London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Agenda

Monday 20 June 2016
6.00pm
Committee Room 2 - Hammersmith Town Hall

MEMBERSHIP

Vanessa Andreae - H&F Clinical Commissioning Group
Liz Bruce - Shared Services Executive Director of Adult Social Care
Andrew Christie – Shared Services Executive Director of Children's Services
Janet Cree - H&F Clinical Commissioning Group
Councillor Vivienne Lukey - Cabinet Member for Health and Adult Social Care (Chair)
Councillor Sue Macmillan - Cabinet Member for Children and Education
Keith Mallinson - Healthwatch Representative
Mike Robinson - Shared Services Director of Public Health
Dr Tim Spicer - H&F Clinical Commissioning Group (Vice-Chair)

Ian Lawry – SOBUS (Co-opted Member)

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Date Issued: 10 June 2016

London Borough of Hammersmith & Fulham

Health & Wellbeing Board
Agenda

20 June 2016

Item **Pages**

1. APPOINTMENT OF VICE-CHAIR

The Board is asked to elect a Vice-Chair from its membership for the 2016/17 municipal year.

2. 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 21 March 2016.

(b) To note the outstanding actions.

3. APOLOGIES FOR ABSENCE

4. 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.

5. HEALTH AND WELLBEING STRATEGY 2016-17 AND NW LONDON SUSTAINABILITY & TRANSFORMATION PLANS 8 - 49

6. BETTER CARE FUND 2015-16 50 - 103

7. COMMUNITY INDEPENDENCE SERVICE PROCUREMENT 104 - 108

8. WORK PROGRAMME 109 - 111

The Board's proposed work programme for the municipal year is set out as Appendix 1 to this report.

The Board is requested to consider the items within the proposed work programme and suggest any amendments or additional topics to be included in the future.

9. DATES OF NEXT MEETINGS

The Board is asked to note the dates of the meetings scheduled for the municipal year 2016/2017:

- 7 September 2016
- 14 November 2016
- 13 February 2017
- 20 March 2017

London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Minutes

Monday 21 March 2016

PRESENT

Committee members: Councillors Vivienne Lukey (Chair) and Sue Macmillan
Dr Tim Spicer, H&F CCG (Vice-chair)
Vanessa Andreae, H&F CCG
Janet Cree, H&F CCG
Stuart Lines, Deputy Director of Public Health
Keith Mallinson, H&F Healthwatch Representative

Nominated Deputies Councillors:
Councillors Sharon Holder and Rory Vaughan

Officers:
Chris Neil, Adult Social Care, Whole Systems Lead
Steve Miley, Director for Family Services

Other attendees:
Professor, Chris Ham, Kings Fund and Kirsten ???? NHS NW London

41. MINUTES AND ACTIONS

RESOLVED

That the minutes of the meeting of the Health and Wellbeing Board, held on 9 February 2016, be agreed and signed as an accurate record by the Chair.

42. APOLOGIES FOR ABSENCE

Apologies for absence were received from Liz Bruce, Executive Director of Adult Social Care, Mike Robinson, Director of Public Health, Ian Lawry from Sobus, Andrew Christie, Director of Children's Services and Harley Collins, Health and Wellbeing Manager.

43. DECLARATIONS OF INTEREST

There were none.

44. PLACE-BASED SYSTEMS OF CARE: A WAY FORWARD FOR THE NHS IN ENGLAND

Professor Chris Ham gave a presentation to the board on 'Place-based systems of care'. The full presentation can be found on pages 61-75 of the agenda. Chris Ham talked about three versions of place based systems and how the NHS was taking the idea forward. He also explained health and social care integration under the aegis of the health and well being boards (HWBs) and outlined the purpose and scope of the sustainability and transformation plans (STPs). He then identified the emerging issues which included the size and complexity of the task and the deadlines, as well as, leadership, management capacity and the role of the local authority.

He outlined the local government version of place based systems and gave the examples of Greater Manchester's devolution plan and the integrated care pioneering which had taken place in Leeds. He explained that the focus was on whole populations and public service and community budgets. He also talked about the bold vision for the 'northern powerhouse'.

Chris Ham then summarised health and social care integration and talked about the Isle of Wight, Torbay and West London and new care models under the NHS. With regard to the Isle of Wight he explained that working under the health and wellbeing board had already been established and provided overall leadership for the transformation programme. He went on to talk about relationships with STP's and the behaviours of leaders and concluded that system leadership was needed at all levels to realise the benefits; and, that HWB's had a role in providing that leadership.

Chris Ham moved onto the implications for Hammersmith and Fultham and across NW London in specialised health services. He talked further on local acute services across the Borough and about community, primary and social care as well as population health at all levels. He explained that there was a broader shift in the focus for individuals and populations and that improving population health and outcomes was the overall goal. He then talked through the challenges and how to ensure progress in Hammersmith and Fulham and posed four questions for the Board which were;

1. What part should the Board play in providing place based leadership?
2. Were the right people sitting around the table?
3. Did the board have the support it needed?
4. Was there an appetite for taking on the role that was emerging for the HWB in the Isle of Wight and was under discussion elsewhere ?

Steve Miley asked how the Isle of Wight model worked and Chris Ham stated that they had a broad vision and an overarching board. That they had split provision and partnering enabled them to provide services effectively.

Keith Mallinson commented that public input was important and that he would like to see more members of the public involved in the future governance arrangements. He also felt it would be useful to have the health unions support for future plans.

Stuart Lines asked if there were any examples of public health input into population health improvement systems and Chris Ham stated that in Manchester the public health had been used as a common research tool for interested parties and that they had retained their statutory responsibilities.

Councillor Lukey expressed concern that existing structures and the complexity of arrangements could be a barrier to effectiveness, as well as, the size and make up of NW London. In response Chris Ham confirmed that in areas where the place based systems of care were happening it was due to the leadership of the local authorities. He added that there were examples of smaller and larger areas where it was working.

Vanessa Andreae commented that it was important for the CCG and local authority to work together and that there was a need to overcome the current issue of Charing Cross hospital. Councillor Vaughan added that the majority of local authorities were opposed to the strategic plans and agreed it was primarily about leadership. He gave the example of the flu immunisation roll out and the fragmentation of the approach. He also reiterated the need to work together and added that personal relationships were more difficult to maintain without workforce sustainability. He also asked how success would be measured. Chris Ham confirmed that it was the role of the commissioners to define success and that his expectation was that there would need to be a huge amount of consensus.

Vanessa Andreae commented that in order the HWB to accept responsibility for overall decisions they would need to be able to influence outcomes. Dr Tim Spicer added that NW London had a more transient population with less predictable needs than some of the example areas. He also noted that the Imperial which had specialised equipment was an asset for the area. He further commented that community ownership was an important issue where residents were more powerful and had greater levels of responsibility; and, he made reference to Baltimore where such a scheme was in place with 51% of residents sitting on a similar decision making board.

Keith Mallinson asked why there was no one from the Mental Health Trust on the board and Chris Neil explained that the next item on the agenda covered the membership of the board. He then asked members for comments on the best practice criteria for the board which was detailed on pages 81-82 of the report. Councillor Lukey stated that some blocks were in place but that the pace was moving too slowly. She also felt that children should be included more in the planning. Councillor Macmillan added that OFSTED had recently criticised the HWB for not covering children sufficiently.

Councillor Lukey proposed a half a day session for the board to discuss the issues more fully. This was agreed by Members.

ACTION CHRIS NEIL

Councillor Holder stated that it was also important to establish as much information around patient communication as possible going forward.

Chris Ham concluded by stating that the Audit Commission had found that not enough attention was given to decision making and membership in partnership working. He also stated that it was about going back to basics to

avoid competitive behaviours between partners and to identify where constituent organisations were willing to give up power.

RESOLVED

That the report be noted.

45. STRATEGIC PLANNING: REVIEWING PROGRESS AND LOOKING FORWARD TO THE REFRESH OF THE JOINT HEALTH AND WELLBEING STRATEGY

Stuart Lines gave a presentation on the Health and Wellbeing Strategy supporting information for Hammersmith and Fulham. The full presentation can be found on pages 90 - 126 of the agenda.

In summary Stuart Lines talked through the characteristics and demographics of the local population. He also touched on life expectancy, age, child and adult health, gender, family breakdown, disability, sexual orientation and deprivation. He went on to present information on health inequality trends and ethnicity health inequalities, housing, patterns of health and vulnerable groups in the Hammersmith and Fulham area. There was also research on mental illness, HIV, problem drug users, changing patterns of need and projections of the prevalence of selected diseases in the area.

In response to a question from the Chair about breaking the information down by ward it was confirmed by Stuart Lines that this would be possible for some of the slides but not all of them. He also confirmed in response to a question from Steve Miley about rising alcohol abuse that identifying parents from hospital admissions was not in line with current practice. Dr Tim Spicer commented that with alcohol abuse there was no age limit when it stopped and that Hammersmith and Fulham were currently providing data in this area which was being utilised across London.

Vanessa Andreae commented that with regard to prevalence of selected diseases in Hammersmith and Fulham there was work to be done on cancer. Stuart Lines added that what was preventable was the key. Councillor Lukey commented that increased monitoring information was useful and Councillor Vaughan asked the CCG what were the key messages for smokers. Councillor Sue Macmillan commented that alcohol abuse was a good area of focus for a future report.

Councillor Lukey stated that community grants were a positive area that the board could influence and join up processes to use finances to improve health outcomes. Vanessa Andreae agreed that it would also be beneficial in terms of governance arrangements. Dr Tim Spencer stated that social isolation and long term conditions were also areas that the board could work together on. Stuart Lines added that smoking cessation was the best way to improve health and the issue was how to target particular groups.

Councillor Lukey reminded Members of the upcoming community event with a focus on poverty, diet and healthy eating.

ACTION - Chris Neil

Chris Neil discussed arranging a half day development session with Members to discuss the care budgets 5-10 year defect and long term financial planning.

RESOLVED

i) That the position of the Health and Wellbeing Boards across the country and progress made to date, be noted.

ii) That population health need in the borough, how needs and demography have changed and how they are expected to change in the future, be noted.

iii) That recent policy announcements and how the board will need to dapt to offer system leadership in the future, be noted.

iv) That early thinking about what the new Health and Wellbeing strategies could cover, be considered.

v) That a high level timeline for the development of the plans at this stage be followed up at a half day meeting to be scheduled in May 2016.

46. LIKE MINDED - UPDATE ON THE TRANSFORMING CARE PARTNERSHIP PLAN FOR PEOPLE WITH A LEARNING DISABILITY AND/OR AND CHALLENGING BEHAVIOUR

Kirsen ???? stated that a NW London plan was being developed to avoid people moving out of the area. She added that it was an all ages plan and that the first draft was in the report on pages 138 - 174. She also stated that they were in collaboration and working on its development with Mary Dalton.

Councillor Lukey asked about the transition task force and Steve Miley confirmed that this was still in the forming stage. There was further discussion amongst Members on what could be included in the final report.

Janet Cree commented that the timeframe ensuring the final plan was reviewed in more detail needed to be signed off in June 2016.

Councillor Lukey concluded that the draft report was impressive.

RESOLVED

i) That the first draft North West London Transforming Care Partnership plan noting that further updates will be made to address the areas of underdevlopment, be endorsed.

ii) That delegated authority to the relevant committee to approve the final local and NW London Transforming Care Partnership plan in order for this to be sibmitted to NHS England on 11 April 2016, be endorsed.

iii) That the final plans will be reviewed by the HWBB in May. The plan will then be implemented from April 2016, and be reviewed in 2019/20, be endorsed.

47. BETTER CARE FUND UPDATE: QUARTER 3 PERFORMANCE REPORT

Chris Neil commented that there was a £200 million budget for the Better Care Fund locally. He also confirmed that there was additional information to go with the report which he would circulate outside of the meeting. He apologised the information was not included in the agenda.

ACTION - Chris Neil

RESOLVED

That the Health and Wellbeing Board commented on progress to date and on the Quarter 3 Better Care Fund submission, be noted.

48. END OF LIFE CARE JSNA

Stuart Lines stated that multi-agency JSNA informed strategy priorities and affected all services. He also added that there were five key recommendations and that the one which was of particular interest to the HWB was strategic leadership for end of life care.

Councillor Lukey proposed that it could be a role for the Board and requested it be added to the forward plan and a report be scheduled for a future meeting. This was seconded by Councillor Vaughan. Dr Tim Spicer talked about the NW London footprint and stated that it would bring together formal providers and the voluntary sector. He added that the JSNA was likely to be acted upon and would build good practice.

An additional item was circulated by Janet Cree which was the 2016/17 Operating Plan - Quality Premium Guidance.

There was a discussion amongst members regarding the forward plan and delegated authority for the June 2016 meeting. Chris Neil agreed to update the forward plan.

Action - Chris Neil

RESOLVED

i) That the Health and Wellbeing Board approved the End of Life Care JSNA for publication, and how the JSNA will be used to inform local strategic approaches to end of life care, be approved and noted.

ii) That the Health and Wellbeing Board considered the recommendations arising from End of Life Care JSNA, in particular Recommendation 3, and provided a steer on how this should be implemented locally, be noted.

iii) That the recommendation that the Health and Wellbeing Board review progress against recommendation in 1 year from publication, be noted.

49. WORK PROGRAMME

Steve Miley suggested that in line with the agreement at the HWBB following discussion on the annual LSCB report that future agenda items could include a report on the recent local serious case reviews where there were health issues and an update report on Female Genital mutilation.

Councillor Macmillan stated it would be good to have reports on education health and care plans soon.

Councillor Lukey agreed to juggle the future work programme where possible at the half day development session in May 2016.

RESOLVED

That the report be noted.

50. DATES OF NEXT MEETINGS

20 June 2016.

Meeting started: 6.30 pm
Meeting ended: 8.30 pm

Chair .....

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London Borough of Hammersmith & Fulham **HEALTH & WELLBEING BOARD** **20 JUNE 2016**	
Health and Wellbeing Strategy 2016-2021 and NW London Sustainability & Transformation Plans	
Report of the Director of Adult Social Services and the Managing Director of Hammersmith & Fulham CCG	
Open Report	
Classification: For Decision **Key Decision: No**	
Wards Affected: All	
Accountable Director: Chris Neill, Director of Whole Systems	
Report Author: Harley Collins, Health & Wellbeing Manager	**Contact Details:** Tel: 020 8753 5072 E-mail: Harley.collins@lbhf.gov.uk

1. EXECUTIVE SUMMARY

1.1. The Health & Wellbeing Board partners and wider stakeholders have developed a new five year Joint Health & Wellbeing Strategy for the borough. This report updates on development and engagement to date and asks the Board to review, comment on and agree the draft strategy for public consultation. The report also provides an update on development of the NW London Sustainability and Transformation Plan and next steps in terms of assurance and approval.

2. RECOMMENDATIONS

2.1. The Health and Wellbeing Board partners are asked to:

- Agree and approve the content of the draft strategy by 10th July as set out at Appendix 1 for public consultation
- Approve a 14 week period of public consultation on the draft strategy to run from 20 July to 27 October
- Agree to undertake further community engagement in the north, central and south of the borough during the public consultation period

- Subject to the findings of the public consultation, consider for approval a revised final Joint Health and Wellbeing Strategy at the meeting on 14 November 2016.
- Consider and comment on the STP update

3. REASONS FOR DECISION

3.1. The Health and Wellbeing Board has a statutory duty to prepare a Joint Health and Wellbeing Strategy for its area. In line with best practice, the Health & Wellbeing Board intends to formally consult with the public and wider partners on the details of the plan prior to formal approval and adoption.

4. INTRODUCTION AND BACKGROUND

4.1. Health and Wellbeing Boards have a statutory duty to produce a Joint Health and Wellbeing Strategy (JHWS) for the area they serve based on information in the Joint Strategic Needs Assessment. The Board's first Joint Health and Wellbeing Strategy expires in 2016.

4.2. Joint Health & Well-being Strategies (JHWSs) are partnership plans developed jointly by the Council, the local CCG, Healthwatch and any other member organisations of the Board. They should draw on the needs identified in the Joint Strategic Needs Assessment (JSNA) and set key strategic priorities for action that will make a real impact on people's lives. JHWSs should translate JSNA findings into clear outcomes the board wants to achieve which will inform local commissioning leading to locally led initiatives that meet those outcomes and address identified need.

4.3. At its meeting in March, the King's Fund Chief Executive Chris Ham facilitated a discussion about place-based systems of care and the solution they offer to the challenges facing the local health and care system. This was in the context of the publication in December 2015 of NHS planning guidance for 2016-21: *Delivering the Forward View* which signalled a shift towards place-based commissioning to meet the three gaps identified by the Five Year Forward View. At that meeting the Board considered the progress made by Health and Wellbeing Boards to date, the changing needs of the Hammersmith & Fulham population and a suggested framework and timeline for refreshing the Joint Health and Wellbeing Strategy in 2016. The Health and Wellbeing Board approved the framework and timeline for a new 5 year strategy and agreed that the Joint Health and Wellbeing Strategy should be aligned with Sustainability & Transformation Plans (STP) being developed across north-west London.

5. Developing the Joint Health and Wellbeing Strategy 2016-21

5.1 The development of a new Joint Health and Wellbeing Strategy offers the Health and Wellbeing Board an opportunity to set out a local vision for health and wellbeing and assume a systems leadership role in addressing the financial and health-related challenges in the borough. The development of the Joint Health and Wellbeing Strategy alongside the north-west London STP also offers

opportunities to agree both local priorities and ambitions and coordinate changes at scale where it makes sense to do so.

5.2 Since the Board's meeting in March, officers, working with commissioning and public health colleagues, have undertaken a wide ranging evidence gathering exercise to understand the changing nature of need in the borough.

5.3 A programme of development workshops has taken place with Health and Wellbeing Board members, wider partners and stakeholders and patient representative groups.

5.4 On 20 May, Board members met for a half-day development session where they discussed their vision for the borough and potential areas of focus for the next five years. Board members agreed that supported self-care and prevention were important parts of their vision for the borough as was enabling good mental health for all and giving children and families the best possible start. Board members spoke about a compassionate and joined up health and social care system and about the potential of digital technologies for patient engagement and self-care (see Appendix 2 for session notes).

5.5 On 24 May, a wide collection of stakeholders and partners including council and NHS commissioners, councillors, council policy officers and provider organisations met to consider the emerging thinking of the Health and Wellbeing Board and potential areas of focus for the next five years. Stakeholder's feedback on the emerging strategy included a call to improve the education and advice offer to people and patients to help them navigate the system and also a call to target system resources on those in greatest need and where action would provide the biggest return on investment in terms of people's health and wellbeing. There was also feedback about the importance of leadership, training and a more collectivist, system-level approach to finances and budgets among other things (see Appendix 3 for session notes).

5.6 On 7 June, service user and voluntary and community sector VCS) representatives met to consider the emerging thinking of the HWB and to discuss the role the public and the VCS could play in delivering the strategy. Service users highlighted the importance of ensuring the strategy and consultation materials were in an accessible format and supporting people to lead healthy lifestyles and tackle social isolation.

5.7 There were recurring themes and priorities that emerged from all three sessions including:

- The importance of improving outcomes for children, young people and families
- The importance of improving mental health outcomes for all and ensuring parity between mental and physical health services
- The role of healthy lifestyles and behaviours in preventing long-term conditions such as cardiovascular disease, cancer, respiratory illness and diabetes and enabling healthy lives

- The importance of finance, technology, workforce and leadership in creating a sustainable and joined up health and social care system

5.8 There was also consensus around a number of approaches and principles to underpin these priorities, including

- Upgrading the role of prevention and early intervention
- Addressing the wider determinants of health (such as employment, education and housing)
- Enabling a shift by both the health and care system and its users towards greater self-care, self-management of conditions and supporting community resilience
- Creating a person-centred health and care system where people are helped to stay well in their communities supported by an effective front line of primary, community and social care.

5.9 Further to these discussions, engagement has been undertaken with local carers and mental health service users groups. It is proposed that further face-to-face community engagement, led by the Health and Wellbeing Board, take place during the public consultation period in the north, south and central areas of the borough.

6. Sustainability & Transformation Plans (STPs)

6.1 Further to the updates received by the Board in February and March, the Board will know that NHS Planning Guidance[1] released in December 2015 provided a clear mandate for local areas to move to a place-based approach to strategic planning. This reflects the reality that local challenges cannot be effectively addressed by any one organisation alone. Collective action and cooperation is required between commissioners, providers and local authorities to manage common resources to secure a financially sustainable system. The strongest place-based plans will unlock funding from 2017/18 onwards to support their planned transformation.

6.2 The STP is a place based plan rather than a plan about individual organisations that sets out how the NHS, local authorities, patients and residents will work together to address the triple aims by 2020/21[2]. It will describe priorities for improving health and social care in NW London over the next 5 years. It is managed through the NW London Strategic Planning Group with representation from lay partners, CCGs, providers and local authorities. The NW London footprint covers 8 boroughs and 2.1 million residents.

6.3 The STP will determine how much money NW London is awarded from the Sustainability and Transformation Fund (STF). The STF is a national fund worth £1.8bn and is a major 'one-off' for sustainability, intended to bring NHS providers

[1] Delivering the Forward View, NHS Planning Guidance 2016/17 – 2020/21", Dec 2015
[2] the health and wellbeing gap, the care and quality gap and the finance and efficiency gap

back to balance. The 44 STP footprints in England are competing for the funding and North West London is the 4th largest. The STF will gradually increase in size, rising to £3.4bn by 2020/21.

6.4 As requested by the Health and Wellbeing Board, the development of the Joint Health and Wellbeing Strategy has taken place alongside the development of the North West London Sustainability and Transformation plan (STP).

6.5 In January, CCG and council officers formed a three Borough Integration and Collaboration Working Group (ICWG) to drive forward the three borough element of the North West London STP and align this with the development of the Joint Health and Wellbeing Strategies in the three boroughs.

6.6 An STP 'Base Case' was submitted to NHS England on 15 April. This set out: the needs of NW London population, the emerging priorities, governance for implementing the plan and emerging delivery areas. The nine priorities addressed in the North West London base case are:

1. Supporting people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthy choices and look after themselves;
2. Reducing social isolation;
3. Improving children's mental and physical health and wellbeing;
4. Ensuring people access the right care in the right place at the right time;
5. Reducing the gap in life expectancy between adults with serious and long-term mental health needs and the rest of the population;
6. Improving the overall quality of care for people in their last phase of life and enabling them to die in their place of choice;
7. Improving consistency in patient outcomes and experience regardless of the day of the week that services are accessed;
8. Reducing unwarranted variation in the management of long term conditions – diabetes, cardio vascular disease and respiratory disease; and
9. Reducing health inequalities and disparity in outcomes for the top 3 killers: cancer, heart disease and respiratory illness.

6.7 The feedback received from NHSE was that NW London's plan is a good plan with strong patient engagement and a good relationship with local government.

6.8 The STP is an umbrella plan and has been developed with local STP teams across the 8 boroughs which include representatives from lay partners, CCGs, providers and local government. The NW London STP team are also working with the NWL programmes – Local Services, Like Minded, etc…to demonstrate that what they are doing is making a real difference to health and care outcomes in NW London.

6.9 The next steps are to submit a draft of the emerging plan to NHSE London for discussion on 10 June and on 30 June to send a checkpoint submission to NHSE to support a conversation that will take place between the NW London STP leadership team (led by Dr Mohini Parmar) and Simon Stevens in July.

6.10 To make the STP a lasting success it needs to be a genuinely collaborative process. Any questions, thoughts or ideas about the STP can be sent to NWLSTP@nw.london.nhs.uk

7. CONSULTATION

7.1. Details of consultation and engagement undertaken so far are contained within this report. This report seeks approval from the Board for a period of formal public consultation between 20 July and 27 October.

8. EQUALITY IMPLICATIONS

8.1. A central goal of the Joint Health and Wellbeing Strategy is to tackle health inequalities within the population and allocate resources to where is need is greatest. An Equality Impact Assessment will be completed for publication alongside the final Joint Health and Wellbeing Strategy.

9. LEGAL IMPLICATIONS

9.1. The duty in respect of Joint Health and Wellbeing Strategies is set out in s116A of the amended Local Government and Public Involvement in Health Act 2007.

9.2. There is also statutory guidance, the "Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies" issued in March 2013. The Guidance states at paragraph 3.5 that Joint Health and Wellbeing Strategies are continuous processes and that it is a decision for the Health and Wellbeing Board to decide when to either update or refresh their JHWS or undertake a fresh process. There is not a requirement that the JHWS be undertaken from scratch each year so long as the Board is confident that their evidence based priorities are up to date and informing local commissioning plans.

9.3. The process being followed to refresh the Council's JHWS "Healthier City, Healthier Lives" is set out in detail above at paragraph 4 of this report, which includes a proposed public consultation commencing in July 2016. Legal Services will have an opportunity to comment on the proposed consultation documentation and consultation process.

9.4. The requirements in respect of the timing and content of Sustainability and Transformation Plans ("STPs") are set out in Delivering the Forward View: NHS Planning Guidance 2016/17. The Guidance was augmented by a Letter dated 16th February 2016 which included additional information about the purpose of STPs and a timeline for the STP process, including key dates.

9.5. The STP will cover the period October 2016 to March 2021. Deadline for submission of the STP checkpoint submission is 30th June 2016 and the STP will be formally assessed in July 2016.

10. FINANCIAL AND RESOURCES IMPLICATIONS

10.1. There are no financial implications at this stage

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

None.

APPENDICES:

- **APPENDIX 1: Joint Health and Wellbeing Strategy 2016-21: Consultation Draft**
- **APPENDIX 2: Health and Wellbeing Board JHWS Development Session – Notes 20 May 2016**
- **APPENDIX 3: Stakeholder JHWS Development Session – Notes 24 May 2016**

Draft Hammersmith & Fulham Joint Health and Wellbeing Strategy 2016-2021

1. Chair's Foreword

- The Hammersmith & Fulham Health and Wellbeing Board Partners[1] are committed to improving the health and wellbeing of the people we serve and putting them at the heart of a high quality and sustainable health and social care system.
- Many of us who sit on the Health and Wellbeing Board live and work in Hammersmith & Fulham and have a strong connection to our local communities as GPs, local representatives and public servants. We are motivated to ensure that everyone has access to the same high quality health and care services that we expect for our families and friends.
- We have a bold and ambitious vision in Hammersmith & Fulham for a people-centred health and social care system that supports communities to stay well, consistently providing the high quality care and support people need when they need it and enabling communities to stay healthy and independent with choice and control over their lives.
- We will use the potential of digital technologies to enable patients to manage their health in the way that best suits them.
- We know we will not achieve this as individual organisations working alone. Whilst there are areas where we have different perspectives about how local health and care needs to change, there is much that we do agree upon.
- To drive standards of health and care up locally we need a collective approach where all local organisations work together as one system, thinking and working beyond organisational boundaries for the good of people in Hammersmith & Fulham.
- The many staff we have working in health and social care services in the borough will need to work together in partnership with our voluntary sector partners, public bodies and the wider community. And families and communities will need support to take greater responsibility for their own health, be more resilient and self-reliant, where appropriate, and with support where they need it.
- We face many challenges including entrenched health inequalities within our communities, higher than average levels of child poverty and child obesity and some of the highest levels of severe and enduring mental illness in the country. We also have growing numbers of people living with long-term conditions who require person-centred, coordinated care and we are face significant financial challenges at a time when demand for health and social care services is growing.
- This plan sets out our ambitions and solutions for overcoming these challenges.
- To deliver the change we need we will work across the public sector to influence the wider determinants of health such as employment, housing and education; We will embed prevention in all that we do, intervening early to help people to stay well; We will support people to stay well in their communities by making community, primary care and social services part of an effective front line of local care; We will support people who want to take greater responsibility for their own health and wellbeing; and we will undertake an ambitious programme of service integration and reform to ensure health and social care services are joined up, in line with the needs of people, families and carers.

[1] Hammersmith & Fulham Council, Hammersmith & Fulham Clinical Commissioning Group, Healthwatch, Sobus

- Our plan acknowledges that we must target resources where need is greatest and where the evidence tells us action will make the greatest improvements to people's health and wellbeing. We have therefore agreed four priorities over the lifespan of this strategy:
    - enabling good mental health for all
    - supporting children, young people and families to have the best possible start in life
    - addressing the rising tide of long-term conditions; and
    - delivering a high quality and sustainable health and social care system.
- Our Joint Health & Wellbeing Strategy for 2016 – 2021 is an ambitious, forward thinking plan for improving the health and wellbeing of people in the borough. Through this strategy and the hard work which will follow, we will achieve even closer working between health, social care, the voluntary sector and other partners to enable people to stay healthy, independent and well and ensure the financial sustainability of local health and social care services for the future.
- I would like to thank the many people who have contributed to the development of this plan. We have had many conversations along the way which have led us to this point. We now embark on the hard work of realising the vision set out here over the next five years.

Councillor Vivienne Lukey
Cabinet Member for Health and Adult Social Care and Chair of the Health & Wellbeing Board
London Borough of Hammersmith & Fulham

1.1 Our population at a glance

Table 1: The borough at a glance… (Hammersmith & Fulham JSNA Highlights report 2013-14)

80,600	Households	**8**	Live births each day
£464,000	Median house price	**2-3**	Deaths each day
189,850	Residents	**11,900**	Local businesses
32%	From BAME groups	**£33,000**	Annual pay
43%	Born abroad (2011 Census)	**3.1%**	Unemployment rate (JSA) *(London 3.1%)*
23%	Main language not English	**22%**	Local jobs in Public Sector
46%	State school pupils whose main language not English	**Ranked 55th**	Most deprived borough in England *(out of 326)* (13th in London)
17k/19k	Annual flows in and out of the borough	**29%**	Children <16 in poverty, 2011 *(HMRC)*
198,900	Registered with local GPs	**Ranked 6th**	Highest carbon emissions in London *(not including City of London)*
260,000	Daytime population in an average weekday	**7.9 years**	Gap in life expectancy between most and least affluent residents
		33%	children of school age either overweight or obese

1.2 Our vision

- Our vision is for a people-centred health and social care system that supports communities to stay well, consistently providing the high quality care and support people need when they need it and enabling communities to stay healthy and independent with choice and control over their lives.
- We are ambitious for the whole of the public and private sectors, not just the health and care system, to recognise the contribution it makes to health and wellbeing, through jobs, housing and human relationships. And we want everyone in our community to have a valued role through work, volunteering or family, have a safe and secure living space and rewarding relationships with their loved ones.
- We are already on our way to achieving this vision. We have a strong record of collaboration. The Better Care Fund is an ambitious plan by health and social care partners across Hammersmith & Fulham, Kensington & Chelsea and Westminster to bring together health and care funding where it makes sense with the goal of driving closer integration of health and care, reducing incidences of crisis and delivering care in out of hospital settings.
- In health, North West London is a whole systems integrated care pioneer site. NHS commissioners across North West London have agreed that Accountable Care Partnerships are the preferred model for delivering an integrated care system by April 2018.
- As we write this plan, we are collaborating with our partners across North West London to agree our ambitions for the NWL Sustainability and Transformation Plan (STP) which will set out how health and care at scale can become sustainable over the next five years and deliver the ambitions of the *Five Year Forward View*[2]. We are working to ensure the ambitions of the STP and local ambitions of our Joint Health and Wellbeing Strategy are aligned so that the local strategy can be front and centre of driving forward the aspirations set out in the STP.
- Achieving our vision is paramount for improving health outcomes in the borough and securing a sustainable system for the future.

1.3 The case for change

- Hammersmith & Fulham is a vibrant and exciting place to live. Most people in our borough consider their health to be good, many residents are affluent and rates of life expectancy for men have been increasing more quickly than nationally over the past decade.
- But we also face significant challenges. A third of children under 16 live in poverty and more than a third of children of school age are either overweight or obese. We must address the longstanding 7.9 year difference in life expectancy between affluent and deprived areas which has been resistant to reduction despite longstanding efforts. The main causes of avoidable death in the borough are cancer, followed by cardiovascular disease and respiratory illnesses which are linked to lifestyle choices such as smoking, drinking alcohol, diet and physical inactivity.
- We know that the current system of health and care can be confusing for patients, families and carers. And as our population gets older and more people develop long-term conditions our system is becoming less able to cope with the changing needs and expectations of the people we serve. This is already leading to higher demand for social care, carers and community health services in out of hospital settings and these pressures will only increase.
- Under the Care Act, local authorities have clear legal duties in the event of provider failure to temporarily ensure people's needs continue to be met. Nevertheless, the care provider market is fragile and is presenting quality and safety issues nationally and in Central London. Health and

[2] Five Year Forward View, NHS England (October 2014)

care partners need to invest in the care market and upskill providers to enable them to support the increasingly complex and acute needs of the population.

- Our current health and care system is unsustainable. The way we pay for health and care services can encourage high end care in expensive settings and reinforce isolated working practices. We spend too much on services which respond at the point of crisis and not enough on early intervention and preventative support that keeps people well.
- Across North West London, if we continue as we are currently doing, there will be between £0.5bn and £1 billion financial gap in our health and care system by 2021.
- This plan is about grasping the opportunity to reform the way services are bought, delivered and accessed in Hammersmith and Fulham.

1.4 Achieving the change we need

- To achieve our vision we know we must deliver change in a number of areas. This includes delivering on our agreed local priorities of personalisation, independence, well-being and prevention as well as integrating our services where it makes sense to do so.

(1) Radically upgrading prevention and early intervention

- The main causes of avoidable death in the borough are cancer, followed by cardiovascular disease and respiratory illnesses which are linked to modifiable lifestyle choices such as smoking, drinking alcohol, diet and physical inactivity.
- Poor mental health is a major cause of illness in itself and a precursor for poor lifestyle and physical conditions.
- We will empower people to make lifestyle choices that will keep them healthy and well and able to lead a full life as active members of their communities and the local economy.

(2) Supporting independence, community resilience and self-care

- Population growth, breakthroughs in treatment and management of conditions and changing needs mean that the health and care system is under increasing pressure. In Hammersmith & Fulham we have a diverse and mobile population. The role patients can play is central to the delivery of an effective and sustainable health and care system, as is working with local organisations and local people to shape the care they want to receive. We have already started this work through our focuses on social isolation and co-commissioning in the Borough.
- The potential benefits of people engaged in the management of their own care are significant. Approximately four-fifths of our population are healthy. Small shifts in self-care have the potential to significantly impact the demand for professional care.
- In Hammersmith & Fulham, we must be ambitious in our attempts to change cultures so that people are better supported by the system and by technology where appropriate to take more responsibility for their own care.
- We know that self-care is a virtuous circle. When a person has the skills, knowledge and confidence to manage their own health and care it is a strong predictor of better health outcomes, healthcare costs and satisfaction with services.
- To support people to take greater responsibility we will need to make sure the right services, facilities and support are provided to help people help themselves. We will harness the potential of digital technologies to facilitate control and choice and enable patients to manage their health in the way that best suits them.

(3) Making community, primary care and social services part of the effective front line of local care

- Our ambition is to support people to stay well in their communities. This means ensuring the right support is available closer to home in GP surgeries, pharmacies and community hubs. It

also means ensuring community facilities like parks, community centres, schools and libraries are well maintained accessible and there to keep people well.

- We know that significant numbers of patients in acute hospital settings do not need to be there. Children in Hammersmith and Fulham attend A&E and other urgent care much more frequently than is typical for London or England. In 2010/11, there were over 8,000 attendances in the borough among under 5s, in many cases for conditions that could be managed in primary care.
- High A&E attendance may relate to the proximity of local A&E services, low levels of registration with GP practices due to population 'churn', and lack of availability of high quality primary and other care services, including preventative services.
- We must deliver high quality and consistent primary, community and social care which is easily accessible and convenient to ensure people access the right care at the right time and are supported to stay well in their homes and communities.

(4) Taking a population-level health management approach

- Being in good health isn't just about the treatment of illness. It encompasses the food we eat, the air we breathe, the relationships we maintain, the environments we live and work in and the opportunities we have in our lives to flourish.
- Thankfully, the majority of people in Hammersmith & Fulham are healthy and supporting people to remain healthy, independent and well is a crucial part of our plan.
- But this plan will not succeed without working across organisational and sector boundaries. The "wider determinants of health" - employment, education, housing, environment and transport – all have a significant impact on health and wellbeing.
- We will work with our partners across the public sector to embed health improvement in all policies. This includes local institutions such as schools, hospitals, parks, roads, housing developments, and cultural institutions which can have huge positive or negative impacts on mental health, how we live our lives and whether we realise our potential for a full and healthy life:

  - ✓ Housing: Poor housing and overcrowding can have an adverse impact on the physical and mental health and wellbeing of individuals, families and communities.
  - ✓ Education: Schools are central to the lives of children and families and it is important that we continue to work both with schools and other educational establishments to give children, young people and families the support they need to achieve and maintain good health and wellbeing.
  - ✓ Culture: Libraries have an important role to play as a source of information and advice as well as venues providing social support and access to the internet. Libraries and cultural organisations are an important asset in bringing communities together, educating people, reducing loneliness and isolation and offering a range of convenient services in a community setting.
  - ✓ Environment: We are fortunate to have many beautiful parks and green spaces that provide opportunities for exercise and relaxation. We will also work to create healthy high streets, reducing the impact of fast food outlets on health, using our licensing powers to control the impact of alcohol related harm and gambling and use planning powers to design out crime and increase physical activity.
  - ✓ Transport: We will continue to encourage people to incorporate active travel into everyday journeys, create safer routes and raise participation in cycling. We will work to encourage the creation of school travel plans and cycle initiatives to contribute to reducing road traffic accidents. Our borough's poor air quality also affects all of us – bringing forward everyone's death by nearly 16 months on average. This compares with the least polluted area, rural Cumbria, where the reduction in life is an average of 4 months. Air pollution affects

vulnerable groups more acutely, particularly young children and people living with chronic heart and respiratory diseases.

- ✓ Employment: Evidence shows that being employed can help improve health and wellbeing and reduce health inequalities, while unemployment is linked to higher levels of sickness and psychological morbidity.[3] At the same time, we know that long-term unemployment is a serious barrier to good health.

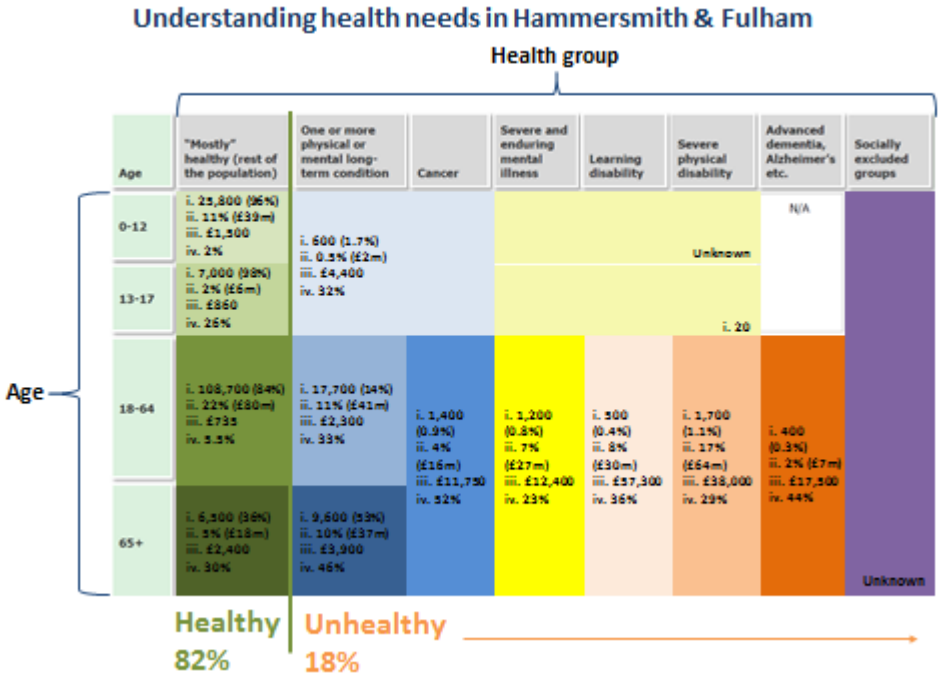
(5) Delivering integration and service reform

- We will work together, taking a collective, place-based approach that moves beyond organisational boundaries to provide care and support that is joined up around the needs of people, families and carers. Staff working in health and social care services in the borough will need to work together in multidisciplinary teams, breaking down artificial barriers between primary and secondary care, physical and mental health and between health and social care. And we will work with families and our communities to support them to take greater responsibility for their own health.
- To get there we will need to transform our workforce, grasp opportunities made possible by modern technology, rethink how we manage and use the public sector estate and revise and update our governance and accountability arrangements to ensure we are able to reach consensus and take decisions in the best possible way.

1.5 Improving population health outcomes

- In Hammersmith & Fulham we have taken a population segmentation approach to understanding local need for health and care. Hammersmith & Fulham has:
    - 182,500 residents and an average weekday daytime population of 260,000. The borough also has significant population 'churn' with annual flows in and out of the borough of approximately 19,000
    - Significant variation in wealth
    - A large young working age population
    - Diverse ethnicity with one in four of the borough's population born abroad
    - Almost a third of children under the age of 16 living in poverty
    - Almost a third of state primary school age children who are overweight or obese
    - Low vaccination and immunisation coverage
    - Poor air quality and the 6th highest carbon emissions in London
    - A large proportion (38%) of one person households, including lone pensioner households and significant numbers living in overcrowded housing conditions
    - High rates of smoking, alcohol use, poor diet and sexually transmitted infections and low levels of physical activity
- Dividing the population into groups of people with similar needs is an important step to achieving our goal of better outcomes through integrated care. Grouping the population will ensure that models of care address the needs of individuals holistically, rather than being structured around different services and organisations.

[3] (2015) Workplace health, National Institute for Health and Care Excellence (NICE) local government briefings



KEY: i = number (%) in age group; ii = % total annual spend on group; iii = average cost per person per year; iv = population increase by 2030

- Population grouping also allows us to move towards delivering outcomes-based commissioning: a way of paying for health and care services based on rewarding the outcomes that are important to the people using them (for more see Appendix A). This typically involves the use of a fixed budget for the care of a particular population group ("capitated budget") with incentives for health and care providers to work together to deliver services which meet specified outcomes. This approach aims to achieve better outcomes through more integrated, person centred services and ultimately provide better value for every pound spent on health and care.
- The table at Appendix B sets out our priorities for addressing the health needs of our population

1.6 Our health and wellbeing priorities

We know that improving health and wellbeing in the borough requires action across the whole life course and taking action to prevent, detect and manage the impact of ill health. The table at Appendix B sets out our approach and priorities for improving the health and wellbeing of the population we serve. But to maximise our impact as a Board we must target finite resources where we know action has the potential to make the biggest improvements to people's lives. Following a wide ranging review of the evidence and ongoing discussions with our partners and residents we have agreed to prioritise the following areas over the next five years:

(1) Good mental health for all

Where are we now?

Mental health disorders have a significant impact on the ability of people to lead fulfilling lives and contribute to society. There is developing evidence that the risk factors for a person's mental health are shaped by various social, economic and physical environments including family history, debt, unemployment, isolation and housing. Locally mental health is the most common reason for sickness absence. Only 7% of people diagnosed with serious mental illness (such as schizophrenia and bi-

polar) will ever have paid work and mental ill health is the number one cause of health-related unemployment.

Common mental illness such as anxiety and depression affects around 1 in 6 people at any one point in time and are one of the leading causes of disability nationally. Prevalence is increasing any yet only a quarter of people with anxiety and depression receive treatment compared to 90% of people with diabetes. The Department of Health estimate that the economic costs of mental illness in England are £105.2 billion each year.

The borough had the 6th highest population with severe and enduring mental illness known to GPs in the country in 2012-13. People with serious and long-term mental illness have the same life expectancy as the general population had in the 1950s, one of the greatest health inequalities in England. People with mental health problems also face significant physical health problems and live significantly shorter lives as a result.

What will we do?

We will prevent, identify and treat mental health in all settings and across all age groups. We will:

- Promote good workplace mental health and wellbeing
- Promote better emotional and mental health and early intervention in schools
- Encourage awareness and improve the quality of local services and support for people living with dementia and their carers
- Work with staff in frontline services across the system to build skills and awareness of mental health
- Provide support for parents and parents-to-be for their own mental health and for the long-term mental health of their children
- Promote access to activities that promote wellbeing, volunteering and stronger social networking to improve outcomes for adults at risk of serious mental health conditions
- Provide early support for older people through effective information and advice and signposting to preventative/universal services
- Work with communities to help change attitudes and develop better understanding of mental health.
- Work with professionals to break down the barriers between physical and mental health and ensure both are treated and resourced equally
- Improve the physical health and lifestyles of people with mental health conditions with a particular focus on people with serious mental health conditions
- Improve access to children and young people's mental health services.

How will we know we're making a difference?

- We will increase the proportion of children and young people referred to child and adolescent mental health services seen within 8 weeks of referral
- We will help more people with mental health conditions into employment, training or volunteering
- We will increase the number of Dementia Friends in the borough each year
- We will increase the number of women, experiencing, or with a previous history of mental health conditions, accessing perinatal mental health services.
- We will reduce preventable early deaths among people with serious mental illness.

Targeted support for vulnerable groups

We will target the support provided for vulnerable groups and those most in need including:

- Those living in deprived or disadvantaged circumstances, or experiencing discrimination who are more likely to have a mental health problem than those in the most affluent areas.

- Children in families vulnerable to mental health conditions who are more likely to develop mental health conditions as adults.
- People in older age who have experienced events that affect emotional well-being, such as bereavement or disability
- Men who are less likely to recognise or act on the early signs of mental health conditions and less likely to seek support from friends, family and community or from their GP or other health professional. This worsens outcomes and contributes to suicide risk
- Ethnic groups who have longstanding inequalities in mental health. Caribbean, African, and Irish communities are significantly over-represented in secondary care mental health services. Community links, and understanding of different cultural contexts for mental health are important to help improve access and outcomes
- People with serious mental illness who are up to 15 times less likely to be employed than the general population and almost three times more likely to die early
- Carers who play a pivotal role in the health system and who often have little time to care for their own health and wellbeing

(2) Giving children, young people and families have the possible best start in life

Where are we now?

A child's early experiences have a huge impact on their long-term health and wellbeing. Babies generally receive a good start in life in the borough: there is good breastfeeding uptake, low numbers of underweight babies born, low numbers of women who are smokers at the time of birth. However, there is still room for improvement. Compared to elsewhere, Hammersmith & Fulham has poor rates of uptake for childhood immunisations, significant proportions of children living in poverty, high rates of child obesity and high rates of tooth decay in children under 5.

What will we do?

We will act with partners to give all children and families the best start in life and offer early help to have healthy lifestyles and good physical and mental health, integrating healthy behaviours into everyday routines to prevent problems at a later stage and providing an ongoing and rounded offer of support once children leave school. Support is provided at this stage of life from maternity services, health visitors, GPs, children's centres and many others but it is not always joined up around the needs of children and families. We will:

- Develop an integrated health promotion offer for children and families focussed on breastfeeding and good nutrition, oral health, play and physical activity, immunisation and tobacco free homes
- Promote effective support for parents around sensitive parenting and attachment
- Support the development of strong communications and language skills in infancy.
- Provide evidence-based support for mothers, fathers and other carers to help prepare them for parenthood and improve their resilience when they have a new baby
- Strengthen the mental health support we provide to parents early on, including training key frontline staff to assess, support or refer families into relevant support services and ensure those needing specialist services receive them
- Support parents of children who are frequent users of primary and unscheduled care services to understand and manage minor illness and ailments at home, and when and how to access wider support.
- Ensure local services work together to minimise duplication and gain the best possible outcomes for families
- Work with schools to promote health and wellbeing messages and harness the energy of young people to improve the health of their families

How will we know we're making a difference?

- Increase the proportion of mothers breastfeeding at six to eight weeks after birth
- Decrease the number of pregnant women smoking and of families exposing infants to second hand smoke
- Decrease in parents of infants with mental health concerns
- A reduction in the average number of teeth which are actively decayed, filled or extracted amongst children aged five years
- Increase in number of children who reach good level of development in communications and language at the end of reception
- Increase in number of children who reach good level of development in personal, social and emotional development at the end of reception

Targeted support for vulnerable groups

We will target the support provided for vulnerable groups and those most in need including:

- children and young people from low income households where poverty is associated with poor health and developmental outcomes
- Children from vulnerable families (e.g. teen pregnancy, homelessness, substance misuse and domestic violence) known to services
- Parents and parents to be with poor mental health which can have a very significant impact on early child development.

(3) Addressing the rising tide of long-term conditions

Where are we now?

Thankfully, because of advances in care and treatment of long-term conditions (LTCs) like hypertension, cardiovascular disease and diabetes, people are living longer. But this care and treatment is consuming an ever greater proportion of resources. Care for LTCs presently accounts for 55% of GP appointments, 68% of outpatient and A&E appointments and 77% of inpatient bed days nationally. Cost pressures on the health and care system deriving from management of LTCs is likely to add £5 billion to the annual costs of the system between 2011 and 2018. It is estimated that £7 out of every £10 spent on health and social care in England is associated with the treatment of people with one or more LTCs. Currently 15 million people are estimated to be living with one or more LTC in England and this is projected to increase to around 18 million by 2025.

What will we do?

We are committed to improving care for people with LTCs in order to enable them to have an independent and fulfilling life and to receive the support they need to manage their health. We will:

- Provide support and information for people to maintain healthy lifestyles
- Provide increased support for self-care and self-management of conditions
- Ensure continuity of care
- Ensure people's conditions are treated holistically by coordinated health and social care services
- Ensure there is 'no wrong door' and effective signposting to health and social care services
- Ensure people their carers and families are involved in decisions about their own care
- Provide support for carers and their families to ensure they are able to support care receivers effectively

How will we know we're making a difference?

- More people feel supported to manage their conditions
- More people and carers feel empowered and involved in their care planning
- More people experience integrated care between services

- Reduction in avoidable (unscheduled) emergency admissions
- Reduction in emergency readmissions after discharge from hospital
- Increase in the percentage of GP appointments with a named GP
- Increase in the number of days spent at home
- Reduction in falls
- Uptake of personal budgets
- Increase in the percentage of people still at home 91 days after discharge from hospital into reablement

Targeted support for vulnerable groups

We will target the support provided for vulnerable groups and those most in need including:

- The homeless population
- BME groups who are disproportionately likely to develop some long-term conditions

(4) Delivering a high quality and sustainable health and social care system.

- The London devolution agreement reached in 2015 provided the basis on which there will be greater scope for decision making in health and care locally. It describes the framework within which decisions around a range of public services including transport, employment, planning and other areas would be devolved to London local authorities, giving people and their local representative's greater control over decisions which have hitherto been taken at a national level.
- The reform of health and social care is a key part of delivering on the national policy shift toward greater devolution of control to local communities. But we know that this will require a shift in our strategic leadership and in the way we deliver this locally. We, in our borough, are a range of statutory and community based organisations coming together to take more control over the public money being spent on health and social care in the borough. We are doing this so that we can work with local people and people who use services to change what they experience locally. We will need to work within the NHS Mandate, Five Year Forward View, our own strategies and the associated national policy and quality assurance parameters to deliver this.
- One of our first tasks will be to put in place the leadership and governance arrangements which will be required to deliver these improvements at pace and scale and ensure that we as a system are able to reach decisions together in a robust, fair and equitable way. Ultimately we need to be able to share some pre-agreed decision making across our organisations, and the Health and Wellbeing Board in Hammersmith and Fulham has the central coordinating role to enable us to deliver effective leadership and decision making locally.

Leadership priorities

- **Agreeing the creation of this Health and Wellbeing strategy for 2016-2021:** Working across organisations, with communities, residents and users of our services, the first critical test for our leadership across health and care in the borough is the creation of, and agreement to, this new Joint Health and Wellbeing Strategy for the next five years. This process is requiring us to set out what we will all work together on and will directly inform how we commission services and on what basis we will do so. Immediately following the publication of this strategy we will be seeking the support of national bodies including NHS Improvement, NHS England, the Local Government Association and others to discuss how we plan to deliver on our plan and how they can support us in this endeavour. Alongside this, we will agree a new vision for how

Hammersmith & Fulham sees its public health duty which it acquired in 2014 being discharged over the next five years.

- **Putting in place the governance and accountability arrangements which will help us to deliver :** In Hammersmith & Fulham, we have a strong history of joint working across health and social care and this strategy builds on that learning and experience. As we work to deliver greater improvements in health and care locally, we will need to revise and update our governance and accountability arrangements – ensuring that we are able to reach consensus and take decisions in a timely and appropriate manner, putting in place the sub-structures and accountability frameworks which will ensure that we deliver on our priorities locally and working alongside governing bodies and overview and scrutiny councillors to check our progress and open up big policy issues to wider discussion across the health and care community. A key priority for us in this respect will be designing in the processes by which local people (including people who use our services) are engaged as active contributors to the decision making process, and how providers of health and care are involved in this process – either as members of our Board or working with us through sub-groups to deliver on our shared aims.

The Workforce Challenge

- In our borough, as with elsewhere in the rest of the country, we have an ageing population, an increase in the number of people with multiple long-term conditions and a growing burden of chronic disease placing the greatest demands on services now and in the future. The changing nature of need in our population means that we need to transform a workforce that has been trained to work on single episodes of care in hospital into one that is trained and equipped to work in integrated and multi-disciplinary ways.
- Advancements in treatments and drugs mean people are living for longer with a correspondingly higher demand for care in out of hospital and social care settings. Despite this, only 35% of the NHS's training budget is spent on nurses and allied health professionals and there is little national investment in the social care workforce or the unqualified workforce, such as healthcare assistants. Equally, the number of number of district nurses fell by 38% between 2001 and 2011 (Royal College of Nursing) and there is a large and growing mismatch between the demand and supply of health and social care workers, including a large undersupply of GPs.
- Strategic workforce planning is therefore crucial to delivering our ambitions for a financially sustainable and safe integrated health and social care system providing quality services to people. If we do not act there is a danger that the available workforce will drive the design of our health and care system rather than the other way around. Planning the workforce we need for the future will require local organisations and patients in our borough to come together to understand the impact of technologies on the role of the health and care workforce in the future and understand the areas of demand growth in our system. It will require us to work with partners such as Health Education England and Public Health England to access funding streams and work with universities, professional colleges and other bodies to offer more generalist professional training that focus on multidisciplinary work in team-based settings.

Early implementation priorities to address the workforce challenge:

- **Map our current workforce :** Following the agreement of this Joint Health and Wellbeing Strategy, one of the immediate tasks for us will be to work with our partners to look at the current and future needs of our population and mapping projected demand for health and care services to understand gaps in our workforce. Strategic workforce design is needed not only to deal with the dwindling workforce but also to address the changing nature of health and care work and the skills required to meet needs. This is a complex challenge that requires both local

and national action. There needs to be a shift to a multi-disciplinary and multi-professional approach to care. The future workforce needs to be based on future needs not by workforce availability. New technologies and ways of working will also profoundly affect the nature of future health social care work, where it is done and by whom.

- **Work with partners to redesign the training and development system:** Once the workforce supply need is understood, we must work with universities, royal colleges, Health Education England and other teaching institutions to refocus local health and care worker training programmes towards the workforce needed for the future. This includes more specialist skills in primary and community care, more generalist skills in hospital care and more collaboration across hospital and community and mental health and physical health workers and more multi-skilled staff to work across NHS and social care sector boundaries. We need a change in the training curriculum to develop the skills to care for people with multi-morbidities that span physical and mental health.
- **Provide the right reward structures and contract flexibility to incentivise the creation of the right workforce:** Retention of current staff is vital. Greater flexibility of pay and terms of conditions must be addressed to incentivise the supply of staff where demand is greatest. Training also needs to prepare staff for multidisciplinary team working rather than the roles of professional groups. We need to support and better harness the power of the informal workforce by creating a 'social movement' to support those in need, including a more strategic approach to the support and development of volunteers.

The changing role of communities and individuals

- Population growth, breakthroughs in treatment and management of conditions and changing needs mean that the health and care system is under increasing pressure and financially unsustainable. In our borough we have a diverse and mobile population. The role patients can play is increasingly important to considerations about how to deliver a system that is effective and sustainable in terms of care quality and value for money. In Hammersmith & Fulham we must be ambitious in our attempts to affect a change in culture so that people are better supported to take more responsibility for their own care.

Early community mobilisation priorities to address this are:

- **Capitalise on the benefits of self-care:** The extent to which a person has the skills, knowledge and confidence to manage their own health and care ("patient activation") is a strong predictor of better health outcomes, healthcare costs and satisfaction with services. The potential benefits of people engaged in the management of their own care are significant. As approximately four-fifths of our population is mostly healthy, we need a greater focus on keeping people well and on self-care. Small shifts in self-care have the potential to significantly impact on the demand for professional care. Some experts argue that as little as a 5% increase in self-care could reduce the demand for professional care by 25%[4]. In Hammersmith and Fulham we need to identify and capitalise on people's strengths and residents' commitment to managing their own care and work with them to find ways to influence others so that they can do the same.

The infrastructure challenge

- Both the NHS and Local Authority have large portfolios of land and buildings. More attention must be given to how this precious resource could be leveraged to improve efficiency, experience and care quality. Estates transformation is also a key enabler of service transformation.

[4] (2014) Imison, C., and Bohmer, R. "NHS and social care workforce: meeting our needs now and in the future?" The King's Fund

- Models of care are still too often designed around buildings. Instead, partners in Hammersmith & Fulham must work together to plan and build the estate required to respond to clinical need and the changing needs and demands of our population. This means bringing together health care, social care, housing and other providers of care and related services in our borough in more integrated ways that create value for the wider community.

Early implementation priorities for our estates:

- **Developing the estate required to facilitate new models of care and support:** In short, a new approach is needed to the design and delivery of health and social care buildings. One that looks across the whole system and brings services together to improve access and experience for patients and opportunities for provider innovation and collaboration. Such approaches offer ways to reduce costs and improve efficiency, improve the quality and appropriateness of care settings, and to generate income for reinvestment. A strategic approach to our estate has the potential to help break down barriers between health and social care, mental and physical health and primary and secondary care. There are opportunities, for instance, for mental health providers, housing and employment services to explore integrated approaches that would better support service users. A more flexible approach involving co-location of NHS and social care staff in non-NHS buildings would make services more flexible and accessible and would release savings that could be reinvested in patient care, staff and technology. School premises for instance are underutilised as settings for providing child health services despite being ideal settings for such provision.
- **Increase value from under used and under-utilised estate in the borough:** The Health and Wellbeing Board partners must work together to understand how we use our buildings and their state of repair across health, social care, housing and the voluntary and community sector. Better strategic management of our estate could realise multiple benefits including the removal of fixed running costs that contribute to our financial challenge, the release of land for housing our workforce and reinvestment of disposal proceeds back into the health and care system. A grasp of use and utilisation can also enable us to become more efficient in how we use our precious resource and identify opportunities for co-location and asset sharing across health and care.

The information and digital challenge

- Investing in information technology and data analytics will all be crucial to enable a successfully integrated health and social care system that provides patients with a good experience of care. We must work together to facilitate and enable information exchange between organisations in a way that respects patient preferences and information governance protocols. Not doing so will hinder inter-organisational collaboration and innovation. We cannot rely on analogue methods such as mail and fax, which are time consuming, unreliable, restrict the ability for advanced analytics and are bad for patient experience.
- We must seek to develop shared digital patient records updated in real-time and shareable across organisational and sector boundaries. Better information collection and management will also enable better retrospective and predictive modelling and both professional and strategic decision making allowing us to understand how efficiently we are utilising our resources and improve quality and safety standards for people.
- We must exploit the smart phone revolution and use people's phones and other digital devices as a new "front door" to self-care, health promotion information and services, building on the "One You" app recently launched by Public Health England and providing a seamless link to self-care and prevention work for adult social care.

Early implementation priorities:

- **All partners across the borough must agree to share information where it makes sense for patients and they are happy for us to do so:** A first crucial step in building our health and social care system will be for local organisations to commit to collect, share and pool information in a way that links data at an individual level and organises it into a format which enables better analysis and decision making by the system. We can only do this with resident support and must be mindful of individual privacy and information governance considerations. It will be vital that data sharing agreements recognise patient preferences and information governance protocols. Ensuring interoperability between different organisation's systems will be a second crucial step.
- **Investigate the role of technology in enabling people to manage their own care:** We should work with local and national partners to explore opportunities to utilise the power of technology to facilitate self-management of care. Remote monitoring of conditions and tele-health (remote consultations) are promising areas where technology could reduce demand on the health and care system and improve patient experience. More should be done to investigate the viability of these approaches locally and scale up what works.

The financial challenge

- To encourage integrated care, payment incentives and health and social care planning cycles need to be aligned. There is an urgent need for experiments in changing the nature of tariffs for NHS care to enable greater investment in primary and secondary prevention, alongside delivering community and acute health services where needed. Commissioners also need to increase the use of pooled budgets where it makes sense as a way of enabling closer health and social care collaboration. Using quality-based incentive payments across pathways of care might likewise incentivise best practice models and partnership working, while ensuring that providers are incentivised to make a contribution to the health and wellbeing of the whole population. Personal health budgets too will enable patients and service users to commission their own care in ways that better meet their needs.

Early implementation priorities:

- **Starting to view our budgets and services in a single joined up way:** The work of the Health and Wellbeing Board and this Strategy provide us with an opportunity to think about health and care services and budgets 'as one'. Indeed, to achieve the kind of radical changes in outcomes that local people expect us to deliver it is vitally important that we do so. Viewing budgets and services separately does not support our aspiration to deliver personalised, integrated, local services to people. But we know that this is how our system is currently constructed. A key leadership challenge for us will therefore be in putting in place arrangements for us to be able to view our budgets and services together as one. We will need to do this by modelling our spend and priorities over the lifetime of this strategy, setting out how much we anticipate we will spend over this period and on what. We will then need to consider how best we can incentivise our whole system to deliver on this by learning from elsewhere and looking at budget capitation models and others. We will progress this work and this thinking in 2016/17 so that we can maximise on the potential that this five year strategy can deliver for local people.

2. Implementing the plan

- This plan signals a radical shift in our local planning approach for health and social care. Building on our last Joint Health and Wellbeing Strategy, we have an opportunity to bring together local NHS commissioners and providers, local government and other local public services to develop a renewed vision for improved health in Hammersmith and Fulham. This place-based approach is

an acknowledgement by us that collective action, cooperation and management of common resources is necessary to secure better and more sustainable care.

- We have already had many conversations with local people and our partners over recent years about improving health and social care and preventing ill health including workshops, consultations, patient and public groups. This plan represents the fruits of these conversations and we will build on these over the next five years using ways of engaging directly with residents, including building on the success of our recent Neighbourhood Health Forums.
- We have many staff in Hammersmith & Fulham working in health and social care services who will be central to the success of this plan. Partner organisations will lead engagement with their own staff to enable them to deliver this vision.
- Following agreement of this plan, the Health and Wellbeing Board partners will set out a timetable for talking with staff and local people about our plans. We will also run events with Healthwatch and with local people about the support they need to take control of their own health and wellbeing.

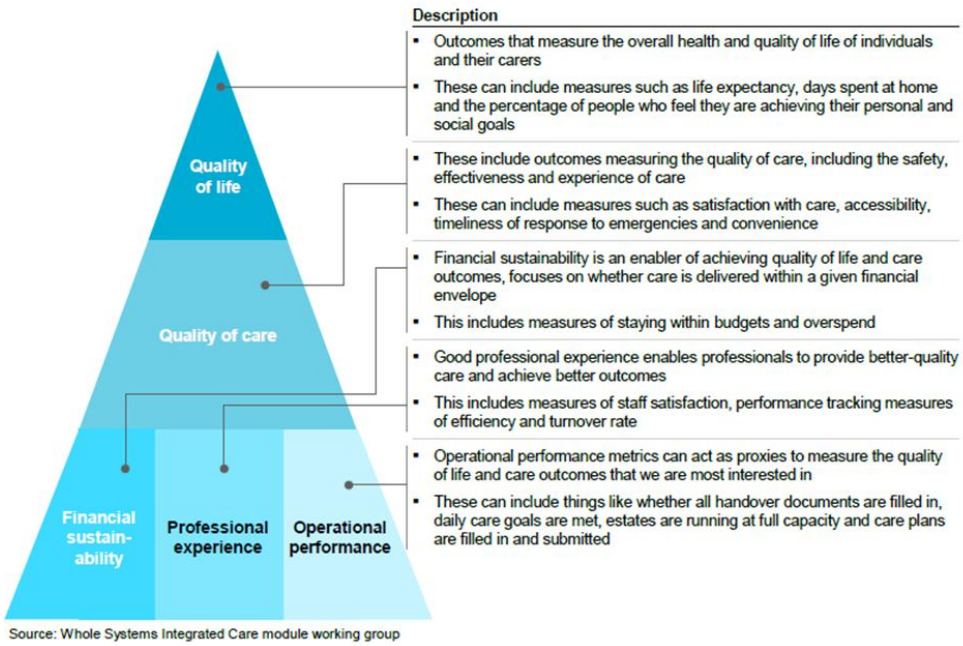
APPENDIX

Appendix A - Outcomes-based commissioning

- Traditional ways of buying health and social care services ("commissioning") have tended to focus on processes, individual organisations and single inputs of care. That is, the people who buy services ("commissioners") have tended to pay the people and organisations that provide health and social care services ("providers") according to the number of instances of treatment provided. This focuses the health and care system on completing specific tasks and away from treating people in a holistic way and on a person's overall wellbeing.
- Funding is attached to treatment, and so providers of health and care try to provide as much treatment to individuals as possible. This can be costly for the system as a whole and militates against the prevention of ill health. This approach has inadvertently helped create a fragmented approach to the way care is delivered and has acted as a barrier to the development of more integrated services and models of care.
- "Outcomes" are the end results we aspire to achieve for people, their families and their carers. Outcomes-based commissioning allows us to focus on the important aspects of care - the result from a patient's perspective. Under outcomes-based commissioning providers are paid for meeting specified outcomes, including things like the patient's experience of care and the extent to which they are kept well. Outcomes based commissioning therefore can be used to incentivise shifting of resources into out-of-hospital settings, focus health and care providers on keeping people healthy and in their own homes and co-ordinated care across settings and regions. It also encourages a focus on the experience of people using the services, and achieving the outcomes that matter to them.
- This is the approach needed in Hammersmith & Fulham. The Health & Wellbeing Board partners commit, through this strategy, to outcomes-based approaches to commissioning.

Our Outcomes Framework

- An outcomes framework allows commissioners and providers within a health and social care system to link what they do on a day to day basis with what they want to achieve and how they commission services. The North West London Outcomes Framework is set out below. It summarises the key outcomes desirable in an integrated system of care to into five domains, as follows:



Source: Whole Systems Integrated Care module working group

- The Hammersmith & Fulham Health and Wellbeing Strategy uses the North West London outcomes framework to ensure that there is a consistent approach to understanding people's needs and buying services in support of them across the sub-region. Being consistent across larger geographies including North West London is important, particularly in London, because so many providers of health and care operate across borough boundaries and because Hammersmith & Fulham residents access services outside of Hammersmith & Fulham.
- Basing our future commissioning on a shared framework in this way allows us to deliver scale to the range of services we have on offer for Hammersmith & Fulham residents and it means that we can make a shift, across the whole system, in the way that health and care is organised, bought, delivered and measured.
- In this outcomes framework and hierarchy, the most important perspective is the well-being of the person who is receiving services and as such, the first two domains – 'quality of life' and 'quality of care' (what we have termed quality of experience of care) - are the most important. The other three outcomes domains – financial sustainability; professional experience; and operational performance – are all crucial enablers for delivering quality care and quality of life for Hammersmith & Fulham residents and are addressed holistically in the systems section.
- Outcomes-based commissioning provides a way of paying for health and care services based on rewarding the outcomes that are important to the people using them. This typically involves the use of a fixed budget for the care of a particular population group ("capitated budget"), with incentives for health and care providers to work together to deliver services which meet specified outcomes. This approach aims to achieve better outcomes through more integrated, person centred services and ultimately provide better value for every pound spent on health and care.
- The approach can help rather than hinder provider coordination and collaboration; incentivise a focus on prevention; allow providers the freedom and flexibility to innovate and personalise care according to what is best for patients' outcomes rather than sticking rigidly to service specifications; and incentivise provides to manage overall system costs because providers are accountable for the end-to-end costs of care for a group there is no advantage in passing on costs to another organisation in the system.

Appendix B - Our population health priorities

	What do health and care services look like today?	Outcomes	Priorities	Measures
pre-birth and early years (0-12 years)	Babies generally receive a good start in life in the borough: there is good breastfeeding uptake, low numbers of underweight babies born, low numbers of women who are smokers at the time of birth. However, there is still room for improvement. Giving every child the best start in life is crucial to reducing health inequalities. Children who live in poverty are at greater risk of health and social problems later in life – from obesity, heart disease and poor mental health, to educational achievement and employment status. The number of 10 and 11 year old children who are obese in our schools is almost 40%. This matters, as they have a much higher risk of growing up to be overweight or obese as adults and of getting diabetes, heart disease, stroke and some cancers as they grow older.	• Children's physical, social and emotional development is improved • Young children, parents and carers are supported to start well and stay healthy and independent	• Planned pregnancy (SRE in school, contraception etc) • Additional support for vulnerable families (e.g. teen pregnancy, homelessness, domestic violence) known to services and supported through pregnancy/early years • Access maternity services early. • Integrated maternity, midwifery and local authority early years and health visiting services to ensure there are valuable connections and information sharing • Supporting a healthy pregnancy (e.g. smoking, alcohol, weight gain, folic acid) • Prepared for birth: antenatal education/maternity care • Parents supported through the healthy child programme (e.g. health visiting, breastfed to 6 months, immunised, support for post-natal depression) • Early help support for families to ensure readiness for school (e.g. development reviews, speech/ language, physical, and emotional health) • All children supported to achieve good educational attainment and qualifications, including vulnerable groups (e.g. healthcare plans for children with additional needs) • Reduce detrimental effects of poverty on educational outcomes • Good oral health: healthy diet, brushing teeth, & visiting dentist	• School readiness • Reducing number of low birth weight babies • Reduce excess weight in 4-5 and 10-11 year old old children • Improve population vaccination coverage at 1, 2 and 5 years

	What do health and care services look like today?	Outcomes	Priorities	Measures
			• Discouraged from starting habits detrimental to health (e.g. smoking, drug use) • Maintaining healthy weight (e.g. school environment, being physically active) • Supported in building mental health resilience (e.g. education, school nursing, anti-bullying) • Intensive support for families facing multiple difficulties where this is resulting in poor outcomes, high costs, or safety issues • Immunisations and vaccinations including uptake of HPV vaccine for girls • Better integration and joint commissioning of social care support services (Early Help) and community health services: health visiting, school nurses, and mental health support in schools. • Improving air quality	
young people (13-17 years)	Young people in the borough face particular challenges. There are a significant number of children living in poverty and many young people are not in education, employment or training. Child obesity rates are high, there is poor child vaccination coverage and high levels of tooth decay in children.	• Young people are supported to start well and stay healthy and independent	• Received screening and advice around STIs and conception • Where appropriate, received additional training or support to get into paid work • Help giving up smoking through a stop smoking service • Integrated health and care services for young people to ensure good care coordination • Received support for low-level mental illness via IAPT programme, if needed • CAMHS support for young people with serious mental health disorders • Support managing any hazardous alcohol or drug use through statutory services • Registered with GP and women attending cervical screening	• Increase parental employment • Reduce child poverty • Reduce child obesity • Improve vaccination and immunisation rates

	What do health and care services look like today?	Outcomes	Priorities	Measures
			• Ensuring multi-agency planning and services for young people in challenging circumstances (e.g. young offenders, gang members, looked after children, homeless young people and young people who have been exploited or abused) • Investment in young people's mental health services • Implementation of the Children and Families Act 2014 (e.g. children with SEN) • Ensuring good transitions between child and adult services (e.g. early care planning, key workers and coordinators)	
working age adults (18-64 years)	Working age adults make a significant contribution to society and to the health and wellbeing of others including as workers, as parents and as carers for parents, relatives or friends. These responsibilities mean it is important adults know how to keep themselves healthy and build this into their everyday lives. There are significant health challenges in this population however: suicide rates are high, there is a large homeless population, high levels of drug misuse and smoking, low uptake of breast and cervical cancer screening, and a high prevalence of mental ill-health. There are a larger proportion of people infected with HIV and high	• Working age adults are supported to stay healthy, independent and well • The gap in life expectancy between adults with serious mental health needs and the rest of the population is reduced	• Support for healthy lifestyles (e.g. smoking cessation, physical activity, diet, alcohol consumption) • Retain an active lifestyle to prevent overweight and the risk of long-term conditions • Undiagnosed long term conditions such as high blood pressure and diabetes is picked up via health checks, to be offered in a range of settings • Effective self-management of these conditions, through information, training, and a change in habits • Good access to sexual health services to detect, diagnose and treat STIs • Women attending cervical and breast screening • Support for those on long-term sickness to return to work • Received support for low-level mental illness via IAPT programme, if needed • Support for people with severe and enduring mental illness	• Increasing the number of parents in good work • Increase the number of people with learning disabilities in employment • Increase the number of people with mental health needs in employment • Reduce health inequalities between most and least affluent residents in the borough • Improving premature mortality from Cancer, CVD, respiratory disease • Reduce statutory homelessness

	What do health and care services look like today?	Outcomes	Priorities	Measures
	proportion of sexually transmitted disease. Unhealthy lifestyle choices tend to cluster together. So people who smoke are more likely to drink too much alcohol or to use other drugs and are also more likely to have poor diets and live inactive lives. We need to consider how we can help people address multiple rather than individual unhealthy behaviours.		• Support for people with learning disabilities • Support for people affected by suicide • Support for homeless communities and those sleeping rough • Early detection and diagnosis of HIV • Mitigating the impact of poor air quality for people living with cardiovascular disease or respiratory disease	• Reduce social isolation of carers and social care users • Reduce smoking prevalence
Older people (65+ years)	Older people make a valuable contribution to society. The majority of volunteers are aged 50 or over, and older people also represent a significant proportion of carers. Older people also have a wealth of skills, knowledge and experience. It is vital therefore that we support older people to age well. Our population is ageing and this means we will need to support growing numbers of people living with multiple conditions including dementia, cardiovascular disease, respiratory disease and frailty. These conditions are often linked	• Social isolation is reduced • Older people are supported to age well and stay healthy and independent	• Undiagnosed conditions picked up and self-managed or managed through GP/ community services, rather than through emergency care • Avoiding social isolation through the active engagement in activities and pastimes. In particular, partaking in gentle physical activity (e.g. walking, gardening) to lower risk of cancer, heart disease, mental ill-health and weak bone strength • Screening for early signs of dementia • Uptake of schemes which improve self-management of care • Receiving high quality health and social care designed around the person, not the condition, in convenient settings and at convenient times • Preventing sight loss • On reaching end of life, support in dying in preferred place of death • Mitigating the impact of poor air quality for	• Reducing the number of people over 65 admitted to hospital due to falls • Reduce emergency readmissions within 30 days of discharge from hospital

	What do health and care services look like today?	Outcomes	Priorities	Measures
	with factors like social isolation and poor housing which can make care more complicated. Preventing chronic disease requires a range of interventions such as screening and vaccinations. Overall there is good uptake of NHS Health Checks and diabetic screening, good flu vaccination uptake, low number of hip fractures and low excess winter deaths.		people living with cardiovascular disease or respiratory disease	

HEALTH AND WELLBEING BOARD WORKSHOP
BALLROOM, LINDEN HOUSE, W6
20 MAY 2016, 11.00am–14.30pm
SESSION REPORT

Attendees:
Councillor Vivienne Lukey (Cabinet Member for Health and Adult Social Care); Councillor Sharon Holder (Lead Member for Hospitals & Health Care); Liz Bruce (Executive Director of Adult Social Services); Chris Neill (Director Whole Systems, Adult Social Services); Rachel Wright-Turner (Director of Children's Commissioning); Stuart Lines (Deputy Director Public Health); Janet Cree (Managing Director, CCG); Vanessa Andreae (Practice nurse, CCG); Dr Tim Spicer (Chair, CCG); Keith Mallinson (Chair, Healthwatch)

Apologies:
Councillor Sue Macmillan (Cabinet Member for Children and Education), Councillor Rory Vaughan (Health, Adult Social Care and Social Inclusion Policy and Accountability Committee Chair), Dr Mike Robinson (Director of Public Health), Ian Lawry (Co-optee, Sobus)

Introductions

Chris Neill welcomed Board members. He reminded people that at the Health and Wellbeing Board meeting in March facilitated by Chris Ham that members agreed to hold an informal half-day session to develop the joint health and wellbeing strategy and that today's session was the result.

Mr Neill began the session by asking board members to share perspectives on health and wellbeing, the content of any conversations members had had with one another since March and on their role on the Board. The following points were made:

- That the role of Healthwatch was ensuring the patient voice was listened to and included in the decision making process.
- That too often changes in health and care feel done to others without people having much of a say.
- That mental health provision had been a Cinderella service for too long and needed to be brought into more of our thinking
- That organisations were often more powerful that patients and that this needs to change.
- That tackling health inequalities and ensuring social mobility were a key driver and personal motivation
- That there was a strong community in Hammersmith & Fulham and the Board needed to build on existing community ties to improve health and wellbeing
- That the role of the Board was about the art of the possible

After perspectives had been shared, Chris outlined the session plan and gave a synopsis of the paperwork in front of members. He particularly highlighted the draft strategy discussion document which set out a potential framework for the Board's next joint health and wellbeing strategy. Chris explained the document would be updated with the feedback gathered at today's session. Chris also drew attention to

an A3 pyramid diagram in front of members explaining that any thoughts and reflections captured here by members throughout the session would also be used to update the draft strategy. Chris highlighted that the next formal Board meeting was 20 June and that officers would bring a near-final draft strategy document to that meeting along with the North West London Sustainability & Transformation Plan (STP).

Case studies: International integrated care systems

Mr Neill gave a presentation that drew out the features of a number of international integrated care systems. He made the following points:

- Kaiser Permanente in California has a strong prevention ethos which stemmed from its origins as a health care system for workers building dams in the Californian desert in the 1930s. Organisational features also included the use of capitated budgets, risk stratification, use of technology and viewing hospital admissions as 'system failure'. Heavy use of data to understand population needs.
- The Nuka System of Care in Alaska as well as integrated health and care services has programmes which tackled wider community issues such as domestic violence, abuse and neglect through education, training and community engagement. The system also displayed strong community ownership with local people in system governance structures.
- Gesundes Kinzigtal, in Germany had a strong workforce element and development with professionals making joint decisions. As well as having traditional contracts with health providers contracted with local gyms, sports clubs, education centres, self-help groups and local government and offered a range of activities and health promotion programmes in schools and workplaces.
- The Jonkoping County Council, Sweden model had a strong data-based model that used a dashboards and a range of indicators to understand population health including non-typical indicators such as rates of obesity, physical activity, diet, deprivation, crime, truancy and educational outcomes. Model built around primary care.
- Canterbury, NZ transformation started with an analysis showing it was unsustainable on its present path. It developed a strong, clear and sustained vision of where the health and social care system had to go ("one budget, one system"), made continued investment in leadership and innovation skills for all levels of staff, empowering staff to innovate providing the freedom and tools to do it (Lean, Six Sigma). It built on existing strengths (strong primary care) and adopted and adapted ideas from elsewhere.

Common features of the systems included:

- Population-level data to understand need across populations and track health outcomes
- Population-based budgets (either real or virtual) to align financial incentives with improving population health
- Community involvement in managing their health and designing local services

- Involvement of a range of partners and services to deliver improvements in population health.
- Population segmentation and risk stratification to identify the needs of different groups within the population
- Targeted strategies for improving the health of different population segments
- Developing 'systems within systems' with relevant organisations, services and stakeholders to focus on different aspects of population health.
- Integrated health records to co-ordinate people's care services
- Scaled-up primary care systems that provide access to a wide range of services and co-ordinate effectively with other services
- Close working across organisations and systems to offer a wide range of interventions to improve people's health
- Close working with individuals to understand the outcomes and services that matter to them, as well as supporting and empowering individuals to manage their own health

Discussion

Following the presentation, members had the following reflections and thoughts on what could be learned from the models:

- That the presentation had offered helpful lessons for the Board but that international models could not always be fruitfully compared with the UK because of differing national taxation regimes. It was highlighted that, for example, in Sweden, citizens pay 40% tax for an excellent healthcare system but that this wasn't the case in the UK.
- That in an ideal world, the NHS and social care would be taken out of national politics altogether to encourage more long-term thinking.
- That the STP had been rushed and was a missed opportunity to have a debate with the public about a broader vision for health and social care in North West London. It was hoped today's session could be used to agree that vision locally and start to communicate it widely.
- That the STP had been done to both patients and professionals and the model of care that it sets out is not one where people own their own health. That digital and app-based technologies that, for instance, allowed you to monitor diet, exercise and other lifestyle factors, promised significant opportunities for catalysing a shift toward self-care.
- That the NHS had been overly patriarchal in the past and that now what was needed was a supportive stance that enabled people to take greater responsibility for their own health and the health and wellbeing of their families.
- That 'coaching for health' training which worked with people to plan and make manageable changes to their lives was a good example of the sort of approach needed.
- That there was considerable waste in the public sector and that we need to consider how to get more out of what we have so that more resources could be used on the frontline.

The group broke up into small groups to consider the presentation. Reflections included:

- That developing a shared vision across HWB organisations was of critical importance. Priorities and outcomes, by comparison, were likely to be relatively uncontroversial given the clear evidence and what we know about health and need locally.
- That early intervention, reducing wasted patient time and giving more responsibility and control to the patient were all crucial features of the model needed locally
- That the importance of prevention and early intervention is known but the question was how to do this i.e. how far upstream do we go? It was suggested that we need to employ behaviour change methods and nudge techniques, looking to the plastic bag ban for instance as an instructive policy example.
- That we need clear messaging such as the five ways to wellbeing
- That we need to bring together and treat physical and mental health equally
- That a key feature of our local model should be an emphasis on empathy and listening to people.

<u>Breakout session one – What is our vision for Hammersmith & Fulham by 2021?</u>

Chris introduced the first breakout session highlighting the draft vision in the discussion document. He asked people to mix up into groups, and drawing on the previous discussion and case studies, discuss a vision for the borough for the next five years and how we will deliver it. Groups had the following feedback:

- That there was consensus by the group that supporting independence and self-care and prevention and early intervention were an important part of the vision and that one of the Board's aims is to enable resident's to be responsible for their own wellbeing and wellbeing of those around them.
- That the best start in life and the children and families agenda needed to feature more prominently in the vision. Using the stream metaphor, going upstream means targeting children to be healthy.
- That the enthusiasm and responsiveness to health messages in schools meant the Board could use children and young people to improve health in families.
- That good mental health had to be a stronger feature of the vision and treated equally with physical health. That the Board should move away from thinking and talking in terms of "mental health" towards something like "social health" – emphasising the important role of community networks and social connections.
- That the pictogram from the Canterbury, NZ model of care described the model needed locally (see Appendix A). I.e. with people, families and communities at the centre with services and community resources wrapping around the outside.
- That joined up thinking was needed so that no matter where people in the system present they are signposted and referred correctly. This meant equipping all public sector staff with a base level of knowledge and skills beyond their core business.
- That it was important to educate people about how the health and social care system works and how and when to access it and that we should use existing

resources such as health champions and carers champions to communicate these messages.
- That the NHS has traditionally done digital very poorly and that we need to exploit the potential of digital technologies to facilitate control and choice and enable patients to manage their health in the way that best suits them (including digital and apps). That digital will increasingly become the way people want to engage but that we still need to offer other channels to interact in the way that best suits people

The Board also commented on the tone of the vision:

- That the tone of the vision needs to be public facing.
- That the tone needs to be less about what the health and care service will do or deliver to people and more about how it will work with people. That there needs to be a shift in perspective emphasised in the language from service provider to catalyst or enabler of change
- That the vision needed to move away from a deficit or disability formulation to an asset and ability based one, emphasising the talents, resources and abilities of people and communities, especially celebrating the ageing population
- That there needed to be a responsibility deal or contract between the public and the health and care system setting out what both can expect from one another. This would include things like being a good neighbour and community member.

Breakout session two

Stuart and Janet introduced the second breakout session with a brief overview of health needs in the borough. Members were given a pack of information on the health needs in the borough and asked to choose their top population health priorities. Group feedback on priorities included:

Areas of commonality across the Board:
- Strong local connection / community focus
- Vision driven by values
- Strong outcomes focus

Priorities:
- Tackling health inequalities
- Social inclusion and isolation
- Best start in life and family support including an emphasis on parenting support, early help, child poverty and obesity and immunisations
- Mental health
- Obesity
- Communication, co-production and co-commissioning with residents
- Resilience, independence and self-care
- Prevention and early intervention
- Integrated services – no wrong door
- Wider determinants of health (air quality, poverty and worklessness)
- Digital: facilitate control, choice and effectiveness

Delivery:

- That once priorities are agreed the Board should dashboard progress measures and ask every item that comes to the board to say how it contributes to our priorities
- That the Board needed to select a small, manageable number of priorities and do them well
- That board members could pair up and take responsibility for the delivery of priorities
- That the priorities should be articulated in terms of the language of outcomes e.g., “our children will be immunised” etc
- That HWB meetings should rotate around areas or themes that play to priority areas and could link with PAC for accountability

Breakout session three

Mr Neill introduced the final breakout session. He explained that a strategy that set out a vision and priorities would also need to say something about how that change will be delivered. These are the enablers of change and included things like technology, workforce and governance. For the last time, people were asked to divide into groups and discuss the enablers of change that would be needed to deliver the vision and priorities discussed already. Group reflections included:

- That communication and representative engagement were important and that the Board could go out to public and make meetings public events
- That there should be a more direct link with the work of CCG governing bodies with a more overt link with GB papers
- That membership was a crucial enabler and should be reviewed to consider how best to engage with NHS providers and others such as housing and the criminal justice system.
- That governance was a key enabler and that the Board should aim to position itself at the top of tree with Governing Bodies and Cabinet delegating responsibility for health and social care decision to the Board
- That a means of tracking progress was crucial including the use of a performance management system or dashboard
- That digital and IT were crucial enablers of further integration, information sharing, analysis and the self-care agenda
- That it was important to seek to embed health in all policies – and work with planning, transport, education and the criminal justice system to do this and hold to account for doing this.

Before concluding, Chris asked Board members if they had any other reflections which they had been unable to share so far. The following reflections were made:

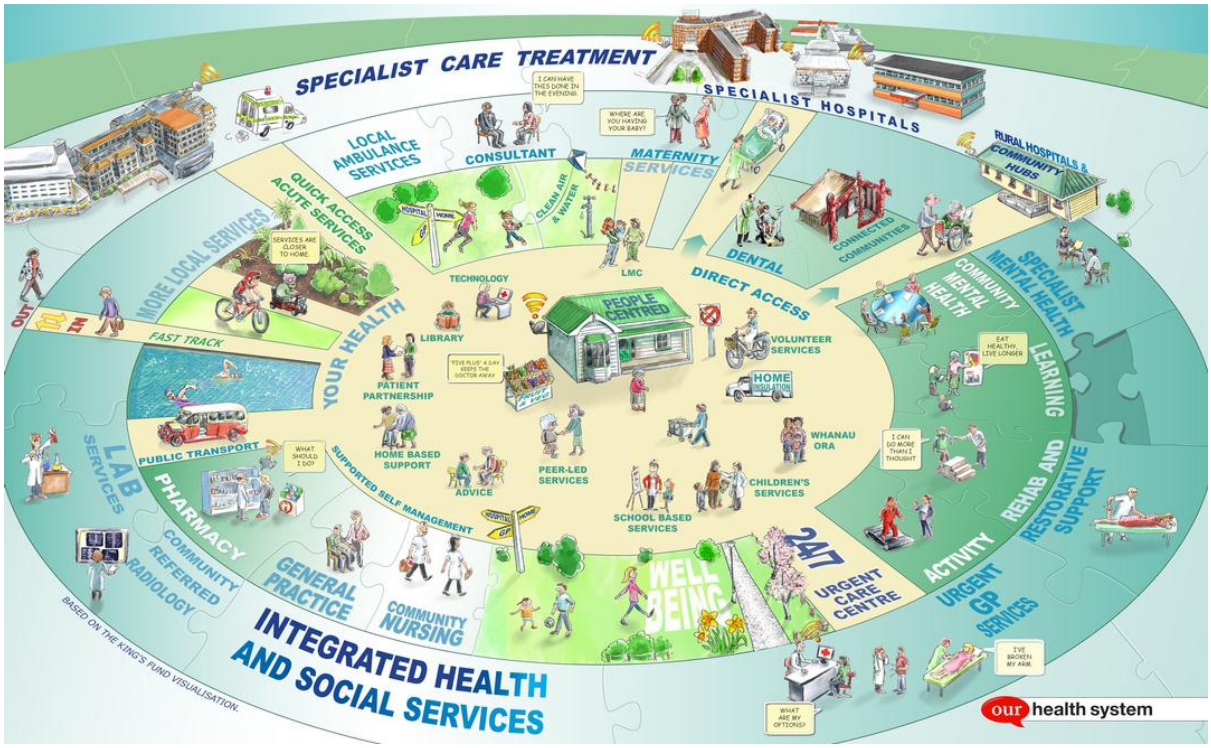
- That information and education were integral to everything and it was vital that people were aware of how the health and social care system worked, and what to access, how and when. From the perspective of the health and care system, a no wrong door approach was needed
- That we should consider other measures of success for the board beyond health outcomes and measures

- That addressing health inequalities and deprivation should be a strong priority that should run throughout the strategy
- That social isolation or social inclusion should be a prioritiy across the whole life course, not just for older people

Next Steps

Councillor Lukey thanked officers for organising the session. She stated that it had been very helpful and that the Board should reflect on how it uses its time during formal sessions. She endorsed the view that in future, the Board could focus on one theme at each meeting and also the idea of Board members pairing up to take joint responsibility for the delivery of the Board's priority areas. Cllr Lukey closed the session by stating her hopes that the Board would continue the discussions started today at its formal meetings.

APPENDIX A – Model of Care pictogram. Canterbury, New Zealand



REFRESHING THE HAMMERSMITH & FULHAM JOINT HEALTH AND WELLBEING STRATEGY 2016-2021: STAKEHOLDER WORKSHOP
LINDEN HOUSE, BALLROOM
24 MAY 2016, 10.30am–12.30pm
SESSION NOTES

Attendees:
Cllr Sharon Holder (Lead Member for Hospitals and Health Care); Stuart Lines (Dep. Dir. of Public Health); Anna Waterman (Public Health); Steve Shaffelburg (Public Health); Jenny Platt (Strategic Lead Integrated Care/Joint Commissioning); Toby Hyde (Head of Strategy, HF CCG); Peter Beard (Head of LD Commissioning, HF CCG); Gayan Perrera (Analyst, Public Health); Tony Barrett (Senior Mental Health Commissioning Lead, LBHF); Nivene Powell (Policy and Strategy Team, LBHF); Bhatti Fawad (Policy & Strategy Team, LBHF); Steve Bywater (CS-Commissioning: RBKC); Chris Neill (Director, ASC Whole Systems); Dominic Conlin (Dir. Strategy and Business Development, Chelwest); Helen Poole (Deputy Managing Director, H&F CCG); Julie Scrivens (Head of Planned Care & Mental Health NHS H&F CCG); Anne Mottram (Director of Strategy, Imperial); Sonya Clinch (West London Mental Health Trust); Pauline Mason (West London Mental Health Trust); Lauren Buckley (Chelwest Strategy Analyst); Jessica Simpson (Programme Manager for Planned Care and Mental Health); Katherine Murray (Mental Health Commissioning Manager); Janice Woodruff (Senior Commissioning Manager NWL CCG); Jennifer Allan (Divisional Director of Operations, CLCH);

Apologies
Dr Mike Robinson (Dir. Public Health); Liz Bruce (Director ASC); Glen Monks (Assoc. Dir. for Mental Health WLCCG); Catherine Williams (H&F CCG); Professor Simon Barton (Chelwest Assoc. Medical Dir. for Integrated Care); Susie Alexander (strategic relationship manager, Agylisis);

Introductions

Chris Neill welcomed everyone to the session. It was explained that the Hammersmith & Fulham Joint Health and Wellbeing Strategy was being refreshed in 2016 and that the session was an opportunity to update people on the work so far, discuss some of the emerging thinking and priority areas and get people's views on the direction of travel from the perspectives of their service areas and organisations.

Chris began the meeting with a reminder of the purpose, membership and role of the health and wellbeing board (HWB) highlighting its role in promoting integration, reducing health inequalities, offering local systems leadership and delivering a collective vision for local commissioning. The approach being taken to the refresh of the Joint Health and Wellbeing Strategy was set out which included the vision, the population and broader priorities, a focus on outcomes and population groups to drive forward more person-centred, place-based commissioning and system enablers of change such as workforce, estates and technology. Chris outlined the development work undertaken so far including a session with the Board in March facilitated by Chris Ham from the King's Fund and the recent development day with the Board on 20 May. Chris mentioned that the team were aiming to have a full draft of the strategy by the end of May. Chris outlined the outputs from the second

workshop session and the Board's emerging thinking and priorities that had been articulated so far as:

- Prevention and early intervention across the life course
- Tackling health inequalities and supporting healthy lifestyle choices
- Best start in life and family support
- Mental health
- Social inclusion
- Enabling and supporting community resilience, independence and self-care
- Communication, co-production and co-commissioning with residents
- Integrated care focusing on patient outcomes and ensuring there is no wrong door for accessing services
- Tackling the wider determinants of health (air quality, poverty and worklessness)
- Digital: facilitate control, choice and effectiveness

Tone

- Enabling resident's to be responsible for their own wellbeing and wellbeing of those around them
- Not doing to people, working with.
- Shift perspective and emphasis from service provider to catalyst/enabler
- Move away from deficit and disability to asset and ability based model.
- Responsibility deal between professionals and people
- Celebrate the ageing population
- People centred with communities, facilities and services wrapped around

Chris then asked the group to reflect back on the emerging themes and whether there were any potential gaps or areas that had been overlooked. The following reflections were made:

- On people taking greater responsibility for their own health, it was noted that this would need to be reciprocal and not just be about the responsibilities of patients and people. That as part of this we would need to ensure the facilities and services are there to help people help themselves. On mental health, it was asked what the local offer would be and what people could expect from services
- On no front door, there was a recognition that the strategy needed to be clear about what this means. For instance, there are ambitions to deliver this approach in many different areas and so there is a danger, if approaches aren't joined up, that there end up being lots of different front doors. To deliver this approach, it was agreed that there would need to be a single training programme implemented across all public services locally and a minimum knowledge base across all services and front line staff.
- That commissioning for population groups split by age groups faces challenges and that transition between age groups can become an issue, especially between child and adult mental health services. It was stated that that commissioning for best start in life (0-2) and early years should be commissioned together.

- That there needs to be a focus on carers and an engagement platform to share information about volunteering and support
- That the strategy should explain role of the Board in delivery of the work
- That “integration” was a term that meant different things to different people and that the strategy should define what is meant by using it
- That people were often unaware of what services were available or how to access them and that the system needed to work together to ensure provision of consistent information and health messages. Also, that we need to do more to co-produce services and pathways with service users.

Gayan Perrera, Senior Public Health Analyst, then gave a presentation setting out the key population health and demographic characteristics in the borough. He highlighted the following points:

- That the borough is densely populated with huge variation in wealth and cultural background.
- That there are a high number of older people living alone.
- That the main causes of premature death are cancers, circulatory diseases and respiratory diseases
- That there are very large numbers of people on GP registers with Severe and Enduring Mental Illness
- That 95% of the determinants of population health are modifiable (health behaviours, social environment and medical care) and only 5% are unmodifiable (genes and biology)
- That we need to support our population to start well (poverty, obesity), stay well (smoking, drinking, diet, exercise, sexual health, mental health) and age well (social isolation, depression, dementia)
- That there would be big increases in the number of patients with diseases over the next 15 years.

<u>Group discussion one: priorities</u>
The group were asked to reflect on the data Gayan had presented and say what the HWB should prioritise. The group had the following reflections:

- Because of high levels of population churn there was a need to be smart about how we target health and care interventions and messaging. Churn was a particular issue for GP registration and immunisation coverage
- Regeneration and developments and their impact on demand for services should also figure into our thinking about targeting services and planning for the future.
- On areas of greatest deprivation we need to be clear what we are trying to achieve and whether it is about bringing all indicators up to a certain level or focusing energy and resources on where need is greatest.
- We need to be clear about where we will target resources most effectively e.g. on preventing harmful drinking or reducing alcohol related admissions. As 95% of the determinants of health are modifiable and 80% of the population is healthy we need to reinvest and target prevention, potentially reinvesting money spent at the acute end of the spectrum
- We know smoking, drinking, diet and exercise are the main causes of preventable death but we need to think about the pressures or reasons why

people lead unhealthy lifestyles or the barrier to leading healthy lifestyles and support people to overcome these.
- Air quality is a key consideration locally and is particularly bad in the borough. This will contribute to deaths from respiratory illness and disproportionately impacts vulnerable groups. We need to offer sustainable and active travel options.
- For younger groups we need to set the right behaviours.
- For adult groups we need to offer support to manage smoking and drinking
- For older people we need to tackle loneliness and isolation and links with income deprivation
- That currently all organisations have different priorities and we need to unify these under the JHWS
- That we need to learn from what we have achieved already against the existing priorities so we know whether to continue or change tack

Group discussion two: system enablers

Chris introduced the final breakout session. He explained that a strategy that set out a vision and priorities would also need to say something about how that change will be delivered. These are the enablers of change and included things like technology, workforce and governance. Group reflections included:

- Board membership – a role for housing?
- Finance – need to think about the LBHF pound and recognise this can only be spent once. We need to stop shifting costs around the system. Also need to commit to pooling budgets across health and care beyond the allocations in the BCF
- Workforce – the social care assessment process is often inefficient and passes people from one place to the next. Training is needed for the workforce using the experience of carers and service users. Also need to support the workforce to stay healthy
- Technology – need to join up our websites and connect up messages
- Community engagement – we need to be bold about this and speak to communities first before we do anything
- Leadership – leadership training and development is needed if we are going to achieve ambitions of managing assets and resources together
- Training – that staff training and development is needed to transition people into closer working with one another

Next Steps

Chris thanked everyone for their contributions and explained the strategy team would be pulling together a draft strategy for the next HWB meeting on June 20th drawing together the themes and discussion points from the meeting.

London Borough of Hammersmith & Fulham **HEALTH AND WELLBEING BOARD** **20 JUNE 2016**	
BETTER CARE FUND PROGRAMME 2016/17	
Report of the Executive Director of Adult Social Services	
Open Report	
Classification - For Information **Key Decision: No**	
Wards Affected: All	
Accountable Director: Chris Neill, Whole Systems Director, Adult Social Services	
Report Author: Chris Neill, Whole Systems Director	**Contact Details:** Tel: 07825 851604 E-mail: chris.neill@lbhf.gov.uk

1. EXECUTIVE SUMMARY

1.1. Following on from the BCF Quarter 3 report presented to the Board on 21st March this report sets out the process for agreeing the Better Care Fund 2016/17 programme.

1.2. In recognition of the emerging NHS Sustainability and Transformation Plan (STP), the proposal is that the BCF 2016/17 will be a continuation of the 2015/16 programme and will be revised during the course of the year to reflect the requirements of the STP which is not planned to be completed until the Autumn.

2. RECOMMENDATIONS

2.1. The Board is asked to note the arrangements for the 2016/17 Better Care Fund

3. BCF 2016/17: THE NATIONAL CONTEXT

3.1 The Department of Health (DH) and the Department for Communities and Local Government (DCLG) have published the local allocations, a detailed policy framework and guidance for the implementation of the Better Care Fund in

2016/17, developed in partnership with the Local Government Association, Association of Directors of Adult Social Services and NHS England.

3.2 For 2016/17 it has been agreed that the BCF planning and assurance process should be integrated as fully as possible with the core NHS operational planning and assurance process and requires the plans to be jointly developed with local government partners, and approved by Health and Wellbeing Boards.

3.3 The policy framework signals the need for stability in 2016/17, and a reduction in the overall planning and assurance requirements on local areas.

3.4 Whilst the policy framework remains stable in 2016/17, local areas are expected to be mindful in developing their plans to ensure linkages with NHS Sustainability and Transformation Plans which NHS partners are required to produce in 2016, and the Government's Spending Review requirement to produce a whole system integration plan for 2017. Both planning requirements will require a whole system approach from 2017-20.

4. BCF 2016/17: PLANNED SCHEMES

4.1 Locally, across the three boroughs, minimal change in scope and approach in 2016/17 and a roll forward of 2015/16 funding levels is being proposed. With an expectation that it will be revised in year to reflect the Sustainability and Transformation Plan in Autumn 2016.

4.2 NHSE London region have requested from CCGs a narrative document setting out progress to date and future direction for using the BCF to facilitate integration. (Appendix A).

4.3 The schemes set out and approved by Cabinets, Governing Bodies and Health & Wellbeing Boards in 2014 have been updated and are listed in Table 1 and further detail is attached as Appendix B. The scheme areas remain the same, slight changes in 2016/17 in two areas (patient and public engagement and personal health budgets). The aim is to mainstream these as approaches rather than having them as separate projects.

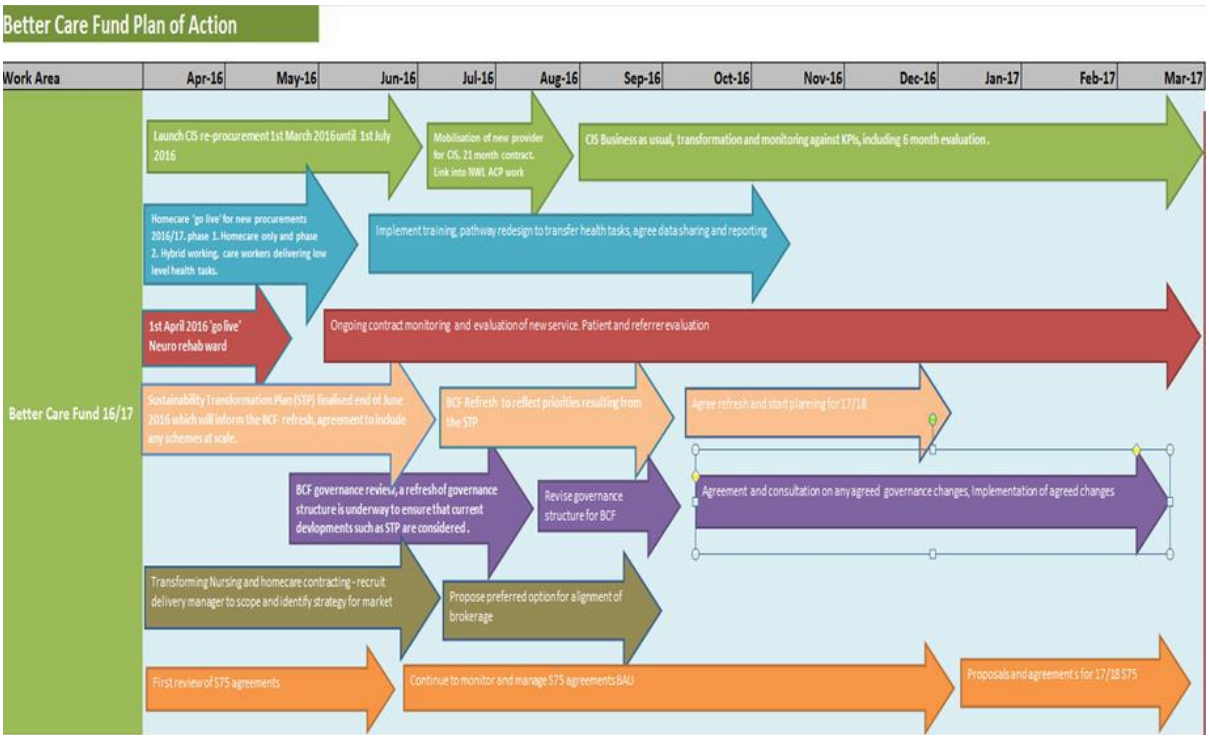
Table 1: Summary of 2016/17 Planned BCF schemes

Ref no.	Scheme	**Non recurring Investment** (£000s)	**New delivery cost** (£000s)	**Existing costs** (£000s)	**Total costs** (£000s)
A1	*Community independence services*	2,688	-	17,221	19,909
A2	*Community Neuro Rehab Beds*	-	2,117	1,562	3,679
A3	*Homecare*	-	1,600	-	1,600

	- Low level health tasks	-	-	-	-
A4	*Integrated Hospital Discharge and 7 Day Working*	-	-	938	938
B1	*Patient/Service Use Experience and Care Planning – including self management and peer support*	-	-	200	200
B2	*Personal Health and Care Budgets*	-	30	20	50
C1/C3	*Transforming Nursing and Home Care*	-	-	721	721
C2	*Review of Jointly Commissioned*	-	-	127,062	127,062
D1	*Information Technology*	-	-	201	201
D2	*Information Governance*	-	-	-	-
D3	*Care Act Implementation*	-	-	1,750	1,750
D4	*BCF Programme Implementation and Monitoring*	-	-	350	350
	Disabled Facilities Grant	-	-	2,867	2,876
	TOTAL	**2,688**	**3,747**	**152,892**	**159,327**

4.4 The summary plan in Table 2 shows a high level timeline of the main milestones to be delivered over the course of the 2016/17 BCF plan. Achievement against this schedule will be closely monitored as part of the BCF Programme Implementation and Monitoring. Appendix C shows further detail of the breakdown across the three CCGs and Local Authorities.

Table 2: Better Care Fund Plan of Action



4.5 None of the above precludes us from making changes to the BCF and planning is already underway for the BCF in 2017/18 and beyond; however the narrative document has been shared with NHSE London region with the aim of starting the financial year with clarity about the size and scope of the fund.

5. LEGAL IMPLICATIONS

5.1. Under the Health and Social Care Act 2012 the Health and Wellbeing Board has a duty to make it easier for health and social care services to work together. Section 3 of the Care Act places the Local Authority under a duty to carry out its care and support functions in a way that promotes integrating services with those of the NHS or other health-related service. The Better Care Programme as outlined in this report discharges those duties.

6. FINANCIAL AND RESOURCES IMPLICATIONS

6.1. In total across the three boroughs, the BCF plan for 2016/17 proposes a budget of £159,327m, which reflects existing pooled budgets or jointly commissioned services, as well as additional investment. In addition Health cost pressures of up to £3m have been identified, this will be risk managed and reviewed through governance processes in year. Mitigating actions will be taken to manage these cost pressures but it may be necessary to offset these against the wider S75 agreements. BCF in 2016/17 ensures that the three boroughs receive funding for the Care Act (£1.75m), investment costs of the new Community Independence Service (£2.7m) and it protects social care by continuing to pass through the Social Care to Benefit Health funding, currently worth £14.2m across the three boroughs. Further there is £1.6m of home care investment but this is subject to internal CCG governance processes.

7. BACKGROUND PAPERS USED IN PREPARING THIS REPORT

None.

LIST OF APPENDICES:

APPENDIX A: Three boroughs (3B) Better Care Fund Plan for 2016/17

APPENDIX B: Summary of 2016/17 Planned BCF Schemes

APPENDIX C: BCF 16-17 Plan - Three boroughs summary

APPENDIX D: BCF – Plan of Action

Appendix A

Three boroughs (3B) Better Care Fund Plan for 2016/17

Updated Summary of Plan 16/17

Local Authorities	City of Westminster London Borough of Hammersmith and Fulham Royal Borough of Kensington and Chelsea
Clinical Commissioning Groups	Central London Clinical Commissioning Group Hammersmith & Fulham Clinical Commissioning Group West London Clinical Commissioning Group
	The Three Borough (3B) *Draft Addendum* 16/17 BCF Plan is being reviewed as part of the formal governance process by the 3B Health and Wellbeing Board Chairs and CCG Chairs and this process will be finalised by Friday 13th May 2016.
Date agreed at Health and Wellbeing Boards:	Original plan agreed 24.03.2014, 2nd revised plan agreed 19.09.2014

1. About this document

This summary narrative document for the 16/17 BCF Plan provides an addendum to the previously agreed 15/16 BCF Plan and summarises our proposed action to take forward the three borough (3B) BCF ambitions for the year ahead. The aims and principles of the original submission remain the same, however the plan is updated to reflect the changes in Health and Social Care since the plan was developed. Together Health and Social Care continue to work towards realising our ambition and moving towards full integration of our services that will enable the creation of local single pooled budgets to work more closely together around people, placing their well-being as the focus of health and care services. This draft narrative for the 3B BCF Plan has been requested by NHS England for assurance purposes and has been prepared alongside early work to create a NWL Sustainability and Transformation Plan (STP) across NW London. Although the STP is not due to be completed and discussed by organisations until June, in line with the government's expectation that health and care services are fully integrated by 2020 the STP will emphasise our approach to integration and collaboration across organisations. The evidence base to support the case for change and support the identification of our agreed BCF schemes was provided in the 15/16 BCF plan.

Integration across the health and social care system is a key priority in each borough's current Joint Health and Wellbeing Strategy (JHWS) and will be so in the creation of refreshed strategies being compiled during early 2016. Each of the JSNAs for the boroughs identifies strategic priorities for which the portfolio of projects in the Better Care Fund Programme is a crucial enabler. Overall there is commonality across health and care in terms of our local strategic priorities and together we are committed to ensuring transformational change that benefits our residents, particularly in out of hospital services. Our vision can be summarised by borough as:

- *Westminster; ensuring access to appropriate care at the right time and supporting people to remain independent for longer*
- *Hammersmith and Fulham; the development of integrated health and social care services which support prevention, early intervention and reduce hospital admissions*
- *Kensington and Chelsea; ensuring safe and timely discharge from hospital.*

2. Better Care Fund Delivery in 16/17

In the main we have agreed a rollover of the approved BCF programme from 15/16 into 16/17, including the agreed investment and the BCF Schemes and their scope. Our vision remains the same but we have updated the range of things we need to do in order to continue to deliver on our original ambition. Updated schemes have been appended to this narrative document (see appendix 1).

2.1 Links to Sustainability and Transformation Planning (STP)

A key part of our collaboration and integration across health and social care is demonstrated in the work we have been developing together to develop our Sustainability and Transformation Plan (STP). An STP base case was submitted to NHSE on 15 April, with a final plan due to be finalised by the end of June 2016. This will support a refresh of our current Better Care Fund (BCF) to ensure that the STP and BCF align and support the realisation of the aims and objectives of the BCF. This presents an opportunity for us to identify some of our BCF schemes that would be better delivered at scale such as Personal and Health Care Budgets (PHB) and Patient and Public Engagement (PPE).
The NHS Five Year Forward View (FYFV), published in October 2014, set out a shared vision for the

future of the NHS, which aligns to our strategic objectives in NW London. Planning Guidance released in December 2015 sets the requirement to develop a shared five-year plan. This should describe how areas will locally deliver the requirements of the Five Year Forward View. Boroughs in NW London will collaborate as 'place based systems' across health and local government, to address the ambition set out in the FYFV. For NW London we are committed to a five year plan that is based on the principle of subsidiarity, where things that can be decided and done locally, The NWL STP will describe plans at different levels of 'place'– across the whole system in North West London, from the local to the sub-regional, as appropriate.

The purpose of our STP is for NW London to:

- Describe clear plans to address the three aims of the Five Year Forward View of improving health and wellbeing, improving care and quality and achieving financial sustainability ;
- Set out a shared vision for health and care services;
- Confirm and align activity, finance, capital and workforce requirements across the region and over the next five years;
- Describe the implementation steps required to deliver the vision and plans at a local and NWL level;
- Be the primary route to accessing Sustainability and Transformation Funding from 2017/18

Once the Sustainability and Transformation Plan is finalised, the 3Bs will review the potential this brings for our BCF and how we further develop our ambition and delivered our stated outcomes.

2.2 Adult Social Care Transformation Programme

In adult social care, the transformation programme which was initiated in 2014 based on customer feedback and views, and which supports the delivery of the Better Care Fund plan, continues in three parts - as follows:

1. The customer journey project is now in full scale delivery - building on the priorities of the department and this plan, this is seeing us implement customer views in the way services are organised and respond to need. Customers wanted clarity of offer, accessibility of services, upfront information and advice and a focus on prevention, wellbeing and independence. Through the customer journey, adult social care are working with health partners to reshape the Community Independence Service (CIS), develop an improved online offer and deliver personalisation, independence, choice and wellbeing in the way individuals with long term needs are supported. This is engaging the department in changes to job roles and the standardisation of social care related practice across population and service groups

2. Commissioning intentions have been established for adult social care, working alongside health, and these are providing the basis for making a marked shift towards delivering outcomes based commissioning. We are moving away from traditional procurement and purchasing (based on units of cost and activity) to more of a focus on driving overall spend and budgets to deliver improving outcomes for users. There are four commissioning intentions (integrated information, advice and prevention, integrated intermediate care services, ongoing support in the community and buildings based support to ongoing care needs). These have all been developed against a baseline and, taken together with a wider review of the care market locally; they are forming ASC's contribution to the development of out of hospital services across the three boroughs.

3. Whole systems working - this area of work falls squarely within the remit of the Better Care Fund plan and is increasingly supporting adult social care and health partners focus on further opportunities to work together in the way services are commissioned, reviewed and delivered.

2.3 Whole Systems Integrated Care (WSiC)

NWL is one of 14 pioneer sites working to implement integrated care at scale and pace. Across the 8 boroughs, 31 partner organisations have agreed to work together in pursuit of a shared person-centred vision for integrated care. All CCG areas are developing their own approach to whole-

systems (with local authorities), however, the principles, which underpin these approaches, are shared.

As part of our BCF the Community Independence Service will work to integrate with and support WSIC Early Adopters and develop a seamless interface during the contract period. This will include responding to the different requirements of each CCG and local authority model and contributing to service developments as the WSiC programme is embedded across the area.
The three clinical commissioning groups are at differing stages of developing and mobilising primary care models for Whole Systems Integrated Care. The principle of each model is the same in which primary care teams will proactively work with patients (who will mostly be over 65 and have one or more long term condition) with the aim of promoting intensive care planning, self-management of conditions and maintenance of long term independence. The aim is for better coordinated, proactive and accessible care.

The WSIC programme aims to bring together planned and unplanned care, including the functions of the CIS, into an overall pathway of care, which enables healthy ageing, improved quality of life and maintains independence. WSIC principles endorse primary care leading intensive case management and care planning as the heart of this integration, organised at both practice and hub/village/locality level.

3. Our vision for health and social care locally

The BCF remains one of the key transformational programmes that aim to improve experience of, and outcomes from, health and social care provision for the populations we serve. As part of our BCF Vision; we have identified some of the key transformation programmes that will support the delivery of the BCF and integrated care. We continue to develop strong alignment in the visions of these programmes which will;

- encourage working as a single team across adult social care, public health, housing, mental health, primary care, community care, hospital care and other allied services
- Are dedicated to improving the health and wellbeing of the 600,000 people who live in Hammersmith & Fulham, Kensington & Chelsea and the City of Westminster.

3.1 Three boroughs (3Bs)

The previously agreed vision across the three borough (3B) is founded on population needs assessment and patient, service user and carer feedback, which has developed over the long-term through a broad spectrum of engagement and consultation.

This approach supports the highest risk proportion of the population who consume the majority of resources, this is a particular focus, and the consequences of these changes in need and environment are already evident. Critical services have been centralised where necessary to deliver higher quality care, (including Major Trauma and Stroke services) and improvements are being made to the way services are delivered in the community so care is delivered as close as possible to where individuals live and is integrated with local hospitals. Drawing on insights from the three JSNAs, we are using the BCF as an opportunity to accelerate the integration of patient-centred delivery across health and social care. Our schemes support a co-commissioning approach that encourages co-ordinated operational management across different service providers to best meet the needs of patients and service users.

We recognise that more must be done to prevent ill health in the first place; to provide easy access to high quality GPs and their teams; to support individuals with long term conditions; and to enable older people to live more independently. Our shared vision for whole systems integrated care is that we want to improve the quality of care for individuals, carers and families, empowering and

supporting people to maintain independence and to lead full lives as active participants in their community. It is based on what people have told us is most important to them. Through patient and service user workshops, interviews and surveys, we know that people want choice and control and for their care to be planned with people working together to help them reach their goals of living longer, staying and living well. They want care delivered by people and organisations that show dignity, compassion and respect at all times.

In order to achieve this approach we are committed to ensuring that;

- **People will be empowered to direct their care and support**, and to receive the care they need in their homes or local community
- **GPs will be at the centre** of organising and coordinating people's care
- **Our systems will enable and not hinder** the provision of integrated care. Our providers will assume joint accountability for achieving a person's outcomes and goals and will be required to show how this delivers efficiencies across the system.

Our aim is to provide care and support to the people of Westminster, Hammersmith & Fulham and Kensington & Chelsea, in their homes and in their communities, with services that:

- **Co-ordinate around individuals**, targeted to their specific needs
- **Improve outcomes**, reducing premature mortality and reducing morbidity
- **Improve experience of care**, with the right services available in the right place at the right time
- **Maximise independence** by providing more support at home and in the community, and by empowering people to manage their own health and wellbeing
- **Through proactive and joined up case management**, avoid unnecessary admissions to hospitals and care homes, and enable people rapidly to regain their independence after episodes of ill-health.

As part of the agreed 15/16 BCF plan we provided detailed information in the form of 'personas' to highlight the engagement and value we have placed upon our patients, service users and carers to ensure that changes to our services and the desired outcomes are co designed. This work continues as we move into the second year of the plan.

3.2 Primary care transformation

The three boroughs (3Bs) CCGs have been jointly co-commissioning primary care with NHS England since April 2015. This approach is one of three different models of co-commissioning available to CCGs and was selected following close engagement with GPs across the three boroughs, as well as with other clinicians, lay members, and other relevant stakeholders. It means that NHS England remains the accountable commissioner for primary care but shares decision-making with the CCGs. This is done through a NHSE/CCG joint committee in each CCG, on top of the close day-to-day working between the NHSE and CCG primary care teams. The joint committees have Health and Wellbeing Boards and Healthwatch representation.

A core task of the co-commissioning joint committees is to design and implement new local models of primary care that meet the specific needs of communities within each CCG, whilst building on local progress with whole-systems integrated care and BCF. This work is now under way in all three boroughs and will deliver local primary care that is accessible, co-ordinated, and proactive.

Having GP practices work together is vital to this, as it is to delivering safe co-ordinated and

proactive care with maximum efficiency. This is why the three CCGs are continuing to support their local GP federations to develop into robust providers of a wider range of primary care services. This is also a critical aspect of the development of Accountable Care Partnerships, which to deliver maximum benefits require general practice voice to play a strong and coherent role.

4. Progress made in 15/16 about the differences to patient and service user outcomes?

Our approved 15/16 BCF Plan identified a number of common challenges for those in greatest need, which if addressed, would genuinely transform the quality of life and wellbeing. These include:

- Mental health problems (diagnosed and undiagnosed)
- Unsuitable housing leading to and exacerbation of conditions/capacity
- The need for reablement now or in the near future
- Mobility and transport issues
- Significant life impacting event e.g. bereavement
- Frequent and unplanned use of multiple services
- Social isolation
- Multiple long term conditions.

Our vision to achieve by 2018/19 is built around tackling these issues, empowering and supporting individuals to live longer and live well. This is about creating services that enable frontline professionals to work with individuals, their carers and families to maximise health and wellbeing and address specific individual needs.

5. Our programme delivery through the BCF in 15/16

As outlined in the 15/16 BCF Plan, we have a broad range of transformational changes across acute and primary care and adult social care – as well as overarching developments towards a whole system approach that have been in place in the three boroughs (3B) over the past few years, the BCF schemes further enhance this strategic change as they are a balanced mix of on the ground operational changes to key services; further understanding of patient and service user needs; more effective joint commissioning; and development of key enablers including systems infrastructure, therefore the BCF schemes continues to support our ambition in 2016/17.

Within the 3Bs, the customer journey project has moved to full scale delivery - building on the priorities of the department and this plan, this is supporting us to implement customer views in the way services are organised and respond to need. Customers wanted clarity of offer, accessibility of services, upfront information and advice and a focus on prevention, wellbeing and independence. Through the customer journey, adult social care are working with health partners to reshape the Community Independence Service, develop an improved online offer and deliver personalisation, independence, choice and wellbeing in the way individuals with long term needs are supported. This is engaging the department in changes to job roles and the standardisation of social care related practice across population and service groups.

Our innovative schemes (See Appendix 1, BCF Schemes 16/17) are driving consideration of new approaches to operational governance, such as the contracting approach we are taking to the Community Independence Service (CIS) reprocurement – that support rather than hinder integration. Over the next 3 years, community healthcare, primary care, hospital and social care teams will work together in an increasingly integrated way, with single assessments for health and social care and rapid and effective joint responses to identified needs, provided in and around the home. We will design and implement new ways of ensuring clarity of delivery responsibility across commissioners and providers – ensuring that there are feedback loops, so that we continue to understand patient and service user perspectives and share learning across the delivery chain

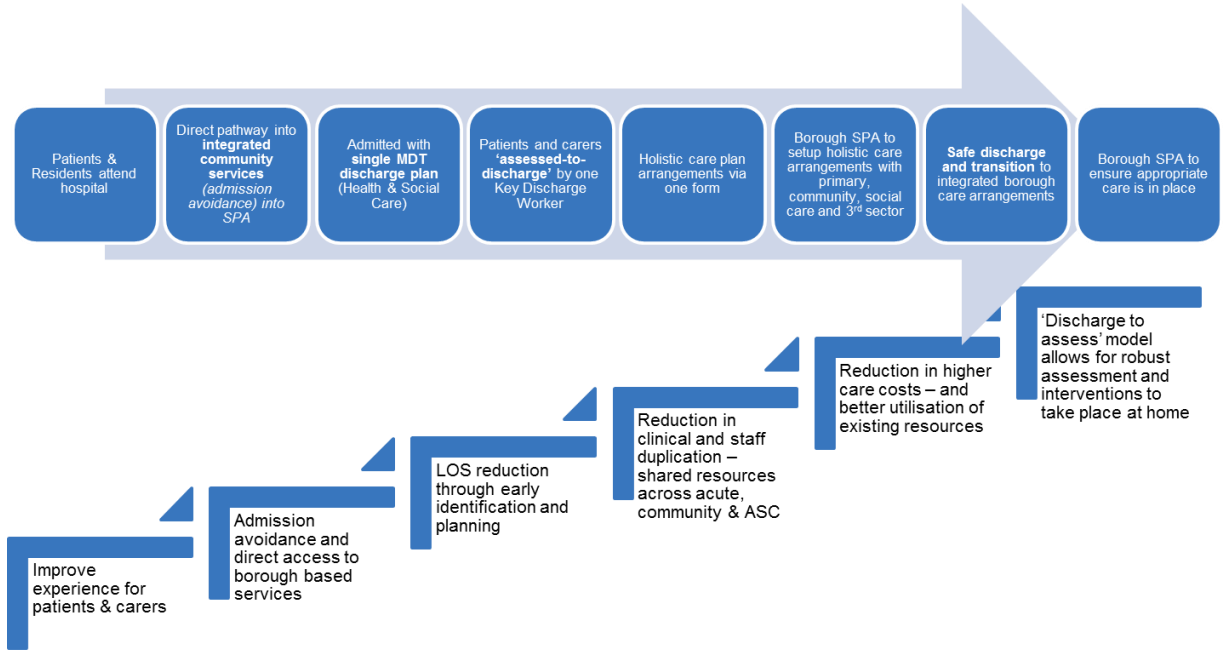
5.1 Development and implementation of 7 day working across Health and Social Care

North West London was awarded "Early Adopter" status by the NHS England/NHSIQ Seven Day Services Improvement Programme in November 2013. In October 2015 we then accepted the opportunity as a sector, to be a national First Wave Delivery Site for the refreshed 7 day services programme (as launched by the PM at the conservative party conference).

The NHS England Seven Day Services Programme centres on delivery of a set of 10 Clinical Standards for Acute Care. Standard 9 sets out the requirement for a 7 day discharge pathway:

Support services, both in the hospital and in primary, community and mental health settings must be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken.

Through the three boroughs (3B) and the BCF we have continued to invest in the development of 7 day service programme from 15/16 and beyond to embed 7 day services in health and social care. Part of this work has been to work towards ONE 7 day single health and social care discharge pathway, not just across the 3Bs, but also across the wider North West London footprint. The following outlines the vision:



Delivery to date has included the development of one agreed health and social care needs based assessment form which will be used across the three boroughs (3B) and the wider North West London sector, to manage referrals from hospitals into community and social services from 1st May 2016.

5.2 Community Independence Service (CIS)

In 15/16 we undertook a transitional year for the Community Independence Service (CIS). This included working to align the service across the 3Bs to deliver, Rapid Response, In-reach, Rehabilitation and Reablement services. Year one was supported by the appointment of a Lead Health Provider working in partnership with Adult Social Care and our Community Services provider to implement the model of care. In 16/17 the CIS service is being reprocured and the new provider should be in place by 1st July 2016. In establishing a new service across Health and Social Care, anticipated

year one benefits were not achieved, this was due to the speed of roll out and the challenges of recruiting the required workforce. In 16/17 we have further enhanced our CIS model and anticipate our ambition for the release of the planned benefits.

5.3 Neuro-rehabilitation

The Neuro-rehabilitation service was reporocured in 15/16 and went live on 1st April 2016 this commission has resulted in an annual efficiency savings for the three boroughs (CCG, Health efficiency) through reduction in DTOCs for neuro-rehab patients and an improved patient pathway.

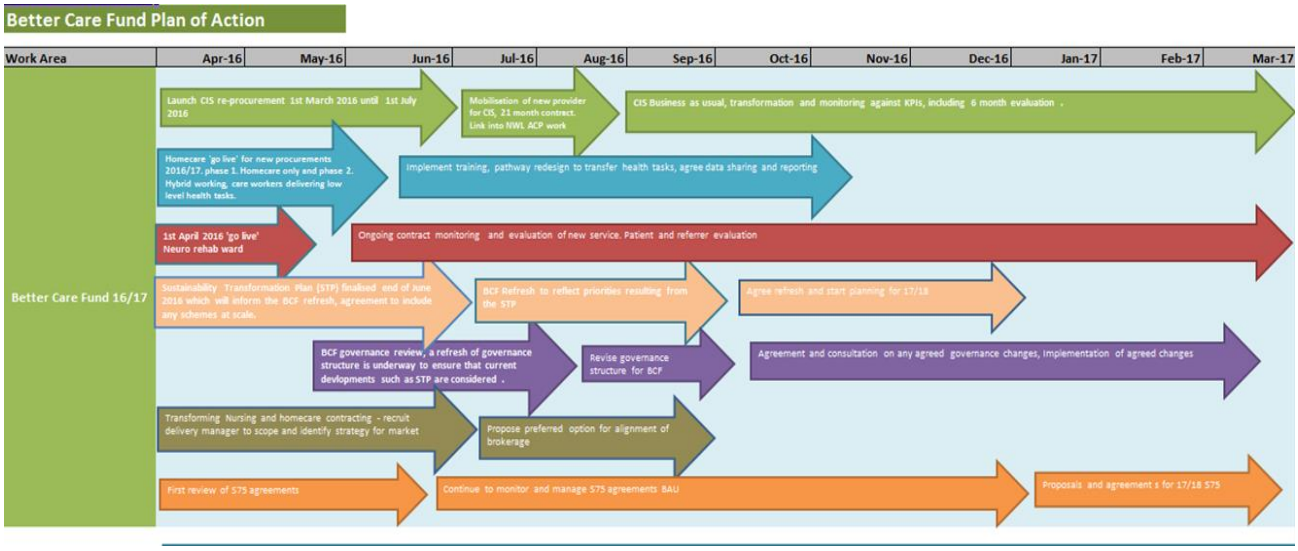
6. Summary of 16/17 planned BCF schemes

The agreed schemes for the15/16 will continue in 16/17 in line with the rollover and continuation of our BCF plan, this includes the same schemes and the overall an agreed investment, £159.3m. We have also identified that there is an additional Health cost pressure of up to £3m, this will be risk managed and reviewed through governance processes in year. We will work together to ensure that mitigating actions are taken in year to manage these cost pressures and these costs may have to be offset against the wider S75 agreements.

Group	Ref no.	Scheme
A	A1	Community Independence Services- *including 7 day services, rehabilitation and reablement*
	A2	Community Neuro Rehab Beds
	A3	Homecare
	A4	Integrated Hospital Discharge and 7 Day Working
B	B1	Patient/Service User Experience and Care Planning – *including self-management and peer support*
	B2	Personal Health and Care Budgets
C	C1	Transforming Nursing and Care Home Contracting
	C2	Review of Jointly Commissioned Services
	C3	Integrated Commissioning
D	D1	Information Technology
	D2	Information Governance
	D3	Care Act Implementation
	D4	BCF Programme Implementation and Monitoring

6.1 Summary of Plan of Action 16/17

The summary plan below shows a high level timeline of the main milestones to be delivered over the course of the 16/17 BCF plan. Achievement against this schedule will be closely monitored as part of the BCF Programme Implementation and Monitoring. For full details see (Appendix 2).



7. How our BCF meets National Conditions for 2016-17

As part of our 16/17 BCF plan we will continue to monitor, develop and meet the requirements of the National Conditions as outlined in the 15/16 BCF Plan. The BCF is now in its second year, the BCF includes national conditions and locally set requirements, this approach continues in to 16/17 with the following national conditions as outlined. Details of the metrics that underpin these are provided within the 16/17 BCF template outlining the agreed ambition, confirming that we have met the 8 required National Conditions and confirmation of the agreed funding levels for 16/17 that is, roll over of the 15/16 BCF investment at £159.3m.

The 16/17 conditions include;

1. **Plans to be jointly agreed**

   The agreed BCF plan for 15/16 was jointly agreed and as outlined includes robust governance and reporting mechanism. In 16/17 this updated narrative and the required template has been agreed across the 3Bs. This includes the detail of the schemes that underpin our BCF, the summary narrative and the investment required to deliver the ambition of our 16/17 BCF plan.

2. **Maintain provision of social care services (not spending)**

   As outlined in the agreed 15/16 BCF plan we will continue to maintain provision of social care services at the same level and all BCF schemes have been carried over (In total we are investing overall £159.3m for our BCF, this is in line with the agreed investment in 15/16. A key component of the 3B BCF plan is the additional investment in social care through the Community Independence Service, which will enhance rehabilitation and reablement services, leading to a reduction in hospital readmissions and residential/nursing home admissions.

3. **Agreement for delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate**

   Through the three boroughs (3B) and the BCF we have continued to invest in the development of 7 day service programme from 15/16 and beyond to embed 7 day services in health and social care. Part of this work has been to work towards ONE 7 day single health and social care discharge pathway, not just across the 3B, but also across the wider North West London footprint, with NWL acting as an early implementer. The Community Independence Service (CIS), also supports this

National Condition with a model that includes Rapid Response, In-reach, Rehabilitation and Reablement.

4. Better data sharing between health and social care, based on the NHS number

In summary during 15/16 our services implemented the NHS number as the single identifier for our patients, having delivered this ambition we now are developing a single integrated IT platform initially as part of the Community Independence Service (CIS). Furthermore, this project will integrate ASC and GP IT systems. The project rational is based on the assumption that sharing of medical and social records across different settings of care reduces risk, reduces duplication and improves outcomes and speed in both assessment and care of the individual, as well as enhancing the client's experience.

5. Ensure a joint approach to assessments and care planning to ensure that, where funding is used for integrated packages of care, there will be an accountable professional

To build upon the approved 15/16 BCF plan, across the 3B an integrated care programme has been implemented that includes assessment and provision of integrated packages of care. This includes care planning, case management and the provision of an accountable professional. Our integrated care pathway and delivery puts GPs at the centre of care (e.g. WSiC) and the CIS with GPs taking the lead in coordinating care as the agreed lead professional.

6. Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans

Across NWL and the 3Bs transformation plans have been developed and consulted upon with the Local Authority, hospitals, community and mental health services and other local stakeholders. As part of the Sustainability and Transformation Planning (STP) we have representation from all organisations. As part of the agreed 15/16 BCF and the 16/17 BCF plan our operating plan agreements have been or are being negotiated with regards to the impact of reductions in activity. Reductions in activity are within CCG QIPP plans that will be reported via our NHSE Operating Plan.

7. Agreement to invest in NHS commissioned out-of-hospital services

In NWL and the 3Bs we continue to develop and invest in our out of hospital services at levels above the mandate. This supports our Out of Hospital strategy to deliver care to our patients closer to home and in the right setting to ensure that we reduce dependency on our hospitals and acute settings.

8. Agreement on a local action plan to reduce delayed transfers of care (DTOC) and improve

We are committed to continuously developing our response to delayed transfers of care. This includes an understanding of our local issues relating to DTOC, a local action plan (see appendix 3, DToC draft local action plan),clear ambition and a trajectory to reduce DToC has been developed to clearly outline what we need to undertake as part of the BCF in 16/17 to address DTOC.

Delayed Transfer of Care (DToC)

As part of our BCF schemes in project A's we recognise the interdependency that supports our ambition for reducing DToC and the principle of quality care is delivered in the right place. Looking to 16/17 both nationally and locally in 3B we recognise the importance of further reduction in DToCs and therefore our BCF plan will continue to priorities delivery against this ambition. The CCGs, Local Authorities and provider partners recognise that any stay in hospital can be a stressful and uncertain time for patients and their families and carers and their experience of being discharged from hospital is often not positive. The BMA in its report on *Hospital Discharge: the patient, carer and doctor perspective (January 2014)* highlighted many of the poor experiences reported on by patients and their families.

It is widely agreed that effective discharge planning and management plays a vital part in ensuring capacity is available for patients needing to access acute care beds, and supporting a resilient

system. In addition the Care Act reinforces the need for the system and people to work together to ensure timely discharge and transfer of people as soon as they are medically optimised and safe to transfer.

Addressing the complexities of hospital discharge processes requires a system response from commissioners and providers. Our aim is to ensure that people in hospital have a timely discharge, and are able to receive the ongoing care they need at home or in the community that enables them to meet their health and wellbeing outcomes. We wish to reduce the current fragmentation of the discharge processes so that people have a positive experience of their discharge from hospital in which they and their family/carers are clear of the process, the multi-disciplinary team involved in their discharge, and are fully involved in the decisions affecting their ongoing care. We believe this is a critical requirement in terms of providing continuity of care once back home or in the community, and to prevent further unnecessary admissions to hospital. This has led to our collective work on Enabling Positive Discharges which started in October 2015 and has generated a willingness to develop common approaches and processes and a system wide DTOC action plan and programme.

The CCGs, Local Authorities, acute providers and community health providers across Tri-borough have therefore formed the Tri-Borough Integrated Hospital Discharge Steering Group to align all the projects concerning hospital discharge into a single programme structure.

The Steering Group will report into the BCF Implementation Board as well as the Tri-borough System Resilience Group who will be identifying positive hospital discharge as one of its 2016/17 priorities. The Steering Group is currently developing an overarching action plan reflecting all the individual projects against key themes and which will enable prioritisation. It will also identify benefits to be achieved through these actions and measurement of these benefits. A summary report will be developed to present a monthly update across the programme and outcomes/benefits being delivered

We have identified a number of priority areas within our DTOC work programme so far which enable improvements both in the processes within hospitals and the capacity available to support people at home and in the community. They include:

- Development of integrated hospital discharge teams and pathways within a number of hospital wards to provide a common discharge approach across the 3 borough (project A2)
- Increased provision of interim beds to enable step down from hospital and to allow for full assessments of people's needs to be undertaken in the community
- Alignment of organisational Choice policies supported by information for patients, families and carers on the local options available for community or home based care upon discharge

Our DTOC work programme therefore has a number of interdependencies with other strategic initiatives including:

- Re-procurement of our Community Independence Service which includes In Reach to facilitate early discharge from hospital
- Review of our provision of Intermediate Care beds to ensure we can meet local needs for step down and step up provision in the community

Disabled Facilities Grant (DFGs)

Housing departments in 2 boroughs administer the DFGs and ASC in one. The plans are developed by Housing and ASC and the agreed funding will be allocated to the Housing depts. However, as Social Care capital and DFG capital funding has been combined from 2016/17, the DFG will be influenced by the Housing plan, spending patterns and commitment and ASC need for capital.

8. BCF Programme arrangements including governance and financial arrangements

Across the three boroughs (3B), we have invested significantly in building strong governance arrangements to support the Better Care Fund. As outlined previously, the governance arrangements described below are designed to ensure all 6 sovereign entities are central to decision making without creating unnecessary delays or blockages.

A BCF Board provides a forum for Cabinet members and CCG Chairs (described in Section 4c below). The BCF Board makes recommendations to HWB members, particularly in relation to the large scale integrated initiatives that require a joint approach. The HWBs meet on a quarterly basis.

The Health and Wellbeing Board in each of the boroughs has continued to develop and mature. We have a joint monthly meeting between the executive teams in CCGs and Local Authorities. Our transformational plans and programmes are formally discussed and approved at local borough governance levels within each Local Authority and CCG.
We continue to have formal Health and Wellbeing Partnership Agreements in place between each borough and CCG providing a legal framework for closer integration of commissioning and an established programme of jointly commissioned services, which are already overseen by the Joint Executive Team (JET). This will enable us to review pooled budget requirements for the new financial year 16/17. We will continue arrangements for hosting with the LA, in view of the practical advantages which this offers in relation to treatment of VAT and the carrying forward of funding, but the pooling agreement will recognise that each scheme will be led by the most appropriate commissioner, be that Local Authority or CCG.

As aforementioned, the Sustainability and Transformation Plan (STP) is currently being developed, the plan is due for completion by the end of June 2016 and following this we will look to refresh the Better Care Fund and also amend the current governance arrangements as required.

9. Risk management and contingency planning

In line with our 15/16 BCF Risks and Contingency we have refreshed our risk plan, (a detailed BCF Risk Log is provided in Appendix 5) we continue to manage these in line with ensuring that all risks are identified and plans are in place to help mitigate these to support delivery against our BCF Plan 16/17. In summary our BCF plan will continue to be developed with providers and is based on the principles of achieving a reduction of acute admissions.

The same core principles of risk sharing have been agreed within the BCF programme:

- Organisations take responsibility for the services they sign-up to deliver (against agreed specification of service quality, type and volume)
- Organisations take responsibility for the benefits that are expected to be realised in their organisation
- Effective monitoring arrangements to identify where there are variances and to reconcile back to the original budget (similar to s.75 arrangement)
- Commitment to a shared approach to resolving variances and amending service model and share of costs if required.

The BCF is based on an agreement to share the financial risks and rewards of new out-of-hospital services between CCGs and Local Authorities. The agreement is based on estimates of activity,

costs and benefits of those services and the previous year's activity has supported us to develop plans that reflect actual activity. There is of course the risk that, if the planned net benefits are not delivered, there will have to be a call on existing resources in the CCGs and Local Authorities. The CCGs have identified contingency funds should the expected benefits not be realised, this demonstrates the strong commitment we have to develop our integrated working under the BCF.

10. Summary of BCF engagement

The agreed 15/16 BCF plan outlined our engagement process in relation to developing our BCF. We continue to work together to support patient, service user and public engagement, develop our service provider engagement and identify the implications for acute providers.

The process of engagement across these stakeholders is iterative and responsive to the live BCF schemes that we continue to develop and implement as highlighted in the schedule. Our BCF progress continues to report to our Health and Well-Being Boards, including this16/17 BCF implementation plan and link to our Strategic Partnership Group (SPG). The development of the Integration and Collaboration Working Group reports to the JET and steers the NWL STP to ensure place based commissioning and transformation for the three boroughs, this new forum is being used to engage all providers in the ambitions of the BCF and scheme progress within the overarching context of the STP.

This year's BCF is a continuation of the agreed 15/16 plan. As this is year 2 of the BCF, the consequential impact to providers is being negotiated via our current QIPP plans as part of the contract negotiations. The activity reduction linked to the CIS, 7 day services and neuro-rehab are part of the 16/17 contract negotiations that reflect the ambition of the BCF and the reduction of activity in these areas.

APPENDIX B

Summary of 2016/17 planned BCF Schemes

Ref no.	**Scheme**	**Non recurring** Investment (£000s)	**New delivery cost** (£000s)	**Existing Costs** (£000s)	**Total costs** (£000s)
A1	*Community Independence Services*	2,688	-	17,221	**19,909**
A2	*Community Neuro Rehab Beds*	-	2,117	1,562	**3,679**
A3	*Homecare*	-	1,600	-	**1,600**
	- *Low level health tasks*	-	-	-	**-**
A4	*Integrated Hospital Discharge and 7*	-	-	938	**938**
B1	*Patient/Service User Experience and Care Planning – including self-management and peer support*	-	-	200	**200**
B2	*Personal Health and Care Budgets*	-	30	20	**50**
C1/C3	*Transforming Nursing and Care Home*	-	-	721	**721**
C2	*Review of Jointly Commissioned*	-	-	127,062	**127,062**
D1	*Information Technology*	-	-	201	**201**
D2	*Information Governance*	-	-	-	**0**
D3	*Care Act Implementation*	-	-	1,750	**1,750**
D4	*BCF Programme Implementation and Monitoring*			350	**350**
	Disabled Facility Grant			2,867	**2,867**
	TOTAL	**2,688**	**3,747**	**152,892**	**159,327**

Three Borough (3B) Better Care Fund Schemes – 2016/17

Group	Ref no.	Scheme
A	A1	Community Independence Services- *including 7 day services, rehabilitation and reablement*
	A2	Community Neuro Rehab Beds
	A3	Homecare
	A4	Integrated Hospital Discharge and 7 Day Working
B	B1	Patient/Service User Experience and Care Planning – *including self-management and peer support*
	B2	Personal Health and Care Budgets
C	C1	Transforming Nursing and Care Home Contracting
	C2	Review of Jointly Commissioned Services
	C3	Integrated Commissioning
D	D1	Information Technology
	D2	Information Governance
	D3	Care Act Implementation
	D4	BCF Programme Implementation and Monitoring

Scheme ref no

A1

Group A: Community Independence Service

Original Intention

The Community Independence Service is a rapid response and reablement service for older people. It aims to support people in the community and avoid the need for unplanned hospital admissions.

The service provides fast and responsive care to support patients at risk of admission to hospital and enables hospital inpatients to be transferred in a timely manner to community settings to ensuring a full recovery whilst retaining independence and remain in their own home.

The CIS represents a single model of care, working across the three boroughs to replace a range of often duplicated services. The model encompasses multi-disciplinary integrated health and social care and (nursing, medical, therapies and social care) and operates 7 days a week.

The service is jointly commissioned across health and social care and delivered across the three boroughs.

The service has four core elements:

- Rapid Response
- In-Reach
- Non-Bedded Intermediate Care/Rehabilitation
- Reablement

The target patient cohort includes individuals:

- With long term care requirements who need support to prevent crises or deterioration
- Who require support following discharge from hospital
- Who need support to prevent (or delay) admission into hospital.
- Who want to regain their independence at home or in another community setting.
- Who require urgent care.

Progress and Delivery to date

The CIS is based on our shared belief in delivering joined up care to people when they need it in the community. It will drive clear clinical benefits for patients in a sustainable way across the health and care system as a whole.

The CIS has been recognised nationally for successfully bringing together a range of services and skills to support people in the community by working work across primary, secondary care, community nursing, therapy and social care.

The benefits delivered in 2015-16 are:

- User satisfaction with the CIS service is very high across health and social care.
- GPs rate the service very highly, however, between a quarter and a third do not refer in. This is probably due to a lack of awareness of the service.
- Delivery of a seven day service for In-Reach, Rapid Response Nursing, Rehabilitation and Reablement.
- Improved partnership working between healthcare organisations across the three boroughs, including establishment of a Partnership Board led by Imperial College Healthcare.
- Establishment of a multi-service clinical redesign group to create more cohesive pathways of care across health and care services.
- Operational staff have made inroads to integration using practical approaches like stronger working networks with colleagues, made possible from co-location, sharing IT/ clinical information and through work to streamline processes.
- CIS is dealing with a high level of acuity, particularly the H&F service – probably more so than in the other two CCGs/ LAs. The service offers a genuine alternative to hospital, although high acuity comes at a cost, with double-up care/ large packages increasingly common.

Challenges experienced in 2015-16, with plans for resolution.

- Further integration and effective working has been hampered by delays in implementing an integrated IT system which is due for delivery in July 2016.
- High turnover of staff and use of agency staff is hampering planning for future service development. A fully integrated service on a 21 month contract with clear plans for the future is currently being procured and will help to address some of these issues.
- Intermediate 'step-down' beds are a service gap that could be a safe alternative for medically stable but unwell patients.
- Mental health is also a gap in the service offer, as well as memory assessment services and end of life care which is being addressed in the current procurement.
- High expectations of commissioners and the BCF Programme Board regarding the level and speed of change in the first year has been a challenge for the Lead Health and Social Care Providers.
- The objective of increasing referrals and activity remains a challenge. Feedback suggests that increased activity has been reliant on increasing GP confidence, knowledge and awareness of the service. The introduction of Rapid Response GPs and Consultant Geriatrician cover across the three boroughs will help to improve confidence in the service (as in H&F).

Delivery

Commissioners

- West London CCG
- Royal Borough of Kensington and Chelsea
- Central London CCG
- Westminster City Council
- Hammersmith and Fulham CCG
- London Borough of Hammersmith and Fulham

Providers:

- Central London Community Healthcare NHS Trust
- Westminster City Council
- Royal Borough of Kensington and Chelsea
- London Borough of Hammersmith and Fulham
- London Central and West Urgent Care Centre
- Central and North West London NHS Foundation Trust
- West London Mental Health NHS Trust
- Allied Healthcare
- GP Federations (West London, Central London and Hammersmith & Fulham)
- Imperial College NHS Healthcare Trust
- Chelsea & Westminster NHS Foundation Trust

Investment Requirements

A1 Community Independence Service (ex BCF08)	
	£'000
Investment	2,688
New Delivery Costs	
Existing Costs	17,221
Total	**19,909**

Changing Context

The development of Accountable Care Partnerships within North West London has shaped the procurement for the delivery of the CIS. The contract has been set for a period of 21 months to align with the North West London ACP timetable.

BCF Scheme Plans 2016/17

The CIS is being recommissioned with a planned start for the new service from 1st July 2016.

In line with NW London wide outcomes, the new provider will be working to deliver the following local outcomes.

- High quality, effective care delivered within available resources (financial, estates and human resources).
- Reduced time (counted as non-elective bed days) our residents are spending in institutional care (acute hospitals, nursing and care homes and long term care).
- Improved patient/customer satisfaction in relation to treatment outcomes.
- Improved Friends/Family/Carer satisfaction in relation to treatment outcomes.
- Financial sustainability of the health and social care system and support the development of an evidence base that informs the future development of the service.
- Add value by increasing links between the CIS and other services, through improved system-wide working that supports further integration across social care, community and primary care as a Whole System.

Scheme ref no.

A2

Community Neuro Rehab Beds

Original Intention

To commission additional rehabilitation capacity across the three boroughs with the objective of providing interventions to restore a patient's optimal functioning (physically, psychologically and socially) to the level they are able or motivated to achieve. This will lead to an anticipated reduction in DTOCs and reduction in LOS for neuro-rehab patients

Progress and Delivery to date

The target cohort are patients who require rehabilitation services to regain a loss of physical, mental or social functionality.

Lack of step down neuro-rehab options means that the system is unable to provide informed and cost effective services when a person is experiencing a wait for specialist neuro-rehab intervention.

This leads to longer lengths of stay in costly specialist centres for some people as they become more debilitated and dependent whilst waiting for specialist services.

In 2015/16, the referral and delivery pathway for bedded and non-bedded community rehabilitation /neuro-rehabilitation services was established with subsequent investment in additional community and bed based capacity (9 additional neuro beds; 5 physical beds and 4 virtual beds) and the extension of the community rehabilitation period up to 12 weeks in the community, including Homecare.

From April 2016 the new neuro-rehabilitation service (15-bedded and 4 virtual beds for community neuro-rehabilitation) commenced, provided by Imperial College Healthcare NHS Trust as the lead provider, with Hillingdon Hospitals NHS Trust and Central London Community Health Trust. The contract will be initially for 3 years, with an option to extend for 2 more years.

Delivery

Commissioners:

- Central London CCG (Lead Commissioner)
- West London CCG
- Hammersmith and Fulham CCG

Providers:

- Imperial College Healthcare NHS Trust (Lead Provider)
- Central London Community Healthcare NHS Trust
- Hillingdon Hospital NHS Trust

Investment requirements

A2 Community Neuro Rehab Beds (ex BCF10)	
	£'000
Investment	
New Delivery Costs	2,117
Existing Costs	1,562
Total	**3,679**

Changing context

Not applicable

BCF Scheme Plans 2016/17

It is estimated that the scheme will deliver an estimated annual efficiency saving of £369k for the tri-borough CCGs for 202016/17 through reduction in DTOCs, which represents 1300 days or 12 days per neuro-rehab patient.

It is anticipated that additional patient benefits will include improved social and economic, health & quality outcomes which will be evaluated over the course of 202016/17 as they emerge with the progression of the scheme.

Scheme ref no.

A3

Scheme name Homecare

Original Intention

To successfully commission, procure and implement a new Homecare service in the three boroughs that will better enable our patients and service users to remain independent in their own homes.

Progress and Delivery to date

The programme aims to deliver a new and improved homecare service across the three local authorities based on:

- Achieving outcomes, rather than "time and task" based provision
- Integration of health and social care tasks over the life of the contract (hybrid working)
- Providers working directly with customers to agree details of care and how outcomes will be achieved
- Ensuring dignity and compassion as core values
- People being helped to feel a part of their local community

A patch based approach to care has been developed across the three boroughs, with one provider delivering all the care in one patch. This allows providers to establish strong connections to existing community assets and offers a greater consistency of care to service users. Contracts for 8 of the 9 patches have been awarded, with the award for the final patch expected for early July 2016.

Delivery

Commissioners:

- West London CCG
- Royal Borough of Kensington and Chelsea
- Central London CCG
- Westminster City Council
- Hammersmith and Fulham CCG
- London Borough of Hammersmith and Fulham

Investment requirements

A3 Homecare	
	£'000
Investment	1,600
New Delivery Costs	
Existing Costs	
Total	**1,600**

Changing context
One of the objectives of the model is the integration of health and social care tasks over the life of the contract. There is agreement to pilot the hybrid working model (for care workers to carry out low level health tasks) in Kensington and Chelsea. However, this has been delayed whilst issues with provider performance and service quality are resolved and will impact on the overall mobilisation and implementation timeline for hybrid working.
BCF Scheme Plans 2016/17
Subject to the successful mobilisation of all Homecare providers, key activities for 202016/17 include: • Provider assurances over training / competency and clinical governance for health tasks • Pathway redesign to transfer health tasks from CLCH to three Local Authorities • Establishing a data sharing agreement between CLCH and three Local Authorities • Establishing a reporting mechanism to monitor health tasks

Scheme ref no.

A4

Scheme name

Integrated Hospital Discharge and 7 Day Working

Original Intention

The scheme aims to implement a single Hospital Discharge function across health and social care. The scheme will build upon 2015/16 work to further embed and scale up the implementation of the integrated discharge function.

Progress and Delivery to date

The two key objectives of the scheme have been delivered in 2015/16:

1. Integration across the three local authorities to provide a single discharge function
    - Implementation of a single hospital discharge team across the three boroughs managing all three boroughs patients who present at hospital
    - Streamlined hospital discharge processes, implemented across the hospital team
    - A new streamlined assessment tool, implemented on Frameworki and used across the hospital team

2. Integration with health partners to fully achieve an effective, efficient and consistent service to residents.
    - Hospital discharge process co-designed with health to work effectively with acute sites
    - Single three boroughs teams providing onsite support to acute sites within the three boroughs
    - Support of key wards (wards with high numbers of discharges) with allocated social workers, working closely with ward staff and supporting the MDT process

The initial pilot showed evidence of improvements within the system:

- 89% of NHS and 79% of Local Authority staff believe the pilot has been effective in improving the patient/carer experience with discharge – a 63-68% improvement on Friends and Family Tests on two wards
- 89% of NHS ward staff and 79% ASC staff believes the new model and approach has significantly improved the overall discharge process
- 63% of NHS staff believe the pilot has reduced the LOS of patients
- Approximately 5-10% decrease in referrals into higher levels of care (e.g. increase in home care support, reablement, placements)
- Some of the wards have shown between 5% and 10% reduction in re-admissions in the same period compared to the previous year

Key challenges of the scheme during 2015/16 include:

- Delays in providing cross organisational access to patient data due to the complexity of the required Information Governance arrangements (with no significant agreements between the organisations previously in place)
- Ongoing staffing challenges to support the transition periods and wider change program (primarily due to shortages of staff in the wider health and care system)

Delivery

Commissioners:

- West London CCG
- Royal Borough of Kensington and Chelsea Central London CCG
- Westminster City Council Hammersmith and Fulham CCG
- London Borough of Hammersmith and Fulham

Providers:

- Imperial Healthcare NHS Trust
- Chelsea & Westminster NHS Foundation Trust
- Westminster City Council
- Royal Borough of Kensington and Chelsea London Borough of Hammersmith and Fulham
- Central London Community Healthcare

Further sub-regional working:

We are working with the CCGs and Councils in Ealing, Brent and Hillingdon to roll-out this model across North West London as part of the West London Alliance (WLA) Hospital Discharge programme.

This will integrate ASC hospital based functions across the six 6 boroughs in the wider North West London sub-region. It will enable seamless discharge for patients across the sub-region – no matter which borough they live in and which hospital they attend.

Investment requirements

7 Day Social Work Hospital Discharge (ex BCF01)	
	£'000
Investment	
New Delivery Costs	
Existing Costs	938
Total	**938**

The scheme for 2015/16 achieved its expected outcomes as per the programme plan. The key changes to the scheme include:

- Early implementation of a single Tri-borough adult social care team due to strategic willingness and operational readiness
- Delays in providing access to hospital systems for adult social care staff and access to Frameworki to hospital staff due to complexity issues regarding information governance

BCF Scheme Plans 2016/17

To achieve the plans for 202016/17 and the benefits associated with these plans the programme will focus on the following key success factors:

- Partnership working between Acute trusts and Local Authorities – to further integrate functions including staff and processes
- Further development of commissioning models for discharge – as part of WLA and NWL work with CCGs and Commissioners
- Information Sharing – ensuring staff from different organisations can access the appropriate information and not duplicate work.

The following focus will be required to address the challenges and support the plans for 202016/17:

- Further service development
- Further health and social care organisational development/training
- Additional pump-priming of staff to facilitate change (e.g. Social Workers)

Our aims for 2016/17 include

- Establish one key discharge worker who has accountability for individual cases from discharge to home.
- Improved patient and carer experience through the Friends and Family Test (FFT)
- Early identification of patients/customers who require social care, community health and 3rd sector services
- Improve sharing of staff & resources across LAs and Hospitals – improving skills and capacity
- Embed one hospital discharge process across health and social care from 1st May 2016
- Improve throughput and decrease of acute capacity
    - Reduced DTOC (related to delayed assessments) – deliver a 785 day reduction in DTOC days (H&F – 344, Kensington & Chelsea – 274, Westminster 177)
    - Reduced Bed day costs (related to delayed assessments) - £278K based on £350/day costs (H&F - £120,472, Kensington & Chelsea - £95,877, Westminster - £61,968)
    - Reduced Emergency Re-admissions (early benefits of holistic discharge planning) – 4-5% reduction of total readmissions

Scheme ref no.

B1

Scheme name: Patient/Service User Experience and Care Planning

Original Intention

The original focus of this scheme was on developing two key aspects of care delivery:

- Patient and Service User Experience
- Self-management and Peer Support

The intention remains unchanged; however, greater clarity has been developed on the intentions and implementation within the current strategic direction of commissioners. Commissioners have agreed that in order to deliver this project at scale we will engage with the wider Sustainability and Transformation Plan (STP) and align it with our journey towards Accountable Care Partnerships by April 2018, this will ensure that the aims, objectives and outcomes are developed across NW London.

Progress and Delivery to date

In 2015/16, further clarity has been developed on the scope of the scheme making it relevant to the current commissioning strategies and landscape.

Delivery

Commissioners:

- West London CCG
- Royal Borough of Kensington and Chelsea
- Central London CCG
- Westminster City Council
- Hammersmith and Fulham CCG
- London Borough of Hammersmith and Fulham

Investment requirements

B1 Patient/Service User Experience and Care Planning (ex BCF02, 06 & 12 combined	
	£'000
Investment	
New Delivery Costs	
Existing Costs	200
Total	**200**

Changing context

The three boroughs' commissioners have independently developed good patient and public engagement and involvement functions, which has resulted in strong engagement and qualitative feedback on patient experience. There have also been developments on the whole systems integrated care programmes which have resulted in extensive engagement and movement towards monitoring and reporting patient experience.

However, within this context the commissioners feel that there is a need to provide an overarching framework within which engagement, involvement and experience is captured and informs commissioning practices. The intention is to deliver this scheme within the context of our STP, so that it can be delivered at scale and also align it with our journey towards developing Accountable Care Partnerships by April 2018.

BCF Scheme Plans 2016/17

The key aims for implementation for 202016/17 include:

- Develop and embed a standardised framework for Patient and Service User Experience to effectively capture, analyse and inform commissioning decisions. It will aim to enable patients and communities to have greater involvement and understanding of their health and wellbeing.
- Develop focused self-management and peer support for Whole Systems and integrated care programmes, enabling a positive impact on patient experience and for the health and care outcomes of service users.

Initial focus for developing self-management and peer support interventions shall be on:

- Whole Systems Integrated Care (WSIC) for frail and elderly patients; and
- Long term enduring mental health conditions.

This scheme will provide Patient/Service User Experience and Care Planning support to:

- Service users, carers and adults with a long term condition, or at risk of a long term condition
- All GP practices within the three borough localities
- Hard to reach communities particularly those in deprived areas
- Enable self-management and Peer Support to be focused on patients over the age of 65 years old and patients with long term enduring mental health conditions

Scheme ref no.
B2
Scheme name
Personal Health and Care Budgets
Original Intention
To extend our current arrangements for personal health budgets, working with patients, service users and front line professionals to empower people with long term conditions to make informed decisions around their care.
Progress and Delivery to date
The Personal Health Budget programme for continuing healthcare was rolled out across all care groups in a consistent manner, with evaluation and quality assurance mechanisms developed and monitored during 2015/16. The programme built on existing arrangements, by developing an integrated approach to the provision of personal care budgets and personal health budgets, including direct payments, so that eligible customers could commission an integrated package of services. The evidence and best practice gathered enabled the three CCGs to develop a Personal Health Budgets policy for identified service user groups
Delivery
The commissioners and providers involved in delivery of the scheme are: • West London CCG • Royal Borough of Kensington and Chelsea • Central London CCG • Westminster City Council • Hammersmith and Fulham CCG • London Borough of Hammersmith and Fulham
Investment requirements

B2 Personal Health & Care Budgets	
	£'000
Investment	
New Delivery Costs	30
Existing Costs	20
Total	**50**

Changing context

The NHS Mandate and NHS Planning Guidance re-affirmed the Government and NHS England's commitment to the roll-out of personal health budgets.

During 15/16 work was undertaken to review emerging best practice and work across the CWHHE collaborative to develop appropriate approaches to delivering PHBs. Work to deliver appropriate initiatives at scale (including internal management arrangements) will be developed through Sustainability and Transformation Plans (STPs) in line with planning guidance.

BCF Scheme Plans 2016/17

Continue to implement Personal Health Care Budgets for Continuing Healthcare across all Children's and Adult Care Groups as required by NHS Operating Plan

Continue to consolidate arrangements for care management and financial management of direct payments of customers with PHBs.

Work through the Integration and Collaboration Board which oversees the development of a wider PHB policy under the Sustainability and Transformation Plan

Gather evidence and best practice from elsewhere which will inform the development of a PHB service offer, which can be delivered at scale.

Integrate Social Care Personal Budgets and Personal Health Budgets for Long Term Conditions through Integrated Care Pathways and Provision

Scheme ref no.

C1

Scheme name

Transforming Nursing and Care Home Contracting

Original Intention

The strategic objectives of this project are:

- To work across health and social care to improve alignment of processes, practices and contracting for funded placements and packages of care to ensure efficiency of process.
- To develop a market strategy for care homes across health and social care to achieve delivery of efficient, high quality placements for local residents underpinned by a sustainable market.

The scheme is to address the approaches to brokerage, commissioning, placement and quality management of care home placements between the LAs and CCGs. These are complex, fragmented and reactive, which impacted the capacity of commissioners to manage a challenging care home market and inhibited the quality of care delivered. This also put pressure on other areas of the care pathway through DTOCs and increased emergency admissions.

The intended outcomes of the scheme are:

- Enhanced service quality through better sharing of information and intelligence, and joint learning between operational teams
- Improved 'soft' market knowledge in operational teams
- A single, best practice, approach to brokerage to be developed if recommended
- Best use of existing joint capacity in services that are stretched
- A clearly defined approach to the future integrated commissioning of residential and nursing care that acknowledges both current pressures and the strategic direction for health and adult social care
- Clarity for CCGs, Local Authorities and providers on the processes and procedures for funded placements and packages of care across all adult health and social care client groups
- Learning from best practice across our current client groups and funding streams to, where possible, align practices and procedures
- Embedding positive joint working relationships through jointly agreed processes, protocols and policies that reflect the holistic needs of our local patients and residents
- Ensuring that across all organisations our increasingly limited resource base is able to work efficiently avoiding duplication or lack of clarity arising from processes or pathways
- Positive experiences for people who need funded placements or packages of care and their families/carers and no delays faced in these processes or from issues resulting from inter-agency working
- Development of a joint market strategy is undertaken as a priority and aligned with wider work around accommodation based care and support across the Local Authorities and CCGs.

Progress and Delivery to date

In 2015/16 a business case was produced based on detailed analysis of the brokerage, commissioning and contracting functions for placements and packages of care for health and adult social care. The recommendations identified in the business case were:

1. Options for co-locating the health placements team and Adult Social Care placements teams are explored to identify a location that best meets the needs of the teams (based on a feasibility study)
2. Options for the brokerage of Adult Social Care (ASC), Funded Nursing Care (FNC) and Continuing Health Care (CHC) placements being channelled through a single brokerage team are developed which would need to be designed collaboratively to ensure it has the necessary capabilities and capacity
3. Development of a joint market strategy is undertaken as a priority and is aligned with wider work around accommodation based care and support across the Local Authorities and CCGs

There have been difficulties in recruiting to the Delivery Manger role, which has delayed progress on this scheme. It is now intended to appoint on an interim basis to scope the project and then review on-going resource requirements.

Delivery

Commissioners:

- West London CCG
- Royal Borough of Kensington and Chelsea Central London CCG
- Westminster City Council Hammersmith and Fulham CCG
- London Borough of Hammersmith and Fulham

Investment requirements

Investment is required for a delivery manager post initially for 6 months at Band 8b but then with consideration for the on-going implementation of the recommendations.

Changing context

During 2015/16 the CCGs with their Local Authority partners identified the need to review the processes and procedures for funded placements and packages of care across all care groups and funding streams (excluding children) and therefore have added the requirements for this review into this project. This will also enable the CCGs, with partners, to meet the actions identified through its internal audit of placements, and NHSE Deep Dive into Continuing Healthcare.

BCF Scheme Plans 2016/17

In 202016/17 the project will deliver the following objectives:

- Co-location of the health placements team and Adult Social Care placements teams (based on a feasibility study)

- The brokerage of Adult Social Care (ASC), Funded Nursing Care (FNC) and Continuing Health Care (CHC) placements are channelled through a co-designed single brokerage team

- As a priority, deliver a joint market strategy which is aligned with wider work around accommodation based care and support across the Local Authorities and CCGs

Furthermore, we will review funded placements and packages of care including:

- A single overview of the different processes and procedures for each client group or funding stream related to assessment, decision making and ratification including panel processes. The overview will cover older people, physical disabilities, learning disabilities, mental health and adult social care pathways and panels.

- Common documentation, based on best practice from our existing processes or wider, that is jointly agreed and adopts similar or aligned approaches across the client groups and funding streams:
  - Identification of training needs around the NHS Continuing Healthcare and Funded Nursing Care Framework, Mental Health Act, Care Act and other relevant legal and statutory frameworks to enhance the draft training plan for 202016/17
  - Development of Joint Dispute Resolution Policy and Joint Funding Policy, based where possible on current good practice, that can be used across the client group pathways and processes
  - Development of Joint Operational Policy (if deemed relevant)

Scheme ref no.

C2

Scheme name

Review of Jointly Commissioned Services

Original Intention

The original intention of the scheme in 2015/16 was:

- To review all existing jointly commissioned services with S75 and S256 partnership arrangements, to ensure services provide value for money and are aligned with the objective of integrated working.
- Each CCG and Local Authority has an existing S75 Partnership Agreement in place with an agreed service schedule of jointly commissioned schemes. The majority of these are lead commissioning arrangements where the Local Authority contracts on behalf of the CCG. There are a small number of pooled budgets, in particular Community Equipment.
- This project will review all of the schemes within these programmes to evaluate the outcomes being achieved and the effectiveness of the commissioning and contracting approach in order to inform commissioning intentions and recommend how these services should be commissioned in future.

Progress and Delivery to date

In 2015/16 a savings target of £1,385m was identified against the Joint Commissioning Services as part of the BCF programme.

Proposals were identified to achieve these savings from within existing services, either through reduction in contract value, service redesign/transformation or de/re-commissioning. However, a double count with savings already attributed to Local Authority savings strategies was subsequently identified. A revised savings target of £634k was agreed and these savings were delivered jointly by CCG and LA commissioners.

Delivery

Commissioners:

- West London CCG
- Royal Borough of Kensington and Chelsea Central London CCG
- Westminster City Council Hammersmith and Fulham CCG
- London Borough of Hammersmith and Fulham

Investment requirements

C2 Review of Jointly Commissioned Services (ex BCF07)	
	£'000
Investment	
New Delivery Costs	
Existing Costs	127,062
Total	**127,062**

Changing context

Since the inception of this project there is further need to ensure alignment of our jointly commissioned services to both our overarching BCF objectives and also those of our Sustainability and Transformation Plan (STP).

BCF Scheme Plans 2016/17

In 202016/17, it is recognised that further review of Jointly Commissioned Services is required to ensure alignment with key strategic objectives and in recognising the financial context of all organisations.

It is proposed that the project will deliver:

- Recommendations for each CCG and Local Authority on the schemes currently being jointly commissioned, comprising an evaluation of the services and the way in which they are being commissioned or contracted
- Setting the schemes within the context of BCF priorities and STP direction of travel indicating how they should be incorporated within commissioning plans going forwards
- Recommendations for those services suitable for a pooled budget and how this could be created

Scheme ref no.

C3

Scheme name

Integrated Commissioning

Original Intention

The original intention of the scheme in 2015/16 was:

- To address the current fragmentation in commissioning across three borough health and social care commissioners. In designing the new commissioning structures, the project will seek to understand, validate and address existing issues.
- This scheme will ensure that these developments contribute to the overall objectives of the Better Care Fund and are linked to make most effective use of resources and systematically review those associated aspects (such as assistive technology and housing support) which will add value to the programme.

Progress and Delivery to date

Key project objectives include:

- Review the as-is model for ASC joint commissioning
- Develop shared understanding between LA and CCGs of current issues
- Design and implementation of new commissioning structures

The key benefits include better value for money and improved efficiency through integrated commissioning. They will have a positive impact on service users and provide an accurate understanding of current risks and issues as well as opportunities for improvement.

In 2015/16, the CCGs and Local Authorities reviewed the issues and structures for Joint Commissioning. However, implementation of the review recommendations have not been progressed pending the outcome of ongoing discussions concerning the future structures and functions of the joint commissioning team, particularly the Mental Health team.

Revised funding contributions for the joint commissioning teams across the six organisations have been agreed and reflected in Section 75 schedules. These were based on the findings of the review concerning the split of health and social care tasks being undertaken by the teams.

Delivery

Commissioners:

- West London CCG
- Royal Borough of Kensington and Chelsea
- Central London CCG
- Westminster City Council Hammersmith and Fulham CCG
- London Borough of Hammersmith and Fulham

Investment requirements

C1 / C3 Transforming Nursing and Care Home Contracting (ex BCF03) & Integrated Commissioning (ex BCF09)	
	£'000
Investment	
New Delivery Costs	
Existing Costs	721
Total	**721**

Changing context

2015/16 has seen a turnover in staff across the CCGs and Local Authorities, which has delayed the process.

Furthermore, the developments made in CCG and LA Whole Systems Integrated Care programmes have merited renewed consideration of the longer term vision for integrated commissioning and the required structures and functions to deliver this. The ongoing validity of the findings from the previous review need to be considered in light of the longer term vision.

BCF Scheme Plans 2016/17

In 202016/17 the project will review how services are currently commissioned and contracted across the organisations and identify better ways to achieve integrated commissioning and the functions and structures that support this in light of the development of Whole Systems Integrated Care models.

Key project objectives include:

- Develop a shared understanding between LA and CCGs of current issues
- Understand direction of travel for the integrated commissioning vision under WSIC, STP and BCF
- Design and implementation of new integrated commissioning structures

Scheme ref no.

D1

Scheme name

Information Technology

Original Intention

To continue to implement IT solutions to link the three boroughs Adult Social Care systems to the GP systems and to ensure consistent use of the NHS number as primary identifier.

Progress and Delivery to date

Preparatory work was undertaken in 2015/16 to improve readiness for our ambition to integrate ASC and GP IT systems. This included developmental work to establish NHS numbers within the ASC Frameworki system and business plan development.

Delivery

Commissioners:

- West London CCG
- Royal Borough of Kensington and Chelsea
- Central London CCG
- Westminster City Council
- Hammersmith and Fulham CCG
- London Borough of Hammersmith and Fulham

Investment requirements

D1 IT Integration (ex BCF05)	
	£'000
Investment	
New Delivery Costs	
Existing Costs	201
Total	**201**

Changing context

There is a growing understanding of the importance of integrated systems working from developmental work in other schemes including hospital discharge and CIS. Further managing dual dependencies across health and ASC means time frames for delivery are longer than originally anticipated.

BCF Scheme Plans 2016/17

The key deliverables for 202016/17 are:

- Implement a mechanism to ensure NHS numbers are up-to-date, validated and available in the ASC. This will be a key identifier which will facilitate creating a single view of a client's record
- Identify the data sets to be shared by ASC and Health Care with lead users from LA and Health Care providers (and potentially users and carers themselves)
- Agree through robust options analysis, the most appropriate manner of achieving IT integration.

There are a number of options available, for example:

- Building direct interfaces to ensure systems are fully integrated
- Data warehouses which hold information centrally to create a 'single view of a client'
- Middleware which views information centrally to create a 'single view of a client'

Once the options are agreed there will be a need to specify and procure for relevant providers, pilot for a service specification and test and implement the new model.

Scheme ref no.
D2
Scheme name
Information Governance
Original Intention
To continue to implement IG solutions to link three borough social care systems to the GP systems and to ensure that other schemes have robust IG arrangements.
Progress and Delivery to date
An Information Governance and Caldicott Support Manager has been appointed to lead on IG issues and to provide direct support to the Caldicott Guardians for Adult Social Care and Public Health and for Children's Services. An IG Training Strategy is being developed in conjunction with Corporate Information Management leads. An Information Governance Training Needs Analysis has been undertaken and on line training made available across all three boroughs. A number of Information Sharing Agreements have been established, including the WSIC Information Sharing and Hosting Agreement including the overarching North West London Information Sharing Protocol. Access to the WSIC Data Warehouse has been established although data has yet to be transferred. Pooled data from Health and Social Care Providers across North West London will be available to support integrated commissioning and contracting. In order to provide a safer mechanism for sharing data with independent providers of services, the Egress email system has been integrated within the mailboxes of LBHF staff. Plans have been developed to extend availability to staff in RBKC and WCC and a roll out programme has been initiated.

Delivery

Commissioners:

- West London CCG
- Royal Borough of Kensington and Chelsea Central London CCG
- Westminster City Council
- Hammersmith and Fulham CCG
- London Borough of Hammersmith and Fulham

Others:

- Caldicott Guardians
- IT leads within Local Authority and NHS IG leads within Local Authority and NHS

Investment requirements

N/A

Changing context

As the scheme is mainly designed to underpin and enable other schemes in the BCF programme and is designed to ensure continuous improvement in IG policies, practice and culture, it is not directly affected by strategic or delivery changes. There may be impact on available resources or on timescales as a result of the effect of any strategic or delivery changes on other schemes.

The WSIC Data Warehouse implementation has been affected by a reticence on the part of some GP Practices to sign up to the agreements and to share data. A great deal of effort has been put in to obtaining sign up and steady progress is being made in obtaining a more extensive buy in.

BCF Scheme Plans 2016/17

Work will continue to regularise the submission of data to the WSIC Data Warehouse and the Information Sharing and Hosting Agreement will be kept under review to ensure that any amendments required by any new signatories are appropriately risk assessed and signed off. This will include full participation in the design and development of enhanced sharing arrangements introduced through the adoption of the Patients Know Best integrated sharing system, although it is not yet certain when access and integration will be proposed for Local Authorities.

Information Sharing Agreements are being developed to support the Community Independence Service (A1) and Integrated Hospital Discharge and 7 Day Working (A4) schemes. All new initiatives will be supported and regulated through the use of Privacy Impact Assessments to ensure that IG solutions are designed in to solutions and that Information Sharing Agreements are deployed as appropriate.

Building on the Training Needs Analysis and the IG Training Strategy, there will be an audit of current compliance with the baseline training requirements for IG with a full campaign to ensure that all staff requiring refresher training is supported in accessing and completing the required courses.

The Egress secure Email System will be rolled out across RBKC and WCC in order to improve the resilience of information sharing arrangements with independent providers of services.

Scheme ref no.

D3

Scheme name

Care Act Implementation

Original Intention

To continue to ensure the key statutory requirements of the Care Act 2014 (detailed in the Care Act Impact Analysis) can continue to be delivered following successful implementation from 1st April 2015. This includes continuing consolidation and bedding down of the changes working closely with Health, Housing and other partners.

Progress and Delivery to date

The Care Act Part 1 set out a range of substantial reforms to the way in adult social care (ASC) is provided, impacting on duties and functions provided by ASC services. Processes and practices were reviewed and changed in the lead up to 1st April 2015 and all requirements were successfully delivered including.

- Duties on prevention and wellbeing
- Duties on information and advice (including advice on paying for care)
- Duty on market shaping
- A national minimum threshold for eligibility for care and support services for adults and carers and associated outcomes as the basis for service delivery
- Assessments (including carers assessments)
- Promoting and progressing Whole Systems Integration between social care and health
- Personal budgets and care and support plans
- Safeguarding
- Universal deferred payment agreements

The key challenge was the scale and range of work required to assure compliance including partnership working with health and housing. This is a continuing challenge in terms of consolidating and bedding down the change and understanding the impact.

Delivery

Commissioners:

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

Investment requirements

D3 Care Act Implementation (ex BCF18)	
	£'000
Investment	
New Delivery Costs	
Existing Costs	1,750
Total	**1,750**

Changing context

The Care Act has led to significant increased demand for in-depth carers reviews and there are signs that demand for lower level care is increasing. These demands will need to continue to be met.

Part 2 of the Care Act which was focused on the funding of long term care and including a capped charging system and care accounts was due to go live in April 2016 , this has now been deferred by the Government until 2020. However there is substantial work to do to develop the personalisation of services offered and to increase uptake of Direct Payments.

BCF Scheme Plans 2016/17

- Following successful delivery of the changes the programme was closed in October 2015.
- Portfolio Deliver Steering Group and Portfolio Review Board chaired by the Director of Finance and Resources and the Executive Director, continue to monitor impact and progress delivering the work plan returns to the Department of Health to track impact on demand, activity and costs and continued implementation on a quarterly basis.
- Staff will need to undergo continued training. Legal expertise will continue to be required to deliver some of this training.
- In order to meet the requirements of the Care Act and support its implementation several projects and working groups are continuing that are tied to the wider ASC Transformation Portfolio, particularly the Customer Journey Programme, these are:
    - Front door, information and advice and prevention offer development.
    - Outcomes based assessment, review and support planning.
    - Market management development.
    - Safeguarding and provider failure development.
    - Personalisation and Direct Payments

Scheme ref no.

D4

Scheme name

BCF Programme Implementation and Monitoring

Original Intention

To successfully programme manage the BCF schemes, ensuring each scheme delivers the agreed outcomes on time and to the right standard.

Progress and Delivery to date

The programme management scheme is an enabler to delivering the agreed BCF ambition. This scheme sits at the centre of the three boroughs (3Bs) BCF and acts as the coordination point for all current schemes. This support enables timely coordination and monitoring of the agreed BCF plan and delivery against the total budget of £157.5m.

In 15/16 it is acknowledged that this scheme experienced some challenges with a change in-year from external PMO support to agreed internal support. During this period there was a focus on BCF Project A schemes, particularly the Community Independence Scheme, which is a high priority in order to support delivery of the BCF.

The internal PMO linked to the CIS supported the development and distribution of flash reports that provided monthly updates about progress on each scheme; these were provided to JET and HWB Boards.

In 15/16 delivery of the CIS was particularly challenging in relation to planned and actual activity. This was closely monitored and provided data and analysis to support reprocurement of the service in 2016/17.

The reprocurement of neurorehab and the shift from acute to community resulted in the expected benefits being realised.

Delivery

Commissioners:

- West London CCG
- Royal Borough of Kensington and Chelsea
- Central London CCG
- Westminster City Council
- Hammersmith and Fulham CCG
- London Borough Hammersmith and Fulham

Investment requirements

D4 BCF Implementation/Monitoring (ex BCF04)	
	£'000
Investment	
New Delivery Costs	
Existing Costs	350
Total	**350**

Changing context

We are currently establishing a revised approach to BCF Programme Implementation and Monitoring, this is to build on our experience in 15/16 and ensure that we have the right support to ensure continued delivery against our BCF ambition in 2016/17.

The BCF has an established SRO and additional management capacity to support delivery, engagement and reporting of the BCF in 2016/17

BCF Scheme Plans 2016/17

The 2016/17 BCF plan is a rollover of the previous year's plan 15/16. All schemes have remained the same and the governance and reporting structure to support the delivery is now embedded in the development, delivery and monitoring of the schemes.

We are continuously reviewing how we can support SROs and implementation leads for the BCF schemes to ensure that we deliver the agreed visions and ambitions related to the BCF. The Sustainability and Transformation Plan (STP) will further support the integration and collaboration and where appropriate we have identified work that can be done at scale via the STP.

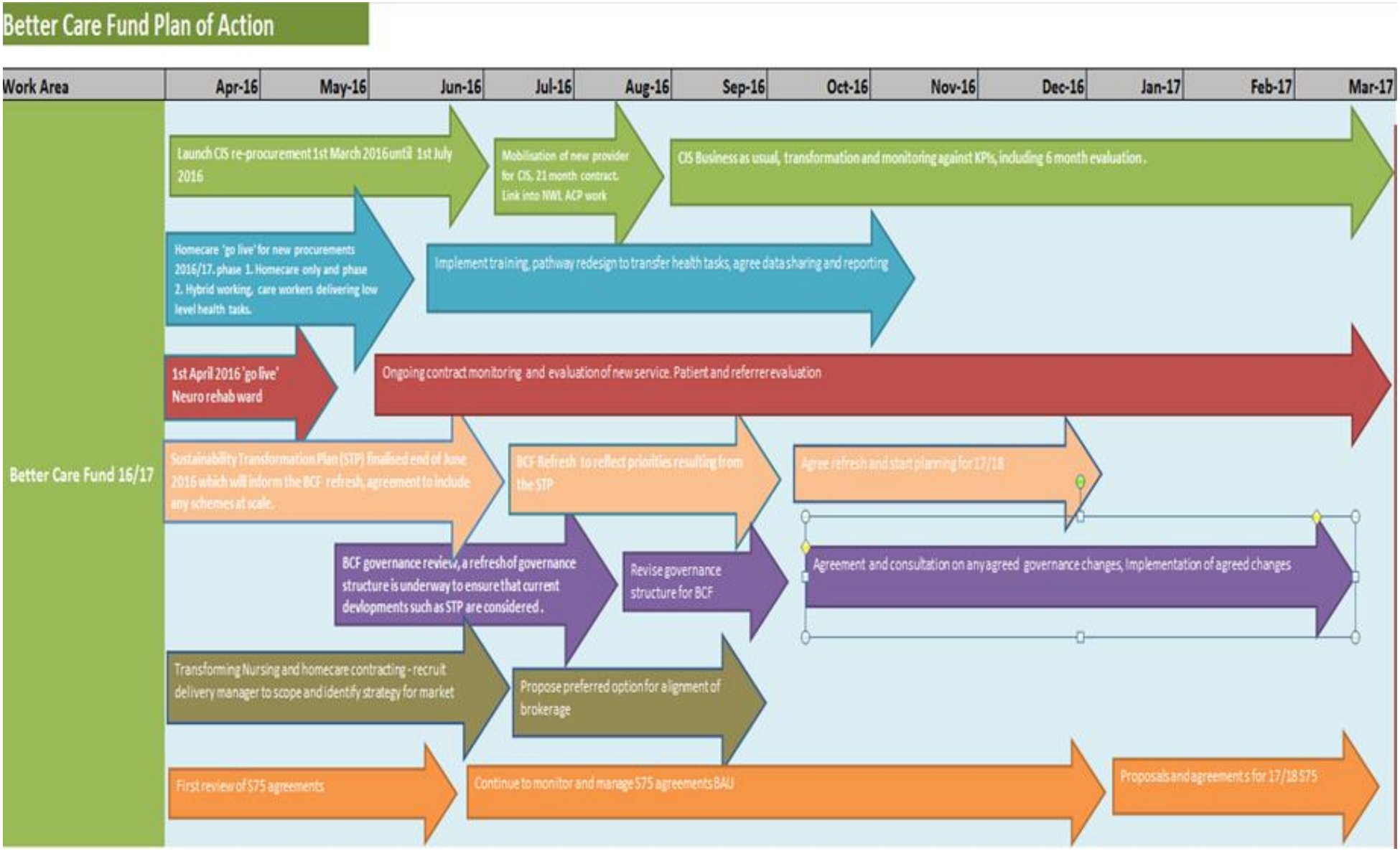
Together we have agreed joint resource to work across the BCF to support implementation and monitoring.

Appendix C

BCF 16-17 Plan - Three Boroughs

Scheme	H&F CCG	LBHF	Total H&F	WL CCG	RBKC	Total RBKC	WL & CL CCG	WCC	Total WCC	Three Boroughs Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
A1 Community Independence Service	4,962	1,115	6,077	4,725	1,148	5,873	6,961	998	7,959	19,909
A2 Community Neuro Rehab Beds	1,103		1,103	720		720	1,856		1,856	3,679
A3 Home Care	800		800	200		200	600		600	1,600
A4 7 Day Social Work Hospital Discharge	313		313	313		313	312		312	938
B1 Patient/Service User Experience and Care Planning	59		59	63		63	78		78	200
B2 Personal Health & Care Budgets	15		15	16		16	19		19	50
C1/C3 Transforming Nursing and Care Home Contracting & Integrated Commissioning	453		453	268		268			0	721
C2 Review of Jointly Commissioned Services	24,652	6,128	30,780	24,976	24,661	49,637	28,558	18,087	46,645	127,062
D1 IT Integration	59		59	63		63	79		79	201
D3 Care Act Implementation	517		517	527		527	706		706	1,750
D4 BCF Implementation/Monitoring	103		103	110		110	137		137	350
Joint Contracts		1,019	1,019		667	667		1,182	1,182	2,868
Total	**33,036**	**8,262**	**41,298**	**31,981**	**26,476**	**58,457**	**39,306**	**20,267**	**59,573**	**159,328**

Appendix D
Better Care Fund Plan of Action



London Borough of Hammersmith & Fulham **HEALTH AND WELLBEING BOARD** **20 JUNE 2016**	
COMMUNITY INDEPENDENCE SERVICE PROCUREMENT	
Report of the Executive Director of Adult Social Services	
Open Report	
Classification - For Information **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: Chris Neill, Director of Whole Systems	
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1. EXECUTIVE SUMMARY

1.1. The Community Independence Service provides integrated community and social care through one multidisciplinary team in each borough. The service operates seven days a week enabling people to regain their independence and remain in their own homes following illness and/or injury. The service provides a patient-centric experience with as few separate interactions or home visits as possible. Services are currently delivered by a multidisciplinary team of community nurses, social workers, occupational therapists, GPs, geriatricians, mental health workers, reablement officers and others providing a range of functions which aim to:

- Avoid hospital admissions where clinically appropriate care can be provided in the community;
- Facilitate early supported discharge from hospital;
- Maximise independence; and
- Reduce dependency on longer term services.

1.2 The CIS provides an opportunity for commissioners to negotiate contracts with acute trusts that reflect penalties to offset investment made in community

services. The introduction of the consequence of breach against KPIs will ensure commissioners are only spending against activity delivered.

1.3 The Community Independence Business Case 2014, described 2015-16 as an intermediate development year for the service using a dual lead provider model (Health and Social Care) and set out a further proposal to use an open market tender to procure a fully integrated CIS with a single lead provider model from 2016.

2. Key Matters for the Committee's Consideration

- The Board are asked to consider the background to and the progress of the Community Independence Service procurement process.

3. Background

3.1 Intermediate care and re-enablement services are a key plan of government healthcare policy to provide health and care closer to home. Intermediate care services are key to reducing the financial, quality and activity pressures being experienced in secondary care and the care service sector. The National Audit of Intermediate Care (2015) provides a comprehensive analysis of models and performance of services which support, typically older, frail people with high levels of need and complex comorbidities, after leaving hospital or at risk of being sent to hospital or long term care. Evidence from this audit (to which CLCH and Central London CCG are contributors) indicates that CI services improve the independence of frail, older people and that reduce the cost of delivering care.

3.2 The CIS delivers the following key functions:

- A Single Point of Referral, Assessment & Rapid Response
- In-Reach/Supported Discharge
- Rehabilitation & Reablement

3.3 The Community Independence Service Business Case (Nov 2014) presented the case for an integrated Community Independence Service to be managed by lead providers from health and social care. The procurement was undertaken as a restricted tender between existing providers delivering services to tri-borough CCGs. The advertised restricted tender was for a one-year contract with no extension as with the intention of using the transition year to procuring a full lead provider model for 2016.

3.4 The timescale for procurement was delayed to allow an evaluation of the current model in October 2015. The evaluation process included 1:1 and group meetings with commissioners, provider teams, GPs and Clinical leads for the service as well as patient feedback and surveys. Following the evaluation commissioners agreed to move to procurement of an integrated CIS under a partnership of providers using either a lead provider or alliance model. Learning from the evaluation has been discussed during Market

Engagement and taken into consideration when developing the service specification.

3.5 The objectives of the service are to:

- Enable people to direct their own care to achieve identified and agreed goals.
- Support integration across health & ASC, through a jointly commissioned service that brings the elements of care into one service, which will reduce fragmentation and delays across the health and social care pathway.
- Supports behaviour change across the system to promote independence in patients and a reablement approach to care which should lead to better patient outcomes, right care in the right place (this also supports Out of Hospital)
- Compliments and supports whole systems integrated care and primary care transformation by providing supporting GPs to manage patients in the community by provision of a step-up service when required as part of a proactive approach to managing patient care and avoiding admission to hospital where conditions can be safely managed in the community.
- Maximise independent living by supporting care at home, delaying possible admission to long term care, avoiding inappropriate admission to a hospital or long-term care institution, and achieving earlier discharge;
- Improve the transition for patients between acute hospital services, community services and primary care;
- Improve value for money by lowering the costs of unscheduled care and care placement admissions as a consequence of reduced unnecessary hospital and long-term care admissions and readmissions;

3.6 In autumn 2015, a Triborough programme team was established to identify the requirements of the service for 2016-18 and develop the tender documentation including PQQ and ITT questions, Memorandum of Information and Service Specification. An evaluation of CIS performance including discussions with patients, clinical and non-clinical staff was undertaken in November and December 2015 and a full market engagement exercise undertaken with providers in January 2016.

4. Procurement Process

Phase 1 – Market Engagement

- In December 2015 Triborough Health commissioners authorised a three month extension of the Lead Health Provider Contract to cover the anticipated procurement timeline.
- A Memorandum of Information was published on the EU Portal on 13th January 2016 to advertise that a potential health & social care procurement of a fully integrated community independence service was being considered. The advertisement offered providers the opportunity to comment on the proposed service design and timescale for procurement through i) written response to a series of questions regarding future development of the Community Independence Service and ii) an opportunity to participate in 1:1 interviews with commissioners.

- Commissioners received 11 expressions of interest, 8 written responses and undertook 7 provider meetings. Responses were positive and all provider written responses contained confirmation of ability to bid and mobilise services within the timeframes indicated in the Memorandum of Information.
- Following a review of the market engagement exercise commissioners agreed to proceed to Phase 2 of this project, an open tender process.

Phase 2 - Procurement

- Following completion of the market engagement exercises commissioners across health and social care jointly revised the CIS service specification. The intention was to strengthen the service model, building upon the first 12 months of the development of the CIS and enhance delivery to patients and residents across the three boroughs. The key service lines within the CIS model remain unchanged and areas identified for immediate improvement and development included:-

Phase 3 - Advertising the Opportunity

- Following development and agreement of a joint service specification, finance and procurement documentation, an advertisement was placed on Contract Finder (EU Procurement Portal) on 4th March 2016. Interested parties were given 6 weeks to provide a written submission to bid for delivery of the service with final deadline of noon on 15th April 2016.

5. Outcomes of Tender Process

5.1 Following development and agreement of a joint service specification, finance and procurement documentation, an advertisement was placed on Contract Finder (EU Procurement Portal) on 4th March 2016. Interested parties were given 6 weeks to provide a written submission to bid for delivery of the service with final deadline of noon on 15th April 2016.

5.2 A number of bids were received and marked by a multi-commissioner evaluation team. Commissioners hope to be in a position to appoint a lead provider in the near future with service commencement in July 2016.

5.3 The intention is to consolidate and improve the current service delivered by integrated community and social care by creating multidisciplinary health and social care teams to work across the boroughs, which operate seven days a week, enabling people to regain their independence following illness and/or injury and remain in their own homes. Healthcare teams must have the ability to flex across borough boundaries for delivery of services to ensure the ability to meet fluctuations in demand.

5.4 The new service procured will be contracted for an interim period of a maximum of 21 months (July 2016-March 2018) which will:

- Provide an opportunity to further develop the service whilst commissioners develop and procure Accountable Care Partnerships (as set out in Commissioning Intentions 2015).
- Allow the existing provider network to develop to a suitable level of competence for involvement in Accountable Care Partnerships.

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.	CIS Business Case 2014		

LIST OF APPENDICES:

None

Hammersmith & Fulham
Health & Wellbeing Board
Work Programme 2016/17

KEY
FOR DECISION
FOR DISCUSSION
FOR INFORMATION
PLANNING

Agenda Item	Summary	Lead	Item
Meeting Date: 20 June 2016			
JOINT PLANNING	comprising: • Update on NWL Sustainability & Transformation Plan • Joint Health & Wellbeing Strategy	**ASC/CCG**	**For decision**
COMMUNITY INDEPENDENCE SERVICE RE-PROCUREMENT		ASC/CCG	**For information**
BETTER CARE FUND 16/17 UPDATE		ASC/CCG	**For information**
Meeting Date: 7 September 2016			
JOINT HEALTH & WELLBEING STRATEGY		ASC/CCG/PH	**For discussion**
INTEGRATION, ACCOUNTABLE CARE AND DEVOLUTION	including CCG commissioning intentions17/18 and beyond	CCG/ASC	**For decision**
ANNUAL PUBLIC HEALTH REPORT 2015/16 / VISION STATEMENTS	For approval ahead of publication	PH	**For discussion**

HOUSING JSNA		PH	
TRANSFORMING PRIMARY CARE	Primary care transformation plans	CCG/NHSE	**for discussion**
SPECIAL EDUCATIONAL NEEDS JOINT COMMISSIONING STRATEGY/ IMPLEMENTATION OF THE CHILDREN AND FAMILIES ACT		CS / ROBIN CUTLER	
MENTAL HEALTH	Update on tackling mental health in the borough Mind briefing on the role of local community services in supporting people with mental health problems	CCG/PH HF Mind	**for discussion**
Meeting Date: 14 November 2016			
JOINT HEALTH AND WELLBEING STRATEGY	The Board is asked to approve the final JHWS post-consultation	ASC/CCG/PH	**For decision**
DELIVERING SUSTAINABILITY AND TRANSFORMATION PLANS: PLANNING UPDATE	6 month update	NWL CCG	**For discussion**
DISCUSSION ITEMS			
SAFEGUARDING CHILDREN BOARD ANNUAL REPORT 2015/16	Consider alignment of strategic priorities and lessons for integrated commissioning	Independent Chair	**For discussion**

SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2015/16	Consider alignment of strategic priorities and lessons for integrated commissioning	Independent Chair	**For discussion**
Meeting Date: 13 February 2017			
STRATEGIC ITEMS			
BETTER CARE FUND PLANNING UPDATE + ALLOCATIONS 2017/18		ASC	**For decision**
JOINT HEALTH AND WELLBEING STRATEGY	discussion focusing on a particular aspect of the strategy tba	ASC	**For discussion**
Meeting Date: 20 March 2017			
STRATEGIC ITEMS			
HEALTH + SOCIAL CARE INTEGRATION PLANS	Update on planning for full integration by 2020	CCG/ASC	**For decision**
LEARNING FROM THE LONDON DEVOLUTION PILOTS	review learning from first year of London devolution pilots	ASC	**For discussion**
THE ROLE OF PHARMACY IN OUR HEALTH AND CARE PLANS		PH	**For discussion**
BUSINESS ITEMS			
JOINT HEALTH AND WELLBEING STRATEGY	discussion focusing on a particular aspect of the strategy tba	ASC	
CCG OPERATING PLANS 2017/18	operating plans for 2017/18	CCG	**For information**