft will be disseminated to wider stakeholders to assist with gaps in data and for comment. A final draft will be completed end of September.

Housing JSNA

5.13. The Housing JSNA is being developed along with stakeholders to support their key business needs, and in particular in relation to the new duties for local authorities around health and wellbeing contained within the Care Act. The JSNA will support the duties of the Care Act to prevent, delay or

reduce an individual's need for care and to support and cooperate across departments and with relevant partners.

5.14. The JSNA will describe the disability and health related housing needs of our local population. It will investigate and map the supply of existing housing stock (e.g. extra care housing, sheltered and supported housing, warden supported housing, temporary accommodation etc.) and any projected changes in future supply. It will explore the links between housing and health and social care needs and provide a picture of local need with a focus on vulnerable groups (e.g. people with learning disabilities, physical disabilities, long term conditions or mental illness).

5.15. The JSNA project team are working closely with colleagues in Adult Social Care and the three Housing departments across the three boroughs to ensure it meets their specific information needs, with the final JSNA product tailored to reflect these needs.

6. Proposals for 2015/2016 JSNA Work Programme

Two new proposals for 2015/16 have been submitted

Evidence Hub

6.1. An initial proposal to develop a JSNA data observatory, or Evidence Hub, was agreed in principle by the JSNA Steering Group in January 2015. The aim of this observatory will be to present information drawn from a range of national and local data and evidence sources, and provide a toolkit for users to interrogate in a more interactive and flexible way e.g. prevalence data for particular conditions, links to evidence briefings, maps to identify the location of services. This will be an online tool which will enable users to find specific data.

6.2. The scope of the Evidence Hub content is currently being developed. Consultation has taken place within Public Health. Consultation with other stakeholders (including the NHS, Adult Social Care, Children's Services, Housing, Planning, Community Safety) has begun and will take place until the early July.

6.3. The scope of the Evidence Hub will be developed by mid-July based on the consultation and taken back to the JSNA Steering Group for agreement. The Health and Wellbeing Board will then be presented with a proposal on how the Evidence Hub will work in practice for their agreement.

6.4. A primary function of the Evidence Hub will be to inform a refresh of the JSNA highlights reports.

Excess Winter Deaths and Fuel Poverty

6.5. A draft proposal for a JSNA on this topic has been submitted and will be scoped in more detail. This provides a potential response to recent recommendations contained in the NICE guidance on Excess Winter Deaths.

7. CONSULTATION

7.1. A consultation with key stakeholders was undertaken for the Dementia JSNA (as described above).

8. EQUALITY IMPLICATIONS

8.1. JSNAs must consider the health, wellbeing and social care needs for the local area addressing the whole local population from pre-conception to end of life.

8.2. The “local area” is that of the borough, and the population living in or accessing services within the area, and those people residing out of the area for whom CCGs and the local authority are responsible for commissioning services

8.3. The “whole local population” includes people in the most vulnerable circumstances or at risk of social exclusion (for example carers, disabled people, offenders, homeless people, people with mental health needs etc.)

9. LEGAL IMPLICATIONS

9.1. The JSNA was introduced in the Local Government and Public Involvement in Health Act 2007

9.2. The Health and Social Care Act 2012 placed the duty to prepare a JSNA equally and explicitly on local authorities (LAs), Clinical Commissioning Groups (CCGs) and the Health and Wellbeing Boards (HWB)

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

10. FINANCIAL AND RESOURCES IMPLICATIONS

10.1. The current JSNA projects are scoped and progressed within existing resources and capacity. The individual JSNAs largely draw on existing staff capacity from across the key departments and stakeholders involved, and from the JSNA team within the Public Health department.

10.2. The two new projects set out above could be progressed within existing resources. Although, the Health and Wellbeing Board may wish to consider these projects more fully at a future meeting alongside other potential draws on the Joint Strategic Needs Assessment resource.

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

11. IMPLICATIONS FOR BUSINESS

11.1 None identified in this update.

12. RISK MANAGEMENT

12.1 None identified in this update

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

13. PROCUREMENT AND IT STRATEGY IMPLICATIONS

13.1 None identified in this update

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

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

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

	London Borough of Hammersmith & Fulham **HEALTH & WELLBEING BOARD** **22 June 2015**
TITLE OF REPORT: 2015-16 CCG Operating Plan, Quality Premium and CCG Narrative supporting Operational Plans	
Report by: Hammersmith & Fulham CCG	
Open Report	
Classification – Ratification of decision on 2015-16 Quality Premium **Key Decision:** Yes	
Wards Affected: All	
Accountable Executive Director: Janet Cree, Interim Managing Director, Hammersmith & Fulham CCG	
Report Author: Bhavesh Patel	**Contact Details:** Tel: 020 33504161 E-mail: Bhavesh.Patel@nw.london.nhs.uk

1. EXECUTIVE SUMMARY

1.1. The Quality premium is intended to reward CCGs to:

- Improvements in the quality of services they commission
- Improvements in health outcomes and
- Reduction in inequalities in access and in health outcomes

1.2. It will be paid to CCGs in 2016/17 based on performance against measures that incorporate a combination of national and local priorities.

1.3. Final submission of our plans was made to NHS England on 14th May-15 after discussion of the quality premium between Dr Tim Spicer, Chair of Hammersmith & Fulham CCG and Cllr Lukey, Chair of Health and Wellbeing Board. A summary of the CCG plans is attached.

2. RECOMMENDATIONS

2.1. The Committee is asked to note that on 2nd June-15; the Governing Body of the CCG ratified the action taken by the CCG Chair on 11th May-15, following a discussion and agreement with Cllr Lukey.

3. REASONS FOR DECISION

3.1. Each CCG is required to submit its Operating Plan along with the choice of quality premium measures for 2015-16.

3.2. The guidance was issued 31st Mar-15 and there has not been a HWB or H & F CCG Governing Body (GB) since. The options around the quality premium were therefore discussed with GB members both virtually and at GB seminars, and by the CCG Chair with Cllr Lukey. This is because CCG is required to choose the menu of measures in conjunction with the Health & Wellbeing Board.

3.3. The GB of 2nd Jun-15 ratified Chair's action.

4. INTRODUCTION AND BACKGROUND

4.1. The Quality premium is based on measures that cover a combination of national and local priorities. These are:

- Reducing potential years of lives lost through causes considered amenable to healthcare
- Urgent and emergency care
- Mental health
- Improving antibiotic prescribing in primary and secondary care
- Two local measures

4.2. The choice of measures along with targets and allocation of quality premium are outlined in Appendix 2.

4.3. The CCG will have its quality premium payment reduced if the providers from whom it commissions services do not meet the NHS Constitution requirements. These requirements and targets for 2015-16 are outlined in Appendix 2.

5. PROPOSAL AND ISSUES

5.1. CCG Chair discussed the Operating plan and Quality premium submission with Cllr Lukey on 11th May-15.

5.2. Following the discussion with CCG Chair, Cllr Lukey approved our choices of measures and targets.

5.3. Implementation plans and process to monitor performance to deliver the targets are being developed locally and a process is in place for escalating any concerns via programme management arrangements that have been established within the CCG and NHS England Assurance meetings.

6. OPTIONS AND ANALYSIS OF OPTIONS

6.1. In agreeing the quality premium measures and targets, review of baseline information and service plans were considered. All proposals were discussed and subject to robust challenge by H&F CCG Governing Body members before a final decision were reached.

7. CONSULTATION

7.1. An extensive consultation process has been followed with discussion of requirements and assessment of baseline information, target, and delivery plans at CCG business planning meetings, the CCG Operational Group, Finance and Performance, and the CCG Governing Body. The H&WB discussed an early list of priorities from which the final decisions were drawn.

8. EQUALITY IMPLICATIONS

8.1 Equality impact assessment not required.

9. LEGAL IMPLICATIONS

9.1. No legal implications are perceived.

10. FINANCIAL AND RESOURCES IMPLICATIONS

10.1. The maximum quality premium payment for this year is approximately £1m, payable in 2016/17 subject to performance.

11. RISK MANAGEMENT

11.1. Any risks related to the delivery of targets will be discussed as part of the programme management meetings and captured in local project /corporate risk registers.

12. PROCUREMENT AND IT STRATEGY IMPLICATIONS

12.1. There are no contractual or procurement arrangements involved.

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
N/A			

LIST OF APPENDICES

Appendix 1: 2015-16 Operating Plan, Quality Premium and Operational Plan
Appendix 2: Operational Planning Narrative

Appendix 1

2015-16 CCG Operating Plan, Quality Premium and Operational Plan

This paper summaries the CCG requirements submitted to NHS England on 14th May-15. These requirements were last discussed at Governing Body seminar on 5th May and Chair's action was taken on 12th May. The quality premiums were also discussed and approved by Councillor Lukey (Chair of Health & Wellbeing Board) with CCG Chair on 11th May.

1. NHS Constitution requirements

In addition to the quality premium, CCGs are also required to deliver the NHS Constitution targets as outlined below.

I.D.	Measure	Target Level	15-16 Level of Ambition
E.B.1	RTT - The percentage of admitted pathways within 18 weeks for admitted patients whose clocks stopped during the period, on an adjusted basis	90%	Achievement of 90% every month from Sept-15.Target to deliver between 85% to 89% each month before Sept-15
E.B.2	RTT - The percentage of non-admitted pathways within 18 weeks for non-admitted patients whose clocks stopped during the period.	95%	Achievement of 95% every month from Sept-15.Target to deliver between 91% to 94% each month before Sept-15
E.B.3	RTT - The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period.	92%	Achievement of 92% every month from May-15. 91% target in April-15
E.B.4	Diagnostics Test Waiting Times - % waiting over 6 weeks	0.9%	Achievement of 0.9% in every month of 15/16
E.B.6	All cancer 2 week wait	93%	Achievement of 93% in every month next year
E.B.7	Cancer 2 week waits for breast symptoms (where cancer not initially	93%	Achievement of 93% every month in 15/16

	suspected)		
E.B.12	All cancer 62 day urgent referral to first treatment list	85%	Achievement of 85% to 87% every month in 15/16
E.B.13	Cancer- 62 day wait for first treatment following referral from an NHS cancer screening service	90%	Achievement of 100% in every month of 15/16
E.B.14	Cancer- 62 day wait for first treatment for cancer following a consultant's decision to upgrade the patients priority	Not set	Achievement of 100% in every month of 15/16
E.B.8	Cancer- Percentage of patients receiving first definitive treatment within 31 days of a cancer diagnosis	96%	Achievement of 96% in every month of 15/16
E.B.9	Cancer- 31 Day standard for subsequent cancer treatments -surgery	94%	Achievement of 95% to 96% in every month of 15/16
E.B.10	Cancer- 31 Day standard for subsequent cancer treatments -anti cancer drug regimens	98%	Achievement of 100% in every month of 15/16
E.B.11	Cancer- 31 Day standard for subsequent cancer treatments - radiotherapy	94%	Achievement of 94% in every month of 15/16
E.B.5	A&E wait times – total time in A&E department, % below 4 hours	95%	Achievement of 95% in every month of 15/16
E.A.S.5	HCAI measure- C Difficile infections	35	Annual target of 35 incidents of infections
E.A.S.1	Dementia – estimated diagnosis rate	67%	Achievement of 67% every month of 15/16
E.A.3	IAPT roll out	16% annual (4% per quarter)	Achievement of 4% every quarter of 15/16
E.A.S.2	IAPT recovery rate	50%	Achievement of 50% every quarter
E.H.1- A1	Mental Health Access - The proportion of people that wait 6 week or less from referral to entering a course of IAPT treatment against the number of	75% by April 2016	Achievement of 75% by the end of year

	people who finish a course of treatment in the reporting period		
E.H.1- A2	Mental Health Access - The proportion of people that wait 18 week or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period	95% by April 2016	Achievement of 95% by the end of year
E.D.1	The aggregated percentage of patients who gave positive answers to five selected questions in the GP survey about the quality of appointments at the GP practice	Locally set	Improvement of 2% to score 367/500
E.D.2	The percentage of patients who gave positive answers to the GP survey question 'Overall, how would you describe your experience of your GP surgery?	Locally set	Improvement of 3% to be best in CWHHE (87%)
E.D.3	The percentage of patients who gave positive answers to the GP survey question 'Overall, how would you describe your experience of making an appointment?'	Locally set	Improvement of 2.9% to bring us to CWHHE average (72%)

2. Quality Premium

The summary of choice of quality premium and target submitted following a period of assessment and discussions is summaried below.

Priority	Proportion and maximum payment of quality premium allocated	Measure selected	Allocation
Reducing potential years of lives lost through causes considered amenable to healthcare (PYLL)	10% (£100,946)	Mandated	10%
Urgent care and emergency care	30% (£302,838)	Avoidable emergency admissions: reduction	10%
		Increase in NEL patients who are discharged at weekends or bank holidays	20%
Mental Health	30% (£302,838)	Reduction in the number of people with severe mental illness who are currently smokers	5%
		Increase in the proportion of adults in contact with secondary mental health services who are in paid employment	25%
Improving antibiotic prescribing in primary and secondary care	10% (£100,946)	Reduction in the no .of antibiotics prescribed in primary care	10%
		No of co-amoxiclav, cephalosporins and quinolones prescribed as a % of total no of selected antibiotics prescribed	
		Secondary care providers have validated their total antibiotic prescribing data as certified by PHE	

Local priorities	20% (£201,892)	Two local priorities that reflect local priorities identified in joint health and wellbeing strategies 1. MMR childhood immunisation: 77.58% 2. Increase in diabetes care plans: 40%	20% (10% each)

3. Operational Plan Narrative

NHS England also required the CCG to share with partners and stakeholders, full narrative detail of commissioners' operating plans (attached). The template provided by NHS England identified the key elements of the CCG operating plan where a full narrative was required.

Appendix 2

CCG Narrative Template to Support Operational Planning, 2015/16

Version 1.2

Context

Supplementary information for commissioner planning, 2015/16 asks that a full narrative detail of commissioners' operating plans must be available locally to be shared with partners and stakeholders including NHS England.

The key elements of CCG operating plans to be covered in a full narrative are set out in the following template. **The template asks that you outline any recovery or action plans where performance is not in line with trajectory. When detailing these, please provide specific actions, measureable ambitions and timeframes for delivery.**

The template should be completed and submitted **in draft by Tuesday 7th April.** The narrative will be reviewed alongside CCG activity data, financial planning data and UNIFY submissions.

CCG:	**Hammersmith & Fulham CCG**
Date:	**14th May-15**
CO signature:	**Clare Parker**

1. Delivery across the five domains and seven outcome measures

	Baseline measure to set a quantifiable ambition	Are you meeting the trajectory that was submitted as part of your 2014/15 operating plan? Please provide your 2014/15 ambition and performance to date.	If you are not meeting the trajectory, what actions are you taking in 2015/16 to recover? Please provide specific actions, measureable ambitions and timeframes for delivery.
Securing additional years of life for your local population	E.A.1 (annual) - Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare	The CCG has delivered reductions in 2012 and 2013 above the mandated 3.2% reduction, and therefore appears to be on trajectory to deliver the 2014 ambition.	The key to achieving this aim is partnership working to make the most of the services that have already been commissioned locally. In 2012/13, the direct causes of the bulk of the inequalities in life expectancy were circulatory disease, cancer and respiratory disease. The tri-borough CCGs' Public Health Project Manager has been working with relevant area leads within the CCG, local authority colleagues and NHS England and has carried out a mapping exercise that focuses on interventions currently commissioned to support the reduction of PYLL for the top three causes of mortality as per the Joint Strategic Needs Assessment document

			A benchmarking report / performance dashboard has been completed that identifies practices that are outliers in performance across a number of Public Health areas (including immunisations, seasonal flu and screening) and we use this to make targeted improvements. Plans are being developed for the revised extended access service for GP practices to include the requirement to provide flu, pneumococcal immunisations and childhood immunisations. **Respiratory disease** The current community respiratory service provides faster access for patients with respiratory illness to specialist care within a community or home environment, a reduction in avoidable emergency admission/outpatient referrals and improved integrated care management between secondary and primary care and community specialist professionals. It helps enable: • Minimised disease progression via improved early identification - so that people recognise the symptoms of lung disease and seek assessment and advice

			from healthcare professionals. • Good quality early diagnosis – so that people get an accurate, quality assured, diagnosis and that there is clear differentiation of COPD from asthma and other diseases. When diagnosed, people get good quality information on the illness and on the services available, both at diagnosis and throughout the course of their care. • High-quality care and support following diagnosis – by developing an organised and proactive multidisciplinary approach to the management of respiratory illness, including both chronic and acute care. Where admitted to hospital, specialist respiratory assessment on the referral will ensure that people with COPD are dealt with in a pathway that most meets their clinical needs. • Improved access to end of life care services. • Equity in care provision for people with severe COPD, regardless of setting. • Reduction in inappropriate conveyances to hospital.

			Cardiovascular disease A business case is under development for a new integrated cardio-respiratory service which supports further prevention around cardiovascular disease. There are also NHS health checks available to adults in England aged 40-74 without a pre-existing condition to check circulatory and vascular health and assess a patient's risk of getting a disabling vascular disease. **Cancer** • There is collaborative work under way improving cervical screening uptake across the three inner North West London CCGs in conjunction with NHS England and LA colleagues via quarterly joint CCG public health meetings. • Snapshot performance data is provided to relevant forums (practice nurses and practice managers). • A cancer clinical lead has been identified to offer professional input/guidance for H&F CCG. • Reviews are currently underway to look at latest practice profiles around cancer screening, diagnosis rates, referrals and

			referral to diagnosis conversion rates as part of PYLL project. • The “Transforming cancer services for London” team will be invited to attend future joint public health meetings to provide local intelligence and identify top cancer mortality areas. In addition to the above, childhood immunisations and flu immunisations help to improve PYLL by protecting spread of disease within the population, particularly to high risk groups. **Childhood immunisation** • Following on from the MMR1 local priority project in 2013-14, we are now continuing to work on improving children’s immunisations uptake across all vaccination areas for children aged 0 to 5 years. • There are regular updates to localities and practices plus snapshot performance pages are planned on each CCG extranet . • We are working with Imperial college and the Local Authority on providing additional support to member practices with low immunisations uptake.

			• We have developed a GP balanced scorecard that will be available to all member practices on the CCG's extranet with benchmarking uptake data across all immunisations, including RAG rating. • We have developed 'Good practice guidance' on immunisations due to be revised to reflect current and new programmes which will then be shared with member practices. • There is a Particular focus on improving uptake for MMR1 and MMR 2. This will now include Public Health Consultants from local authorities. **Seasonal Flu** • Seasonal flu planning starts in April-15. • The public health project manager provides weekly trend analysis of seasonal flu immunisation to the CCG using 'inform' from December (week 36) to end of January, with special focus on children's flu uptake during the campaigning period from October to end of March.

Improving the health related quality of life for people with long-term conditions, including mental health conditions	E.A.2 (annual) - Health related quality of life for people with long-term conditions	In 2013, the CCG delivered an improvement of 2.92%. We aimed for a further 0.2% improvement in 2014 against the 2012 baseline. 2015 trajectory will remain as submitted in 2014 Operating plan	Our Better Care Fund plan includes some specific policy developments to enhance patient and service user experience. A core focus is on providing joined up support for individuals with long-term conditions and complex health needs, including schemes to enable improved self-management and to extend current arrangements for personal health budgets. There has been broad engagement (including patients with long-term conditions and voluntary groups that represent them) to inform development of approaches to self-management. In addition, the ability to access personal health budgets (PHBs) is already starting to help those with continuing healthcare and mental health needs to make informed decisions around their care. Through the BCF, it is expected that PHB access will begin to be extended to those with long-term conditions. We have led development of a diabetes strategy across CWHHE with a focus on educational elements for patients, access to their own care plan and online

			communities. This is evidenced to improve outcomes and experience for diabetic patients. Please also refer to Community Independence Service and Whole Systems Integrated Care (WSIC) in section E.A.4.
Reducing the amount of time people spend avoidably in hospital	E.A.4 (quarterly) - Quality Premium Composite measure on emergency admissions	In 2013, the CCG delivered an improvement of 2.82%. In 2014 we aimed for a further reduction in avoidable admissions of 2.58% against the 2012 baseline. 2015 trajectory will remain as submitted in 2014 Operating plan	Significant redesign programmes are underway within Hammersmith & Fulham CCG to improve health related quality of life, reduce emergency admission and support older people to live independently at home following discharge. These are the Community Independence Service Plus and Whole Systems Integrated Care, which are outlined below. **Community Independence Service Plus** The Tri-borough CCGs and local authorities are commissioning a single, integrated Community Independence Service (CIS) in 2015/16. This builds upon the H&F "virtual ward" scheme which officially launched in 14/15. The Community Independence Service will provide a range of functions, including rapid response services to prevent people going into hospital, in reach services to support people with early

			discharge from hospital, and rehabilitation and reablement, which enable people to regain their independence and remain in their own homes. The single integrated CIS specification that has been developed for 2015/16 will ensure that there are consistent standards and services available across the Tri-borough. The specification proposes an integrated, multidisciplinary model of care that includes: • A Single Point of Referral into the service. • A rapid response multidisciplinary team (MDT) providing community care within 2 hours and for up to 5 days. • Non-bedded community rehabilitation, treating non-complex conditions in a community setting. • Integrated reablement with access to short term community beds for between 6 and 12 weeks. • 7 day support to help people

			leave hospital. This improved, integrated and standardised service aims to address an anticipated increase in demand for intermediate care services. It will also meet demand for care and support services in the community, especially home care and, for people with acute and complex needs to be safely cared for where appropriate. The integrated CIS will improve the person's and practitioner's experience of community- based care and drive improved quality and savings by treating people outside of the acute hospital setting. **Whole Systems Integrated Care (WSIC)** Hammersmith and Fulham CCG is building on its Whole Systems model of care in 2015/16. Our aim is to transform patient care by further developing our Community Independence Service (CIS), enhancing primary care and developing new approaches to prevention and self-care for a more comprehensive and proactive approach to keeping people healthy at

			home. Key elements of our 2015/16 programme of work include: • Building on existing programmes of work, such as the implementation of Patient Knows Best (an IT solution to share care information across primary and secondary care). • Working with the Lead Health and Lead Social Care Providers to implement the Tri-borough CIS. • Rolling out 19 new Out of Hospital contracts to enhance primary care locally. • Developing a second and third health and well-being hub in the centre and south of the borough. • Putting on a series of 'Simulation Event' workshops to identify and implement improvements to our care model (e.g. care planning, MDT working, case management and self-care) together with local patients and clinicians. This programme of work is designed to contribute to the successful first stage implementation of capitated budgets in

<table>
<tr><td></td><td></td><td></td><td>the borough by April 2017.</td></tr>
<tr><td>Increasing the proportion of older people living independently at home following discharge from hospital</td><td>E.A.S.3 (annual) - Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services</td><td>Note: as CCGs are not required to submit data against this measure, please include details of the ambition set in your Better Care Fund plan and any improvements against baseline.

<table><tr><td></td><td>Baseline (2013/14)</td><td>Planned 14/15</td><td>Planned 15/16</td></tr><tr><td>Annual %</td><td>92.9</td><td>89.2</td><td>89.8</td></tr><tr><td>Numerator</td><td>260</td><td>252</td><td>253</td></tr><tr><td>Denominator</td><td>280</td><td>282</td><td>282</td></tr><tr><td>Annual change in proportion</td><td></td><td>-3.7%</td><td>0.5%</td></tr><tr><td>Annual change in %</td><td></td><td>-3.9%</td><td>0.6%</td></tr></table>
Note: the 13/14 baseline data used is considered to be inaccurate (too high) owing to the changes in the law around data sharing between agencies</td><td>A key component of the BCF plan is the additional investment in health and social care through the CIS (see section E.A. 4) to enhance rehabilitation and reablement services. This should result in a reduction in residential and nursing home admissions as well as hospital re-admissions. Services will be integrated across health and social care, operating 8am to 8pm, 7 days a week, providing time-bound support for referrals via a single point of referral.

Other enabling schemes – such as commissioning and procurement of a new homecare service, and enhancements to social work components of hospital discharge – will support the CIS and help to maintain older people’s independence at home.

In summary, the BCF plan aims to support joint working to reduce long-term dependency across the health and social care systems, promoting independence and driving improvement in overall health and wellbeing.</td></tr>
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Increasing the number of people having a positive experience of hospital care	E.A.5 (annual) – Proportion of people having a positive experience of hospital care	In 2013, CCG reported an improvement of 5.24%. We aimed in 2014 for an improvement of 1.03% against the 2012 baseline. This needs refreshing now that the 2013 baseline is available.	The CCG is committed to working in partnership with patients, carers, the wider public and local partners to ensure that the services that are commissioned are responsive to the needs of the population. More specifically, the CCGs are committed to ensuring both the continuous improvement in patient experience and the overall quality of care that is provided locally. The CWHHE Patient and Carer Experience Strategy was co-designed with patients, carers and stakeholders. It has identified key priority areas that the CCG has committed to resourcing and these are reflected in the core quality schedule for 14/15. These include: • Ensuring that providers produce quarterly patient experience reports which: ○ Incorporate qualitative as well as quantitative data ○ Compare feedback from weekday and weekend services ○ Capture feedback that reflects the diversity of their patient and carer population ○ Include actions and evidence

			of improvements to address gaps in satisfaction and experience • Promoting patient and lay voice at a strategic level and in collaboration with CWHHE and North West London CCGs by ensuring that the following committees have lay partner representation: ○ Clinical Quality Groups ○ CCGs Quality, Patient Safety and Risk Committees ○ NWL Quality Working Group ○ CWHHE Quality, Patient Safety and Risk Committee which is also chaired by a Lay Member
Increasing the number of people having a positive experience of care outside hospital, in general practice and in the community	E.A.7 (annual) – Proportion of people having a positive experience of care outside hospital, in general practice and the community	In 2013, CCG delivered an improvement performance of 4.71%. We aimed in 2014 for an improvement of 13.4% against the 2012 baseline. 2015 trajectory will remain as submitted in 2014 Operating plan.	As part of the Prime Ministers Challenge Fund initiative, the CCG is supporting the GP Federation to further develop existing Patient Participation Groups. They will all be subscribing to the National Association of Patient Participation (NAPP) and workshops will be held with NAPP in the 2nd Quarter of 2015/16 to provide practices with the training and the techniques that they need to get the most of their Patient Participation Groups. The Federation is

			also working to ensure that there are mechanisms to capture real time patient feedback to influence service change and improve patient satisfaction with services. The CCG will be commissioning a suite of 19 Out of Hospital Services that patients across the borough are able to access. Patient engagement and feedback on the delivery of these out of hospital services will be a key and will form part of the regular reviews that the CCG will be having with the GP Federation. The CCG is also working in collaboration with health and social care organisations through the Whole Systems Integration and Transforming Primary Care Programmes to embed patient and carer experience at every stage of development and implementation of the Out of Hospital Strategy. This will include: • Ensuring that patients are actively involved in shared decision making and supported by clear information that it is appropriate to their needs. • Improving staff learning and experience (see workforce section).

			• Undertaking a Community Independence Service insight project in order to capture patients', service users' and carers' insight to enable us to have a baseline on which we can evaluate impact in the future.
Making significant progress towards eliminating avoidable deaths in our hospitals	E.A.8 (annual)	*Note: Indicator in development, this should be available for measuring a national ambition in Autumn 2015 and local ambitions in 2016/17.For the purpose of your 2015/16 operating plan, please outline any local measures currently in use and any improvements against baseline.*	The CCG's have been monitoring the Summary Hospital-level Mortality Indicator (SHMI), all providers are either 'as expected' or 'below expected' for the SHMI scores at present and throughout the year. One Trust has displayed a significant downward trend across a two year period. We are seeking further clarity as to the change that led to this positive trend. We await the full guidance later this year.

2. Improving Health: Your planned outcomes from taking the five steps recommended in the "commissioning for prevention" report

	Commentary
What analysis have you undertaken of key health problems?	As part of the QIPP review for 2015/16, the CCG has undertaken a comprehensive review of NHS England's "Commissioning for Value" packs which serve as a benchmarking tool to compare pathways across similar CCGs. The work included discussions and workshops which included clinical leads and management team members. We also work closely with public health colleagues who have supported us to identify priority areas of work relating to specific health needs in our population (see section 3). Over the year we will seek to build further our business intelligence capability to provide a more comprehensive view of past and current performance by providers at local level that will help us inform potential misalignment or variances in planning assumptions as part of our QIPP monitoring, but also as part of our planning exercise for 2016/17. This is underpinned by a major business intelligence project (WHYSE) to implement an easier front-end to access data. See response to E.A.1 for further information on our local early intervention programmes.
Based on this analysis, what are your priorities and common goals?	Our draft strategic objectives are as follows: • Objective 1: Enabling patients to take more control of their health and wellbeing • Objective 2: Securing high quality services that improve patients' experience and outcomes for patients and addressing health inequalities • Objective 3: Developing the mechanisms by which we can deliver high quality commissioning such as co-production with patients and co-commissioning primary care with NHS England • Objective 4: Working with partner organisations to deliver improved integration of services • Objective 5: Delivering strategic change programmes in the areas of primary care transformation,

mental health, whole systems integrated care, and hospital reconfiguration
- Objective 6: Delivering our statutory and organisational duties

As part of 'Breaking the cycle week' commencing 27th April-15, we will be able to refresh our strategic objectives.

Our contracting intentions give more details on our commissioning priorities:

FINAL HFCCG contracting intentions

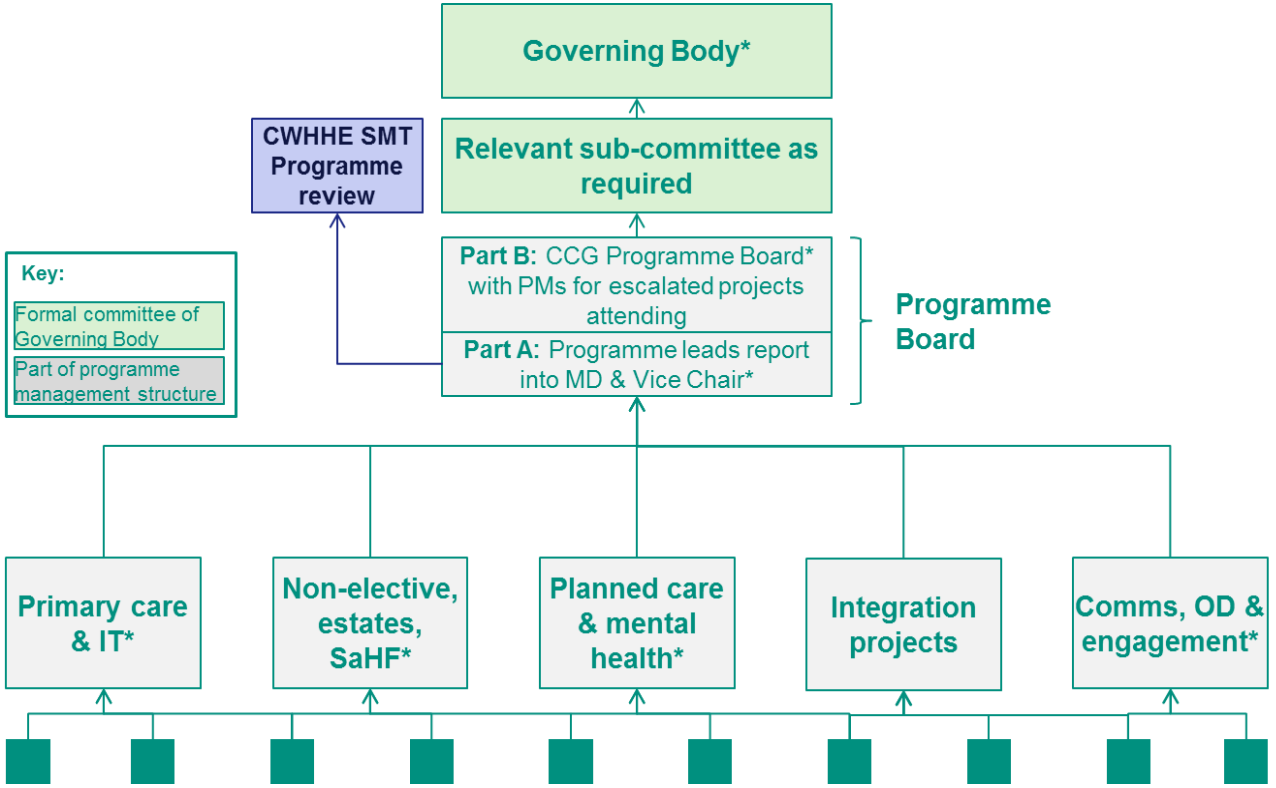
Have you identified your high impact programmes?

Priority projects which will support delivery of each our strategic objectives are as follows:

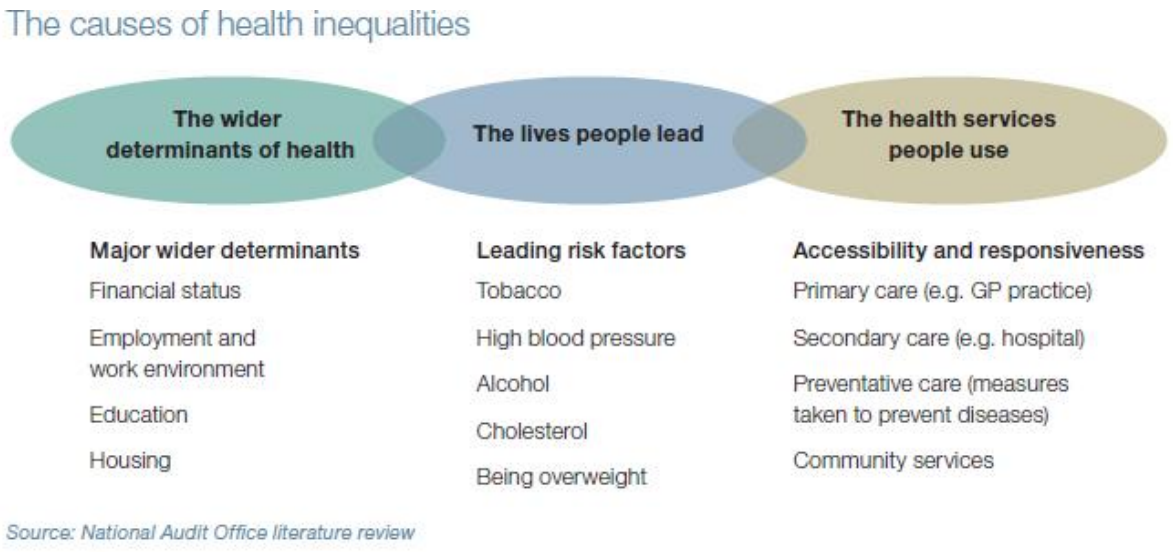
Strategic Objectives	Annual Objectives / Priority Projects	Outcome measure
Objective 1: Enabling patients to take more control of their health and wellbeing	• Diabetes self-management programme • Access to own records • Whole Systems Integrated Care • Children's hubs (north: live and south: planned) • Better Care Fund programmes (Community Independence Service, Nursing & residential care) • Prime Ministers Challenge Fund • Developing the business case for self-management Commissioning framework	• Measures in development through Better Care Fund programme and Whole Systems programme • NEL admissions reductions linked to CIS plus - 5% • Increase update of personal health budgets • Excess bed days reduction

	Objective 2: Securing high quality services and improved outcomes for patients	• IAPT- access, recovery, waiting times • Dementia / Dementia service procurement • Primary care transformation • Improving access to GPs • Urgent care centres • Mental Health • Out of Hospital Services	• IAPT targets in operating plan- access (16%), recovery (50%), waiting time to first treatment (85.4% in 6 weeks and 86% in 18 weeks) • Dementia diagnosis rate target in operating plan- 67% • Primary care targets in operating plan- experience of GP surgery (87%), experience of making appointment (72%) • Hammersmith & Charing Cross UCCs moved to 24/7 • Mental Health- psychiatric liaison service, PCMH workers
	Objective 3: Putting in place the infrastructure to deliver high quality commissioning	• MSK • Gynaecology • Ophthalmology • Developing our approach to patient involvement in commissioning (project)	• Performance reporting via QIPP schemes • NEL admissions reductions linked to CIS plus- 5% • Outpatient attendance activity shift into community
	Objective 4: Building relationships with local authorities and Health & Wellbeing Boards to deliver the Better Care Fund plan, and	•BCF work streams •Planned care •Public health (prevention) •Connecting care for children	•CIS Plus - reduction in NEL admissions of 5% •Outpatient attendance activity shift into community •PYLL and quality of life

	developing and delivering joint plans with other CCGs across North West London		•Local priority targets
	Objective 5: Delivering the Out of Hospital Strategy and acute hospital changes set out in the SaHF Strategy	• SaHF • Out of Hospital services • Formation of GP Federation • Whole Systems Integrated Care • Better Care Fund programmes (Community • Independence Service, Nursing & residential care) • Dementia service procurement • Urgent care reprocurement • IT plan • OD plan development	Primary care targets in operating plan • Experience of GP surgery (87%), experience of making appointment (72%) • Activity levels in hospital and community services
	Objective 6: Delivering our statutory and organisational duties	•NHS Constitution •Operating plan standards •Financial plans •QIPP plans •OD Plan development •IT strategy	•NHS Constitution measures •Financial reporting •QIPP performance •Operating plan measures
What are your plan resources?	Every Project Initiation Document (PID) includes a resource section which details resource required for the project. We also use a consistent scoring framework to assess proposed investments across the CCG and make decisions based on this framework.		

How will you measure progress?	See table above for measures against individual strategic objectives. We will use the following programme management structure to monitor progress in 15/16 with all of these meetings taking place on a monthly basis: 

3. Reducing health inequalities

Which groups of people in your area have the worst outcomes and experience of care? How are you planning to close the gap?	The people with the worst outcomes in Hammersmith and Fulham include those under the age of 75. Hammersmith and Fulham has a higher than average early death rate (in people under 75), particularly with CVD and cancer. This is much worse in areas of higher deprivation. Childhood obesity is also higher than the national average. The CCG has equalities objectives in place to ensure that there are better health outcomes for all as well as improved patient experience. The CCG collaborative is currently developing an equalities strategy across the five CCGs to ensure that these health inequalities are addressed. This will include a stakeholder survey to identify key priority areas across the Boroughs. Also refer to section E.A.1. for further information on prevention activities.
Does this include implementation of the five most cost-effective high impact interventions recommended by the NAO report on health inequalities?	The NAO report has identified 5 leading risk factors below: 

In addition, there are 3 cost-effective high impact interventions recommended in the report:

1. Increasing the number of smoking quitters through smoking cessation services;
2. Improving control of blood pressure through prescribing anti-hypertensive to patients at risk of or already diagnosed with cardiovascular disease; and
3. Reducing cholesterol levels through prescribing statins to patients at risk of or already diagnosed with cardiovascular disease.

The CCG and local authority partners are committed to delivering interventions in each of these three areas:

1. Smoking Cessation

Stopping Smoking is one of the top priorities for public health in H&F. We have commissioned a stop smoking quitting and prevention service. The service runs three national and three local prevention campaigns each year and works in schools and with young people to prevent the uptake of smoking.

In addition, the service works with GPs, pharmacies, community groups, hospitals and mental health trusts to promote and develop the stop smoking agenda, with specific targets for 4 week quitters (this refers to the number of people who have aimed to quit smoking and have then not smoked for a 4 week period). The targets are focused on areas of deprivation and amongst communities where smoking rates are highest. Work is also commissioned to support smoke free homes and cars; smoke free hospital grounds; and work with maternity services to reduce smoking amongst pregnant women.

The Smoke free Alliance brings together all agencies involved in tobacco control across the three boroughs, reviews KPIs on underage sales, illicit tobacco, counterfeit tobacco, compliance with the health act, numbers of quitters, and reviews progress across all the Smoke free agenda.

2. Ambulatory Blood Pressure Monitoring - Out of Hospital (OOH) Service

A key part of the H&F OOH strategy is the intent to support the continued development of high quality primary care at both a practice level and network of practices level. As part of this work, the

	CCGs are commissioning an Ambulatory Blood Pressure Monitoring service from practices. This service is aimed at adults who need a diagnosis of primary hypertension, particularly for patients with suspected "white-coat hypertension," and also in patients with apparent drug resistance, hypotensive symptoms with antihypertensive medications, episodic hypertension, and autonomic dysfunction to provide reliable, convenient and accurate blood pressure readings. The service will enable further assessment, enabling a more accurate assessment of blood pressure for those patients where this is clinically indicated. Practices will be expected to implement best practice prescribing guidelines as part of the model. **3. Supporting patients with cardiovascular disease** Hammersmith & Fulham CCG plan to procure a new community cardiology and respiratory service in 2016/17, which will support treatment and management of patients in community settings, closer to home. In addition the CCG is working to tackle obesity amongst adults and children in the H&F. Childhood obesity is one of the top five public health priorities in H&F. Data is collected on obesity for children through the National Child Measurement Programme. High rates of overweight and obese children have led to the recommissioning of children's weight management services and public health dietetics services. These interventions will bring all groups to work together around reducing childhood obesity through a series of bi-monthly meetings led by public health. For adults in tri-borough CCGs, including H&F, the NHS health check evaluation reveals that amongst otherwise healthy adults between 40-74 the proportion of overweight adults is 31%, obese adults 18% and physically inactive adults 17%. Following a health check, referrals are made to services including health trainers, Weight Watchers (with free vouchers), community dieticians, and physical activity programmes. In addition diabetes champions, community champions and physical activity champions all raise awareness in the community and signpost people to prevention programmes and services. **4. Other: Alcohol** 2015-16 will be a year of transformation for substance misuse services due to the re-procurement of

	core drug and core alcohol services. The new system, due to go live in April 2016, will have a greater focus on outreach and will be equipped to respond to a broader range of substance misuse to reflect local need. During the year there will be a number of alcohol initiatives developed with the intention of engaging residents who drink problematically but are treatment naive. Particular attention will be given to improving access to community alcohol detoxification within primary care and developing joint initiatives to help identification and engagement via the local hospitals. By strengthening pathways, we will aim to improve access for residents to community based treatment services and will reduce the burden that alcohol related hospital admissions has on the NHS.
How are you planning to reduce health inequalities for Looked After Children and people with a Learning Disability and offenders?	The CCG is working with the Local Authority and Safeguarding Children Board to: • Ensure that health assessments are completed in a timely way and are embedded into the individual child's care plan. • Use the care plans to inform the development of a clear profile of children looked after by Hounslow including age, gender, culture, specific health needs. • Identify specific areas of vulnerability for LAC such as child sexual exploitation. • Consider location of placement and identify gaps in provision whether locally or out of borough. • Agree priorities for 2016/17 commissioning intentions for LAC to address gaps. • Ensure that LAC is kept visible at LSCBs and that both borough and system wide views are taken. • The tri-borough CCGs all have action plans from the LD SAF to improve health outcomes and reduce health inequalities for people with Learning Disabilities. Adults reducing re-offending services are commissioned across tri-borough. The services work with offenders to try and reduce their offending. As part of this, they will produce a care plan to identify any support needs they may have and refer on to specialist agencies as required.
What progress have you made in implementing Equality Delivery System (EDS2)?	The CCG has published progress against equality objectives for 2013 in accordance with EDS2 Requirements. The Equalities Objectives have been identified in consultation with patients, service

	users and 3rd sector organisations. The priority areas include:
	
	• Improving the quality of data collection in relation to patient experience by providers by ensuring that all data reports for 15/16 include:
	  ○ 80% of data relevant to equalities groups within the local area
	  ○ Relevant to reasons for access and non-access
	  ○ Actions taken to improve equalities outcomes
	• Health and wellbeing for young carers.
	• Health and wellbeing for adults with autism.
	• Reducing social isolation for adults with learning disabilities.
	• Reducing social isolation for older adults.
	• Improved access to bilingual counselling.
	• Improved access to mental health services , including 'Improved Access to Psychological Therapies' (IAPT) for:
	  ○ Older adults
	  ○ Young people (18 – 25)
	  ○ People with a long term condition
	  ○ Carers
	  ○ BME communities
	
	The CCG is also working in partnership with Collaborative CCGs through the CWHHE Equalities Reference Group to:
	
	• Promote peer learning and review of equality plans and progress.
	• Embed Equalities Analysis in all aspects of CCG business - the inclusion of equalities analysis within all policies/proposals being sent to governing bodies across the CWHHE collaborative. For purposes of quality assurances, all equalities analysis will have to be sent and approved by the Assistant Director of Equalities before proposals are submitted to governing bodies.
	• Implementing Governing Body Leadership in Equalities Seminar

4. Quality - Responding to Francis, Berwick and Winterbourne View

	What quantifiable progress has been made in 14/15?	What quantifiable ambitions are in place for 2015/16? What action plans are agreed to deliver this and over what timeframe?	Supporting documents / references
What is your ambition for quality improvement in response to Francis, Berwick and Winterbourne View	Winterbourne View project across 8 CCGs	Develop commissioning framework across the 5 CCGs for Winterbourne View to improve access to local community services with specialist support.	Mental Health - LD.docx
What is your ambition for reducing the number of inpatients beds for people with a learning disability and improving the availability of community services for people with a learning disability?	Work has been achieved to reduce the number of people placed in inpatient beds. This is reported to NHS England on a fortnightly basis. The CCG has cooperated with NHS England in carrying out Care and Treatment Reviews on those where there are difficulties in finding appropriate placements.	There are discharge plans in place for any patient who remains in an inappropriate ATU placement. By the end of Q2 a business case will be developed by each of the CCGs to consider and that will provide options for the commissioning of local services to reduce the need to use out of area assessment and treatment places and to improve the local crisis, respite responses and potentially specialist community services including those to support some clients with a forensic history.	WinterB reducing the number of inpatients WinterB reducing the number of inpatients

Quality – Patient Safety			
How are you addressing the need to understand and measure the harm that can occur in healthcare services? *For example, duty of candour, HCAI and CQC themes and action reports related to providers from 2014/15.*	Using information from the reporting and investigation of serious incidents, the Quality and Safety Team works with colleagues across the five CCG's to improve the quality and safety of NHS commissioned services across The North West London Collaborative of Clinical Commissioning Groups. The sole purpose of reporting serious patient safety incidents is to generate and share learning to prevent harm to patients recurring. The Key Performance Indicators for providers for the Reporting and Investigating of Serious Incidents are: • To report on the Strategic Executive Information System	In addition to safety assurance activity, the Collaborative Patient Safety Strategy (2015-16) will outline plans for a health system-wide improvement programme aimed at reducing harm from Pressure Ulcers. Pressure Ulcers continue to reflect a high human and financial cost and the success of provider trust approaches to reduce Pressure Ulcers is often an indicator of quality and safety in the organisation. The programme will use the Breakthrough Series Collaborative approach pioneered by the Institute for Healthcare Improvement and used with great success in the QIPP Safe Care Programme in 2011-12.	 CQG ToR - Final Draft.pdf

	(STEIS) within 48 hours, the details of healthcare incidents meeting the nationally agreed definition of a Serious Incident. • To investigate using robust and reliable investigation techniques and submit a report to commissioners within 45 working days. • To develop an action plan designed to prevent recurrence and submit with the investigation report. • To be open and transparent with patient and their families about the incident, it's investigation and outcomes. • To demonstrate an open patient safety culture through high reporting numbers, and by learning lessons from investigations and not repeating the same		

	mistakes. These KPI are subject to amendment in the new National Framework for Reporting and investigating Serious Incidents which is due to be published in March 2015. This revised Framework will provide the basis for the Collaborative Patient Safety Strategy. The Patient Safety Team quality assures investigation reports received from providers, returning reports which fail to meet quality standards. A monthly report to Quality, Patient Safety and Risk Committees details provider performance over a six month period. This report will identify themes and trends from investigations. The Assistant Directors work together to identify remedies and to agree approaches with providers to improve quality and patient safety.		

	Data from a number of sources is used to create a broad picture of the organisational patient safety culture. In addition to STEIS, data form the National Reporting and Learning Service and the NHS Safety Thermometer help to understand the approach a provider has to safety, to data and to the use of data for improvement.		
How are you increasing the reporting of harm to patients, particularly in primary care with a focus on learning and improvement?	GPs are encouraged to report their concerns and CCGs have systems in place to gather intelligence on primary care services. The CCGs supported and funded the Practice Nurse Development Programme for primary care nurses in CWHHE.	The quality team will work closely with NHS England to develop systems and processes to further support the development of a reporting and learning culture in primary care. In 15/16 the CCGs and HENWL have supported the creation of fixed term posts to support the further development of practice nurses.	
How are you tackling sepsis and acute kidney injury?	• The Sepsis alert (Sept 14) was sent to all Trust IPC teams and discussion has taken place with them regarding its implementation: http://www.england.nhs.uk/wp-content/uploads/2014/09/psa-sepsis.pdf	• A quality indicator on Sepsis has been included in Trust Quality Schedules for 2015/16 (acute, community and mental health), which Trusts will be required to report on quarterly to CQGs. • Work will take place to encourage Trusts to adopt the NHS urinary catheter passport, to improve	

	• A Sepsis Workshop was jointly coordinated with NHSE and the UK Sepsis Trust in Feb 2015, attended by 40 senior clinicians from across the health economy, to discuss and share approaches. • All cases of MRSA sepsis are reviewed (whether Trust or CCG attributed) for any lessons to be learnt and action plans are monitored. • All RCAs from SIs linked to sepsis are reviewed by the Quality Team.	communication on catheter management between all care providers and avoid associated sepsis. The need for this has been identified through MRSA Post Infection Reviews in 2014/15 identifying catheters as a risk for sepsis. • The Sepsis CQUIN – is being implemented in trusts who have accepted the 14/15 tariff arrangements and the plan is that it will locally negotiated for those trust who have not accepted this. • Acute kidney information is being included in the templates for discharge from hospital.	
How are you improving antibiotic prescribing in primary and secondary care and how?	**Primary Care** Each CCG has had initiatives in 2014/15 which focus on improving antibiotic prescribing. All CCGs monitor antibiotic prescribing and identify GP practices which our outliers when compared with others. Ealing and West London CCGs have been working with their local acute trusts to produce local antimicrobial prescribing guidelines. All the other CCGs in CWHHE have antibiotic prescribing indicators within their	**Primary Care** Each CCG has agreed initiatives which will continue to focus on antibiotic prescribing in 2015/16. In each CCG there will be 2 indicators within GP Prescribing Incentive Schemes which focus on: • Overall volume of antibiotic prescribing measured as quantity of antibiotics prescribed per 1000 antibiotic STAR PU • Appropriate choice of antibiotic measured as, for example, number of oral cephalosporin quinolone and co-amoxiclav items as a percentage of all antibiotic	Trust IPC guidance.docx

	Prescribing Incentive Scheme which focus on both quantity of antibiotics prescribed and choice (reflecting national guidelines). CCG Medicines Management Pharmacists are members of the multi-disciplinary Infection Clinical Network. CCG pharmacists have taken the opportunity to present to GP networks on good antimicrobial stewardship and promote resources such as the TARGET tool-kit. **Secondary care** • This issue is discussed with IPC teams/antimicrobial prescribing leads at quarterly meetings and is a standing item on the quarterly Infection Clinical Network agenda. • Results of Trust antimicrobial prescribing audits have been reviewed during 2014/15 and scrutiny applied to the development and implementation of action plans.	items or percentage of preferred antibiotics prescribed Exact targets for improvement will be set when e-PACT data for 2014/15 is released. Each CCG has plans to discuss whether additional actions are required to address the antibiotic elements of the Quality Premium. Regular meetings between primary care and secondary care pharmacists to discuss cross-sector antimicrobial issues are being planned from quarter 1 2015/16. **Secondary care** • A quality indicator on antimicrobial prescribing is included in acute Trust Quality Schedules for 2015/16. • Trusts will participate in the data validation exercise linked to the CCG Quality Premium in 2015/16 (one large acute Trust participated in the pilot exercise). CCGs await further information on the detail of this, and in due course the prescribing indicators anticipated for 2016/17. • The CCG Antimicrobial Lead Pharmacist will attend the Imperial Antimicrobial Review Group to	

		provide oversight for commissioners on the effective management of this function.	

Quality – Patient Experience

Have you set measureable ambitions to reduce poor experience of inpatient care and poor experience in general practice. How will you deliver against your ambitions? *Suggestions include FFT, PPG development – reference to CQC and action reports.*	The CCG is committed to working in partnership with patients, carers, the wider public and local partners to ensure that the services that are commissioned are responsive to the needs of the population. More specifically, the CCGs are committed to ensuring both the continuous improvement in patient experience and the overall quality of care that is provided locally. Our Patient and Carer Experience Strategy was co-designed with patients, carers and stakeholders, to ensure it has identified key areas of priorities that the CCG has committed to resourcing and these are reflected in core quality schedule for 14/15. These include: Ensuring that providers produce quarterly patient experience reports which: ○ incorporate qualitative as well as quantitative data including FFT data and narrative comments ○ compare feedback from weekday and weekend services ○ capture feedback that reflects the diversity of their patient and carer population ○ Where poor experience has been identified, the report will include actions and evidence of improvements to address gaps in satisfaction and experience Working in collaboration with Health and Social Care organisations through the Whole systems Integration and Transforming Primary Care Programmes, embed patient and carer experience at every stage of development and implementation. More specifically to: ○ Ensure that patients are actively involved in shared decision making and supported by clear information that it appropriate to the patient and carer needs ○ Improve staff learning and experience

	○ To undertake a Community Independent Service insight project in order to capture patients, service users and carers insight to enable us to have a baseline on which we can evaluate impact in the future Promoting patient and lay voice at a strategic level and in collaboration with CWHHE and North West London CCGs by ensuring that the following Committees have lay and patient representation: ○ Clinical Quality Groups ○ CCGs Quality, Patient Safety and Risk Committees ○ NWL Quality Working Group ○ H&F CCG Finance & Performance Committee and Patient Reference Group is chaired by a Lay member ○ H&F CCG OD and Engagement Committee is also attended by 2 Lay members, once of whom is the vice-chair
How will you assess the quality of care experienced by vulnerable groups of patients and how and where experiences will be improved for patients? *Suggestions include CQC reports, care homes and domiciliary care.*	• The CCG Quality, Patient safety and Safeguarding teams work closely together, have established links with local Healthwatch and now have a structured formalised process for reporting of 'Dignity Champions' visits to provider organisations. These reports are received and then shared with the Clinical Quality Groups where actions are monitored. • There is a provider concerns meeting at which the CCG, safeguarding and local authority partners come together to discuss care homes causing concern or to take a joint approach to addressing issues that arise. • Safeguarding Information Sharing panels have been established in each borough to which the CQC are also invited participants.
How will you demonstrate improvements from FFT, complaints and other feedback?	The CCGs will work closely with the provider organisations that are required to produce quarterly reports addressing patient experience through information from FFT, complaints and the link with incident reporting.
How will you ensure that all the NHS Constitution patient rights and commitments to patients are met?	The CCGs will ensure that the principles of the NHS constitution enable patients' rights to be met through working closely with lay partners as equals at committees, in procurement. In our review and assurance of the services commissioned by the CCGs.
How will you ensure that the recommendations of the Caldicott Review relevant to patient experience are implemented?	During 2014/15 the CCGs have been working with a diverse range of stakeholders to further the principles outlined in the Caldicott 2 review. A governance framework has been established across the health economy to facilitate the sharing of patient records for direct patient care. A memorandum of understanding (MOU) for the sharing of records for direct patient care has been developed that

	sites best practice and legal frameworks that apply across the NHS. This MOU has been cited as good practice in the Independent Information Governance Oversight Panel's report to the Secretary of State for Health in 2014. All provider Trusts in North West London, all other healthcare providers and all primary care providers have signed up to the memorandum of understanding. Patient and staff information materials have been produced and circulated initially across all GP practices (see attached example leaflet). Also during 2014/15 GP practices have enabled the functionality to provide online access for patients to their GP held records. During 2015/16 the CCG will be embedding and deploying the preparatory work carried out during 2014/15. This will involve : • Enabling IT systems across the health economy to adhere to the mechanisms outlined in the memorandum of understanding. • Further establishing a NW London regular forum of data controllers in common for the governance and management of patient information flows and increase confidence in organisations and patients in the secure sharing of patient records. • Establishing workflow processes where patients are routinely asked to provide explicit consent to share their records at point of registration and referral. • Increasing public and staff awareness across the health economy to understand the principles and mechanisms of patient record sharing. • Encouraging more patients to access their online records and on line services through their GP practice through awareness raising campaigns. • Establishing a website and a help line for further information provision or queries from staff and patients.

Quality – Compassion in practice

How will you ensure that local providers are delivering against the six action areas of Compassion in Practice?	The 2015/16 quality schedules include specific requirements for all providers to report on how the nursing and quality strategies demonstrate Compassion in Practice.
How are you working with providers to ensure the roll out 6C's across all staff groups?	• The CCG's Quality Strategy is in development – provider organisations have been given the opportunity to contribute to the strategy and to link us with local provider strategies. • The CCGs are supporting providers through clinical walk rounds, peer reviews, and patient experience feedback systems which are discussed at monthly Clinical Quality review groups. Where areas are causing concern there are direct discussions with the nursing and medical directors by the clinical leads within the CCGs to address those areas. • In the tri-borough area Compassion in Practice has been a focus for care homes.

Quality – Staff Satisfaction

What is your understanding of the factors affecting staff satisfaction in the local health economy and how staff satisfaction locally benchmarks against others? *Suggestions include FFT for staff, annual staff surveys, care homes and domiciliary care.*	The factors impacting on staff are multifactorial and include staff satisfaction; in areas where this is low it is clear that patient experience and FFT are also low. CWHHE have captured patient, service user and carer feedback as part of the engagement with patients, service, users, carers and frontline staff to co-design the Patient Experience Strategy (attached below). The strategy makes explicit reference to the impact of staff experience on improving patient experience. The Quality team has produced an annual review of data relating to patient experience, which also captures staff experience (attached below). The report is shared with all providers to enable for discussion and action at the Clinical Quality Group Meetings. CWHHE Patient Experience Strategy . Annual Patient Experience Quality R

How will you ensure measureable improvements in staff experience in order to improve patient experience? *Suggestions include London BME standards, linkage to patient staffing surveys.*	In 2015/16 the CCGs' quality teams will be requesting providers to analyse the link between the ward staffing submissions, staff experience and patient experience, assessing how the planned and actual staffing is impacting on patient care.

Seven Day Services

How will you make significant progress in 2015/16 to implement at least 5 of the 10 clinical standards for seven day working, supported by a Service Delivery and Improvement Plan (SDIP) with providers?	There are two key work streams in Hammersmith & Fulham CCG to progress implementation of 7 day services in 2015/16:
	
	1. **Commissioning and contracting**: to commission providers to deliver services in line with the national seven day standards, including:
	  ○ SDIP: working collaboratively with Imperial College Healthcare NHS Trust (ICHT) to develop an SDIP plan to implement at least 5 clinical standards for seven day working, and then monitoring implementation over the course of 2015/16.
	  ○ CQUINs: regional 7 day working CQUINs have been developed for acute, mental health and community providers, and while the selected ICHT tariff does not support CQUINs, H&F CCG will ensure that community providers, including Central London Healthcare NHS Trust (CLCH), develop their 7 day working CQUIN in collaboration with other stakeholders across the local health and care system, through the Imperial Urgent Care Board.
	
	2. **System design**: to lead the design and implementation of the local 'out of hospital' changes required to support 7 day admission avoidance and discharge, including through:
	  ○ The Imperial Urgent Care Board, with representation across the local urgent care pathway
	  ○ The Triborough Better Care Fund, including the new 7-day Community Independence Service delivering integrated 7 day rapid response and discharge support services

	(including social care). In addition, North West London CCGs are working collaboratively as an 'Early Adopter' for Seven Day Services, and a set of key activities that can be 'done once and shared' will be prioritised on a pan-NWL basis for completion in 2015/16.

Safeguarding: Adults and Children	
How do you plan to meet the requirements of the Accountability and Assurance Framework for protecting vulnerable people (adults and children)? *Suggestions include the Care Act Implementation, Prevent, FGM and CSE.*	The CCG will maintain and develop the safeguarding team to ensure that it continues to meet the requirements of the Accountability and Assurance Framework. The priorities for 2015/16 for safeguarding children are: • Ensure that the statutory roles are filled and any vacant posts are filled within appropriate timescales • Develop the strategic aspects of the Designated LAC roles to embed within the work of the CCGs • Complete the review of the provision of FGM services across the area and use this to inform service design • Work with the LSCB to develop the CSE strategy and identify health services to support those abused The priorities for 2015/16 for safeguarding adults are to: ○ implement the Care Act (2015) requirements for safeguarding through reviewing capacity, roles and responsibilities ○ improve the functions in relation to the CCG responsibilities for Prevent and MCA ○ work with the Safeguarding Adults Board to develop a learning and improvement framework through safeguarding adult reviews ○ strengthen the monitoring of compliance by commissioned services
What is the ambition for quality improvement in child and adult safeguarding?	The CCG will work with partners to satisfy legislative requirements e.g. the Children Act 2004 and Care Act 2014 through contractual measures and quarterly reporting on how commissioned providers maintain safe structures and leadership for safeguarding, training compliance, evidence of

Suggestions include the identification of a baseline including preventing harm (minimisation of SCRs for adult and children through integration with the Local Authority and early help and domestic violence agenda).	learning from cases and reports both local and national. Additionally, the CCG will continue to have an overview of the whole local health economy in relation to issues that impact on the welfare of children and young people, including gathering information from services not commissioned by the CCG. The CCG will continue to work with the Local Authority, partners, Health and Wellbeing Board and Local Safeguarding Boards to: • Utilise the JSNA and serious case reviews (from the previous 5 years) to identify the vulnerability factors for children and adults • Review the outcome frameworks for children and adults in providing evidence of quality Improvement • Continue to encourage health engagement with local safeguarding boards for children and adults • Review the health involvement with the Violence Against Women and Girls Strategic Group to ensure that commissioned services are engaged and that CCG is effectively informed in developing its commissioning intentions for 2016/17 • Review effectiveness of service design in addressing known vulnerability factors such as mobile families, marginalisation of young people and adults, child sexual exploitation and FGM, dementia and others with care and support needs
How will improvement be achieved in the application of the Mental Capacity Act (House of Lords Recommendation 2014)? *Please take into account Cheshire West (DOLS) and Commissioning for Compliance.*	As a CCG we wish to be assured that the services we are commissioning on behalf of our local populations are being delivered in a way that respects and supports the rights of individuals in particular those that may not be able to take decisions on their own behalf. This is the policy framework that the CCGs expect the providers to have in place and to report on: • An MCA policy • An MCA lead • Evidence of MCA-compliant capacity assessments and best interests decision-making documentation and procedures • Evidence that rights of patients and compliance with the Act are being recognised and actioned within care planning, policies, guidance and training • Evidence that the MCA is linked into the provider's systems and processes relating to improving service users' experience and the quality of their care and treatment

	• Evidence of patient access to advocacy Following the Cheshire West judgement the CCG acknowledges that the threshold for DoLs has been altered and, therefore, the CCG will be seeking assurance that care providers: • Are aware of the Supreme Court judgement • Have plans in place to map requirements for Best Interest Assessors (BIAs) and work collaboratively with other providers to reduce training costs The CCG will undertake deep dive audits of case files in collaboration with care providers and the Local Authority to assess the level of health compliance with the Cheshire West judgement. The CCG will work with the Safeguarding Adult Board to undertake an annual review of progress. For DOLs the CCG expects: • Evidence the provider is aware of their responsibility to report DoLS authorisation applications and the outcome to the CQC • Evidence that the safeguards feature in reports relating to the care and treatment of at risk patients particularly those with dementia, a mental illness or learning disability, acquired brain injury etc • Staff has access to the DoLS Code of Practice • Staff have access to legal advisors who are familiar with the safeguards and can brief them on necessary DoLS related case law • There is policy and procedure covering DoLS in providers' MCA policy or a separate policy but linked to the MCA policy • There is staff training on the DoLS safeguards • Guidance and training on care planning covers the importance of staff being aware of the safeguards in cases where restriction and restraint might be in the patient's best interests • Staff knows how to access the various DoLS authorisation forms, have had training on their completion and know where they should be submitted Following the Cheshire West judgement the CCG acknowledges that threshold for DoLs has been altered and, therefore, the CCG will be seeking assurance that care providers: • Are aware of the Supreme Court judgment

	• Have plans in place to map requirements for Best Interest Assessors (BIAs) and work collaboratively with other providers to reduce training costs The CCG will undertake deep dive audits of case files in collaboration with care providers and the Local Authority to assess the level of health compliance with the Cheshire West judgement. The CCG will work with the Safeguarding Adult Board to undertake an annual review of progress.
What improvements will be made through the Implementation of the Care Act from April 2015? *Please take into account statutory requirements including the Statutory Duty to Corporate with the Local Authority and widening of scope of safeguarding to include Human Trafficking, Domestic Violence and Modern Slavery, self-neglect.*	The CCG will continue to work with the Local Authority to ensure that there is effective cooperation in recognising and responding to safeguarding issues. This will include further development of the Safeguarding Adult Board to ensure it receives the resources to implement its strategic plan to intervene in cases of abuse and neglect and work to identify vulnerability factors and establish preventative measures.
How will you measure the requirements set out in plans in order to meet the standards in the prevent agenda (taking into account Tier 1-3 priority areas)?	The CCG will work with commissioned services, partners and the Local Authority to develop and implement a strategic Prevent plan. This will focus on improving the awareness and training of staff across agencies. Prevent training compliance has been included in the quality schedule for 2015/16 with commissioned services required to report on compliance on a quarterly basis.

Workforce

What are the workforce implications from your 2015/16 operational plans and how will these be addressed?	**Non-elective** The Lead Health Provider for the Community Independence Service is working closely with HENWL and partners in the health and social care system to develop new workforce models and to anticipate

	and plan for changes in health care provision over the next 5-10 years, addressing specific gaps in the GP workforce, therapists and community and district nursing. Some of the forecast deficit in these areas will result in retraining of existing staff and some will be met by the establishment of a new pipeline of appropriately skilled staff to work in integrated, community-based models. **Planned care** We are focussed on maintaining a stable permanent workforce throughout all our transformational programmes. There are a number of TUPE implications of planned care service changes in 15/16. Nursing staff are expected to TUPE from the local community provider to secondary care for TB. Staffs are expected to TUPE from secondary care to the new Community Ophthalmology Service which is due to go live during 15/16. We are expecting to implement a Tri-borough Tissue Viability service during 15/16 and a small increase in clinical workforce will be required in this area for Hammersmith and Fulham as a result. The Community Dermatology service will also be increasing in capacity requiring the recruitment of a small clinical workforce in early 2015/16. During 15/16 we are developing plans to implement a Dementia Memory Service to go live in April 16; the service model is expected to shift from a secondary care focussed model to one centred on primary care delivery. We are therefore in the process of identifying the workforce implications of this for GPs, consultants and other support roles. **Paediatric care** The key objectives of the Connecting Care for Children project are to increase the skills and capacity within primary care to manage patients in the community and avoid unnecessary unscheduled care and inappropriate referrals to paediatric outpatient clinics. This will be achieved through • GPs leading joint community paediatric GP clinics with consultant paediatricians and specialist allergy clinicians and by sharing case studies at the MDTs • Involving and improving links with other professionals such as health visitors, social workers and school nurses

	Primary Care The delivery of the full range of Out of Hospital Services by GP Practices working under the GP Federation umbrella will have implications on workforce capacity. Through funding received through Health Education North West London(HENWL), a programme of training to provide relevant staff with the skills that they need to provide the new services (as per service specifications) will be delivered in the first quarter of 2015/16. In addition to this and as part of the HENWL funds, the CCG will also be providing training for the following: • Accredited training for Health Care Assistants so that they can develop their role within the practice to play an active part in the delivery of OOH services • Receptionist / customer care training, to ensure that practice staff have the appropriate skills to offer the best customer service experience to our patients • Empathy training for our clinicians to ensure that they have the tools to effectively manage difficult and aggressive patients to again ensure that patients have the best experience and make the best use of practitioners time • Developmental training opportunities to support Practice Managers and their staff to anticipate the challenges that lie ahead in terms of service delivery and workforce implications • Practice nurse appraisal training so that Practices Nurses can develop their role in the Practice to play an active part in the delivery of OOH services HENWL have also block commissioned two additional training areas: • Motivational Interviewing – to provide clinical staff with an understanding of the specific interventions associated with the motivational interviewing counselling style. This training programme aims to enable staff to acquire competence, confidence and capability to work in partnership with patients and carers in order to promote healthier lifestyles and understand the techniques to encourage and support behaviour change and health gain. • Introduction to primary care workforce planning - to provide staff working in general practices with an understanding of the basic principles of primary care workforce planning in order to

	support future service delivery. The course will provide an overview of all aspects of workforce planning including the acquisition and analysis of data, the development of a supporting narrative to accompany staffing figures and forecasting future workforce requirements, particularly in the context of whole systems service redesign in North West London.
How are you developing a workforce that is able to work across acute and community boundaries?	**Whole Systems Integrated Care (WSIC)** Our series of Simulation Events, used to engage with a range of patients, carers and health and social care professionals, in April 2015 will be used to identify improvements to be made to Hammersmith and Fulham's Whole Systems model of care. Following these events, an implementation plan will be developed to embed improvements, accounting for workforce development requirements in the medium to long -term. One way that we will develop our Whole Systems workforce is through engagement with the Change Academy, which is a workforce and organisational development programme, procured by North West London, targeted at three levels: • Senior system sponsors; • System leaders; and • Integrated care teams and team leaders. See section E.A.4 for more detail on the WSIC programme.

5. Constitution Standards – RTT, A&E, Cancer, Mental Health Plans should demonstrate the commissioning of sufficient services, based on robust demand planning, to deliver the NHS Constitution rights and pledges for patients on access to treatment as set out in Annex B of the planning guidance and how they will be maintained during busy periods. Where standards have not been met in 2014/15, details should be provided of specific steps being taken to ensure improvement this year, measureable ambitions for improvement and timelines for delivery.	
RTT and Diagnostics	
Does your provider have residual RTT backlogs - patients waiting over 18 weeks on either admitted or non-admitted pathways - who will need to be treated in 2015/16 in order to support sustainable delivery of the RTT standards?	ICHT - Yes West Middlesex - No Chelsea & Westminster - No LNWHT - Yes
If yes, have you agreed an additional activity profile with that provider (which is likely to be above and beyond BAU activity) to manage those backlogs?	Via the contracting round additional activity is being identified at specialty level to ensure that any residual backlogs going in to 15/16 are commissioned for and delivered. Detailed capacity and demand work has been and is being undertaken early in 15/16 to ensure that providers have critically reviewed their service and understand what recovery and sustainability looks like going forward. The NWL performance team are leading this work and monitoring delivery action plans to ensure commitments are met. Some risks remain around date quality with ICHT which is being reviewed on a weekly basis.
Have you agreed the timeline required for this additional activity –ensuring that patients are treated as quickly as possible?	This is being agreed through the contract process and is being supported by the NWL performance team. Providers and Commissioners focus is on treating patient is order of wait ensuring the longest waiters are treated as a priority. ICHT currently has a data quality RAP in place due to on-going Cerner issues.
Have you agreed performance trajectories based on the profile of backlogs and the timeline required to clear them? I.e. managing backlogs is likely to mean that the performance measures may not be achieved until	Recovery trajectories are in place for challenged providers, Performance is not being achieved at ICHT or LNWHT and is subject to the process described above to ensure recovery and delivery going in to Q1 of 15/16.

they are managed back to a sustainable level.	
Have you and the provider agreed a RTT recovery plan based on the above information?	This work is underway for our challenged providers (ICHT and LNWHT), a key part of this is the conclusion of the detailed Demand & Capacity work and the completion of the contracting round where agreement will be reached for additional activity required to recover performance as well as delivering.
Has your provider(s) completed detailed demand and capacity modelling at speciality level for non-admitted and admitted activity – and have they shared this with you?	ICHT is the last remaining provider to complete the full Capacity & Demand work, this is being undertaken in April with support and will inform the conclusion of the contracting round to ensure the right level of activity is commissioned to recover any underperformance and maintain that level of performance through the year.
Has this been used to calculate elective capacity and activity for 2015/16?	For all providers this will be used to inform the contracting round.
Does the Trust have sufficient capacity to meet demand or will alternative providers need to be identified and agreed?	The expectation is that the providers of elective services will undertake the required level of activity to deliver the standards as agreed via the contracting round.
If the Trust(s) has backlogs to clear in 2015/16 have these been profiled against BAU demand and capacity/run rates?	Yes, this has been included for providers where this has been identified.
Does the Trust(s) have sufficient capacity to deliver both BAU run rates and clear backlog or will alternative providers need to be identified to support the backlog activity and ensure that patients are treated as quickly as possible?	The expectation is that the providers of elective services will undertake the required level of activity to deliver the standards as agreed via the contracting round.

<table>
<tr><th colspan="2">A&E Waits</th></tr>
<tr><td>By each A&E provider, provide your performance against the 4 hour standard for each quarter of 2014/15. How did this vary from your planned trajectory?</td><td>
<table>
<tr><th colspan="5">All Types A&E Performance</th></tr>
<tr><th></th><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr>
<tr><td>ChelWest</td><td>97.38%</td><td>95.92%</td><td>95.65%</td><td>96.46%</td></tr>
<tr><td>ICHT</td><td>95.87%</td><td>95.58%</td><td>91.21%</td><td>92.00%</td></tr>
<tr><td>LNWHT</td><td></td><td></td><td>87.33%</td><td>88.57%</td></tr>
<tr><td>EHT</td><td>97.31%</td><td>96.30%</td><td></td><td></td></tr>
<tr><td>NWLHT</td><td>92.06%</td><td>91.66%</td><td></td><td></td></tr>
<tr><td>THH</td><td>95.47%</td><td>95.28%</td><td>92.47%</td><td>93.64%</td></tr>
<tr><td>WMUH</td><td>96.45%</td><td>96.90%</td><td>93.39%</td><td>93.50%</td></tr>
</table>
*Please note this is provider performance not CCG registered population
</td></tr>
<tr><td>Where 4 hour performance did not meet trajectory, have the major factors affecting performance been identified?</td><td>There have been a significant number of varying and complicated issues impacting A&E performance during 14/15. NWL providers have all had a challenging winter period with increased levels of demand. McKinsey have been working with both ICHT and LNWHT to develop a single version of the truth. This work is being jointly managed across providers and commissioners. This work is yet to be completed and has been extended in scope and sites covered. The various SRGs are sighted on this work and will be taking on the monitoring and implementation of recovery plans that come out of that work.

The main issues have been identified as
Patient flow
Demand
Senior decision makers at the front door
Step down capacity of the appropriate type.
This is an example of some of the issues and the basis of our Resilience Planning for 15/16</td></tr>
<tr><td>What are the proposed mitigating actions to recover / maintain progress against your trajectory for 2015/16?</td><td>A number of actions have and are being undertaken to recover performance at our challenged providers. Work is on-going to identify the full scale of the issues through the McKinsey work and resulting actions will be taken through SRGs. NWL performance on DToC has been a focus and has resulted in significant reductions in DToC. Further work is being done across health and social care to identify the larger ‘pathway’ cohort to improve flow out of acute sites.</td></tr>
</table>

<table>
<tr><td>Has your plan taken into account the impact of various schemes and investment? E.g. QIPP, NETA, BCF</td><td>All of our plans have been cross matched against any activity reduction plans (BCF/QIPP). This has been reflected in our operating plan submissions and contracting agreements.</td></tr>
<tr><td colspan="2">Cancer waits – 62 day</td></tr>
<tr><td>By each provider, what is current performance against 2014/15 plan?</td><td>
<table>
<tr><th>62 Day Standard</th><th>Apr</th><th>May</th><th>Jun</th><th>Jul</th><th>Aug</th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th></tr>
<tr><td>Chelsea and Westminster Hospital NHS Foundation Trust</td><td>100.0</td><td>82.6</td><td>85.7</td><td>91.3</td><td>92.0</td><td>81.5</td><td>95.7</td><td>100.0</td><td>97.6</td><td>92.6</td></tr>
<tr><td>Ealing Hospital NHS Trust</td><td>88.6</td><td>88.5</td><td>78.6</td><td>86.1</td><td>86.4</td><td>85.0</td><td>66.7</td><td>89.3</td><td>90.5</td><td>-</td></tr>
<tr><td>Imperial College Healthcare NHS Trust</td><td>89.1</td><td>86.8</td><td>80.8</td><td>85.6</td><td>87.1</td><td>83.1</td><td>85.5</td><td>82.5</td><td>88.7</td><td>77.7</td></tr>
<tr><td>North West London Hospitals NHS Trust *</td><td>83.8</td><td>82.4</td><td>76.0</td><td>81.3</td><td>83.9</td><td>79.4</td><td>81.6</td><td>80.2</td><td>92.8</td><td>77.0</td></tr>
<tr><td>Royal Brompton and Harefield NHS Foundation Trust</td><td>80.0</td><td>80.0</td><td>69.2</td><td>71.4</td><td>38.5</td><td>46.7</td><td>71.4</td><td>77.8</td><td>68.8</td><td>69.2</td></tr>
<tr><td>The Hillingdon NHS Foundation Trust</td><td>93.3</td><td>88.5</td><td>95.3</td><td>97.2</td><td>83.3</td><td>94.0</td><td>89.4</td><td>97.7</td><td>91.7</td><td>88.2</td></tr>
<tr><td>West Middlesex University NHS Trust</td><td>81.6</td><td>77.8</td><td>72.2</td><td>73.9</td><td>82.0</td><td>80.4</td><td>86.9</td><td>88.5</td><td>88.2</td><td>88.5</td></tr>
</table>
*Please note this is provider performance not CCG registered population
</td></tr>
<tr><td>Where performance is not meeting trajectory, has a comprehensive action plan and recovery date been agreed with the provider?</td><td>Improvement has been seen across 14/15 across all cancer waits, a joint NWL action plan is in place as well as specific recovery and improvement plans for challenged sites</td></tr>
<tr><td>How will you work with the provider to sustain improvement in 2015/16 to meet your trajectory?</td><td>NWL has a joint action plan agreed across all providers. This plan and process includes a number of out of area Trusts where there is a patient transfer flow. This plan has seen some success in informing performance. On top of the formal contract and performance meetings NWL holds a bi monthly meeting with providers to monitor progress against the action plan. This is supported by a dedicated Senior Performance Manager. In addition the Collaborative Performance Committee, represented by CCG Cancer Leads and Clinical Chairs, undertakes a deep dive on a rolling quarterly basis where senior provider leads present progress and agrees next steps.</td></tr>
<tr><td colspan="2">Mental Health</td></tr>
<tr><td>IAPT: By April 2016, at least 75% of adults should have had their first treatment session within six weeks of referral, with a minimum of 95% treated within 18 weeks. How are you working</td><td>The new access and waiting time standards for IAPT and Psychosis have been introduced directly into the Quality Requirements Schedule for the 2015-16 Contract. These standards will be measured through the Review of Monthly Service Quality Performance and as a consequence of</td></tr>
</table>

<table>
<tr>
<td>with providers to achieve new waiting time standards for people entering a course of treatment in adult IAPT services?

Please confirm your trajectory for meeting this standard by April 2016 and the actions you are taking to deliver it.</td>
<td>breach General Condition 9 will be applied which would include a Remedial Action Plan.

We have worked with our IAPT provider throughout 14/15 to ensure that they will meet these access targets, and have invested additional funding to ensure we meet this target. The Trust is already performing above the new access standards and we are in the process of trying to agree targets within contracts.

We are waiting on agreement of trajectories from providers.</td>
</tr>
<tr>
<td>Early intervention in psychosis (EIP): By April 2016, it is expected that more than 50% of people experiencing a first episode of psychosis will receive treatment within two weeks. This will require dedicated specialist early intervention-in-psychosis services. How are you working with local secondary mental health providers to ensure this waiting time standard is met?

Please confirm your trajectory for meeting this standard by April 2016 and the actions you are taking to deliver it.</td>
<td>Actions supporting the delivery of EIPS are included in the SDIP agreed with the provider:
<table>
<tr><th>Milestone</th><th>Timescale</th><th>Expected benefit</th></tr>
<tr><td>Undertake a baselining exercise of where the EIPS service is against the measure- more than 50% of people experiencing there first episode of psychosis have a maximum wait of two weeks from referral to treatment</td><td>By end of Month 4</td><td>CCGs and WLMHT will understand where they stand in relation to national requirements</td></tr>
<tr><td>Undertake an assessment to determine if the EIP service is providing patients with a NICE concordant treatment</td><td>By end of Month 4`</td><td>CCGs and WLMHT will understand where they stand in relation to national requirements</td></tr>
</table>
</td>
</tr>
</table>

	Test the existing pathway for referral to treatment to ensure it meets the measure using the national expected approach to the measurement of the standard	By end of Month 6	CCGs and Provider will understand what is required to deliver the national requirements
	Agree a plan to deliver the pathway to meet the standard	By end of Month 6	CCGs and Provider will understand what is required to deliver the national requirements
	Develop an action plan to ensure that all treatments meet the NICE requirements as detailed within the national supporting guidance document	By end of Month 6	
	Determine whether any additional funding is required in addition to the recurrent investment already made in 1516 for EIPs services	By end of Month 7	
	Ensure that there is capacity in place to deliver the target at the start of Q4	By start of Month 9	One quarter to ensure the pathway delivers within 2 weeks and treatments are compliant providing CCGs and provider with assurance they are delivering ahead of 16/17
	Guidance document to be used for this indicator unless superseded by further national guidance. http://www.england.nhs.uk/wp-content/uploads/2015/02/mh-access-wait-time-guid.pdf		

	Trajectories: Developing and monitoring during 2015/16 with delivery from April 2016.
Have you agreed a Service Delivery and Improvement Plan (SDIP) as part of contracts with mental health providers? Does this plan set out how providers will prepare for and implement the new standards for EIP and IAPT during 2015/16 and achieve them on an on-going basis from 1st April 2016?	It has been agreed with Providers that the new access and waiting time standards for IAPT and Psychosis targets to be delivered by April 2016 will be included in the Service Delivery and Improvement Plan – the trajectories are to be agreed with Providers. The new access and waiting time standards for IAPT and Psychosis have been introduced directly into the Quality Requirements Schedule for the 2015-16 Contract. These standards will be measured through the Review of Monthly Service Quality Performance and as a consequence of breach General Condition 9 will be applied which would include a Remedial Action Plan.
Have you ensured the provision of mental health support as an integral part of NHS 111 services? If not, what do you currently have in place instead? Do you have plans to build this into future procurement specifications?	NHS 111 services are currently being reproduced across NWL, this will include evidence based, best practice. The 111 procurement board includes the NHSE lead ensuring alignment across London.
In commissioning mental health services and working towards meeting new standards, have you developed robust demand and capacity plans? Please provide details of these.	We have worked with our mental health Trust and primary care through our mental health transformation board to ensure that there is enough capacity in the system to meet these standards. We have achieved a successful enhanced primary care service which enables patients to be discharged from community mental health teams to a less intensive setting, i.e. their local GP practices, and we have invested in primary care mental health workers to support our GPs to meet the mental health needs of their patients. We also ensure that any patients who are referred into secondary care have an opportunity to be seen in our enhanced primary care service, and all referrals into secondary care are discussed between the GP and Psychiatrist who have an advisory phone line accessible to GPs.
How are you working with other local commissioners to invest in community child and adolescent mental health	The National CAMHS Taskforce will report on the 17th of march 2015, the CCG will digest this carefully and benchmark local services in line with the recommendations of the task force, this will then inform future investment and commissioning intentions.

services?	1. The pilot of a dedicated CAMHS Out of Hours Service across the NWL CCGs will offer a number of benefits: a. Access to specialist child and adolescent mental health services from first contact an improved face-to-face experience for young people from a specialist child and adolescent mental health service b. Specialist CAMHS advice for General Practitioners, Accident & Emergency staff, paediatricians, police, emergency duty teams, young people and families c. The pilot will collect a wide range of data to ensure that we commission an appropriate service going forward. 2. The NWL CCGs will, through CQUINs for 2015/2016, ensure that the nationally supported CYIAPT programme is introduced fully into the local CAMHS services, to ensure that evidence based practice is utilised and that session by session outcome measures are embedded. 3. West London, Central London and Hammersmith and Fulham CCGs were involved in the Tri-borough CAMHS Task and Finish Group which reported to Health and Wellbeing boards in December 2014. The CCGs are committed to supporting the recommendations of the group and the implementation of these. An example of this is that all three CCGS will via the contractual process ensure that there are comprehensive changes to transition process to support a better experience for young people needing to access Adult Mental health services at the age of 18 years. 4. There will be an additional CAMHs Task and finish group in Hammersmith and Fulham and the CCG have committed to supporting this and working with the local authority to produce an action plan with realistic recommendations that improve services and that are tailored to meet the local needs of the population. The task force is looking at all aspects of young peoples' mental health; joining up commissioning (schools, Public Health, Social care and CCGs), identifying gaps and hearing direct from young people. It will build on the recent national reports and the 12 recommendations from the inner London CCG CAMHS Task & Finish Group (2014) as endorsed by the Children's Trust and all three Health and Well Being Boards.

6. Operational resilience

Have you extended all of your operational resilience schemes from 2014/15 into April 2015 and beyond?	All resilience schemes have been extended during April, a review process is underway where decisions will be made on making more exceptional resilience schemes BAU if appropriate
If no and where you are stopping specific schemes, has this been approved by your SRG? Are you assured there will be no impact on performance?	N/A, due to allocations being made in baselines work is underway to agree resilience plans for 15/16, this will build on the last 2 years' experience and will be agreed and managed through SRGs.

Public Health England

NHS England

Heatwave plan for England

Protecting health and reducing harm from severe heat and heatwaves

May 2015

Local Government Association

Met Office

Contents

Glossary of abbreviations

CCGs	clinical commissioning groups
CCS	Civil Contingencies Secretariat
CO	Cabinet Office
DCLG	Department for Communities and Local Government
DH	Department of Health
EH	environmental health
EPRR	emergency preparedness, resilience and response
HHSRS	housing health and safety rating system
HWB	Health and Wellbeing Boards
HWS	Health and Wellbeing Strategy
JSNA	joint strategic needs assessment
LA	local authority
LHRP	Local Health Resilience Partnership
LRF	Local Resilience Forum
OGD	other government department
PHE	Public Health England
RED	Resilience and Emergencies Division, DCLG

Foreword

Professor Dame Sally C Davies
Chief Medical Officer
Chief Scientific Adviser
Department of Health

Although many of us enjoy the sunshine, as a result of climate change we are increasingly likely to experience extreme summer temperatures that may be harmful to health. For example the temperatures reached in 2003 are likely to be a 'normal' summer by 2040, and indeed globally, countries have already experienced record temperatures. We do not know whether or not there will be severe heat over the course of this summer, but we do want to make sure that everyone takes simple precautions to stay healthy during periods of hot weather and when in the sun.

The Heatwave plan for England remains a central part of the Department of Health's support to the NHS, social care and local authorities, providing guidance on how to prepare for and respond to a heatwave which can affect everybody's health, but particularly the most vulnerable people in society.

The purpose of this heatwave plan is to reduce summer deaths and illness by raising public awareness and triggering actions in the NHS, public health, social care and other community and voluntary organisations to support people who have health, housing or economic circumstances that increase their vulnerability to heat. Communities can also help their neighbours, friends and relatives to protect against avoidable harm to health this summer.

This plan builds on many years of experience of developing and improving the ability of the health sector and its partners to deal with significant periods of hot weather. It is up to each locality to consider the actions in this plan and to adapt and incorporate them in local plans as appropriate to the local situation.

We know that the Heatwave plan for England has successfully helped individuals, communities and authorities better prepare and plan for severe summer temperatures. We want people to enjoy the summer and to reduce the harm from heatwaves to those most at risk, for now and in the future.

Professor Dame Sally C Davies
Chief Medical Officer
Chief Scientific Adviser
Department of Health

Executive summary

The Heatwave plan for England is a plan intended to protect the population from heat-related harm to health. It aims to prepare for, alert people to, and prevent, the major avoidable effects on health during periods of severe heat in England.

It recommends a series of steps to reduce the risks to health from prolonged exposure to severe heat for:

- the NHS, local authorities, social care, and other public agencies
- professionals working with people at risk
- individuals, local communities and voluntary groups

The heatwave plan has been published annually since 2004, following the devastating pan-European heatwave in 2003. This year's plan builds on many years of experience of developing and improving the ability of the health sector and its partners to deal with significant periods of hot weather.

The heatwave plan was significantly re-shaped in 2012 from previous years. There have since been changes to reflect the changes in the health care and public health landscape, to align the heatwave plan more closely with its sister Cold weather plan and to link planning for severe heat with the Public Health Outcomes Framework.

The plan continues to be underpinned by a system of heatwave alerts, developed with the Met Office. The heatwave plan describes the **heat-health watch system** which operates in England from 1 June to 15 September each year. During this period, the Met Office may forecast heatwaves, as defined by forecasts of day and night-time temperatures and their duration.

The heat-health watch system now comprises five main levels (Levels 0-4), from long-term planning for severe heat, through summer and heatwave preparedness, to a major national emergency. Each alert level should trigger a series of appropriate actions which are detailed in the heatwave plan.

The plan is a good practice guide and the actions denoted within it are illustrative.
It is a collaborative plan supported by NHS England to protect and promote the health of the population. There are three key messages we recommend to all local areas, particularly in view of recent structural changes:

1. All local organisations should consider this document and satisfy themselves that the suggested actions and heat-health watch alerts are understood across the system, and that **local plans are adapted as appropriate** to the local context.

2. NHS and local authority commissioners, together with multi-agency Local Resilience Forums and Local Health Resilience Partnerships, should satisfy themselves that the distribution of **heat-health watch alerts will reach those that need to take action**, especially in light of recent structural changes.

3. NHS and local authority commissioners, together with multi-agency Local Resilience Forums, should satisfy themselves that **providers and stakeholders take appropriate action** according to the heat-health watch alert level in place and their professional judgements.

Chapter 1

Why this plan is needed

Bright, hot summer days are what many of us look forward to for the rest of the year – especially in cold, wet England!

However, while we're enjoying the balmy days of summer, we should not forget that the temperature can get too high, that it can become uncomfortably hot, and for some, it can become dangerously hot.

The evidence about the risks to health from heatwaves is extensive and consistent from around the world. Excessive exposure to high temperatures can kill. During the summer heatwave in Northern France in August 2003, unprecedentedly high day- and night-time temperatures for a period of three weeks resulted in 15,000 excess deaths. The vast majority of these were among older people.

In England that year, there were over 2,000 excess deaths over the 10 day heatwave period which lasted from 4 to 13 August 2003, compared to the previous five years over the same period.

The first Heatwave Plan for England was published in 2004 in response to this event. Since that time we have had a significant heatwave in 2006 (when it was estimated that there were about 680 excess deaths compared to similar periods in previous years). In 2009 there were approximately 300 excess summer deaths during a heatwave compared to similar periods in previous years.

Excess deaths are not just deaths of those who would have died anyway in the next few weeks or months due to illness or old age. There is strong evidence that these summer deaths are indeed 'extra' and are the result of heat-related conditions.

In contrast to deaths associated with cold snaps in winter, the rise in mortality as a result of very warm weather follows very sharply – within one or two days of the temperature rising.

This means that:

- by the time a heatwave starts, the window of opportunity for effective action is very short indeed; and therefore
- advanced planning and preparedness is essential.

We know that effective action, taken early, can reduce the health impacts of exposure to excessive heat. Most of these are simple preventive measures which to be effective, need to be planned in advance of a heatwave.

The aim of this plan is to raise public awareness of the dangers of excessive heat to health and to ensure that health, social care and other voluntary and community organisations and wider civic society is prepared and able to deal with a heatwave when it comes so as to protect the most vulnerable.

1.1 Making the case: the impact of heat on health – now and in the future

We continue to focus the plan itself on actions with the supporting material in a separate companion volume entitled, **"**Making the case: the impact of heat on health – now and in the future.

As in previous years, the heatwave plan is also supported by a series of Information Guides published online which aim to provide an authoritative source of additional information about the effects of severe hot weather on health for:

- looking after yourself and others during hot weather (for Individuals, families and carers)
- supporting vulnerable people before and during a heatwave: advice for health and social care professionals
- supporting vulnerable people before and during a heatwave: advice for care home managers and staff
- looking after children and those in early years settings during heatwaves: guidance for teachers and professionals

These supporting documents were previously updated to reflect the changing responsibilities as a result of the Health and Social Care Act (2012).

1.2 The heatwave plan – a plan to protect health from heat-related harm

The heatwave plan sets out what should happen before and during periods of severe heat in England. It spells out what preparations both individuals and organisations can make to reduce health risks and includes specific measures to protect at-risk groups.

The arrangements describe what needs to be done by health and social care organisations and other bodies to raise awareness of the risks relating to severe hot weather and what preparations both individuals and organisations should make to reduce those risks.

The plan provides good practice and advice on how to respond and what to do once severe hot weather has been forecast. It also explains the responsibilities at national and local level

for alerting people once a heatwave has been forecast, and for advising them how to respond and what to do during a heatwave.

The plan is primarily for health and social care services and other public agencies and professionals who interact with those most at risk from excessive heat during heatwaves.

At-risk groups include older people, the very young and people with pre-existing medical conditions as well as those whose health, housing or economic circumstances put them at greater risk of harm from very hot weather. For example, some medications make the skin especially sensitive to sunlight with potential harm caused by ultraviolet rays. (See Section 1.2 in the accompanying document, '*Making the Case'*, for more information).

The plan is also intended to mobilise individuals and communities to help to protect their neighbours, friends, relatives, and themselves against avoidable health problems during spells of very hot weather. Broadcast media and alerting agencies may also find this plan useful.

The plan focuses on the effects of severe hot weather on health and wellbeing, however, severe and extended heatwaves can also cause severe disruption to general services. For this reason, multi-agency **Local Health Resilience Partnerships and Local Resilience Forums** will have a critical role in preparing and responding to heatwaves at a local level, working closely with **Health and Wellbeing Boards** on longer term strategic planning.

1.3 The heatwave plan and new arrangements

The implementation of the Health and Social Care Act 2012 has seen the abolition of Primary Care Trusts and Strategic Health Authorities and the creation of a number of new bodies including Public Health England (PHE), NHS England and clinical commissioning groups (CCGs). At a local level, responsibility for public health has transferred to local authorities.

The **Department of Health** (DH) is responsible for strategic leadership of both health and social care systems, but no longer has direct management of most NHS systems. **NHS England** provides national leadership for improving health care outcomes, directly commissions general practice services, some specialist services, and oversees **clinical commissioning groups**. CCGs now commission planned hospital care, rehabilitative care, urgent and emergency care, most community health services and mental health and learning disability services. **Directors of Public Health** in local authorities are responsible for population health outcomes, supported by **Public Health England** (PHE), which provides national leadership and expert services to support public health.

Responsibility for preparing and publishing the Heatwave plan for England has passed to PHE. PHE will seek to ensure that the heatwave plan is widely communicated using a variety of channels to ensure maximum publicity.

PHE will make advice available to the public and health and social care professionals in affected regions, in preparation for an imminent heatwave, via NHS Choices, and the websites of the Met Office, PHE and DH.

NHS Choices (www.nhs.uk) continues to provide reliable advice and guidance throughout the year on how to keep fit and well. It includes information on how to stay well in hot weather (www.nhs.uk/summerhealth).

The heatwave plan builds on existing measures taken by DH, the NHS and local authorities to protect individuals and communities from the effects of severe heatwaves and encourage community resilience. It outlines the key areas where public, independent and voluntary sector health and social care organisations should work together to maintain and improve integrated arrangements for planning and response in order to deliver the best outcomes possible during a heatwave during the summer. It is the responsibility of each local area to ensure that preparedness and response plans are drawn up and tested.

At local level emergency planning arrangements run by local government and the NHS are brought together in the **Local Resilience Forum** (LRF), which has many years of experience of the heatwave plan and heat-health watch alert system. **Local Health Resilience Partnerships** (LHRPs) have been established to bring together local health sector organisations to support strategic planning.

Health and Wellbeing Boards act as forums for commissioners across the NHS, social care and public health systems and are responsible for joint strategic needs assessments and Health and Wellbeing Strategies to inform commissioning. Engagement of these boards in the long-term strategic preparation for heatwaves and other aspects related to climate change adaptation is critical in order to reduce the risks and harness opportunities to improve health. **Councillors**, especially those with portfolio responsibility for health, have important strategic overview and scrutiny functions, as well as community engagement and decision-making roles.

1.3.1 The core elements of the plan

The heatwave plan depends on having well co-ordinated plans in place for how to deal with severe hot weather before it strikes. It builds on our own experience in England and on expert advice from the WHO and the EuroHEAT project (Section 4 of companion document ‘Making the case’) in developing other national heatwave plans. The core elements of the plan are:

1.3.2 Strategic planning

The climate is changing and current analysis in the first national UK climate change risk assessment suggests that summers are going to get hotter in the future (see 'Making the case'). Long-term planning now is essential to support:

- co-ordinated long-term planning between agencies to protect people and infrastructure from the effects of severe hot weather and thus reduce excess summer illness and death;
- long-term multi-agency planning to adapt to and reduce the impact of climate change, including 'greening the built environment', building design (eg increasing shading around and insulation of buildings), increasing energy efficiency (eg reducing carbon emissions); and transport policies

We strongly recommend that this is considered by Health and Wellbeing Boards and included in joint strategic needs assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs), in order to inform commissioning.

1.3.3 Alert system (advance warning and advice over the summer)

The following systems are in place:

- a heat-health watch alert system operates from 1 June to 15 September, based on Met Office forecasts and data. This will trigger levels of response from the NHS, government and public health system, and communicate risks.
- advice and information for the public and for health and social care professionals, particularly those working with at-risk groups. This includes both general preparation for hot weather and more specific advice when a severe heatwave is forecast

1.3.4 Heatwave and summer preparedness

The following elements also need to be in place:

- agreement on a lead body at local or sub-national level is required to co-ordinate multi-agency collaboration and to direct the response. This may be for example, NHS-England whose role, in collaboration with CCGs, will be to ensure that local providers of NHS commissioned care have the capacity and capability to deliver their functions as laid out in this plan - NHS England will hold the providers of NHS commissioned care to account for implementation, in co-ordination with CCGs as appropriate
- other elements which local NHS, public health and social care organisations will oversee:
  - action to reduce indoor heat exposure (medium and short term)
  - particular care for vulnerable population groups
  - preparedness of the health and social care system – staff training and planning, appropriate healthcare and the physical environment

1.3.5 Communicating with the public

Working with the media to get advice to people quickly, both before and during a heatwave:

- the Civil Contingencies Act 2004 provides a duty on category 1 responders to warn and inform the public before, during and after an emergency
- there should be a local heat-related health information plan – specifying what is communicated, to whom, when and why
- this should raise awareness of how excessive exposure to severe heat affects health and what preventive action people can take, both throughout the year and during heatwaves to stay cool
- attention should especially be given to ensuring that key public health messages (box 1, section 3.2) reach vulnerable groups and those who care for them (eg caregivers of the chronically ill, parents of infants) in a suitable and timely way

1.3.6 Working with service providers

The following is required:

- advising hospitals and care, residential and nursing homes to provide cool areas and monitor indoor temperatures to reduce the risk of heat-related illness and death in the most vulnerable populations
- helping GPs and district nurses and social workers to identify vulnerable patients and clients on their practice lists by providing them with heatwave information and good practice
- ensuring that health and social care organisations and voluntary groups implement measures to protect people in their care and reduce heat-related illness and death in those most at risk
- recommending health visitors and school nurses provide advice to parents and childcare providers and schools and young people respectively regarding behaviours to protect health during hot weather (eg fluid intake, reducing excessive sun exposure, avoiding diving into cold water)
- working with registered providers of housing to encourage wardens/caretakers to keep an eye out for vulnerable tenants during heatwaves, and to consider measures to promote environmental cooling such as tree planting on their estates and building design
- supporting staff to remain fit and well during spells of hot weather

1.3.7 Engaging the community

The following is required:

- providing extra help, where possible, to care for those most at risk, including isolated older people and those with a serious illness or disability. This could come from local authorities, health and social care services, the voluntary sector, communities and faith groups, families and others. This is determined locally as part of the person's individual care plan and will be based on existing relationships between statutory and voluntary bodies
- additional help to ensure that people are claiming their entitlements to benefits should be signposted

1.3.8 Monitoring/evaluation

The following is required:

- real-time surveillance and evaluation, such as that provided by PHE (see Chapter 5)

Chapter 2

The heat-health alert service

A heat-health watch alert system will operate in England from 1 June to 15 September each year. During this period, the Met Office may forecast heatwaves, as defined by forecasts of day and night-time temperatures and their duration.

The heat-health watch system comprises five main levels (Levels 0 to 4) outlined in Figure 2.1 and described in further detail below.

Level 0 is year round long term planning, so that longer term actions (such as those linked to spatial planning and housing) are taken to reduce the harm to health of severe heat when it occurs. Level 1 encourages organisations to plan for the summer while Levels 2 to 3 are based on threshold day and night-time temperatures as defined by the Met Office. These vary from region to region, but the average threshold temperature is 30ºC during the day and 15ºC overnight. Level 4 is a judgement at national level made as a result of a cross-government assessment of the weather conditions, and occurs when the impacts of heat extend beyond the health sector. Details of individual regional thresholds are given in **Annex 1**. **Annex 2** shows the core messages to be broadcast as official PHE warnings alongside national and regional weather forecasts at different heatwave alert levels. They may be expanded or otherwise refined in discussion with broadcasters and weather presenters.

While heat-health watch is in operation, PHE will routinely monitor outputs from real-time syndromic surveillance systems. PHE will also produce three key mortality outputs for heatwave monitoring in the event of a heatwave and share these as internal reports to DH. Further detailed information on these outputs in line with the heat health levels can be found in Chapter 5.

Level 0: Long-term planning to reduce risk from heatwaves

Long-term planning includes year-round joint working to reduce the impact of climate change and ensure maximum adaptation to reduce harm from heatwaves. This involves influencing urban planning to keep housing, workplaces, transport systems and the built environment cool and energy efficient. Long-term heatwave planning is a key consideration highlighted in the National Adaptation Programme (NAP), which sets out actions to address the risks identified in the UK Climate Change Risk Assessment.

Figure 2.1: Heatwave Alert levels

Level 0	**Long-term planning -** All year
Level 1	**Heatwave and Summer preparedness programme -** 1 June – 15 September
Level 2	**Heatwave is forecast – Alert and readiness -** 60% risk of heatwave in the next 2 to 3 days
Level 3	**Heatwave Action -** temperature reached in one or more Met Office National Severe Weather Warning Service regions
Level 4	**Major incident – Emergency response -** central government will declare a Level 4 alert in the event of severe or prolonged heatwave affecting sectors other than health

Level 1: Heatwave and summer preparedness

Summer preparedness runs from 1 June to 15 September when a Level 1 alert will be issued. The heatwave plan will remain at Level 1 unless a higher alert is triggered. During the summer months, social and healthcare services need to ensure that awareness and background preparedness are maintained by implementing the measures set out in the heatwave plan.

Level 2: Alert and readiness

This is triggered as soon as the Met Office forecasts that there is a 60 per cent chance of temperatures being high enough on at least two consecutive days to have significant effects on health. This will normally occur 2 to 3 days before the event is expected. As death rates rise soon after temperature increases, with many deaths occurring in the first two days, this is an important stage to ensure readiness and swift action to reduce harm from a potential heatwave.

Level 3: Heatwave action

This is triggered as soon as the Met Office confirms that threshold temperatures have been reached in any one region or more. This stage requires specific actions targeted at high-risk groups.

Level 4: National emergency

This is reached when a heatwave is so severe and/or prolonged that its effects extend outside health and social care, such as power or water shortages, and/or where the integrity of health and social care systems is threatened. At this level, illness and death may occur among the fit and healthy, and not just in high-risk groups and will require a multi-sector response at national and regional levels.

The decision to go to a Level 4 is made at national level and will be taken in light of a cross-government assessment of the weather conditions, co-ordinated by the Civil Contingencies Secretariat (Cabinet Office).

2.1 Met Office heatwave warnings

Heatwave warnings will:

- be colour-coded to indicate more easily the National Severe Weather Warning Service (NSWWS) regions affected by a change from one Heatwave Warning level to another (eg from Level 2 to Level 3) – this will help responders to clarify what actions in turn need to be taken
- published and sent by the Met Office at 09:00 rather than 10:00 to aid planners
- indicate which local resilience forum (LRF) is situated within the NSWWS region, in order to help responders
- include a link to Met Office and weather pattern maps
- use social media (e.g. Twitter/Facebook). The alerts are already backed up by tweets, linking to the alert webpage through the Met Office twitter feed. You can subscribe to this feed by following: @metoffice. (http://twitter.com/metoffice)

Figure 2.2: Met Office service and notifications

Service	Purpose	Distribution	Timing
Heatwave warning	To provide early warning of high temperatures. The alert levels have been set with thresholds known to cause ill health from severe hot weather. They are to help ensure that healthcare staff and resources are fully prepared for hot weather periods that might impact on health and to raise awareness for those individuals who are more vulnerable to hot weather conditions.	E-mail	Alert issued as soon as agreed threshold has been reached and when there is a change in alert level. Issued between 1 June and 15 September
Heatwave planning advice	To provide advice throughout the summer period relating to high temperatures.	E-mail	Twice a week (9am each Monday and Friday from 1 June to 15 September)
National Severe Weather Warning Service (NSWWS)	To provide warnings of severe or hazardous weather that has the potential to cause danger to life or widespread disruption. These warnings are issued to: • the public, to prompt consideration of actions they may need to take • emergency responders, to trigger their plans to protect the public from impacts in advance of an event, and to help them recover from any impacts after the event	Email, web, SMS, TV, radio	When required
General weather forecasts	To enable the public to make informed decisions about their day to day activities	Web, TV, radio	Every day

Figure 2.2 summarises the Met Office service and notifications. A dummy alert for illustration purposes is given in Figure 2.3, and Figure 2.4 illustrates how heatwave alert messages should be cascaded by e-mail throughout the local community and nationally as appropriate. Local Resilience Forums, Local Health Resilience Partnerships, and health and social care organisations will want to develop this into a specific cascade system that is appropriate for their local area.

Figure 2.3: Example of a Heat-Health Watch Alert

Heatwave Warning

Tel: 0870 900 0100 www.metoffice.gov.uk

NHS (Ref: MO43) Page 1 of 2

Forecast Issued on Saturday, 18 August 2012 at 09:00

Heat-Health Watch

Level 2 - Alert & Readiness

http://www.metoffice.gov.uk/public/weather/heat-health/#?tab=hotWeatherAlert

The probability of heatwave conditions in part of England between 0900 on Sunday and 0800 on Wednesday is 60%

An update will be issued when the alert level changes in any region. Alerts are issued once a day by 0900 if required and are not subject to amendment in between standard issue times. Note that the details of the forecast weather are valid at the time of issue but may change over the period that an alert remains in force. These details will not be updated here unless the alert level also changes, the latest forecast details can be obtained at the following link:
http://www.metoffice.gov.uk/public/weather/forecast/#?tab=map

Regional Risk Assessments For Occurrence of Heatwave Conditions between 0900 Local Time on Sunday and 0800 Local Time on Wednesday.

The areas that are likely to be affected are:

Region	Risk	Comments
North East England	40 %	Cooler near coasts.
North West England	60 %	Cooler near coasts.
Yorkshire and the Humber	50 %	Cooler near coasts.
West Midlands	60 %	
East Midlands	60 %	Cooler near Lincolnshire coasts.
East of England	70 %	Cooler near coasts.
Southeast England	80 %	Cooler near coasts.
London	90 %	
Southwest England	60 %	Cooler near coasts.
Wales	60 %	Cooler near coasts.

General Comments:- High pressure over Scandinavia will allow very warm air to spread in from the continent. The warmest conditions will be across Southeast England, up into the Midlands and into eastern Wales. Maximum temperatures of between 32 and 33C are likely in these areas, with minima in the order of 20C in London and 18C in the Midlands. Sea breezes will moderate the temperatures near coasts, particularly in east as easterly flow increases.

Organisations providing health and social care should be aware of the advice and guidance set out in the Public Health England's Heatwave Plan, and the Heatwave Plan for Wales, as to the actions necessary before and during a Level 2 or Level 3 heatwave. Specific advice to be followed by health care professionals, and the managers and staff of residential and nursing homes in the event of a heatwave is available from Public Health England's website https://www.gov.uk/government/publications/heatwave-plan-for-england-2013 and the Welsh Government website http://wales.gov.uk.

These alerts are sent to the CE of every provider of NHS commissioned care, Local Authority and Social Care Organisation in England, and to Health Board CEs and Local Authority Directors of Social Services in Wales. If you would like to add a colleague to receive these alerts we would be grateful if you could set up an internal cascade within your organisation. If this is not possible, or you feel you are receiving this message in error please contact:
For England: **summer_heatwave_alerts@dh.gsi.gov.uk**
For Wales: **Health.Protection@wales.gsi.gov.uk**

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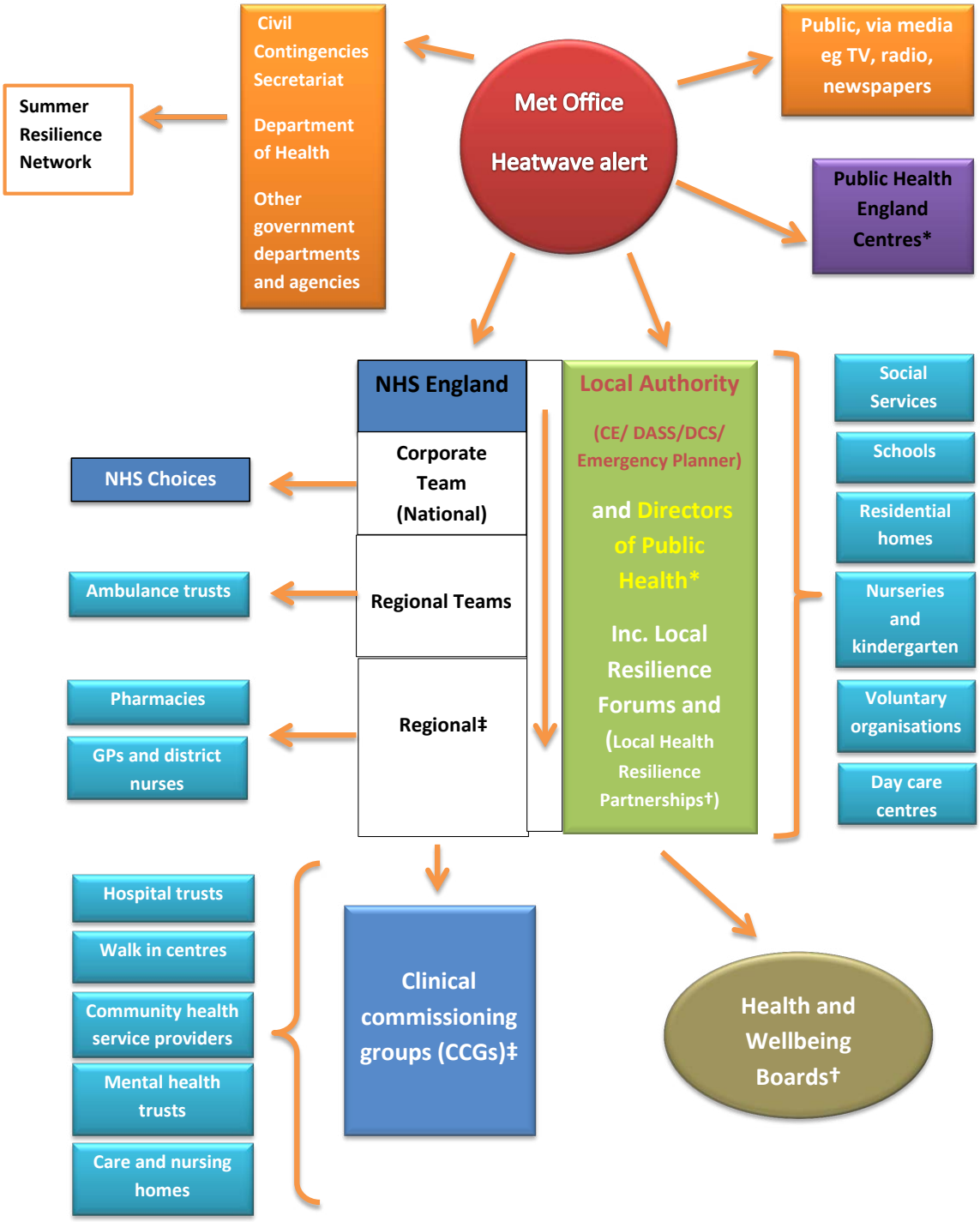
To aid local planning, listed below are the Local resilience Forum (LRFs) matched against their regions.

NHS Region	NSWWS Region	Local Resilience Forum
North	North East England	Durham and Darlington Northumbria Cleveland
	Yorkshire and the Humber	Humber North Yorkshire West Yorkshire South Yorkshire
	North West England	Cheshire Cumbria Greater Manchester Lancashire Merseyside
Midlands	West Midlands	Staffordshire Warwickshire West Mercia West Midlands
	East Midlands	Derbyshire Leicestershire Lincolnshire Northamptonshire Nottinghamshire
	East of England	Bedfordshire Cambridgeshire Essex Hertfordshire Norfolk Suffolk
South	South East England	Sussex Kent Surrey Thames Valley Hampshire and Isle of Wight
	South West England	Avon & Somerset Devon, Cornwall & Isle of Scilly Dorset Gloucestershire Wiltshire and Swindon
London	London	London
Wales	Wales	Dyfed Powys Gwent North Wales South Wales

Figure 2.4: Typical cascade of heatwave alerts



Notes

‡NHS England Regional and CCGs should work collaboratively to ensure that between them they have a cascade mechanism for heatwave alerts to all providers of NHS commissioned care both in business as usual hours and the out of hours period in their area.

*PHE Centres would be expected to liaise with Directors of Public Health to offer support, but formal alerting would be expected through usual local authority channels.

†LHRPs and HWBs are strategic and planning bodies, but may wish to be included in local alert cascades.

Chapter 3

Summary of heatwave plan levels and actions

As noted above, the issue of a heatwave alert should trigger a series of actions by different organisations and professionals as well as the general public. The tables that follow summarise the actions to be taken by different organisations and groups from the previous section in order to respond to the alert level, be it preparing for, or responding to, an actual episode of severe hot weather.

3.1 Using the action tables

The actions outlined in the tables are illustrative. Local areas should consider these as guides when developing local heatwave preparedness arrangements. The heatwave plan for England is a broad framework and local areas need to tailor the suggested actions to their local situation and ensure that they have the best fit with wider local arrangements.

The tables emphasise the importance of joint working across agencies including the voluntary and community sector, and highlight one of the aims of the plan, which is to ensure that there is an integrated response to severe heat events across sectors. Local areas will need to consider those actions indicated in the tables which will need to be taken jointly across organisations and sectors.

Local organisations are asked to consider the action tables and to recast the suggested actions in ways that are most appropriate for them. NHS, local authorities, Local Health Resilience Partnerships and Local Resilience Forums should assure themselves that heatwave response plans are in place for the coming summer as part of wider preparedness and response plans to extreme climate events. Chapter 6 highlights the overarching next steps which NHS and local authorities should take to ensure that the heatwave alerts are being disseminated and acted upon locally.

It is also worth reiterating:

- the actions for each alert level are not intended to be an ‘all or none’ situation – we would expect staff and organisations to develop action plans which make sense to them using these as a broad template; we would also expect staff to exercise professional judgement in a ‘clinical’ setting with a patient or client and respond appropriately to that patient’s needs

- we are asking staff to be much more aware of the effects of severe heat on health and when they notice a client or patient at risk of overheating, for example, from living in a home that is too hot, that they know what immediate actions to take to ensure safety and that there are clear guidelines for them to make other necessary arrangements (eg addressing housing issues) in the immediate and longer term
- we strongly support a system-wide approach to assessing the nature of the problem and addressing these across organisations locally that makes most effective and efficient use of resources – local areas may also wish to refer to an earlier DH toolkit How to reduce the risk of seasonal excess deaths systematically in vulnerable older people at population level. – this is designed to help local communities to take a systematic approach to reduce the risk of seasonal excess deaths in older people

Please refer to the glossary of abbreviations on page 2 and note that both NHS England and PHE have sub-national arrangements for liaison; communication, coordination and response during emergency events and how they in turn work with local providers of NHS commissioned care and local authorities.

In 2012, the Royal College of General Practitioners published a factsheet based on the Heatwave Plan to provide advice for GPs and their teams.

Figure 3.1: Commissioners of health and social care (all settings) and local authority Directors of Public Health

Level 0	Level 1	Level 2	Level 3	Level 4
Long-term planning All year See accompanying document 'Making the Case' for more detail	**Heatwave and summer preparedness programme** 1 June to 15 September	**Heatwave is forecast – alert and readiness** 60% risk of heatwave in the next 2 to 3 days	**Heatwave action** Temperature reached in one or more Met Office National Severe Weather Warning Service regions	**Major incident – emergency response** Central Government will declare a Level 4 alert in the event of severe or prolonged heatwave affecting sectors other than health
Working with partner agencies, incorporate into JSNA's/HWS's long term plans to prepare for, and mitigate, the impact of heatwaves, including: • how to identify and improve the resilience of those individuals and communities most at risk • ensuring that a local, joined-up programme is in place covering: • housing (inc loft and wall insulation and other plans to reduce internal energy use and heat production) • environmental action: (eg increase trees and green spaces; external shading; reflective paint; water features) • other infrastructure changes (eg porous pavements) • engaging the community and voluntary sector to support development of local community emergency plans • making progress on relevant Public Health Outcomes Framework indicators	• work with partner agencies, providers and businesses to coordinate heatwave plans, ensuring vulnerable and marginalised groups are appropriately supported • work with partners and staff on risk reduction awareness (eg key public health messages – box 1), using a variety of methods to maximise dissemination • ensure care homes and hospitals are aware of the heatwave plan and are engaged in preparing for heatwaves • continue to engage the community and voluntary sector to support communities to help those most at risk • ensure other institutional establishments (eg prisons, schools) are aware of heatwave guidance • ensure organisers of large events take account of possible heat risks	• communicate public media messages – especially to 'hard to reach' vulnerable groups • communicate alerts to staff and make sure that they are aware of heatwave plans • implement business continuity • increase advice to health and social care workers working in community, care homes and hospitals	• media alerts about keeping cool • support organisations to reduce unnecessary travel • review safety of public events • mobilise community and voluntary support	**National emergency** Continue actions as per Level 3 unless advised to the contrary **Central government will declare a Level 4 alert in the event of severe or prolonged heatwave affecting sectors other than health and if requiring coordinated multi-agency**

High-risk groups

Community: over 75, female, living on own and isolated, severe physical or mental illness; urban areas, south-facing top flat; alcohol and/or drug dependency, homeless, babies and young children, multiple medications and over-exertion

Care home or hospital: over 75, female, frail, severe physical or mental illness; multiple medications; babies and young children (hospitals).

*Because Level 2 is based on a prediction, there may be jumps between levels. Following Level 3, wait until temperatures cool to Level 1 before stopping Level 3 actions.

** Level 4: A decision to issue a Level 4 alert at national level will be taken in light of a cross-government assessment of the weather conditions, co-ordinated by the Civil Contingencies Secretariat

Figure 3.2: Providers – health and social care staff in all settings (community, hospitals and care homes)

Level 0	Level 1	Level 2	Level 3	Level 4
Long-term planning All year See accompanying document 'Making the Case' for more detail	**Heatwave and summer preparedness programme** 1 June to 15 September	**Heatwave is forecast – alert and readiness** 60% risk of heatwave in the next 2 to 3 days	**Heatwave action** Temperature reached in one or more Met Office National Severe Weather Warning Service regions	**Major incident – emergency response** Central government will declare a Level 4 alert in the event of severe or prolonged heatwave affecting sectors other than health
Professional staff (all settings): • develop systems to identify and improve resilience of high-risk individuals • request an HHSRS assessment from EH for clients at particular risk • encourage cycling/walking where possible to reduce heat levels and poor air quality in urban areas **Care homes and hospitals:** • work with commissioners to develop longer term plans to prepare for heatwaves • make environmental improvements to provide a safe environment for clients in the event of a heatwave • prepare business continuity plans to cover the event of a heatwave (eg storage of medicines, computer resilience, etc) • work with partners and staff to raise awareness of the impacts of severe heat and on risk reduction awareness (key public health messages – box 1)	**Professional staff (all settings):** • identify high-risk individuals on your caseload and raise awareness of heat illnesses and their prevention among clients and carers (see key public health messages – box 1) • include risk in care records and consider whether changes might be necessary to care plans in the event of a heatwave (eg initiating daily visits by formal or informal care givers for those living alone) **Care homes and hospitals:** • ensure business continuity plans are in place and implement as required; ensure appropriate contact details are provided to LA/NHS emergency planning officers to facilitate transfer of emergency information • identify or create cool rooms/areas (able to be maintained below 26°C) • install thermometers where vulnerable individuals spend substantial time	**Professional staff (all settings):** • check high-risk people have visitor/phone call arrangements in place • reconfirm key public health messages to clients • check client's room temperature if visiting **Care homes and hospitals:** • check indoor temperatures are recorded regularly during the hottest periods for all areas where patients reside • ensure cool areas are below 26°C • review and prioritise high-risk people • ensure sufficient cold water and ice • consider weighing clients regularly to identify dehydration and rescheduling physio to cooler hours • communicate alerts to staff and make sure that they are aware of heatwave plans • ensure sufficient staffing • implement business continuity	**Professional staff (all settings):** • visit/phone high-risk people • reconfirm key public health messages to clients • advise carers to contact GP if concerns re health **Care homes and hospitals:** • activate plans to maintain business continuity – including a possible surge in demand • check indoor temperatures are recorded regularly during the hottest periods for all areas where patients reside • ensure staff can help and advise clients including access to cool rooms, close monitoring of vulnerable individuals, reducing internal temperatures through shading, turning off unnecessary lights/equipment, cooling building at night, ensuring discharge planning takes home temperatures and support into account	**National emergency** Continue actions as per Level 3 unless advised to the contrary **Central government will declare a Level 4 alert in the event of severe or prolonged heatwave affecting sectors other than health and if requiring coordinated multi-agency response**

High-risk groups

Community: Over 75, female, living on own and isolated, severe physical or mental illness; urban areas, south-facing top flat; alcohol and/or drug dependency, homeless, babies and young children, multiple medications and over-exertion

Care home or hospital: over 75, female, frail, severe physical or mental illness; multiple medications; babies and young children (hospitals).

*Because Level 2 is based on a prediction, there may be jumps between levels. Following Level 3, wait until temperatures cool to Level 1 before stopping Level 3 actions.

** Level 4: A decision to issue a Level 4 alert at national level will be taken in light of a cross-government assessment of the weather conditions, co-ordinated by the Civil Contingencies Secretariat

Figure 3.3: Community and voluntary sector and individuals

Level 0	Level 1	Level 2	Level 3	Level 4
Long-term planning All year See accompanying document 'Making the Case' for more detail	**Heatwave and summer preparedness programme** 1 June to 15 September	**Heatwave is forecast – alert and readiness** 60% risk of heatwave in the next 2 to 3 days	**Heatwave action** Temperature reached in one or more Met Office National Severe Weather Warning Service regions	**Major incident – emergency response** Central government will declare a Level 4 alert in the event of severe or prolonged heatwave affecting sectors other than health
Community groups: • develop a community emergency plan to identify and support vulnerable neighbours in event of a heatwave • assess the impact a heatwave might have on the provision and use of usual community venues • support those at-risk to make sure they are receiving the benefits they are entitled to **Individuals:** • make environmental improvements inside and outside the house which reduce internal energy and heat • install loft and wall insulation • identify cool areas in the house to use in the event of a heatwave • of on medications, ensure that these can be stored at safe levels in a heatwave	**Community groups:** • further develop community emergency plan • support the provision of good information about health risks especially with those vulnerable groups and individuals (see key public health messages – box 1) **Individuals:** • find good information about health risks and key public health messages to stay healthy during spells of severe heat (see key public health messages box 1) • look out for vulnerable neighbours	**Community groups:** • keep an eye on people you know to be at risk • stay tuned into the weather forecast and keep stocked with food and medications • check ambient room temperatures **Individuals** • stay tuned into the weather forecast • check ambient room temperatures – especially those rooms where disabled or high risk individuals spend most of their time • keep an eye on people you know to be at risk – ensure they have access to plenty of cool liquids • look out for vulnerable neighbours	**Community groups:** • activate community emergency plan • check those you know are at risk **Individuals** • follow key public health messages • check those you know are at risk	**National emergency** Continue actions as per Level 3 unless advised to the contrary **Central government will declare a Level 4 alert in the event of severe or prolonged heatwave affecting sectors other than health and if requiring coordinated multi-agency response**
High-risk groups **Community**: Over 75, female, living on own and isolated, severe physical or mental illness; urban areas, south-facing top flat; alcohol and/or drug dependency, homeless, babies and young children, multiple medications and over-exertion **Care home or hospital**: over 75, female, frail, severe physical or mental illness; multiple medications; babies and young children (hospitals).				
*Because Level 2 is based on a prediction, there may be jumps between levels. Following Level 3, wait until temperatures cool to Level 1 before stopping Level 3 actions. ** Level 4: A decision to issue a Level 4 alert at national level will be taken in light of a cross-government assessment of the weather conditions, co-ordinated by the Civil Contingencies Secretariat				

Figure 3.4: National Level: NHS England, PHE, DH, Met Office, Other Government Departments

Level 0	Level 1	Level 2	Level 3	Level 4
Long-term planning All year	**Heatwave and summer preparedness programme** 1 June to 15 September	**Heatwave is forecast – alert and readiness** 60% risk of heatwave in the next 2 to 3 days	**Heatwave action** Temperature reached in one or more Met Office National Severe Weather Warning Service regions	**Major incident – emergency response** Central government will declare a Level 4 alert in the event of severe or prolonged heatwave affecting sectors other than health
• the Cabinet Office will take the lead on coordinating and working across government to prepare for severe heatwave and other associated extreme climate events - individual government departments will work with their partners on such preparations • national implementation of the National Adaptation Programme will continue, improving protection from severe weather events • DH, PHE and NHS England will look to improve monitoring and analysis of heat-related illness and deaths and evaluate the heatwave plan • PHE and NHS England will issue general advice to the public and professionals and work closely with the NHS, OGDs and other national organisations that produce advice on staying healthy and ensuring service continuity during periods of prolonged severe heatwaves	• preparations are the overall responsibility of PHE in collaboration with the Met Office, NHS England, DH and local bodies • PHE and NHS England will make advice available to the public and professionals • NHS England will ensure national guidance is cascaded to local services, and identify organisations most vulnerable to heatwaves • heat-health watch alerts will be sent by the Met Office to the agreed list of organisations and Category 1 responders as noted in Figure 2.4 – PHE and NHS England will cascade the alerts to sub-national units within their organisations • DH will liaise with CO and OGDs to ensure agreed responses are mobilised as required –DCLG will share info with LRFs • PHE will routinely monitor syndromic and mortality surveillance	• a Level 2 alert will be sent by the Met Office to the agreed list of organisations and Category 1 responders as noted in Figure 2.4 • central government departments, which should then cascade the information through their own stakeholder networks and front-line communication systems • DH will ensure OGDs, particularly DCLG RED are aware of the change in alert level and brief ministers as appropriate • PHE will make advice available to the public and professionals in affected regions via NHS Choices, NHS England, DH (GovNet), and Met Office websites • NHS England will hold health services to account for taking appropriate actions to prepare for a heatwave • PHE will continue to monitor syndromic and mortality surveillance	• as per Level 2 arrangements • Met Office will continue to monitor and forecast temperatures in each area, including the likely duration of the period of the heatwave, the likely temperatures to be expected and the probability of other regions exceeding the Level 3 threshold • NHS England will muster mutual aid when requested by local services • PHE will continue to monitor syndromic and mortality surveillance and produce a weekly report for inclusion within a weekly PHE heatwave output	Level 4 alert issued at national level in light of cross-Government assessment of the weather conditions, coordinated by the CCS based in the CO. Implementation of national emergency response arrangements by central government. Response likely to involve: • national government departments • executive agencies • public sector, including health sector • voluntary sector PHE will continue to monitor syndromic and mortality surveillance and produce a weekly report for inclusion within a daily PHE heatwave output

High-risk groups

Community: Over 75, female, living on own and isolated, severe physical or mental illness; urban areas, south-facing top flat; alcohol and/or drug dependency, homeless, babies and young children, multiple medications and over-exertion

Care home or hospital: over 75, female, frail, severe physical or mental illness; multiple medications; babies and young children (hospitals).

*Because Level 2 is based on a prediction, there may be jumps between levels. Following Level 3, wait until temperatures cool to Level 1 before stopping Level 3 actions.

** Level 4: A decision to issue a Level 4 alert at national level will be taken in light of a cross-government assessment of the weather conditions, co-ordinated by the Civil Contingencies Secretariat

3.2 Box 1 – key public health messages[1]

Stay out of the heat:

- keep out of the sun between 11am and 3pm
- if you have to go out in the heat, walk in the shade, apply sunscreen and wear a hat and light scarf
- avoid extreme physical exertion
- wear light, loose-fitting cotton clothes

Cool yourself down:

- have plenty of cold drinks, and avoid excess alcohol, caffeine and hot drinks
- eat cold foods, particularly salads and fruit with a high water content
- take a cool shower, bath or body wash
- sprinkle water over the skin or clothing, or keep a damp cloth on the back of your neck

Keep your environment cool:

- keeping your living space cool is especially important for infants, the elderly or those with chronic health conditions or who can't look after themselves
- place a thermometer in your main living room and bedroom to keep a check on the temperature
- keep windows that are exposed to the sun closed during the day, and open windows at night when the temperature has dropped
- close curtains that receive morning or afternoon sun, however, care should be taken with metal blinds and dark curtains, as these can absorb heat – consider replacing or putting reflective material in-between them and the window space
- turn off non-essential lights and electrical equipment – they generate heat
- keep indoor plants and bowls of water in the house as evaporation helps cool the air
- if possible, move into a cooler room, especially for sleeping
- electric fans may provide some relief, if temperatures are below 35°C[2]

1 Adapted from: WHO Europe public health advice on preventing health effects of heat

2 NOTE: Use of fans: at temperatures above 35°C fans may not prevent heat related illness. Additionally fans can cause excess dehydration (Cochrane Review). The advice is to place the fan at a certain distance from people, not aiming it directly on the body and to have regular drinks. This is especially important in the case of sick people confined to bed.

(Longer-term)

- consider putting up external shading outside windows
- use pale, reflective external paints
- have your loft and cavity walls insulated – this keeps the heat in when it is cold and out when it is hot
- grow trees and leafy plants near windows to act as natural air-conditioners (see 'Making the Case')

Look out for others:

- keep an eye on isolated, elderly, ill or very young people and make sure they are able to keep cool
- ensure that babies, children or elderly people are not left alone in stationary cars
- check on elderly or sick neighbours, family or friends every day during a heatwave
- be alert and call a doctor or social services if someone is unwell or further help is needed

If you have a health problem:

- keep medicines below 25 °C or in the refrigerator (read the storage instructions on the packaging)
- seek medical advice if you are suffering from a chronic medical condition or taking multiple medications

If you or others feel unwell:

- try to get help if you feel dizzy, weak, anxious or have intense thirst and headache; move to a cool place as soon as possible and measure your body temperature
- drink some water or fruit juice to rehydrate
- rest immediately in a cool place if you have painful muscular spasms (particularly in the legs, arms or abdomen, in many cases after sustained exercise during very hot weather), and drink oral rehydration solutions containing electrolytes.
- medical attention is needed if heat cramps last more than one hour
- consult your doctor if you feel unusual symptoms or if symptoms persist

3.3 Guidance for those looking after schoolchildren and those in early years settings during heatwaves

Outdoors:

- on very hot days (ie where temperatures are in excess of 30°C) children should not take part in vigorous physical activity
- children playing outdoors should be encouraged to stay in the shade as much as possible
- loose, light-coloured clothing should be worn to help children keep cool and hats of a closed construction with wide brims should be worn to avoid sunburn
- thin clothing or suncream should be used to protect skin if children are playing or taking lessons outdoors for more than 20 minutes
- children must be provided with plenty of cool water *and encouraged to drink more than usual when conditions are hot
  *the temperature of water supplied from the cold tap is adequate for this purpose

Indoors:

- windows and other ventilation openings should be opened during the cool of early morning or preferably overnight to allow stored heat to escape from the building – it is important to check insurance conditions and the need for security if windows are to be left open overnight
- windows and other ventilation openings should not be closed, but their openings reduced when the outdoor air becomes warmer than the air indoors – this should help keep rooms cool whilst allowing adequate ventilation
- use outdoor sun awnings if available, or indoor blinds, but do not let solar shading devices block ventilation openings or windows
- keep the use of electric lighting to a minimum during heatwaves
- all electrical equipment, including computers, monitors and printers should be switched off when not in use and should not be left in ‘standby mode’ – electrical equipment, when left on, or in ‘standby’ mode generates heat

Which children are likely to be most affected by high temperatures?

Children’s susceptibility to high temperatures varies; those who are overweight or who are taking medication may be at increased risk of adverse effects. Children under four years of age are also at increased risk.

Some children with disabilities or complex health needs may be more susceptible to temperature extremes. The school nurse, community health practitioner, family health visitor or the child’s specialist health professional may be able to advise on the particular needs of the individual child. Schools need to provide for children’s individual needs. Support staff should be made aware of the risks and how to manage them.

Further information is available in the PHE leaflet: Looking after children and those in early years settings during heatwaves: guidance for teachers and professionals.

3.4 Other considerations for summer preparedness

3.4.1 Heatwaves and large public events

Summer is a time for people to get outside and enjoy themselves. Large scale public events, such as music and arts festivals; sports events; and national celebrations are held up and down the country every summer providing enjoyment to millions of people.

Local agencies are generally well equipped to plan and deal with such events. There is well-tried and tested guidance, especially from the Health and Safety Executive *'Events Safety Guide' (*see Annex 3). However, the effects of excessive heat and sun exposure are sometimes not highlighted enough.

Large public events increase exposure to heat and direct sunlight and can make organisational responses more difficult. Individual behaviours often change (for example, people may be reluctant to use the toilet facilities due to the long queues and so purposely reduce fluid intake). At many large events, people get into a good position to see the event and then reduce fluid intake and heat avoidance behaviours so as not to lose their spot. This can lead to heat-related illness, dehydration and/or collapse.

3.4.2 Ramadan

Box 2 heat health advice during Ramadan

Many members of the Muslim community may be fasting during the daylight hours in the month of Ramadan. All local areas should familiarise themselves with the dates of Ramadan each year and build appropriate actions into their local plans if it falls during the summer months. It is common to have one meal just before sunrise and an evening meal after sunset during Ramadan. During hot weather, dehydration is a common and serious risk. It's important to balance food and fluid intake between fasts and especially to drink enough water.

If you start to feel unwell, disoriented or confused, or collapse or faint, advice is to stop fasting and have a drink of water or other fluid. This is especially important for older adults, those with poorly controlled medical conditions such as low/high blood pressure, diabetes and those who are receiving dialysis treatment. The Muslim Council of Britain has confirmed that breaking fast in such conditions is allowable under Islamic law. Also make sure to check on others in the community who may be at greater risk and keep an eye on children to ensure they are having a safe and healthy Ramadan.

Guidance has been produced to help ensure that members of the Muslim community have a safe and healthy Ramadan – Ramadan Health Guide: A guide to healthy fasting produced in association with the NHS with further information available on NHS Choices – Healthy Ramadan.

Chapter 4

Anticipated impacts for other sectors during a Level 4 heatwave

Declaring a Level 4 alert indicates a major incident. The government will decide whether to go to Level 4 when there is a very severe heatwave which will last for a considerable period of time and will also affect transport, food and water, energy supplies and businesses as well as health and social care services.

The decision to issue a Level 4 alert is made at national level and will be taken in light of a cross-government assessment of the weather conditions, co-ordinated by the Civil Contingencies Secretariat (Cabinet Office). A Level 4 alert is not triggered automatically by a greater than four day period of severe hot weather.

In the event of a major incident being declared, all existing emergency policies and procedures will apply. All Level 3 responsibilities will also continue.

4.1 Heatwave – cross-government response:

- the decision to issue a Level 4 alert at national level will be taken in light of a cross-government assessment of the weather conditions, co-ordinated by the Civil Contingencies Secretariat
- in undertaking this assessment, the Civil Contingencies Secretariat would consult with a range of interested departments/agencies, including the DH emergency planning functions, the Met Office, the Department for Transport, the Department for Communities and Local Government and others as required
- in line with its approach to all major national incidents, in the event of a Level 4 emergency being declared, the Cabinet Office will nominate a lead government department to coordinate the central government response machinery as necessary. This is most likely to be the Department of Health as a prolonged heatwave would primarily be a public health issue
- PHE will continue to monitor routine surveillance systems for any increases in heat-related morbidity or mortality. For further details on output frequency see Chapter 5
- while other issues are likely to arise as part of any heatwave emergency, such as power failures and transport disruption, these would be dealt with by the departments concerned as part of a coordinated response unless they became the overriding concern, in which case the overall central government department lead may transfer responsibility

- response arrangements will need to be necessarily flexible, in order to adapt to the nature of the challenge and other circumstances at the time while applying good practice, including lessons from previous emergencies

Anticipated risks and responses during a heatwave Level 4, according to different sectors, are summarised below.

The previous pages have highlighted the risks to public health from a heatwave. The risks to other important areas of life from four or more days where temperatures have reached threshold values during the day and overnight are equally important and will have an impact on health and the ability of health services to respond. These wider risks, which have the potential to generate disruption at a national, regional and local level, include the following:

4.2 Transport infrastructure:

- road surfaces are susceptible to melting under extreme or prolonged temperatures; however, as the surface temperature may not be dependent on the air temperature, melting is more likely to be as a result of direct sunlight
- traffic congestion leading to delays on motorways or trunk roads has potentially serious consequences for those stranded in vehicles, particularly vulnerable people such as the elderly or young children
- the rail network will be susceptible to rails warping or buckling under extreme or prolonged temperatures and this will vary according to specific local factors including local geography and the maintenance status of the track. As a very approximate guide, staged preventative measures begin to be applied when air temperatures reach 22°C. The most extreme precautions would only cut in at air temperatures of 36°C (which is likely to give a railhead temperature of over 50°C).
- extreme temperatures on the London Underground network could lead to a range of health and safety challenges. London Underground network operations monitor Met Office weather forecasts, and if temperatures are forecast not to fall below 24°C for three days running they will get ready to implement plans to deploy hot weather notices and bottled water supply, as well as measures to prevent track buckling

4.3 Power supplies:

- at a time when energy companies traditionally maintain power stations for the winter by standing units down over the summer, rising temperatures increase the demand for supply due to the use of air-conditioning units and reduce the power-carrying capacity of the system, as it is harder to cool conductors – this will restrict the ‘maintenance window’ available and could ultimately require greater redundancy on the system to permit maintenance

- rising temperatures cause cooling problems for power stations as they are unable to cool components. This effect has been experienced in France, but not yet to a serious extent in the UK
- high air temperatures are more of a problem and nuclear reactors can trip out at above 40°C, although this has never yet been reached at any site (38°C being the record)
- rising temperatures lower power station efficiency – this effect is of lower concern than the two effects above

4.4 Environmental pollution:

- air quality – smogs typically accompany heatwaves as these often occur during periods of limited dispersion and/or easterly continental air masses arriving in the UK – as a result pollutants are less well spread or added to a higher background concentration which can lead to high concentrations of nitrogen dioxide and particulate matter. Heatwave conditions often lead to increased ozone levels following interactions of other pollutants with sunlight. Information on the latest pollution levels and the air quality forecast can be found on the UK-Air website (Defra)
- water quality – prolonged sunshine can accelerate the growth of blue-green algae, which can cause problems for aquatic life, including fish, as well as toxic algal blooms, causing problems for public recreational water activities
- a prolonged heatwave may cause increased health and environmental problems including odour, dust and vermin infestation, increasing public nuisance and complaint – additional measures would be necessary to mitigate these problems, including more frequent refuse collections and enhanced pollution control measures at landfills and other waste treatment facilities

4.5 The potential for wildfires:

The risks during a heatwave can be greater because the vegetation will be that much drier than usual. The smoke and other risks from wildfire can cause the closure of motorways and contributes to local and regional air pollution. For more information please see the Health Protection Agency website on response to wildfires, in the National Archives.

4.6 Animal welfare:

- rising temperatures would require the increase of ventilation requirements for animals temporarily housed at farms, markets and slaughterhouses
- rising temperatures lead to changes in transport, markets and temporarily housed animal stocking densities
- delays on transport have the potential to lead to increased distress and suffering of animals and increase the number of deaths of animals in transit

- slaughterhouses' killing throughput may be affected due to reduced working hours at slaughterhouses and the transport of a lower number of animals
- there is the potential for an increase in the number of pet fatalities due to irresponsible owners leaving them in restricted enclosures with poor ventilation (eg dogs in cars)

4.7 Water shortages:

- water companies have plans in place to deal with failure in the supply of mains water or sewerage services – these plans are regularly reviewed and tested by the water companies and are independently certified every year
- in the event of a reduced mains supply, water companies would introduce water saving measures such as reducing water pressure or limiting 24/7 supply. In the event of a loss of mains supply, water companies are required to supply water by alternative means, such as in static tanks or bottled water. There is a requirement to provide not less than 10 litres per person per day, with special attention given to the needs of vulnerable people, hospitals and schools
- where an interruption to the piped water supply exceeds five days, the minimum requirement rises to 20 litres per person per day
- strong demand during a heatwave has the potential to jeopardise the availability of water supplies, particularly in southern and some other parts of the UK, and could lead to local hose-pipe restrictions if high temperatures persist

4.8 Children's sector:

Some schools have had to close classrooms where conditions are too hot. Please refer to PHE guidance: Looking after children and those in early years settings during heatwaves: guidance for teachers and professionals.

4.9 Crops:

- horticulture is very sensitive to rising temperatures, as crops start to experience stress due to heat and water shortage, and will die if prolonged
- crops may not be harvested at appropriate times and may be lost or quality and nutritional value may be reduced
- high temperatures may mean crops cannot be sown at appropriate times or need more water
- flowering and pollination may be affected, reducing fruit and grains
- it may become difficult to store crops such as potatoes at the appropriate temperature as machinery has to work harder

Chapter 5

Monitoring and surveillance

5.1 The public health outcomes framework: Level 0

The public health outcomes framework sets out desired outcomes and indicators to help us understand how well public health is being improved and protected. A number of outcome framework indicators can be linked to long-term planning for severe heat and heatwaves (see companion document Making the Case). PHE will publish data in an online tool that allows local authorities to compare themselves with other authorities in the region and benchmark themselves against the England average.

5.2 Real time monitoring and surveillance: Levels 1-4

PHE, in collaboration with other agencies provides both information on excess mortality and morbidity due to heatwaves. Much of this is recorded in as near 'real-time' as possible to provide agencies with a source of intelligence on how health is affected by a spell of hot weather. The frequency of outputs at each heatwave level are given below.

Level 1: heatwave and summer preparedness: PHE will routinely monitor outputs from real-time syndromic surveillance systems including calls to NHS 111, GP in hours and out of hours consultations and emergency department attendances (on a daily basis, week days only), for the impact of heat-related morbidity using a range of syndromic health indicators. Information on heat-related illness will be included in routine weekly surveillance reports published on the PHE website; these will provide a source of intelligence on how severe the effects are and how well services are responding.

PHE will continue to provide heatwave mortality surveillance, producing weekly excess all-cause mortality estimates based on ONS weekly data during the summer and publish outputs once a fortnight on the PHE website in the PHE mortality report.

Level 2: alert and readiness: PHE will continue to monitor routine syndromic surveillance systems for any increases in heat-related illness including calls to NHS 111, GP in hours and out of hours consultations and emergency department attendances (on a daily basis, week days only). It will continue to provide information on heat-related illness in routine weekly surveillance reports.

PHE will continue to produce weekly excess all-cause mortality estimates based on weekly ONS data during the summer and publish outputs once a fortnight on the PHE website in the PHE mortality report. In addition, PHE will request release of daily deaths data and monitor

daily any increase in excess summer deaths based on available data. Daily monitoring will continue up until one week after return to level 1.

Level 3: heatwave action: PHE will continue to monitor any increases in heat-related illness reported in calls to NHS 111, GP in hours and out of hours consultations and emergency department attendances (on a daily basis, week days only) and will produce an additional single weekly heat wave syndromic surveillance report, in addition to the routine weekly surveillance outputs, for incorporation into a weekly PHE heatwave output. This additional report will provide a source of intelligence on how severe the reported effects are including further information on the impact on existing regions and age groups.

PHE will continue to monitor any increase in mortality based on available daily and weekly data.

Level 4: emergency: PHE will continue to monitor any increases in heat-related illness reported in calls to NHS 111, GP in hours and out of hours consultations and emergency department attendances (on a daily basis, week days only), providing a daily (weekday only) syndromic surveillance report on heat-related illness in the community, for incorporation into a daily PHE output.

Mortality will be monitored as per level 3.

5.3 Evaluation

PHE will work together with the DH to prepare an annual review of the Heatwave Plan which takes place each spring.

Chapter 6

Recommended next steps for the NHS and local authorities

We have stressed that the *Heatwave plan for England* is a good-practice document and the actions denoted are illustrative. It is up to each local authority and their NHS partners to consider the actions in this plan; adapt them and incorporate them as appropriate to the local situation, as a component of wider heatwave planning and other climate change adaptation arrangements. Local teams from NHS England and PHE are there to support, to advise, and to coordinate these arrangements as required.

In light of the guidance and good practice recommendations made in the *Heatwave plan for England*, there are three key messages we would like to recommend to all local areas:

1. All local authorities, NHS commissioners and their partner organisations should consider the *Heatwave plan for England* and satisfy themselves that the suggested actions and the heatwave alert service are understood across their locality. Local heatwave and climate change adaptation plans should be reviewed in light of this plan.

2. NHS and local authority commissioners, together with Local Resilience Forums, should review or audit the distribution of the heatwave alerts across the local health and social care systems to satisfy themselves that the alerts reach those that need to take appropriate actions, immediately after issue. Figure 2.4 is an illustrative diagram showing a cascade of a heatwave alert message. Local areas need to adapt these to their particular situations and ensure themselves that the cascades are working appropriately. We would ask that particular care is taken to ensure independent care homes and hospitals and healthcare providers are made aware of the plan, and for care homes, of the specific risks associated with residents of homes and of the specific advice directed at care home managers and staff.

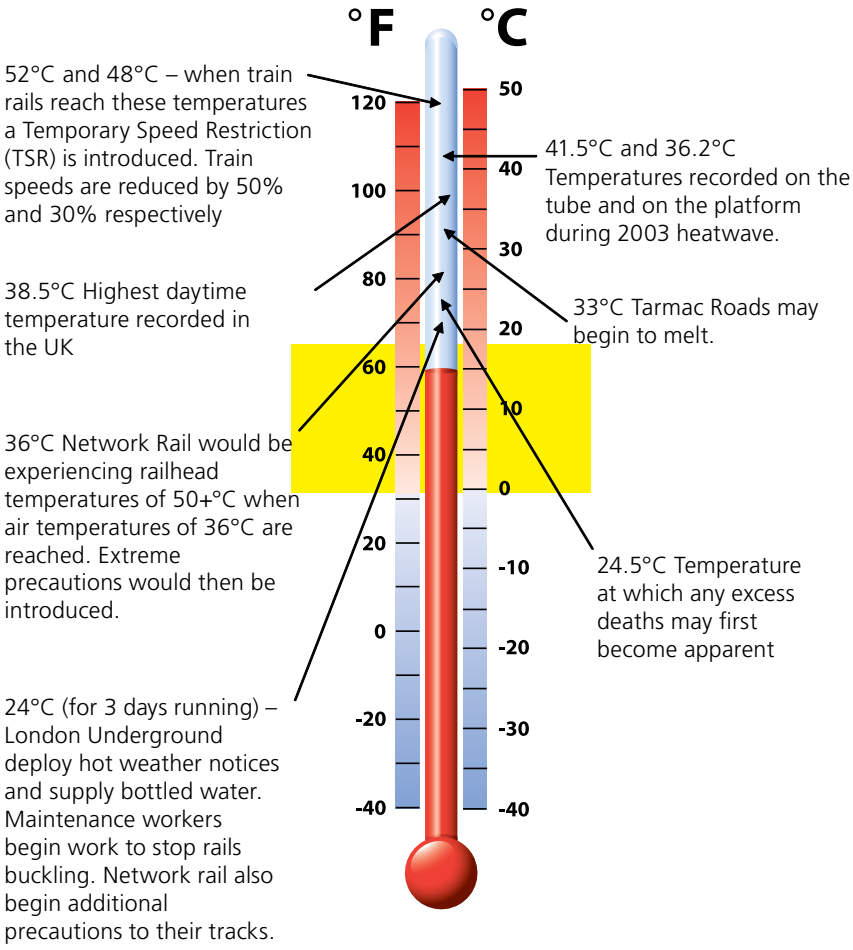
3. NHS and local authority commissioners, together with Local Resilience Forums, should seek assurance that organisations and key stakeholders are taking appropriate actions in light of the heatwave alert messages. The actions identified in Chapter 3 are based on the best evidence and practice available, but are illustrative. It is for local areas to amend and adapt this guidance and to clarify procedures for staff and organisations in a way which is appropriate for the local situation. As ever, it is for professionals to use their judgement in any individual situation to ensure that they are doing the best they can for their patient or client.

Annex 1

Key trigger temperatures

Figure 4 summarises the key trigger temperatures during a heatwave. Although excess seasonal deaths start to occur at approximately 25°C, for practical reasons the health heatwave alert system is based upon temperature thresholds where the odds ratio is above 1.15 to 1.2 (a 15 to 20% increased risk). The different trigger temperatures for local areas are summarised below with regional variations due to relative adaptation to heat, however, a significant proportion of excess summer deaths occur before the health heatwave alert is triggered, which emphasises the importance of long-term planning actions by local authorities and the health sector.

Figure 4. Trigger temperatures



Local threshold temperatures

Threshold maximum day and night temperatures defined by the Met Office National Severe Weather Warning Service (NSWWS) region are set out below.

Maximum temperatures (°C)

NSWWS Region	Day	Night
London	32	18
South East	31	16
South West	30	15
Eastern	30	15
West Midlands	30	15
East Midlands	30	15
North West	30	15
Yorkshire and Humber	29	15
North East	28	15

Annex 2

Public health core messages

These are the core messages to be broadcast as official PHE warnings alongside national and regional weather forecasts. They may be expanded or otherwise refined in discussion with broadcasters and weather presenters.

Level 1: summer preparedness and long-term planning

No warning required unless there is a 60 per cent probability of the situation reaching Level 2 somewhere in the UK within the next three days, then something along the lines of:

"If this does turn out to be a heatwave, we'll try to give you as much warning as possible. But in the meantime, if you are worried about what to do, either for yourself or somebody you know who you think might be at risk, for advice go to NHS Choices at www.nhs.uk/summerhealth. Alternatively ring NHS 111.

Level 2: alert and readiness

The Met Office, in conjunction with PHE, is issuing the following heatwave warning for [regions identified]:

"Heatwaves can be dangerous, especially for the very young or very old or those with chronic disease. Advice on how to reduce the risk either for yourself or somebody you know can be obtained from NHS Choices at www.nhs.uk/summerhealth, NHS 111 or from your local chemist."

Level 3 and 4: heatwave action/emergency

The Met Office, in conjunction with PHE, is issuing the following heatwave advice for [regions identified]:

"Stay out of the sun. Keep your home as cool as possible – shading windows and shutting them during the day may help. Open them when it is cooler at night. Keep drinking fluids. If there's anybody you know, for example an older person living on their own, who might be at special risk, make sure they know what to do."

Annex 3

Heatwave advice and mass gatherings

The attached list provides a quick heat-health checklist that can be used when planning large scale public events (mass gatherings). This should be used in conjunction with other more detailed planning advice (e.g. Health and Safety Executive's 'Events Safety Guide').

Heat-health risk	Actions to consider:
Increased exposure to heat	• provide temporary shaded areas at event locations (umbrellas, tents) • reduce the need to queue (efficient check in, additional staffing, or staggered ticket entry) • provide a water spray/mist area/spraying (showers, garden hose) • make available a map of local public air-conditioned spaces where people can have respite from the heat (consider extending opening hours of these venues) • divert strenuous activities for cooler days or cooler periods of the day and provide an alternative, less strenuous program for hot days
Communication barriers	• prepare advice for tourists and distribute around hotels, money exchanges and transport hubs • produce and distribute heat-health advice printed onto free fans or caps (can be used to fan/protect against sun while containing information on protecting against and recognising heat-related illnesses, and provide emergency phone number in case of identified heat related illness) • inform your audience and/or your members about the health risks and possible preventive measures through digital screens/speakers/announcements
Reduced access to water	• distribute water bottles or temporary water dispensers • ensure an adequate supply of drinking water – on hot days it is advisable to provide free drinking water

Heat-health risk	Actions to consider:
Severe heat emergency	• consider moving date, location or cancel event in extreme heat alert (especially at a Level 4 alert) • ensure adequate immediate relief for people in emergency and ensure their transport to the first aid/health unit
Medical needs	• remember that people with asthma, heart disease and/or other additional chronic conditions are additionally health sensitive to ozone and/or heat • keep in mind that alcohol and some (prescription) drugs can worsen effect of heat • ensure adequately trained personnel who notify authorities as soon as there are incidences of heat illness observed
Food needs	• provide water-rich foods such as salads, yogurt and ensure that food is kept cool to prevent contamination

Adapted using best practice advice from:

1. Lowe D, Ebi K, Forsberg B *Heatwave Early Warning Systems and Adaptation Advice to Reduce Human Health Consequences of Heatwaves*. *Int. J. Environ. Res. Public Health* **2011**, *8*, 4623-4648
2. Plan Nacional de Actuaciones Preventivas de los Efectos del Exceso de temperaturas Sobre la Salud (Spain). Available online: http://www.msps.es/ciudadanos/saludAmbLaboral/planAltasTemp/2011/docs/planNacionalExcesoTemperaturas.pdf
3. Plano De Contingência Para Ondas De Calor (Portugal). Available online: http://www.dgs.pt/upload/membro.id/ficheiros/i010993.pdf
4. Dianne Lowe (Personal Communication)
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References

A selection of key references may be found in section 4 of ‘Making the Case’.

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