London Borough of Hammersmith & Fulham

Health, Adult Social Care and Social Inclusion Policy and Accountability Committee

Agenda

Monday 14 September 2015
7.00 pm
Courtyard Room - Hammersmith Town Hall

MEMBERSHIP

Administration:	Opposition	Co-optees
Councillor Rory Vaughan (Chair) Councillor Hannah Barlow Councillor Natalia Perez Shepherd	Councillor Andrew Brown Councillor Joe Carlebach	Patrick McVeigh, Action on Disability Bryan Naylor, Age UK Debbie Domb, HAFCAC

CONTACT OFFICER: Sue Perrin
Committee Co-ordinator
Governance and Scrutiny
☎: 020 8753 2094
E-mail: sue.perrin@lbhf.gov.uk

Reports on the open agenda are available on the Council's website:
http://www.lbhf.gov.uk/Directory/Council_and_Democracy

Members of the public are welcome to attend. A loop system for hearing impairment is provided, along with disabled access to the building.

Date Issued: 04 September 2015

London Borough of Hammersmith & Fulham

Health, Adult Social Care and Social Inclusion Policy and Accountability Committee

Agenda

14 September 2015

Hammersmith & Fulham and action plans to improve the uptake rate of the flu vaccine.

6. NEW HOME CARE SERVICES 52 - 67

This report sets out the proposal for contract awards for new Home Care Services for people who meet Adult Social Care eligibility criteria in the London Borough of Hammersmith and Fulham.

7. CUSTOMER SATISFACTION 68 - 86

This report provides a description of current mechanisms to understand customer satisfaction and experience in adult social care; a summary of some current findings from the annual service user survey and carers survey; and how the mechanisms for obtaining customer experience and satisfaction are being developed.

8. WORK PROGRAMME 87 - 88

The Committee is asked to consider its work programme for the remainder of the municipal year.

9. DATES OF FUTURE MEETINGS

4 November 2015
2 December 2015
2 February 2106
14 March 2016
18 April 2016

London Borough of Hammersmith & Fulham

Health, Adult Social Care and Social Inclusion Policy and Accountability Committee

Minutes

Tuesday 7 July 2015

PRESENT

Committee members: Councillors Rory Vaughan (Chair), Hannah Barlow, Andrew Brown and Joe Carlebach

Co-opted members: Bryan Naylor (Age UK)

Other Councillors: Vivienne Lukey (Cabinet Member for Health and Adult Social Care), Sue Fennimore (Cabinet Member for Social Inclusion) and Sharon Holder (Lead Member for Health),

Chelsea and Westminster Hospital NHS Foundation Trust: Elizabeth McManus (Chief Executive), Dominic Conlin (Director of Strategy and Integration), Vanessa Sloane (Director of Nursing), Dr Roger Chinn (WMUH Medical Director) and Prof Simon Barton (Associate Medical Director)

Hammersmith & Fulham CCG: Dr Tim Spicer (Chair), Janet Cree (Managing Director) and Clare Parker (Chief Officer)

Officers: Liz Bruce (Executive Director of Adult Social Care & Health), Sue Perrin (Committee Co-ordinator) and Sue Spiller (Head of Community Investment)

12. MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 3 June 2015 were approved as an accurate record and signed by the Chair.

Matters Arising

Preparing for Adulthood: A Report About Young People Aged 14-25 Years with Disabilities

(i) It was noted that information in respect of the stage of the consultation (Alison Farmer) and the information requested, as detailed in the minutes of the meeting held on 3 June 2015 (Ian Heggs) was outstanding.

(ii) Mrs Bruce clarified, on behalf of Mr Christie, comments allegedly made by him. Mr Christie did not recall making such an unequivocal statement. Whilst children had to move on from children's services to an adult environment, they would be supported through the process and the changes being put in place would help improve the transition for children and their families.

There was an issue in that some services were funded only for children aged 18 and below, and it was therefore necessary to negotiate the continued provision. There was a need for flexibility and continuity to support a good transition.

13. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Perez Shepherd, Debbie Domb and Patrick McVeigh.

14. DECLARATION OF INTEREST

The following declarations of interest were made:

Councillor Vivienne Lukey is a trustee of H&F Mind.

Councillor Joe Carlebach is an ambassador for Mencap.

15. ADDRESSING FOOD POVERTY IN HAMMERSMITH & FULHAM

Councillor Vaughan stated that Daphine Aikens, Manager of the Hammersmith & Fulham Foodbank (HFFB) was unable to attend the meeting, but had read the report and had no comments, 'other than to say that my Trustees and I are very grateful for all that the Council are doing to help us in our effort to launch a third Distribution Centre at 75 Bloemfontein Road'.

Ms Spiller introduced the progress report on addressing food poverty in Hammersmith & Fulham, which included measures to provide support, Food Bank services and further research being undertaken.

A food collection point had been installed at Hammersmith Town Hall, was proving to be a success.

The Council had agreed a Citizen's Advice Bureau (CAB) funding proposal to enable the service to work in partnership with HFFB to train their volunteers to become CAB Information and Budgeting Assistants and provide assisted

information on money, benefits, budgeting, employment matters and housing matters and carry out an assessment of any further advice and support required and signpost/refer accordingly.

75 Bloemfontein Road had been identified as a suitable location for an additional H&F Food Bank in the north of the borough. The space was in need of renovations and refurbishing and Amey, the Council's contractor for property repairs and maintenance had agreed to undertake the works under its Corporate Social Responsibility programme. In addition, Amey had agreed to collect the food from Hammersmith Town Hall and take to HFFB.

HFFB would need to secure additional funding for the Bloemfontein Road site. It was proposed that the Council provided a grant from the 3rd Sector Investment Fund to support the HFFB service, and to provide support to identify and apply for alternative funding sources as the service developed.

The Trussell Trust was interested in working with the Council and HFFB in the alleviation of food poverty at an early stage.

Councillor Fennimore stated that she was delighted with the joined up approach, and it was planned to put in place other areas of support to reduce the number of people using the foodbank. The Trussell Trust had commended the Council's innovative way of working.

Mr Naylor queried whether there was a distribution method to help older people who found it difficult to travel. Ms Spiller agreed to discuss this with HFFB and noted that the Winter Pressures work included food packs being left with community organisations for distribution.

Councillor Vaughan queried the age profile of those using HFFB. Ms Spiller responded that there was a fairly broad age range. It was difficult to get data from the Trussell Trust, which had concerns about confidentiality and use of the data. Food poverty tended to be a short term issue, with people using the foodbank maybe three/four times over a six month period.

Ms Spiller responded to Councillor Carlebach that the highest number of referrals tended to be from the Job Centre in Hammersmith and the CAB. The food vouchers were distributed by some 250 partners across the borough, but people did not always redeem these vouchers. It was planned to undertake a piece of work with HFFB to identify the number of partner vouchers redeemed.

Councillor Vaughan queried how it was intended to sustain the progress. Ms Spiller responded that addressing food poverty was a priority for the Cabinet Member for Social Inclusion. There would be a timescale for what needed to happen to put an infrastructure in place. However, there were resource issues in respect of HFFB being run entirely by volunteers and the capacity of the Council, HFFB and Trussell Trust. Longer term work would include the prevention of food poverty. A piece of work into the links between worklessness and poverty was at the early stage of scoping.

Councillor Fennimore added that the partnership work was very strong and, whilst the Council would support HFFB, the ultimate goal was for there to be no need for foodbanks.

RESOLVED THAT:

1. The Committee highly commended the progress made against the PAC recommendations made at its October 2014 meeting, and specifically the opening of a site in the north of the borough.

2. The Committee was highly interested in research into who used the foodbank and the age profile.

3. A further report on the recommendations arising from the work with the Trussell Trust should be added to the work programme.

4. The Committee recommended that the Council and HFFB consider how to accommodate the problem of foodbanks being site specific and people being unable to travel.

16. CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST INTEGRATION WITH WEST MIDDLESEX HOSPITAL

Councillor Vaughan welcomed the representatives of Chelsea and Westminster Hospital NHS Foundation Trust.

Ms McManus outlined the process, which had commenced in October 2012, with West Middlesex Hospital seeking initial expressions of interest to find a suitable partner to achieve NHS foundation trust status. Following a rigorous process, Chelsea and Westminster Hospital had been selected in April 2013.

Ms McManus stated that the decision represented the best option for securing the future of both organisations as major acute hospitals. The two trusts were similar culturally and both were relatively small. Acquisition would create a combined entity serving a population of around 1.1 million. A single organisation would provide greater opportunity to develop clinical services and more security for smaller services. There would be significant financial pressures for both, should they not become one organisation.

There was a regulatory process, but formal consultation was not required as there was not a service change: Chelsea & Westminster Trust Board would acquire West Middlesex Hospital. There was considerable discussion with the Council of Governors. The acquisition had been cleared by the Competition and Markets Authority.

The process was reviewed by the external regulators, the Trust Development Agency and Monitor, which would issue a risk rating. This would be considered by the Chelsea and Westminster Trust Board, which would make

the formal decision to proceed. An application would be made to the Secretary of State for the transaction to take place on 1 September 2015.

The business case would remain confidential until the transition had been agreed by all parties. However, it would be available at the hospital for members of the PAC to view.

There were difficulties in terms of recruitment and retention. Three members of the Chelsea and Westminster Hospital management team had been seconded to West Middlesex Hospital.

Members raised concerns in respect of the lack of financial information, which should have been shared in order to facilitate proper scrutiny. Councillor Carlebach suggested that the merger was a financial transaction because the West Middlesex PFI had become too expensive to manage.

Ms McManus responded that the merger was clinically driven, putting patient safety first. As one organisation, there would be a large enough population to continue to provide services and to ensure long term sustainability. It was not possible to share the financial detail as a confidentiality agreement had been signed.

Mr Conlin added that clinical sustainability was the catalyst of the deal. However, there were risks to the trust if the acquisition was not approved. The West Middlesex PFI was one of the smallest in London, some £2 million per annum. This would continue to be a drain until the estate was improved as an asset. There was a short term plan to make the estate work harder.

There were over 100,000 attendances by Hammersmith & Fulham residents at Chelsea and Westminster Hospital annually and there would be no significant change. Those services currently provided would still be available on the Chelsea and Westminster site.

Councillor Holder queried patient involvement which had taken place and was planned for the future. Ms McManus responded that statutory requirements for consultation were different from expectations. Consultation had been through existing networks such as the CCGs and the Council of Governors and there had been some communication with patients and their representatives. In hindsight, it would have been appropriate to provide reassurance that there would be no service change on 1 September.

Mr Conlin added that the formal guidance around transition had been followed. The proposals had been reviewed with colleagues in Hounslow and Richmond, and there had been a number of constituency events. There would be clinical benefits going forward for a number of services. The Council of Governors and patient representatives were testing the assumptions. There would be no significant service changes.

In respect of maternity services, comments from patients had indicated the need for a more local model. Local services would be maintained. Systems

would be improved with technology and best practice pathways developed and integrated with GP services.

Councillor Brown considered that the acquisition would create future risk and that West Middlesex had invited expressions of interest for financial not clinical reasons and queried which other trusts had expressed an interest.

Ms Parker stated that whilst the merger was primarily clinically driven, it was also designed to reduce the pressure on West Middlesex Hospital finances. There had been two expressions of interest: Chelsea and Westminster Hospital and Imperial College Healthcare NHS Trust. The clinical synergies with Chelsea and Westminster were much stronger and would ensure no service losses for either site. The CCG was the lead commissioner representing Hammersmith and Fulham. Chelsea and Westminster had strong clinical and management leadership, and the acquisition would provide increased opportunities and access on the West Middlesex site. In addition, it would be an opportunity to attract funding to invest in one electronic patient system (EPR) across the two sites.

Councillor Brown queried whether the acquisition would have proceeded without the financial incentive. Mr Conlin responded that whilst the EPR would be fully funded, this was not the reason for the acquisition. Financial settlement had been negotiated to support the new organisation to address key risks identified in the due diligence to year five, after which the Trust would stand alone. The risks associated with the PFI were significantly outweighed by other incentives.

Councillor Lukey considered that there was a lack of clarity in respect of management and protection of front line services. There was a significant risk in respect of recruitment and retention. The current service was not sustainable and management change alone would not address the issues.

Ms McManus responded that whilst there were potentially management job losses, there would be no cuts for frontline staff involved in direct patient care. Where there were intended changes in clinical services, patient groups would be contacted.

Dr Chinn stated that there were clinical sustainability issues because of difficulties in retention of consultant medical staff at West Middlesex Hospital. However, it had been possible to recruit successfully to a number of different clinical specialties because of the proposed merger.

In respect of maternity services, together the two hospitals could offer a better model of care. West Middlesex Hospital did not have a good enough team of midwives and obstetricians. There was a need to offer new sub-specialist services. Chelsea and Westminster Hospital was providing a tertiary service for West Middlesex Hospital, but there were some unnecessary transfers. The merged service would replicate good care closer to home.

Currently, there was inadequate acute coronary care and it was necessary to refer patients to other providers such as Imperial College Healthcare or the

Royal Brompton, where there could be considerable waiting times, or even Wycombe and Ashford hospitals. The merged service would be able to offer a cost effective service in a more timely manner.

Councillor Carlebach queried the rational for developing coronary care, when Hammersmith Hospital already specialised in coronary care. Mr Conlin responded that the intention was to invest in diagnostic services. Complex cases would continue to be transferred to specialist centres.

Councillor Carlebach referred to a patient complaint which had been referred to him because it had not been possible to get a satisfactory response from Chelsea and Westminster Hospital. He did not consider that there was any evidence of management capacity and queried whether the proposed merger had been discussed with the Council.

Ms McManus responded that incidents were normally investigated quickly. Contact with patients and relatives was maintained and an explanation given. In respect of management capacity, the non-executive directors were part of the transition and together the executive and non-executive directors had significant expertise in health service management and in the private sector.

Ms Parker added that management capacity and clinical leadership had been one of the CCG's key concerns, and it had been made explicit that there had to be sufficient managers on both sites. In respect of communications, the focus had been more towards West Middlesex Hospital, as the impact on Chelsea and Westminster Hospital had been deemed to be negligible. There had been a number of visits to Hounslow and also to Kensington & Chelsea.

Councillor Brown queried whether the organisational change had caused the CQC rating of 'Requires Improvement'. Ms McManus responded that whilst the CQC report was less than ideal, it was not the result of staff being distracted. Chelsea and Westminster Hospital had put in place an action plan, much of which had already been implemented. The West Middlesex Hospital report had been similar.

Mr Conlin noted the commitment to improve retention rates which would also improve patient experience. The EPR would be a key enabler. The merged hospitals would provide the larger patient base necessary for some of the services which could not be provided on a stand-alone basis.

Councillor Carlebach suggested that Chelsea and Westminster Hospital should invest more in the services in which it specialised and roll out across the country. Professor Barton outlined the investment in sexual health services and the importance of the merger with West Middlesex Hospital. The commitment to local access for a larger population would ensure the best services for all those individuals. For Chelsea and Westminster to continue its award winning work, sufficient scale to sub-specialise was required and new models of care, enabled through information technology. It would not be possible to invest in an EPR, without significant funding from the Department of Health.

Mr Naylor stated that older people would ask about the difference which the merger would make and how the service would be different. Ms McManus responded that the Trust welcomed the opportunity to engage with people to discuss future models of care.

Councillor Vaughan queried whether the business case included the changes under the Shaping a Healthier Future (SaHF) proposals and the patient flows from Ealing and Charing Cross; if the investment due under SaHF for both sites had been factored in; and how the estate could be made to work harder.

Mr Conlin responded that to make the estate work harder, there needed to be more patients using the hospital. The Trust had been asked to make the base case compliant with SaHF and the patient flows assumed under SaHF had been included. Both sites would extend their Accident & Emergency departments to meet the increased activity. Ms McManus added that the Trust would look to make back office functions more efficient to protect front line staff.

Councillor Vaughan queried the impact on existing services should the merger not go through and whether any of these services be regarded as unsafe in a year's time. Mr Conlin responded that the management capacity at West Middlesex Hospital would not exist and the external financial rating would dip quickly in year two, leading to extra scrutiny of all services. Chelsea and Westminster Hospital would post a deficit for the first time in the current year and was entering even more challenging times.

Mr Conlin stated that should the merger not go ahead, the Trust would move quickly to discussions with other partners to put in place other solutions, and potentially plans B and C.

Councillor Vaughan queried why Chelsea and Westminster Hospital had not looked at other partners to develop services, rather than taking on the issues at West Middlesex Hospital, and specifically the recruitment difficulties. Ms McManus responded that a year had been spent looking at other opportunities. The recruitment difficulties were just in respect of consultant medical staff. There was a better trend in recruitment and retention of nursing and midwifery staff.

Chelsea and Westminster was one of the highest performing trusts, and West Middlesex represented an opportunity to work with a larger population and to sub-specialise. Both trusts had extremely similar values and behaviours, kind to patients and relatives and inviting feedback. The ability to recruit would be easier as one organisation.

Dr Chinn emphasised the high level of staff engagement and that staff put patients first.

Councillor Brown stated that assurance had not been provided around the financial case and suggested that smaller multiple changes would have lower risk. Ms McManus responded that this had been tested in the longer term

financial model and repeated the invitation for members to go through this with the Chief Financial Officer at Chelsea and Westminster Hospital.

Councillor Carlebach considered that the PAC had been excluded from the process and that it had not been possible to adequately cover the merger in two meetings.

RESOLVED THAT:

1. The PAC did not support the merger. The main concerns were in respect of the financial case, which had not been adequately explained and had been based on patient flows as predicted in the Shaping a Healthier Future proposals.

2. There had been inadequate consultation.

3. There was concern in respect of the adequacy of the proposed management structure.

4. There was not an alternative plan.

5. There were workforce issues at both sites and there was reliance on the successful implementation of a new EPR system.

6. The patient commitment at both sites was noted.

7. An update report should be added to the work programme.

Councillor Vaughan thanked the representative of Chelsea and Westminster Hospital for their attendance.

17. PRIMARY CARE BRIEFING: GP NETWORKS NETWORK PLAN 2015-2016 AND OUT OF HOSPITAL SERVICES

The PAC received a report on the Hammersmith & Fulham GP Networks, GP Network Plan 2015/2016, extended hours and Out of Hospital services.

Councillor Carlebach requested an update on the flu vaccination programme and integration with GPs in Kensington & Chelsea.

Ms Parker stated that a bundle of services were being implemented across the five GP Networks, and that patients would be able to access these and move from one practice to another. Patients' records could be shared, subject to consent and network information sharing agreement. The model would be rolled out across the borough in March 2016.

Action:

A timetable for rolling out the model across boroughs to be provided.

Hammersmith & Fulham CCG

Ms Cree responded to queries in respect of educating patients that there would be a publicity campaign for extended hours, similar to Central London and Westminster, which saw a significant increase in GP attendances and reduction in Accident & Emergency Department attendances.

Information in respect of the 24 hour pharmacy at Earls Court was provided through NHS Choices/111. In addition, there were many pharmacies with extended hours across the borough.

Councillor Lukey queried whether there was coverage for the resident population or registered population; whether mental health assessments were currently only available after first going to a GP; and if there was capacity to meet increased demand with the Out of Hospital model.

Dr Spicer was not aware of any requirement to visit a GP before receiving a mental health assessment, and would provide a written response.

Action: Hammersmith & Fulham CCG

Dr Spicer stated that services were predominantly for the registered population. Unregistered patients tended to go to the Urgent Care Centre, where they would be advised to register with a GP.

Dr Spicer stated that the CCG was committed to the OHH model and would ensure that there was capacity

Councillor Barlow queried recruitment and the SystemOne interface between primary and secondary care. Dr Spicer responded that workforce was the biggest challenge at all levels and grades across West London. Trainees were attracted to London, but retention was difficult. The networks were working with Bucks New University in respect of placements. The CCG was one of the national pilot sites for physician associates. It was also looking at how to retain staff and change the skill mix.

Councillor Vaughan proposed and it was agreed by the Committee that the guillotine be extended to 10.15pm.

Mr Naylor gave an example of a GP practice which closed half day on Thursdays and Saturday, and noted that the CCG could not insist that an independent businesses could extend its hours.

Councillor Holder noted that the Council could assist with publicity of the new model and queried the frequency of evaluation. Ms Cree responded that there would be six monthly reviews to test that the theory and specification were right.

Mrs Bruce noted that Adult Social Care was also facing a skills shortage and that there needed to be a shared strategy for some key roles and joint work to retain staff.

Councillor Vaughan concluded that the PAC welcomed the GP Federation, the GP Network Plan, and the extended hours for GP practices, and was interested in the detail and specifically targets and how monitored. Councillor Vaughan queried whether registered patients within the borough could go to any surgery in the network.

Dr Spicer responded that patients would be able to pick any of the practices providing an extended hours service. SystmOne, the single GP record system used across Hammersmith & Fulham, would be used to provide access to records for the extended hours service (with patient consent) and the information would be available at the original practice immediately.

The majority of appointments would be booked in advance for routine appointments and on the day for urgent care. There would be one slot for 111 referrals. It was intended that there would be three practices every weeks, providing extended hours from 6.30pm.

RESOLVED THAT:

1. There were some queries in respect of the implementation of extended hours.

2. The need for publicity and education of patients and the constraints around workforce were noted.

3. A report on GP access be added to the work programme.

18. WORK PROGRAMME

RESOLVED THAT:

1. The work programme be noted.

2. That an update on the Immunisation Programme be taken at the September meeting.

19. DATES OF FUTURE MEETINGS

14 September 2015
4 November 2015
2 December 2015
2 February 2106
14 March 2016
18 April 2016

Meeting started: 7.00 pm
Meeting ended: 10.15 pm

Chair .....

Contact officer: Sue Perrin
Committee Co-ordinator
Governance and Scrutiny
☎: 020 8753 2094
E-mail: sue.perrin@lbhf.gov.uk

APPENDIX 1

Recommendation and Action Tracking

The schedule below sets out progress in respect of those substantive recommendations and actions arising from the Health, Adult Social Care and Social Inclusion Policy and Accountability Committee

Minute No.	Item	Action/recommendation	Lead Responsibility Progress/Outcome	Status
6.	Preparing for Adulthood: A Report About Young People Aged 14-25 Years with Disabilities	(i) The stage of the consultation to be clarified. (ii) Information requested, as detailed in the minutes. (iii) Clarification of comments allegedly made by Andrew Christie 'however, we cannot change the fact that, once young people turn 18, they must transition to Adult Services.'	Alison Farmer Ian Heggs Response from Mr Christie reported to July PAC.	Chased/ Outstanding Complete
17.	Primary Care Briefing: GP Networks Plan 2015-2016 and Out of Hospital Services	(i) A timetable for rolling out the model across boroughs to be provided. (ii) A written response to be provided in respect of a mental health assessment, and the requirement to visit a GP beforehand.	H&F CCG	Outstanding

	London Borough of Hammersmith & Fulham **HEALTH, ADULT SOCIAL CARE AND SOCIAL INCLUSION POLICY AND ACCOUNTABILITY COMMITTEE** **14 September 2015**
TITLE OF REPORT Immunisations in Hammersmith & Fulham	
Report of Screening and Immunisations Team, Public Health Commissioning, NHS England (London)	
Open Report	
Classification - For Information **Key Decision:** No	
Wards Affected: All	
Accountable Executive Director: **n/a**	
Report Author: Dr Catherine Heffernan, Principal Advisor for Commissioning Early Years, Immunisations and Vaccinations Cecile Henderson, Immunisation Commissioner	**Contact Details:** Tel: 01138070064 E-mail: Catherine.heffernan@nhs.net

1. EXECUTIVE SUMMARY

- The purpose of this paper is to provide the Policy Committee with an update of Section 7a immunisation programmes in Hammersmith & Fulham.
- Hammersmith & Fulham and London have performed below national averages on almost all the Section 7A immunization programmes. However, the London Immunisation Board is overseeing pan-London approaches to improve uptake and coverage.
- For 2015/16, each London borough has been assigned an immunisation commissioner who is responsible for delivering a multi-agency borough specific action plan. The aim of each plan is to increase uptake and vaccination coverage within the boroughs, which in turn will increase London averages. The plans will also address health equities in access to immunisations and health inequalities in uptake. Enfield has a borough specific plan and at time of writing, a draft of this plan is currently being agreed and shaped with local partners

2. RECOMMENDATIONS

Members of the Committee are asked to note the report and support NHS England and Public Health England in improving uptake in the borough.

3. REASONS FOR DECISION

N/A

Appendix 1: Hammersmith and Fulham Flu Vaccination Action Plan Winter 2015-2016 (Public Health Department)

Appendix 2: Hammersmith & Fulham CCH: Arrangements for improving the uptake rate of the flu vaccine amongst children

Hammersmith and Fulham

Report for Health, Adult Social Care and Social Inclusion Policy and Accountability Committee

14th September 2015

Immunisations in Hammersmith & Fulham

Prepared by:

Cécile Henderson, Immunisation Commissioner
Dr Catherine Heffernan, Principal Advisor for Commissioning Early Years, Immunisations and Vaccination Services

Final version: 24th August 2015.

Classification: OFFICIAL

Contents

1 Aim

- The purpose of this paper is to provide the Policy and Accountability Committee of Health and Wellbeing Board of Hammersmith and Fulham with assurance that appropriate governance arrangements are in place within NHS England and that appropriate initiatives are being delivered to increase uptake of immunisations, in order to protect the health of people in Hammersmith and Fulham.
- The reports gives an update on the performance of all immunisation programmes for Hammersmith & Fulham and details the actions taken to improve uptake.
- Section 7a immunisation programmes are universally provided immunisation programmes that cover the life-course and comprise of:
    - Antenatal and targeted new-born vaccinations
    - Routine Childhood Immunisation Programme for 0-5 years
    - School age vaccinations
    - Adult vaccinations such as the annual seasonal 'flu vaccination
- The Policy and Accountability Committee of Health and Wellbeing Board are asked to note and support the work NHS England (London) are doing to increase vaccination coverage and immunisation uptake in Hammersmith & Fulham.

2 Initiatives and Actions for Hammersmith & Fulham 2015/16

- The London Immunisation Board is overseeing pan-London approaches to improve uptake and coverage across London with a five year strategic plan. Quarterly reports from the Board are issued to all directors of public health across London.

- NHS England (NHSE London) initiated, organised and led a Round Table event for Hammersmith & Fulham which took place on 1st April 2015. The event was chaired by George Leahy, Public Health Consultant, NHSE and Public Health England (PHE), and the key stakeholders were represented, including the CCG, the local authority, the CHIS hosted by Central London Community Healthcare NHS Trust (CLCH), NHSE and PHE. The aims of the Round Table event was to review the performance, discuss common issues and blocks to improving performance, re-energise partners in their work to improve coverage and reduce inequalities and finally agree actions, timescales and accountabilities. The following areas were pinpointed as areas that would need to be addressed in priority in 2015/16:

    - data management,
    - clinical coding,
    - the changing workforce,

  - disparity between performance and payment systems,
  - the impact of demographic changes,
  - the need to revitalise and empower staff to promote immunisation to their registered patient populations
  - the need to address the increasing ambivalence of health professionals and patients towards influenza vaccinations.

- During Quarter 1 of 2014/15, there was a temporary suspension of the call and recall arrangements between CLCH (the Child Health Information System providers) and general practice (GP) providers in Hammersmith and Fulham. A remedial action was taken and services are now resumed, however the impact of this temporary suspension may have a future negative impact on the coverage data for 2 and 5 year olds.

- In order to ensure timely payment and re-imbursement for activity, NHSE has enhanced payment systems and implemented contingency arrangements in the absence of National payment systems. A monthly bulletin to GP practice teams is distributed across London providing the latest information.

- All GP Practices in Hammersmith and Fulham are now using TPPSystemOne as the preferred clinical patient record IT system. There have been challenges to extracting timely data using the appropriate coding. The issue was escalated to the national team for mitigation of risk and future resolution.

- For Quarter 1 2015/16, NHSE have implemented a protocol for early scrutiny of immunisation rates prior to submission to COVER. This highlights any issues prior to submission of data to COVER and enables examination of the validity of data.

- NHSE are working with CLCH on ensuring the continuation of improving data quality through meetings and via an Action Plan. The Action Plan addresses Early Years touch-points throughout the child health record: Output based specifications, Antenatal Referrals, NHS numbers for babies, New-born Bloodspot Screening, New-born Hearing, New Infant Physical Examination at 72 hours and 6-8 weeks, and Communication between CHIS providers. One of the key areas in the action plan is ensuring interoperability between systems following migration of CLCH current clinical system (Rio) to TPP SystemOne in July 2015.

- For 2015/16, NHS England (London) is operating annual borough specific plans in an effort to improve vaccine uptake and reduce health inequalities across London. These plans sit with the pan-London approaches overseen by the London Immunisation Board and the improved contractual management and quality assurance processes that NHS England (London) are operating to improve quality of delivery and performance of Section 7a programmes. The Hammersmith & Fulham Immunisation Action Plan focuses on the key improvement areas highlighted at the Round Table Event with jointly agreed actions and outputs for NHSE and its partner organisations to ensure that high levels of immunisation coverage are achieved and sustained. The plan was discussed and agreed in principle with the CCG and Local Authority earlier

this year. Improvements to quality assurance and contractual management include an audit of all GP practices in London and an established London incident protocol to reduce occurrences of vaccine incidents.

- Immunisation commissioners from NHS England (London) are visiting the GP Practices which have the highest numbers of unimmunised children for MMR2 (from COVER data, using the average across Quarter 4, 2013/14 and Quarters 1, 2 and 3, 2014/15). MMR2 and the preschool booster are good indicators of completed immunisation schedules. Five practices have been identified for Hammersmith & Fulham to be visited. To support GP Practices in achieving higher COVER rates, NHSE will design an IT support card for Hammersmith and Fulham practices to be able to prioritise immunisation of the children whose birthdays are in the COVER quarter's cohort.

3 Antenatal and New-born Vaccinations

3.1 Pertussis vaccination for Pregnant Women

- In 2012, a national outbreak of pertussis (whooping cough) was declared by the Health Protection Agency. In 2012, pertussis activity increased beyond levels reported in the previous 20 years and extended into all age groups, including infants less than three months of age. This young infant group is disproportionately affected and the primary aim of the pertussis vaccination programme is to minimise disease, hospitalisation and death in young infants. In September 2012 The Chief Medical Officer (CMO) announced the establishment of the *Temporary programme of pertussis (whooping cough) vaccination of pregnant women* to halt in the increase of confirmed pertussis (whooping cough) cases. This programme has been extended for another 5 years by the Department of Health (DH) in 2014. Since its introduction, Pertussis disease incidence in infants has dropped to pre2012 levels.
- Statistics for pertussis vaccine uptake are reported monthly and by region/area. They cover those women who delivered a baby within the survey month at more than 28 weeks gestational age and who are registered on the general practitioner (GP) systems. However the submission is currently optional and 100% of Hammersmith & Fulham GP practices submitted reports (ImmForm, 2015). Nationally 70% of the population of pregnant women are reflected in the sentinel surveillance data.
- In England, pertussis vaccine coverage in pregnant women reached 62.6% in December 2014 – the highest recorded since the start of the programme. Nationally, the uptake of pertussis vaccine is increasing year on year.
- There are seasonal patterns with the winter months of November and December each year reporting the highest proportion vaccinated whilst there's a drop between April and July
    - Difference attributed to pertussis given with seasonal 'flu vaccination during November and December
- London monthly averages are ~10% lower than national averages and London was one of only two area teams (Birmingham Black Country being the other)

that reported coverage rates of under 50% between Oct 2012 and December 2014

- The annual average for London for 2014/15 (April 2014 – March 2015) was 46.1%. Hammersmith & Fulham CCG reported an average of 43.2% uptake (ImmForm, 2015).
- NHS England has a pan-London action plan to increase uptake amongst pregnant women with a named lead. This includes a project to women's reasons for not being vaccinated and an audit on how well the vaccine is prompted by the health professionals involved. A maternity service level agreement (SLA) has been implemented for 2015/16 with Clinical Commissioning Groups (CCGs) specialised commissioning to enable all maternity services to administer seasonal 'flu and pertussis to all pregnant women.

3.2 Universal BCG vaccination

- The national reporting system is currently under review so no data has been collected since 2012. However, since the London TB Board and the London Immunisation Board both recommended a universal BCG vaccination programme in London, providers of Child Health Information Systems (CHIS) are now contracted to submit quarterly data as part of the Cohort of Vaccination Evaluated Rapidly (COVER) returns. This data will be available from Q1 2015/16 onwards. However, there is data available from a CQUIN that NHS England offered to all CHIS providers in 2014/15 that shows that for Q3 2014/15, 25% of babies in Hammersmith & Fulham received BCG and 22.7% in Quarter 4.
- NHS England (London) will be rolling out a 100% offer of BCG vaccine to all babies up to the age of one year across London. This offer will primarily be given in the maternity units with a community offer for those parents who missed out on the vaccine in maternity hospitals.
- Since April 2015, there has been a shortage of BCG vaccine nationally resulting in low stocks within London. It is anticipated that providers can reorder the vaccine from mid June onwards and have been recommended to adhere to the Public Health England advice of prioritising those infants most at risk of TB.

3.3 Neonatal Hep B vaccination

- Babies born to mother who are Hepatitis B positive should receive a course of 4 does of Hepatitis B vaccine and a serology by 12 months of age. Mothers are identified through the antenatal screening programme and babies are followed up through primary care in Hammersmith & Fulham.
- Numbers for babies born to mothers who are Hepatitis B positive are small so annual figures are more robust. The latest annual data available is for 2013/14 (year ending March 31st 2014. There were no Hepatitis B at risk babies recorded for Hammersmith & Fulham.
- NHS England's intention is to have all babies vaccinated by their first birthday and serology conducted. This is being enacted through commissioning endeavours (including CQUIN to improve reporting) in 2014/15 and a pan-

London action plan being delivered by a Hep B sub-group of the London Immunisation Board.

4 Routine Childhood Immunisation Programme (0-5 years)

4.1 COVER Trends

- Cohort of Vaccination Evaluated Rapidly (COVER) monitors immunisation coverage data for children in UK who reach their first, second or fifth birthday during each evaluation quarter – e.g. 1st January 2012 to 31st March 2012, 1st April 2012 – 30th June 2012. Children having their first birthday in the quarter should have been vaccinated at 2, 3 and 4 months, those turning 2 should have been vaccinated at 12/13 months and those who are having their 5th birthday should have been vaccinated before 5 years, ideally 3 years 3 months to 4 years.

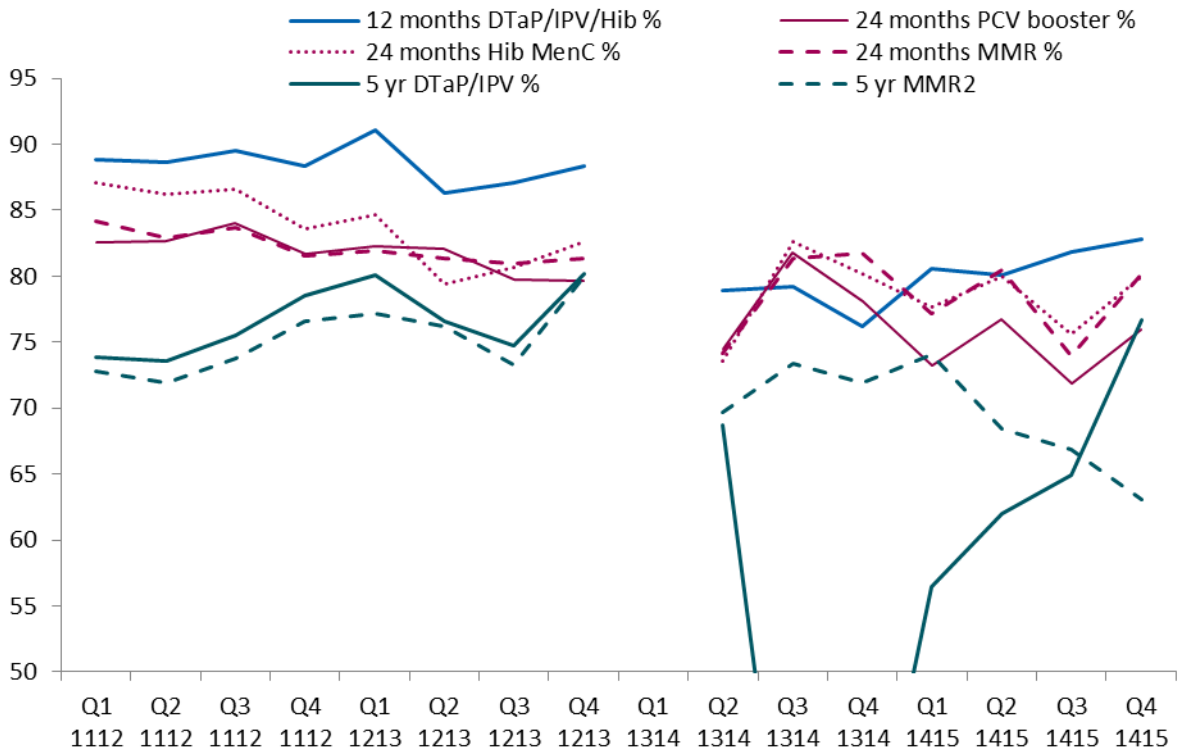
- London has in recent years delivered significantly poorer uptake than the remainder of the country. Reasons provided for the low coverage include the increasing birth rate in London which results in a growing 0-5 population and puts pressure on existing resources such as GP practices, London's high population mobility, difficulties in data collection particularly as there is no real incentive for GPs to submit data for COVER statistics and large numbers of deprived or vulnerable groups. In addition, there is a 20-40% annual turnover on GP patient lists which affects the accuracy of the denominator for COVER submissions, which in Hammersmith & Fulham's case inflates the denominator (i.e. number of children requiring immunisation) resulting in a lower uptake percentage. Like many other London boroughs, Hammersmith & Fulham has not achieved the required 95% herd immunity (i.e. the proportion of people that need to be vaccinated in order to stop a disease spreading in the population).

- Throughout 2011/12 to 2014/15, London has consistently performed below national on all COVER indicators by ~4% for the age 1 vaccinations, ~6% for age 2 vaccinations and ~10% for the age 5 vaccinations. The rates dipped at the start of 2013/14 but have since increased to the pre-dip levels.

- Figure 1 illustrates the quarterly COVER statistics for the uptake of the six COVER indicators for uptake. The primaries (i.e. completed three doses of DTaP/IPV/Hib) are used to indicate age one immunisations, PCV and Hib/MenC boosters and first dose of MMR for immunisations by age 2 and preschool booster and second dose of MMR for age 5. Quarterly rates vary considerably more than annual rates but are used for monitoring purposes. This graph only contains up to Q4 2014/15 as that was the latest available data in this format at time of writing. It can be seen that between Q4 2012/13 and Q2 2013/14 that there is a gap in the data due to data submission difficulties at the time. Since then the time lines for all indicators fluctuate widely, again due to data collection difficulties. Since Q1 2014/15 there is a continual increase across indicators and it is anticipated that this will follow in 2015/16, reflecting the initiatives and actions outlined in section 2 of this report.

Figure 1

Time Trend of COVER Indicators for Hammersmith & Fulham 2011/12 to 2014/15



Source: Public Health England (2015)

4.2 Hammersmith & Fulham compared to Neighbouring Boroughs

- Table 1 shows Hammersmith & Fulham compared to its neighbouring boroughs in North East London (data for COVER is still reported as PCT areas) for Quarters 3 and 4 (i.e. October 1st 2014 to March 31st 2015). Hammersmith & Fulham had a significant increase between Q3 and Q4 for the Age 5 preschool booster of 12%. The other indicators remained stable with no significant changes (i.e. the confidence intervals for each indicator uptake rate overlapped with the previous quarter). No other North West London borough/PCT area achieved 95% on any indicator.
- Compared to London, Hammersmith & Fulham performs below London average for the age 1 and 2 vaccinations but higher than age 5 preschool booster and slightly lower for the 2nd dose of MMR.
- When compared to quarter 4 2013/14, there are significant increases in two of the indicators for Hammersmith & Fulham – a rise from 76.2% in Q4 2013/14 to 82.8% in Q4 2014/15 for age one vaccinations, 31.3% to 76.7% for the age 5 vaccination (preschool booster) and a decrease from 72% to 63.1% for the 2nd dose of MMR.

Table 1

Hammersmith & Fulham PCT and Neighbouring PCTs Comparisons between Q3 and Q4 2014/15

Q3 1415 & Q4 1415 Immunisations		Immunisation rate for children aged 1 who have been immunised for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib) - (DTaP/IPV/Hib)- 3Doses			Immunisation rate for children aged 2 who have been immunised for Pneumococcal infection (PCV) - (PCV booster)			Immunisation rate for children aged 2 who have been immunised for Haemophilus influenza type b (Hib), meningitis C (MenC) - (Hib/MenC)			Immunisation rate for children aged 2 who have been immunised for measles, mumps and rubella (MMR) - (MMR)			Immunisation rate for children aged 5 who have been immunised for Diphtheria, Tetanus, Polio, Pertussis (DTaP/IPV) - pre-school booster			Immunisation rate for children aged 5 who have been immunised for measles, mumps and rubella (MMR2)		
PCT Name	PCT Code	Q3 1415	Q4 1415	Signif. change	Q3 1415	Q4 1415	Signif. change	Q3 1415	Q4 1415	Signif. change	Q3 1415	Q4 1415	Signif. change	Q3 1415	Q4 1415	Signif. change	Q3 1415	Q4 1415	Signif. change
North West London (NW)		%	%		%	%		%	%		%	%		%	%		%	%	
Brent Teaching PCT	5K5	92.0	92.2	⇨	85.9	85.8	⇨	86.8	86.4	⇨	86.4	85.8	⇨	81.3	0.0	⇩	81.8	80.6	⇨
Westminster PCT	5LC	73.2	72.8	⇨	72.1	70.0	⇨	72.3	69.7	⇨	72.4	72.0	⇨	65.0	75.1	⇧	65.5	59.0	⇨
Ealing PCT	5HX	84.4	83.1	⇨	85.3	81.9	⇨	83.9	82.5	⇨	84.4	83.6	⇨	80.6	66.7	⇩	81.7	77.0	⇩
Hammersmith & Fulham PCT	5H1	81.8	82.8	⇨	71.9	76.0	⇨	75.6	80.0	⇨	74.0	80.2	⇨	64.9	76.7	⇧	66.9	63.1	⇨
Harrow PCT	5K6	92.1	93.8	⇨	84.9	85.7	⇨	88.3	89.2	⇨	89.6	91.0	⇨	79.6	0.0	⇩	82.4	85.2	⇨
Hillingdon PCT	5AT	92.7	91.0	⇨	88.2	89.0	⇨	88.8	88.7	⇨	87.8	88.2	⇨	87.8	86.3	⇨	87.9	86.9	⇨
Hounslow PCT	5HY	91.1	90.9	⇨	79.5	81.6	⇨	81.5	84.7	⇨	81.7	84.1	⇨	62.6	58.4	⇨	72.4	71.2	⇨
Kensington & Chelsea PCT	5LA	71.5	75.9	⇨	65.7	68.5	⇨	68.8	74.2	⇨	68.8	72.6	⇨	59.8	82.4	⇧	62.5	60.8	⇨
London	London	90.0	90.3	⇨	85.5	85.7	⇨	86.1	86.3	⇨	86.0	86.5	⇨	78.0	77.0	⇩	80.5	80.1	⇨

Source: PHE (2015)

4.3 Rotavirus

- Rotavirus vaccine was introduced into the Routine Childhood Immunisation Schedule in 2013/14 and is measured monthly. Since June 2014 both London and England averages have been 90% or over.
- The programme has been very successful in reducing incidences of rotavirus with laboratory reports of rotavirus for July 2013 – June 2014 being 67% lower than the ten season average for the same period in the seasons 2003/04 to 2012/13 (Public Health England, 2014).
- An updated information standard for the COVER surveillance scheme has been approved and will be published soon. The new scheme will include the collection of rotavirus vaccination data so that this can be reported along with the other childhood vaccinations.
- The latest available data on ImmForm shows that, for the month ended 31/07/2015 (monthly data, not cumulative), 100% of the Hammersmith and Fulham CCG GP Practices reported (95.4% for London). The rate was 85.8% for the first dose and 80.3% for the second dose. The London rates for the same period were 90.7% and 83.2%.

5 School Age Vaccinations

5.1 HPV vaccination

- Human papillomavirus (HPV) vaccination has been offered to 12-13 year old girls (Year 8) since the academic year 2008/09. Originally the course was 3 doses but following the recommendation of the Joint Committee of Vaccinations and Immunisations (JCVI) in 2014 a two dose schedule will be operated from 2014/15 onwards.
- Since 2008/09, there has been a steady increase of uptake both nationally and in London. England has increase from 80.1% in 2008/09 to 86.7% in 2013/14 (the latest published data) whilst London has performed lower but still increasing from 73.8% in 2008/09 to 80% in 2013/14. However, the 2013/14 figures are still below the national target of 90%, the level set for herd immunity. Nevertheless, data for 2014/15 will be available in December 2015.
- Table 2 ranks the performance of London's Primary Care Trusts (PCTs) comparing 2013/14 to the performance of 2012/13 (data is still published as PCT areas for comparison reasons). It can be seen that Hammersmith & Fulham is within the bottom 5 performers of London with 73.3% girls completing their course of vaccinations in 2013/14. Unlike other London boroughs the drop between first and third doses is small – only 3%. This means that the introduction of the two dose schedule will not mean a big jump for Hammersmith and Fulham.
- A big factor in contributing to the poor uptake with the borough is the large number of schools across Hammersmith and Fulham who do not engage with the HPV vaccination programme. This results in missed vaccination opportunities and requires future management. In the academic year 2015/16, NHSE will include in the procurement process an obligation for the provider to engage with local schools and parents and an obligation to mitigate against schools refusing access. The provider will be incentivised through the contractual arrangement and subsequent monitoring to achieve high performance.

Table 2
Ranking of London Primary Care Trusts (PCTs) in relation to percentage of Year 8 girls who completed the HPV course in 2013/14 and 2012/13

Name of Organisation	% 2013/14	% 2012/13	Difference
NEWHAM PCT	92.3	90.3	2.0
SUTTON AND MERTON PCT	89.4	87.3	2.1
ISLINGTON PCT	87.1	87	0.1
WALTHAM FOREST PCT	86.8	86.5	0.3
BROMLEY PCT	86.8	85.5	1.3
HILLINGDON PCT	86.5	85.4	1.1
HOUNSLOW PCT	86.2	85.3	0.9
HAVERING PCT	86.2	84.8	1.4
SOUTHWARK PCT	85.7	83.9	1.8
HARROW PCT	83.2	83.7	-0.5
LEWISHAM PCT	82.9	83.2	-0.3
RICHMOND AND TWICKENHAM PCT	81.8	82.7	-0.9
KINGSTON PCT	81.6	81.3	0.3
BRENT TEACHING PCT	81.1	80.2	0.9
LAMBETH PCT	80.9	79.1	1.8
BARKING AND DAGENHAM PCT	79.2	78.8	0.4
WANDSWORTH PCT	79.1	78.8	0.3
KENSINGTON AND CHELSEA PCT	78.9	78.7	0.2
WESTMINSTER PCT	77.9	78.5	-0.6
GREENWICH TEACHING PCT	77.6	78.3	-0.7
EALING PCT	77.0	77.7	-0.7
CAMDEN PCT	77.0	77.4	-0.4
BEXLEY CARE TRUST	76.6	76	0.6
HARINGEY TEACHING PCT	76.4	75.7	0.7
CROYDON PCT	76.4	74.7	1.7
TOWER HAMLETS PCT	75.6	74.5	1.1
HAMMERSMITH AND FULHAM PCT	73.3	72.2	1.1
BARNET PCT	69.5	72	-2.5
CITY AND HACKNEY TEACHING PCT	69.4	66.9	2.5
REDBRIDGE PCT	69.2	66.7	2.5
ENFIELD PCT	68.3	62.1	6.2

Source: PHE (2014)

5.2 Other school age vaccinations

- To date, data is not routinely collected and published for Meningococcal C (Men C) vaccination programme and for the teenage booster.
- NHS England is currently undertaking a procurement of immunisation services to deliver school age vaccinations, which will provide provision in sites outside school as well as deliver school-based vaccinations. Through the new contracts, NHS England will be routinely collecting data on coverage and

uptake. The new national Maternal and Child Health Data set Portal which is due later this year will also provide data on uptake.

- From September 2014, it is planned to deliver Meningococcal ACWY instead of Men C in Year 9 with a catch up in years 12 and 13. This is a national programme following the rise in Meningococcal W (Men W) cases in England over the last two years. A sub-group of the London Immunisation Board has been set up to deliver London's action plan to implement the new programme for 2015/16.
- Following two years of piloting delivery of child 'flu vaccination programme in primary and secondary schools, the programme is being rolled out from September 2015.

6 Adult Vaccinations

6.1 Shingles

- The Shingles vaccination programme commenced in September 2013.
- Shingles vaccine is offered to people who are 70 years or 79 years old on 1st September in the given year. Data on vaccine coverage is collected between 1st September and 31st August. London has excellent reporting rates with 98.35 of GP practices submitting data returns.
- Although data for 2014/15 only covers up to May 2015, this year London and England appear to be performing lower than last year despite the national trend projecting an increase on last year. London's average for uptake amongst the 70 year old cohort is 42% (lower than England's 52.8% and lower than 2013/14 when it was 51.3%). For the same period, London's average for uptake amongst the 79 year old cohort is 45.8% (lower than England's 53.8% and last year's 50.9%).
- For Hammersmith & Fulham, 36.6% of the age 70 year olds were vaccinated in 2013/14 which has decreased to 27.7% for 2014/15. There was also a decrease for the 79 year old cohort with 32.1% vaccinated in 2013/14 and 25.5% vaccinated so far in 2014/15. (See Table 3).
- In 2013/14 London had 35,616 unvaccinated 70 and 79 year olds (48.5% of the total). Within Hammersmith & Fulham, 975 were unvaccinated (65% of the overall total 70 and 79 year old population).
- Nationally and within London, there is no difference between ethnic groups in terms of uptake.

Table 3

Uptake of Shingles Vaccine for the 70 and 79 age cohorts by London CCG for 2013/14 and 2014/15

CCG	% of 70 years age cohort vaccinated 2013/14	% of 70 years age cohort vaccinated 2014/15*	% of 79 years age cohort vaccinated 2013/14	% of 79 years age cohort vaccinated 2014/15*
Barking and Dagenham CCG	51.9	44.6	45.1	48.3
Barnet CCG	56.1	47.6	55.3	54.3
Bexley CCG	47	45.5	39.8	44.5
Brent	51.8	46.9	50.1	48.5
Bromley CCG	55.6	44.6	57.3	50.4
Camden CCG	50.3	36.1	52.6	40.4
Central London (Westminster) CCG	34.6	29.4	36.7	32.8
City and Hackney CCG	43	32.8	42.5	37.5
Croydon CCG	55.6	46.9	55.1	46.1
Ealing CCG	49.8	36.8	48.4	36.8
Enfield CCG	52	43.7	51.7	50.1
Greenwich CCG	51.4	43.2	48.7	45.9
Hammersmith & Fulham CCG	36.6	27.7	32.1	25.5
Haringey CCG	47.7	38.8	49.4	41.1
Harrow CCG	51	43.3	53.3	50.5
Havering CCG	54.6	47.2	55.1	49.2
Hilllingdon CCG	62	48.2	60.3	57.4
Hounslow CCG	44.6	39.9	44.6	40.2
Islington CCG	51.2	41.6	45.9	50.9
Kingston CCG	52.6	51.4	56.1	46.4
Lambeth CCG	51.2	35.7	50.1	42.6
Lewisham CCG	49	42.6	48.5	46.4
Merton CCG	51.1	43.2	54.3	49.3
Newham CCG	60.7	47.8	59.1	55.3
Redbridge CCG	51.2	42.4	49.4	42.8
Richmond CCG	61.8	46.8	59.8	45.8
Southwark CCG	45.5	33.9	46	39.6
Sutton CCG	56.2	49.8	60.1	54.5
Tower Hamlets CCG	50.9	43.2	56.3	43.2

Wandsworth CCG	52	41.4	50.5	46.5
Waltham Forrest CCG	48.7	39.3	45.5	41.9
West London (K&C & QPP) CCG	42.1	21.4	42	24.1
London	**51.3**	**42**	**50.9**	**45.8**
England	**61.8**	**52.8**	**59.6**	**53.8**

* collection of data still ongoing

Source: PHE (2015)

6.2 PPV

- Pneumococcal Polysachride Vaccine (PPV) is offered to all those aged 65 and older to protect against 23 strains of pneumococcal bacterium. It is a one off vaccine which protects for life.
- Vaccine uptake and reporting coverage is published cumulatively. The latest published data is for 2013/14. Up to and including 31st March 2015, 56.6% of those aged 65 years and older were vaccinated with PPV in Hammersmith & Fulham. This is lower than London's average of 65% and lower than England's average of 69.8%. Reporting coverage rates are good –100% for Hammersmith & Fulham compared to 98.1% for London and 96.7% for England.

6.3 Seasonal 'Flu

- Table 4 illustrates the uptake of seasonal 'flu vaccine for each of the identified 'at risk' groups for Hammersmith & Fulham CCG compared to London and England averages for the winter 2014 (September 1st 2014 to January 31st 2015). It can be seen that Hammersmith & Fulham CCG performs lower than both London and England averages. Hammersmith & Fulham was the poorest performing borough for seasonal 'flu vaccine uptake in London.
- Overall, the uptake rates for seasonal 'flu vaccination were down from 2013/14's performance. In England, 72.7% of 65+ year olds were vaccinated (down from 73.2% in 2013/14), 50.3% of those aged 6 months to 65 years with one or more underlying clinical risk factors (down from 52.3% in 2013/14). Vaccination rates of pregnant women increased from 39.8% in 2013/14 to 44.1% in 2014/15 for England.
- London, England and Hammersmith & Fulham all performed below the recommended 75% uptake level for all at risk groups.
- In April 2015, NHS England (London) undertook a review of how the 2014/15 seasonal 'flu programme was delivered. This review was presented to the London Immunisation Board in May 2015 and the reflections and recommendations will be incorporated in the planning for the 2015/15 'flu programme.

Table 4

Uptake of the 'at risk' Groups of Seasonal 'flu for Hammersmith & Fulham CCG compared to London and England for Winter 2014 (September 1st 2014 – January 31st 2015)

Local Authority	% of practices responding	% of uptake 65 +	% of at risk patients (6 months - 64 years)	% of pregnant women	% of 2 year olds	% of 3 year olds	% of 4 year olds
Hammersmith & Fulham	100	61.7	38.4	31.1	26.2	22.7	19.6
London	100	69.2	49.8	39.9	30.3	32.7	23.6
England	100	72.7	50.3	44.1	38.5	41.3	32.9

Source: PHE (2015)

7 Conclusions

- Hammersmith & Fulham and London have performed below national averages on almost all the Section 7A immunization programmes. However, the London Immunisation Board is overseeing pan-London approaches and borough specific plans to improve uptake and coverage.
- For 2015/16, each London borough has been assigned an immunisation commissioner who is responsible for delivering a multi-agency borough specific action plan. The aim of each plan is to increase uptake and vaccination coverage within the boroughs, which in turn will increase London averages. The plans will also address health equities in access to immunisations and health inequalities in uptake.

Appendix 1

Hammersmith and Fulham Flu Vaccination Action Plan Winter 2015-2016

PAC 14th September

Public Health Department, Three Boroughs Shared Services

August 28th 2015

Executive Summary

The flu vaccine is offered free to 'at risk' populations nationwide (over 65s, those with long-term medical problems and pregnant women) and in addition a nasal spray vaccine for children aged two to four and school years 1 and 2 is now available. Unfortunately uptake of the flu vaccine within the Hammersmith and Fulham has been low, below both the national and London averages in all eligible groups.

A wide range of national and local organisations are involved in the delivery of vaccination programmes. NHS England local area teams are responsible for commissioning vaccination programmes, monitoring GP flu vaccination programmes and ensuring that these programmes meet the needs of the local population. While local authorities do not commission or deliver vaccinations, our role is to provide independent challenge and scrutiny of the local vaccination arrangements and to support promotion of the flu vaccination among eligible groups.

The 2015-2016 Public Health Hammersmith and Fulham flu action plan focuses on promoting community flu vaccination locally, and aims to increase uptake in 2 main ways:

- Advertising directly to the community
- Increasing awareness among professionals and volunteers who work with eligible people and therefore can promote flu vaccinations to their service users.

This will be accomplished through articles in borough newspapers and newsletters, articles in staff newsletters, intranet articles, via social media, letters to professionals and volunteers, digital TV screen advertising, and posters/leaflets in a wide range of locations. The campaign will be aimed at all eligible populations, and will include schools, nurseries, children's centres, libraries, day centres, residential/nursing homes, advocacy services and charities.

Contents

1. Who is responsible for different aspects of vaccination programmes nationally?

Immunisations Board (Representatives of the Department of Health, PHE and NHS England)

- Provides strategic leadership and governance.
- Ensures strategic alignment within the partnership.

Department of Health

- National strategic oversight and financing.
- Engaging with national and international partners to increase knowledge and understanding of vaccines and vaccine-preventable conditions.

NHS England

- Routine commissioning of the vaccination programme through the local area teams.
- Monitoring GP flu vaccination programmes and ensuring that these programmes meet the needs of the local population
- Building close working relationships with directors of public health to ensure that local population needs are understood and addressed by providers of flu vaccination services

Public Health England

- Plans the national approach, procurement and distribution of the vaccines.
- Oversees supply and reserves.
- Purchases all vaccines for children.
- Applies research, surveillance and analysis to inform and evaluate vaccine programmes.
- Undertakes public communications to promote uptake of the vaccination.
- Manages pilots of new programmes.
- Provides specialist advice and information to ensure consistency and safety.
- Supports the DH and NHS England.

Local Government

- Provides independent scrutiny and challenge of NHS England, PHE and providers.
- Works with other organisations to ensure that local vaccination strategies and policies address inequalities.
- Promotes vaccination among frontline social care workers and encourages external providers to also offer vaccination for staff where appropriate.

CCGs

- Quality assurance and improvement of vaccine services, which extends to GP services.

Providers of vaccines

i) **GP Surgeries**
   - Ordering the correct amount and type of vaccine.
   - Delivering vaccines and maintaining appropriate records.
   - Vaccinating their own staff.
   - Ensure that all those who are eligible for the annual flu vaccine are invited personally.

ii) **Employers of Individuals working as providers of NHS services**
   - Management and oversight of vaccination campaigns among their own staff.
   - Support to providers to ensure access to vaccinations and to maximise uptake among those eligible to receive it.

iii) **Central and North West London NHS Foundation Trust (CNWL)**

- In the Three Boroughs the new local provider for school vaccinations.

2. Who should have the flu vaccine 2015-2016?

1. People aged 65 and over
2. People aged 6 months to 65 years with specific clinical conditions Include those with chronic heart, lung, kidney, neurological and liver disease, diabetes, learning disabilities, asplenia and others if considered at risk. Consider household contacts of immunocompromised individuals.
3. People living in long-term residential care
4. All pregnant women
5. All two, three and four-year-olds, via GPs
6. Children of school years 1 and 2 age
7. Healthcare workers with direct patient contact – including primary and secondary care, dental care, optometry practices, community pharmacies and social care workers. Also trainees/students and volunteers in these sectors.
8. Carers

3. Flu vaccination uptake 2014-2015

a) Uptake in GP surgeries 2014 to 2015

	65 years and over (%)	6 months to 65 years at risk (%)	Pregnant (%)	Age 2 and NOT in a clinical risk group (%)	Ages 2 and IN a clinical risk group (%)	Age 3 and NOT in a clinical risk group (%)	Ages 3 and IN a clinical risk group (%)	Age 4 and NOT in a clinical risk group (%)	Ages 4 and IN a clinical risk group (%)
PHE Target	75%	No specific target	No specific target	40-60%*	-	40-60%*	-	40-60%*	-
England	72.7	50.3	44.1	38.1	53.7	40.7	56.4	31.9	52.3
London Area Team	69.2	49.8	39.9	29.9	47.6	32.1	50.8	22.7	45.8
NHS Central London (Westminster) CCG	64.8	43.1	34.0	20.9	28.9	24.6	45.8	17.7	52.2
NHS Hammersmith and Fulham CCG	61.7	38.4	31.1	26.0	35.1	22.4	34.2	18.9	41.0
NHS West London (K&C and QPP) CCG	64.1	41.7	31.7	18.4	33.3	19.0	40.0	13.8	44.7

*PHE expects a minimum uptake of 40 to 60%. The flu vaccination programme was first offered to healthy children aged 2 and 3 in 2013/2014 and has been extended this year to 4 year olds and school years 1 and 2. Pilots have demonstrated that a minimum uptake of 40% is achievable. Uptake should be consistent across all localities and sectors of the population.

b) Uptake in frontline healthcare workers 2014 to 2015 (PHE target 75%)

Organisation name	All HCWs involved in direct patient care			All doctors			All qualified nurses			All other professionally qualified clinical staff			All support staff		
	No. involved with direct patient care	Doses given		No. involved with direct patient care	Doses given		No. involved with direct patient care	Doses given		No. involved with direct patient care	Doses given		No. involved with direct patient care	Doses given	
		No.	%		No.	%		No.	%		No.	%		No.	%
England	987,310	541,757	54.9	137,033	76,557	55.9	368,964	183,038	49.6	162,976	90,087	55.3	318,337	192,075	60.3
Chelsea and Westminster Hospital NHS Foundation Trust	2,799	1,618	57.8	644	340	52.8	1,069	565	52.9	404	238	58.9	682	475	69.6
Imperial College Healthcare Trust	8,399	4,027	48.0	2,159	1,052	48.7	3,291	1,395	42.4	1,337	556	41.6	1,612	1,024	63.5
Central and North West London NHS Foundation Trust	4,888	1,810	37.0	533	186	34.9	2,107	668	31.7	1,213	385	31.7	1,035	571	55.2
Central London Community Healthcare NHS Trust	2,142	568	26.5	71	13	18.3	1,063	253	23.8	589	159	27.0	419	143	34.1

4. Options for increasing coverage

a. NHS England

NHS England (London) is in a position to commission extended provision of flu vaccinations by offering new locations and providers.

Action currently:

- Some community pharmacies are offering the flu vaccine (numbers of pharmacies yet to be confirmed).
- Vaccination teams are visiting special schools this year.
- Service level agreements have been offered to district nurses to vaccinate house bound patients.

It may be possible in the future to organise vaccinations in more settings such as nursing/residential homes, hostels, nurseries, children's centres. This could target specific groups of people. However arranging vaccinations in these settings is likely to be costly.

One option advocated by PHE is to enable midwives, both in the community and in their acute trusts, to vaccinate pregnant women. This has been offered as a service level agreement (SLA) to midwifery services in London, however none of the trusts in the three boroughs have signed the contract this year. It may be possible in future years to address the barriers which are preventing midwifery services from accepting these SLAs.

GPs are currently rewarded under the quality and outcomes framework (QOF) for higher percentage uptake of flu vaccination among patients with coronary heart disease, diabetes, stroke/TIA and COPD. It may be possible to offer rewards for high uptake in other settings (eg schools, maternity services etc), although it may be difficult to secure funding for this.

b. Clinical Commissioning Groups (CCGs) and NHS trusts

Local NHS trusts have the responsibility to vaccinate their staff. One barrier to vaccinating frontline healthcare workers may be the opening hours of occupational health for those on shift work and/or the location of the vaccinations for those who work in the community eg district nurses and health visitors. Therefore increasing uptake may involve going to the wards or places of work to administer the vaccines, or perhaps offering extended hours for a short period of time.

CCGs are also in a position to provide regular updates on uptake through the flu season to the local providers.

c. GPs

All GPs should write individually to all their eligible patients to offer them the flu vaccine.

Action that GPs could take (if not already offering):

- Offer out-of-hours vaccinations in GP surgeries
- Ensure that electronic 'pop-ups or flags' are activated on the GP system to alert them to patients at risk.
- Display posters and offer leaflets within the GP surgery
- Arrange vaccination in residential and nursing homes linked to their practice.

d. Central and North West London NHS Foundation Trust

NHS England (London) has requested their flu vaccinations service delivery plan.

e. Local Authorities

Local Authorities can promote uptake of the flu vaccine by increasing awareness locally of flu vaccination.

- One option is to contact local organisations, stakeholders or services who do not provide vaccinations themselves but come into contact with patients and service users who need the flu vaccination. The aim of this would be that the services could circulate reminders to their users and also that staff could discuss the flu vaccine with their service users individually.

Who could local authorities contact to increase uptake?:

Target Group		**Possible Action**
6 months-65 years At-Risk	Long-term chronic conditions	Contact relevant outpatient departments in acute trusts, requesting them to remind their patients and also to put up posters. Day Centres. Voluntary organisations.
	Learning difficulties	Contact day centres and charities working with people with learning difficulties.
	Residential care	Residential care homes and nursing homes to ensure that they are aware that the residents should all be vaccinated unless there are contraindications.
Children	Children 2-4s	Nurseries, health visitors, social workers, library services. Posters, letters to professionals, articles in children's newsletters.
	School Years 1 and 2	Contact school head teachers, school bulletins
Over 65s		Charities such as age concern, social workers. Library services.
Frontline Healthcare Staff	Community staff	Contact community opticians, pharmacies, residential care homes etc reminding them to vaccinate their staff. Contact head of social services, health visitors etc to ensure it is put in staff communication eg newsletter, email, intranet.
Pregnant Women		Midwives – ensure they are aware and that they inform all pregnant women. NCT classes.
Carers		Carers support groups, social workers

- Local Authorities also advertise material in areas where those requiring the vaccine are more likely to see it. The material can be directed at the specific client group eg pregnant women.

Where could posters/advertising material be displayed?:

- Secondary care outpatient departments – particularly renal/cardiology/neurology/Liver/respiratory/ paediatrics
- A&E
- GP surgeries.
- Children's centres
- Play centres / Nurseries
- Day centres
- School receptions (where parents would see it)
- Day centres
- Hostels/Soup Kitchens
- Voluntary Organisations
- Pharmacies
- Opticians

5. NHS England (London) Action Plan

Workstream	Action	Timeline
At risk cohort	Offer SLA t to providers to Vaccinate children in special schools across London.	21/07/2015
	Briefings for LAs, Directors of Children services	
	Highlight practices with low uptake and ask CCGs to communicate with their practices the importance of ensuring that patients on at risk registers were actively invited for their flu vaccination.	31/07/2015
	Send out communication to all GPs to ensure GP clinical systems 'flags/pop ups' are operational regarding alerting clinicians to those at risk.	03/08/2015
	Send out a briefing on flu to long term condition charities.	14/08/2015
	Homeless Charities, soup kitchens and winter shelters to be contacted to inform their staff those eligible cohorts could be vaccinated in community pharmacies.	22/08/2015
	Ranking Trusts performance Monthly	Ongoing monthly
	Draft a letters to achieving trusts	
Over 65 cohort	Offer district nursing (DN)SLA to all provider	14/07/2015
	Item in HPT newsletter to nursing and Residential homes	15/08/2015
	Item in GP Bulletin regarding importance flu for house bound patients	15/08/2015
	Liaise with providers regarding their capacity on vaccinating house bound patients.	25/07/201
	Monitor uptake of DN SLA	Ongoing from 03 August 2015
Frontline Healthcare Workers	Update SOP	03/08/2015
	Contact / meet with MONITOR and NTDA	03/08/2015
	Write to all Trusts asking for their plans to vaccinate FHCW	10/08/2015
	Write to CCGs asking them to remind GP's to put in place plan to vaccinate their HCW	10/08/2015
	Monitoring	Ongoing from November 2015 to March 2016.

6. Action Planned by Public Health Shared Services for Hammersmith and Fulham

Most GPs offer flu vaccinations from early October. The PHE flu vaccination campaign material will be available for download from 17th September.

This action plan will be updated as more avenues become available.

Action	Details	Contact	Timeline
Borough Communications			
Local Borough Public Newsletter Article	E newsletter	Russell Butt	September
Digital Screens Advertisement		Geoff Cowart	From Mid-September
Social Media Promotion (twitter/facebook etc)		Russell Butt	From Mid-September
Library Services	Posters and Leaflets in the Library, Open Age Partnerships and other groups	Kate Gielgud	25.9.15
Local Council Staff Newsletter Article		Kirsty Langley	September
Internal Intranet Article		Kirsty Langley	September
Public Health Leadership Forum	Presentation to staff from Three Boroughs with an interest in Public Health	Kate May	22.9.15
Adult Social Care			
Tri-angles PH and ASC newsletter Article		Cheryl Graham	Deadline 9th September, Issue 14th September
Day Centres letter and advertising material	List of addresses prepared	Cheryl Graham	25.9.15
Nursing/Residential Homes letter and advertising material	Awaiting up to date list and contacts of local residential homes and nursing homes		25.9.15
Eletter to ASC	ASC heads to distribute	Cheryl Graham to distribute send to ASC heads	20.9.15
Advertisement at Silver Sunday (older age event)		Kate Gielgud	4.10.15
Voluntary Sector			
Voluntary Organisation Emails +/- Posters	Age UK and carers network Local organisations email distribution list	Kate Gielgud Pete Westmore	25.9.15
Community Champions Email +/- Posters	Email List for community champions	Leslie Derry	25.9.15
	White City Enterprise (Healthy Winters Event)	Kim Barclay	November
Children's Communications			
Nurseries posters, leaflets and letter to staff	Early Years Foundation	Rosemary Salliss	October
Children's centres posters, leaflets and letter	List of children's centres contacts prepared	Yacoba Godwyll	25.9.15

to staff			
Letters to Health Visitors/School Nurses	Email to circulate	CLCH contact - Catriona Noble	25.9.15
Schools Bulletin Article	Sent each week	Sarah Kamen	Late September
Library Children's Groups	Promotion in the groups	Kate Gielgud	September/October
Healthy Early Years Newsletter Article		Anna Brennan	September
Other			
Healthy Homes Scheme leaflet distribution		Justine Dornan	October

Hospital Action (aimed at community vaccine uptake rather than staff)

	Imperial	**Chelsea and Westminster**
Staff bulletin	In brief – staff intranet Jenny Stott	Awaiting Response from C&W
Letter to Consultants/ Heads of Departments	Clementine Brun (PA to medical director)	
Digital TV screens	Joanne McGee	
Letter to Community Midwives	Nora Farrelly (Queen Charlotte's)	Emma Bartlett (Outpatient Midwifery Matron)

Resources

1. Public Health England, NHS England. Immunisation and Screening: National Delivery Framework & Local Operating Model. 23/5/2013
2. Department of Health, NHS England, Public Health England. Flu Plan: Winter 2015/2016
3. Department of Health, NHS England, Public Health England. Annual Flu Letter 27/3/2015
4. Public Health England. Seasonal flu vaccine uptake in GP patients final data from 1 September 2014 to 31 January 2015: area teams and CCGs
5. Public Health England. Seasonal influenza vaccine uptake amongst frontline HCWs in England: winter season 2014 to 2015
6. Immunisations, London. Flu Action Plan

Appendix 2

Paper for the Policy and Accountability Committee

Arrangements for improving the uptake rate of the flu vaccine amongst children

The purpose of this paper is to:

- Share childhood influenza immunisation performance for 2013/14 and 2014/15
- Actions to be taken by the CCG for maximising flu uptake amongst children

1. Background

1.1 Providing adequate levels of protection against flu for both designated at risk children and the wider, more general child population remains the central message of the drive by NHS England to improve the levels of childhood flu immunisation uptake.

1.2 At risk children are immunised to reduce the direct impact of flu on their existing conditions. Over recent years the groups of children identified as being at risk and eligible for the flu vaccine have changed as the benefits and impacts on these groups have become clearer.

1.3 The wider childhood population programme of vaccination supports the general principle that reducing the risk of flu within the wider population reduces the overall risks of flu related ill health and the consequent impacts.

1.4 NHS England has the lead responsibility for determining policy and commissioning services in relation to flu. Primary care and other healthcare professionals have key responsibilities in ensuring that the public have access to the flu vaccine and to ensure that they patients are provided with the highest possible levels of support and information in order to make effective choices.

2. Groups included in the Flu immunisation programme for 15/16

2.1 NHS England has reiterated its ambition to ensure that all eligible individuals are offered flu vaccine to ensure as high an uptake as possible. The specific childhood target groups are:

- Those aged six months to under 65 in clinical at risk groups (75%)
- Two, Three and Four Year olds on 31st August 2015 (40-60% uptake)
- All children of school years 1 and 2 age (40-60% uptake)

2.2 The uptake targets for the wider childhood population of 40-60% reflects the outcomes from pilots which have shown that these levels are sufficient to reduce the spread of disease to the wider population.

3. Extension of the programme to children

3.1 The immunisation of children against flu began in 2013/14 with all two and three year olds being offered vaccination through general practice. In 2014/15, this was extended to four year olds. The programme has been further extended in 2015/16 to include children of school years 1 and 2. This group will predominantly be vaccinated in primary school settings by services commissioned by NHS England. It is expected that the programme will be further extended to include older primary school aged children in 16/17.

4. Hammersmith and Fulham Influenza performance

2013/14

CCG	% of Practices responding	Aged 2 and not in an at risk group	Aged 2 and in an at risk group	% of all 2 year olds	Aged 3 and not in an at risk group	Aged 3 and in an at risk group	% of all 3 year olds
Hammersmith and Fulham	100	20.8% (512)	34.5% (20)	**21.1 (532/2521)**	16.2%(398)	35.1%(20)	**16.6(418/2520)**
London	100	32.4%	48.4%	**32.7**	28.8%	48.1%	**29.4**
England	100	42.2%	56.1%	**42.6**	38.9%	56.8%	**39.5**

2014/15

CCG	% of Practices responding	Aged 2 and not in an at risk group	Aged 2 and in an at risk group	% of all 2 year olds	Aged 3 and not in an at risk group	Aged 3 and in an at risk group	% of all 3 year olds
Hammersmith and Fulham	100	26% (643)	35.1% (20)	**26.2 (663 / 2534)**	22.4% (530)	34.2%(26)	**22.7(556/2446)**
London	100	29.9%	47.6%	**30.3**	32.1%	50.8%	**32.7**
England	100	38.1%	53.7%	**38.5**	40.7%	38.9%	**41.3**

CCG	% of Practices responding	Aged 4 and not in an at risk group	Aged 4 and in an at risk group	% of all 4 year olds
Hammersmith and Fulham	100	18.9%(448)	41%(34)	**19.6%(482/2457)**
London	100	22.7%	45.8%	**23.6%**
England	100	31.9%	52.3%	**32.9%**

**figures in brackets denote numbers immunised; brackets for all immunised in each cohort includes total size of cohort*

4.1 The data indicates that immunisation of children aged two and three increased from the introductory first year in 2013/14 by 5 and 6% respectively, although still lower than the London and England averages.

5. Role of Primary Care

5.1 Primary care has a key role in delivering the programme to increase the uptake of flu immunisation both within the vulnerable children group and the wider childhood population now covered by the immunisation programme. As the point of access to healthcare for the majority of children, primary care is best placed to ensure that information is provided to parents, that targeted services are available and that the overall health impacts are communicated. Primary care should provide strong clinical leadership for the flu immunisation campaign. Parents will see GPs as the first point of reference for advice and support. Practitioners should proactively engage with parents to provide both advice and guidance they need as well as provide accessible provision to enable parents to make informed decision and make having a flu vaccination easy and straightforward.

6. Actions to be taken by the CCG for maximising flu uptake for children

6.1 In recognition of the improvement required to achieve optimum immunisation uptake for children the CCG, in partnership with NHS England and the local council, has agreed to work collaboratively together and will be meeting to discuss how they can collectively improve flu immunisation at a meeting scheduled on Wednesday 16th September 2015.

The CCG will continue to work with the council and NHS England on its plans to improve flu immunisation rates and will be developing a project plan for delivery which will be broadly based on the following themes:

A) Encouraging clinical leadership to maximise flu immunisation amongst general practice staff as well as patients.

The CCG is actively engaging with its members through GP network meetings and GP Members meetings to be clear of their responsibility in adhering to Good Medical Practice guidance which advises "against common serious communicable diseases"[1]. Furthermore, and as part of the local Practice nurses forums, the importance of flu immunisation for staff is being emphasised. The CCG will work proactively with all practices to ensure practice staff immunisation as well as to ensure that staff understand the importance of immunising all eligible cohorts, children in particular, and are able to advise patients they come into contact with.

[1] Www. Gmc-uk.org/guidance/good_medical_practice/your_health.asp

B) Media campaign.

Communications Plan

The CCG will engage in proactive locally focused communications and engagement campaigns to encourage the use of flu jabs to prevent emergency flu-related admissions to hospital via A&E, along with other winter pressure related objectives.

A major focus of the local communications campaign will be the importance of those patients within the at risk groups, including certain children, take advantage of the flu immunisation. Parents of under 5s have been identified as a priority target audience for both the national and local campaigns.

We intend to work closely with the council and voluntary sector to leverage existing free of charge channels of information as detailed in appendix A. If the bid for funds is approved the CCG will also undertake a range of other initiatives also set out in appendix A.

C) Maximising General Practice Extended Hours Hubs

In 2013/14 and 2014/15, the CCG facilitated the delivery of one-off weekend GP clinics open to all practice patients during the flu season to increase access to children requiring flu immunisation. These clinics were successful in ensuring that a number of patients had access to immunisation outside of core GP practice opening hours. In 2014/15, the CCG proactively marketed the clinics available at Children's centres, with the bulk of referrals for immunisations coming via this route.

The CCG has recently commissioned an Extended Access Out of Hospital Service specification which stipulates that the hub locations providing extended access both during the week and at weekend will be required to provide both Childhood Immunisations as well as Influenza Immunisations. The hub locations have been selected and are equitably distributed across the borough for full population coverage and there is therefore an opportunity to use the hubs to provide dedicated childhood immunisations, adult and children's flu clinics. These hubs are due to go live on delivering extended access services from 26th September and the CCG will be working with the hubs on delivering specific immunisation clinics on a planned basis throughout the flu season

D) Maximising the support that our community providers can provide

School Nurses

We will be working closely with NHS England who will be commissioning Central North West London (CNWL) to provide a school nursing service and will be responsible for delivering flu immunisation for primary school children.

Community Pharmacy

As in previous years, our community pharmacies are able to offer NHS flu vaccinations to adult patients over 18. This will free up practices to proactively implement their call and recall procedures to encourage patients to present for immunisation, with a particular emphasis on at risk groups (including all children at risk) and the wider under 5 population.

7. Summary

7.1 This report provides an update on the CCG's current plans with regard to childhood flu immunisation. The CCG will keep the Committee informed of progress and updates as and when requested.

Appendix A

Communication Campaign Information Channels

Free of charge media channels

- Social media to parents of infants in H&F
- Press releases to local media and media for parents of infants (EG 'Families' newsletters for parents of under 5s) and council magazines
- Stakeholder newsletters and websites
- Text messaging to GP-registered patients
- Messages to CCG websites, social media and stakeholder websites and newsletters
- Editorial in council and community / voluntary sector publications
- Tailored local communications around the importance of flu jabs for infants in partnership with Community Champion hubs
- Electronic messaging screens for GP surgery waiting room display monitors
- Internal communications to primary and secondary provider staff
- Engagement via Public Health “health trainers” and Community Champion hubs
- Local face to face engagement by CCG engagement teams
- Engagement with local community groups via voluntary community service networks, children’s centres

Communication channels to be used subject to funding being approved

- Support of local and digital channels
- Posters and leaflets with detailed information on how to get flu jabs for infants
- Local newspaper and telephone box advertising
- Targeted advertising in specialist local media (EG 'Families' newsletters for parents of under 5s) and council magazines
- Easy read communications for local BME communities and disability groups
- Inclusion of flu vaccination for infants messages in reprinted North West London leaflet to homes in the area
- Tailored local communications around flu vaccines for infants in partnership with Community Champion hubs
- Advertising on receipts for local 99p and Argos retailers
- Healthcaremessaging.co.uk: electronic messaging at A&E departments
- Commissioning local voluntary organisations/Community Champion hubs and/or social marketing agencies to carry out targeted engagement with parents of infants in community settings such as supermarkets and SureStart centres for infants and their parents

	London Borough of Hammersmith & Fulham **HEALTH, ADULT SOCIAL CARE AND SOCIAL INCLUSION POLICY AND ACCOUNTABILITY COMMITTEE** **14 September 2015**
HOME CARE SERVICES	
Report of Selina Douglas - Director of Strategic Commissioning and Enterprise, Adult Social Care.	
Open Report	
Classification - For Policy and Accountability Committee Review & Comment **Key Decision: Yes**	
Wards Affected: All	
Accountable Executive Director: Liz Bruce - Executive Director of Adult Social Care	
Report Author: Christian Markandu – ASC Commissioner and Programme Lead for Home Care	**Contact Details:** Tel: 020 8753 1960 E-mail: christian.markandu@lbhf.gov.uk

1. EXECUTIVE SUMMARY

1.1. This report sets out the proposal for contract awards for new Home Care Services for people who meet Adult Social Care (ASC) eligibility criteria in the London Borough of Hammersmith and Fulham (H&F).

1.2. This report addresses the recommendation to Cabinet on 7th September 2015 that H&F awards three Home Care Services Contracts, one of which will provide services to customers in the north of the borough, one to customers in the central area of the borough and one to customers in the south of the borough.

2. RECOMMENDATIONS

2.1. For the Committee to review and comment on this report.

3. REASONS FOR DECISION

Most economically advantageous submission

3.1. In accordance with the Restricted Procedure as set out in the Procurement Strategy, the Procurement Board developed a Specification and ran a Pre-Qualification Questionnaire (PQQ) and an Invitation to Tender (ITT) to identify one provider for each Contract Area. For the three Contract Areas, out of all the tenderers who submitted a tender, the evaluation process

found the selected tenderer's submission to be the most economically advantageous submission that met the required quality thresholds.

4. INTRODUCTION AND BACKGROUND

4.1. Home Care Services are considered the main provision of a raft of measures which enable people to continue to live in their own homes as independently as possible.

4.2. The table below shows a snapshot of people using home care at the current time

	H&F
Current **approximate** annual budget	£6,642,000 p.a.
Home care customers (average numbers)	1,192
Number of hours per year	592,782 p.a.
Number of current providers used	4 Providers who were on a Framework contract plus additional spot purchase
Estimated percentage increase in people over 65 with a limiting life long illness in 2020	8%
Percentage increase in people with dementia in 2020	7%

4.3. In H&F, care is currently provided on a spot purchase basis by the same 4 providers with whom there has been a contract for the past 4 years. The service was provided as part of a call off from a Framework Agreement with West London Alliance which ended on 30th September 2014. It was not possible to further extend contracts on an out of date Framework. Negotiations have been agreed with the main Providers being used regarding rates and accepting work and are continuing to be used as before.

4.4. The current provision of home care services are contract managed by the ASC Procurement Team. Data pertaining to referrals, training, staff leaving and joining, safeguarding issues etc. are collated. The quality of service provision is monitored by the team through feedback from operational staff.

Home Care Management System (HCMS)

4.5. RBKC currently has an electronic monitoring system that tracks care worker visits and that can be viewed by ASC staff. This allows payment to be made based on the actual level of service delivered rather than the level of service ordered, thus enabling savings to be achieved.

4.6. Although it cannot measure the quality of the service being delivered, it does provide information on who has delivered the care. It can also confirm whether visits have been undertaken on time or at all, thereby safeguarding customers.

4.7. This system has proved efficient and effective and has enabled savings to be made on home care spend in RBKC. During the design of the new home care service it was agreed that Hammersmith and Fulham and Westminster City Council would also adopt a HCMS system to underpin service delivery and ensure accurate billing. As the nature of the service delivery will change, a system that underpins safe delivery, can assist in measuring stipulated quality measures and delivers efficiencies across all boroughs will be vital in supporting the service design.

4.8. A separate procurement has been undertaken to purchase a new electronic HCMS system for the three boroughs to enable these efficiencies and effectiveness to be achieved.

4.9. The contract for this service has now been awarded to eziTracker. The system will be operational from the start of the new service and is being tailored to meet the specification requirements at present.

4.10. The system will ensure customers and their families, and contract monitoring and finance staff, have information on when care workers have visited, overall monthly hours and consistency of care worker.

4.11. The electronic monitoring system will allow electronic invoicing based on accurate billing and automated payments, a key efficiency saving for the service.

4.12. A central Home Care Management Team (HCMT) will be developed from existing resources to manage referrals, ensure provision of services, monitor quality of services and payment of invoices. The structure and functions of the team will be based on the successful learning of the existing RBKC team.

Service design

4.13. Soft market testing with providers as part of the specification development confirmed and shaped the direction of travel for the new service. The procurement was designed to facilitate the involvement of locally based small and medium size providers. This was either individually or as part of a consortium bid or as a sub-contractor. The requirements of the Financial Capability test at PQQ stage were lessened to increase the number of providers eligible to tender for the contracts without exposing the councils to an unacceptable level of risk.

4.14. The new service is a retender of an existing service, with a change to the service design. It is a key service for Adult Social Care in their strategy to support people to remain living at home as independently as possible. The service has been designed to be fit for purpose for the needs of a range of people with complex needs being supported at the current time, with an emphasis on achieving outcomes, a reabling approach and improving local connections. The service will support a reduction in numbers of people admitted to hospital or to residential care, as well as facilitating timely discharge from hospital, thus supporting the Council's strategic direction as well as the CCG Out of Hospital Strategies to increase the number of people supported in their own homes.

4.15. The current arrangements for the delivery of Home Care Services are not aligned with the strategies for the delivery of efficient and effective services in the future. The services are no longer fit for purpose and the needs of those living at home are changing and increasing.

4.16. The demand for home care in the borough has increased over recent years with a resultant increase in cost. This is partly attributable to the work to maintain people to live in their own home rather than admit them to a care home. As well as supporting the CCG's Out of Hospital strategy as highlighted above. The abolition of home care charging has also impacted on the overall budget.

4.17. Current activity and future projections show that Home Care Services need to be able to support more people to live at home who have increasingly complex care needs. This requires closer integration with local health services, a greater focus on supporting the whole person and forming connections with the wider community, and in some cases care workers who can undertake both health and social care tasks.

4.18. The current provision of home care in the three boroughs is fragmented. This procurement changes the way care is provided by:

- a new more fit for purpose model of provision meeting the demands of increasingly complex needs of Customers
- being based on improved outcomes for Customers
- a better working relationship with a small number of providers and shared learning across the boroughs
- a positive experience and increased job satisfaction for care workers as standards for employees improve

4.19. A Home Care Services Board has worked together from the start of this procurement to understand concerns and issues about the current service, assess good practice models, incorporate current strategies and the move to integration, use data to forecast future needs and develop the service specification and delivery model. There has been consultation with a range of stakeholders throughout this process as to what constitutes effective and good Home Care Services.

4.20. The Home Care Services that have been procured are based on:

- An area based service, giving a local approach to care delivery.

- A reablement approach as part of care provision with people being encouraged to do as much for themselves as possible.
- Achieving outcomes for customers and thereby moving away from 'time and task' focused provision.
- Providers working more directly with customers to agree the details of their care and how their outcomes will be achieved.
- Ensuring dignity and compassion are core values of the service.
- A more consistent service provision with regular care workers who are familiar to Customers being a business critical measure.
- People being assisted to feel a part of their local community.
- The use of electronic monitoring to record care delivery, safeguard customers and enable accurate billing

4.21. There is a change in emphasis on the provision of care in the developed model to make it more fit for purpose to deliver the intended outcomes. These include:

- A mixed skills workforce, with improved terms and conditions for care workers.
- Working towards the provision of low level health tasks through the integration of care over the length of the contract.
- More regular reviews to ensure the right level of care provision.
- A greater involvement of customers in providing feedback as part of contract monitoring.
- Joint working with the commissioned providers across the three boroughs to share knowledge and improve quality.

4.22. Because of the greater focus on a skilled workforce and a reablement approach and by showing how Home Care Services can support the work of the CCG's, the CCG have agreed to contribute financially to the budget and discussions continue about the model of future investment. Home Care Services are now part of the suite of services delivered through the Better Care Fund.

4.23. The benefits of this are:

- A better patient experience where customers only tell their story once.
- Better outcomes for the individual customer through a collaborative approach between professionals who share knowledge and problem solve together.
- A more responsive service where the whole team of professionals are aware of the changing needs of the individual customer and can respond with the most appropriate care.
- Efficiencies through reducing the total number of visits and ensuring tasks are allocated to the most appropriately skilled staff.

4.24. The Care Act requires Councils to provide Personal Budgets, including Direct Payments, to everyone who uses ASC services. The increasing popularity of Direct Payments will ensure there is a healthy market of home care providers for people to choose from and will enable smaller organisations to continue providing services. This will allow people a

choice of providers to use should they not wish the Council to commission a service on their behalf.

5. PROPOSAL AND ISSUES

Contract Implementation

5.1. Following award of contract a three month period of implementation will commence.

5.2. The contract manager will work with the successful providers to implement the contracts as per their implementation plan which formed part of their tender submission.

5.3. The contract manager and programme lead will also work with the new providers, incumbent providers and operational teams to transition existing customers wishing to take a commissioned service.

5.4. It will be important to continue working with all current home care providers until the successful providers are in a position to accept new referrals.

Contract Management

5.5. Following contract implementation the new home care contracts will commence as per the specification.

5.6. The success of the new home care service will be dependent on robust contract management of the successful providers throughout the life of the contracts against an agreed set of Key Performance Indicators and Critical Business Measures.

5.7. The contract manager will work together with the operational teams, safeguarding leads, the Home Care Management Team, Customer Feedback Team, business analysis and in partnership with Healthwatch and other external stakeholders to ascertain the success of the providers in delivering the new service model.

5.8. All contract and performance information will be retained by the contract manager.

Workforce Development

5.9. The new home care contracts will require a major shift in the way internal staff commission home care and the way external staff deliver care to customers. Fundamentally this means the council and social workers having greater trust in the providers and care workers to deliver home care.

5.10. There are two programmes which underpin the development of both internal staff and external providers and their workforce.

5.11. The contracts team have a programme of provider development workshops including values-based recruitment to ensure providers recruit

the right sorts of people to the organisation as well as equipping them with the knowledge and skills to deliver the new service model.

5.12. The contracts and commissioning team will continue to work with providers and care workers to support them deliver the new model.

5.13. Successful providers will be supported and encouraged to build capacity locally by recruiting from the local workforce. This will be facilitated by the Council via a number of local events.

Working with the Voluntary Sector

5.14. The new service model emphasises the need for the successful providers to work with the voluntary and community sector to connect people to their local communities and thus support independence. Following the implementation period and contract start date, contracts officers will facilitate partnership arrangements between the successful providers and the voluntary and community sector.

The Wider Home Care Market

5.15. Under the Care Act the Council has a responsibility to work with the whole home care market to ensure that it is buoyant and that both self-funders and those receiving a Direct Payment receive a good service and have choice.

5.16. Work with local spot purchase providers will continue, many customers will take Direct Payments and others will be self-funders etc. The market will continue and we need to keep working with providers.

5.17. The three successful providers can subcontract with other smaller providers and a number of events are being arranged to facilitate this process.

5.18. As part of the provider development work stream there will be a number of opportunities for the successful contracted providers to meet with other local providers to develop sub-contracting arrangements.

5.19. Providers from the wider home care market will be included in the provider forums that form part of the contract management of the new services. This will help to align and raise the quality of home care across all providers in Hammersmith and Fulham.

Working in partnership with 'User-led' organisations

5.20. There are a number of 'User-led' organisations and forums who support customers and their close networks. As part of the contract management process officers will actively seek the input from organisations like Healthwatch and other forums to ensure our customers voices are heard.

5.21. Representatives from the contracts and commissioning teams will attend meetings facilitated by these organisations to provide updates as well as listening to members talk about he services from their perspectives.

6. OPTIONS AND ANALYSIS OF OPTIONS

6.1. There was an option to continue with a time and task approach to Home Care Services and to procure new services based solely on the lowest unit price per hour. With this model there would be no incentive for providers to encourage independence and the Councils would face increasing budget pressures as more people with more complex needs are supported to continue living in their own homes. This model also offers limited opportunities for integration with health services or for the delivery of health tasks. For reasons of quality of service, whole systems integration, customer satisfaction and budgetary control this option is not recommended.

6.2. To take account of the feedback from Customers, organisations that deliver home care and the NHS, various models have been assessed during the development of the new service. These have both cost and service implications and have been previously presented to Cabinet members, jointly and separately to enable decisions to be made.

6.3. These options have included various rates of pay, allowance for travel time and the use of a mixed-skills workforce to provide more complex support.

6.4. The recommended option informally agreed prior to the procurement by ASC Cabinet Members was to offer the new service using a mixed skills workforce and with the expectation of improved employment terms and conditions for care workers. This would be supported by the evaluation at ITT of the minimum hourly rates paid by tenderers.

7. CONSULTATION

7.1. Following the decision to retender Home Care Services a series of consultation events were held to ask stakeholders how they considered a good and compassionate service could be achieved. Four events were held in the summer of 2012, attended by 184 people, 17% of whom were customers and carers of those using services.

7.2. A consultation report was produced by Frameworks 4 Change, an independent provider who facilitated the consultation events on behalf of the three boroughs.

7.3. The consultation events concluded that people considered that the key features of any new service should be:

- Consistency of care worker.
- A service which looks more widely at people's lives including outcomes for them.
- A more streamlined assessment process.
- Integrated care provision.
- Support for people to lead good lives.

7.4. Two soft market testing events were held for providers to establish their views on the proposed outline model of care delivery. Subsequently and to

further refine the delivery of the proposed model, questionnaires were sent to current home care providers on more specific issues of delivery.

7.5. Officers have also met and shared detailed information of the proposed service model with carers' organisations and voluntary community services and taken account of their feedback.

7.6. Operational staff have also been part of the on-going consultation and feedback process.

7.7. Healthwatch have been involved since the start of this work in 2012 as the representation of customers' voices and voluntary organisations in the three boroughs. A home care group working across the three boroughs was established and has met regularly since. This is made up of customers, carers and organisations representing people's needs. Officers attend the meetings to hear views, discuss current services and provide updates on the proposed service.

7.8. The group has worked with officers in delivering the consultation; helped shape the specification and informed of the priority areas that are relevant to them during the procurement process and will continue to be involved in the development and monitoring of the new service.

7.9. There has also been a closed confidential group established within Healthwatch to work directly with the procurement of the new service. They have been involved in agreeing the specification, agreeing the priorities to question providers on at both the PQQ and ITT stages of the procurement, and in discussing with officers the evaluation of some responses from tenderers on the area of communication, a key priority for customers.

7.10. The main issues raised by Healthwatch include:

- People being treated with dignity
- Consistency of care worker
- Pay for workers
- Timekeeping/travel
- A more streamlined assessment process
- Helping people link with their local community

These have been included in the service specification and in assessing tenderers at ITT tender stage.

7.11. The Healthwatch home care group will continue to be involved in the development and implementation of the new service, working with providers on embedding good practices and what is important to customers as well as continuing their dignity champion work with customers on their views on the service they receive.

8. EQUALITY IMPLICATIONS

8.1. An Equality Impact Assessment was completed at the start of the procurement process. There are no negative equality impacts as a result

of the proposed contract awards. Providers have been asked about their ability to provide a service to a diverse population as part of the tender evaluation and the service specification is clear on the need for an inclusive service approach and an ability to meet the needs of people from a range of cultures and with a range of different needs.

8.2. Direct Payments will be available to customers who want to purchase their care from a different provider or individual, if they wish to continue receiving their care from a current provider, or to meet a particular protected need.

9. LEGAL IMPLICATIONS

9.1. Confidential not for publication

10. FINANCIAL AND RESOURCES IMPLICATIONS

10.1. There are additional financial implications for H&F. The hourly charge to the Council is significantly higher under the proposed arrangements, this is in part due to the new requirement to pay London Living Wage (LLW). The allocated budget is under existing pressure due to the increased number of people supported at home.

10.2. There are expected to be savings achieved through the electronic billing and invoicing for the service achieved through the HCMS, (see sections 4.6 and 4.11) ensuring that only care delivered is actually paid for.

10.3. The deduction in costs due to more frequent reviews is dependent on Operational staff being able to undertake these reviews.

Director of Finance Comments.

10.4. The costs arising under these contract arrangements are dependent upon the volume of home care commissioned.

10.5. The financial modelling has been based on the hours of home care purchased in 2014/15. The following table summarises the financial position in a full year i.e. once the new arrangements have been fully implemented:

	£000's
Full year cost of purchasing care under the new arrangements (less cost reductions mentioned in section 4)	7,451
Current budget provision	6,642
Projected Overspend	**809**
This overspend can be broken down as follows:	

Increase in unit rates (the retendered rate includes the minimum hourly rate at least equal to the current the London Living wage rate)	680
Increase in Demand	129
Projected Overspend	**809**

10.6. Some additional temporary resources are being engaged to support the implementation process which will be undertaken over several months. Additional costs arising in 2015/16 will be funded within the overall Adult Social Care budget.

10.7. Over the last year, expenditure on home care has increased. Officers are working with the health service to determine whether some of this additional expenditure should legitimately be funded from health budgets.

10.8. The Department has made provision through the carry forward of underspends to fund the new contractual pressures for the last quarter of 2015/16 and the full year in 2016/17. The Department is proposing an MTFS growth bid of £820,000 from 2017/18 for the remaining lifetime of the new contracts. This will still leave budgetary pressures on the Home care service which will continue to be closely monitored with the ongoing shortfall to be addressed as part of the Financial Planning process and with the conclusion of discussions on health funding.

Implications completed by: Prakash Daryanani, H&F Head of Finance (Adult Social Care), 020 8753 2587.

11. RISK MANAGEMENT

11.1. The ASC department is responsible for ongoing risk identification and mitigation of risks (risk management), such as they may arise, that are associated with the procurement. Should any significant risks materialise they must be communicated across the three councils and inform the Adult Social Care Department level Risk Register. A project register has been completed and is kept under review that follows the Shared Services risk management approach.

11.2. Resilience in providing Home Care Provision is essential, as an interruption to the service could have far reaching consequences. Resilience is best achieved by looking at viable options to remove any risk associated with the provider, plus having robust and workable strategies that are able to continue the service offered.

11.3. Officers tested Providers financial stability at PQQ stage to ensure they have a robust financial basis for the work they will be undertaking. Advice and sign off was sought from Corporate Finance to ensure this.

11.4. The Care Act gives Council's greater responsibility for predicting and managing any consequences of provider failure in Adult Social Care. For example this could include regular reviews of an organisations financial standing. The Head of Procurement has been working with the Bi-Borough Business Continuity Manager to address this issue in general, and specifically relating to the new home care services.

11.5. A Resilience strategy is being developed as part of the project group work. This will involve a range of stakeholders, including commissioning officers, contracts officers, care management as well as external providers such as CQC and other local providers.

11.6. Resilience, market testing (achieving best value to the local taxpayer) and managing statutory duties are corporately acknowledged strategic risks noted on the Shared Services Risk Register.

Implications completed by: Michael Sloniowski, Shared Services Risk Manager, 020 8753 2587.

12. PROCUREMENT AND IT STRATEGY IMPLICATIONS

Gate 1 Procurement route/OJEU approach

12.1. The Restricted tender process was selected on the basis that there are a large number of providers in this market and this would allow only those with appropriate experience and sufficient financial capability to be shortlisted to proceed to the Invitation to Tender (ITT) stage.

12.2. As this procurement commenced before 26th February 2015 it has been conducted in accordance with The Public Contract Regulations 2006. Home Care Services are classified as a Part B Service and accordingly there is no requirement to publish a Prior Information Notice (PIN) or Contract Notice in OJEU.

12.3. The procurement was run on the basis of legal advice that the Transfer of Undertakings (Protection of Employment) Regulations (TUPE) did not apply as no current working arrangements were replicated by the proposed geographical contract area model.

12.4. In accordance with the current procurement policy of the three boroughs adverts for tenders are only placed on the e-tendering portal, capitalEsourcing. At two provider events held in February 2015 potential providers were told of the need to register their organisation on capitalEsourcing so they were aware when the procurement process started. This information was also circulated by e-mail to home care providers listed on a large database maintained by the Council.

12.5. The home care contracts were tendered out across the London Borough of Hammersmith and Fulham (H&F), the Royal Borough of Kensington and Chelsea (RBKC) and Westminster City Council (WCC). H&F were the lead borough for the procurement, as the Adult Social Care (ASC) lead.

12.6. The Services in H&F were divided into three geographically based contract areas. These are:

Contract Area 1: H&F North
Contract Area 2: H&F Central
Contract Area 3: H&F South

12.7. The contract areas were based on existing demand levels of approximately 3,000 hours per week. Contracts of this size are large enough for providers to achieve economies of scale and not overly large that medium size organisations are prevented from tendering.

12.8. Area based contracts also minimise the amount of time that Care Workers spend travelling between customers.

12.9. The procurement was designed to award one contract for each contract area, accordingly a provider would be required to accept all referrals for the contract area they are awarded. A traditional two party contracting model will be used with each council contracting directly with the providers awarded contracts in their borough.

12.10. Tenderers would be permitted to proceed to ITT for a maximum of two contract areas to avoid providers acquiring a dominant market position and to reduce the risk of provider failure due to an inability to meet demand levels. Additionally where a tenderer was shortlisted to proceed to ITT for two contract areas these would be in different boroughs to avoid the consequences of provider failure being borne entirely by one borough.

Gate 2 Supplier selection and award proposal

12.11. The Pre-Qualification Questionnaire (PQQ) comprised qualification areas and technical questions. For a potential provider to proceed to ITT they had to pass all qualification questions and score a minimum of five out of ten for all of the technical questions.

12.12. The qualification areas covered:

- Organisation information
- Mandatory and discretionary grounds for exclusion
- Financial capacity
- Insurance
- Contractual matters
- Health and Safety
- Quality Assurance

12.13. The technical questions covered:

- General experience and diversity – 10% weighting – tie break priority 5
- Workforce training and skills – 10% weighting – tie break priority 7
- Workforce development and conditions – 15% weighting – tie break priority 3
- Safeguarding – 10% weighting – tie break priority 4

- Complexity of needs – 20% weighting – tie break priority 1
- Promoting independence – 15% weighting – tie break priority 2
- Customer engagement – 10% weighting – tie break priority 8
- Health – 10% weighting – tie break priority 6

12.14. The tie break priorities were established to enable the separation of tenderers in the event they achieved identical overall scores.

12.15. Potential providers were required to indicate whether they wanted their application be considered for one or two contract areas and to rank the contract areas they wanted to be considered for in order of preference. Potential providers were then allocated to contract areas in the order of their total Technical score, with the highest scoring potential provider being allocated first. The higher therefore a potential provider's Technical score, the greater the chance they would be allocated to their highest ranked contract areas.

12.16. Using this method of allocation to contract areas, it was necessary to eliminate tied scoring. A scoring model using 0 to 10, as opposed to 0 to 5, was selected to reduce this possibility. Where tied scoring still occurred all questions were prioritised and used as "tie breakers" until potential providers could be separated for the purposes of allocation to contract areas.

12.17. As it was anticipated that there would be a high number of PQQ's returned Tender Appraisal Panels (TAP's) were set up, each with the responsibility to mark all returned submissions for one question. The members of the TAP's were required to individually mark submissions and then meet to agree consensus scoring for all submissions for the question they were responsible for.

12.18. The qualification submissions were evaluated by (ASC) Procurement Team officers with input from officers from H&F Corporate Accountancy Team with regard to the evaluation of potential providers' financial capability.

12.19. The aggregation of the qualification and technical evaluations was coordinated by the ASC Procurement Team.

12.20. The PQQ was published on the capitalEsourcing portal on 24th June 2014. A total of thirty seven completed PQQ's were returned by the submission deadline date of 31st July 2014.

12.21. Thirteen potential providers were rejected at this stage. Seven failed to satisfy the minimum financial requirement as set out in the PQQ and scored less than five for at least one of the eight technical questions. Two failed to satisfy the minimum financial requirement and four scored less than five for at least one of the eight technical questions.

12.22. Of the twenty four tenderers who passed the PQQ, nineteen were shortlisted to proceed to ITT for two contract areas. Two elected to only be shortlisted for one contract area and three only satisfied the minimum financial requirement for one contract area.

12.23. In accordance with H&F Contract Standing Orders a minimum of five tenders should be sought for contracts with a value equal or greater than £173,934. For the nine contract areas this would require 45 tenders. As the maximum number of tenders that could be obtained following the evaluation of PQQ's would be 43 it was agreed that the procurement could continue on this basis. Following the allocation of tenders to contract areas four tenderers were shortlisted to Contract Areas 2 (H&F Central) and 7 (WCC North East) while five were shortlisted for each of the other seven Contract Areas.

12.24. The ITT was published on 4th December 2014.

12.25. The Evaluation Methodology was based on 50:50 commercial: technical ratio, also referred to as the price/quality split.

12.26. Tenderers were required to submit written answers to twelve technical questions covering the following areas:

- Implementation – 10% weighting
- Workforce – 15% weighting
- Service delivery – 15% weighting
- Complexity of care – 15% weighting
- Communication – 5% weighting
- Partnership working – 5% weighting
- Added value – 5% weighting
- Health: provision of health tasks – 5% weighting
- Health: multi-disciplinary working – 5% weighting
- Safeguarding – 5% weighting
- Independence and reablement – 10% weighting
- Business continuity – 5% weighting

12.27. Each tenderers' technical submissions were marked independently of the contract area(s) they related to. Due to the volume of technical submissions nine TAP's were set up of which six marked all submissions relating to one question and three marked all submissions relating to two questions. TAP members were required to individually mark submissions and then meet to agree consensus scoring for all submissions for the question(s) they were responsible for.

12.28. Technical submissions were marked using a scoring model of 0 to 10. Following the application of the percentage weightings to scores each tenderer was awarded a mark out of 100 which was then halved to give a score out of 50. A tenderer who scored less than five out of ten for any of their twelve submissions was rejected and their tender excluded from any further consideration.

12.29. Unlike a tenderer's commercial score which was contract area specific, for those tenderers shortlisted for two contract areas their technical score was the same for both areas.

12.30. Twenty one tenderers submitted a tender by the submission deadline date of 28th January 2015. Three tenderers who had each been shortlisted to submit tenders for two contract areas failed to submit.

12.31. A total of 37 tenders were received across the nine contract areas:

For Hammersmith & Fulham:

Contract Area 1: H&F North: 4 tenders were received
Contract Area 2: H&F Central: 4 tenders were received
Contract Area 3: H&F South: 4 tenders were received

12.32. In legal discussions during the procurement, it was agreed that due to the changed nature of the service provision into three discrete patches, TUPE would not apply to the new contracts.

12.33. There are no in house Council staff involved in this process.

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

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

	London Borough of Hammersmith & Fulham **HEALTH, ADULT SOCIAL CARE AND SOCIAL INCLUSION POLICY AND ACCOUNTABILITY COMMITTEE** **14th September 2015**
TITLE OF REPORT Adult Social Care - Customer satisfaction	
Report of the Executive Director, Adult Social Care and Health	
Open Report	
Classification - For Review & Comment **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: Liz Bruce	
Report Authors: Mike Rogers Head of BA, Planning & Workforce	**Contact Details:** Tel: 020 7641 2425 E-mail: mrogers@westminster.gov.uk

1. EXECUTIVE SUMMARY

1.1. This report provides a description of current mechanisms to understand customer satisfaction and experience in adult social care (ASC); a summary of some current findings from the annual service user survey and carers survey; how the mechanisms for obtaining customer experience and satisfaction are being developed.

2. RECOMMENDATIONS

2.1. The Committee is asked to review and comment on the contents of the report.

3. INTRODUCTION AND BACKGROUND

3.1 A ‘customer’ of ASC is someone who has received support or assistance of some kind. This can range from someone offered tailored information and advice, preventive services, such as equipment or assistive technology, to someone with complex needs which requires on-going support such as home care or residential care to achieve positive health and wellbeing outcomes. Carers are also ‘customers’. They are individuals who provide support or who looks after a family member, partner or friend

who needs help because of their age, physical or mental illness, or disability.

3.3 Historically a key focus nationally and locally for both local authorities and the NHS in understanding customer satisfaction has been the use of statutory experience and satisfaction surveys and the complaints and representation processes. These include the annual ASC User Survey, bi annual Carers Survey, GP survey, and various NHS provider trust surveys. One of the main drawbacks of this approach is that it can give only a narrow picture of experience and satisfaction and takes the individual service out of the 'care pathway' the individual customer/patient is experiencing. These approaches have not kept pace with service redesign and tend to exclude people who have received short term interventions (such as reablement) or preventive services; neither do they explore satisfaction with integrated services with the NHS or housing.

3.4 The Council wants to ensure that every contact between customers, carers and local services is seen as an important opportunity to hear their views, address their concerns and tell us when we have got things right and importantly, how things can be done differently. The Council is committed to enhancing the range of methods used to get customer feedback and hear about satisfaction and experience and putting these at the heart of how services are developed in future. ASC wishes to develop a more proactive approach to customer feedback which better hears customers concerns at an early stage, reducing formal complaints. Other developments include a greater focus on co production with customers to support more innovative approaches to commissioning services, making sure as many customer voices as possible are heard and developing ways of understanding customer satisfaction with integrated and new services.

3.5 The Council is committed to listening to customers and their carers and putting their voices at the heart of service improvements and developments. This paper is intended to support this approach.

4. Adult Social Care customers

4.1 The latest population estimates from the GLA suggest there are 147,556 adult residents in the borough. Of the adult resident population 12.2% are aged 65 years or over years and 5.3% 75 or over..

4.2 During 2014/15, ASC had contact with over 4,000 customers. At anyone time the service is supporting approximately 3,600 adult residents with on going social care, equivalent to 2.4% of the adult population. Typically 14% of older residents, aged 65 and over, are supported with on going social care at anyone time. The service is also working with over 900 carers.

5. Customer satisfaction – the current position

5.1 <u>ASC User survey results</u>

5.1.1 The Adult Users Survey takes place every year and contributes to 7 key indicators used to assess ASC performance nationally. Customers are asked a number of questions about the quality of their lives, (which are then aggregated together to give a quality of life score) and also about their satisfaction with services. A sample of customers in who had received a service in the last year were invited to respond to the survey, which took place from Jan-Mar 2015. 513 people responded, a response rate of 31%. This was a substantial increase on the response rate in 2013/14, which gives us more confidence in the findings.

5.1.2 Summary national results show in common with previous years that in London there are generally lower scores for quality of life and lower rates of satisfaction with services.

5.1.2 A summary of the results for the Council are set out below:

- 8 out of ten customers who responded to the survey said they would recommend the service to their friends or family.
- More disappointing was that only 56% of respondents were very or extremely satisfied with services down from 59% the previous year.
- In common with elsewhere, learning disability customers have the highest level of satisfaction with services, with 83% very happy with services.
- Older people in residential care also have a high level of satisfaction (65% very/ extremely).
- In contrast, just under half (46%) of older people receiving community services at home were extremely/ very satisfied with services.
- Adults 18-64 (with either a physical disability or mental health needs) had a broader range of satisfaction – 55% very / extremely satisfied but 10% very/ extremely dissatisfied.
- In relation to self reported 'quality of life', the survey collates the scores of 8 individual questions to generate a Quality Of Life (QoL) score. A higher score suggests that customers experience a higher quality of life, with 24 the maximum that can be achieved. When reviewing scores at an Inner London borough level the Council appears to have the joint second lowest rate of QoL of 18. However, there is very little statistically significant difference between the scores of 9 of the authorities – suggesting they are performing at a very similar level,

5.1.3 National and local results show that the health of respondents is an important factor in how people are likely to respond to the Quality of Life question, irrespective of the quality of the service they receive. Where people have poor health, they are typically likely to report lower quality of life. Customers with learning disabilities report the best health of the customer groups, followed by 65+ residential. Over half of those aged 65+ receiving community services rated their health as only 'fair'. A third (36%) of customers in LBHF have good or very good health, lower than Inner London (42%). Whereas a third of 18-64 year olds rated their health as 'bad' or 'very bad' – a third suffer from extreme pain/ discomfort and a

quarter from extreme anxiety or depression. These factors are likely to contribute to the quality of life results locally.

5.1.4 The local results of the survey are currently being analysed further and discussed with the Cabinet Member and senior management to inform the drafting of an action plan.

‘

5.2 Carer Survey results

5.2.1 The results of the Carers Survey have been reported to Committee in detail previously.

5.2.2 In summary:

- Carer satisfaction with the Councils services has improved since the last survey and is higher than the inner London average.
- Those caring for someone with a learning disability express the lowest level of satisfaction.
- Satisfaction amongst those caring for someone with dementia was significantly higher that other groups
- Carers report that the things that help them the most are services and support for the person they care for, carers personal budgets and short breaks/respite care.

5.2.3 In response to the results of the survey and feedback from Committee an action plan has been developed.

5.3 ASC Complaints

5.3.1 There were 80 formal complaints made to ASC in 2014/15. Of these, the majority related to quality of service, service failure and service delay. A significant number of complaints related to unhappiness at the change of service providers for the transport service and carers support services.

5.3.2 32 complaints were upheld (40%) and 22 were partially upheld (28%). 23 were not upheld (29%) and 5 were withdrawn.

5.3.3 4,019 customers received support from ASC during the year, and of these 2% of customers/family members raised formal concerns about their services. However the service continues to promote and encourage complaints, comments and feedback to help improve services and the overall customer experience. Each complaint is analysed to ensure that any organisational or service learning is made and adjustments to services made as appropriate.

6. Putting the customer voice more firmly at the centre

6.1 The Council recognises that customer feedback is an essential means to help improve the quality of services. We encourage care management and service providers to create a trusting environment where customer feedback is positively encouraged and customers feel able to be open and

honest with their care workers about what they want, what works well, and what works less well for them. We want to create an environment where a customer service approach is taken where all feedback is treated as positive and welcomed; even where this amounts to a more formal complaint. The Council recognises that it is not always easy to achieve this trusting relationship with customers. A key part of the care worker: customer relationship we want all staff to promote is that customers feel safe to give feedback or make complaints about a care worker, service or provider, and that they have the confidence to do this without fear of this impacting negatively on the service they receive.

6.2 To achieve this, where customers need help in improving their confidence so they are able articulate their experiences and wants staff actively encourage and help individuals to link into local user boards, organisations or advocacy services. We expect this approach to be a fundamental part of every individual support plan.

6.3 We expect all providers to have a robust complaints procedures in place and mechanisms for dealing with and managing all complaints. Using the principles of good customer service they must have an effective process in place to ensure that complaints and other feedback from customers is used to improve the quality of services provided.

6.4 The Council is committed to making the formal complaints processes as easy to understand as possible and our expectation is that service providers own processes are similarly accessible and individuals are encouraged to complain where a service falls short of expected quality standards.

6.5 Work is being taken forward through a review of ASC commissioning services and the development of a new commissioning strategy for ASC aimed at strengthening our approach to customer feedback. This includes how to use customer feedback in a more holistic and proactive way, better co-ordinating all feedback, using the results of national surveys, extended local surveys, making better use of feedback from user and community groups and enhancing how we learn from complaints. Customer feedback will be at the core of contract monitoring of providers.

6.6 <u>Home care</u>

6.6.1 The new home care service specification was directly informed by customer views about what constitutes service quality. Based on this work the following quality standards will be used to help evaluate how the service is meeting individuals expectations. The results of the excellent work carried out locally by Healthwatch around Dignity in Care have also been used to inform our new approach which replaces a previous focus on time and task. As the new service is rolled out, customers will be encouraged to tell us whether:

- they would :recommend their care worker to a friend or relative,

and whether they thought their care workers:

- were good at their job,
- were always polite and treat them with dignity,
- helped them feel in control of their lives,
- helped them keep in touch with their community,
- always listen to what they want and work with them so that they can be as independent as possible,
- asked them how they want their care to be provided,
- come at times which suited them.

6.6.2 In future in monitoring the new service the Council intends to ensure that feedback on the quality of service from customers is put at the heart of new performance and contract monitoring. We are currently exploring ways this can be achieved a=in a cost effective and accessible way this includes looking for potential external partners, such as Patient Choice for example, who already have established and well used methods for customers to provide feedback on NHS services in their own wards and in a form they want.

6.7 Customer Journey

6.7.1 'Customer Voice' research was commissioned from Charteris an independent organisation with a brief to provide a rounded view of what was important to customers and their experience of services. The research provided helpful, arm's length in sight into customer experience and is being used to underpin the redesign of social work services through the Customer Journey transformation programme.

6.8 Co production

6.8.1 Given the challenges to commissioning more effective services with reduced resources, the Council is particularly committed to exploring new approaches to co production of services with local residents to help ensure that residents needs are met. In the borough there is a Customer Pathway Working Group, which is hosted by SOBUS (a new Community Development Agency for Hammersmith & Fulham). SOBUS aims to provide a wide range of support services for local charities, community groups, social enterprises and start up businesses. Both ASC and CCG commissioners are members of the working group. An initial co-production meeting with voluntary sector representatives is scheduled to take place in September and a number of elected members have been invited. The meeting will be used to establish some shared principles of co-production and identify and agree priority areas of work. The approach will then engage wider cross sections of customers more directly through through local voluntary organisations networks.

6.9 Satisfaction with wider NHS and Council services.

6.9.1 The performance of other services outside of traditional social care, and also of integrated services with the NHS, are of increasing importance in delivering the ambitions of the Care Act and meeting the demographic and financial challenges.

- The integrated Community Independence Service is at the centre of our Better Care Fund plans locally. The ambitions of streamlining and integrating services with health are that a more joined up, holistic and consistent approach is experienced by customers, with less focus on individual professional roles and more on holistically what a customer needs. To compliment this a series of interviews with people currently using the new integrated service are being carried out. This feedback will be tested against our design principles. The lead provider (Imperial NHS Trust) for the new service is committed to undertaking comprehensive customer / patient survey research towards the end of the year, to get an indication of overall satisfaction with the new service.

- The new duties on local authorities arising from the Care Act to promote health and well being will mean customer satisfaction with wider Council and community services such as housing, and those with a role providing preventive services and advice and information; will be of increasing significance.

7. CONSULTATION

7.1 This report is for information only. However we will be consulting groups of residents, customers and carers about how to develop our plans for co-production. As we take forward our ideas to put the customer voice more at the heart of commissioning, service design and provider performance, we will be consulting customers about how this is working and make refinements in response to feedback.

8. EQUALITY IMPLICATIONS

8.1 There are no direct equality implications arising from this report.. However a commitment to equal opportunities and equalities are core values underpinning our approach to customer feedback and analysis of satisfaction and experience.

9. LEGAL IMPLICATIONS

9.1 There are no legal implications arising from this report.

10. FINANCIAL AND RESOURCES IMPLICATIONS

10.1 There are no direct financial or resource implications arising from this report.

11. RISK MANAGEMENT

11.1 There are no issues in relation to risk directly arising from this report.

12. PROCUREMENT ISSUES

12.1 There are no direct procurement issues arising from this report. However, as the new ASC Commissioning Strategy is developed this will include a commitment to improving the involvement of customers in the design of new services and in the evaluation of performance of services.

13. CONCLUSION

13.1 This report is for information. It provides description of existing approaches to gaining in sight, satisfaction and experience of ASC customers and some current issues which these approaches have identified. The report also describes our plans for the future and how we will take forward work to identify customer experience and satisfaction in the future and how we will ensure this is used to directly help shape and evaluate services.

Appendix 1 – Adult Social Care - Customer Satisfaction - a summary

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

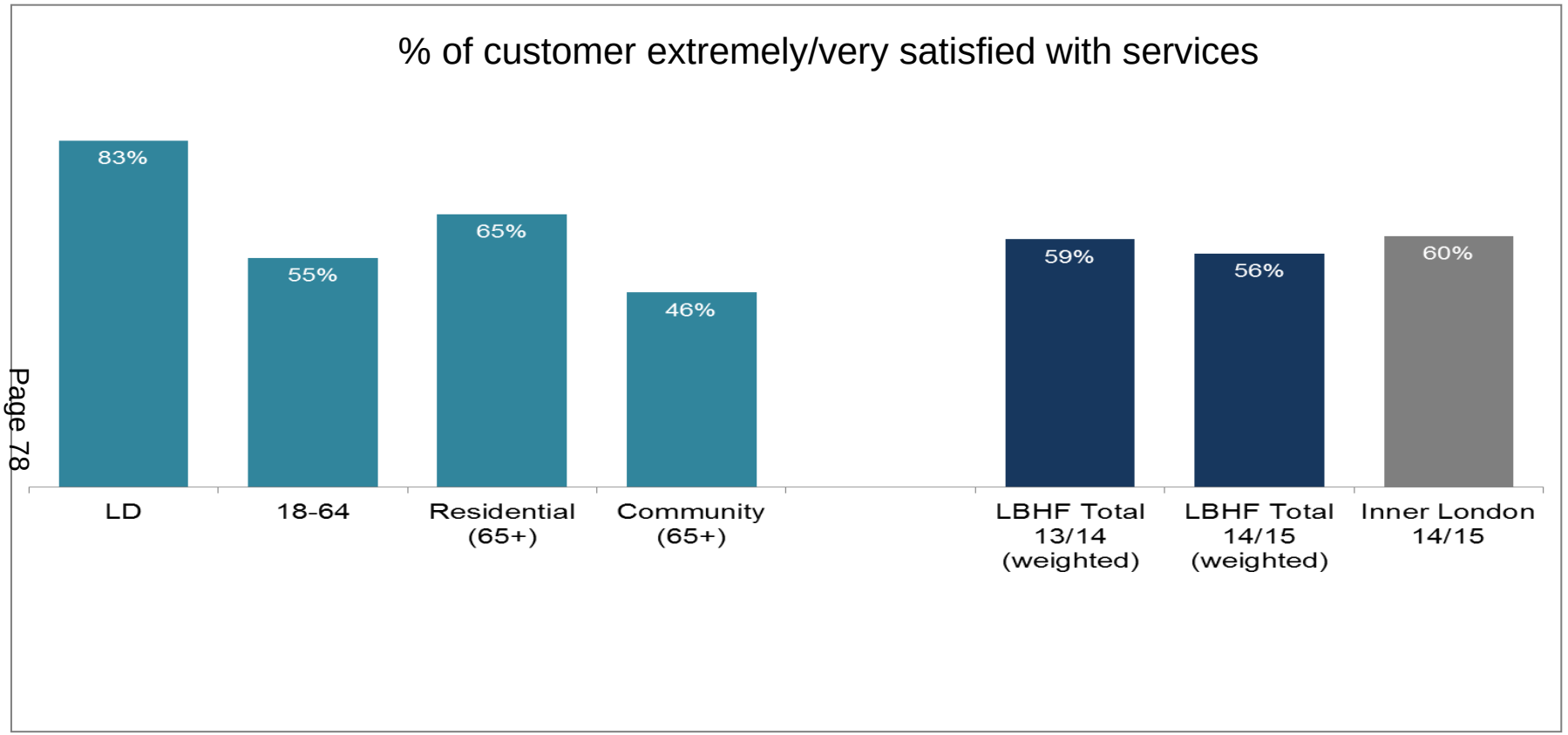
Adult Social Care Customer Satisfaction

Key context

- Co-production in the future is a priority in the new commissioning strategy.

- All feedback is valuable and our aim to create a different culture around feedback and customer voice.

Overall Satisfaction with LBHF Services



In common with elsewhere, **learning disability customers** have the highest level of satisfaction with services, with 83% very happy with services.

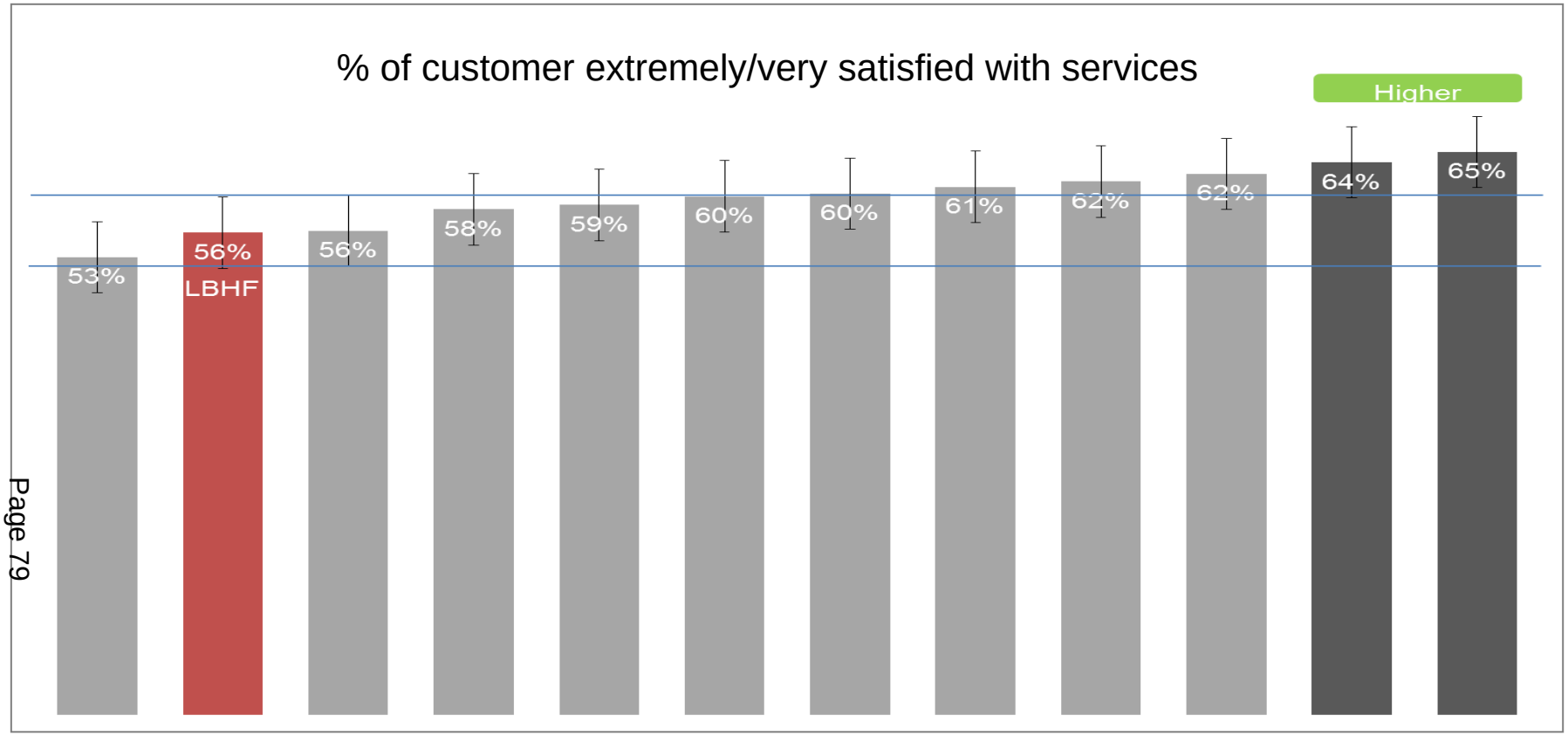
Older people in residential care also have a high level of satisfaction (65% very/ extremely).

Just under half (46%) of **older people receiving community services** were extremely/ very satisfied with services.

Adults 18-64 had a broader range of satisfaction – 55% very/ extremely satisfied but 10% very/ extremely dissatisfied

There has been a **slight reduction in satisfaction** between 13/14 and 14/15. Current levels are also below the Inner London average.

Overall Satisfaction with LBHF Services – Inner London



When reviewing satisfaction at an Inner London borough level LBHF appears to have the **second lowest** rate of satisfaction.

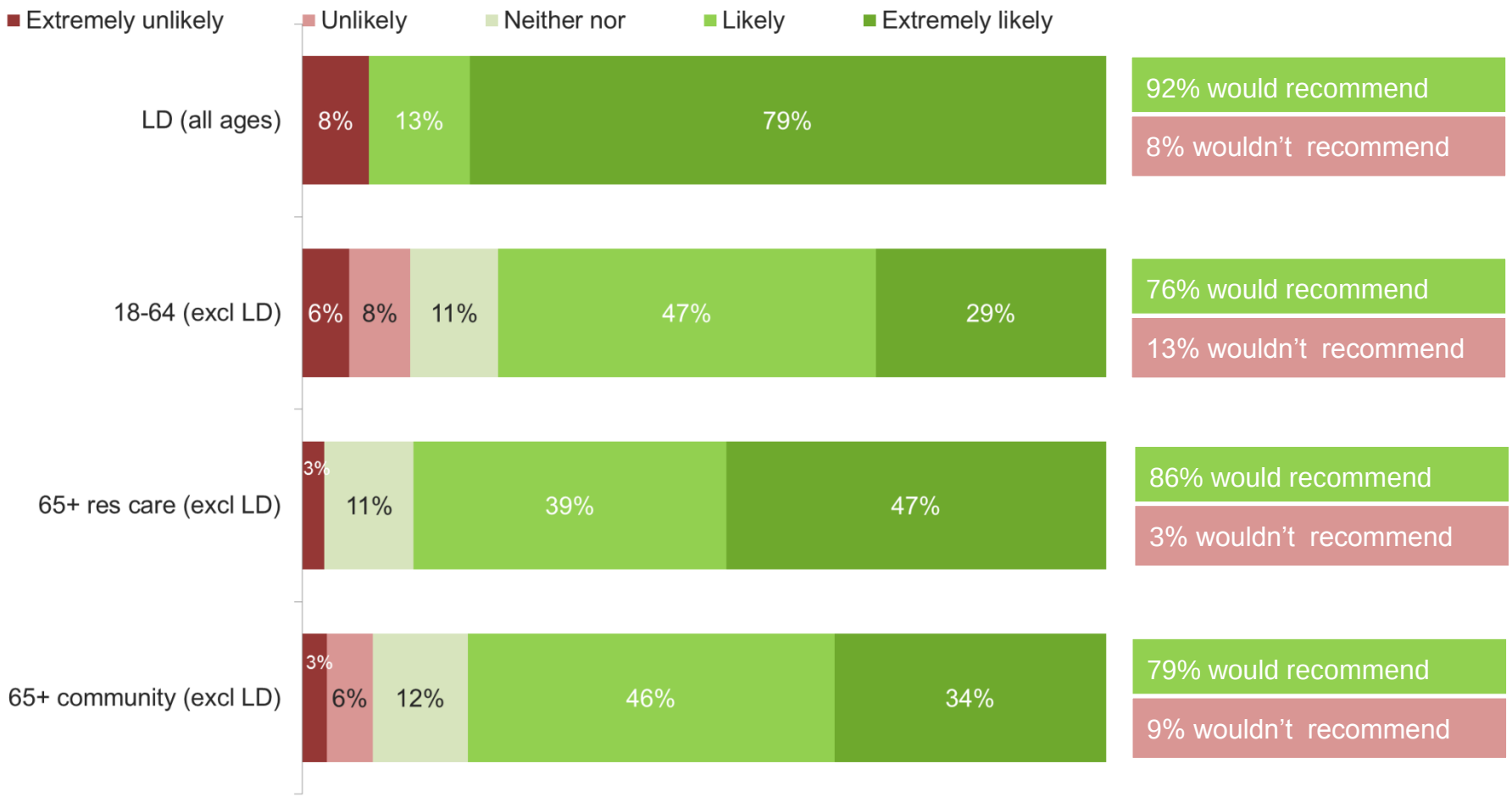
When the statistical significance of the range of scores is examined, 10 of the 12 boroughs fall within the same range. **This suggests that any variation across these scores is not significant** and they are likely to be performing at the same level.

The scores for two Inner London boroughs are outside of this range, suggesting that they do **have a higher level of customer satisfaction** when compared to the other 10.

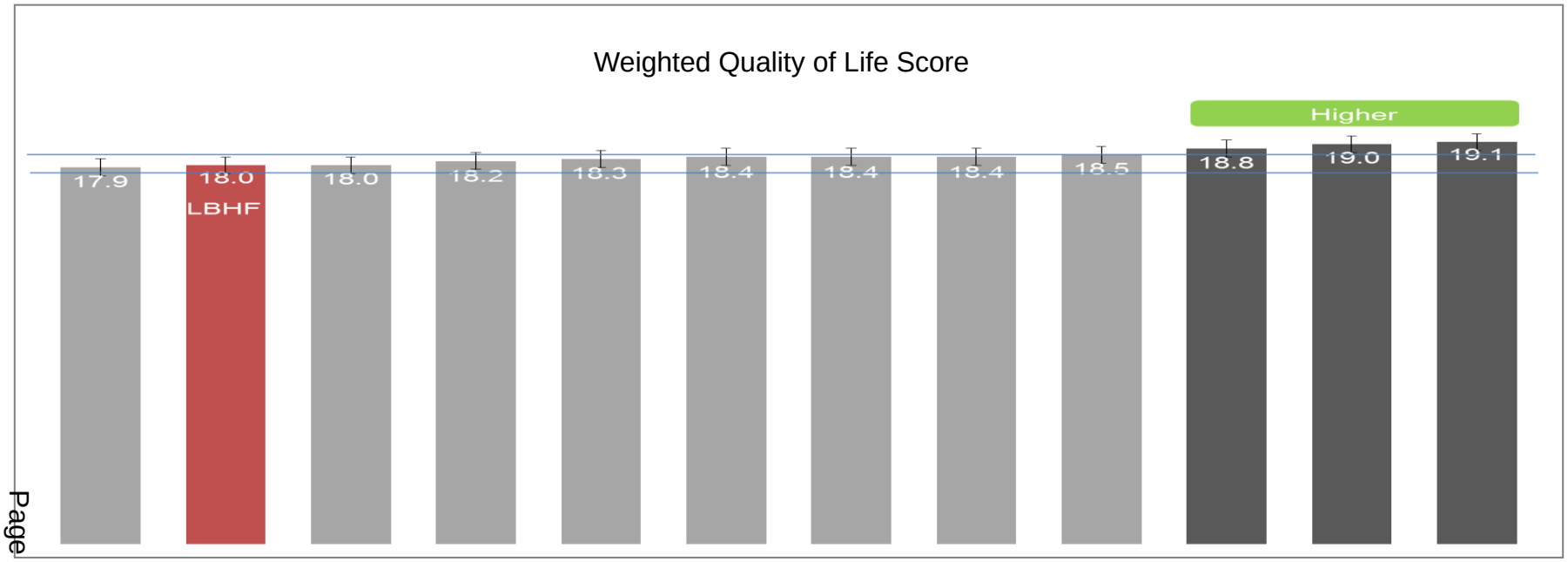
The London average for satisfaction is also 60% while the national England average is higher at 65%of respondents stating they are very or extremely satisfied with the care and support they receive.

Would Recommend Care and Support Services

8 out of 10 customers in LBHF would recommend care and support services to friends and family ('don't know' responses have been excluded)



Composite Quality of Life Score - ASCS



The annual Adult Social Care Survey collates the scores of 8 individual questions and uses a weighted method to generate a Quality Of Life (QoL) score. All 8 questions are weighted equally. A higher score suggests that customers experience a higher quality of life, with 24 the maximum that can be achieved.

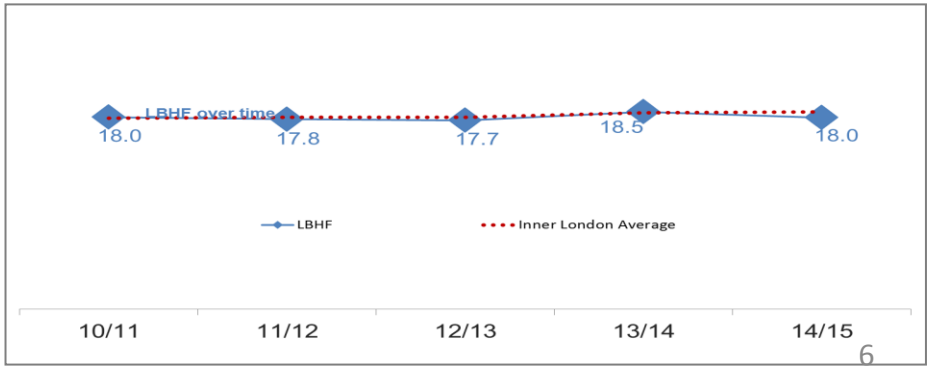
When reviewing scores at an Inner London borough level LBHF appears to have the **joint second lowest** rate of QoL.

When the statistical significance of the range of scores is examined, 9 of the 12 boroughs fall within the same range. **This suggests that any variation across these scores is not significant** and they are likely to be performing at the same level.

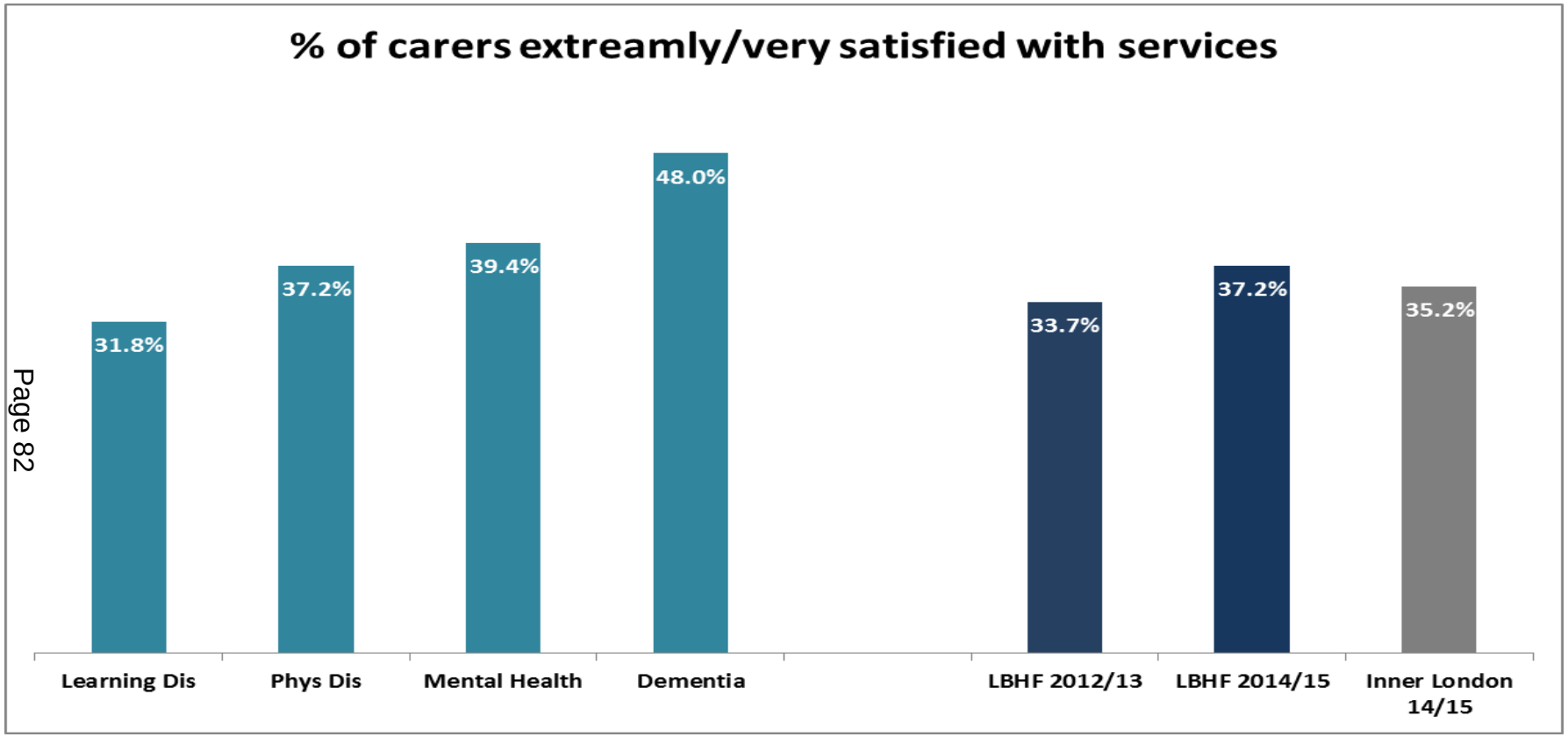
The scores for 3 Inner London boroughs are outside of this range, suggesting that they do **have a higher level of QoL** when compared to the other 9.

The Inner London average for QoL is 18.4. The London average is 18.5 while the national England average is higher at 19.1.

The QoL score has fluctuated over the years with 17.7 the lowest that has been achieved in 12/13 and 18.5 the highest in 13/14.



Carers Satisfaction with LBHF Services



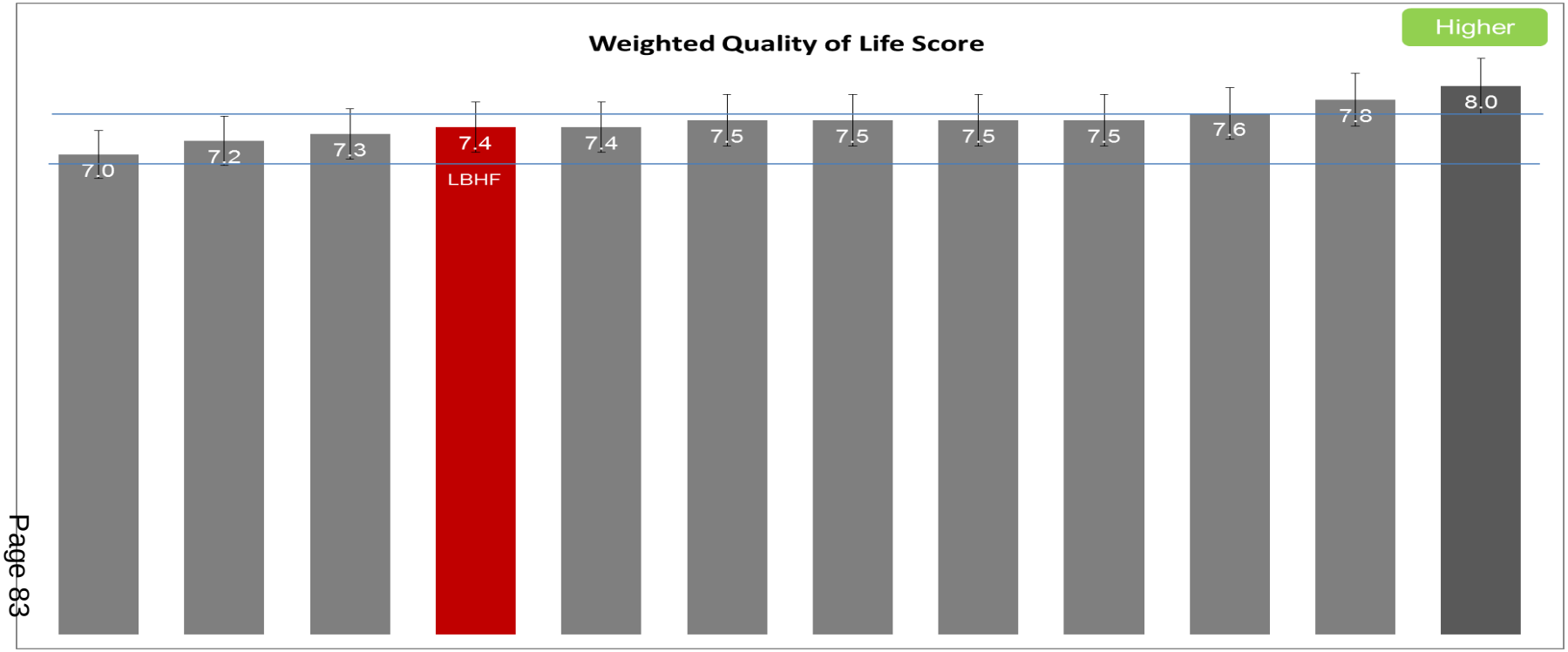
Carer satisfaction with LBHF services has **improved since the last survey** and is **higher than the inner London average.**

Those caring for someone with a **learning disability** express the lowest level of satisfaction.

Satisfaction amongst those caring for someone with **dementia** was significantly higher that other groups

Carers report that the **things that help them the most** are services and support for the person they care for, carers personal budgets and short breaks/respite care

Carers Quality of Life



The biennial Survey of Adult Cares collates the scores of 6 individual questions and uses a weighted method to generate a Quality Of Life (QoL) score. All 6 questions are weighted equally. A higher score suggests that carers experience a higher quality of life, with 12 the maximum that can be achieved. When reviewing scores at an Inner London borough level LBHF appears to have the **fourth lowest** rate of QoL.

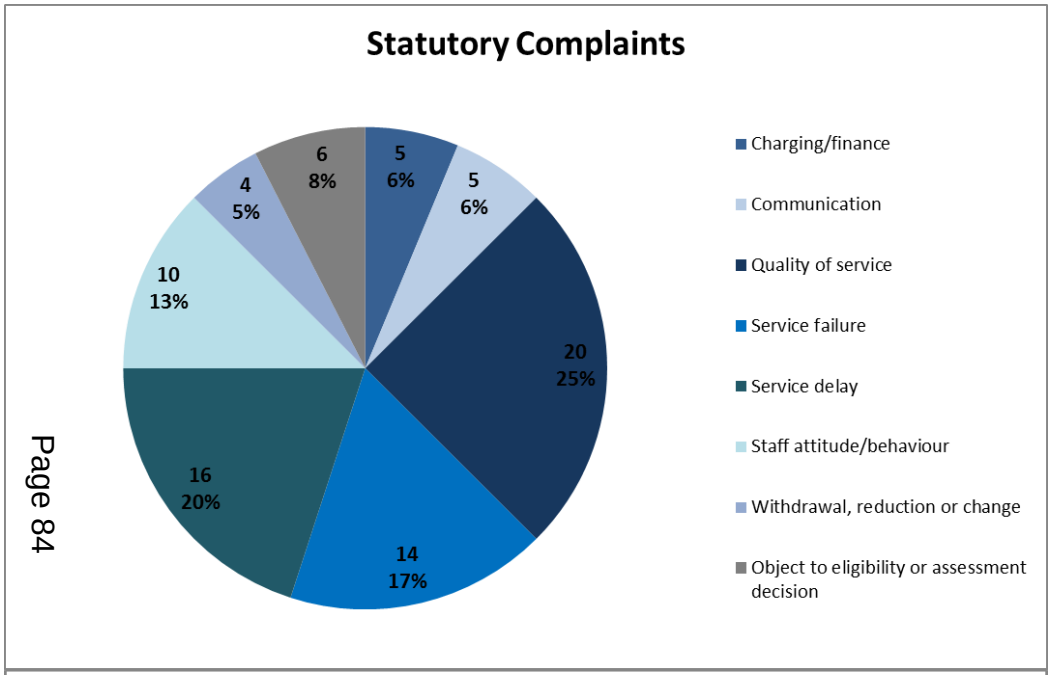
When the statistical significance of the range of scores is examined, 11 of the 12 boroughs fall within the same range. **This suggests that any variation across these scores is not significant** and they are likely to be performing at the same level.

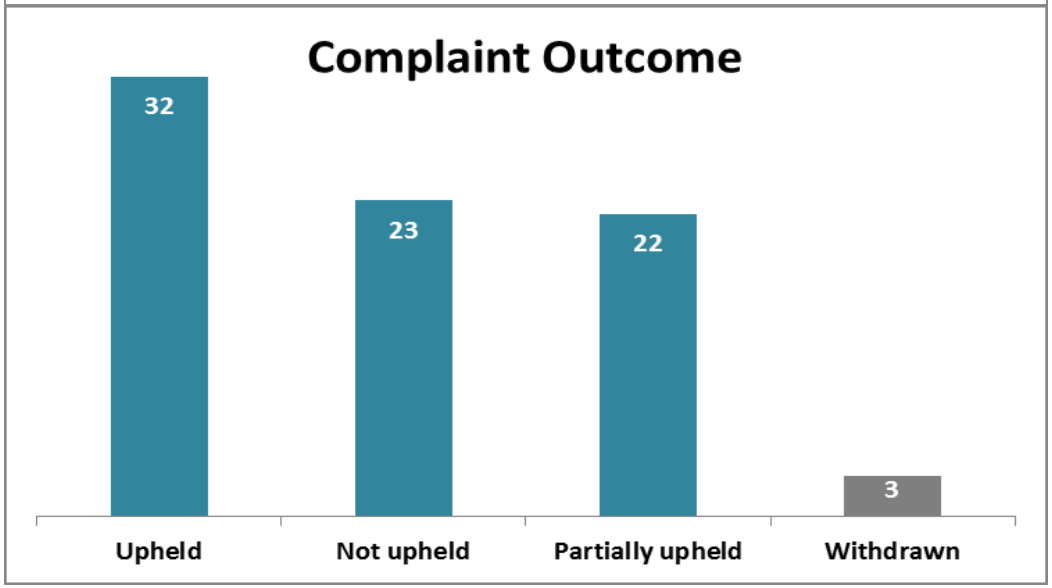
The scores for 1 Inner London boroughs is outside of this range, suggesting that they do **have a higher level of QoL** when compared to the other 11.

The London and Inner London average for QoL is 7.5 while the national England average is higher at 7.9.

The score has improved from the 12/13 score of 7.2 which was the fist year of the survey.

Statutory Complaints





There were **80 formal complaints** made to ASC in 14/15. Of these, the majority related to quality of service, service failure and service delay. A significant number of complaints related to unhappiness at the change of service providers for the transport service and carers support services.

32 complaints were upheld (40%) and 22 were partially upheld (28%). 23 were not upheld (29%) and 5 were withdrawn.

4019 customers received support from ASC during the year, and of these 2% of customers/family members raised formal concerns about their services. However the department continues to promote and encourage complaints, comments and feedback to help improve services and the overall customer experience.

What customers tell us they would like

What customers told us they would change about local services:

KEY IMPROVEMENTS – commonly stated

"I would like to have the same care daily and at around same time daily."

"I would like to know in advance if a different carer is coming even if it is short notice. Nothing worse than opening door to a stranger"

*"I would like to **go out on activities more often**, especially because I would like to lose weight. I would like to go swimming twice a week. "*

*"Having **one person to act as a guide** to the care system - all the various services available and the function of different organisations etc "*

*"**Better cleaning** in my room, especially the toilet"*

*"I would like **help with my shopping** for food and clothes"*

*"**More frequent contact** by phone and in person from social services to offer encouragement and support"*

*"That the staff would take time out to **sit and talk with me** and take time to help me to engage and interact with the other residents instead of leaving me to spend so much time in my room as I am bedbound "*

*"**Communication in between services and informal carers** needs to be improved if we are to effectively support service users"*

*"I would like to do **cooking and go out** on more day trips"*

*"to be **regularly washed at a reasonable time** in the morning"*

*"**Better advertising your service**. I suffered for a few years before getting your excellent services. "*

*"Services and support need to be available **outside working hours** so that informal carers who are in full time employment are still given support and advice"*

Improving LBHF Services

Care at Home	Operational Review	Commissioning Review
• **Enabling** approach to care and support • **Consistency** of care worker • Providers working in **partnership** with customers to agree outcomes the customer would like to achieve • Focus on **communication** • Regular reviews of service and **satisfaction** • Partnership working with VCS to **connect customers with the community**	• Improving the **quality and consistency** of assessment, support planning and reviews • Helping customers plan and manage their **own care** • Meeting customers' needs in a **tailored and personalised** way • Providing **accurate info and advice** including signposting to VCS • new **management** structure • **Simpler and leaner** processes reducing hand-off	• **Proactive** provider engagement • Market development to **shape the care market** • **Improved service outcomes** for customers and carers through contracts and commissioning • **Innovation** in service delivery and contracting • **Strengthen partnership working** with council and external partners • Focus on **customer engagement** and user led service design

Health, Social Care and Social Inclusion Policy and Accountability Committee

Work Programme 2015/2016
3 June 2015
Preparing for Adulthood: A Report About Young People Aged 14-25 with Disabilities Chelsea and Westminster Hospital NHS Foundation Trust: CQC Report The Francis Inquiry Recommendations: Responses by Chelsea and Westminster Hospital NHSFT and Imperial College Healthcare NHS Trust Chelsea and Westminster Hospital NHSFT: Integration with West Middlesex Hospital
7 July 2015
Addressing Food Poverty in Hammersmith & Fulham Chelsea and Westminster Hospital NHSFT: Integration with West Middlesex Hospital Primary Care Briefing: GP Networks Network Plan 2015-2016 and Out of Hospital Services
14 September 2015
Customer Satisfaction Immunisation Uptake New Home Care Service West London Mental Health NHS Trust: Development of Services
4 November 2015
Immunisation Uptake: Update CQC Inspections: Central London Community Healthcare NHS Trust and West London Mental Health NHS Trust Healthcare Commission Report
2 December 2015
H&F CCG Performance GP Access Imperial College Healthcare NHS Trust: Outpatients PAS Update Public Health: introduction to community services and strategy and in year Public Health savings Safeguarding Adults: H&F Report
2 February 2016
2016 Medium Term Financial Strategy Commissioning Strategy: Providers

14 March 2016
18 April 2016
Meal Agenda
Future Meetings
Care Act Chelsea and Westminster Hospital NHS Foundation Trust: Integration with West Middlesex Hospital Community Independence Service Customer Journey: Update Digital Inclusion Strategy Equality and Diversity Programmes and Support for Vulnerable Groups H&F Foodbank Immunisation: Report from the HWB Task and Finish Group Integration of Healthcare, Social Care and Public Health Listening To and Supporting Carers Self-directed Support: Progress Update