London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Agenda

Tuesday 9 February 2016
6pm
Courtyard Room

MEMBERSHIP

Councillor Vivienne Lukey, Cabinet Member for Health and Adult Social Care (Chair)
Dr Tim Spicer, Chair of H&F CCG (Vice-chair)
Councillor Sue Macmillan, Cabinet Member for Children and Education
Vanessa Andreae, H&F CCG
Liz Bruce, Executive Director of Adult Social Care
Andrew Christie, Director of Children's Services
Janet Cree, H&F CCG
Trish Pashley, Local Healthwatch representative
Director of Public Health

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Date Issued: 01 February 2016

London Borough of Hammersmith & Fulham

Health & Wellbeing Board
Agenda

9 February 2016

Item		Pages
1.	**MINUTES AND ACTIONS**	1 - 7

(a) To approve as an accurate record and the Chair to sign the minutes of the meeting of the Health & Wellbeing Board held on 9 November 2015.

(b) To note the outstanding actions.

2. APOLOGIES FOR ABSENCE

3. DECLARATIONS OF INTEREST

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

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

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

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

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8. FLU VACCINATION 135 - 138

9. JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) STEERING GROUP 139 - 143

To note the minutes of the meeting held on 26 January 2016.

10. DATES OF NEXT MEETINGS

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

21 March 2016

London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Minutes

Monday 9 November 2015

PRESENT

Committee members:
Councillor Vivienne Lukey (Cabinet Member for Health and Adult Social Care) (Chair)
Dr Tim Spicer, H&F CCG (Vice-chair)
Vanessa Andreae, H&F CCG
Liz Bruce, Executive Director of Adult Social Care
Janet Cree, H&F CCG
Councillor Sue MacMillan (Cabinet Member for Children and Education)

Nominated Deputies:
Councillor Sharon Holder
Keith Mallinson, Healthwatch Representative
Councillor Rory Vaughan
Rachael Wright-Turner, Director of Commissioning

Officers: Dr Ike Anya (Deputy Director of Public Health), Steve Miley (Director of Family Services) and Sue Perrin (Committee Co-ordinator)

NHS England: Johan van Wijgerden

NHS NWLondon: Eleanor Wyllie

23. MINUTES AND ACTIONS

The minutes of the meeting held on 9 September 2015 were approved as an accurate record and signed by the Chair.

24. APOLOGIES FOR ABSENCE

There were no apologies for absence.

It was noted that Trish Pashley had resigned as the Healthwatch representative.

25. DECLARATIONS OF INTEREST

Councillor Vivienne Lukey is the Chair of the Trustees of H&F Mind and Keith Mallinson is an advisor to H&F Mind.

26. FLU ACTION PLAN 2015/2016: UPDATE

The Board received an update on the work undertaken by NHS England (NHSE), Public Health and Hammersmith & Fulham Clinical Commissioning Group (CCG), both jointly and independently, to increase vaccine uptake and future action plans.

Mr van Wijgerden responded to queries. The national supply issue with the children's nasal spray flu vaccine had been resolved. There had been a regulatory and quality issue and additional vaccine had been purchased by the Department of Health. The programme was now continuing as normal.

It would be possible to share school level uptake data with the local authority, with the caveat that data from small schools would not be shared, as it might inadvertently identify the children. The data would be shared through the Systems Leadership Workshop. Other data from Public Health England and GP practice data would also be shared.

Mrs Andreae stated that the CCG was supportive of a Children's Centre. Potentially, there could be three or four sessions.

Councillor Vaughan stated that the Health, Adult Social Care & Social Inclusion Policy & Accountability Committee (PAC), at its recent meeting, had been very encouraged by the work done and the way in which the different parties had come together to work towards the shared goal of improved flu vaccination rates. The PAC had however recognised that a number of challenges remained, and particularly attitudes towards the vaccination.

Mrs Andreae referred to the issue of vaccinations for patients undergoing chemotherapy, which had been raised at the PAC. The CCG would discuss with acute hospitals and also disseminate information to GP practices, including guidance about when the vaccination could be given. GPs would be sent the link to information in respect of the reasons why people declined the vaccination.

Dr Anya stated that whilst work was ongoing to promote the vaccination to all groups, children and pregnant women were the current year's priorities. Public health was in touch with the local hospitals and the vaccination was being promoted in out-patient departments. It was not always appropriate for the vaccination to be given at hospitals.

Mrs Bruce stated that the provision of the vaccine to people with long term conditions and those aged 65 plus was being picked up by the Community Independence Service.

Councillor Lukey stated that it was intended that Carers' Day would include community pharmacists, who were able to vaccinate outside their premises

and that work was ongoing with NHSE. to ensure that supplies of the vaccine were available.

Mr Lawry stated that Sobus was in touch with some 500 voluntary organisations and offered to promote communications material. He considered that it was important to understand why people might not access the vaccination and address those concerns. Mrs Andreae responded that there would be further discussion at the Patient Reference Group and with Community Champions, and suggested that Public Health should talk about the benefits in more depth.

Mr Lawry suggested that Public Health should liaise with Children's Services to target the group which did not attend Children's Centres and health services.
Councillor Vaughan noted that whilst years one and two had been prioritised, reception and nursery classes had not. Parents of these children should be informed that the vaccination was a priority and would be given through GPs.
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RESOLVED THAT:

1. The report be noted.

2. The Board noted that the borough was in a much better position than the previous year and encouraged everyone to keep up the good work.

27. LIKE MINDED: NORTH WEST LONDON MENTAL HEALTH & WELLBEING STRATEGY: CASE FOR CHANGE

The Board received a report on the North West London Mental Health and Wellbeing Strategy Case for Change, as part of the Like Minded Programme.

Mr Mallinson stated that Healthwatch's observations were that many patients fell between services and felt isolated and that no-one was listening. In some cases the partnership between the various services was not working well. For a number of years, some patients had not attended appointments, maybe because of the transition between adults and children's services.

Ms Wyllie responded that the ethos in respect of people's wellbeing was to improve self- management and to raise awareness of mental health facilities. New high quality services would be developed in the community, with care focused on community based support. A local model of care and support would be developed which best fitted the needs of the local population, and linked to other boroughs and voluntary organisations.

Eight major issues had been identified and submitted to the Transformation Board, one of which was the redesign of child and adolescent mental health services.

Mr Lawry queried engagement with the voluntary sector. Ms Wyllie responded that there had been some engagement, and specifically with Mind and through the CCGs. Mr Lawry stated that Sobus would be happy to offer support.

Mr Lawry commented that there was a need to balance the resources allocated for services and the preventative agenda. Ms Wyllie referred to the six work streams, which had been prioritised by the programme. 'Wellbeing and prevention' included the two priorities of workplace wellbeing interventions and prevention of conduct disorder.

Councillor Vaughan queried what could be done, in a Hammersmith & Fulham context, to promote a broader understanding of mental health needs, change attitudes and link with any national work. Ms Wyllie responded that there was not a specific programme, but this work was most likely to sit within work area three 'Common mental health needs' or even two, 'Serious and long term mental health needs', However, the issue was wider than North West London.

Mr Lawry stated that voluntary organisations would help people access the right support at the right time, and that there was a good spread of such organisations throughout Hammersmith & Fulham.

Mrs Wright-Turner referred to the Children and Young People's work and queried: the extent to which Hammersmith & Fulham would be able to influence the balance between development of local and sector services; whether the £741,000 was Hammersmith specific; and the extent to which existing resources and service redesign had been considered.

Ms Wyllie responded that the objective of priority 5, 'Existing projects' was to take a Whole Systems view and rethink CAMHs.

Mrs Bruce stated that there was a need to translate to local level from NWL Transformation Board level, with the exception of the very acute end. Dr Spicer responded that whilst there was a need for a specialist body, anything which could be delivered locally would be.

Councillor Lukey considered that raising standards of GPs not committed to dealing with mental health problems, was more problematic if GPs were gatekeepers of mental health referrals. The patient pathway needed to be made easier. There were difficulties in getting a GP appointment and a GP having enough time to make a proper assessment. People with long term conditions tended not to accept that there was anything wrong with them. There was a need for GPs to make home visits, rather than tell people to go to the surgery.

Dr Spicer stated that domestic assessments for urgent care were being introduced from April 2016.

Ms Wyllie stated that work stream 6 'Enablers' would consider workforce, in addition to estates and finance. Workforce shortages would be considered and linked to training opportunities for primary care staff.

Ms Cree updated on information sharing in respect of patients with serious mental illness elements, between GPs from neighbouring practices and network localities. A new model of urgent care around a single point of access would be implemented from January, bringing about significant improvements for patients presenting at Accident & Emergency Departments.

Some additional money had been allocated for specialist psychiatric liaison services to support people presenting at St. Charles Hospital. The money would be spent on additional staff and training.

RESOLVED THAT:

1. The report be noted.

2. The Board endorsed the overall approach outlined in the Like Minded Case for Change.

28. BETTER CARE FUND: UPDATE

The Board received an update on progress with the delivery of the Better Care Fund (BCF), and the continuing work on integrating care. Further work to validate savings had been undertaken, including section 75 agreements.

A reduction in the savings/benefits due as a result of the delivery of the plan amounting to £2.489 million was expected. Officers were working on a range of options to make further savings through integration and joint commissioning. Whilst the financial benefits were not as hoped, benefits to residents were very positive.

Councillor Vaughan referred to the 'Summary of Benefits by Organisation' set out in the report, and queried why Hammersmith & Fulham had the highest savings gap, at £815,000. Ms Cree suggested that the higher activity was one of the reasons and agreed to provide a written response.

Action: Janet Cree

Ms Cree stated that the new Neuro Rehabilitation Service was not expected to be operational until the start of 2016/2017. Work was ongoing to define the service specification and some market testing had been done.

Mrs Bruce noted two pieces of detailed work: an overview of BCF cost benefits and outcomes; and a full evaluation of the Community Independence Service.

Councillor Lukey noted that whilst the financial aspects were disappointing, this should not eclipse the benefits to residents. Officers needed to consider the overall aspiration of the new model and service offer going forward.

RESOLVED THAT:

The report be noted.

29. LOCAL SAFEGUARDING CHILDREN BOARD ANNUAL REPORT

The Board received the Local Safeguarding Children Board (LSCB) Annual Report 2014/2015. Steve Miley gave apologies for absence on behalf of Jean Daintith, the Independent LSCB Chair, and noted that she was keen to strengthen links between the HWB and LSCB.

The report set out progress on priority areas, demonstrated that the LSCB had fulfilled its statutory responsibilities, and set out future priorities.

The HWB was asked to consider whether there were any specific issues or priorities on which it would be helpful to receive more detailed reports.

Councillor MacMillan queried the reasons behind the comment in the report in respect of strengthening the contribution of Public Health to the Panel. Mr Miley responded that the death of a child was the ultimate failure. The Panel tried to identify the reasons why a child had died. There were normally a range of reasons, some of which included Public Health issues. Social Care and Public Health needed to interact in a proactive way to influence health outcomes. Mrs Bruce stated that the Public Health contribution and how this could be resourced was being reviewed.

Councillor MacMillan referred to the female genital mutilation (fgm) pilot and the reluctance of Chelsea & Westminster Hospital to share information. Councillor Lukey stated that she and Mrs Bruce were meeting with the hospital (in respect of the BCF) and would raise the issue. Pilots with other hospitals were working well.

Mrs Andreae stated that nursing records would hold information about advice given to families travelling to areas where fgm was performed. Ms Cree stated that there would be follow up through the contract route. Dr Spicer stated that clinicians had an obligation to report where fgm was found in children under age 18.

RESOLVED THAT:

1. The report be noted.

2. A report on the fgm pilot be added to the work programme.

3. The Board requested that reports on child death reviews and case reviews be shared.

Councillor Lukey thanked Ms Daintith and the LSCB for its report.

30. DATES OF NEXT MEETINGS

9 February 2016
21 March 2016

Meeting started: 6.00 pm
Meeting ended: 7.25 pm

Chair .....

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London Borough of Hammersmith & Fulham **Health & Wellbeing Board** **9 February 2016**	
PROGRESS MADE IN IMPROVING PARTNERSHIP AND INTEGRATION RELATING TO CHILD HEALTH AND WELLBEING	
Report of the Divisional Director – Andrew Christie	
Open Report	
Classification - For Information **Key Decision: No**	
Wards Affected: **ALL**	
Accountable Executive Director: Andrew Christie, Executive Director for Children's Services	
Report Author: Sarah Bright, Lead Commissioner Early Years	**Contact Details:** Tel: 07770 702 347 E-mail: sarah.bright@lbhf.gov.uk

1. EXECUTIVE SUMMARY

1.1. Officers have been working to bring together services currently provided by Early Help, Children's Centres, and Youth Services into a single offer that sustains and enhances universal provision, whilst providing further support to those families who need additional help through more targeted services.

1.2. Integration discussions with Public Health commissioners of services, such as Health Visiting, Family Nurse Partnership and School Nursing are ongoing and expected to lead to full co-operation and co-design to enable seamless working and clear pathways across the range of services offered by any future models of care.

2. RECOMMENDATIONS

2.1. The Board note and comment on the paper

3. REASONS FOR DECISION

3.1. N/A

4. INTRODUCTION AND BACKGROUND

4.1. Officers have been working to bring together services currently provided by Early Help, Children's Centres, and Youth Services into a single offer that sustains and enhances universal provision, whilst providing further support to those families who need additional help through more targeted services.

4.2. Integration discussions with Public Health commissioners of services, such as Health Visiting, Family Nurse Partnership and School Nursing are ongoing and expected to lead to full co-operation and co-design to enable seamless working and clear pathways across the range of services offered by any future models of care.

5. PROGRESS TO DATE

5.1. **Commitment between Children's Services and Public Health to a set of shared outcomes for children 0-5.**

5.2. Both Public Health and Children's services have an overall aim of ensuring all children reach a good level of development by the age of five and are ready to succeed at school:

5.3.

Public Health: Focus Public Health Outcomes Framework	Children's Services: Core purpose focused on:
▪ Improving life expectancy and healthy life expectancy; ▪ Reducing infant mortality; ▪ Reducing low birth weight of term babies; ▪ Reducing smoking at delivery; ▪ Improving breastfeeding initiation; ▪ Increasing breastfeeding prevalence at 6-8 weeks; ▪ Improving child development at 2-2.5 years; ▪ Reducing the number of children in poverty ▪ Improving school readiness ▪ Reducing excess weight in 4-5 and 10-11 year olds ▪ Reducing hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14 • Improving population vaccination coverage	• Improving outcomes for young children and their families, with a particular focus on the most disadvantaged families, in order to reduce inequalities in: • Child development and school readiness; Supported by improved: • Parenting aspirations, self-esteem and parenting skills; • Child and family health and life chances.

5.4. Therefore, Children's Services and Public Health are committed to deliver services that:

- Utilise evidence based interventions to maximise impact and lasting benefits for families.
- Work together to provide seamless care for clients, including appropriate information sharing.
- Offer universal access to a range of provision delivered in partnership and from multiple locations - connecting communities and local provision where they need them most, in a flexible way that is easy to use.
- Maximise the use of volunteers and networks of community support recognising the strength and value of local activity. This will include the local community champions.
- Support families to build their resilience and help them to support themselves and reducing the need for future interventions
- Extends a case work model approach to targeted work with families

5.5. **Developing a single strategy for service design for 0-18s**

5.6. Early Help and Children's Centres have been working together to develop an approach for an integrated 0-18 Children and Families Partnership model. Work is continuing on the design of this approach ready for implementation in 2017.

5.7. **Vision for Integration:**

5.8. Building on the existing infrastructure and expertise in place to deliver the best possible offer for children and families, it is proposed to develop a single integrated early help offer from Children's Centres and Family Services – a "Children and Families Partnership" - providing a single early help offer that supports children and families at all levels of need (Level 1-3). Work with a range of partners (Public Health, Clinical Commissioning Groups (CCGs) and other relevant Children's Services), is underway to ensure that these services are fully aligned to address effectively the needs of the 0-18 year olds in Hammersmith and Fulham.

5.9. The proposed approach would marshal key resources to intervene earlier and to better target support to the most vulnerable children and families. This approach would work with families of children and young people from conception to age 18, (or up to 25 where there is an identified Special Educational Need).

5.10. This approach would ensure a core offer of support from conception into the early years of a child's life, but would recognise that children and families' needs do not stop there and that support is needed at different ages and stages.

5.11. The proposed approach is an opportunity for Children's Services and Health partners to work innovatively and more effectively with partners, enabling them to further bring services and professionals together around a child and family to identify problems at an earlier stage, ensure a joined up response and improve outcomes for children and families. The engagement and commitment from key partners is critical to the realisation of benefits and the implementation of the new model.

5.12. **Operational progress**

5.13. The Best Start in Life (BSiL) is a partnership programme of work across (Children's Centres, CCGs, GPs, midwifery and health visiting) to develop a systematic pathway of care for families from pregnancy to age 5 in order to improve outcomes for children, families and communities, as well as creating services that provide better access and experience. (see appendix 1)

5.14. The strategic outcomes for this piece of work include:

- Strengthen preventative support within the universal offer
- Spot those who need help early and connect to appropriate support
- Increase availability of childcare and take up amongst vulnerable groups
- Improve parenting capacity and family attachment
- Support families to lead healthier and more active lifestyles
- Improve school readiness
- Strengthen pathways for parents to sustainable employment

5.15. This programme of work has so far achieved the following:

- Improved partnership between Children's Services and key health professionals such as Health Visiting, Midwifery, Family Nurse Partnership (FNP)
- Early identification and support offer for vulnerable families as a direct result of health and early help staff attendances at Connected Care, Team Around Children's Centres and BSiL meetings
- Joint delivery of services from local community sites such as targeted NSPCC Baby Steps, universal antenatal parent education class, midwifery and health clinics.
- Joint development and understanding of care pathway between professionals working with families with children 0-5 years.
- Co-location of provision in one site/locality has significantly improved professional understanding and partnership working between children services and health resulting in joined up delivery of support to families
- Delivery of integrated family healthy weight pathways to guide families to recently commissioned effective services delivered through schools, children centres and other community settings.

- Joint training of frontline professionals to motivate people to change and making every contact count

5.16. Example of key successful joint projects and changes

- Children's Services work with Public health, CCGs and Children's Centres to increase uptake of the children's flu vaccine. Immunisation sessions in Children's Centres with an attached nursery which successfully increased uptake. Future possibilities of delivering vaccinations in innovative settings are being explored with NHS England.
- Each Children's Centre now has a named health visitor, and there is an FNP lead for Hammersmith and Fulham.
- Central London Community Healthcare (CLCH) share New Birth Data with Children's Centres for all families.
- All families receive information on Children's Centres from health visitors.
- Health Visitors deliver child health clinics from some of the hub Children's Centres sites
- Health development reviews are also carried out in some Children's Centres, alongside stay and play sessions.
- The integrated 2 year review is carried out by health visitors with Early Years settings.
- There is a partnership agreement in place between the council and the CLCH Health Visiting team which sets out the expectation of how partners will work together.
- Health visitors and midwives attend the Team Around Children's Centres (TACC) in LBHF facilitating multi-professional discussion about individual families who require additional support
- Children's Services, in partnership with CLCH is in the process of developing a pilot to deliver antenatal parent education classes, to universal families, delivered by midwives, health visitors and Children's Centre staff from March 2016. For vulnerable families the NSPCC Baby Steps programme will be piloted from April 2016. This will support Health Visiting to deliver a new aspect of the Health Visiting contract, and enable Children's Centres to be able to support vulnerable families early, as well as develop closer working between midwifery, health visiting and Children's Centres.
- Continuously raising number of schools taking part in the Healthy Schools Partnership with schools being awarded the bronze, silver and gold awards as they increasingly focus on promoting health and wellbeing as part of the curriculum
- Piloting a similar, Healthy Early Years settings scheme in Children's Centres and nurseries

5.17. **Next Steps:**

- Engagement with Public Health and CCG to co-design and shape the Children and Family Partnership model (0-18), benefitting from their best practice and expertise which will support a smooth transition to the new offer.

- From April 2016, in tandem with the development and co-design of the Children and Families Partnership model, Children's Centres will be commissioned in a manner that supports the transition to the proposed Children and Families Partnership model

- Health Visiting will be recommissioned in October 2017 following extensive stakeholder engagement in the service design and specification.

- To identify further opportunities with PH and CCG to ensure aligned commissioning. This may include:

- Health Visiting
- School Health services
- Drug and Alcohol
- Sexual Health
- CAMHS
- Maternity services

6. CONSULTATION

6.1. *There is no requirement to consult on the content of this report.*

7. EQUALITY IMPLICATIONS

7.1. *There are no equality implications to be considered within this report.*

8. LEGAL IMPLICATIONS

8.1. *There are no legal implications to be considered within this report.*

9. FINANCIAL AND RESOURCES IMPLICATIONS

9.1. *There are no financial implcationsto be considered as part of this report.*

11. IMPLICATIONS FOR BUSINESS

11.1 *There are no implications for business to be considered as part of this report*

12. RISK MANAGEMENT

12.1 *There are no risk management implications to be considered as part of this report*

13. PROCUREMENT AND IT STRATEGY IMPLICATIONS

13.1 *There are no procurement or IT strategy implications to be considered as part of this report.*

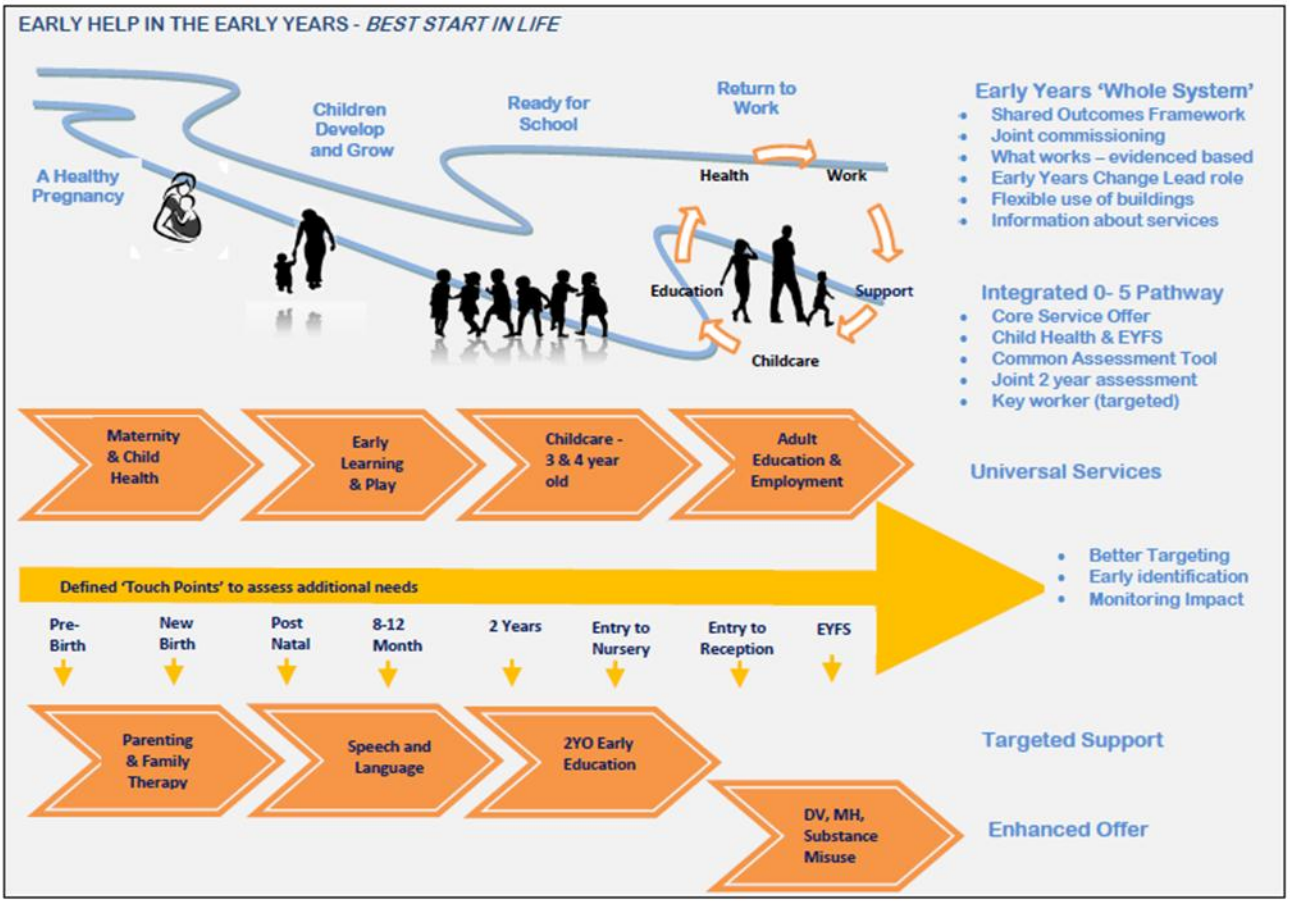
LOCAL GOVERNMENT ACT 2000

LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

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

LIST OF APPENDICES:

Appendix 1: Best Start in Life Care Pathway



London Borough of Hammersmith & Fulham **HEALTH & WELLBEING BOARD** **9th February 2016**	
TITLE OF REPORT: *CHILD POVERTY STRATEGY – UPDATE ON PROGRESS AND NEXT STEPS*	
REPORT BY THE EXECUTIVE DIRECTOR OF CHILDREN'S SERVICES *Andrew Christie*	
Open Report	
Classification – For Information **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: Andrew Christie	
Report Author: Ian Elliott, Children's Policy Team	**Contact Details:** E-mail: ian.elliott@rbkc.gov.uk

1. INTRODUCTION

This report provides an update to the Board on the emerging Child Poverty strategy for Hammersmith and Fulham. The following report outlines the background and structure of the strategy and notes key actions proposed in a draft strategy that has been passed to other departments including Public Health, Housing, Skills and Economic Development for comment. It is proposed to return to the Board with a final version of the completed strategy in the summer, following wider consultation in the spring of 2016.

2. BACKGROUND

2.1 The borough committed to produce its first child poverty strategy, following the JSNA in 2013 on child poverty and the development of a strategy on Early Help in 2015. The Health and Wellbeing Board is the governance body for child poverty and it was agreed for the Lead member for children to be the lead on behalf of the Board and for a strategy to be developed across council departments, led by Children's Services.

2.2 The Board previously asked for the strategy to reflect headline priorities of all departments where relevant, especially Housing and Health given the correlations / causes / consequences to poverty. Much of the work of the local authority is to mitigate against the effects of poverty in a national taxation and benefits system dictated by central government policy.

3. STRUCTURE OF THE DRAFT STRATEGY

3.1 Approach

3.2 Child poverty is, in effect, family poverty and reflective of deprivation. Whilst areas of deprivation in the borough are well known, the high cost of housing and childcare in London are a major contributor / cause of families finding themselves in poverty, even if in full time work. The implementation of welfare reforms, benefit caps and suppression of wages (particularly since the recession) has also contributed.

3.3 The consequences to a child growing up in poverty are proven and profound. As such, the child poverty strategy is "everybody's business" and should reflect the activity of other partners in reducing and alleviating poverty in the borough.

3.4 Structure

3.5 The structure of the draft strategy is based on good practice examples from other local areas and to reflect four themes that emerged from the JSNA and discussions with young people and families during that process. There are four major themes against which the strategy is currently structured, as outlined in the draft table below.

Theme	Policy area	Immediate issues	Wider opportunities
1.Housing	• Welfare reform / Housing Benefit caps • Affordable Housing Delivery Strategy • Improve private rented sector • Protect social rented housing	• Responding to families affected by Housing Benefit cap. • Alleviate impact of overcrowding	• Housing Renewal Strategy: Master planning • Strategic stock options • Strategy on social inclusion • Private sector landlords charter • Revised statutory Homelessness Strategy
2.Work and money	• Employability • Work and skills development • Work Matters strategy • 'a better place to do business' • Business Impact Review	• Supporting families into work • Parental skills development • Apprenticeships • Foodbank donations taken in libraries	• Work and skills development plan • Local Economic Partnership • Community Budgets
3.Children's Services	• Early Help • Early years / Childcare • Family friendly policy	• Support for families affected by welfare reform • Review of childcare	• Sustainable 'Early Help' offer • Building community resilience • Affordable childcare
4.Health	• Wider determinants of health • Partnerships with NHS providers and commissioners • Whole systems approaches	• Ensuring policy and services are appropriately targeted at those most at risk of health and wellbeing issues.	• Whole Council engagement with Public Health agenda • Food Poverty Action Statement and Delivery Plan.

4. Strategy contents - draft

The draft Child Poverty strategy contains the following contents, to be agreed by each council department prior to consultation with the public in spring 2016.

Section 1: Foreword by the Leader / Lead member for children

We will state our duty and priority to combat causes and consequences of child poverty, recognising difficulties for families, especially since the recession and in an era of austerity. We will refer to activity underway in all Departments (especially Housing and Health) and that this is a joint endeavour.

Section 2: Executive summary, to summarise the strategy and actions within.

Section 3: Context of child poverty, introducing four themes relating to child poverty and the key policy areas.

Section 4: Child poverty locally: need, indicators and JSNA findings

This section summarises existing local indicators and also give commentary on the national measure of child poverty. We have not conducted further analysis of needs specifically for

the strategy because existing local data, indices of deprivation and the comprehensive JSNA on child poverty are sufficient.

The strategy will find that child poverty in the borough mirrors the established measures of deprivation although there is a cohort of low paid and often lone parents who work and are classified as living in poverty. This is consistent across London. Childcare and housing costs are significant at a time when wages have been suppressed. Unlike previous generations we now have a situation where there are more working families 'in poverty' than workless.

At this stage we do not anticipate any new 'need' arising from the indicators / measures that are not already familiar to us. The JSNA suggested some priority areas and these are summarised in the strategy.

Section 5: Responding to poverty: actions and activity to alleviate child poverty

The draft strategy is arranged in four themes: housing; work; children's services and health. Each theme is covered in detail in the strategy, with proposed actions and activity to alleviate child poverty locally.

Theme one: Housing

The child poverty strategy links to the emerging Housing strategy and in particular the work ongoing to increase affordable housing in the borough. Prevention of homelessness will also be included in strategy, particularly young people who are homeless.

Theme two: work and pay

The local authority will recognise that it has limited influence in a national system of tax and benefits, other than (e.g.) implementation of welfare reforms and benefit caps. Much of our work is to mitigate against poverty. However we are ambitious to support families in this context. We will recognise that unemployment is comparatively low locally but acknowledge that there are cohorts in our local population for whom sustainable work is some distance away, due to other difficulties. Links will be made to Troubled Families and support for long-term unemployed. This section will also cover debt and money advice services.

Theme three: Children's Services

This notes how we have safeguarded the most vulnerable children during implementation of welfare reforms and how our Early Help strategy targets those most in need (and likely to be in poverty) via early intervention, including the Best Start in Life programme. Support for young people not in employment, education or training (NEET) will also feature, to prevent young people becoming NEET and assisting those who already are.

The childcare taskforce findings are incorporated, with potential areas for the council to prioritise:

- The importance of accurate information for local families and improvement to the Family Information Service;

- Improving support for childminders and the effectiveness of the offer of childminding services for local families;
- The role of Children's Centres in delivering effective, high quality childcare;
- Building on the findings of the 8-6 out of core hours pilot for support in schools; and
- Innovative solutions for growing a skilled workforce.

Theme four: Health

Child poverty is a priority in the Public Health strategy. The child poverty strategy will link with the Food Poverty Action Statement and subsequent delivery plan and there are a number of council commitments on health which will alleviate the consequences of poverty for families and children, e.g. obesity.

Section 6: Next steps, actions and monitoring progress

The actions in the child poverty strategy will reflect existing commitments, strategies, plans and findings from relevant task groups across the council and its partners.

We will measure the success of the strategy via established deprivation measures, as well as measuring family income. For example the level of attainment and skills is an important measure, to enable a family to therefore maximise its income. A narrow measure of income alone does not fully explain the causes and consequences of a child living in poverty.

The draft strategy will be subject to public consultation, including specifically young people and parents. It is anticipated that consultation will take place during the spring of 2016 and final strategy published in the summer of 2016, following approval at a future Health and Wellbeing Board meeting.

Contact officer:

Ian Elliott, Children's Policy Team.

London Borough of Hammersmith & Fulham **HEALTH & WELLBEING BOARD** **9 February 2016**	
CHILDHOOD OBESITY JSNA	
Report of the Director of Public Health	
Open Report	
Classification - For Decision **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: Liz Bruce, Executive Director for Adult Social Care and Health	
Report Author: Eva Hrobonova, Deputy Director of Public Health	**Contact Details:** Tel: 02076414669 E-mail: ehrobonova@westminster.gov.uk

1. EXECUTIVE SUMMARY

1.1. This report summarises the work and findings of the JSNA on Childhood Obesity, including the recommendations for key partners.

1.2. This report requests the Board to formally approve this JSNA for publication, and to take responsibility for monitoring the implementation of the recommendations, holding the relevant partners to account.

2. RECOMMENDATIONS

2.1. The Board is asked to approve the JSNA for publication.

2.2. The Board is asked to agree to monitor the progress of the implementation on the recommendations, holding to account the parties involved.

2.3. The Board is asked to continue to support and to actively promote the whole council partnership initiative to tackle childhood obesity

3. REASONS FOR DECISION

3.1. A JSNA has been carried out to identify and provide an evidence base on the causes and consequences of childhood obesity in Hammersmith and Fulham, and the prevalence in the local communities to identify who are most at risk. The JSNA will inform the next phase of the Tackling Childhood Obesity Programme.

3.2. The Health and Social Care Act 2012 placed the duty to prepare a JSNA equally and explicitly on local authorities (LAs), Clinical Commissioning Groups (CCGs) and the Health and Wellbeing Boards (HWB). Local governance arrangements require final approval from the Health and Wellbeing Board prior to publication.

4. INTRODUCTION AND BACKGROUND

4.1. A JSNA has been carried out to identify and provide an evidence base on the causes and consequences of childhood obesity in Hammersmith and Fulham, and the prevalence in the local communities to identify who are most at risk.

4.2. While the proportion of children who are overweight has remained largely unchanged since the mid-1990s, there has been a substantial increase in those who are obese over time, which will have a significant impact on our population and services. The current numbers in Hammersmith and Fulham is 22.4% obese and 15.2% overweight by the end of year 6, a total of 37.6%.

4.3. The JSNA provides a comprehensive evidence base and information about the local population to support the development of future strategies to tackle childhood obesity by all partners.

4.4. The JSNA will inform the next phase of the Tackling Childhood Obesity Programme.

5. JSNA Findings

5.1. In Hammersmith and Fulham, 1 in 5 Reception age children (20.3%) and over 1 in 3 children in Year 6 (37.6%) are overweight and obese, and around 70% of obese adolescents go on to be obese adults.

5.2. Childhood obesity presents a major challenge to health and wellbeing and is associated with an increased risk of premature mortality in adults as well as poor health and development in children. Childhood obesity also

impacts on mental wellbeing including increasing the risk of low self-esteem, anxiety, depression, bullying and poor educational attainment.

5.3. An obese child in London is likely to cost around £31 per year in direct costs which could rise to a total (direct and indirect) cost of £611 per year if they continue to be obese in adulthood. This projection is likely to be an underestimate, because of the probability that prolonged obesity has more serious and other health consequences.

5.4. Childhood obesity has complex web of causes, and requires a whole system approach to tackle it.

6. JSNA Recommendations

6.1. Every department/organisation has a role to play in creating and / or supporting increasingly healthier environments to make healthy choices easy choices. Be creative within roles/responsibilities.

6.2. Utilise every engagement with partners to achieve shared understanding of the need to address this complex problem collectively and to identify opportunities, for example:

6.2.1. Systematically use contracting as a delivery mechanism for healthy lifestyles.

6.2.2. Find ways to encourage food businesses with poor hygiene ratings to improve and join in the Healthy Catering Commitment.

6.3. Focus on early years. Exploit all possible opportunities to encourage children and families to be more active.

6.4. Develop clear and consistent messages that are readily understood by all audiences. Use the optimal communication channels for each audience. Communicate constantly and consistently.

6.5. Contribute to, and keep abreast of, national and regional developments.

6.6. Act on, and increase the evidence base.

7. CONSULTATION

7.1. A stakeholder workshop was held in Hammersmith and Fulham on 23/11/15 with attendees from departments across the councils, the NHS, and the Community and Voluntary Sector.

7.2. The JSNA was presented to the Hammersmith and Fulham CCG Governing Body Seminar on 03/11/2015

8. EQUALITY IMPLICATIONS

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

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

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

9. LEGAL IMPLICATIONS

9.1. The JSNA was introduced by the Local Government and Public Involvement in Health Act 2007. Sections 192 and 196 Health and Social Care Act 2012 place the duty to prepare a JSNA equally on local authorities (LAs), Clinical Commissioning Groups (CCGs) and the Health and Wellbeing Boards (HWB).

9.2. Section 2 Care Act 2014 imposes a duty on LAs to provide or arrange for the provision of services that contribute towards preventing, delaying or reducing care needs.

9.3. Section 3 Care Act 2014 imposed a duty on LAs to exercise its Care Act functions with a view to ensuring the integration of care and support provision with health provision to promote well-being, contribute to the prevention or delay of care needs and improve the quality of care and support.

9.4. JSNAs are a key means whereby LAs work with CCGs to identify and plan to meet the care and support needs of the local population, contributing to fulfilment of LA s2 and s3 Care Act duties.

9.5. Implications verified/completed by: Kevin Beale, Principal Social Care Lawyer, 020 8753 2740.

10. FINANCIAL AND RESOURCES IMPLICATIONS

10.1. There are no financial implications arising directly from this report. Any future financial implications that may be identified as a result of the review and re-commissioning projects will be presented to the appropriate board & governance channels in a separate report.

10.2. Implications verified/completed by: Safia Khan, Lead Business Partner Adults, 020 7641 1060

11. RISK MANAGEMENT

11.1. Public Health risks are integrated into the Council‟s Strategic Risk Management framework and are noted on the Shared Services risk register, risk number 5. Market Testing risks, achieving high quality commissioned services at lowest possible cost to the local taxpayer is also acknowledged, risk number 4. Statutory duties are referred to in the register under risk 8, compliance with laws and regulations. Risks are regularly reviewed at Business Board and are referenced to in the periodic report to Audit, Pensions and Standards Committee.

11.2. Risk Management implications verified by Michael Sloniowski, Shared Services Risk Manager, telephone 020 8753 2587.

12. PROCUREMENT AND IT STRATEGY IMPLICATIONS

12.1. Any future contractual arrangements and procurement proposals identified as a result of the JSNA and re-commissioning projects will be cleared by the relevant Procurement Officer.

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

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

LIST OF APPENDICES:

Appendix 1: Draft Childhood Obesity JSNA

Childhood Obesity in Hammersmith & Fulham, Kensington & Chelsea and Westminster

Joint Strategic Needs Assessment (JSNA) Report

December 2015

www.jsna.info/

Synopsis

This report describes the extent and nature of childhood obesity in the boroughs of Hammersmith & Fulham, Kensington & Chelsea and Westminster and summarises:

- How childhood obesity is defined
- The causes and consequences of childhood obesity
- The local prevalence of childhood obesity
- The national response
- The local response

Report authors and contributors

This report was written by Gayan Perera, Connie Junghans and Kristelle McNeir, with contributions from Jessica Nyman, Lynne Horn, Thilina Jayatilleke, Eszter Vamos and Colin Brodie.

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1. Introduction

1.1 Purpose of the report

The World Health Organisation regards childhood obesity as one of the most serious global public health challenges for the 21st century. Obesity has a substantial impact on the health of children, both now and in the future.

The causes of obesity are multi-factorial: there is no single effective solution. Tackling obesity requires a whole systems approach across the entire social, environmental and cultural environment and requires partnership between government, science, business and civil society.

This Joint Strategic Needs Assessment (JSNA) explores the causes and consequences of childhood obesity and provides a local picture the prevalence in our local communities, identifying those groups who are most at risk. The JSNA also aims to capture range of existing programmes of work which support the development of healthier environments and identify further opportunities that can further focus our joint efforts to tackle this issue. The report will also serve as a baseline against which progress will be measured.

1.2 The definition of overweight and obesity

Overweight and obesity are terms which refer to the excess accumulation of body fat. The classifications of overweight and obesity are different for adults and children.

In adults, overweight and obesity is usually measured using Body Mass Index (BMI). BMI compares the distribution of weight with respect to a person's height (Table 1).

Table 1: Classification of BMI in adults (WHO, 2004)

Classification	BMI (kg/m2)
Underweight	Less than 18.5
Healthy Weight	18.5 - 24.9
Overweight	25 - 29.9
Obese	30 – 34.9

In children, the relationship between BMI and overweight or obesity varies according to age and gender. Therefore, overweight and obesity are defined with reference to age and gender specific BMI distributions. The Department of Health uses the 1990 growth reference (UK90) charts to interpret a BMI result in children and young people.

When measuring a population of children, weight status is defined using slightly lower cut off points than the clinical cut off points in order to capture those children who may be on the borderline of being overweight or obese (Table 2). This supports the planning of adequate services for the whole population.

Table 2: Classification of overweight and obesity in children

	Individual children (clinical definition)	Groups of children (population monitoring)
Classification	**BMI centile range**	**BMI centile range**
Healthy Weight	Between 2nd and 90th BMI centile	Between 2nd and 84th BMI centile
Overweight	Between 91st and 97th BMI centile	Between 85th and 94th BMI centile
Obese	At or above 98th centile	At or above 95th centile

1.3 Childhood obesity prevalence in England

Two data sets are currently used to estimate the prevalence of childhood obesity: the **Health Survey for England** (HSE) and the **National Child Measurement Programme** (NCMP). A comparison of the two surveys is shown in Table 3.

The HSE is a series of annual surveys designed to monitor trends in the nation's health and health related behaviours. Each year, there is also a particular focus on a population group, disease or condition. Topics are repeated at appropriate intervals in order to monitor changes with time.

The NCMP measures the height and weight of school children in reception class (aged 4-5 years) and year 6 (aged 10-11 years). NCMP participation rates over the past 3 years are shown in **Appendix A**.

Table 3: Comparison of the Health Survey for England (HSE) and National Child Measurement Programme (NCMP)

	Health Survey for England	National Child Measurement Programme
Frequency	Annual	Annual
Year established	1991 (although children have only been included since 1995)	School year 2005/2006
Who takes part	Sample of households across England	All school children in Reception & Year 6 state schools (who don't opt out)
Total number included in most recent survey	In 2013 (Nationally): 2,185 children (aged 2-15) 8,795 adults	In school year 2013/2014 (Nationally): 1,101,611 children
Data captured (specific to childhood obesity)	Obesity and overweight prevalence across England	Ward level overweight and obesity prevalence in Reception and Year 6 (*aggregated data over 3 years can be shown by school)
Summary	Covers a wide age range of children, however the sample size is smaller	Large sample size, however only measures a narrow age range

According to the HSE (2013), 30% children aged 2-15 years were classed as either overweight or obese: this is one of the highest rates in Europe.

The 2013-2014 NCMP demonstrated that in England, one in five children (22.5%) aged 4-5 years old is overweight or obese, and one in three children (33.5%) aged 10-11 years is overweight or obese (Figure 1). The percentage of obese children in Year 6 (19.1%) is over double that of children in Reception year (9.3%).

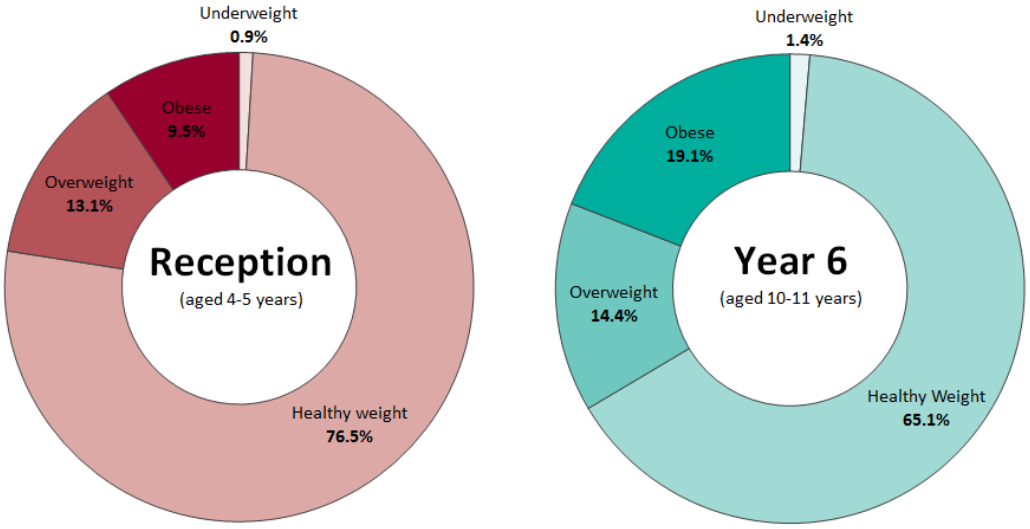


Figure 1: Weight status of children in England by age (NCMP, 2013/2014, Public Health England)

While the proportion of children who are overweight has remained largely unchanged since the mid-1990s, there has been a significant increase in those who are obese over time (Figure 2).

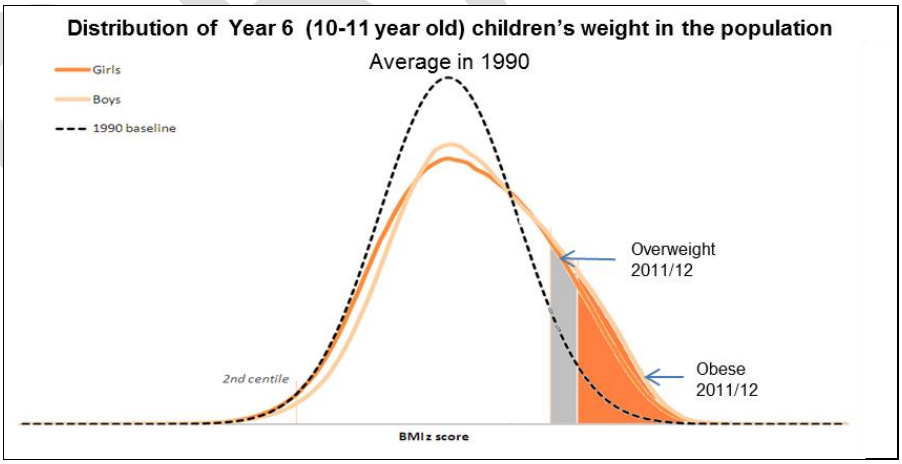


Figure 2: The increase in children's weight from 1990 to 20011 in England

Levels of childhood obesity are predicted to further increase: it is suggested that by 2050, 70% of girls and 55% of boys could be overweight or obese (Foresight, 2007).

1.4 Childhood obesity prevalence in London

Levels of childhood obesity are significantly higher in London than England as a whole and are continuing to increase. As shown in Figure 3 below, London has the highest rate of childhood obesity of any major city in the world (London Health Commission, 2014). In contrast to London, New York has seen a decline over time, following the implementation of collaborative multi-agency and city-wide focussed efforts.

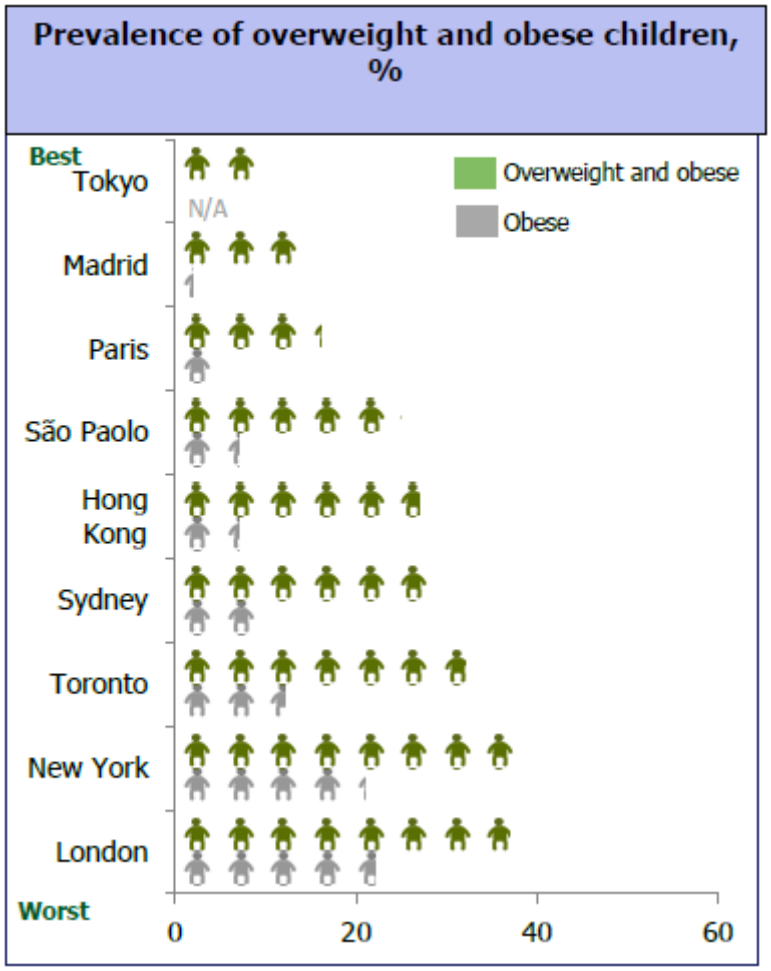


Figure 3: Prevalence of overweight and obese children in cities worldwide (London Health Commission, Global Cities Analysis, 2014) ** In Tokyo, obesity is classed as BMI≥25 instead of 30, therefore separate overweight/obesity measures are difficult to obtain

2. What causes childhood obesity?

Evidence shows that at a basic level, obesity is caused by an intake of calories in excess of calories expended. However, obesity is a complex problem with a range of influences and determinants which makes it difficult for people to adapt their behaviour to make changes to their diet and lifestyle. There is no single effective solution.

The obesity systems map depicted in the Foresight Report (2007) illustrates how a complex interplay of factors drives this imbalance of calorie intake and calorie expenditure **(Appendix B)**. More than 100 variables are identified that directly or indirectly affect obesity outcomes. These variables were grouped into seven themes and are briefly summarised in Table 4 below.

Table 4: Description of the thematic clusters of the obesity systems map

Theme	Description of Theme
Individual Physiology	An individual's biological make up
Food Consumption	The quantity, quality and frequency of an individual's diet
Food Environment	The influence of the food environment on an individual's food choice, for example, a decision to eat more fruit and vegetables may be influenced by the availability and quality of fruit and vegetables at home
Societal Influences	The impact of society, for example the influence of media, education, peer pressure or culture
Individual Psychology	For example, a person's individual psychological drive for particular foods and consumption patterns, or physical activity patterns or preferences
Activity Environment	The influence of the environment on an individual's activity behaviour, for example a decision to cycle to work may be influenced by road safety, air pollution or provision of a cycle shelter and shower
Individual Physical Activity	The type, frequency and intensity of activities an individual carries out, such as cycling vigorously to work every day

Tackling obesity requires a whole system approach across a wide range of issues and partnerships; from planning roads, to promoting cycling and maximising the use of open spaces; to working with local businesses to provide healthy menu options, and developing workplace initiatives that support staff to improve their health and increase activity levels.

Swinburn et al., (2011) depicted the key drivers of the global obesity epidemic and present an overview framework for understanding population level obesity determinants and solutions (Figure 5). The framework highlights the strengths of policy led interventions which may offer larger effects as a result of their sustainability and ability to affect the whole population (including hard to reach groups), but recognises that these may be difficult to implement. By contrast, health education programmes which focus on individual behaviour change may be easier to implement, yet are often less sustainable and reach fewer people.

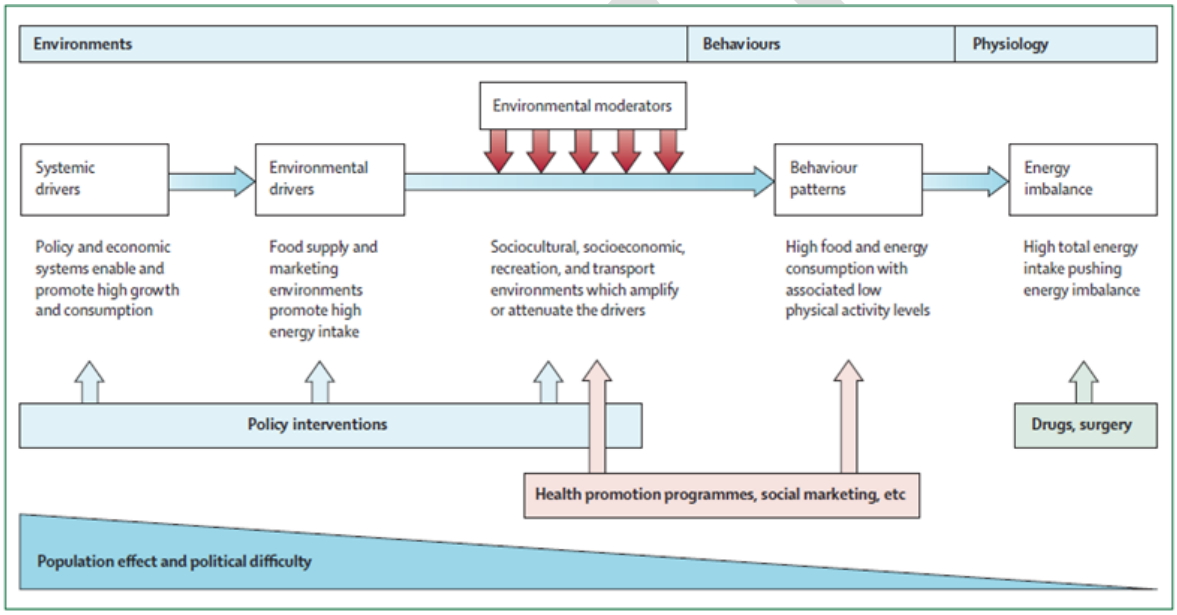


Figure 4: A framework to categorise obesity determinants and solutions (Swinburn et al., 2011)

3. Consequences of childhood obesity

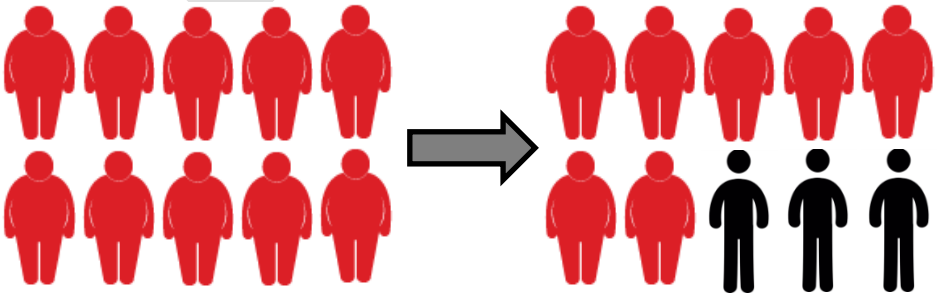
3.1 Impact on health

Childhood obesity presents a major challenge to health and wellbeing and is associated with an increased risk of premature mortality in adults, as well as poor health and development in children (Table 5). Childhood obesity also impacts on mental wellbeing, including increasing the risk of low self-esteem, anxiety, depression, bullying and poor educational attainment (De Neit et al., 2011).

Table 5: Health conditions associated with childhood obesity (London Health Commission, 2014)

Health condition	Evidence
Type 2 diabetes	Among children with Type 2 diabetes, 95% are either overweight or obese
Asthma	A 35% to 50% increased risk of being diagnosed with asthma for overweight and obese children respectively
Obstructive Sleep Apnoea	Incidence in healthy children is 1% - 3%, but can be up to 60% in obese children
Musculoskeletal complaints	Positive association between overweight children and lower back pain, musculoskeletal pain and injuries and fractures
Cardiovascular risk factors	67% of severely obese children have at least 1 risk factor and 56% have hypertension
Health related quality of life	Significantly lower for severely obese relative to healthy children and adolescents Physical, social and psychological functioning for severely obese children is similar to that of children with cancer

However, perhaps most concerning is the likelihood that this excess weight will continue through adulthood: overweight adolescents have a 70% change of becoming overweight or obese adults Simmonds et al., 2015). In adulthood, obesity increases mortality, and is a risk factor for a range of chronic diseases including type 2 diabetes, coronary heart disease and some cancers (Summerbell et al., 2005).



Overweight adolescents have a 70% chance of becoming overweight or obese adults

3.2 Economic impact

The costs of obesity are very likely to grow significantly in the next few decades. An obese child in London is likely to cost around £31 per year in direct costs which could rise to a total (direct and indirect) cost of £611 per year if they continue to be obese in adulthood (GLA, 2011). This projection is likely to be an underestimate, because of the probability that prolonged obesity has more serious and other health consequences.

It is estimated that the current generation of obese children will cost London at least £111 million per year in healthcare costs and productivity losses if they enter the workforce as obese adults (GLA, 2011). The estimated lifetime cost for those children in the three boroughs who become obese in adulthood is over £316 million (GLA, 2011).

Effective actions to tackle childhood obesity are vital given its causal relationship with a range of physical and mental health problems and its link to poor educational outcomes. Treating obesity is costly and evidence suggests that preventative interventions targeting children and young people pay off, with a return on investment of 6-10% expected across the economy from interventions implemented in early life (Strelitz, 2013).

4. Childhood obesity in the three boroughs

Nearly

1 in 4

children are overweight or obese in **Reception** (NCMP 2013/2014)

Over

1 in 3

children are overweight or obese in **Year 6** (NCMP 2013/2014)

On average across the three boroughs, rates of overweight and obesity are similar to the London average but higher than the England average (NCMP 2013/2014). Further analysis by borough reveals significantly higher levels of obesity in 10-11 year olds in Westminster (Table 6).

Table 6: Prevalence of excess weight by school year (NCMP 2013/2014)

Reception Year (4-5 year olds)					
	Hammersmith &Fulham	**Kensington & Chelsea**	**Westminster**	**London**	**England**
% children overweight	11.4	13.4	12.5	12.3	13
% of children obese	8.9	9.6	10.7	10.8	9.5
Total	20.3	23.0	23.2	23.1	22.5
Year 6 (10-11 year olds)					
	Hammersmith &Fulham	**Kensington & Chelsea**	**Westminster**	**London**	**England**
% children overweight	15.2	14.8	14.4	15.2	14.4
% of children obese	22.4	21.3	25.6	22.4	19.1
Total	37.6	36.1	40.0	37.6	33.5

The prevalence of obesity in Reception and Year 6 children in Hammersmith and Fulham, Kensington and Chelsea and Westminster is compared with other London boroughs in Figures 5 and 6 below.

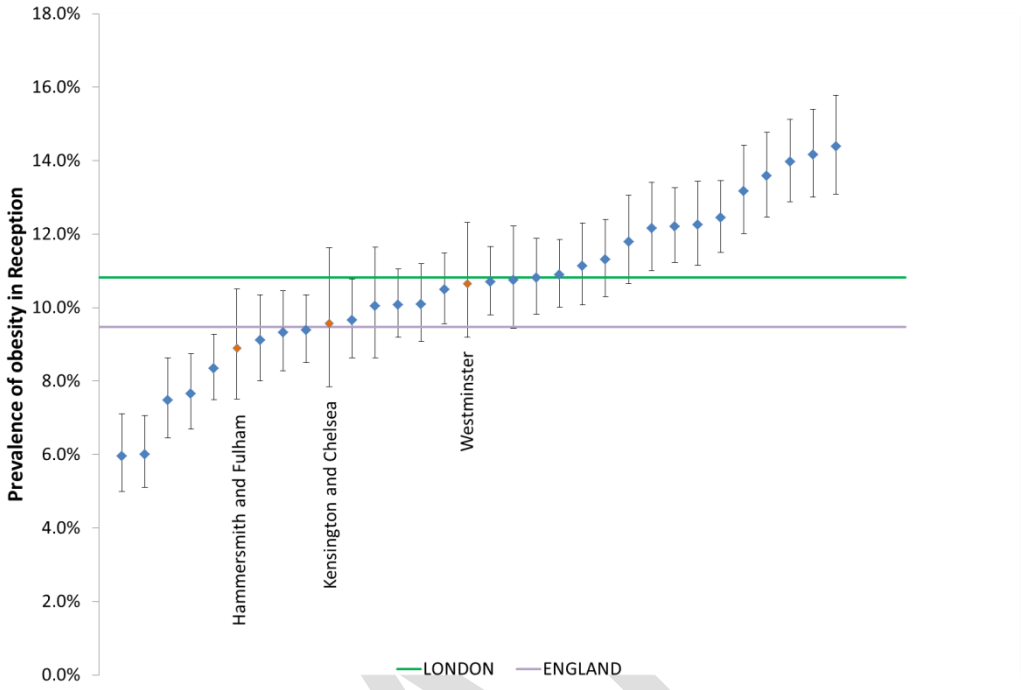


Figure 5: The proportion of Reception classified as obese compared to other London boroughs (NCMP 2013/2014)

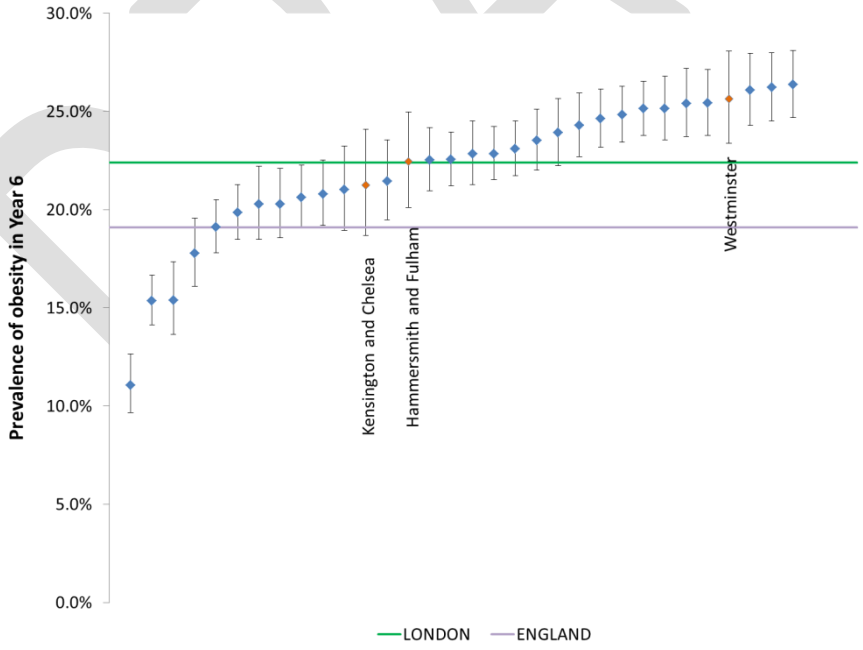


Figure 6: Proportion of Year 6 children classified as obese compared to other London boroughs (NCMP 2013/2014)

4.1 Childhood obesity prevalence over time

Across England, the prevalence of obesity in Reception age children is decreasing slightly (9.6% 2008/2009 to 9.5% 2013/2014). Across London, the trend is similar (11.2% 2008/09 to 10.8% in 2013/14), however rates are higher. Across the three boroughs, the prevalence of obesity among reception age children is mixed (Figure 7).

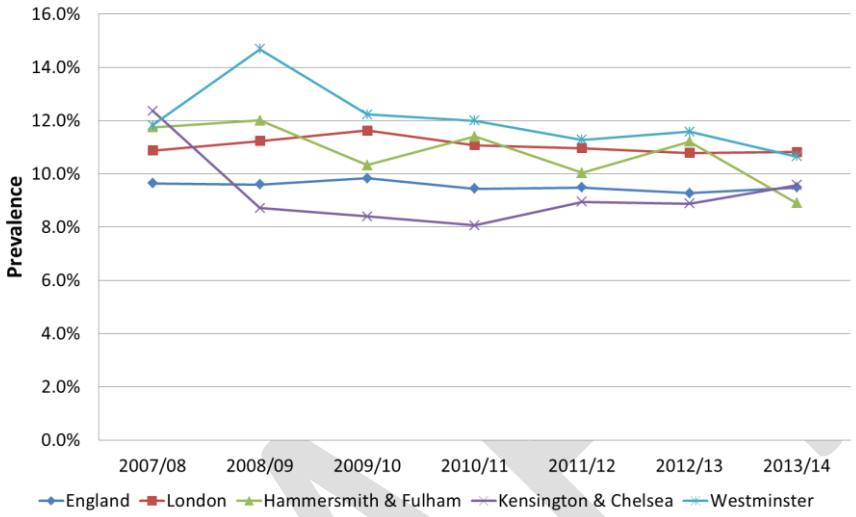


Figure 7: Obesity prevalence among reception age pupils across the three boroughs, compared to London and England averages from 2007/2008 to 2013/2014

Across England, the prevalence of obesity in year 6 children is increasing slightly (18.3% 2008/2009 to 19.1% 2013/2014). Across London, the trend is similar (21.3% 2008/09 to 22.4% in 2013/14), however rates are higher. Across the three boroughs, the prevalence of obesity among year 6 children is mixed (Figure 8).

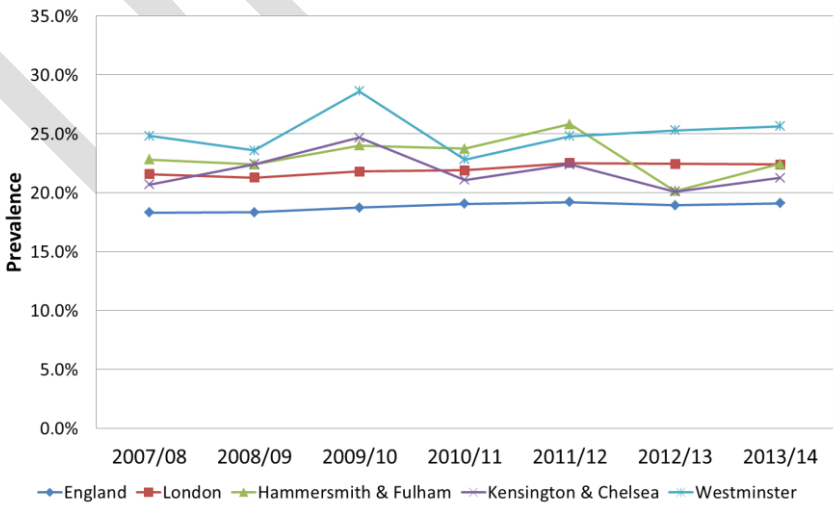


Figure 8: Obesity prevalence among year 6 pupils across the three boroughs, compared to London and England averages from 2007 to 2013/2014

4.2 Deprivation

High levels of obesity are associated with high levels of deprivation. Opportunities to make healthy choices and achieve a healthy weight can be particularly limited in more deprived areas due to factors including income poverty, restricted availability to access to healthy food and fewer options for children to be physically active.

The Income Deprivation Affecting Children Index (IDACI) is an index of deprivation, which measures the proportion of children under the age of 16 that live in low income households. As demonstrated in Figure 9, there is a significant association between IDACI and childhood obesity across the three boroughs; as the levels of deprivation increase, so does the prevalence of childhood obesity.

The Child Poverty JSNA for Westminster, Kensington and Chelsea, and Hammersmith and Fulham (2014) details further indicators relating to child poverty, including borough and ward level estimates of child poverty and numbers and characteristics of groups most at risk locally.

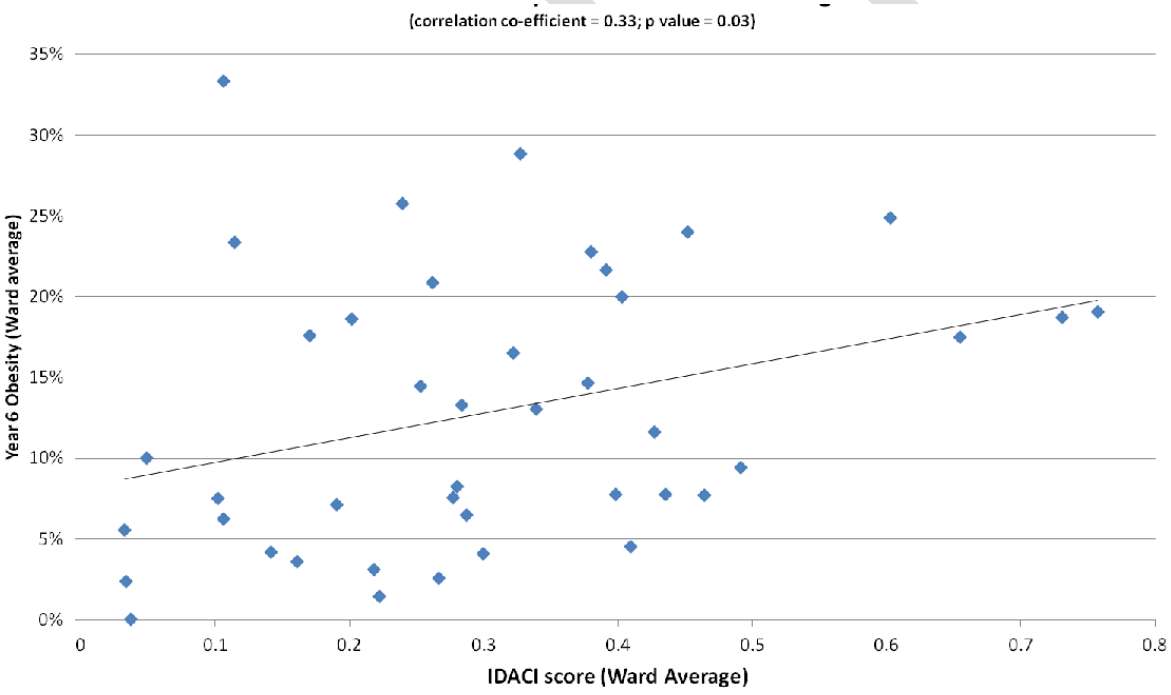


Figure 9: Association between income deprivation and year 6 obesity levels across the three boroughs by ward

4.3 Geographical variation

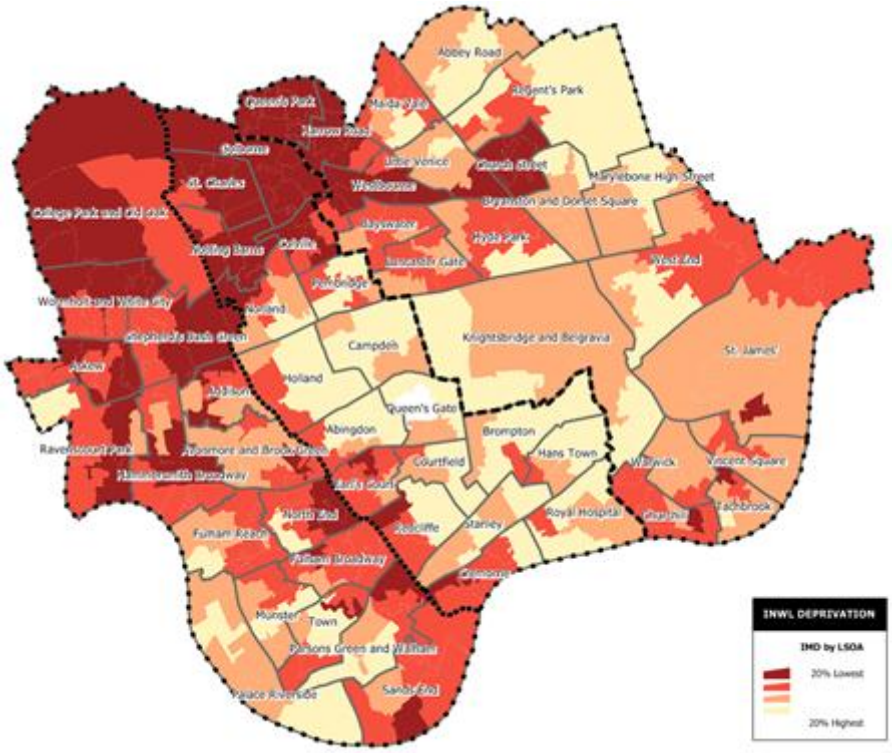


Figure 10: Levels of deprivation by ward across the three boroughs (Office for National Statistics, 2011)

Many wards in the north of the three boroughs score highly on the Index of Multiple Deprivation (IMD), with some parts of the northern area being among the most deprived in England (Figure 10). These correlate largely with prevalence of childhood obesity in Reception year (Figure 11) and Year 6 (Figure 12).

A summary of the five wards in each borough with the highest prevalence of childhood obesity in Reception and Year 6 is shown in Table 7 below.

Table 7: Top 5 wards childhood obesity during 2011/12 to 2013/14

	Hammersmith and Fulham		Kensington and Chelsea		Westminster	
	Reception	Year 6	Reception	Year 6	Reception	Year 6
1	Sands End	Wormholt & White City	Colville	Notting Dale	Church Street	Queen's Park
2	College Park and Old Oak	Shepherd's Bush Green	Holland	Dalgarno	Westbourne	Church Street
3	Town	Sands End	Golborne	Golborne	Churchill	Westbourne
4	Fulham Reach	North End	Notting Dale	Colville	Queen's Park	Harrow Road
5	Avonmore & Brook Green	Avonmore & Brook Green	Chelsea Riverside	Campden	Harrow Road	Churchill

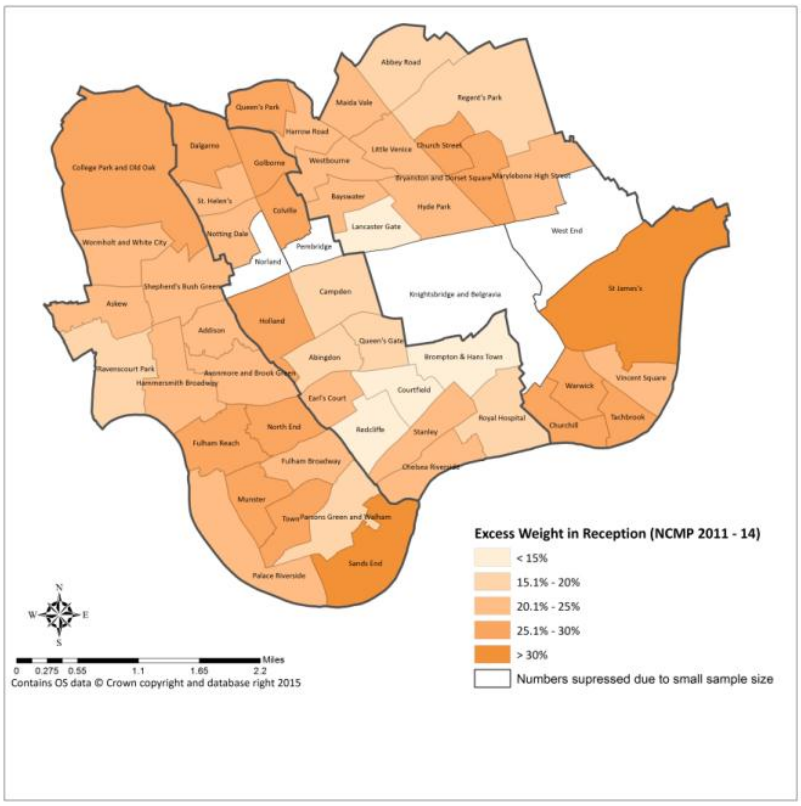


Figure 11: Overweight and obesity prevalence in Reception year (NCMP, 2011-2014)

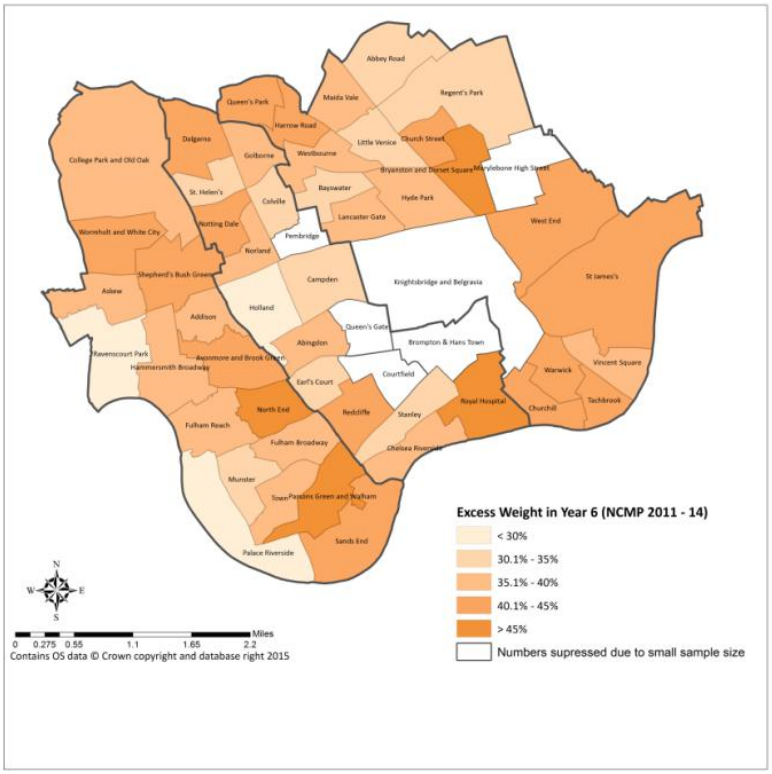


Figure 12: Overweight and obesity prevalence in Year 6 (NCMP, 2011-2014)

4.4 Ethnicity

Nationally, child obesity prevalence has been found to vary substantially between ethnic groups, with obesity prevalence generally lower in children of White British ethnicity (NOO, 2011). It has been observed that in Reception and Year 6, obesity prevalence is especially high for children of both sexes from Black African and Black Other ethnic groups, and boys from the Bangladeshi ethnic group.

This pattern is largely reflected across the three boroughs, with the exception of Year 6 children in Kensington and Chelsea, where obesity is most prevalent among Asian ethnic groups (Figure 13).

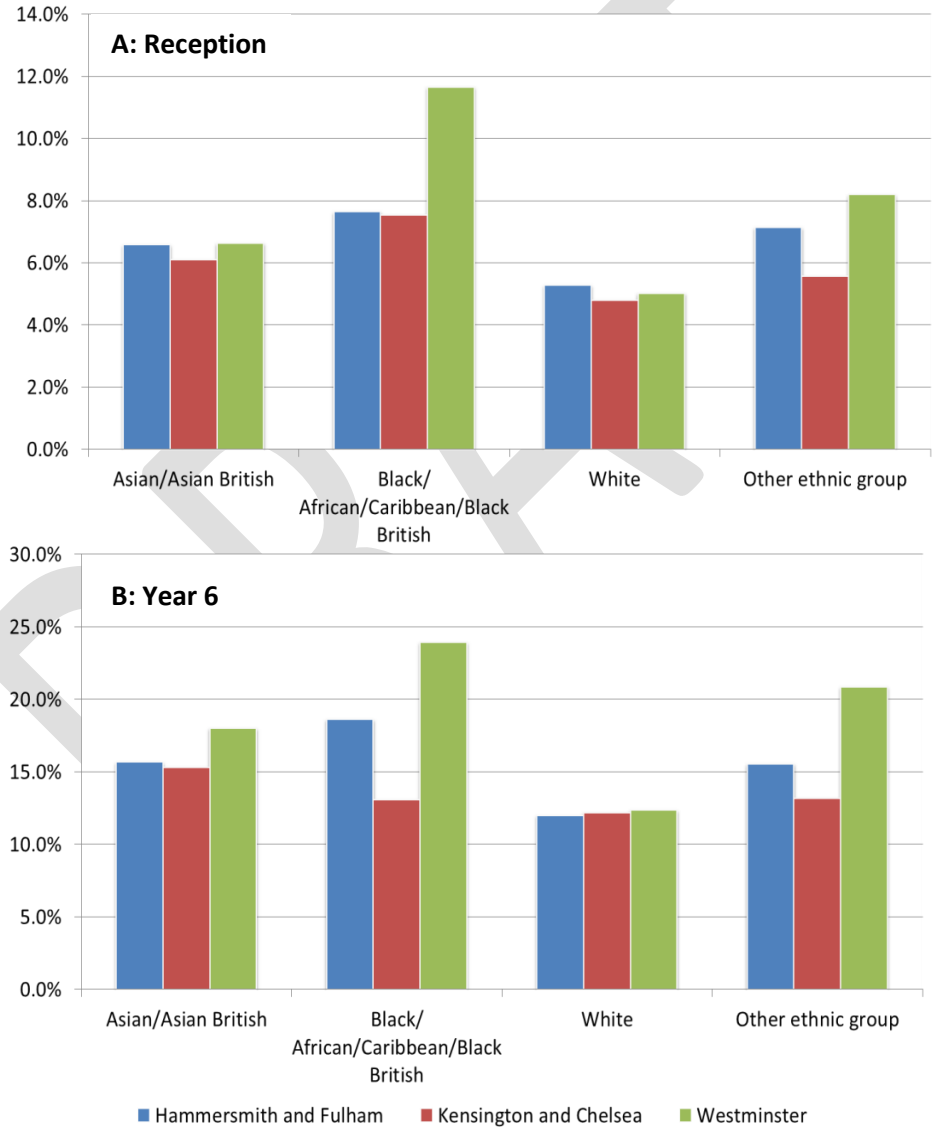


Figure 13: Obesity prevalence in Reception (A) and Year 6 (B) by ethnicity (NCMP, 2012/2013)

4.5 School population

The numbers of children's centres, school, and school populations are depicted in Figure 14 below.

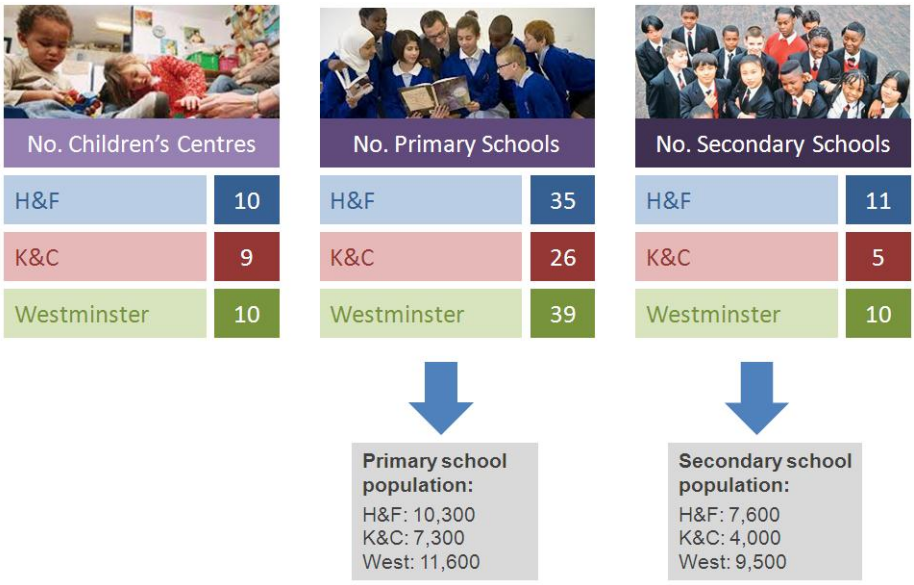


Figure 14: Number of school children in the three boroughs

4.6 Physical activity levels

Generally, children in the three boroughs have lower participation rates in high quality PE and school sport for at least two hours in a typical week compared with their peers in London and England. Hammersmith and Fulham has the lowest figures, with 70% of pupils participating in at least two hours of high quality PE and school sport with, compared to 75% of pupils in Westminster and 77% in Kensington and Chelsea (Figure 15).

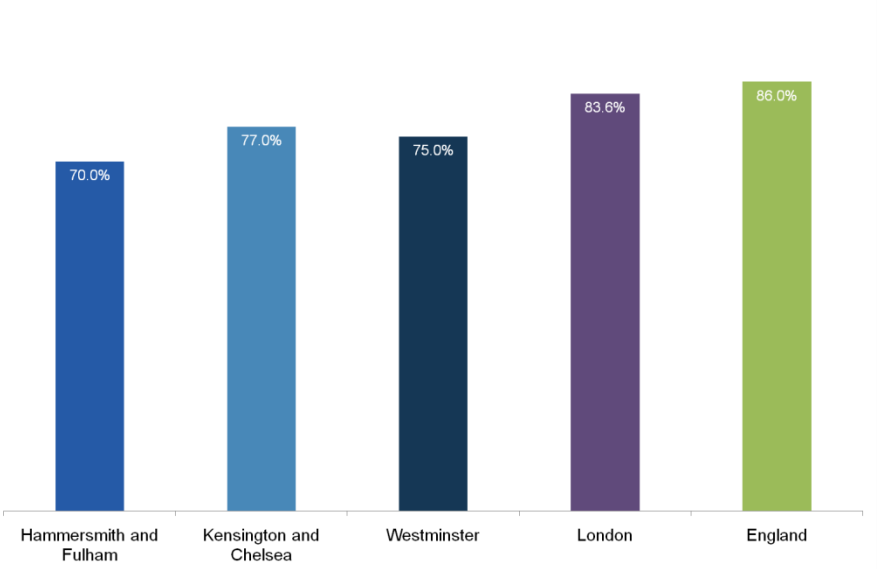


Figure 15: The percentage of state school children in Year 1-11 participating in at least two hours of high quality PE or school sport in a typical week (TNS Social Research, Annual Survey of School Sports Partnerships 2009/2010)

Nationally, whilst participation in school PE has increases, schools in deprived areas with a higher proportion of ethnic minority pupils, and pupils with special educational needs have the lowest level of participation in sports in and outside the school environment.

4.7 Access to healthy and affordable food

A number of studies have found that takeaway food outlets are often located in areas of higher socioeconomic deprivation, where obesity prevalence is generally higher (National Obesity Observatory). Evidence links the fast food environment and health, although a clear relationship between fast food restaurants and obesity rates is less obviously demonstrated (CIEH, 2014).

A series of mapping has been undertaken to further understand the food environment across Westminster and Kensington and Chelsea (Figures 16 and 17), with maps in development for Hammersmith and Fulham.

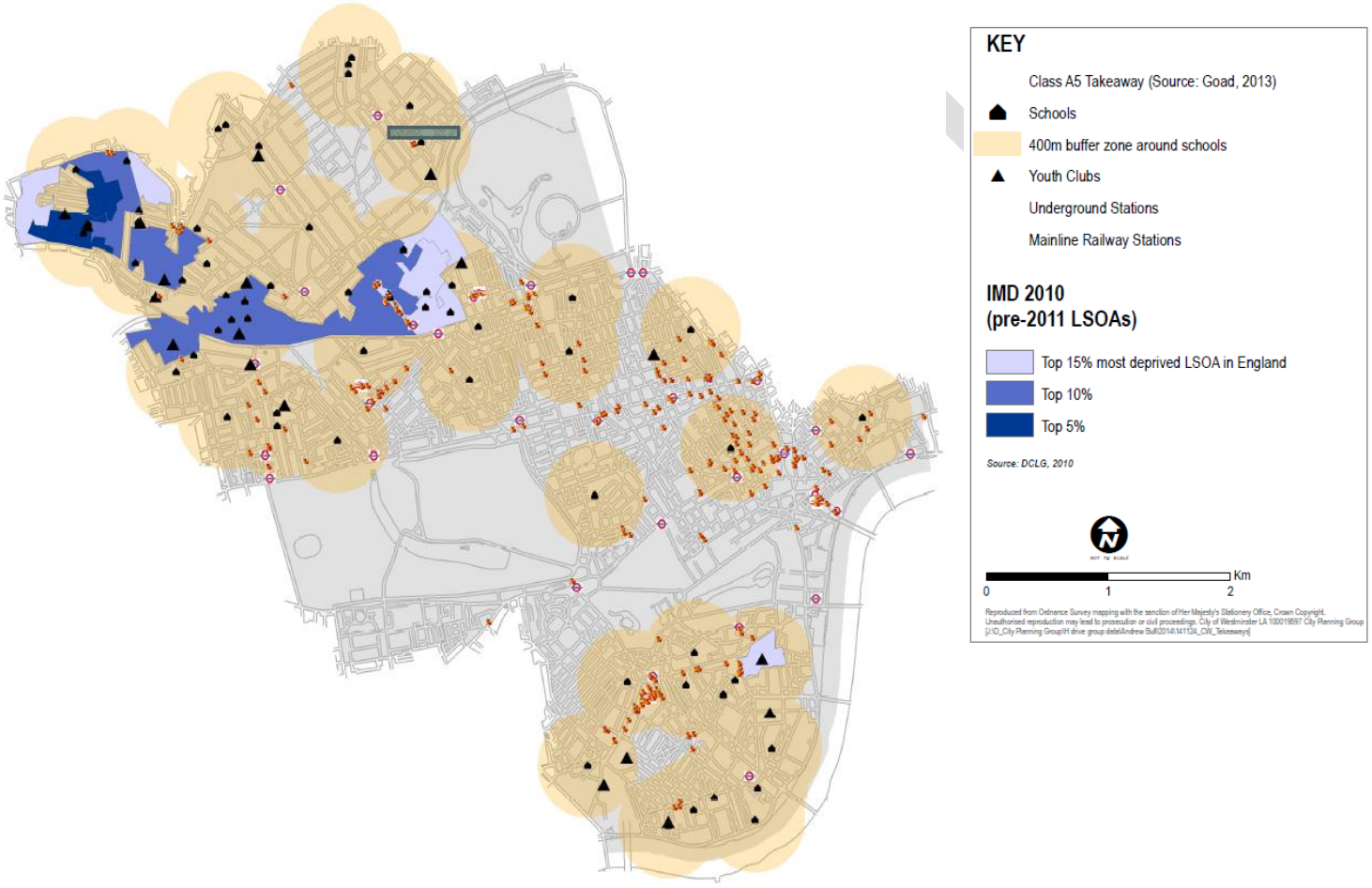


Figure 16: A5 Takeaway stores in Westminster mapped against school and youth clubs

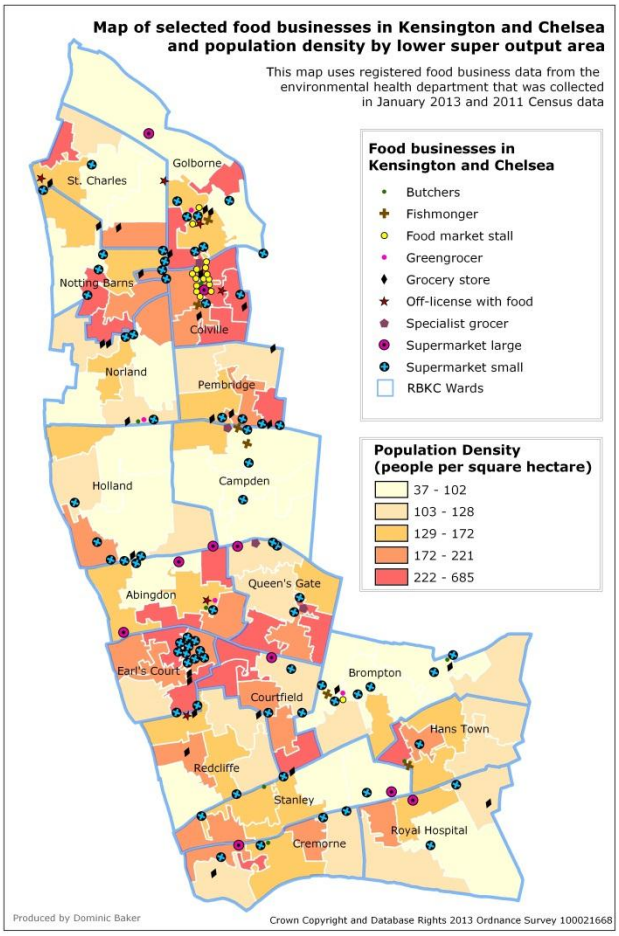


Figure 17: Map of selected food businesses in Kensington and Chelsea and population density by lower super output area

The Good Food for All report, developed by the Public Health Nutrition Team at Central London Community Healthcare (CLCH) sought to understand the social, personal and environmental issues that surround food choice for local communities in North Kensington (CLCH, 2013).

Key highlights of the report include:

- A significant proportion of low income households spend less than £30 per week on food, with which they are unlikely to meet a nutritionally adequate diet,
- Half of survey respondents indicated that they do not have enough money to buy a range of foods each week
- Fruit and vegetable prices in markets and local greengrocers were often half that of the same product in a supermarket
- Inconsistent price labelling makes it difficult to ascertain the best value, for example comparing £1 bowls with unit pricing or cost per weight (used both in kilograms and pounds)
- Two areas identified with highest expense and lowest availability of the healthy food basket exercise were Dalgarno in St Charles and St James in Norland

5. National Response

5.1 Tackling overweight and obesity is a national government priority

The Government policy paper '*Healthy Lives, Healthy People: A call to action on obesity in England*' (2011) sets out the national approach for tackling obesity, building on the whole system approach described in the Government Office for Science's Foresight report '*Tackling Obesity: Future Choices*' (2007).

The Government's strategy clearly emphasises that preventing and treating childhood obesity requires a comprehensive approach and action at every level, from the individual and across all sectors which includes:

- A multi-level approach where preventing obesity and treating those already obese is happening at the same time
- A multi-stage approach where opportunities for intervention and support at key life stages, from before birth until early adulthood and then again at pregnancy, are exploited
- A multi-disciplinary and agency action approach where a range of stakeholders from different fields work together to address the obesogenic environment and support behaviour change, integrating strategies, policy development and redesigning services to improve health and wellbeing.

As part of the strategy, two national ambitions were set:

- A downward trend in the level of excess weight averaged across all adults by 2020
- A sustained downward trend in the level of excess weight in children by 2020.

The three most recent amendments to legislation and policy which are directly relevant to childhood obesity are summarised below.

Health and Social Care Act 2012 (Chapter 7), March 2012

The Health and Social Care Act places local government at the core of the health and care service with statutory responsibility for commissioning services that improve the health and wellbeing of their local population. This includes addressing the wider determinants of health and wellbeing through a life-stages approach as the basis for the new public health service.

National Planning Framework, Department for Communities and Local Government, March 2012
The National Planning Policy Framework provides a framework within which local people and their accountable councils can produce their own distinctive local and neighbourhood plans, which reflect the needs and priorities of their communities. Local planning authorities should "work with public health leads and organisations to understand and take account of the health status and needs of the local population… including expected changes, and any information about relevant barriers to improving health and wellbeing".

Localism Act 2011 (Chapter 20), November 2011
The Localism Act contains a number of proposals to give local authorities new freedoms and flexibility to meet local people's needs. This includes a 'general power of competence' which will give local authorities more freedom to take action in the interests of their areas, reflecting the priorities of local people. It also includes provisions to make the planning system clearer, more democratic, and more effective. Neighbourhood planning will allow communities, both residents, employees and business, to come together through a local parish council or neighbourhood forum and say where they think new houses, businesses and shops should go – and what they should look like.

5.2 Accountability

The foundation for accountability arrangements for improving health in our local communities is the Public Health Outcomes Framework for England 2013-2016. This includes several indicators which are directly or indirectly related to childhood obesity:

- 2.6i: Proportion of children aged 4-5 years classified as overweight or obese
- 2.6ii: Proportion of children aged 10-11 years classified as overweight or obese
- 2.2i: Breastfeeding initiation
- 2.2ii: Breastfeeding prevalence
- 2.11: Diet
- 2.12: Excess weight in adults
- 1.16: Utilisation of green space for exercise/ health reasons

5.3 UK and International Guidance

In the UK, the National Institute for Health and Clinical Excellence (NICE) have produced public health guidance aimed at preventing and managing childhood obesity across a range of settings. Most recently, NICE published a quality standard which covers a range of approaches at a population level to prevent children and young people aged under 18 years from becoming overweight or obese (NICE, 2015). NICE quality standards consist of a prioritised set of specific, concise and measurable statements. They draw on existing guidance and are designed to support the measurement of improvement.

The quality statements for prevention of obesity in children in young people are:

- Children and young people, and their parents or carers, using vending machines in local authority and NHS venues can buy healthy food and drink options.
- Children and young people, and their parents or carers, see details of nutritional information on menus at local authority and NHS venues.
- Children and young people, and their parents or carers, see healthy food and drink choices displayed prominently in local authority and NHS venues.
- Children and young people, and their parents or carers, have access to a publicly available up-to-date list of local lifestyle weight management programmes.
- Children and young people identified as being overweight or obese, and their parents or carers as appropriate, are given information about local lifestyle weight management programmes.
- Family members or carers of children and young people are invited to attend lifestyle weight management programmes, regardless of their weight.
- Children and young people, and their parents or carers, can access data on attendance, outcomes and the views of participants and staff from lifestyle weight management programmes.
- (placeholder) Reducing sedentary behaviour. A placeholder is an area that has been identified as a priority but for which no guidance currently exists. There is an identified need for evidence based guidance on interventions to reduce sedentary behaviour in children and young people.

Tackling child obesity requires action across a number of areas and settings and it is generally acknowledged to be difficult to identify the specific components of prevention programmes that are most successful.

While recognising this limitation in the evidence base, the authors of a Cochrane review on interventions for preventing obesity in children (Waters et al., 2011) reported that the following could be promising policies and strategies:

- School curriculum that includes healthy eating, physical activity and body image
- Increased sessions for physical activity and the development of fundamental movement skills throughout the school week
- Improvements in nutritional quality of the food supply in schools
- Environments and cultural practices that support children to eat healthier foods and being active throughout each day
- Support for teachers and other staff to implement health promotion strategies and activities (eg professional development, capacity building activities)
- Parent support and home activities that encourage children to be more active, eat more nutritious foods and spend less time in screen based activities

The review did find strong evidence to support the beneficial effects of child obesity prevention programmes on BMI, particularly for programmes targeted to children aged six to twelve years. However, the authors noted some other limitations of the evidence base and report that more robust research is required, including identifying any impact on health inequalities and the sustainability of interventions

Lessons from Australia

A benchmarking tool – the Obesity Action Award – was developed to compare obesity prevention policies implemented across states and territories within Australia (Martin et al., 2014). Based on a review of the evidence and consultation with experts the framework identified nine domains for potential government action on obesity prevention:

- whole-of-government approaches
- marketing restrictions
- access to affordable, healthy food
- school food and physical activity
- food in public facilities
- urban design and transport
- leisure and local environments
- health services
- social marketing

A scoring system for these domains was then developed for use by non-government stakeholders, resulting in a league table to identify the best and worst performers across Australia. The key factors for success for the best performing governments were:

(1) those with whole-of-government approaches and strategies;

(2) those who had extended common initiatives. For example, measures within schools, such as canteen guidelines and physical education are now considered a standard approach.

However these can be stepped up to have a greater impact, such as extending the focus on healthy eating and active play to early childhood centres;

(3) and those who demonstrated innovation and strong political will.

Social marketing campaigns were only considered effective if they were supporting other initiatives, not as a strategy in themselves

EPODE Model

The EPODE model (from the French Ensemble, Prevenons l'Obesite des Enfants/ Together Let's Prevent Childhood Obesity), is a coordinated, capacity-building approach aimed at reducing childhood obesity though a societal process in which local environments, childhood setting and family norms are directed and encouraged to facilitate the adoption of healthy lifestyles in children (Borys et al., 2012).

Central to the model are four critical factors which form the four pillars of the methodology:

1) **Political commitment:** Gaining formal political commitment at central and local levels from the leaders of the key organisations which influence national, federal or state polities as well as local policies, environments and childhood settings;
2) **Resources:** Securing sufficient resources to fund central support services and evaluation, as well as contributions from local organisations to fund local implementation:
3) **Support services:** Planning, coordination and providing the social marketing, communication and support services for community practitioners and leaders:
4) **Evidence:** Using evidence from a wide variety of sources to inform the delivery of EPODE and to evaluate process, impact and outcomes of the EPODE programme

The methodology was shaped over 5 years of pilot implementation in France in 10 towns, and is now being used in over 300 worldwide.

McKinsey Global Institute Review

In 2014, McKinsey published a paper which aimed to start a global discussion on the components of a successful societal response to overcome obesity. The main findings of the paper included:

- No single solution creates sufficient impact to reverse obesity: only a comprehensive, systemic programme of multiple interventions is likely to be effective
- Almost all of the interventions analysed were highly cost effective from the viewpoint of society
- Education and encouraging personal responsibility are necessary but not sufficient – restructuring the context that shapes physical activity and nutritional behaviour is a vital part of any obesity programme
- Capturing the full potential impact is likely to require commitment from government, employers, educators, retailers, restaurants and food and beverage manufacturers, and a combination of top-down corporate and government interventions and bottom-up community based ones

Community based interventions

Recently, there is emerging international evidence on the effectiveness of more complex, multifaceted community-based prevention initiatives (de Silva-Sanigorski et al., 2010; Economos et al., 2007; Taylor et al., 2007). These interventions have focussed on improving opportunities for healthy eating and participation in physical activity through building community capacity, promoting sociocultural and environmental change, and policy development.

A common theme from the studies is the importance of active and committed involvement from local stakeholders in the development, implementation and evaluation of the intervention (de Silva-Sanigorski et al., 2010; Economos et al., 2007). This partnership working is key to ensuring that the intervention (i.e. access to healthy foods and opportunities for physical activity) is embedded into the community and is sustainable long term.

5.4 UK Initiatives

The Government is leading a number of initiatives which have both direct and indirect links to tackling childhood obesity. These include:

- **The Change4Life social marketing campaign**: providing information to support families and individuals to make simple changes to their diet and activity levels
- **The Public Health Responsibility Deal**: working with the food and drink industry to voluntarily agree actions that support people to make healthier choices
- **The National Child Measurement Programme**: to inform local planning and commissioning
- **The Healthy Child Programme**: the main delivery mechanism for obesity prevention in early years and now provides greater emphasis on nutrition, breastfeeding and physical activity
- **Early Years Foundation Stage framework**: statutory requirements for all early years providers to ensure children in their care are provided with healthy, balanced and nutritious food
- **Standards for School Food**: Standards stipulating nutrients required for all school food including breakfast, lunch, vending machines and tuck shops
- **Healthy Start**: Vitamin and food voucher distribution initiative for pregnant women and women with children up to 5 years

In London, the Mayor has made childhood obesity the number one health priority. The report, *Tipping the Scales: childhood obesity in London (2011)* outlines the co-ordinated strategic approach to address this. The three key elements are:

- Setting strategic vision
- Directly supporting and funding city-wide interventions
- Promotion, evaluation and spreading good practice

6. Local strategies

6.1 Health and Wellbeing Board priorities

The interest and willingness to act effectively on the issue of childhood obesity has been communicated clearly by local politicians and leaders across the three boroughs. This has been achieved through commitments embedded into each borough's Health and Wellbeing Board's strategies to give every child the best start in life:

Westminster Health and Wellbeing Strategy

Royal Borough of Kensington & Chelsea Health and Wellbeing Strategy

Hammersmith and Fulham Health and Wellbeing Strategy

6.2 Tackling childhood obesity across the three boroughs programme

Tackling childhood obesity across the three boroughs (TCOT) is the overarching 5 year programme which aims to halt and reverse the rising trend in childhood obesity across the three boroughs. It comprises of three components (Figure 12):

1. Cross-agency child healthy weight care pathway and child obesity prevention and family healthy lifestyles services
2. A whole system approach to tackle childhood obesity in Westminster City Council working with internal and external partners to deliver an environment where making healthy choices are the easier choices
3. 'Go Golborne' – a community based project in the Golborne area of the Royal Borough of Kensington & Chelsea

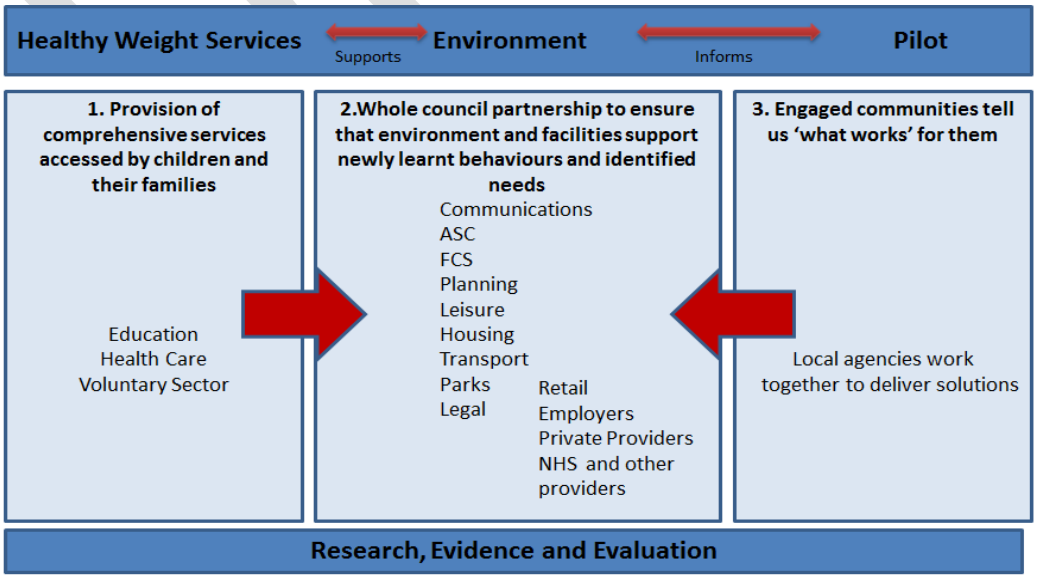


Figure 9: Tackling childhood obesity across the three boroughs programme

The following objectives for the programme have been identified:

- Children and families are more physically active in their daily lives
- Children and families develop a positive food culture within their families and communities
- Children and families are able, and supported, to make healthier choices where they live

These objectives will be delivered through action and increasing opportunities in the following areas:

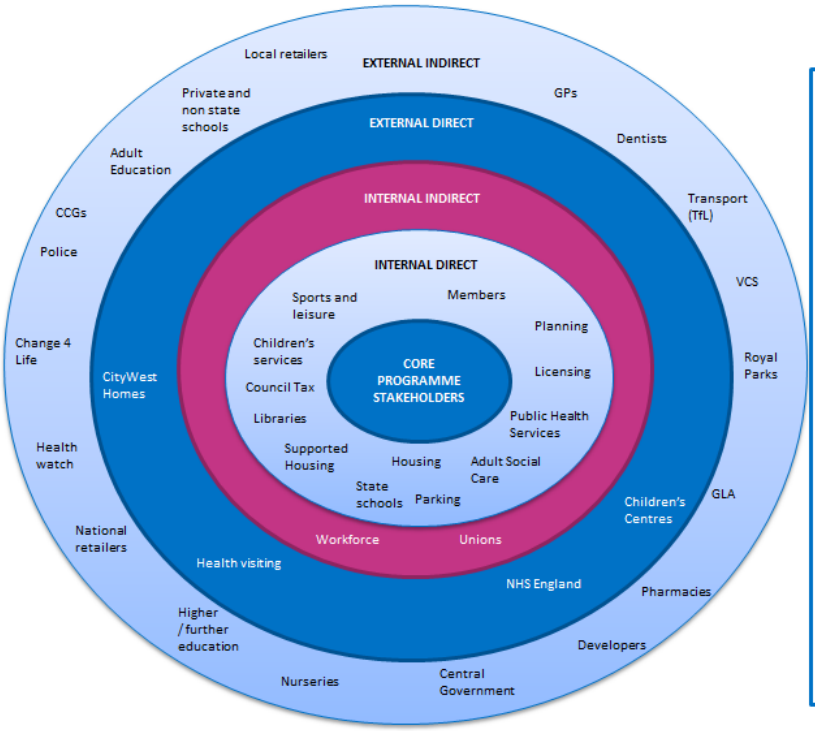
- **Supporting a healthy start in life** by supporting early years services to develop healthy lifestyle interventions
- **Healthier preschools and schools** by supporting a 'whole school' approach to healthy eating and physical activity
- **Strengthening partnership working and integration** across services and organisations to increase opportunities for children and their families to be active and eat healthily
- **Utilisation of system levers** to address the wider determinants of obesity and create local environments that better support healthy lifestyle choices
- **Providing consistent messages** to children and families about healthy lifestyles
- **Maximising the use of existing services and assets** within the community
- **Increasing the involvement of community members** in the design and delivery of healthy lifestyle initiatives
- **Monitoring, evaluation and increased research** to ensure we can evidence the difference our programme makes and contributing to the evidence base on 'what works' to tackle childhood obesity
- **Making health options** the easy option by addressing barriers to healthy lifestyles that children and families face in their day to day lives

The programme will follow these principles to halt and reverse the rising trend in childhood obesity across the three boroughs:

- Evidence based interventions
- Engagement, collaboration and co-production (internally to LAs and with external stakeholders) recognising children and young people as agents for change, building on existing assets and achievements
- Identifying and utilising opportunities, systems/levers and mechanisms available in house and through partners to counteract the adverse obesogenic environment (including marketing and advertising where appropriate)
- Taking action to reduce inequalities
- Ensuring the sustainability of redesigned services and interventions

There are 4 elements that are fundamental to the success of the programme:

- Visible and vocal **political leadership**
- A **vision** shared by all parties
- **Commitment** from senior leaders and influential figures, with regular **engagement**
- **Priorities** which are clear, shared and ambitious that stimulate **debate**



Core programme Stakeholders:

- Residents and Communities
- Programme Sponsor
- Tri-borough Executive Director of Adult Social Care Services
- Director of Public Health
- Public Health Integration Transformation Board
- Workstream leads
- Chief of Staff
- WCC Cabinet Member for Adults and Public
- WCC Deputy Cabinet Member for Adults and Public Health
- K&C WCC Cabinet Member for Adults and Public Health
- H&F WCC Cabinet Member for Adults and Public Health
- Tri-borough Executive Director of Children's Services
- Public Health Family and Children Services commissioner
- EMT
- JMT

Figure 10: Stakeholders for the tackling childhood obesity across the three boroughs programme

Key to informing the development of the programme, particularly component 1, was the review of existing service provision for child obesity prevention and healthy family weight services, published in April 2014.

In November 2015, the TCOT programme was accepted as member of the EPODE International Network, which is the first UK Council intervention to join the network.

The following section described the progress made in the first year for each component of the programme.

Component 1 – Commissioned Services

Two lots of services have been commissioned for three years across all three boroughs.

Lot 1: *Policy and Workforce Development* aims to improve settings and environments to ensure healthier choices are the easy choices for children and families in relation to physical activity and healthy eating (including those related to oral health) e.g. schools, nurseries, parks, leisure centres. Professional development and support for staff that have contact with children and their families is offered to raise the issue of healthy weight e.g. brief interventions, therefore 'making every contact count.'

Current work:

The contract was awarded to 'MyTime Active' and commenced on 1st August 2015. The provider is contracted to deliver the following services:

Work Force Training: Supports front line staff to better identify those who are, or are at risk, of becoming overweight or obese and to enable them to provide effective first line advice and appropriate signposting.

Whole School Approach and Curriculum Support: Schools and Early Years settings will be provided with support to achieve Bronze, Silver and Gold Healthy Schools and Early Years Awards. This includes guidance and training on cooking in the curriculum, and nutrition education for Key Stage 1 to Key Stage 3

Healthier Catering Commitment: Support environmental health teams to work with local food businesses to increase those achieving the Healthier Catering Commitment award and sustain improvements in healthy catering practice.

Lot 2: *Obesity Prevention and Lifestyle and Weight Management Services* provide a range of services for families with children for cohorts aged 0-4 years; 5-12 years; and teenagers. There will also be services for targeted schools where there is delivery of practical, fun, healthy eating sessions for a term for years 1 and 4 and extra physical activity for a year each year for 3 years.

Current work:

The contract was awarded to 'MyTime Active' and commenced on 1st August 2015. The provider is contracted to deliver the following services:

- **MEND Mums:** A six week postnatal weight management programme for new mums
- **MEND 2-4:** A six week healthy lifestyle programme for children aged 2-4 years and their parents and carers
- **One to ones:** Tailored advice from a dietician for parents with children aged up to 4 years for whom a group programme is not suitable, or have additional needs
- **MEND 5-7 and MEND 7-13:** Ten week programme for children who are above a healthy weight and their parents and carers
- **MEND Teens**: Developed in collaboration with 13-18 year olds across the three boroughs who are above a healthy weight
- **MEND in schools:** Targeted work with schools identified as having high levels of overweight and obesity to deliver a multicomponent whole schools obesity prevention programme.

Family Healthy Weight care Pathway and Toolkit

A range of stakeholders, from Public Health, Children's Services, Clinical Commissioning Groups (CCGs), Acute Healthcare, Community Health Services, Obesity Prevention and Weight Management Services, and Healthwatch have worked together to produce a holistic, evidence based, and system wide care pathway. The objective of the pathway is to ensure that those who work with children know their role in the prevention and treatment of childhood obesity and can appropriately promote and refer on to services.

The pathways and toolkit can be found here: http://www.lbhf.gov.uk/familyhealthyweightcare

Component 2 – Whole Council Partnership

In order to see a demonstrable and sustained reduction in childhood obesity, the services provided through Component 1 need to be accompanied by an integrated approach which uses the full levers available to councils and their partners to address the many environmental factors contributing to childhood obesity over the longer-term.

The approach for Component 2 is to identify opportunities within the council, and then across external networks, to work with partners to make positive changes to the wider environment within the borough. The aim is to engage children and young people and their families and communities, colleagues in e.g. sport and leisure, planning and housing, children and family services, as well as partners across the local geography and economy including the NHS, education, academia, catering and retail to secure collaboration, co-design and longstanding commitment to action.

The key aims of this component are to work with every council department to consolidate and strengthen activities that contribute to the prevention of childhood obesity by:

- understanding work already underway across the council contributing to preventing childhood obesity;
- identifying actions to be included departmental business plans to deliver the corporate strategy;
- understanding the areas where the council currently has limited control or opportunity to influence; and
- identifying opportunity areas for further development

This approach will be developed in Westminster initially, before being taken forward in the other two boroughs.

Current work in Westminster:

Initial engagement with Executive Directors identified areas where opportunities may exist to strengthen prevention of childhood obesity. Initial cross service workshops developed the first tranche of action plans signed off by members and officers. These cover:

- Food growing and education: Pilot food growing projects in two schools and a housing estate in a regeneration area
- Increasing physical activity: Working with priority schools to engage with the school sports development team membership offer and services
- Healthier Catering commitment: Working with 20 fast food providers to improve the nutritional content and quality of their food offer

Work is underway to develop action plans covering

- Planning
- Food and poverty: Mapping fast food and convenience stores; developing a social supermarket model; applying for capital funding to host a social supermarket
- Cook and Eat programmes – mapping current provision and assets
- Increased availability of drinking water
- Procurement
- Housing and Social Landlords

Planning is also underway to design our engagement approach with food businesses. The aim is to:

- Increase access to healthy and affordable food
- Engaging residents and organisations to support sustainable food retail change in their community
- Influencing supply and demand to facilitate the purchase and promotion of healthy food

Component 3: Whole place intervention pilot

The third component of the programme is a pilot project that has been developed to tackle childhood obesity within one community called 'Go Golborne'. This is based on evidence that initiatives to tackle obesity are most effective when they are designed at a local level, so they respond to the unique demographic, economic and cultural characteristics of individual communities.

Golborne, in North Kensington, was chosen for this pilot as it is densely populated and has relatively high levels of both childhood obesity and deprivation. The pilot offers the opportunity to try relevant multi-agency interventions on a smaller scale to identify what works (and what does not) before replicating in other areas across the three boroughs.

Through the development of a network of local organisations, existing work to promote healthy lifestyles will be consolidated, as well as identifying opportunities to extend and implement new initiatives. Every six months, activities will focus on a different headline theme linked to a specific behaviour change goal. The six themes are:

- Five a day: Promoting fruit and vegetable consumption
- Snack check: promoting healthy snacking habits
- Sugar sways: reducing sugar consumption
- Active travel: promoting walking and cycling
- Active play: promoting play and physical activity
- Screen time: reducing sedentary time watching TV/ playing with tablets and other devices

Current work:

Go Golborne launched in May 2015 with numerous events in different settings including schools, community centres, play services, parks, the library and local market. A range of resources were disseminated to children and parents to introduce them to Go Golborne, including a guide to local services and activities that can support healthy lifestyles.

Prior to this, extensive engagement with local organisations was carried out to establish a network which aims to help promote consistent lifestyle messages to children and families and create new ways to implement them.

A website has been created including information for parents and a 'partner zone' where local partners can access information about forthcoming activities, resources, and opportunities to get involved in Go Golborne www.rbkc.gov.uk/gogolborne.

A wide range of local partners have attended a series of workshops to help shape project plans and identify priorities for action, including plans for the 5 A DAY campaign due to launch across the community on 23rd November 2015.

Training sessions on key nutrition and physical activity messages was delivered to staff and volunteers in partner organisations in June/July 2015 and will be available on a rolling basis.

Links have been developed with key departments across RBKC to explore opportunities for partnership work and align activities to help meet the objectives of Go Golborne (i.e. food growing and healthy catering projects, planning consultations, park refurbishments etc).

The school nursing service has been commissioned to deliver an extended National Child Measurement Programme (NCMP) in local schools and link children who are above or below a healthy weight with family healthy lifestyle services provided by Mytime Active.

The University of Kent has been commissioned to conduct a process and outcome evaluation of Go Golborne to capture learning from the project and high quality evidence of its impact on the health of local children. Baseline data is currently being captured via local schools.

6.3 Local Authority departments

The following tables aim to provide an overview of work currently being delivered by Local Authority teams that contribute to tackling childhood obesity.

PLANNING			
	Hammersmith & Fulham	**Kensington and Chelsea**	**Westminster**
Strategy & Focus	The Core Strategy (2011) Recognises the importance of the promotion of healthy lifestyles to address health inequalities The strategy aims to improve cycling and walking by working with partners to improve the opportunities for cycling and walking	Planning policies protect existing and encourage new health and sports facilities Policies ensure neighbourhoods benefit from shopping facilities and community facilities within a walkable distance	Westminster's City Plan: Strategic Policies (2013) Plan revision: - Focus on pedestrians - Policies of food and drink Development of the following strategies: - Walking and cycling - Open space - Biodiversity
Hot food Takeaways	Planning policies restrict A3-A5 uses to a specified percentage of frontages in shopping areas (DM C2, C4 & C5 in Development Management Local Plan). A5 uses also restricted within 400m of a school or other places that children are likely to congregate (SPD Amenity 1).	Planning policies ensure a balance of use within and outside centres (including A5 use). No specific policies to restrict the proximity of takeaways to schools	Planning policies ensure a balance of use within and outside centres (including A5 use). No specific policies to restrict the proximity of takeaways to schools
Open Space	In particular, the strategy notes that many of the schools in H&F are built on sites with limited outdoor space and therefore it is important to improve access to and provision of sports facilities to improve health and reduce child obesity levels.		The plan includes commitments to protecting and enhancing open spaces, including addressing active play space deficiency, as well as protecting existing and encouraging new facilities including playgrounds, leisure centres, and sports facilities.

TRANSPORT			
	Hammersmith and Fulham	**Kensington and Chelsea**	**Westminster**
Strategies	Air Quality Action Plan to be rolled out April 2016 Cycling Strategy in place Walking Strategy in place	Air Quality and Climate Change Action Plan (2016 – 2021) (specific objectives to encourage walking and cycling) Council Travel Plan to be updated April 2016	Air Quality Action Plan (2013-2018) Cycling Strategy in place Walking Strategy currently being refreshed Sustainable modes of travel strategy in place
Travel Plans	School travel plans Support offered to developers to incorporate active travel into new developments	School travel plans Small grants (up to £500 per school) available to implement tailored projects based on school needs	School travel plans
Pupil-led projects	Junior Travel Ambassadors (Primary Schools) and Youth Travel Ambassadors (Secondary Schools)	Junior Travel Ambassadors (Primary Schools) and Youth Travel Ambassadors (Secondary Schools)	Junior Travel Ambassadors (Primary Schools) and Youth Travel Ambassadors (Secondary Schools)
Cycling	Bike maintenance sessions (free) Lorry danger awareness sessions (free), including training for HGV operators Refurbished bikes and discounts from Bikeworks for LBHF employees Bike It (sustrans-funded) scheme encourages residents to cycle Barclays Cycle Hire scheme: 1,700 bikes and 60 docking stations Free cycle training to pupils in Year 5 & 6 (Bikeability). Free or subsidised cycle training for those living, working or studying in H&F.	Free cycle training for those who work, study or live in RBKC: Bikeability Level 1 & Level 2 All Ability Cycling for those with disabilities Recycle the way you travel – provision of free second hand bikes for people on low incomes Lorry driver training: Safer Urban Driving Cycling campaign: Bikeminded website & events Bike maintenance sessions (free) Workplace Travel Network supports companies to promote sustainable travel choices to and from work	Free cycle training for those who work, study or live in Westminster Subsidised bike maintenance courses Lorry danger awareness sessions (free) Free city cycling courses Business Engagement programme: developing a web based toolkit and direct engagement aimed at bike use for employees Incentive based app being developed to encourage employees to move 3x10mins per day

Walking		Promotion of walk on weekdays and walk to school campaigns The 'naked street' on Exhibition Road encourages walking and discourages car driving	Westminster Wiser Walking Scheme: Child pedestrian training scheme offered to Year 2 & 3 pupils at all Westminster primary schools
SPORT AND LEISURE			
	Hammersmith and Fulham	**Kensington and Chelsea**	**Westminster**
Strategy & Focus	CSPAN Physical Activity Strategy 2011-2016 Focus on 'those who are not participating in enough physical activity, in particular 16–24 year olds, BME groups, women and girls, and disabled people'	A sports and physical activity policy for Kensington and Chelsea 2010 to 2016 Focus on areas and groups where health is poor and participation levels are low. Additionally, focus on physical activity through the life course	Active Westminster Physical Activity Strategy 2015-2020 currently in development Active Communities approach embedded within this: asset mapping/ identifying needs/ prioritising services better
Leisure Facilities & Memberships	Leisure Provider: GLL Concessionary memberships available for eligible residents	Leisure Provider: GLL Concessionary memberships available for eligible residents (including a Family Pass for up to 2 children for those in receipt of Income Support; or Job Seekers Allowance)	Leisure Provider: GLL Re-let of contract –each facility required to provide 10hrs of Active Communities delivery per week Concession cards for 0-19 year olds (Active Westminster Passport) Free swimming for 0-19 year olds and over 60s
Sports Development Team	Sport England Project: Family activity sessions within children's centres. Work with a lead school on promoting Change4Life clubs in Primary Schools: promote physical activity to pupils 'Get Going' summer activity programme to encourage young people and adults to access local green spaces Offer support to third sector to access funding and developing activity programmes	Work with schools to encourage active lifestyles.	Westminster Mile Westminster Active Awards Primary School membership offer Neighbourhood Sports Clubs

CHILDREN'S SERVICES			
	Hammersmith and Fulham	**Kensington and Chelsea**	**Westminster**
Children's Centres	Contracts have clear outcomes for 'healthy children under 5', including healthy eating, promotion of breast feeding and weaning advice. Additionally, only healthy snacks are available for children during sessions		
Early Years	Nurseries and childminders who are rated less than 'good' receive support from the councils including meeting the 'healthy lifestyle' criteria.		
School Meals	Maintaining school meals support service and monitoring take up of school meals.		

ENVIRONMENTAL HEALTH			
	Hammersmith and Fulham	**Kensington and Chelsea**	**Westminster**
Strategies	Air Quality Action Plans highlighted previously in transport section		
Healthier Catering Commitment	The Healthier Catering Commitment (HCC) is a voluntary award scheme which encourages food businesses to demonstrate a commitment to offer healthier options		
	To date, 25 premises have achieved HCC award	To date, 59 businesses have achieved HCC award	To date, 21 businesses have achieved HCC award
Food Businesses	EH work with all food businesses to reinforce good principles on preparing healthy food and healthier food preparation processes		
Other	Fuel poverty service across two boroughs: advice and support on budgeting for food and fuel		

PARKS AND OPEN SPACES			
	Hammersmith and Fulham	**Kensington and Chelsea**	**Westminster**
Strategy	Parks and Open Spaces Strategy (2008-2018)	Park strategy outlines investments into parks, including outdoor gyms	Open Spaces and Biodiversity Plan being refreshed
Access to Open Space	Considerable work has been undertaken to improve parks	Capital improvements being made to encourage greater use by under-represented groups	All major parks awarded Green Flag Status (healthy, safe and secure)
Other	Parks police patrol the parks to increase safety and use	Healthy Parks projects. Capital investments in parks to increase use such as installing distance markers Community kitchen gardens: Over 60 food growing gardens installed with over 1000 residents and community groups involved in growing fruit and vegetables	Parkmakers develop accessible activities in parks and open spaces, delivered by appropriately qualified coaches, personal trainers, park staff and volunteers

PUBLIC HEALTH			
	Hammersmith and Fulham	**Kensington and Chelsea**	**Westminster**
Health Visiting	Commissioning responsibility for the three borough Health Visiting service transferred from NHS England to Local Authority on 1st October 2015. The service works across a number of stakeholders, organisations and settings to lead the delivery of the Healthy Child Programme (0-5); a prevention and early intervention public health programme. Advice and support provided on breastfeeding and weaning, weighing and measuring.		
Healthy Schools &Early Years Partnership	The Healthy Schools Partnership provides advice and guidance to early years settings and schools on how to take a whole setting approach to health and wellbeing		
	Schools have achieved the following Healthy Schools London awards: • 16 achieved Bronze • 5 achieved Silver • 1 achieved Gold	Schools have achieved the following Healthy Schools London awards: • 11 achieved Bronze • 5 achieved Silver • 0 achieved Gold	Schools have achieved the following Healthy Schools London awards: • 11 achieved Bronze • 5 achieved Silver • 1 achieved Gold
School Nursing	Delivers the National Child Measurement Programme. Conducting an extended NCMP programme in RBKC as part of the evaluation of the 'Go Golborne' project.		

Oral Health Promotion	Oral Health Promotion Team deliver evidence based oral health advice and implement oral health improvement programmes at schools, children's centres and community centres. The team work with children and families and vulnerable adults who require education to improve their oral health		
Workplaces	Tri-borough Workforce Wellbeing Strategy (2015-2018) and Workforce Wellbeing Group Work with businesses to raise awareness of workforce wellbeing and support offered to sign up to the London Healthy Workplace Charter		
	Council not currently engaged to sign up with the London Healthy Workplace Charter, however have carried out a partial gap analysis	Council not currently engaged to sign up with the London Healthy Workplace Charter, however have carried out a partial gap analysis	Council preparing to submit evidence to GLA to achieve commitment level of London Healthy Workplace Charter

LIBRARY SERVICES			
	Hammersmith and Fulham	**Kensington and Chelsea**	**Westminster**
Health Info Project	The Health Information Project has worked in partnership with a number of professionals and organisations to promote key messages, including Dieticians, MyTime Active and are working closely with the Go Golborne Pilot		

6.4 External Partners

Health Services

Two paediatric dietetics services are offered by Chelsea and Westminster Hospital, and Central London Community Healthcare NHS Trust (CLCH) which offer specialist advice and care for children.

Further information is detailed in the Family Healthy Weight care Pathway Toolkit, which can be found here: http://www.lbhf.gov.uk/familyhealthyweightcare

Additionally, Chelsea and Westminster Hospital, CLCH and Imperial College Healthcare NHS Trust have all been accredited with Level 3 UNICEF UK Baby Friendly Initiative; ensuring good quality support is available across the community for all mothers and babies aiming to improve breastfeeding prevalence and very early child development.

Furthermore, West London Clinical Commissioning Group (WLCCG) support Child Health GP Practice Hubs which provide an environment in which health and social care professionals can work together in multi-disciplinary teams to provide integrated care for children most in need.

Voluntary Sector

The three boroughs benefit from an active and vibrant voluntary sector which delivers a range of programmes and activities that support healthy lifestyle messages. For example, healthy cooking classes, parenting classes which cover healthy eating, physical activity sessions for under-represented groups and opportunities for children to play in safe open environments. Other initiatives include the 'Snack Right' project, promoting healthy after school snacks.

The three boroughs are also home to a number of football teams who deliver outreach programmes to inspire young people to participate in physical activity; these include Chelsea Football Club and Queens Park Rangers.

7. Recommendations

1. Every department/organisation has a role to play in creating and / or supporting increasingly healthier environments to make healthy choices easy choices. Be creative within roles/responsibilities.
2. Utilise every engagement with partners to achieve shared understanding of the need to address this complex problem collectively and to identify opportunities, for example:
    a. Systematically use contracting as a delivery mechanism for healthy lifestyles.
    b. Find ways to encourage food businesses with poor hygiene ratings to improve and join in the Healthy Catering Commitment.
3. Focus on early years. Exploit all possible opportunities to encourage children and families to be more active.
4. Develop clear and consistent messages that are readily understood by all audiences. Use the optimal communication channels for each audience. Communicate constantly and consistently.
5. Contribute to, and keep abreast of, national and regional developments.
6. Act on, and increase the evidence base.

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9. Appendices

Appendix A: National Child Measurement Programme (NCMP) Participation Rates

The NCMP participation rate is calculated as a proportion of the number of students who are measured during the programme over the number of students who are eligible for measurement. Participation in the programme is not compulsory, but non-participation is on an opt-out basis only.

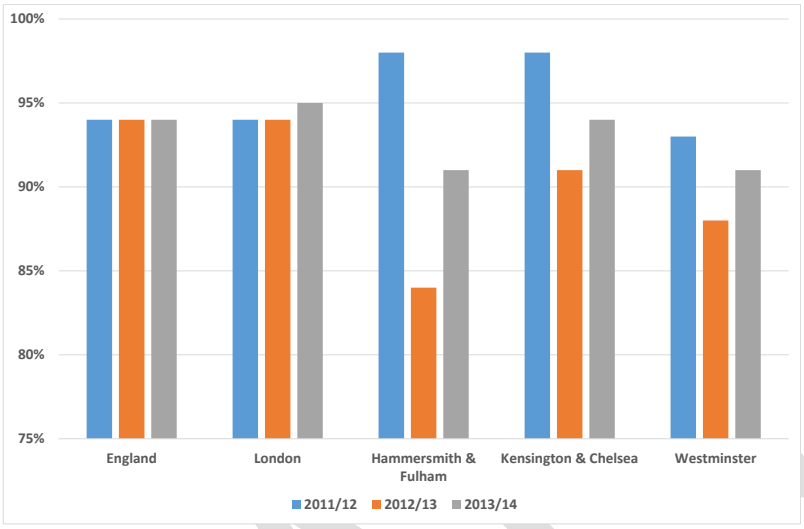


Figure A: Trends in NCMP participation rates: Reception Year

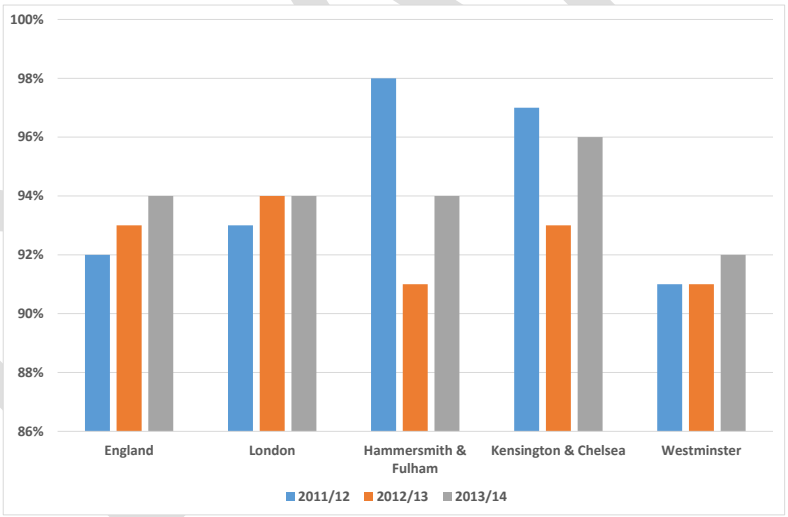
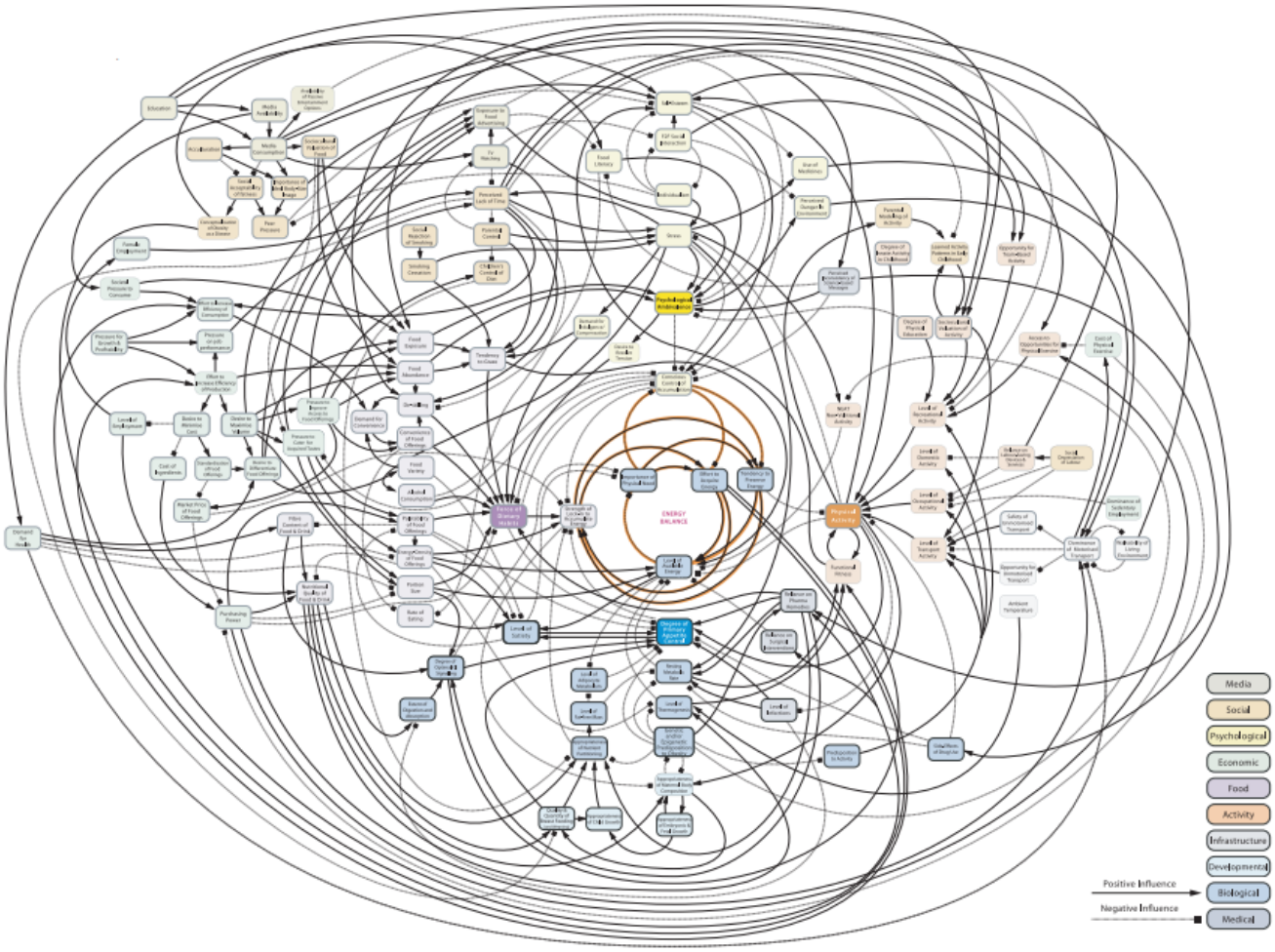


Figure B: Trends in NCMP participation rates: Year 6

As demonstrated in Figures A and B, overall London and England have 95% and 91% participation rates for Reception year and Year 6 respectively. Over the past three years, the three boroughs have had good participation rates for NCMP and therefore represent an accurate prevalence of obesity among state school children.

Appendix B: Obesity Systems Map



Appendix C: Evidence based opportunities for Local Authorities to support the development of the environment

Transport and Active Travel

Prioritising walking and cycling

- NICE recommends that pedestrians, cyclists and users of other modes of transport involving physical activity be given priority in the development of streets and roads. This may include:
  - Widening foot paths
  - Introducing cycling lanes
  - Reducing motor traffic by narrowing roads, introducing lower speed limits and creating calm routes to schools and designating streets as home zones
- Foot paths and bike lanes should be networked with paths and routes to destinations aiming at continuity and usability of routes by:
  - Ensuring sidewalk construction or improvements consider pedestrian needs
  - Increasing the ease and safety of crossing streets
  - Improving signage and markings at crosswalks and school zones
  - Implementing zoning standards that support mixed land use
- Introduce 20mph default speed limits to ensure traffic calming and improve perceptions of safety
- Association of Directors of Public Health (Take action on active travel) recommends the allocation of 10% of transport budgets to active travel
- Promote awareness amongst motorists of the needs of both cyclists and pedestrians
- All policies and design should be evaluated in accordance to their ability to also meet the needs of children with special needs

Shifting travel mode

- Social marketing campaigns can shift perceptions of car use and demonstrate the benefits of active travel. Campaigns should consider the age and locality of the audience and make use of prominent trends, for example increased awareness of environmental issues, especially amongst children
- Campaigns should also address parental concerns in relation to safety, convenience and social norms
- Using Active Travel Routes that link destinations to make walking quicker and more convenient than car travel (Everyday Activity Destinations by Sports England)

Tackling fear

- Promote schemes such as “walking bus” schemes and other “walk to school” together with initiatives to address safety (including traffic calming, improvements of lighting and addressing bullying)
- Involve the public, including parents and schools in developing neighborhood walking and cycling schemes
- Encourage children’s autonomy and confidence in active travel through schemes like Bikeability which teach children skills to navigate different road conditions.

Parks and Public Open Spaces (POS)

- **Environmental Quality of the Park:** Improve aesthetic factors of the park such as the number and placement of trees (shady trees along walking paths), presence of water features (lakes and ponds), birdlife, park maintenance (irrigated lawns), park size (which in itself provides opportunities for various activities), park contours (slopes).
- **Enabling visual cues**: Use signs and banners in parks and POS that are encouraging of physical activity. For example assess proposals for signs restricting physical activity in public spaces and facilities (such as those banning ball games) to judge the effect on physical activity levels.
- **Availability of amenities:** Consider the presence and placement of walking paths, children's play facilities, outdoor gyms and sports facilities, specifically age appropriate facilities. Also consider location of toilets, food retail amenities and shelters.
- **Perceived safety**: Ensure parks and open spaces are maintained to a high standard to ensure they are safe, attractive and welcoming to everyone. Consider lighting, visibility of surrounding houses or roads, types of surrounding roads (quiet roads) and presence of crossings. Whether dogs are allowed (leashed or unleashed) can also affect receptions of child safety. Ensure the cleanness of the park including the presence of graffiti.
- **Expanding use of available open spaces:** increae the use of vacant spaces in inner city areas to create mini-parks or pocket parks. In park poor neighborhoods, encourage recreational programmers in school playgrounds and other existing areas.
- **Involve local communities and experts:** Involvement at all stages of the development can help ensure that the potential for physical activity is maximized. Engaging with community can itself increase park usage.
- **Planning of new developments**: Work with local communities to help develop strategic parks and open spaces within neighbourhood plans – particularly for lower socio-economic groups this could help prioritise green spaces.
- **Involving other sectors:** Work collaboratively with third sector and private sector to build partnerships, specifically in relation to funding opportunities.

Built Environment

- Health and well-being should be prioritised and integrated into planning processes
- Consult children and families through-out the planning, design and delivery processes, ensuring that people in different socioeconomic and minority groups are involved and that the needs of disabled community members are considered

Streets, squares and other urban spaces

- Design street space to support active travel (widening foot paths, restricting motor vehicle access and parking)
- Introduce traffic-calming schemes to safe routes to school and facilities
- Balance the needs of pedestrians, cyclists, local businesses and institutions to create healthy streetscapes that are attractive and safe
- Squares and open spaces should be flexibly designed to support community, cultural and sporting events

Parks and Open Spaces

- Design open spaces that are connected to paths, public transportation and existing amenities
- Parks and open spaces should complement cultural preferences of the local community and accommodate different of age groups including parents
- Provide street lights and outdoors play areas to encourage physical activity in the evenings
- Actively promote public parks and facilities, including non-traditional spaces such as car parks, unused green spaces in housing estates and the use of school playgrounds after hours

Buildings and Housing

- Ensure public buildings and spaces are designed to encourage people to be more physically active (positioning and signing of stairs, entrances and walkways)
- Design courtyards, gardens, terraces and roofs that can serve as outdoors spaces for children to play
- Housing design should ensure adequate space for families to eat meals together and for children to engage in active play
- Integrate cycle storage into design of new homes

Schools and Child care facilities

- Use ground markings and colour-coordinated zones to encourage more vigorous activity for children in school playgrounds
- Design new school physical activity facilities to potentially allow for public use outside school hours
- Nurseries and other childcare facilities should aim to minimize sedentary activities. Indoor and outdoor facilities should provide sufficient space for active play
- Design of school should incorporate building layout, recreational spaces and catering facilities that promote physical activity, healthy eating and safe enjoyable environment to encourage healthy behavior

London Borough of Hammersmith & Fulham **HEALTH & WELLBEING BOARD** **9 FEBRUARY 2016**	
HAMMERSMITH & FULHAM CCG PLANNING UPDATE 2016-17	
Report of the Hammersmith & Fulham CCG	
Open Report	
Classification - For Information **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: Janet Cree, Interim Managing Director, Hammersmith & Fulham CCG	
Report Author: Harley Collins	**Contact Details:** Tel: 020 8753 5072 E-mail: harley.collins@lbhf.gov.uk

1. EXECUTIVE SUMMARY

1.1. This paper provides an update on the key planning tasks Hammersmith and Fulham CCG are current engaged in for financial year 2016/17. Specifically

- The NHS Shared Planning Guidance 2016/17
- The Better Care Fund 2016/17
- Quality Premium

1.2. The paper also identifies opportunities for the Health and Wellbeing Board to align the refresh of its Joint Health and Wellbeing Strategy with the planning and development process for Sustainability and Transformation Plans (STPs) which are a key component of the 2016/17 NHS Planning Guidance

2. RECOMMENDATIONS

2.1. The Health and Wellbeing Board is asked to note the update on key planning activities by the CCG in 2016/17; and

2.2. Review and comment on the opportunities to align the Joint Health and Wellbeing Strategy refresh with the development of Sustainability and Transformation Plans

3. REASONS FOR DECISION

3.1. Each CCG is required to submit its Operating Plan along with the choice of quality premium measures for 2016/17.

4. INTRODUCTION AND BACKGROUND

4.1 The Government announced in the Comprehensive Spending Review (CSR) on 25 November 2015 an ambitious plan for health and social care to be fully integrated across the country by 2020 and for every part of the country to have a plan for this in 2017 to be implemented by 2020.

4.2 Locally, across north west London, the local authorities, CCGs and provider Trusts have an aspiration to become a fully integrated Accountable Care Partnership (ACP) by 2018.

5. DELIVERING THE FORWARD VIEW: SHARED PLANNING GUIDANCE 2016/17 – 2020/21

5.1 The leading health and care bodies in England published *Delivering the Forward View: NHS Shared Planning Guidance 2016/17 – 2020/21* on 22nd December 2015 (for a full summary of the guidance see Appendix A).

5.2 The guidance is backed by £560 billion of NHS funding, including a new Sustainability and Transformation Fund (STF) worth £2.1 billion in 2016/17 and increasing year on year to 2020.

5.3 As part of the planning process all NHS organisations have been asked to produce two separate but interconnected plans:

1. Local place-based health and care system Sustainability and Transformation Plans (STP), for the period October 2016 to March 2021.
2. One year organisation based **operational** plans for 2016/17 consistent with emerging STPs.

5.4 STPs will require Local system leaders to come together as a team and develop a shared vision with the local community, including local government and voluntary and independent sectors. STPs require programming of a coherent set of activities and ultimately execution against the plan. Importantly, STPs must cover better integration with Local Authority services, prevention and reflecting local agreed Joint Health and Wellbeing Strategies.

5.6 STPs will become part of a single application and approval process for being accepted onto programmes with transformational funding from 2017/18 onwards for initiatives such as: the development and spread of new care models through and beyond vanguard; primary care access and infrastructure; and technology roll-out to drive clinical priorities such as diabetes prevention, Learning Disabilities, cancer and Mental Health.

5.7 Timelines for the development and agreement of STPs are challenging. The first critical task that leaders have undertaken, with local authority engagement, is agree the transformational footprint, or geographic scope, of the local STP which was submitted on Friday 29th January 2016 for national agreement. In discussion with NHS England local area teams, it was agreed that the footprint would cover the eight CCGs of north west London, reflecting historic and existing working relationships, patient flows and the scale required to tackle issues such as mental health and public health programmes.

6. PROPOSALS AND ISSUES: Action taken on Sustainability and Transformation Plans

6.1 On 28th January, leaders from across north west London attended a *Whole Systems Integrated Care Leadership Summit* to discuss the joint vision and ambitions for north west London, what the system wants to achieve over the next five years in the context of the *Five Year Forward View* and current strategic programmes, and how the system will use the STP process to enable this focusing on how best we take forward the development of the STP and immediate next steps.

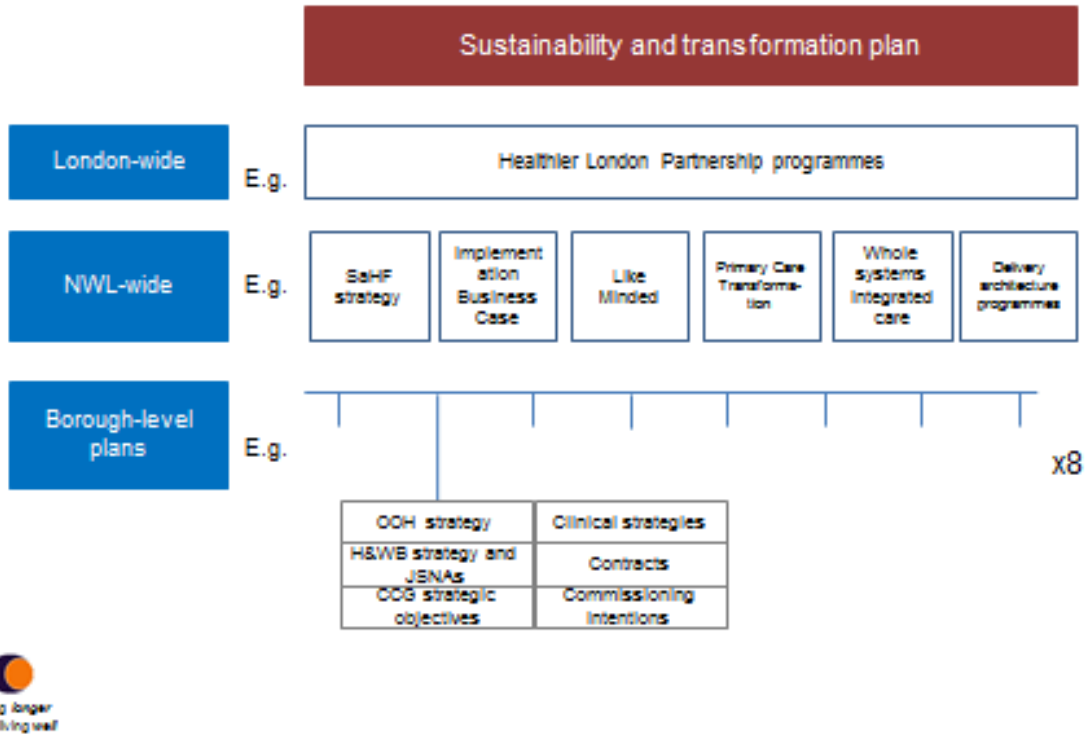
6.2 At the Summit, Leaders discussed if the vision set out in *Shaping a Healthier Future* was well enough understood across north west London, how to ensure STP development is collaborative and 'system led' and how to achieve a balance between subsidiarity, equality of service offerings across the system and transformation at scale. Leaders also discussed possible governance arrangements and representation on the body who will oversee the development of the STP.

We are considering the governance arrangements required in NW London to oversee the next phase of transformation

Living longer and living well

6.3 Colleagues across the eight north west London CCGs are currently undertaking a gap analysis to better understand the extent to which existing plans (both local and NWL wide) address the requirements set out in the initial planning guidance.

We have been asked as an SPG to produce a Sustainability and Transformation Plan that describes how we will deliver our vision and the Five Year Forward View over the next five years



6.4 Local authority and CCG officers have also established a working group to develop a joint and collaborative project plan for the development of the STP that aligns with local health and wellbeing strategies. Officers will work together over the coming months to deliver appropriate engagement and plan development that respects the principle of subsidiarity within each borough.

6.5 The timetable for the development of local STPs is:

- 29th January - Submit proposals for STP footprints
- 8th February – first submission of full draft 2016/17 operational plans
- 31 March – Boards of commissioners and providers approve budgets and final plans
- 11th April – submission of final 16/17 operational plans, aligned with contracts
- 20-22 April – stock-take
- End June 2016 – Submission of full STPs
- End July 2016 – Assessment and review of STPs

6.6 To ensure Local authorities/Health and Wellbeing Boards are actively engaged in the STP development process as equal partners over the coming months, officers will bring regular updates to the appropriate fora including the BCF Board and Borough Health and Wellbeing Board meetings at points between February and June, setting out a proposed timeline for engagement and development of the principles, approach, and plan itself.

6.7 To aid health and care systems develop ambitions for their populations, the Planning Guidance sets out some questions for plans to address including the plans local health and care systems have to deliver an upgrade in prevention, patient engagement choice and control; new (primary, out-of-hospital, urgent and emergency) care models, improving clinical priorities and rollout of digital healthcare; and achieving financial balance and improve efficiency.

6.8 This planning process presents opportunities locally around the development of local Joint Health and Wellbeing Strategies which are due to expire in 2016 in the three Boroughs of Hammersmith and Fulham, Westminster and Kensington and Chelsea. Instead of duplicating, or running parallel and disconnected development processes, there are significant opportunities for Health and Wellbeing Boards to capitalise on, engage with and shape the STP development process, and through that, local joint health and wellbeing strategies.

7. BETTER CARE FUND POLICY FRAMEWORK 2016/17

7.1 In October 2015 Government Ministers announced that the Better Care Fund would be extended until at least 2017. Further detail was provided in the Comprehensive Spending Review on 25 November 2015. The key points regarding integration and the Better Care Fund (BCF) were:

- That the BCF will continue into 2016-17, maintaining the NHS's mandated contribution in real terms over the Parliament.
- That from 2017, the government will make funding available to local government, worth £1.5 billion in 2019-20, to be included in the BCF.
- Areas will be able to graduate from the existing BCF programme management once they can demonstrate that they have moved beyond its requirements, meeting the Government's key criteria for devolution.
- That there will be a commitment of over £500 million by 2019-20 for the Disabled Facilities Grant.
- That there will be a new social care precept to give local authorities who are responsible for social care the ability to raise new funding to spend exclusively on adult social care, allowing local authorities the flexibility to raise council tax in their area by up to 2% above the existing threshold, to spend on adult social care.

7.2 On 8th January, the Department of Health (DH) and Department for Communities and Local Government (DCLG) published the *Better Care Fund Policy Framework* setting out the way in which the BCF will run in financial year 2016-2017. The framework covers the legal and financial basis of the fund, conditions of access, national performance metrics and the assurance and approval process to be used for local plans.

7.2.1 *Legal and financial basis of the fund.* In 2016-17, the mandated minimum BCF will be increased to £3.9bn (comprising £3.519bn of the overall allocation to CCGs and £394m Disabled Facilities Grant) but flexibility to pool more than the mandated minimum will remain. 2016-17 BCF plans will need to align with programmes of work such as new models of care and 7-day services.

7.2.2 *Conditions of access.* The £1bn payment for performance framework has been removed in 2016-17 and replaced by two new national conditions requiring local areas to fund out-of-hospital services and develop plans for reducing delayed transfers of care (DTOC). Plans must also meet a range of national conditions such as how they will: continue to protect local adult social care services; provide seven-day services across health and social care; facilitate better data sharing between health and social care based on the NHS number; ensure a joint approach to assessments and care planning with a named accountable professional for integrated packages of care covering a specified proportion of the population; and reach agreement with local acute health and care providers on the impact of local plans.

7.2.3 *Assurance process.* The first stage of assurance of local plans will be sign-off by Health and Wellbeing Boards (HWBs) who will agree narrative high-level plans, BCF operational plans and confirm that their local BCF plans meet stipulated national conditions. This will be followed by a process of regional moderation and assurance which will be "proportional to the perceived level of risk in the local system". Recommendations made at a regional level to approve the plans of high risk areas will be quality assured by the Integration Partnership Board (comprising DH, DCLG, NHS, LGA and ADASS) with final decisions on approval made by NHS England.

7.2.4 *Performance metrics.* Local areas will be expected to maintain progress made against national performance metrics set out in the 2015-16 policy framework i.e.

- Admissions to residential care homes
- Effectiveness of reablement
- Delayed transfers of care
- Patient/service user experience
- Locally proposed metrics (as agreed in 2015-16 plans)

7.3 Implementation of local plans formally begins from 1 April 2016. Requirements and timings for submissions will be confirmed in the detailed planning guidance expected in late January. Allocations for each Health and Wellbeing Board area in 2016-17 are also expected in late January.

8. QUARTER THREE BETTER CARE FUND SUBMISSIONS

8.1 The Quarter three reporting template has now been released and officers are working through it. The timetable is as follows:

- 1st Draft completed - 10th February
- Consolidated return available for Senior Officer sign off - 17th February

- Final return submitted to Health Lead for submission to NHSE – 24th February
- Final Submission signed off by the Health and Wellbeing Board - 26th February

8.2 As deadlines do not align with scheduled HWB meeting dates, Q3 returns will come to Chairs and vice-Chairs meetings for sign off as detailed above with reports being received at the next HWB meeting

8.3 Additional scope has been added to the Q3 return with further detail required on the following areas:

- Use of NHS Number across care settings
- Revision to the questions on Personal Health Budgets
- Additional questions on Multi-Disciplinary/Integrated Care Teams in both the non-acute and the acute setting

8.4 Specific attention needs lending to the section on 'Understanding Support Needs' to ensure the system is accessing the available National support.

8.5 Additionally, the 'National Conditions' section, where the system needs to take a view on the delivery of the outstanding conditions. Currently it's been identified that all conditions will be met by the end of this financial year. The outstanding conditions are below:

- Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?
- Is the NHS Number being used as the primary identifier for health and care services?
- Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?

9. QUALITY PREMIUM

9.1 The quality premium rewards CCGs for improvements in services they commission and associated improvements in health outcomes and reducing inequalities. The detailed guidance has not yet been published but it is expected to include a combination of national and locally determined measures, as in previous years. The local measures should reflect Joint Health and Wellbeing Strategies and the STP.

9.2 We propose to follow a similar process to last year, as below. Timescales will be contingent on the date the guidance is published:

- February - Establish a long list, based on the published criteria and aligned with the HWB strategy and STP
- February/March - Engage with internal and external stakeholders - including the HWBB - on the long list in order to produce an agreed short list

- March/April - Undertake detailed work on rationale, current baselines, ability to measure performance and achievement, and level of ambition. Consult with stakeholders to prioritise the short list.
- April - Sign off of the priorities by the CCG Finance and Performance Committee and HWBB
- May - Submit to NHS England.

10. CONSULTATION

10.1 Patient, public and professional engagement will be a vital component of the development of Sustainability and Transformation Plans. The success and credibility of plans will depend on having an open, engaging, and iterative process that harnesses the energies of clinicians, patients, carers, citizens, and local community partners including the independent and voluntary sectors, and local government through health and wellbeing boards.

11. EQUALITY IMPLICATIONS

11.1. No implications have been identified at this stage

12. LEGAL IMPLICATIONS

12.1. No implications at this stage

13. FINANCIAL AND RESOURCES IMPLICATIONS

13.1. No specific financial implications have been identified at this stage

11. IMPLICATIONS FOR BUSINESS

11.1 There are no implications for businesses in the borough at this stage

12. RISK MANAGEMENT

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

13. PROCUREMENT AND IT STRATEGY IMPLICATIONS

13.1 There are no implications at this stage

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

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

LIST OF APPENDICES:

Appendix 1 – NHS Planning Guidance Summary

Appendix 2 – Delivering the Forward View: NHS Shared Planning Guidance 2016/17 – 2020/21

Summary of NHS Planning Guidance 2016/17 to 2020/21
(Published 23rd December 2015)

Delivering the Forward View: NHS Shared Planning Guidance 2016/17 – 2020/21

- This year, the leading health and care bodies in England have come together to publish shared planning guidance for the NHS
- The guidance is backed up by £560 billion of NHS funding, including a new Sustainability and Transformation Fund (STP) which will support:
    1. Financial balance
    2. Delivery of the Five Year Forward View and
    3. Enabling new investment in key priorities
- As part of the planning process, ALL NHS organisations are asked to produce **two** separate but interconnected plans:
    1. A local health and care system place based **Sustainability and Transformation** Plan (STP), for the period October 2016 to March 2021. This will be subject to formal assessment in July 2016 following submission in June 2016 - **NEW**
    2. One year organisation based **operational plan for 2016/17** but consistent with the emerging STP. Spanning providers and commissioners, these plans will set out a combination of:
- demand moderation
- allocative efficiency
- provider productivity
- income generation required for the NHS locally to balance its books
- final drafts of supporting technical guidance for commissioners and providers will be published in early January 2016
- emphasis is on population based services

Sustainability and Transformation Plan (STP) - place based planning

This will require:

1. Local leaders coming together as a team
2. Developing a shared vision with the local community including local government and voluntary and independent sectors
3. Programming coherent set of activities to make it happen
4. Execution against the plan
5. Learning and adapting

A truly place-based plan must cover all areas of CCG and NHSE commissioned activity including:

1. Specialised services and
2. Primary medical care

Importantly, the STP must also cover better integration with LA services, prevention and reflecting local agreed H&WB strategies.

STPs will become part of a single application and approval process for being accepted onto programmes with transformational funding from 2017/18 onwards. Credible STPs will secure additional funding from April 2017 onwards. The process will be iterative and will consider:

- Quality of plan: the scale of ambition and track record of progress already made. Whether we have adopted good practice from other geographies/ national framework
- Quality of local process including engagement with LA, community, voluntary sector
- Clear governance in place to deliver the plans
- Confidence in implementation actions

Sustainability and Transformation Fund (STF)

The protected fund is for initiatives such as:

- the development and spread of new care models through and beyond vanguard
- primary care access and infrastructure
- technology roll-out to drive clinical priorities such as diabetes prevention, LD, cancer and MH

For 2016/17 only, the transformational funding will continue to be run through separate processes.

Agreeing 'transformation footprint'

- The first critical task is to consider the transformation footprint- the geographic scope of the STP
- This needs to be submitted **by Friday 29th January 2016** for national agreement and the LA should be engaged with these proposals
- Where geographies are already involved in success regime or devolution bids, these should determine the transformation footprint
- The footprint may develop over time and focus must be on the content of the plan rather than lengthy debates about boundaries
- Further brief guidance on the STP process will be published in January 2016

Involving local communities and citizens

Bulding on the 6 principles of the Five Year Forward View (below), will need to involve local communities and citizens in creating a credible STP.

National MUST DO for 2016/17

Ambition by end of March 2017 is:

- 25% of population will have access to acute hospital services that comply with four priority clinicial standards on every day of the week - NEW
- 20% of the population will have access to enhanced access to primary care- NEW

The 3 distinct challenges under 7 day services are:

1. Reducing excess deaths by increasing the level of consultant cover and diagnostic services in hospitals at weekend. During 2016/17, a quarter of the country must be offering 4 out of 10 standards, rising to half the country by 2018 and complete coverage by 2020
2. Improving access to out of hours care by achieving better integration and redesign of 111, minor injuries unit, UCCs and GP out of hours services
3. Improving access to primary care at weekends and evening where patients need it by increasing the capacity and resilience of primary care over the next few years

Where relevant, local systems will need to reflect this in their 2016/17 Operational plans and all areas will need to set out their ambition for 7 day services as part of their STPs

Nine MUST Dos for 2016/17

1. Develop a **high quality and agreed** STP - NEW

2. Return the system to **aggregate financial balance**. For CCGs, this will mean delivering savings by tackling unwarranted variations in demand through implementing the Right Care programme in every locality - NEW
3. Plans to delivery **sustainability and quality of general practice**, including workforce and workload issues
4. Delivery access standards for **A&E** (95%) and **ambulance waits** (75% of Cat A within 8 minutes)
5. More than 92% of patients on non-emergency pathway wait no more than 18 weeks from **referral to treatment**, including offering patient choice
6. Deliver **62 day cancer waiting** standard and 2 week and 31 day cancer standards and make progress in improving 1 year **survival rate**
7. Several MH targets:
    - More than 50% of people experiencing a first episode of **psychosis** will commence treatment with a NICE approved care package within 2 weeks of referral - NEW
    - Continue with IAPT referral to treatment target (75% for 6 weeks and 95% for 18 weeks)
    - Continue to meet the dementia diagnosis rate (around 67%)
8. Transform care for **people with LD** including implementing enhanced community provision, reducing inpatient and rolling out care and treatment reviews
9. Make **improvements in quality** and providers to participate in the annual publication of **avoidable mortality** rates

Trialling new approaches with volunteers:

- secondary mental health providers managing care budgets for tertiary mental health services
- **the reinvention of the acute medical model in small district general hospitals.**

Operational plans for 2016/17

- An early task is to run a shared and open-book operational planning process for 2016/17. This will cover activity, finance, capacity and 2016/17 deliverables from the emerging STP.

The provider and commissioner plans will need to demonstrate:

1. how we intend to reconcile finance with activity
2. planned contribution to the efficiency savings
3. plans to deliver the key must-do's
4. how quality and safety will be maintained and improved for patients
5. how risks across local health economy have been jointly identified and mitigated
6. how plans link with and support local emerging STPs

Allocations

- Allocations will reflect a closer alignment with the population need through improve allocation formulae
- Commissioner allocations will be published in early 2016

- Overall primary medical care spend will rise by 4-5% each year
- Specialised services funding will rise by 7% in 2016/17, with growth of at least 4.5% in each year
- Funding reflects forecast pressures from new NICE legally mandated drugs and treatments
- NHSE has set 3 year allocations for CCGs, followed by 2 indicative years
- For 2016/17, allocation will rise by 3.4% and no CCG will be more than 5% below its target funding level
- NHSE to also publish allocations for primary care and specialised commissioned activity

Returning the NHS provider sector to balance

- £1.8 billion of income from the 2016/17 STF will replace direct DoH funding. The distribution of this funding will be calculated on a trust by trust basis by NHS Improvement and then agreed with NHSE
- Deficit reduction in providers will require forensic examination of spend, with focus on cost reduction (incl workforce productivity) and NOT income growth
- Capital investment is constrained
- Quarterly release of Sustainability Funds to trusts and foundation trusts will depend on achieving recovery milestones for (i) deficit reduction; (ii) access standards; and (iii) progress on transformation.

Efficiency assumptions and business rules

- For planning purpose, an indicative tariff list is being made available on the Monitor website
- The consultation on tariff will propose a 2% efficiency deflator and 3.1% inflation uplift for 2016/17
- Remain on HRG4 for a further year and there will be no changes to specialist top-ups in 2016/17
- NHSE is developing a single national purchasing and supply chain arrangement for specialised commissioning high cost tariff excluded devices with effect from April 2016
- Expect providers to deliver a 2% efficiency (provided forecast deficit of £1.8m at the end of 2015/16 is met)
- Commissioners will be required to deliver a cumulative reserve (surplus) of 1%
- Those who are unable to meet the cumulative reserve (surplus) requirement, must deliver an in-year break even position
- Commissioner is required to plan to spend at least 1% of their allocation non-recurrently. This should be uncommitted at the start of the year
- In addition, commissioners are also required to hold an additional contingency of 0.5%
- CCGs and councils will need to agree a joint plan to deliver the requirements of the BCF in 2016/17. CCGs will be advised of the minimum amount that they are required to pool as part of the notification of their wider notification. BCF funding should explicitly support reductions in unplanned admissions and hospital delayed transfer of care- further guidance on BCF will be forthcoming in the new year

- Commissioners must continue to increase investment in MH services each year at the level which at least matches their overall expenditure increase

Measuring progress - NEW

- Will be measured through a new CCG Assessment Framework- NHSE will consult in Jan-2016
- Will be in the form of a mandated CCG Scorecard - it's about how local health and care systems and communities can assess their own progress

Timetable

Timetable	Date
Publish planning guidance	22 December 2015
Publish 2016/17 indicative prices	By 22 December 2015
Issue commissioner allocations, and technical annexes to planning guidance	Early January 2016
Launch consultation on standard contract, announce CQUIN and Quality Premium	January 2016
Issue further process guidance on STPs	January 2016
Localities to submit proposals for STP footprints and volunteers for mental health and small DGHs trials	By 29 January 2016
First submission of full draft 16/17 Operational Plans	8 February 2016
National Tariff S118 consultation	January/February 2016
Publish National Tariff	March 2016
Boards of providers and commissioners approve budgets and final plans	By 31 March 2016
National deadline for signing of contracts	31 March 2016
Submission of final 16/17 Operational Plans, aligned with contracts	11 April 2016
Submission of full STPs	End June 2016
Assessment and Review of STPs	End July 2016

So what's new in 2016/17?

Sustainability and Transformation Plan (STPs)

- Holistic pursuit of the triple aim: better health, transformed quality of care delivery and sustainable finances. Three overarching questions:

A. How will we close the health and wellbeing gap?

Our plans should focus on a 'radical upgrade' of prevention, patient activation, choice and control and community engagement. Questions our plans should address:

1. Have we assessed and addressed our most important and highest cost preventable causes of ill health?
- What are we doing to address health demand and tackle health inequalities?
- Are we working closely with local government?
- How rapidly can we achieve full local implementation of the national diabetes prevention programme? Is our area prioritised for national funding?
- What actions are we taking to tackle childhood obesity?
- How are we doing on self-care agenda?

2. **Coordinated care plan**: How are we designing a person centred coordinated care plan to ensure patient have access to named accountable consultants?

3. **Powers to patients - how are** we dealing with integrated PHB and implementation of choice- particularly in maternity, EoL and elective care?

4. **Workforce Wellbeing**: How are we (as an NHS organisation) and other employers in our area going to improve the health of our workforce?

B. How will we drive transformation to close the care and quality gap?

Our plans should focus on development of new care models, improving against clinical priorities and rollout of digital healthcare. Questions our plans should address:

1. **Primary care infrastructure**: Sustainable general practice and wider primary care. Improving primary care infrastructure - supported in part through access to national primary care transformation funding

2. **Primary care access**: Access to primary care in evening and weekend and using technology - why should NHSE prioritise our area for additional funding?

3. **New models of care**: what are our plans on adopting new models of out of hospital care e.g. Multi-specialty community providers (MCPs) or Primary and acute care systems (PACs)

4. **New models of care**: How will we adopt new models of acute care collaborations? (Accountable clinical networks, specialty franchises, foundation groups)

5. **Transform Urgent care**: Do we have plans to transform urgent and emergency care in our area? Have we agreed recovery plans to achieve and maintain A&E and ambulance access targets?

6. **RTT**: What are our plans to maintain the elective care referral to treatment standards? Are we buying sufficient activity, tackling unwarranted variation in demand, offering patients choice of alternatives and increasing provider productivity?

7. **Cancer**: What are we doing in transforming cancer care (prevention, diagnosis, treatment, after care)

8. **MH**: What are we doing in improving MH services - are we making measurable progress towards 'parity of esteem for MH'?

9. **Dementia**: What are we doing locally to improve dementia services?

10. **LD**: Are we ensuring that people with LD are supported at home rather than in hospital? What are we doing in closing out-moded inpatient beds and reinvesting in continuing learning disability support

11. **CQC rating**: Are we ensuring that no organisation receives/has an overall inadequate rating from CQC?

12. **Governance**: What are we doing to promote and embed an open, learning and safety culture? Are we improving on reporting, investigations and supporting patients, their families and carers as well as staff who have been involved in an incident?

13. **Prescribing**: What plans do we have to reduce antimicrobial resistance and ensure prescribing of antibiotics/right drugs responsibly? Have we implemented good practice in reducing avoidable mortality from sepsis?

14. **7 day service**: Do we have a plan in place to achieve a full 7 day services for the four priority clinical standards by 2020? The four prioritised clinical standards to be achieved by April-2017 are:

    - Time to consult review
    - Access to diagnostics
    - Access to consultant-directed interventions
    - On-going review

15. **Maternity review**: Do we have plans to implement the forthcoming national maternity review?

16. **MH**: How will we put Children and Young People MH plan into practice?

17. **Digital roadmap**: What plans do we have to deliver a fully interoperable health and care system by 2020 that is paper-free at the point of care? Ensure patients have access to digital health records and increase services that can be offer online (e.g. repeat prescriptions and GP appts)

18. **Workforce development**: What plans do we have to develop and retain workforce to support delivery of transformed care vision? How ambitious are our plans to implement new workforce? (physician associates, community paramedics, pharmacists in general practice)

19. **Improving commissioning**: How rapidly will we move to place-based commissioning? How will the implementing 'devolution' (if in the area) deliver real improvements for patients?

20. **Innovation**: How will services change in the next 5 years as they embrace technological breakthroughs? Are we being innovative and learning from test bed programmes?

C. How will we close the financial and efficiency gap?

Our plans should focus on how we will achieve financial balance across health system and improve the efficiency of NHS services

Questions our plans should address:

1. **QIPP**: How will we deliver the annual efficiency required to support the total NHS funding base in NWL by 2020/21?

2. **Growth**: How are we managing growth? What are we doing to

(a) tackle unwarranted variation in care utilisation
(b) encourage patient activation and self-care
(c) develop new models of care
(d) implement urgent and emergency care reforms

3. **Reducing costs**: What plans do we have to reduce our costs (e.g. better purchasing and medicines mgt) and how will we get most out of our existing workforce? What plans are in place to improve workforce productivity?

4. **Capital investment**: What capital investment is required and how will this be financed?

5. **Estates**: What plans do we have to utilise our estate better, dispose unneeded assets and review of estates requirement to support delivery of redesigned care models?

The Government's mandate

The table below shows NHSE objectives with measurable goals for this parliament and clear priorities for 2016/17. These will need to be achieved in partnership with many organisations (e.g. DH, PHE, CQC, HEE, NHS Improvement, and LA).
Nb this is not a template and the focus needs to be on a wider overall vision and plan

1. Through better commissioning, improve local and national health outcomes, by addressing poor outcomes and inequalities	
1.1 CCG Performance	
2020 Goals	*2016/17 deliverables*
Consistent improvement in CCGs performance against new CCG assessment framework	• By June-2016, publish results of the CCG assessment framework for 2015-16. This will allow to benchmark against other CCGs and inform if NHSE intervention is required • Ensure new Ofsted-style CCG framework for 2016-17 includes health economy metrics to measure performance against priorities set out in mandate and NHS planning guidance • By the end of Q1 2016-17, publish first overall assessment for each of the 6 clinical areas (cancer, dementia, maternity, MH, LD, diabetes)

2. To help create a safer, highest quality health and care service	
2.1 Avoidable deaths and 7 day service	
2020 Goals	*2016/17 deliverables*
• Roll our 7 day service in hospital to 100% of the population, so patients receive same standard of care, 7 days a week • Significant reduction in avoidable deaths, with ALL trusts to have seen measurable reduction from their baseline • Support increase in trusts rated	• Publish avoidable deaths per trust annually and support improvement programme from March 2016 baseline • Rollout of 4 clinical priority standards in all relevant specialties to 25% of the population • Implement agreed recommendations of the National

outstanding/good and length of time they remain in special measures • Reduce rate of stillbirths, neonatal and maternal deaths and brain injuries soon after birth by 50% by 2030 with a measurable reduction by 2020 • Support new culture of learning for clinical mistakes and organisations to act on concerns raised • Measurable improvement in antimicrobial prescribing and resistance rates	Maternity review • Establish baseline and ambition for antimicrobial prescribing and resistance rates
2.2 Patient Experience	
2020 Goals	*2016/17 deliverables*
• Maintain and increase the no of people recommending services in FFT (currently 88%-96%) • 5—10k people to have PHBs or integrated personal budget (current est. is 4k) • Significant improvement in patient choice (maternity, EoLC, increase in no of people able to die in the place of their choice)	• Need to produce a plan with milestones for improving patient choice by 2020, particularly in maternity, EoLC (including preferred place of care/death) and PHBs • Develop proposal on how feedback could be enhanced to drive up improvements to services
2.3 Cancer	
2020 Goals	*2016/17 deliverables*
• Deliver recommendations of the Independent Cancer taskforce Improving 1 year survival rate to achieve 75% by 2020 for all cancers combined Patients given definitive cancer diagnosis or all clear within 28 days of being referred by a GP	• Achieve 62 day cancer wait time standard • Patient to wait no more than 6 weeks from referral to test • Agree trajectory for increase in diagnostic capacity required to 2020 and achieve 2016/17 target • Investment of £340m in Cancer drugs fund

3. To balance the NHS budget and improve efficiency and productivity	
3.1 Balancing the NHS budget	
2020 Goals	*2016/17 deliverables*
• Ensure NHS balances its budget in each financial year • Achieve year on year improvements in NHS efficiency and productivity (2%-3% each year), including	• Commissioners and providers to operate within their budgets and supporting £1.3b of efficiency savings- Lord Carter's

reducing growth in activity and maximising cost recovery	recommendations Delivering year 1 of trust deficit reduction plans and a balanced financial position Reduce agency spend by at least £0.8b • Rollout 2nd cohort of RightCare methodology to further 60 CCGs • Improve primary care productivity • Increase cost recovery up to £500m by 2017/18 from OVS patients • Ensure CCGs local estates strategies support overall goal of releasing £2b and land for 26k homes by 2020

4. To lead a step change in the NHS in preventing ill health and supporting people to live healthier lives	
4.1 Obesity and diabetes	
2020 Goals	*2016/17 deliverables*
• Reduction in child obesity (as part of Government's childhood obesity strategy) • Diabetes prevention programme- support 100k people to reduce their risk of diabetes • Reduction in variation in management and care of people with diabetes	• Plan an improvement trajectory for the % of children who are overweight or obese – delivery 16/17 target • 10k people referred to the diabetes prevention programme
4.2 Dementia	
2020 Goals	*2016/17 deliverables*
Deliver improvements on dementia 2020 including • Maintain diagnosis rate of at least 2/3rd • Increase the no of people receiving a dementia diagnosis within 6 weeks of a GP referral • Improving quality of post-diagnosis treatment and support for people with dementia and their carers	• Maintain diagnosis rate of at least 2/3rd • Improve quality of post-diagnosis treatment and support

5. To maintain and improve performance against core standards
5.1 A&E, Ambulances and RTT

2020 Goals	*2016/17 deliverables*
• 95% of people attending A&E seen within 4 hours • Urgent and Emergency care networks rolled out to 100% of the population • 75% of Cat A ambulance calls responded within 8 minutes • 92% receive first treatment within 18 weeks of referral and no one waits more than 52 weeks	• Plan trajectory for A&E and deliver 16/17 target • Implement urgent and emergency care networks in 20% of the country designed as transformation areas • Plan and deliver 16/17 trajectory for ambulance responses • Reduce unwarrant variation between CCG referral rates to better manage demand • Meet 18 week RTT standard including implementing patient choice

6. To improve out of hospital care	
6.1 New models of care and general practice	
2020 Goals	*2016/17 deliverables*
• 100% of population to have access to weekend/evening routine GP appts • Reduction in age standardised EM admission rate and EM IP bed days • Progress in health & social care integration, urgent and EM care and electronic health record sharing • 5k extra doctors in general practice	New models of care covering 20% of population to: • Access to enhanced GP services including evening & weekend, same day GP appt for all over 75s who need them • Make progress on integration of in health & social care, integrated urgent and EM care and electronic health record sharing Publish practice-level metrics on quality of and access to GP services and HSCIC to provide GPs with benchmarking information for named patient lists Develop new voluntary contract for GPs (multidisciplinary community provider contract) ready for implementation in 2017-18
6.2 Health and Social Care Integration	
2020 Goals	*2016/17 deliverables*
• Significant improvements in performance against integration metrics within the new CCG assessment framework • NHS plays its part in significantly reducing DTOC	• Implement BCF in line with the BCF Policy Framework for 2016/17 • Every area to have an agreed plan by March 2017 for better integrating health & social care (e.g.: sharing electronic health records, integrated

	assessment and provision) • Ring fenced £3.519m within allocation to CCGs to establish BCF, to be used for the purpose of integrated care • Plan trajectory and delivery 2016/17 ambition for DTOC
6.3 Mental health, LD and Autism	
2020 Goals	*2016/17 deliverables*
• To close the gap between people with MH problems, learning disabilities and autism and the population as a whole • MH access and waiting times include: 50% of people experiencing first episode of psychosis to access treatment within 2 weeks and 75% of people with relevant conditions to access talking therapies in 6 weeks and 95% in 18 weeks	• 50% of people experiencing first episode of psychosis to access treatment within 2 weeks • 75% of people with relevant conditions to access talking therapies in 6 weeks and 95% in 18 weeks • Increase in people with LD/autism being care for by community not IP services (implement 2016-17 actions for Transforming Care) • Agree and implement a plan to improve crisis care for ALL ages, investing in places of safety • Implement plans for children and young people's MH (improve prevention and early intervention) • Deliver children and young people's IAPT programme by 2018 • Implement agreed actions from MH Taskforce

7. To support research, innovation and growth	
7.1 Research and growth	
2020 Goals	*2016/17 deliverables*
• Improve UK's international ranking for health research • Implement research proposals and initiatives • New affordable and cost-effective new innovations • Commitment to deliver 10k genomes	• Uptake of affordable and cost-effective new innovations
7.2 Technology	
2020 Goals	*2016/17 deliverables*
• Support delivery of 'Personalised Health and Care 2020' (local digital	• Minimum of 10% of patients accessing primary care services

roadmap, NHS that is paper free at the point of care) • 95% of patients to be offered e-consultation and other digital services • 95% of tests to be digitally transferred between organisation	online or through apps- set a trajectory with a significant increase by 2020 • Appt booking app with access to full medical record and agreed data sharing opt-out available from April-2016 • Robust data security standards in place • Deliver new consent-based data services for effective data sharing for commissioning and health & care benefits • Increase in patient access to and use of electronic health record
7.3 Health and work	
2020 Goals	*2016/17 deliverables*
• Reduce disability employment gap • Support increasing the use of fit for work	• Improve the health and wellbeing of workforce • Expand / trial interventions to support people with LT health conditions and disabilities back into employment

Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21

December 2015

Delivering the Forward View: NHS planning guidance

2016/17 – 2020/21

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This document is for: Commissioners, NHS trusts and NHS foundation trusts.

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The NHS Five Year Forward View sets out a vision for the future of the NHS. It was developed by the partner organisations that deliver and oversee health and care services including:

- NHS England*
- NHS Improvement (Monitor and the NHS Trust Development Authority)
- Health Education England (HEE)
- The National Institute for Health and Care Excellence (NICE)
- Public Health England (PHE)
- Care Quality Commission (CQC)

*The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.

Introduction

1. The Spending Review provided the NHS in England with a credible basis on which to accomplish three interdependent and essential tasks: first, to implement the Five Year Forward View; second, to restore and maintain financial balance; and third, to deliver core access and quality standards for patients.

2. It included an £8.4 billion real terms increase by 2020/21, front-loaded. With these resources, we now need to close the health and wellbeing gap, the care and quality gap, and the finance and efficiency gap.

3. In this document, authored by the six national NHS bodies, we set out a clear list of national priorities for 2016/17 and longer-term challenges for local systems, together with financial assumptions and business rules. We reflect the settlement reached with the Government through its new Mandate to NHS England (annex 2). For the first time, the Mandate is not solely for the commissioning system, but sets objectives for the NHS as a whole.

4. We are requiring the NHS to produce two separate but connected plans:

   - a five year Sustainability and Transformation Plan (STP), place-based and driving the Five Year Forward View; and
   - a one year Operational Plan for 2016/17, organisation-based but consistent with the emerging STP.

5. The scale of what we need to do in future depends on how well we end the current year. The 2016/17 financial challenge for each trust will be contingent upon its end-of-year financial outturn, and the winter period calls for a relentless focus on maintaining standards in emergency care. It is also the case that local NHS systems will only become sustainable if they accelerate their work on prevention and care redesign. We don't have the luxury of waiting until perfect plans are completed. So we ask local systems, early in the New Year, to go faster on transformation in a few priority areas, as a way of building momentum.

Local health system Sustainability and Transformation Plans

6. We are asking every health and care system to come together, to create its own ambitious local blueprint for accelerating its implementation of the Forward View. STPs will cover the period between October 2016[1] and March 2021, and will be subject to formal assessment in July 2016 following submission in June 2016. We are asking the NHS to spend the next six months delivering core access, quality and financial standards while planning properly for the next five years.

Place-based planning

7. Planning by individual institutions will increasingly be supplemented with planning by place for local populations. For many years now, the NHS has emphasised an organisational separation and autonomy that doesn't make sense to staff or the patients and communities they serve.

8. System leadership is needed. Producing a STP is not just about writing a document, nor is it a job that can be outsourced or delegated. Instead it involves five things: (i) local leaders coming together as a team; (ii) developing a shared vision with the local community, which also involves local government as appropriate; (iii) programming a coherent set of activities to make it happen; (iv) execution against plan; and (v) learning and adapting. Where collaborative and capable leadership can't be found, NHS England and NHS Improvement[2] will need to help secure remedies through more joined-up and effective system oversight.

9. Success also depends on having an open, engaging, and iterative process that harnesses the energies of clinicians, patients, carers, citizens, and local community partners including the independent and voluntary sectors, and local government through health and wellbeing boards.

10. As a truly place-based plan, the STPs must cover all areas of CCG and NHS England commissioned activity including: (i) specialised services, where the planning will be led from the 10 collaborative commissioning hubs; and (ii) primary medical care, and do so from a local CCG perspective, irrespective of delegation arrangements. The STP must also cover better integration with local authority services, including, but not limited to, prevention and social care, reflecting local agreed health and wellbeing strategies.

[1] For the period October 2016 – March 2017, the STP should set out what actions are planned but it does not need to revisit the activity and financial assumptions in the 2016/17 Operational Plan.

[2] NHS Improvement will be the combined provider body, bringing together Monitor and the NHS Trust Development Authority (TDA).

Access to future transformation funding

11. For the first time, the local NHS planning process will have significant central money attached. The STPs will become the single application and approval process for being accepted onto programmes with transformational funding for 2017/18 onwards. This step is intended to reduce bureaucracy and help with the local join-up of multiple national initiatives.

12. The Spending Review provided additional dedicated funding streams for transformational change, building up over the next five years. This protected funding is for initiatives such as the spread of new care models through and beyond the vanguards, primary care access and infrastructure, technology roll-out, and to drive clinical priorities such as diabetes prevention, learning disability, cancer and mental health. Many of these streams of transformation funding form part of the new wider national Sustainability and Transformation Fund (STF). For 2016/17 only, to enable timely allocation, the limited available additional transformation funding will continue to be run through separate processes.

13. The most compelling and credible STPs will secure the earliest additional funding from April 2017 onwards. The process will be iterative. We will consider:

    (i) the quality of plans, particularly the scale of ambition and track record of progress already made. The best plans will have a clear and powerful vision. They will create coherence across different elements, for example a prevention plan; self-care and patient empowerment; workforce; digital; new care models; and finance. They will systematically borrow good practice from other geographies, and adopt national frameworks;

    (ii) the reach and quality of the local process, including community, voluntary sector and local authority engagement;

    (iii) the strength and unity of local system leadership and partnerships, with clear governance structures to deliver them; and

    (iv) how confident we are that a clear sequence of implementation actions will follow as intended, through defined governance and demonstrable capabilities.

Content of STPs

14. The strategic planning process is intended to be developmental and supportive as well as hard-edged. We set out in annex 1 of this document a list of 'national challenges' to help local systems set out their ambitions for their populations. This list of questions includes the objectives set in the Mandate. Do not over-interpret the list as a narrow template for what constitutes a good local plan: the most important initial task is to create a clear overall vision and plan for your area.

15. Local health systems now need to develop their own system wide local financial sustainability plan as part of their STP. Spanning providers and commissioners, these plans will set out the mixture of demand moderation, allocative efficiency, provider productivity, and income generation required for the NHS locally to balance its books.

Agreeing 'transformation footprints'

16. The STP will be the umbrella plan, holding underneath it a number of different specific delivery plans, some of which will necessarily be on different geographical footprints. For example, planning for urgent and emergency care will range across multiple levels: a locality focus for enhanced primary care right through to major trauma centres.

17. The first critical task is for local health and care systems to consider their transformation footprint – the geographic scope of their STP. They must make proposals to us by Friday 29 January 2016, for national agreement. Local authorities should be engaged with these proposals. Taken together, all the transformation footprints must form a complete national map. The scale of the planning task may point to larger rather than smaller footprints.

18. Transformation footprints should be locally defined, based on natural communities, existing working relationships, patient flows and take account of the scale needed to deliver the services, transformation and public health programmes required, and how it best fits with other footprints such as local digital roadmaps and learning disability units of planning. In future years we will be open to simplifying some of these arrangements. Where geographies are already involved in the Success Regime, or devolution bids, we would expect these to determine the transformation footprint. Although it is important to get this right, there is no single right answer. The footprints may well adapt over time. We want people to focus their energies on the content of plans rather than have lengthy debates about boundaries.

19. We will issue further brief guidance on the STP process in January. This will set out the timetable and early phasing of national products and engagement events that are intended to make it much easier to answer the challenges we have posed, and include how local areas can best involve their local communities in creating their STPs, building on the 'six principles' created to support the delivery of the Five Year Forward View. By spring 2016, we intend to develop and make available roadmaps for national transformation initiatives.

20. We would welcome any early reactions, by Friday 29 January 2016, as to what additional material you would find most helpful in developing your STP. Please email england.fiveyearview@nhs.net, with the subject title 'STP feedback'. We would also like to work with a few local systems to develop exemplar, fast-tracked plans, and would welcome expressions of interest to the above inbox.

National ‘must dos’ for 2016/17

21. Whilst developing long-term plans for 2020/21, the NHS has a clear set of plans and priorities for 2016/17 that reflect the Mandate to the NHS and the next steps on Forward View implementation.

22. Some of our most important jobs for 2016/17 involve partial roll-out rather than full national coverage. Our ambition is that by March 2017, 25 percent of the population will have access to acute hospital services that comply with four priority clinical standards on every day of the week, and 20 percent of the population will have enhanced access to primary care. There are three distinct challenges under the banner of seven day services:

(i) reducing excess deaths by increasing the level of consultant cover and diagnostic services available in hospitals at weekends. During 16/17, a quarter of the country must be offering four of the ten standards, rising to half of the country by 2018 and complete coverage by 2020;

(ii) improving access to out of hours care by achieving better integration and redesign of 111, minor injuries units, urgent care centres and GP out of hours services to enhance the patient offer and flows into hospital; and

(iii) improving access to primary care at weekends and evenings where patients need it by increasing the capacity and resilience of primary care over the next few years.

23. Where relevant, local systems need to reflect this in their 2016/17 Operational Plans, and all areas will need to set out their ambitions for seven day services as part of their STPs.

The nine ‘must dos’ for 2016/17 for every local system:

1. Develop a high quality and agreed **STP**, and subsequently achieve what you determine are your most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the **Forward View**.

2. Return the system to **aggregate financial balance**. This includes secondary care providers delivering efficiency savings through actively engaging with the Lord Carter provider productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement. CCGs will additionally be expected to deliver savings by tackling unwarranted variation in demand through implementing the RightCare programme in every locality.

3. Develop and implement a local plan to address the **sustainability and quality of general practice**, including workforce and workload issues.

4. Get back on track with **access standards for A&E and ambulance waits**, ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots.

5. Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from **referral to treatment**, including offering patient choice.

6. Deliver the NHS Constitution **62 day cancer waiting standard**, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving **one-year survival rates** by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.

7. Achieve and maintain the **two new mental health access standards**: more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral; 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a **dementia diagnosis** rate of at least two-thirds of the estimated number of people with dementia.

8. Deliver actions set out in local plans to transform care for people with **learning disabilities**, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy.

9. Develop and implement an affordable plan to make **improvements in quality** particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of **avoidable mortality** rates by individual trusts.

24. We expect the development of new care models will feature prominently within STPs. In addition to existing approaches, in 2016/17 we are interested in trialing two new specific approaches with local volunteers:
    - secondary mental health providers managing care budgets for tertiary mental health services; and
    - the reinvention of the acute medical model in small district general hospitals.

Organisations interested in working with us on either of these approaches should let us know by 29 January 2016 by emailing england.fiveyearview@nhs.net

Operational Plans for 2016/17

25. An early task for local system leaders is to run a shared and open-book operational planning process for 2016/17. This will cover activity, capacity, finance and 2016/17 deliverables from the emerging STP. By April 2016, commissioner and provider plans for 2016/17 will need to be agreed by NHS England and NHS Improvement, based on local contracts that must be signed by March 2016.

26. The detailed requirements for commissioner and provider plans are set out in the technical guidance that will accompany this document. All plans will need to demonstrate:

    - how they intend to reconcile finance with activity (and where a deficit exists, set out clear plans to return to balance);
    - their planned contribution to the efficiency savings;
    - their plans to deliver the key must-dos;
    - how quality and safety will be maintained and improved for patients;
    - how risks across the local health economy plans have been jointly identified and mitigated through an agreed contingency plan; and
    - how they link with and support with local emerging STPs.

    The 2016/17 Operational Plan should be regarded as year one of the five year STP, and we expect significant progress on transformation through the 2016/17 Operational Plan.

27. Building credible plans for 2016/17 will rely on a clear understanding of demand and capacity, alignment between commissioners and providers, and the skills to plan effectively. A support programme is being developed jointly by national partners to help local health economies in preparing robust activity plans for 2016/17 and beyond.

Allocations

28. NHS England's allocations to commissioners are intended to achieve:

    - greater equity of access through pace of change, both for CCG allocations and on a place-based basis;

    - closer alignment with population need through improved allocation formulae including a new inequalities adjustment for specialised care, more sensitive adjustments for CCGs and primary care, and a new sparsity adjustment for remote areas; and

    - faster progress with our strategic goals through higher funding growth for GP services and mental health, and the introduction of the Sustainability and Transformation Fund.

29. In line with our strategic priorities, overall primary medical care spend will rise by 4-5 percent each year. Specialised services funding will rise by 7 percent in 2016/17, with growth of at least 4.5 percent in each subsequent year. The relatively high level of funding reflects forecast pressures from new NICE legally mandated drugs and treatments.

30. To support long-term planning, NHS England has set firm three year allocations for CCGs, followed by two indicative years. For 2016/17, CCG allocations will rise by an average of 3.4 percent, and we will make good on our commitment that no CCG will be more than 5 percent below its target funding level. To provide CCGs with a total place-based understanding of all commissioned spend, alongside allocations for CCG commissioned activities, we will also publish allocations for primary care and specialized commissioned activity.

    NHS England will in principle support any proposals from groups of CCGs, particularly in areas working towards devolution who wish to implement a more accelerated cross-area pace-of-change policy by mutual agreement.

31. Mirroring the conditionality of providers accessing the Sustainability and Transformation Fund, the real terms element of growth in CCG allocations for 2017/18 onwards will be contingent upon the development and sign off of a robust STP during 2016/17.

Returning the NHS provider sector to balance

32. During 2016/17 the NHS trust and foundation trust sector will, in aggregate, be required to return to financial balance. £1.8 billion of income from the 2016/17 Sustainability and Transformation Fund will replace direct Department of Health (DH) funding. The distribution of this funding will be calculated on a trust by trust basis by NHS Improvement and then agreed with NHS England.

33. NHS England and NHS Improvement are working together to ensure greater alignment between commissioner and provider financial levers. Providers who are eligible for sustainability and transformation funding in 2016/17 will not face a double jeopardy scenario whereby they incur penalties as well as losing access to funding; a single penalty will be imposed.

34. Quarterly release of these Sustainability Funds to trusts and foundation trusts will depend on achieving recovery milestones for (i) deficit reduction; (ii) access standards; and (iii) progress on transformation. The three conditions attached to the transitional NHS provider fund have to be hard-edged. Where trusts default on the conditions access to the fund will be denied and sanctions will be applied.

35. Deficit reduction in providers will require a forensic examination of every pound spent on delivering healthcare and embedding a culture of relentless cost containment. Trusts need to focus on cost reduction not income growth; there needs to be far greater consistency between trusts' financial plans and their workforce plans in 2016/17. Workforce productivity will therefore be a particular priority as just a 1 percent improvement represents £400 million of savings. All providers will be expected to evidence the effective use of e-rostering for nurses, midwives, Health Care Assistants (HCAs) and other clinicians to make sure the right staff are in the right place at the right time to ensure patients get the right hours of care and minimum time is wasted on bureaucracy. This approach will enable providers to reduce their reliance on agency staffing whilst compliance with the agency staffing rules will also reduce the rates paid. In addition, providers will need to adopt tightly controlled procurement practices with compliance incentives and sanctions to drive down price and unwarranted variation. For example, all providers will be expected to report and share data on what they are paying for the top 100 most common non-pay items, and be required to only pay the best price available for the NHS.

36. Capital investments proposed by providers should be consistent with their clinical strategy and clearly demonstrate the delivery of safe, productive services with a business case that describes affordability and value for money. Given the constrained level of capital resource available from 2016/17, there will be very limited levels of financing available and the repayment of existing and new borrowing related to capital investment will need to be funded from within the trust's own internally generated capital resource in all but the most exceptionally pre-agreed cases. Trusts will need to procure capital assets more efficiently, consider alternative methods of securing assets such as managed equipment services, maximize disposals and extend asset lives. In January, the DH will be issuing some revisions to how the PDC dividend will be calculated and a number of other changes to the capital financing regime.

Efficiency assumptions and business rules

37. The consultation on the tariff will propose a 2 percent efficiency deflator and 3.1 percent inflation uplift for 2016/17 (the latter reflecting a step change in pension-related costs). This reflects Monitor and NHS England's assessment of cost inflation including the effect of pension changes. To support system stability, we plan to remain on HRG4 for a further year and there will also be no changes to specialist top- ups in 2016/17; the specialised service risk share is also being suspended for 2016/17. We will work with stakeholders to better understand the impact of the move to HRG4+ and other related changes in 2017/18. For planning purposes, an indicative price list is being made available on the Monitor website. The consultation on the tariff will also include the timetable for implementing new payment approaches for mental health.

38. As notified in Commissioning Intentions 2016/2017 for Prescribed Specialised Services, NHS England is developing a single national purchasing and supply chain arrangement for specialised commissioning high cost tariff excluded devices with effect from April 2016. Transition plans will be put in place prior to this date with each provider to transition from local to national procurement arrangements.

39. The 2 percent efficiency requirement is predicated upon the provider system meeting a forecast deficit of £1.8 billion at the end of 2015/16. Any further deterioration of this position will require the relevant providers to deliver higher efficiency levels to achieve the control totals to be set by NHS Improvement.

40. For 2016/17 the business rules for commissioners will remain similar to those for last year. Commissioners (excluding public health and specialised commissioning) will be required to deliver a cumulative reserve (surplus) of 1 percent. At the very least, commissioners who are unable to meet the cumulative reserve (surplus) requirement must deliver an in-year break-even position. Commissioners with a cumulative deficit will be expected to apply their increase in allocation to improving their bottom line position, other than the amount necessary to fund nationally recognised new policy requirements. Drawdown will be available to commissioners in line with the process for the previous financial year. CCGs should plan to drawdown all cumulative surpluses in excess of 1 percent over the next three years, enabling drawdown to become a more fluid mechanism for managing financial pressures across the year-end boundary.

41. Commissioners are required to plan to spend 1 percent of their allocations non-recurrently, consistent with previous years. In order to provide funds to insulate the health economy from financial risks, the 1 percent non-recurrent expenditure should be uncommitted at the start of the year, to enable progressive release in agreement with NHS England as evidence emerges of risks not arising or being effectively mitigated through other means. Commissioners will also be required to hold an additional contingency of 0.5 percent, again consistent with previous years.

42. CCGs and councils will need to agree a joint plan to deliver the requirements of the Better Care Fund (BCF) in 2016/17. The plan should build on the 2015/16 BCF plan, taking account of what has worked well in meeting the objectives of the fund, and what has not. CCGs will be advised of the minimum amount that they are required to pool as part of the notification of their wider allocation. BCF funding should explicitly support reductions in unplanned admissions and hospital delayed transfers of care; further guidance on the BCF will be forthcoming in the New Year.

43. Commissioners must continue to increase investment in mental health services each year at a level which at least matches their overall expenditure increase. Where CCGs collaborate with specialised commissioning to improve service efficiency, they will be eligible for a share of the benefits.

44. NHS England and NHS Improvement continue to be open to new approaches to contracting and business rules, as part of these agreements. For example, we are willing to explore applying a single financial control total across local commissioners and providers with a few local systems.

Measuring progress

45. We will measure progress through a new CCG Assessment Framework. NHS England will consult on this in January 2016, and it will be aligned with this planning guidance. The framework is referred in the Mandate as a CCG scorecard. It is our new version of the CCG assurance framework, and it will apply from 2016/17. Its relevance reaches beyond CCGs, because it's about how local health and care systems and communities can assess their own progress.

Timetable

Timetable	Date
Publish planning guidance	22 December 2015
Publish 2016/17 indicative prices	By 22 December 2015
Issue commissioner allocations, and technical annexes to planning guidance	Early January 2016
Launch consultation on standard contract, announce CQUIN and Quality Premium	January 2016
Issue further process guidance on STPs	January 2016
Localities to submit proposals for STP footprints and volunteers for mental health and small DGHs trials	By 29 January 2016
First submission of full draft 16/17 Operational Plans	8 February 2016
National Tariff S118 consultation	January/February 2016
Publish National Tariff	March 2016
Boards of providers and commissioners approve budgets and final plans	By 31 March 2016
National deadline for signing of contracts	31 March 2016
Submission of final 16/17 Operational Plans, aligned with contracts	11 April 2016
Submission of full STPs	End June 2016
Assessment and Review of STPs	End July 2016

Please note that we will announce the timetable for consultation and issuing of the standard contract separately. A more detailed timetable and milestones is included in the technical guidance that will accompany this document.

Annex 1: Indicative 'national challenges' for STPs

STPs are about the holistic pursuit of the triple aim – better health, transformed quality of care delivery, and sustainable finances. They also need to set out how local systems will play their part in delivering the Mandate (annex 2).

We will publish further guidance early in 2016 to help areas construct the strongest possible process and plan.

We will also make available aids (e.g. exemplar plans) and some hands-on support for areas as they develop their plans.

The questions below give an early sense of what you will need to address to gain sign-off and attract additional national investment.

We are asking local systems first to focus on creating an overall local vision, and the three overarching questions – rather than attempting to answer all of the specifics right from the start. We will be developing a process to offer feedback on these first, prior to development of the first draft of the detailed plans.

A. How will you close the health and wellbeing gap?

This section should include your plans for a 'radical upgrade' in prevention, patient activation, choice and control, and community engagement.

Questions your plan should answer:

1. How will you assess and address your most important and highest cost preventable causes of ill health, to reduce healthcare demand and tackle health inequalities working closely with local government?

    - How rapidly could you achieve full local implementation of the national Diabetes Prevention Programme? Why should Public Health England (PHE) and NHS England prioritise your geographical area (e.g. with national funding to support the programme)?

    - What action will you take to address obesity, including childhood obesity?

    - How will you achieve a step-change in patient activation and self-care? How will this help you moderate demand and achieve financial balance? How will you embed the six principles of engagement and involvement of local patients, carers, and communities developed to help deliver the Five Year Forward View?

2. How will you make real the aspiration to design person-centred coordinated care, including plans to ensure patients have access to named, accountable consultants?

3. How will a major expansion of integrated personal health budgets and implementation of choice – particularly in maternity, end-of-life and elective care – be an integral part of your programme to hand power to patients?

4. How are NHS and other employers in your area going to improve the health of their own workforce – for example by participating in the national roll out the Healthy NHS programme?

B. How will you drive transformation to close the care and quality gap?

This section should include plans for new care model development, improving against clinical priorities, and rollout of digital healthcare.

Questions your plan should answer:

1 What is your plan for sustainable general practice and wider primary care? How will you improve primary care infrastructure, supported in part through access to national primary care transformation funding?

2. How rapidly can you implement enhanced access to primary care in evenings and weekends and using technology? Why should NHS England prioritise your area for additional funding?

3. What are your plans to adopt new models of out-of-hospital care, e.g Multi-specialty Community Providers (MCPs) or Primary and Acute Care Systems (PACS)? Why should NHS England prioritise your area for transformation funding? And when are you planning to adopt forthcoming best practice from the enhanced health in care homes vanguards?

4. How will you adopt new models of acute care collaboration (accountable clinical networks, specialty franchises, and Foundation Groups)? How will you work with organisations outside your area and learn from best practice from abroad, other sectors and industry?

5. What is your plan for transforming urgent and emergency care in your area? How will you simplify the current confusing array of entry points? What's your agreed recovery plan to achieve and maintain A&E and ambulance access standards?

6. What's your plan to maintain the elective care referral to treatment standard? Are you buying sufficient activity, tackling unwarranted variation in demand, proactively offering patient choice of alternatives, and increasing provider productivity?

7. How will you deliver a transformation in cancer prevention, diagnosis, treatment and aftercare in line with the cancer taskforce report?

8. How will you improve mental health services, in line with the forthcoming mental health taskforce report, to ensure measureable progress towards parity of esteem for mental health?

9. What steps will your local area take to improve dementia services?

10. As part of the Transforming Care programme, how will your area ensure that people with learning disabilities are, wherever possible, supported at home rather than in hospital? How far are you closing out-moded inpatient beds and reinvesting in continuing learning disability support

11. How fast are you aspiring to improve the quality of care and safety in your organisations as judged by the Care Quality Commission (CQC)? What is your trajectory for no NHS trust and no GP practice to have an overall inadequate rating from the Care Quality Commission (CQC)?

12. What are you doing to embed an open, learning and safety culture locally that is ambitious enough? What steps are you taking to improving reporting, investigations and supporting patients, their families and carers, as well as staff who have been involved in an incident?

13. What plans do you have in place to reduce antimicrobial resistance and ensure responsible prescribing of antibiotics in all care settings? How are you supporting prescribers to enable them issue the right drugs responsibly? At the same time, how rapidly will you achieve full implementation of good practice in reducing avoidable mortality from sepsis?

14. How will you achieve by 2020 the full-roll out of seven day services for the four priority clinical standards?

15. How will you implement the forthcoming national maternity review, including progress towards new national ambitions for improving safety and increased personalisation and choice?

16. How will you put your Children and Young People Mental Health Plan into practice?

17. How quickly will you implement your local digital roadmap, taking the steps needed to deliver a fully interoperable health and care system by 2020 that is paper-free at the point of care? How will you make sure that every patient has access to digital health records that they can share with their families, carers and clinical teams? How will you increase your online offer to patients beyond repeat prescriptions and GP appointments?

18. What is your plan to develop, retrain and retain a workforce with the right skills, values and behaviours in sufficient numbers and in the right locations to deliver your vision for transformed care? How will you build the multidisciplinary teams to underpin new models of care? How ambitious are your plans to implement new workforce roles such as associate nurses, physician associates, community paramedics and pharmacists in general practice?

19. What is your plan to improve commissioning? How rapidly will the CCGs in your system move to place-based commissioning? If you are a devolution area, how will implementation delivery real improvements for patients?

20. How will your system be at the forefront of science, research and innovation? How are you implementing combinatorial innovation, learning from the forthcoming test bed programme? How will services changes over the next five years embrace breakthroughs in genomics, precision medicine and diagnostics?

C. How will you close the finance and efficiency gap?

This section should describe how you will achieve financial balance across your local health system and improve the efficiency of NHS services.

Questions your plan should answer:

1. How will you deliver the necessary per annum efficiency across the total NHS funding base in your local area by 2020/21?

2. What is your comprehensive and credible plan to moderate demand growth? What are the respective contributions in your local system of: (i) tackling unwarranted variation in care utilisation, e.g. through RightCare; (ii) patient activation and self-care; (iii) new models of care; and (iv) urgent and emergency care reform implementation?

3. How will you reduce costs (as opposed to growing income) and how will you get the most out of your existing workforce? What savings will you make from financial controls on agency, whilst ensuring appropriate staffing levels? What are your plans for improving workforce productivity, e.g. through e-rostering of nurses and HCAs? How are you planning to reduce cost through better purchasing and medicines management? What efficiency improvements are you planning to make across primary care and specialised care delivery?

4. What capital investments do you plan to unlock additional efficiency? How will they be affordable and how will they be financed?

5. What actions will you take as a system to utilise NHS estate better, disposing of unneeded assets or monetising those that could create longer-term income streams? How does this local system estates plan support the plans you're taking to redesign care models in your area?

Annex 2: The Government's mandate to NHS England 2016/17

The table below shows NHS England's objectives with an overall measurable goal for this Parliament and clear priority deliverables for 2016-17. The majority of these goals will be achieved in partnership with the Department of Health (DH), NHS Improvement and other health bodies such as Public Health England (PHE), Health Education England (HEE) and the Care Quality Commission (CQC). It also sets out requirements for NHS England to comply with in paragraph 6.2.

Read the full Mandate to NHS England

1. Through better commissioning, improve local and national health outcomes, particularly by addressing poor outcomes and inequalities.	
1.1 CCG performance	**Overall 2020 goals:** • Consistent improvement in performance of CCGs against new CCG assessment framework.
	2016-17 deliverables: • By June, publish results of the CCG assessment framework for 2015-16, which provides CCGs with an aggregated Ofsted style assessment of performance and allows them to benchmark against other CCGs and informs whether NHS England intervention is needed. • Ensure new Ofsted-style CCG framework for 2016-17 includes health economy metrics to measure progress on priorities set out in the mandate and the NHS planning guidance including overall Ofsted-style assessment for each of cancer, dementia, maternity, mental health, learning disabilities and diabetes, as well as metrics on efficiency, core performance, technology and prevention. • By the end of Q1 of 2016-17, publish the first overall assessment for each of the six clinical areas above.

2. To help create the safest, highest quality health and care service.	
2.1 Avoidable deaths and seven-day services	**Overall 2020 goals:** • Roll out of seven-day services in hospital to 100 percent of the population (four priority clinical standards in all relevant specialities, with progress also made on the other six standards), so that patients receive the same standards of care, seven days a week. • Achieve a significant reduction in avoidable deaths, with all trusts to have seen measurable reduction from their baseline on the basis of annual measurements. • Support NHS Improvement to significantly increase the number of trusts rated outstanding or good, including significantly reducing the length of time trusts remain in special measures. • Measurable progress towards reducing the rate of stillbirths, neonatal and maternal deaths and brain injuries that are caused during or soon after birth by 50 percent by 2030 with a measurable reduction by 2020. • Support the NHS to be the world's largest learning organisation with a new culture of learning from clinical mistakes, including improving the number of staff who feel their organisation acts on concerns raised by clinical staff or patients. • Measurable improvement in antimicrobial prescribing and resistance rates.
	2016-17 deliverables: • Publish avoidable deaths per trust annually and support NHS Improvement to help trusts to implement programme to improve from March 2016 baseline. • Rollout of four clinical priority standards in all relevant specialties to 25 percent of population. • Implement agreed recommendations of the National Maternity Review in relation to safety, and support progress on delivering Sign up to Safety. • Support the Government's goal to establish global and UK baseline and ambition for antimicrobial prescribing and resistance rates.

2.2 Patient experience	**Overall 2020 goals**: • Maintain and increase the number of people recommending services in the Friends and Family Test (FFT) (currently 88-96 percent), and ensure its effectiveness, alongside other sources of feedback to improve services. • 50-100,000 people to have a personal health budget or integrated personal budget (up from current estimate of 4,000). • Significantly improve patient choice, including in maternity, end-of-life care and for people with long-term conditions, including ensuring an increase in the number of people able to die in the place of their choice, including at home.
	2016-17 deliverables: • Produce a plan with specific milestones for improving patient choice by 2020, particularly in maternity, end-of-life care (including to ensure more people are able to achieve their preferred place of care and death), and personal health budgets. • Building on the FFT, develop proposals about how feedback, particularly in maternity services, could be enhanced to drive improvements to services at clinical and ward levels.
2.3 Cancer	**Overall 2020 goals:** • Deliver recommendations of the Independent Cancer Taskforce, including: o significantly improving one-year survival to achieve 75 percent by 2020 for all cancers combined (up from 69 percent currently); and o patients given definitive cancer diagnosis, or all clear, within 28 days of being referred by a GP.
	2016-17 deliverables: • Achieve 62-day cancer waiting time standard. • Support NHS Improvement to achieve measurable progress towards the national diagnostic standard of patients waiting no more than six weeks from referral to test. • Agree trajectory for increases in diagnostic capacity required to 2020 and achieve it for year one. • Invest £340 million in providing cancer treatments not routinely provided on the NHS through the Cancer Drugs Fund, and ensure effective transition to the agreed operating model to improve its effectiveness within its existing budget.

3. To balance the NHS budget and improve efficiency and productivity	
3.1 Balancing the NHS budget	**Overall 2020 goals**: • With NHS Improvement, ensure the NHS balances its budget in each financial year. • With the Department of Health and NHS Improvement, achieve year on year improvements in NHS efficiency and productivity (2-3 percent each year), including from reducing growth in activity and maximising cost recovery.
	2016-17 deliverables: • With NHS Improvement ensure the NHS balances its budget, with commissioners and providers living within their budgets, and support NHS Improvement in: o securing £1.3 billion of efficiency savings through implementing Lord Carter's recommendations and collaborating with local authorities on Continuing Healthcare spending; o delivering year one of trust deficit reduction plans and ensuring a balanced financial position across the trust sector, supported by effective deployment of the Sustainability and Transformation Fund; and o reducing spend on agency staff by at least £0.8 billion on a path to further reductions over the Parliament. • Roll-out of second cohort of RightCare methodology to a further 60 CCGs. • Measurable improvement in primary care productivity, including through supporting community pharmacy reform. • Work with CCGs to support Government's goal to increase NHS cost recovery up to £500 million by 2017-18 from overseas patients. • Ensure CCGs' local estates strategies support the overall goal of releasing £2 billion and land for 26,000 homes by 2020.

4. To lead a step change in the NHS in preventing ill health and supporting people to live healthier lives.	
4.1 Obesity and diabetes	**Overall 2020 goals:** • Measurable reduction in child obesity as part of the Government's childhood obesity strategy. • 100,000 people supported to reduce their risk of diabetes through the Diabetes Prevention Programme. • Measurable reduction in variation in management and care for people with diabetes.
	2016-17 deliverables: • Contribute to the agreed child obesity implementation plan, including wider action to achieve year on year improvement trajectory for the percentage of children who are overweight or obese. • 10,000 people referred to the Diabetes Prevention Programme.
4.2 Dementia	**Overall 2020 goals:** • Measurable improvement on all areas of Prime Minister's challenge on dementia 2020, including: o maintain a diagnosis rate of at least two thirds; o increase the numbers of people receiving a dementia diagnosis within six weeks of a GP referral; and o improve quality of post-diagnosis treatment and support for people with dementia and their carers.
	2016-17 deliverables: • Maintain a minimum of two thirds diagnosis rates for people with dementia. • Work with National Institute for Health Research on location of Dementia Institute. • Agree an affordable implementation plan for the Prime Minister's challenge on dementia 2020, including to improve the quality of post-diagnosis treatment and support.

5. To maintain and improve performance against core standards	
5.1 A&E, ambulances and Referral to Treatment (RTT)	**Overall 2020 goals:** • 95 percent of people attending A&E seen within four hours; Urgent and Emergency Care Networks rolled out to 100 percent of the population. • 75 percent of Category A ambulance calls responded to within 8 minutes. • 92 percent receive first treatment within 18 weeks of referral; no-one waits more than 52 weeks.
	2016-17 deliverables: • With NHS Improvement, agree improvement trajectory and deliver the plan for year one for A&E. • Implement Urgent and Emergency Care Networks in 20 percent of the country designated as transformation areas, including clear steps towards a single point of contact. • With NHS Improvement, agree improvement trajectory and deliver the plan for year one for ambulance responses; complete Red 2 pilots and decide on full roll-out. • With NHS Improvement, meet the 18-week referral-to-treatment standard, including implementing patient choice in line with the NHS Constitution; and reduce unwarranted variation between CCG referral rates to better manage demand.
6. To improve out-of-hospital care.	
6.1 New models of care and general practice	**Overall 2020 goals:** • 100 percent of population has access to weekend/evening routine GP appointments. • Measurable reduction in age standardised emergency admission rates and emergency inpatient bed-day rates; more significant reductions through the New Care Model programme covering at least 50 percent of population. • Significant measurable progress in health and social care integration, urgent and emergency care (including ensuring a single point of contact), and electronic health record sharing, in areas covered by the New Care Model programme. • 5,000 extra doctors in general practice.

	2016-17 deliverables: • New models of care covering the 20 percent of the population designated as being in a transformation area to: o provide access to enhanced GP services, including evening and weekend access and same-day GP appointments for all over 75s who need them; and o make progress on integration of health and social care, integrated urgent and emergency care, and electronic record sharing. • Publish practice-level metrics on quality of and access to GP services and, with the Health and Social Care Information Centre, provide GPs with benchmarking information for named patient lists. • Develop new voluntary contract for GPs (Multidisciplinary Community Provider contract) ready for implementation in 2017-18.
6.2 Health and social care integration	**Overall 2020 goals:** • Achieve better integration of health and social care in every area of the country, with significant improvements in performance against integration metrics within the new CCG assessment framework. Areas will graduate from the Better Care Fund programme management once they can demonstrate they have moved beyond its requirements, meeting the government's key criteria for devolution. • Ensure the NHS plays its part in significantly reducing delayed transfers of care, including through developing and applying new incentives.
	2016-17 deliverables: • Implement the Better Care Fund (BCF) in line with the BCF Policy Framework for 2016-17. • Every area to have an agreed plan by March 2017 for better integrating health and social care. • Working with partners, achieve accelerated implementation of health and social care integration in the 20 percent of the country designated as transformation areas, by sharing electronic health records and making measurable progress towards integrated assessment and provision. • Work with the Department of Health, other national partners and local areas to agree and support implementation of local devolution deals. • Agree a system-wide plan for reducing delayed transfers of care with overall goal and trajectory for improvement, and with local government and NHS partners implement year one of this plan.

	2016-17 requirements: • NHS England is required to: o ring-fence £3.519 billion within its allocation to CCGs to establish the Better Care Fund, to be used for the purposes of integrated care; o consult the Department of Health and the Department for Communities and Local Government before approving spending plans drawn up by each local area; and o consult the Department of Health and the Department for Communities and Local Government before exercising its powers in relation to failure to meet specified conditions attached to the Better Care Fund as set out in the BCF Policy Framework.
6.3 Mental health, learning disabilities and autism	**Overall 2020 goal:** • To close the health gap between people with mental health problems, learning disabilities and autism and the population as a whole (defined ambitions to be agreed based on report by Mental Health Taskforce). • Access and waiting time standards for mental health services embedded, including: o 50 percent of people experiencing first episode of psychosis to access treatment within two weeks; and o 75 percent of people with relevant conditions to access talking therapies in six weeks; 95 percent in 18 weeks.
	2016-17 deliverables: • 50 percent of people experiencing first episode of psychosis to access treatment within two weeks. • 75 percent of people with relevant conditions to access talking therapies in six weeks; 95 percent in 18 weeks. • Increase in people with learning disabilities/autism being cared for by community not inpatient services, including implementing the 2016-17 actions for Transforming Care. • Agree and implement a plan to improve crisis care for all ages, including investing in places of safety. • Oversee the implementation of locally led transformation plans for children and young people's mental health, which improve prevention and early intervention activity, and be on track to deliver national coverage of the children and young people's Improving Access to Psychological Therapies (IAPT) programme by 2018. • Implement agreed actions from the Mental Health Taskforce.

7. To support research, innovation and growth.	
7.1 Research and growth	**Overall 2020 goals:** • Support the Department of Health and the Health Research Authority in their ambition to improve the UK's international ranking for health research. • Implement research proposals and initiatives in the NHS England research plan. • Measurable improvement in NHS uptake of affordable and cost-effective new innovations. • To assure and monitor NHS Genomic Medicine Centre performance to deliver the 100,000 genomes commitment.
	2016-17 deliverables: • Implement the agreed recommendations of the Accelerated Access Review including developing ambition and trajectory on NHS uptake of affordable and cost-effective new innovations.
7.2 Technology	**Overall 2020 goals:** • Support delivery of the National Information Board Framework 'Personalised Health and Care 2020' including local digital roadmaps, leading to measurable improvement on the new digital maturity index and achievement of an NHS which is paper-free at the point of care. • 95 percent of GP patients to be offered e-consultation and other digital services; and 95 percent of tests to be digitally transferred between organisations.
	2016-17 deliverables: • Minimum of 10 percent of patients actively accessing primary care services online or through apps, and set trajectory and plan for achieving a significant increase by 2020. • Ensure high quality appointment booking app with access to full medical record and agreed data sharing opt-out available from April 2016. • Robust data security standards in place and being enforced for patient confidential data. • Make progress in delivering new consent-based data services to enable effective data sharing for commissioning and other purposes for the benefit of health and care. • Significant increase in patient access to and use of the electronic health record.

7.3 Health and work	**Overall 2020 goal:** • Contribute to reducing the disability employment gap. • Contribute to the Government's goal of increasing the use of Fit for Work.
	2016-17 deliverables: • Continue to deliver and evaluate NHS England's plan to improve the health and wellbeing of the NHS workforce. • Work with Government to develop proposals to expand and trial promising interventions to support people with long-term health conditions and disabilities back into employment.

#FutureNHS

London Borough of Hammersmith & Fulham **HEALTH & WELLBEING BOARD** **9th February 2016**	
FLU VACCINATION: UPDATE	
Open Report	
Classification - For Information **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: Liz Bruce, Executive Director Adult Social Care and Health.	
Report Author: Sarah Wallace, Public Health Registrar and Sophie Ruiz, Hammersmith and Fulham CCG	**Contact Details:** Tel: 02076411256 E-mail: swallace@wesminster.gov.uk

1. EXECUTIVE SUMMARY

1.1. Hammersmith and Fulham systems immunisations group has been meeting throughout the flu season. Membership includes Local Authority Public Health, Hammersmith and Fulham CCG, Children's Services, NHS England and CNWL.

1.2. The latest nationally published data available is for December 2015. Across London uptake of flu immunisations has dropped in all groups. Hammersmith and Fulham has shown an improvement in uptake among pregnant women, and 3 year olds. The decrease in over 65s and under 65 at-risk groups has been in the context of a London-wide drop.

1.3. While the detailed activities of this flu season was described to the board in a November paper, further community engagement, a flu pilot and three flu sessions hosted by three practices offering extended hours access to all registered patients have been undertaken following this.

2. INTRODUCTION AND BACKGROUND

2.1. Uptake of flu immunisations in Hammersmith and Fulham has been low in previous flu seasons. This year a systems immunisations group has been

convened which brings together the Local Authority, Hammersmith and Fulham CCG and NHS England. This group aims to look at been working to establish reasons and solutions to the poor uptake of flu immunisations in Hammersmith and Fulham, with a particular focus on the 2, 3 and 4 age group.

2.2. A full report of the activities around the flu vaccination was submitted to both the Hammersmith and Fulham Health and Wellbeing Board and the Policy and Accountability Committee. The purpose of this report is to provide an update on the latest published flu data, and some notes on the activities of the group since the last paper. A full lessons report on lessons learned and plan for next flu season is planned for March 2016, once the final data is available from Public Health England.

3. DATA

Data is published monthly. The latest nationally published data available is for December 2015. Overall, in London there has been a drop in every area. However, Hammersmith and Fulham had shown increased uptake in pregnant women and in 3 year olds, and a much lower drop in 2 and 4 year olds. This may reflect the focus of the systems group which has been on 2, 3 and 4 year olds.

	2 years	**3 years**	**4 years**
LBHF Sept-Dec 2014[1]	25.1%	22.0%	18.9%
LBHF Sept-Dec 2015[2]	**24.0%**	**25.1%**	**18.6%**
% Change	-1.1%	+3.1%	-0.3%
London Sept-Dec 2014[1]	28.4%	30.8%	22.1%
London Sept-Dec 2015[2]	24.6%	26.8%	20.5%
% Change	-3.8%	-4.0%	-1.6%

	Over 65s	**Under 65 'At Risk'**	**Pregnant Women**
LBHF Sept-Dec 2014[1]	59.2%	36.9%	30.5%
LBHF Sept-Dec 2015[2]	**56.2%**	**31.8%**	**32.2%**
% Change	-3.0%	-5.1%	+1.7%
London Sept-Dec 2014[1]	66.9%	46.6%	38.3
London Sept-Dec 2015[2]	64.6	41.9	37.2
% Change	-2.3%	-4.7%	-1.1%

Final data for the flu season will not be published until March 2016.

4. ACTIVITY UPDATE

The previous report to the Hammersmith and Fulham Health and Wellbeing Board provides a comprehensive list of activities. Below are updates of some actions taken since the last HWBB.

4.1. Flu Pilot in Children's Centres

Public Health, CCG, NHSE and Children's Services worked together to deliver a flu pilot based in 2 Children's centres in the borough. The pilot was delivered by Vanessa Andreae in four clinics across two Hammersmith and Fulham Children's Centres (Melcombe and Randolf Beresford). 71 children in total were immunised. Promotional activity prior to this (of both the flu vaccine and the pilot), including flyering nurseries, pharmacies and GP surgeries, asking GP surgeries to text patients, distribution by the children's centres and early help teams working in the area were asked to promote the flu vaccine. However the vast majority of immunisations were still opportunistic of children who attended the onsite nursery.

4.2. GP session uptake

There are three practices in the borough that have been commissioned to provide extended hours services to all H&F registered patients. The commissioned service includes a requirement to immunise eligible patients for flu. In order to maximise uptake across all eligible age groups, each of the three hubs hosted a three hour flu immunisation clinic on a Saturday morning (31st October, 28th November, 19th December and 30th January). A total of 217 flu immunisations have been administered to patients at 'weekend plus' hubs this season. Details publicising the January session was issued to all Children's Centres with a view of further maximising uptake amongst the 2-4 year olds.

4.3. Community Engagement Activities

A flu question and answer session was offered to local residents, community champions and local voluntary sector organisation, it aimed to particularly look at questions related to the porcine gelatine content of the children's flu nasal spray. It took place in Parkview Surgery, adjacent to the White City Estate. There was poor attendance at this event, however this is something that could be considered next season in an alternative location. Some information was gained around potential strategies for engaging the Muslim population in discussion around the children's flu immunisation in future seasons.

There was CCG representation at the carers' network event and flu vaccinations were delivered at this event. In addition Public Health have attended Age UK and housing fora to promote the flu immunisation directly to residents.

4.4. School Immunisations

Local Authority Public Health and Children's services have worked with CNWL, the provider of the school vaccinations service to engage schools in the flu immunisation programme, and those schools which had not engaged were contacted by both CNWL and the local authority to encourage them to agree to a session.

5. CONCLUSION AND FUTURE PLANS

5.1. The immunisation campaign will continue during February until the end of the vaccine availability. Final uptake data for the 2015/16 season will be published in March 2016.

5.2. The systems immunisation group's working has evolved and improved throughout the season. The group will continue to meet and a 'wash-up' session is planned for March, following this years' flu season. Learning from this season has led to a timetable for the flu season 2016/17 already being put in place; the first meeting is planned for June 2016, to begin activities for next year's flu season.

5.3. While improvements have been small, this is against a background of a drop in uptake in every eligible group across London. It is hoped that this year's work will be built on next year and Hammersmith and Fulham will see continued improvement in uptake of flu immunisation across all groups.

5.4. Many of the actions taken to promote the flu vaccine are also applicable to other immunisations. The group plans to ensure that best practice and the learning from the flu campaign, is expanded to include all immunisations. This will be discussed in further detail in May's systems group.

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
	None.		

LIST OF REFERENCES:

1. Public Health England. Seasonal influenza vaccine uptake amongst GP Patients in England Provisional monthly data for 1 September 2014 to 31 December 2014 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/398712/2903322_SeasonalFlu_GPDec14_acc.pdf (Accessed 27/1/2016)
2. Public Health England. Seasonal influenza vaccine uptake amongst GP Patients in England Provisional monthly data for 1 September 2015 to 31 December 2015 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/495088/December_2015_Seasonal_flu_GP_patients_01Sept_31Dec.pdf (Accessed 28/1/2016).

Joint Strategic Needs Assessment (JSNA) Steering Group

26th January 2016 2.00-4.00pm

Committee Room 3, 2nd floor Hammersmith Town Hall, King Street

Notes

In attendance	
Danielle Valdes (DV) (chair)	Head of Planning of Governance, CLCCG
Angela McCall (AM) (minutes)	Business Support Officer, Public Health
Aliya Rajah (AR)	Healthwatch CWL
Harley Collins (HC)	HWB Manager (Shared Services)
Jessica Nyman (JN)	JSNA Manager, Public Health
Colin Brodie (CB)	Public Health Knowledge Manager
Jackie Rosenberg (JR)	CEO, One Westminster
Shelley Prince (SP)	Public Health Performance Manager
Angelica Silversides (AS)	Healthwatch K&C
Angela Spence (ASp)	Kensington and Chelsea Social Council
Samar Pankanti (SP)	Public Health Project Manager, CLCCG
Shad Haliban (SH)	Head of Organisational Development, Sobus
Rachel Krausz	Strategic Delivery Manager, WLCCG
Rebecca McKie (RM) (observing)	Public Health Officer
Apologies: Stuart Lines, Eva Hrobonova, Meenara Islam, Kerry Doyle	

Item	Action
1. Minutes of last meeting and matters arising	Minutes agreed as accurate. The following are outstanding: ❖ **CB to follow up with PB on the NWL Children's Mental Health work.** ❖ **End of Life Care Service Mapping: Bridget is thinking of having a service directory as a live piece of work so that it can be updated regularly, so CB encouraged the group to send any updates.** ❖ **JSNA Review: JN asked the group to come forward for an interview if they haven't already done so.**

	❖ **WCC H&WB Strategy: MR to discuss with Liz Bruce, including the governance processes and 3 H&WBBs. There also needs to be a discussion in each of the H&WBBs – MR will bring this up under AOB, if they have thought about reviewing strategies in light of the upcoming reforms. As MR has been on holiday, this is an ongoing action and will be tied in with the JSNA review.** ❖ **JN to circulate K&C Social Council's Research report on private renting in RBKC.**
2. Updates from current JSNAs	**End of Life Care JSNA** In draft format and being taken to H&WBBs. Signed off at RBKC, but not at WCC yet where Board members want 2 more weeks to give responses and feedback for 3rd February. Publication date will still hopefully be 10th Feb. CB is working with the LBHF H&WBB committee coordinator for virtual sign off for the same publication date as there was not space for it on the February agenda. **Childhood Obesity** In draft format and being taken to H&WBBs for sign off, so far approved by K&C and WCC. ❖ **JN is working on a Comms and dissemination plan for End of Life Care and Childhood Obesity, and asked for any ideas to be submitted to her by the group.** ❖ **JN to discuss with Steve Buckerfield communications opportunities through Children's Services and also look into the School Nursing website.** **Health and Disability related Housing JSNA** A workshop took place on November the 30th for Housing, Housing Providers and Adult Social Care staff. JN ran a workshop this morning with K&C Social Council's Community and Voluntary Sector Forum for their perspective, and will do the same in Westminster. Lines of enquiry include people with multiple needs; accessibility of stock; needs of carers and JN hopes to finish a draft report around the end of March. **Students and Young Adults** Data gathering is underway to develop the key levels of enquiry. JN is looking at building a wider stakeholder reference group, and asked the group of any forums and individuals to engage with for primary qualitative research.

	JR suggested 18-25 year olds are historically underfunded and JN could get in touch with drug and alcohol centres who are involved in these groups, as well as Working With Men who work specifically in this age group. Sally Metha is the chief contact. **JN to contact** Children's and Employment Commissioners to pass on her details to providers, NWL Mental Health Project and Westminster Society for People with Learning Disabilities. **Online JSNA Highlight Report** A temp agency staff member has been recruited to cover the lead analyst's post. Work is needed around the narrative and context to deal with changes that will come up over the next couple of years. This will come back to JSNA Steering Group for input for feedback and views on other issues in the March meeting, with a beta version to be tested and the information to be addressed. Key Commissioners would need to be linked in on what they would like to do with the tool and more people could be brought in as part of this process. It was agreed that this would be good first group to look at the tool, and it can then be taken to other groups. **Risks & Issues** ❖ Delay in recruiting backfill for lead analyst's post may delay delivery.
3. JSNA Review – workshop / discussion, presentation of findings to date	❖ **JN asked people to complete the online survey for the JSNA Steering Group and forward the link to the wider stakeholder survey to colleagues.** ❖ As part of this process, interviews have been taking place with the DPH, CCG staff, past project leads, the Adult's Director of Commissioning, Cabinet Members and 3rd Sector leaders. **JN asked for further volunteers for interviews.** The group split in to 2 teams and discussed the following: Q1: Who are the key stakeholders for the JSNA, and how can we all engage with them better? It depends on the subject of the JSNA, but could be **anyone** including Commissioners; Providers; Resident's Forums; CVSOs; GPs; Police; Transport. Being clear from the beginning on the reasons for the JSNA would better engage

	people in the process. Better scoping, maintaining and developing relationships, and understanding the benefits of the JSNA. The new online JSNA will be a good way of engaging people better. Additionally, the use of case studies to explain how JSNAs can be used and what impact they can have would be a powerful way of increasing engagement. <u>Q2: What is the role of the JSNA Steering Group members, in and outside of meetings?</u> In meetings: quality check and assurance of JSNAs; monitoring work programme; feeding in information from member's services; making links between the JSNA work and other relevant projects; informing the JSNA team on priority areas emerging from their services. Outside of meetings: JSNA evangelism, feeding back and communicating meetings; feeds into commissioning, quality and strategy; evidence base to inform policy and procedures; informs commissioning and availability for providers; reminding member's organisations to use JSNAs to inform their decision making; keeping their organisations informed of the JSNA work programme. <u>Q3: Does the JSNA align with or support your own organisation's strategic priorities?</u> In an ideal system, the JSNA should inform the Joint Health and Wellbeing Strategy, which should then inform commissioning across health and social care. However in practice, timing is key. More work needs to be done to tie looking into the JSNA into commissioning processes to better align strategic priorities. From the VSO point of view, yes as it is a useful easy way of obtaining information, such as for completing funding applications and of gaining a better understanding of what is happening in the borough. For Healthwatch, the JSNA helps shape the priorities for the next year. Aligning new services, re-commissioning can be informed by the JSNA, and general CCG aims come from the bigger JSNAs. The JNSA application process could be more democratic, as currently only those in the know are aware of how to start a deep dive JSNA off.
4. Sobus	Sobus presented on their key work and current projects, and how this links with

presentation: the CVS and JSNAs	JSNAs. Some key points were: • SH's team are undertaking a big project to map existing networks and forums in Hammersmith &Fulham. This information could be useful for JSNA engagement. • Community engagement organisers have been knocking on residents' doors and have identified a number of issues of concern. • All partners are being engaged with to help develop a neighbourhood plan for the large regeneration areas in Hammersmith & Fulham. SH would like more engagement with developers. • JSNA needs to use accessible language to engage the third sector, and they could be more relevant if views of CVSO are included as LA funding is being cut and the same standard of service for less investment is requested. • Changing the mind-set of how CVSO's and LAs work together. • SOBUS engages with the other CVSO's. ASp, SH and JR to work closely together with the voluntary sector across the three boroughs. • JR suggested a JSNA into the necessity of CVOs.
5. AOB	❖ JN encouraged all to sign up to the **JSNA Newsletter here**, and forward to the link to interested colleagues. ❖ CB encouraged everyone to complete the **survey for the JSNA Steering Group and forward the link to the wider stakeholder survey to colleagues.**
Date and time of next meeting: Tuesday 29th March, Hammersmith Town Hall, 2nd floor, Committee Room 3	