London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Agenda

Monday 21 March 2016
6:30pm
Courtyard Room - Hammersmith Town Hall

MEMBERSHIP

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

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Date Issued: 11 March 2016

London Borough of Hammersmith & Fulham

Health & Wellbeing Board
Agenda

21 March 2016

Item		Pages
1.	**MINUTES AND ACTIONS** (a) To approve as an accurate record and the Chair to sign the minutes of the meeting of the Health & Wellbeing Board held on (b) To note the outstanding actions.	1 - 7
2.	**APOLOGIES FOR ABSENCE**	
3.	**DECLARATIONS OF INTEREST***	
4.	**PLACE-BASED SYSTEMS OF CARE: A WAY FORWARD FOR THE NHS IN ENGLAND** Professor Chris Ham (King's Fund) has kindly agreed to attend the meeting and the Board is requested to discuss place based systems of care and the solution they potentially offer to the challenges facing the local health and care system.	8 - 75
5.	**STRATEGIC PLANNING: REVIEWING PROGRESS AND LOOKING FORWARD TO THE REFRESH OF THE JOINT HEALTH AND WELLBEING STRATEGY** This report considers research into the effectiveness of Health and Wellbeing Boards across the country, outlines the changing needs of the Hammersmith & Fulham population and sets out a framework for the refresh of the Joint Health and Wellbeing Strategy in 2016.	76 - 126
6.	**LIKE MINDED - UPDATE ON THE TRANSFORMING CARE PARTNERSHIP PLAN FOR PEOPLE WITH A LEARNING DISABILITY AND/OR AND CHALLENGING BEHAVIOUR** This report provides an update to the Health and Wellbeing Board on progress made to date within the North West London 'Transforming Care Partnership Plan'.	127 - 175
7.	**BETTER CARE FUND UPDATE: QUARTER 3 PERFORMANCE REPORT** This report presents the quarter 3 Better Care Fund performance.	176 - 181
8.	**END OF LIFE CARE JSNA** This report summarises the work and findings of the JSNA on End of Life Care, including the recommendations for key partners.	182 - 187

9. WORK PROGRAMME

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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.

10. DATES OF NEXT MEETINGS

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

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

** 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.

London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Minutes

Tuesday 9 February 2016

PRESENT

Committee members:
Councillor Vivienne Lukey (Cabinet Member for Health and Adult Social Care (Chair))
Councillor Sue Macmillan (Cabinet Member for Children and Education)
Dr Tim Spicer, H&F CCG (Vice-chair)
Andrew Christie, Executive Director of Children's Services
Janet Cree, H&F CCG
Mike Robinson, Director of Public Health
Keith Mallinson, H&F Healthwatch Representative

Nominated Deputies:
Councillor Sharon Holder
Councillor Rory Vaughan
Chris Neill

Officers:
Sarah Bright (Lead Commissioner, Early Years), Harley Collins (Health and Wellbeing Manager), Ian Elliott (Policy), Ibrahim Ibrahim (Assistant Committee Coordinator), Sarah Wallace (Public Health Registrar).

31. MINUTES AND ACTIONS

Councillor Vivienne Lukey introduced Mike Robinson (Director of Public Health) and Keith Mallinson (H&F Healthwatch Representative) who had been recently appointed to the Health and Wellbeing Board.

RESOLVED –

THAT, the minutes of the meeting held on 9 November 2015 were approved as an accurate record and signed by the Chair.

THAT, Mike Robinson and Keith Mallinson were appointed to the Health and Wellbeing Board.

32. APOLOGIES FOR ABSENCE

Apologies for absence were received from Vanessa Andreae (H&F CCG), Liz Bruce (Executive Director of Adult Social Care) and Ian Lawry (SOBUS).

33. DECLARATIONS OF INTEREST

There were no declarations of interest.

34. EARLY YEARS

The Board received an update on the progress made in improving partnership and integration in relation to Child Health and Wellbeing. Sarah Bright reported that Early Help and Children's Centres have been working together to develop an approach for an integrated 0-18 Children and Families Partnership model. It was additionally reported that work was continuing on the design of this approach that would be ready for implementation by 2017.

Andrew Christie drew Members attention to page 14; appendix 1 of the report, which set out the 'Best Start in Life Care Pathway'. The Best Start in Life (BSiL) was a partnership programme of work across Children's Centres, CCGs, GPs and midwifery to develop a systematic pathway of care for families from pregnancy to age 5 in order to improve outcomes for children, families and communities, as well as creating services that provide better access and experience.

It was noted that the programme of work had achieved the following:

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

Keith Mallinson referred to the issue of early identification and support offer for vulnerable families, as it was felt that there was a lack of provision in the north of Hammersmith and Fulham. Sarah Bright commented that there were two key children's centres in the North of the Borough; Old Oak Children's Centre and Randolph Beresford Children's Centre and they both had strong links with partners.

Councillor Vaughan queried the number of schools involved in the Healthy School Partnership as there had been an increasing number of schools taking part. Sarah Bright and Sarah Wallace agreed to provide information on the schools that were taking part and what they were doing in this area either on their own or in conjunction with partners.

ACTION: Sarah Bright and Sarah Wallace

Councillor Lukey referred to the number of families that were not registered with GPs and what could be done to encourage registration of new families moving into Hammersmith and Fulham. Sarah Bright commented that this was being monitored continuously at children's centre who were working towards signing families up. In addition, it was reported that officers were looking to implement a streamlined service to encourage registration through the use of online forms by moving away from traditional and outdated paper forms.

Sarah Bright drew Members attention to the next steps on pages 12 – 13 of the report and Councillor Lukey queried the progress made on aligned commissioning (early years and adult commissioning). Chris Neill commented on discussions on co-commissioning implications and changes to primary care contracts, which officers were focusing on although there would be an opportunity to examine this in further detail as the Health and Wellbeing Strategy would be updated later in 2016.

RESOLVED –

THAT, the report be noted.

35. CHILD POVERTY

Ian Elliott provided the Board an update on the emerging Child Poverty strategy for Hammersmith and Fulham. It was noted that Hammersmith and Fulham committed to produce its first child poverty strategy, following the JSNA in 2013 on child poverty and the development of a strategy on Early Help in 2015. It was proposed to return to the Board with a final version of the completed strategy in the summer, following wider consultation in the spring of 2016.

Ian Elliott drew Members attention to pages 18 – 19 of the report, which set out the draft strategy that had been arranged into four themes, which were Housing, Work and Pay, Children's Services and Health. It was noted that each theme was covered in detail in the strategy, with proposed actions and activity to alleviate child poverty locally.

Keith Mallinson welcomed the report and offered his support during the consultation process as it was noted that Healthwatch had a greater reach in many areas. It was felt that the strategy should consider the mental health of parents and its impact on children and child poverty. In addition, Tim Spicer commented that there was an opportunity for partners such as GPs to offer patients information on financial advice, debt advice and foodbanks to help to alleviate child poverty. It was felt that there was an opportunity to collate information for patients in order to provide a readily available service or offer.

RESOLVED –

THAT, the Board approved the consultation process.

THAT, the report be noted.

36. CHILDHOOD OBESITY JSNA

Mike Robinson introduced the report on Joint Strategic Needs Assessment Childhood Obesity. This forms a common foundation and shared understanding across partners on the needs for health improvement to provide an evidence base on the causes and consequences of childhood obesity in Hammersmith and Fulham. It was noted that the JSNA would inform the next phase of the Tackling Childhood Obesity Programme.

Councillor Macmillan queried the table data (table 7) on page 41; appendix 1 of the report, as the prevalence of childhood obesity in Reception and Year 6 from a ward level perspective was different. In reply, Mike Robinson commented that this was an area of research as there was no obvious pattern and data was being collected every year in order to provide a better understanding. In addition, Councillor Macmillan referred to figure 15 on page 46, appendix 1 of the report, as the number of children participating in two hours of high quality PE or school sport was lower than the London average. Mike Robinson agreed to examine this in further detail and then provide the Health and Wellbeing Board an update.

ACTION: Mike Robinson

Mike Robinson noted the current work being undertaken by Westminster City Council (WCC)regarding the Healthy Catering Commitment as Members felt it would be useful to understand the learning outcomes from this area of work. The pilot at would involve WCC working with 20 fast food providers to improve the nutritional content and quality of their food offer.

ACTION: Mike Robinson

Members noted that the information on children's centres on page 45 of the report was incorrect and Mike Robinson agreed to the information in the report accordingly.

ACTION: Mike Robinson

Keith Mallinson referred to the high cost of transport and lack of access to sports/outdoor facilities, which can impact on children obesity. In addition, many schools no longer run short outdoor breaks to places like the Isle of Wight due to budgetary constraints, which was considered an opportunity for many children to experience outdoor activities. Councillor Lukey noted that officers were closely with schools to encourage children to take part in sports outside of school time.

Andrew Christie and Mike Robinson drew Members attentions to the recommendations on page 71; appendix 1 of the report. It was agreed that they would present the paper to Hammersmith and Fulham Business Board to

gather support as it was felt that every Council department had a role to play in creating and supporting increasingly healthier environments to make healthy choices easy choices.

ACTION: Andrew Christie and Mike Robinson

RESOLVED –

THAT, the Board approved the JSNA for publication.

THAT, the Board agreed to monitor the progress of the implementation on the recommendations, holding to account the parties involved.

THAT, the Board continues to support and to actively promote the whole council partnership initiative to tackle childhood obesity

37. OPERATING PLAN

Janet Cree introduced the report, which provided an update on the key planning tasks Hammersmith and Fulham CCG were engaged in for financial year 2016/17. It was noted that the Government announced in the Comprehensive Spending Review (CSR) on 25 November 2015 a plan for health and social care to be fully integrated across the country by 2020 and for every part of the country to have a plan for this in 2017. In order to achieve this, all NHS organisations had been asked to produce two separate but interconnected plans:

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

Janet Cree drew Members attention to page 82 of the report, which set out the timetable for the development of local STPs:

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

The Spending Review provided additional dedicated funding streams for transformational change, building up over the next five years. This protected funding is for initiatives such as the spread of new care models through and beyond the vanguards, primary care access and infrastructure, technology roll-out, and to drive clinical priorities such as diabetes prevention, learning disability, cancer and mental health. Members commented on the Like Minded Programme and highlighted the Board's focus on mental health,

particularly in respect of children and young people. In response to issues raised by the Board, Andrew Christie advised that the Future In Mind programme had been created to tackle issues concerning children and young people's mental health and that he would be happy for a report on the Future In Mind programme to be considered at a future Board meeting. Andrew Christie added that the Like Minded Programme offered a good opportunity to involve a number of organisations in tackling mental health.

Janet Cree reported that the STP production will be developed alongside the refresh of the HWBB strategy. In addition, the Health and Wellbeing Board would be updated on the first stage of the assurance process and would continue to receive regular updates moving forward.

ACTION: Janet Cree

RESOLVED –

THAT, the report be noted.

38. FLU VACCINATION

Sarah Wallace provided the Board an update report on flu immunisations in Hammersmith and Fulham.

Sarah Wallace drew Members attention to page 136 of the report, which set out the immunisation data for the period September – December 2014 and September – December 2015 for 2 years, 3 years, 4 years, over 65s, under 65s 'at risk' and pregnant women. Members felt that the numbers were encouraging compared to London averages. It was reported that Public Health, CCG, NHSE and Children's Services worked together to deliver a flu pilot based in 2 Children's centres in Hammersmith and Fulham. The pilot was delivered in four clinics and 71 children were immunised in total.

There were three practices in Hammersmith and Fulham that were commissioned to provide extended hours services to all Hammersmith and Fulham registered patients and the commissioned service includes a requirement to immunise eligible patients for flu. It was reported that a total of 217 flu immunisations had been administered to patients at 'weekend plus' hubs this season. The immunisation campaign will continue during February until the end of the vaccine availability. It was additionally reported that the final uptake data for the 2015/16 season will be published in March 2016.

Keith Mallinson commented that the voluntary sector provides a good opportunity to offer immunisations. Sarah Wallace noted that officers work closely with SOBUS, Carers Network and Age UK.

Sarah Wallace commented that a 'wash up' session would take place once the final data had been received to take away the learning outcomes. It was noted that the timetable for the flu season 2016/17 already being put in place and the first meeting had been planned for June 2016, to begin activities for next year's flu season. Councillor Lukey welcomed the data made available to

the Board and future planning and requested an update following the 'wash up' session.

ACTION: Sarah Wallace

RESOLVED –

THAT, the report be noted.

39. JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) STEERING GROUP

RESOLVED –

THAT, the Board noted the minutes of the meeting held on 26 January 2016.

40. DATES OF NEXT MEETINGS

21 March 2016.

Meeting started: 6:00pm
Meeting ended: 8:15pm

Chair .....

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London Borough of Hammersmith & Fulham **HEALTH & WELLBEING BOARD** **21 MARCH 2016**	
PLACE-BASED SYSTEMS OF CARE: A WAY FORWARD FOR THE NHS IN ENGLAND	
Report of the Executive Director Adult Social Care	
Open Report	
Classification - For Information **Key Decision: No**	
Wards Affected: None	
Accountable Executive Director: Liz Bruce, Executive Director, Adult Social Care	
Report Author: Harley Collins, Health & Wellbeing Manager, Adult Social Care	**Contact Details:** Tel: 0208 753 5072 harley.collins@lbhf.gov.uk

1. EXECUTIVE SUMMARY

This report by the King's Fund argues that providers of services should establish place-based 'systems of care' in which they work together to improve health and care for the populations they serve. The Board is requested to discuss place based systems of care and the solution they potentially offer to the challenges facing the local health and care system

2. RECOMMENDATIONS

2.1 It is recommended that the Health and Wellbeing Board note the paper and discuss the potential solution offered by place-based systems of care to the challenges facing the local health and care system.

3. INTRODUCTION AND BACKGROUND

3.1. In a context of complex and fragmented organisational arrangements, the report at Appendix 1 offers a new approach to tackling the financial and demand-based challenges facing the NHS and Social Care in England. The paper argues that provider organisations should come together in place based 'systems of care', typically on footprints bigger than those covered by CCGs, to manage common

resources. The paper outlines a set of 10 design principles to enable this to happen.

3.2. Place based systems of care require future commissioning to be strategic and coordinated, based on long-term contracts tied to the delivery of defined outcomes.

3.3. The paper argues that this approach offers the best opportunity for developing sustainable health and care services but notes leaders will need to surrender some of their autonomy to collectively improve the health and wellbeing of the populations they serve.

3.4. Shortly after the publication of *Place-based systems of care* in November 2015, the leading national health bodies published *Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21* which set out a radical shift for the NHS over the coming years from organisation-based to a place-based approach to planning.

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

(December 2015) Delivering the Forward View: NHS Shared Planning Guidance 2016/17 – 2020/21, NHS England, NHS Improvement, Care Quality Commission, Health Education England, National Institute of Care Excellence, Public Health England (available at: https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf)

LIST OF APPENDICES:

Appendix 1: Place-based systems of care: A way forward for the NHS in England (King's Fund, Nov 2015)

The King's Fund

Ideas that change health care

Place-based systems of care

A way forward for the NHS in England

Authors

Chris Ham

Hugh Alderwick

November 2015

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Summary

The NHS is facing growing pressures, with finances deteriorating rapidly and patient care likely to suffer as a consequence. It is also developing new care models designed to deliver services more appropriate to the changing needs of the population.

The NHS is seeking to tackle these challenges in the context of organisational arrangements that are more complex and fragmented than at any time in its history. The question is how to adapt these arrangements and make them fit for purpose while avoiding another damaging reorganisation.

This paper argues that providers of services should establish place-based 'systems of care' in which they work together to improve health and care for the populations they serve. This means organisations collaborating to manage the common resources available to them.

The approach taken to developing systems of care should be determined by NHS organisations and their partners, based on a set of design principles that we outline in this paper. These principles include developing an appropriate governance structure, putting system leadership in place and developing a sustainable financial model.

Government and national bodies in the NHS should work to remove the barriers that get in the way of working in place-based systems of care and should themselves work in a co-ordinated way to support the development of these systems. This includes creating stronger incentives for systems of care to evolve to tackle current and future challenges.

Fundamental changes to the role of commissioners are needed to support the emergence of systems of care. Commissioning in future needs to be both strategic and integrated, based on long-term contracts tied to the delivery of defined outcomes. Scarce commissioning expertise needs to be brought together in footprints much bigger than those typically covered by clinical commissioning groups (CCGs), while retaining the local knowledge and clinical understanding of general practitioners (GPs).

Systems of care hold out the prospect of NHS organisations developing services that are financially and clinically sustainable and putting in place new care models that are able to improve the health and wellbeing of the populations they serve. The alternative is for each NHS organisation to adopt a 'fortress mentality' in which it acts to secure its own future regardless of the impact on others.

The argument of this paper is that collaboration through place-based systems of care offers the best opportunity for NHS organisations to tackle the growing challenges that they are faced with. It will, however, require organisational leaders to surrender some of their autonomy in pursuit of the greater good of the populations they collectively serve, and national leaders to act urgently to enable systems of care to evolve rapidly.

1 From fortresses to systems

The NHS in England is facing growing financial and service pressures at a time of rising demand and constrained resources. It is seeking to tackle these pressures in the context of the Health and Social Care Act 2012 and its legacy of organisational arrangements that are more complex and fragmented than at any time in the history of the NHS (*see* Ham *et al* 2015a).

This paper argues that making progress in this environment depends on providers working together in place-based 'systems of care' while avoiding further destabilising and distracting changes to the structure of the NHS. It also argues that commissioning should be much more integrated and strategic in order to support the development of place-based systems of care.

There is real urgency in tackling these issues as NHS finances are already in crisis and patient care is likely to suffer as a consequence. Leaders at both national and local levels cannot afford to indulge in navel-gazing and need to decide how the proposals set out in this paper can be taken forward in 2016 and beyond.

The case for systems of care derives in part from the absence of a designated system leader in the English NHS following the abolition of strategic health authorities in 2013. One of the consequences has been to leave a vacuum in the organisation of the NHS in relation to the oversight of services at regional and local levels. The contribution of strategic health authorities when they worked at their best has not been replaced and has left a sense in many areas that 'no one is in charge' (Timmins 2015).

Previous work by The King's Fund (Ham *et al* 2013) has highlighted the risks this entails in London, for instance, where financial and service pressures are particularly acute. The option of 'constellations of leadership' emerging to fill the vacuum left by the abolition of strategic health authorities, put forward in the report, has been only

partially realised, often because the skills needed to work across organisational and service boundaries are in short supply. A notable exception is north-west London where commissioners have come together to reconfigure services.

A different example is UCL Partners, which has facilitated improvements in clinical care among providers in parts of London and south-east England. Elsewhere it has proved difficult to put in place the system leadership needed to bring about changes in how care is delivered. The separation of responsibilities between providers and commissioners adds a further layer of complexity in an already fragmented environment, accentuated by the sheer number of organisations involved in providing and commissioning care in England.

The alternative to place-based systems of care is for each NHS organisation to adopt a 'fortress mentality', acting to secure its own future regardless of the impact on others. A fortress mentality is a logical response in the existing NHS environment where provider autonomy, competition and regulation figure prominently. Faced with persistent demands from regulators to improve performance, the leaders of provider organisations in particular are under pressure to focus on the services for which they are responsible rather than working with other providers and commissioners for the greater good of the populations they serve.

The obvious risk in a fortress mentality is that 'success' for one organisation almost invariably accentuates the challenges facing others. Oversimplifying only a little, an acute provider that improves its financial performance by increasing activity may add to the pressures facing commissioners who may lack the resources to pay for it. It may also frustrate plans to give greater priority to mental health, community-based services and primary care.

Organisations commissioning and providing care with a common pool of limited resources find themselves in a zero-sum game in which winners co-exist with losers in a set of relationships that are often fragile. Failure to act collectively is likely to result in poor outcomes for the population and at worst a descent into a 'war of all against all', to borrow the words of the philosopher Thomas Hobbes. The central argument of this paper is that NHS organisations must work together and with others to govern the common resources available for meeting their population's health needs.

If the fortress mentality prevails, the major challenges facing local health systems and the populations they serve are likely to go unmet. These well-known challenges – such as delivering care for people with long-term conditions and managing demand for urgent care services – are best tackled by collective action across organisations and services. Collective action is also needed to improve the health and wellbeing of the population by acting on the wider social, economic and environmental determinants of health (Canadian Institute for Advanced Research *et al*, cited in Kuznetsova 2012; Booske *et al* 2010; Marmot *et al* 2010; McGinnis *et al* 2002; Bunker *et al* 1995).

The case set out here echoes the view of the 2014 BBC Reith lecturer, Atul Gawande, who argued that we are living in the 'century of the system' (Gawande 2014). By this he means that individuals and organisations cannot solve the problems facing today's society on their own. Instead, we must design new ways in which individuals can work together in teams and across systems to make the best use of collective skills and knowledge.

We believe that systems of care offer both short- and long-term solutions to the challenges facing the NHS. In the short term, they provide a way for local health services to work together to tackle the immediate financial and service pressures that are universally faced across the country. In the longer term – and more fundamentally – they provide a platform for implementing radically new models of care across local areas in England, with the aim of improving population health and wellbeing. Elsewhere we have described this as a shift towards population health systems (Alderwick *et al* 2015).

The rationale

The need for organisations to work together in place-based systems of care has been recognised recently in the so-called 'success regime' developed by NHS England, Monitor and the NHS Trust Development Authority, working with the Care Quality Commission.

This is described as a 'whole-systems intervention' where national bodies work with commissioners and providers in areas of England facing deep-seated challenges (NHS England 2015). Three areas have been identified initially for participation in the regime, which involves a single diagnosis of the issues facing the health and care economy, leading to a set of interventions and support to bring about improvement.

Unlike previous approaches focused on individual organisations, such as the special measures programme, the regime adopts a place-based approach in which all relevant NHS organisations are involved.

This paper argues that many of the elements of the success regime should be adopted and adapted in other areas of England, whether or not they have deep-seated challenges. The potential benefits include the opportunity to:

- avoid place-based discussions descending into a zero-sum game that inhibits the development of collaborative working between local NHS leaders
- develop new care models that span organisational and service boundaries, supported by new approaches to commissioning and paying for care
- establish robust governance arrangements that balance organisational autonomy and accountability with a commitment to partnership working and shared responsibility
- develop services that are financially and clinically sustainable through greater integration of care and a focus on improving population health and wellbeing
- provide a foundation for collaboration with a wider range of organisations from different sectors
- put in place the leadership required to work in this way by sharing expertise and skills in different organisations
- work in partnership with the public and local communities to transform the way that services are delivered
- enable national bodies to work differently and in a joined-up way to support providers and commissioners in finding solutions to their challenges.

Different types of emerging systems in the NHS

There are similarities between what we are proposing and plans to devolve responsibility for public services in Greater Manchester, which go beyond the NHS

to encompass a wide range of services. There are also similarities with the acute care collaboration vanguards programme, which includes three approaches:

- accountable clinical networks linking district general hospitals and teaching hospitals for key services such as cancer care
- clinical services at district general hospitals run by specialists from regional centres of excellence
- NHS foundation groups in which high-performing NHS hospitals establish hospital chains.

The third of these approaches is a development of thinking put forward in the Dalton review (Dalton 2014), which sets out a range of ways in which provider organisations might work together in future. An important difference between our approach and the Dalton review is our argument for a place-based approach in which providers in the same area are supported to collaborate. This is based on a conviction that, for the most part, health care provision is essentially local and the opportunities to develop systems of care are therefore best pursued among those serving the same or similar populations.

Similarities can also be found in the approaches being taken by multispecialty community provider and primary and acute care system vanguard sites, which involve providers and commissioners in a local area working together to develop new models of health care. Ministers and NHS leaders have drawn parallels with accountable care organisations (ACOs) in the United States in discussing new care models needed in the NHS in England. We discuss ACOs and new care models in section 3.

A new approach to the challenges facing the NHS

Place-based systems of care are quite different from a number of approaches that have been used in the NHS in the past. Most obviously, we are not advocating mergers and acquisitions, for the simple reason that they have a mixed record and typically take an age to transact. There are also substantial costs involved in mergers, which are not typically repaid by the benefits initially promised or expected (Collins 2015a). An analysis of the impact of mergers between NHS hospitals on financial

performance, productivity, waiting times and measures of clinical quality found little evidence of improvement in any of these areas, and on some measures performance actually declined (Gaynor *et al* 2012). Evidence suggests that it is clinical and service integration that really matters, not organisational integration (Curry and Ham 2010).

For the avoidance of doubt, we are also not proposing top-down structural change to the NHS, because of the well-known costs involved and the limited evidence of benefits. In line with our work on reforming the NHS from within (Ham 2014), we argue that the approach taken to systems of care should be determined within each area using a common set of design principles, which are outlined in the next section of this paper. As this happens, it will be important to draw on previous experience in the NHS, including in the use of clinical and service networks, which offer some parallels with what we are proposing, as well as experience in other parts of the public sector and other sectors too.

Place-based systems most certainly do not involve the reinvention of strategic health authorities. This is because the systems that we are proposing would be developed and established by NHS organisations and their partners rather than being a formal part of the NHS structure in England. Systems of care would also vary in their functions and form and would exist only for as long as the organisations involved think they serve a useful purpose.

2 Design principles to guide systems of care

This section sets out a small set of design principles to guide the development of place-based systems of care in the NHS. This is because complex systems, such as health services, are governed by simple rules (Plesk 2001). As the systems of care that we are proposing are very different from the way that health services are currently organised, they will require new rules to guide the way they work.

In developing these principles, we have drawn on the work of Elinor Ostrom and others on managing common pool resources (*see* Ostrom 1991, 2010). Common pool resources are things that are more or less available to everyone, but where what we use effectively ends up taking away from others – things such as land for grazing animals or water for irrigation. We have done this because local health services in England are essentially common pool resources too. Put simply, providers of services in a local area have a limited set of resources to draw on when people need them – say staff or buildings – which are paid for from a limited pot of money allocated to health services. If too many resources are used by one set of providers, or one set of patients, fewer will be available for others.

The problem with common pool resources is that they can run out if they are not managed effectively – what Hardin (1968) famously described as the 'tragedy of the commons'. If individuals or organisations act independently of others – for example, if NHS providers adopt the fortress mentality described earlier in this paper – the common pool of resources is likely to be used unsustainably. In the end, of course, this is worse for everyone. Traditional policy responses to this problem include turning to the state or the market.

The research of Ostrom and others shows how this tragedy can be avoided not by states or markets but by local communities developing their own arrangements for managing common pool resources. In many examples across the world, resources such as irrigation systems, forests and fisheries have been successfully governed by communities who define their own rules and approaches to how resources will be

used. Based on an analysis of cases such as these that worked well, as well as ones that failed, Ostrom's work identifies a set of principles that characterise successful approaches to governing common resources (*see* Ostrom 2010, p 13). While these principles should not be applied uncritically to health services and require some adaptation – as McGinnis's (2013) discussion of the principles in the US context shows – they provide useful pointers for the systems of care that we are proposing.

We have also drawn on other work about how partners can achieve collective impact (such as Kania and Kramer 2011), as well as our own work on integrated care and population health (such as Alderwick *et al* 2015; Curry and Ham 2010), to develop the following 10 principles to guide the development of systems of care in the NHS.

1. Define the population group served and the boundaries of the system.

2. Identify the right partners and services that need to be involved.

3. Develop a shared vision and objectives reflecting the local context and the needs and wants of the public.

4. Develop an appropriate governance structure for the system of care, which must meaningfully involve patients and the public in decision-making.

5. Identify the right leaders to be involved in managing the system and develop a new form of system leadership.

6. Agree how conflicts will be resolved and what will happen when people fail to play by the agreed rules of the system.

7. Develop a sustainable financing model for the system across three different levels:

    - the combined resources available to achieve the aims of the system
    - the way that these resources will flow down to providers
    - how these resources are allocated between providers and the way that costs, risks and rewards will be shared.

8. Create a dedicated team to manage the work of the system.

9. Develop 'systems within systems' to focus on different parts of the group's objectives.

10. Develop a single set of measures to understand progress and use for improvement.

These principles are now described in more detail.

Define the population group served and the boundaries of the system

The starting point in establishing place-based systems of care is to define the population served and the boundaries of the system. In some cases this will be relatively straightforward – Cornwall and the Isle of Wight being obvious examples – but in others it will be more complex, particularly in large urban areas where people move across administrative boundaries to access care and support. Local systems may also exist within regional systems (as in the areas that make up Greater Manchester), requiring different arrangements at different levels.

Whatever geographical boundaries are chosen, place-based systems of care should be focused on the whole of the population that they serve – in other words, they should take responsibility for all the people living within a given area – rather than focusing only on one part of a local population such as older people or people with specific medical conditions. The latter approach risks creating new forms of fragmentation in addition to those that currently exist, when the rationale of systems of care is to bring organisations together around the population they serve.

Identify the right partners and services

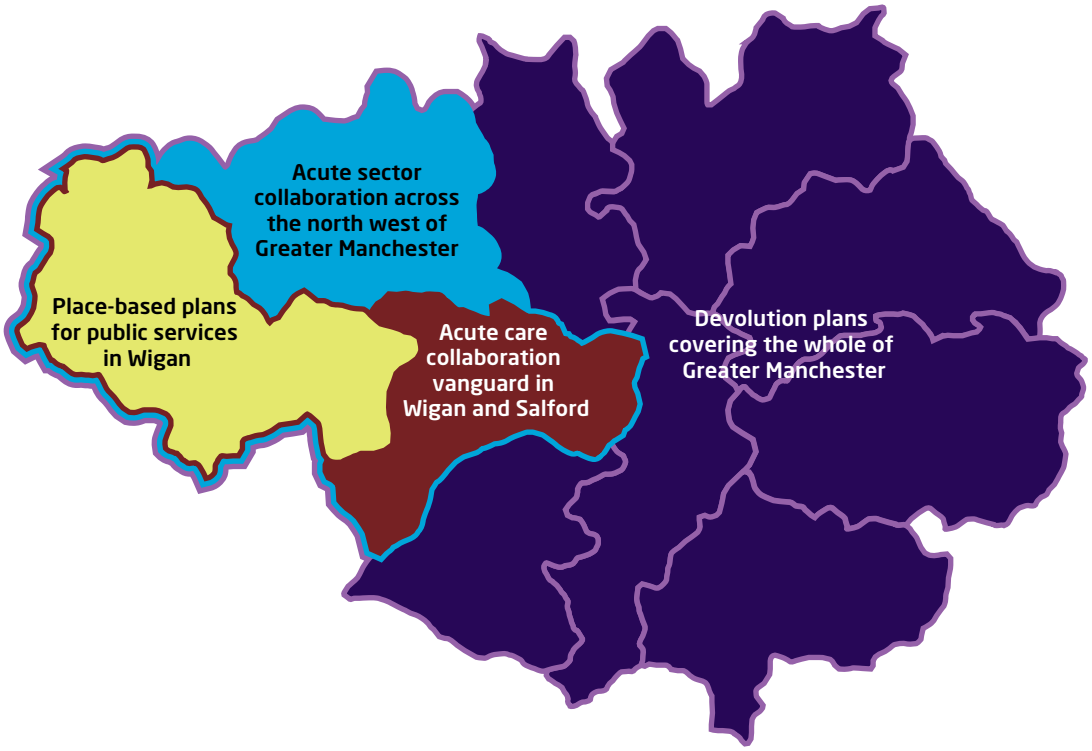
While place-based systems of care will have a strong focus on the NHS, they should also involve local authorities, the third sector and other partners. This is particularly the case where the aim is to focus on population health and not just health and care services. In practice, some organisations may prefer to play a supporting role rather than a leading role in the arrangements we have described, depending on the contribution they make to the health of the population concerned.

In many cases, NHS providers may find themselves involved in more than one system of care because of their role in providing services to patients drawn from a wide catchment area. Most obviously, major teaching hospitals provide a general hospital service to the local population and more specialised care both to the local population and to patients referred from other areas. This may mean that these hospitals, and indeed other providers working across boundaries, are members of more than one system of care, creating challenges around their capacity to be involved effectively in more than one system and potentially several.

One example to illustrate how different systems overlap is in Greater Manchester (*see* Figure 1). NHS organisations in Wigan, for example, will be involved in a number of different systems, including (and probably not limited to):

- devolution plans covering the whole of Greater Manchester
- plans for transforming public services in Wigan

Figure 1 Overlapping systems



- the new acute care collaboration vanguard site across Wigan and Salford
- a wider acute sector collaboration across Wigan, Salford and Bolton as part of the Healthier Together programme in Greater Manchester.

Our argument centres on the case for providers to take the lead in establishing place-based systems of care – because of the need for providers to collaborate in developing new models of care that are clinically and financially sustainable – and leaves open the question of exactly how commissioners are involved alongside them. However, as we outline below, commissioners will need to be involved in working with providers to develop new models of commissioning and contracting to support the kinds of systems that we are describing.

Our argument also raises the much bigger question of how the commissioning function is organised. Successive attempts to develop commissioning in the NHS over the past 25 years have met with limited success, because commissioning health care is inherently complex wherever it has been attempted (Ham 2008). There are also specific challenges in England with the division of responsibilities between CCGs and NHS England, as well as between the NHS, local government and Public Health England. In view of the failure of commissioning to make a major impact, and the huge challenges facing the NHS, a quite different approach is needed in future. We explore this further in the final section of the paper, where we make the case for commissioning to be strategic and integrated in order to support the development of place-based systems of care.

Develop a shared vision and objectives

Having defined the system in question and organisations involved, it falls to these organisations to agree their shared vision and objectives. A good example is the *Memorandum of understanding* developed in Greater Manchester (AGMA *et al* 2015), which includes a number of objectives that are summarised in the box below.

Objectives need to be tailored to the needs of different areas, reflecting the challenges that exist and the level of ambition of the partners. They should build on work done by commissioners and health and wellbeing boards in understanding the needs of the local population, as well as the knowledge of providers about local services.

Objectives in Greater Manchester's *Memorandum of understanding*

- To improve the health and wellbeing of all of the residents of Greater Manchester (GM) from early age to the elderly, recognising that this will only be achieved with a focus on prevention of ill health and the promotion of wellbeing. We want to move from having some of the worst health outcomes to having some of the best.
- To close the health inequalities gap within GM and between GM and the rest of the United Kingdom faster.
- To deliver effective integrated health and social care across GM.
- To continue to redress the balance of care to move it closer to home where possible.
- To strengthen the focus on wellbeing, including greater focus on prevention and public health.
- To contribute to growth and to connect people to growth, eg supporting employment and early years services.
- To forge a partnership between the NHS, social care, universities and science and knowledge industries for the benefit of the population.

Source: AGMA *et al* 2015

In most cases, we would expect the focus to be initially on achieving the financial and clinical sustainability of local services as well as the development of new care models that cut across current organisational and service boundaries. Areas that have more experience in partnership working may choose to focus on the broader aim of improving population health and wellbeing from the outset. The vision and objectives underpinning systems of care will shape the partners that are involved and how they work together.

Agreeing objectives needs to be informed by the wants and needs of patients and the public. But in most health systems, we know very little about what patients and the public really want – and at the front lines of care the silent misdiagnosis of patients' preferences is widespread (Mulley *et al* 2012). Over time, systems of care must develop more meaningful and systematic ways of gathering and disseminating information about patients' preferences. This includes developing tools to continuously measure patients' preferences and acting on the information generated.

Develop an appropriate governance structure

Having agreed objectives, the organisations involved need to develop an appropriate governance structure to enable them to collaborate and take decisions in the pursuit of these objectives. These arrangements must reflect existing accountabilities while also creating a basis for collective action. To do this successfully, they must be inclusive enough to ensure that those involved in delivering and receiving services are meaningfully involved in decision-making. The Nuka system of care in Alaska is one example where patients and the public have been actively involved in the governance of the local system (*see* the box below). The governance arrangements must also be strong enough to be able to co-ordinate the range of activities involved in meeting the group's objectives – something that is far easier said than done.

Involving patients and the public in governing the Nuka system of care

The Southcentral Foundation is a non-profit health care organisation serving a population of around 65,000 Alaska Native and American Indian people in Southcentral Alaska, supporting the community through what is known as the Nuka system of care.

Nuka was developed in the late 1990s after legislation allowed Alaska Native people to take greater control over their health services. This fundamentally changed the community's role from 'recipients of services' in a top-down, paternalistic system to 'customer-owners' involved in designing and managing their health care (Gottlieb 2013).

The Southcentral Foundation involves patients and the public – its 'customer-owners' – in the governance of the health system in a number of different ways. This includes:

- having members of the public on its non-executive board
- involving members of the public on operating boards and advisory committees, which meet periodically with the senior leadership team to provide feedback
- involving members of the public in its strategic planning cycles, including through an annual gathering, an elders' council and planning sessions with village communities
- providing multiple opportunities for people to provide real-time feedback on services.

A forthcoming case study of the Nuka system argues that this model of 'customer-ownership' – set in context – has provided an effective form of governance in a system largely free from oversight from external bodies (Collins 2015b). Instead, services are governed based on a commitment from leaders and staff to serve their community and a commitment from the community to actively engage in the management of the system.

Experience with partnership boards of various kinds in the past offers a cautionary tale in ensuring that governance arrangements are fit for purpose and allow decisions to be made jointly, rather than descending into a talking shop or, even worse, failing to deliver the objectives. Analysis undertaken by the Audit Commission (2005), discussed further in section 3 of this paper, contains important lessons in this regard. Our experience suggests that the partners involved should be willing to be flexible about how governance arrangements evolve over time – for example, by including new members or rules.

It is also likely to mean the organisations involved agreeing to cede some of their own sovereignty as well as determining whether there are some issues over which they should retain the right to approve decisions taken collectively. Place-based systems are unlikely to be effective if they are merely a forum for discussion of issues of common concern without executive responsibilities. These and other issues need to be thought through at the outset to enable the right vehicles for collaboration to be established which are both binding and collective.

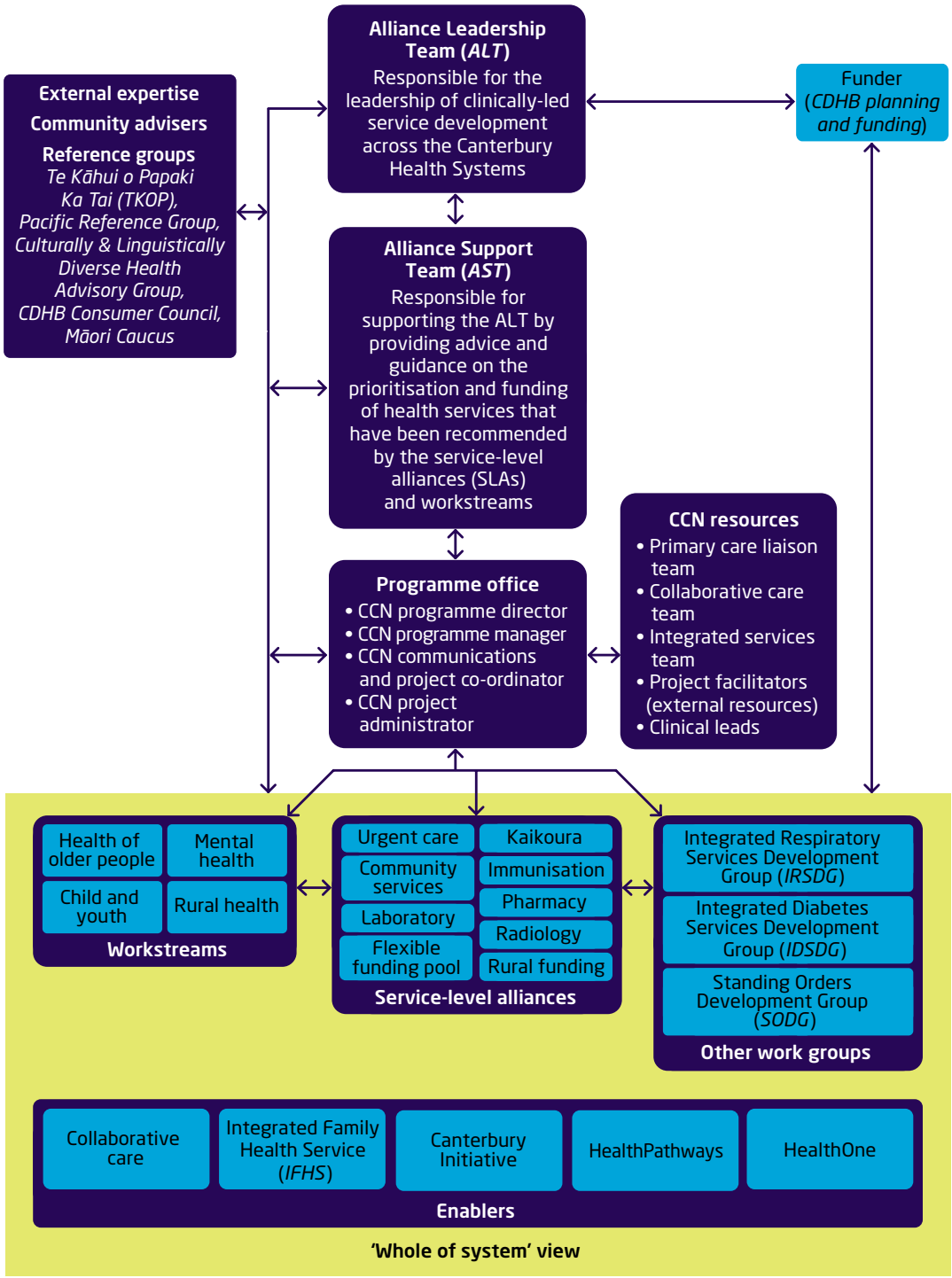
The Canterbury Clinical Network in New Zealand is one example where organisations involved in delivering health and care services have come together to lead clinical service improvements collectively across their local system. As Figure 2 outlines, the network is led by an alliance leadership team and supported by a dedicated alliance support team. Different work streams and service level alliances fit within a single governance structure, which is underpinned by a 'one-system, one-budget' approach. This approach has supported partners in Canterbury to develop more integrated health and care services which have allowed more care to be delivered out of hospital (Timmins and Ham 2013).

Identify the right leaders and develop a new form of system leadership

Ensuring that the right leaders are involved in managing the system of care at the appropriate level of seniority, including chairs and board members where appropriate, is essential. Much will depend on the strength of the relationships between organisational leaders and the extent to which there is mutual trust and respect.

In many cases it will not be possible to secure agreement to even explore the issues discussed in this paper without a basic willingness to work together and an acknowledgement that collective action is needed to deal with the growing pressures

Figure 2 Canterbury Clinical Network structure



Source: Canterbury Clinical Network 2014

facing NHS and related services. In the absence of such agreement, the fortress mentality is likely to prevail with the attendant risks we identified at the beginning of this paper.

In some cases the leadership of experienced and credible individuals from outside the NHS may help to galvanise collaboration, as can be seen in the role of local authority leaders in Greater Manchester and in our work elsewhere.

The effectiveness of governance arrangements hinges on the ability of leaders to work collaboratively in an environment where they may have less authority than has often been the case in the past. This requires the development of a new kind of system leadership based on negotiation and influence rather than direction. Leadership of this kind is often best developed through teams rather than individuals, involving a guiding coalition taking responsibility to lead system-wide change.

Developing this kind of leadership may benefit from agreement on the values and behaviours to be used in taking collaboration forward. Statements of values and behaviours are of most use when they are developed jointly and used explicitly. This includes leaders holding each other to account for working in a way that is consistent with these values and behaviours, and giving each other permission to draw attention to examples where this does not happen. Again, there is experience in other parts of the public sector on which to draw in developing system leadership (Timmins 2015).

Leadership needs to extend right through the organisations involved in place-based systems of care and we would emphasise in particular the role of clinical leaders in developing new care models that span organisational and service boundaries. System leadership that is not underpinned by clinical leadership and the engagement of frontline clinical teams will not deliver the benefits we have argued for.

Agree how conflicts will be resolved

Governance arrangements also need to allow for the possibility of conflict between the organisations involved and give direction on how this will be handled locally. Agreeing how conflicts will be resolved within the system of care is therefore essential. There should be an emphasis on informal mechanisms such as mediation

rather than resorting to legal action. Wherever possible, conflict should be viewed as a healthy reflection of the state of collaborative working and the ability of the organisations involved to disagree and move on. At the same time, partners should be clear about the consequences for organisations that fail to play by the agreed rules and behaviours of the system. This, again, is where statements of values and behaviours are likely to be useful.

Develop a sustainable financing model

Conflicts are possible in many areas but especially in relation to how resources are used and distributed. Creating a sustainable financing model for the system of care is not simple and requires commissioners and providers to work together. We have argued elsewhere that this means taking a new approach to paying for across three different levels (Ham and Alderwick 2015).

First, local partners need to agree the collective resources available to meet the objectives of the system. For example, if the objective is to implement radically different models of health and social care for the whole of the local population, this might involve pooling resources currently spent on health and social care services in a local area. In practice, this is likely to mean commissioners of health services and local authorities working together to pool their budgets and commission services jointly.

Second, commissioners must develop new ways of contracting with providers to align incentives behind the system's objectives. Our proposed approach is for commissioners of health and social care to pool resources and create a single, capitated budget covering all care for the local population, for providers to manage under a contract extending over a number of years. A proportion of payments made to providers within the budget should be linked to the delivery of a common set of outcomes, developed through engagement with people using services about what matters to them. Rather than an approach focused on single disease groups, a population approach recognises that people's needs are multiple and overlapping and avoids creating new silos to replace the old ones.

There are a range of different contracting vehicles that could be used to support this type of approach. Examples include prime contracts and alliance contracts, both of which are being explored and tested in various parts of the NHS in England,

as well as in other countries (Addicott 2014). In stylised terms, prime contracts involve payments being made to single providers, who in effect become *de-facto* commissioners, responsible for managing the budget, co-ordinating the supply chain and making payments to other providers. Under alliance contracts there is no lead provider, as commissioners and providers enter into a single contract to share the risk and responsibility for meeting a common set of outcomes, relying on internal governance arrangements to manage relationships and the delivery of care. These models are best seen as ideal types, with a range of versions and variants in between.

Third, providers of care within the system will need to agree how they allocate resources and share costs, risks and rewards. This might involve developing multilateral risk-sharing agreements that set out how resources will flow between providers in different scenarios to support the system's objectives. For example, partners could agree what happens if activity for one provider grows above an agreed threshold to ensure that care in other areas is not damaged as a result. They could also agree how any savings made from reductions in activity in certain areas will be shared between providers in the system to reinvest in service changes. More important than the technical detail, this will require strong relationships between local leaders willing to work together rather than compete for resources.

The challenge for the NHS in developing more sustainable financing models is the growing imbalance between providers' incomes and spending – an imbalance that in the first quarter of this financial year (April to June 2015) amounted to £930 million for NHS trusts and foundation trusts (Monitor 2015; NHS Trust Development Authority 2015). This is something that requires national action as well as the local action that we describe here.

Create a dedicated team

To make these kinds of arrangements work, a dedicated team should be established to support the work of the system and act on behalf of leaders in implementing decisions. This team must have authorisation to drive the work of the system from its most senior leaders. Evidence from other sectors tells us that this is best done by a new team able to focus solely on the work of the system, rather than a team made up of people simultaneously trying to manage the ongoing operations of individual organisations (Govindarajan and Trimble 2010). In the absence of such support,

there is the ever-present risk that plans will not be executed, resulting in frustration and loss of commitment.

Of course, new ideas and ways of doing things will only make a difference if they can be successfully implemented across the organisations involved, which means that the dedicated team should not work independently of others. Doing this will require people who are able to make connections between different parts of the system to help make change happen (Battilana and Casciaro 2012).

Develop systems within systems

In working to meet common objectives and particularly when systems of care evolve, it is likely that different partnerships will emerge within and also across place-based systems to tackle particular issues of concern. For example, one group of partners might work together to reduce demand on urgent and emergency care services, another might focus on the interventions needed to help reduce obesity across the population, while another might focus specifically on improving care for people at the end of life – and some might work on all three.

This means that systems of care must develop 'systems within systems' to focus on different aspects of their objectives, drawing on skills and services from across the community. The important task is to ensure that activities of different groups form part of a coherent, mutually reinforcing approach, rather than becoming a disjointed set of initiatives.

Develop a single set of measures

Finally, a system of care must decide on a single set of measures to underpin its shared objectives. This is likely to involve agreeing a small set of metrics to assess the overall performance of the system, as well as how these metrics will be collected and reported – including to the public. A larger set of metrics should also be collected to allow partners to understand how they are contributing to the overall goals of the system and identify areas for improvement (similar to the approach set out in Ham *et al* 2015b).

As well as routinely collected performance data, this should include measures to test whether the system is behaving in a way that aligns with its agreed values and

behaviours. For example, measures such as IntegRATE developed by researchers in Dartmouth College in the United States can be used to measure how well teams are collaborating to deliver more integrated services to their patients (Elwyn *et al* 2015), while tools such as CollaboRATE can be used to measure patient engagement and shared decision-making in routine practice (www.collaboratescore.org/).

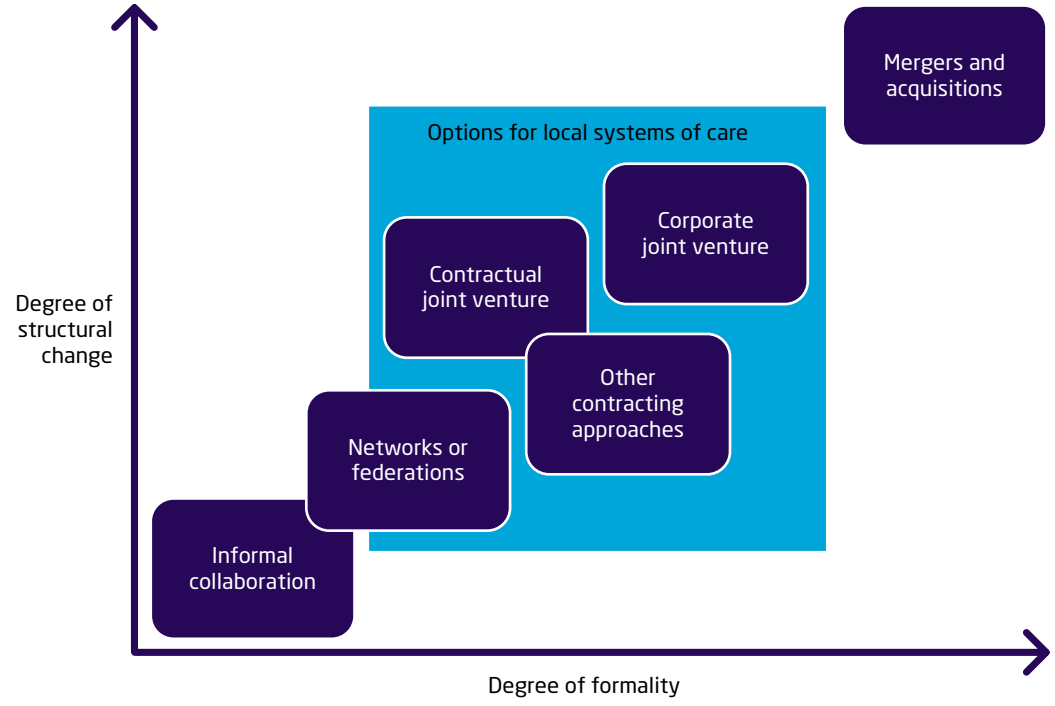
The experience of high-performing health care systems in other countries illustrates the value of a sustained commitment to quality improvement based on clarity of the system's goals and systematic measurement of progress towards them (Ham 2014). This should be reinforced by an explicit quality improvement methodology that is consistently applied.

One of the risks in developing systems of care is that of adding further complexity to an already complex system. While this cannot be avoided entirely, the design of governance arrangements needs to be done in a way that minimises transaction costs and seeks to keep these arrangements as simple as possible.

3 Options for collaboration

Various options exist for formalising how organisations will work together in place-based systems of care. A helpful starting point is the high-level framework illustrated in Figure 3, which sets out a spectrum of organisational options, ranging from informal collaborations at one extreme, to formal mergers and acquisitions at the other. For this we have adapted and revised a similar framework set out in the Dalton review (Dalton 2014, p 20).

Figure 3 A high-level framework for organisational collaboration



Place-based systems of care sit somewhere in the middle of the two extremes of the spectrum and may be established as either a contractual or corporate form of collaboration (Hempsons 2015). An example of a *corporate* collaboration would be the creation of a corporate joint venture established as a new legal entity, which could take a variety of different forms, including:

- companies limited by shares
- limited liability partnerships
- community interest companies.

Developing new forms of corporate collaboration in the existing policy and regulatory environment in the NHS is not always simple. For example, it is important to note that current statutory powers for non-foundation trust providers limit the use of corporate vehicles such as limited companies and limited liability partnerships. It is also worth noting that collaborations involving limited liability partnerships are unable to hold contracts for essential primary care services unless GPs are willing to opt out of their General Medical Services/Personal Medical Services contracts. Various 'workarounds' exist to achieve similar goals, but the rules are not straightforward.

Examples of *contractual* options include prime contracts, alliance contracts and contractual joint ventures, all of which are currently being developed in different parts of England (Addicott 2014).

The challenges in establishing and sustaining more formal collaborations such as these should not be underestimated. In creating a new legal entity, for example, the organisations involved will be sharing control and therefore surrendering some of their own autonomy. In the right circumstances, this has the potential to achieve more than through organisations working independently but there is always a risk that a new entity will acquire a life of is its own and result in friction between the organisations involved.

Whatever option for collaboration is pursued, it is vital that the partners involved agree how decisions will be made, how they will be held to account, how different stakeholders will participate in the running of the system, and so on. The same applies if the basis for collaboration is contractual, as networks of providers will need to develop appropriate governance structures to manage the contract and work together to implement new models of care (Addicott 2014).

To make these points is to emphasise the detailed work needed to put in place the right arrangements to make a reality of systems of care. As this happens, it will be

important not to focus on the legal and technical aspects to the exclusion of the relationships on which effective collaboration ultimately depends.

Networks

Clinical networks are located towards the less formal end of the collaborations identified in Figure 3 and there is previous experience from within the NHS on how these have fared. A major research review published in 2010 described different types of networks in health care and summarised evidence on their experience (Ferlie *et al* 2010). The authors' empirical work in eight networks – including managed cancer networks, sexual health networks, older people's networks and genetics knowledge parks – highlighted a number of advantages and disadvantages of organising in this kind of way. Advantages included the potential to:

- address 'wicked problems' in health policy that require action across sectors and organisations
- secure high levels of clinical engagement
- implement national policy goals or major service reconfigurations within localities.

On the other side of the balance sheet, a number of disadvantages were identified in the networks that were studied, including:

- a degeneration into 'talking shops', with many meetings and little output to show for it
- a weak focus, which could be helped by clear targets or milestones
- difficulty in maintaining momentum without dedicated resources
- challenges in performance managing the network
- high transaction costs and few short-term wins

- the potential to become dominated by certain professional groups
- the need for skilled, well-resourced management to be effective.

These lessons from past experience emphasise some of the potential challenges that come with working in networks, as well as pointers for how they could be avoided – for example, through ensuring that networks have enough resources and dedicated support to run effectively, as well as leaders able to mix the 'hard' and 'soft' management styles needed to work effectively across systems.

Evidence reviewed by 6 *et al* (2006) similarly emphasises the need to strike a balance in how networks in health care are managed. While tight control in more hierarchical networks risks demotivating professionals and creating friction among partners, networks that are too loosely regulated risk 'professional capture' by some groups – and in some cases may simply lead to the maintenance of the status quo. This in turn emphasises the need to recognise that not all networks are the same: they can be more or less tightly regulated by rules and institutions, and they can be more or less integrated in terms of the relationships between partners (6 *et al* 2006). In practice, network leaders will likely need to navigate a course between these extremes to be successful.

Public sector partnerships

Looking at the broad spectrum of partnership models used by organisations in the public sector back in 2005, the Audit Commission found that partnership working takes up a lot of time and other resources, and can extract value as well as add it (Audit Commission 2005). It also found that problems arose when governance and accountability were weak, and leadership, decision-making, scrutiny, and systems and processes were under-developed. The Audit Commission argued that partners need clarity on governance – specifically, agreement on the purpose, membership and accountabilities of the partnership. This requires a governing document that clarifies roles and relationships and helps to build goodwill and trust. Part of the purpose of such a document is to set out accountabilities both internally between the partners and externally to the public.

More recent initiatives to develop partnership working in public services include the Total Place and Whole Place Community Budget programmes, established under

both Labour and coalition governments (*see* National Audit Office 2013; Humphries and Gregory 2010). These initiatives were motivated by many of the same concerns that lie behind this paper – in particular that collaboration across public services would deliver better value for citizens than organisations working independently of each other. In practice, they typically involved collaborations between local authorities and other partners based on information sharing and joint needs analysis of the populations served, rather than shared decision-making and more formal collaborations.

This kind of collaboration brought some benefits, but there were obvious limits to their impact on the use of resources and outcomes in the areas involved (House of Commons Communities and Local Government Committee 2013; National Audit Office 2013). Current interest in devolution in Greater Manchester and other areas is in some respects the successor to these initiatives and it remains to be seen whether this will be more effective.

Experience in Scotland

The Scottish government has put in place a legislative framework to support integration between health and social care commissioning and delivery. An important difference from England is that the NHS in Scotland has a much simpler structure in which place-based health boards are already responsible for both commissioning and providing health services in their areas. These boards are required either to adopt a lead agency model with relevant local authorities or to create a joint integration board to which functions and resources are delegated. The joint integration board is a legal entity in its own right, established under relevant legislation.

These arrangements have only just been established and there is little evidence as yet on how effectively they are working. In principle, they could be used in England with adaptation to support the place-based systems of care we have argued for, if national bodies think it necessary to mandate partnership working instead of allowing it to evolve from the bottom up. An alternative would be for the government to legislate to create options for place-based collaborations without requiring their use.

Emerging examples in the NHS

In our work we are aware of steps already being taken in some parts of England to establish place-based systems of care on a more formal basis. In York, for example, providers have formed an out-of-hospital provider alliance involving the foundation trust, two GP federations, local authorities and the York CVS. At the time of writing, the alliance operates under a non-legally binding statement of principles.

In Solihull, the main public sector organisations have formed a partnership called 'Solihull Together for better lives', with a shared vision of:

- supporting economic growth to provide long-term stability and quality jobs
- making communities stronger
- improving people's health and wellbeing.

The core group includes the local authority, Solihull CCG, Birmingham and Solihull Mental Health NHS Foundation Trust, Heart of England NHS Foundation Trust and West Midlands Police, who also work closely with primary care providers, third sector groups, patient representatives, the fire service and others across the local area. A compact has been agreed defining the group's objectives and how they will work together, and a single governance structure has been developed to lead their work. Dedicated programme management support has been funded jointly, and chief executive officers and finance directors of each organisation meet regularly to work out how financial costs and risks will be shared across the group to meet their objectives.

Another emerging example can be found on the Isle of Wight, where NHS organisations and the local authority are changing the way that they are organised as part of their work as a primary and acute care system vanguard site known as 'My Life A Full Life'. Working under the health and wellbeing board, a joint commissioning board and a joint provider board have been established, together with a board that provides overall leadership of the programme. Emphasis has been placed on developing system leadership and a 'one island £', echoing the approach used in Canterbury, New Zealand, which was based on the vision of there being 'one system, one budget' (Timmins and Ham 2013).

The vanguard site is investing in leadership and organisational development as part of its work.

In Morecambe Bay, providers and commissioners are working with local authorities and GP federations to develop what they are calling an 'accountable care system'. This builds on a recent history of joint working and selection as one of the primary and acute care system vanguards. The aim is to commission and provide health and care services around the needs of the population, with providers working together under a capitated budget.

There are some similarities between this approach and work in Northumberland – another area that has been selected as a primary and acute care system vanguard – where there are plans to establish an accountable care organisation (ACO). This builds on longstanding efforts to integrate services in Northumberland, in particular between the foundation trust which provides acute, community and adult social care services and local GP federations (*see* Naylor *et al* 2015). An important difference from Morecambe Bay is that the CCG will not be directly involved in the special purpose vehicle being established to develop the ACO.

Sir Robert Naylor, chief executive of University College London Hospitals NHS Foundation Trust, has argued that ACO-type systems could play a major part in ensuring the sustainability of NHS services in future. In his view, ACOs would involve collaboration between providers working under a capitated budget and focused on the health of the population served. Under this arrangement, there would be an incentive to invest in prevention and services outside hospitals to reduce the use of expensive specialist care. Naylor has also questioned the need for commissioning in its present form if ACOs do emerge (Barnes 2015).

Many others, including the Secretary of State for Health, have also drawn parallels between ACOs in the United States and the kind of changes needed in the NHS in England.

Accountable care organisations

A range of approaches to collaboration between organisations are being explored by ACOs in the United States. The first national survey of ACOs in 2012 and 2013 highlighted the diversity of organisational models being developed to meet ACOs'

aim of improving quality and reducing costs – including hospital-led ACOs, physician-led ACOs and a variety of hybrid models in between (Colla *et al* 2014).

Whatever form ACOs take, researchers have emphasised the critical role of clinical leadership if they are going to be able to fundamentally change the way that care is delivered for their local populations. And just like the experience of partnership working in the NHS, emerging ACOs have found it difficult to develop governance arrangements that are able to hold partners to account as a collective and meaningfully affect people's behaviour (Addicott and Shortell 2014).

In thinking about how ACOs might develop in England, it is important to remember that early evidence on their impact in the United States is both limited and mixed (**Shortell *et al* 2015**). We summarise early evidence of the impact of ACOs on quality and cost in the box below. Much more is known about the various forerunners of ACOs, including established integrated systems such as Geisinger, Group Health, Intermountain Healthcare and Kaiser Permanente (for example, *see* **Curry and Ham 2010**). A number of lessons can be drawn from the experience of these systems and that of ACOs, including allowing sufficient time for new care models to evolve and mature. The challenge this presents for the NHS is that time is in short supply.

Early evidence from accountable care organisations in the United States

ACOs in the United States involve groups of providers taking responsibility for providing all care for a given population within a capitated budget, under a contractual arrangement with an insurer. Broadly speaking, there are three types of ACOs (Shortell *et al* 2014):

- organisations with integrated delivery systems offering a relatively large number of services
- smaller physician-led medical groups offering a smaller number of services
- hybrid groups led by a combination of hospitals, physicians and health centres that offer an intermediate range of services.

In 2014 there were more than 750 ACOs in the United States serving around 20 million people (Muhlestein 2014). Early evidence about their impact on cost and quality is mixed. Results for the second year of the Medicare Pioneer and Shared Savings ACOs report savings of more than US$372 million and mean improvements on measures of quality and

patient experience (Centers for Medicare and Medicaid Services 2014). On the flipside, it is worth recognising that most of these savings were made by a small number of high-performing ACOs and some Pioneer ACOs chose to drop out of the programme.

The best results have been achieved by groups operating under Blue Cross Blue Shield's Alternative Quality Contract in Massachusetts. Providers are given a capitated budget linked to incentives to manage costs and improve quality together. Evaluation after four years showed that providers operating under an Alternative Quality Contract compared with a control group experienced lower spending growth (equivalent to a saving of around 7 per cent) and greater improvements in quality of care across a number of measures (Song *et al* 2014).

4 Implications for national bodies and policy-makers

While the main responsibility for developing place-based systems of care rests with NHS organisations and their partners, national bodies have an important part to play in removing obstacles to their development and offering advice and support. Issues here include:

- extending the approach used in the success regime in which NHS England, Monitor and the NHS Trust Development Authority, working with the Care Quality Commission, adopt a co-ordinated approach in their interventions in local systems
- ensuring that rules on procurement and competition do not create barriers to the emergence and functioning of place-based systems of care
- supporting innovations in commissioning and contracting, including prime contract and alliance contract models
- encouraging innovations in payment systems such as capitated budgets linked to the delivery of agreed outcomes of care
- supporting commissioners within the NHS and between the NHS and local government to pool their budgets and commission services jointly
- putting in place an integrated performance assessment framework using metrics that reflect whole-system performance
- identifying and sharing innovations in the development of place-based systems of care to avoid wasteful duplication of effort in different areas
- supporting areas that are testing out new ways of working to work with, and learn from, each other

- providing legal and technical advice on the organisational forms that are available to make a reality of partnership working
- making it easy for providers to amend their licences with Monitor and the Care Quality Commission to support local system working
- allowing greater flexibility for providers in establishing new corporate vehicles to support joint working
- considering whether to follow the approach used in Scotland where the government has created a legislative framework to enable partnership working.

A new form of strategic commissioning

Returning to a point made earlier in this paper, place-based systems of care require fundamental changes in the role of commissioners.

In our analysis of the challenges facing health services in London (Ham *et al* 2013), we argued the case for a London-wide strategic commissioner alongside a small number of provider networks to tackle the growing financial and service pressures in the capital. In the two years that have intervened since that analysis, we have become even more convinced that the fragmentation of commissioning and provision will not deliver the changes that are needed, and that there is increasing urgency in putting in place an alternative. Hence the ideas set out in this paper.

Drawing on the experience of the Veterans Health Administration in the United States in the 1990s (*see* the box below), we have suggested that commissioning should be seen primarily as a strategic function that brings together scarce expertise rather than diffusing it to a large number of small organisations that struggle to negotiate on equal terms with providers (Ham *et al* 2013). We would add that commissioning also needs to be integrated, including between the NHS and social care, to enable greater collaboration between providers. Options for doing so have been outlined in a recent report from The King's Fund (Humphries and Wenzel 2015) and are integral to the plans for devolution under development in Greater Manchester.

Strategic commissioning as we understand it encompasses the funding and planning of services as well as holding providers to account for the delivery of agreed

Parallels with the transformation of the Veterans Health Administration in the 1990s

The ideas set out in this paper contain important parallels with the experience of the Veterans Health Administration (VA) in the United States, which underwent a major transformation in the 1990s. The VA's experience lends strong support to our argument for place-based systems of care, as these systems have strong similarities with the regionally based integrated service networks that helped to transform the delivery of care in the VA during its transformation.

Networks in the VA received a population-based capitated budget to deliver care and had the flexibility to use this on hospitals or other services based on their assessment of local needs (*see* the summary in Curry and Ham 2010). The VA's headquarters acted as the strategic funder and planner of services from these service networks and reviewed their performance against targets on a regular basis. Many of these targets related to the quality and outcomes of care.

This organisational model was one of the ingredients behind the transformation of the VA which over a period of five years moved from being a system on the brink of failure ('special measures' in NHS parlance) to an organisation widely admired for the quality of care it delivered. The VA also invested in the development of its leaders to support the implementation of the model.

By extension, place-based systems of care would bring together NHS foundation trusts, NHS trusts and other providers in an area – including community-based groups, federations of general practices and third sector providers – under the leadership of experienced clinicians and managers. At a time when there is growing evidence of difficulties in recruiting leaders to senior NHS roles (Janjua 2014), this would be a way of using the expertise that does exist as effectively as possible.

Working within the framework of locally defined governance arrangements, system leaders would have the latitude to reconfigure services as happened in the VA, where there was a substantial reduction in hospital capacity and a major investment in out-of-hospital care – both in people's homes and through strengthening primary care (*see* Ashton *et al* 2003). As the *HSJ*'s commission on leadership argued recently (*HSJ* 2015), this will require a streamlining and simplification of current arrangements for consulting on service changes to avoid necessary decisions being delayed or derailed.

In drawing on the experience of the VA, we are not suggesting that the NHS can simply extrapolate from the approach it adopted without modification. We are arguing that the core ingredients of place-based systems of care involving relevant providers, strategic commissioning, capitated budgets and providers being held to account for delivery against defined outcomes are what matters.

outcomes of care. We have argued that this should be done by commissioners developing capitated budgets covering the whole of a population's care, for groups of providers to collectively manage over a number of years (*see* pp 20–22). Commissioners would define clear outcomes for providers to deliver within the budget, rather than being involved in multiple transactional relationships and the day-to-day performance management of a complex array of contracts.

The box below summarises the key points of what this means for commissioning in the NHS.

What does our proposed approach mean for commissioning in the NHS?

- Commissioners taking a strategic role, defining outcomes and measuring the performance of the system as a whole.
- Commissioners in many parts of England working together across larger geographies than they do today.
- Health and social care commissioners pooling budgets and working together to commission services jointly.
- Commissioners developing capitated budgets covering the whole of a population's care, for local providers to collectively manage.
- Commissioners setting clear outcomes expected for providers to deliver using the resources available.
- Commissioners negotiating longer-term contracts with providers in order to reduce transaction costs.
- Commissioners doing less detailed contract negotiation and performance management of multiple providers.
- The existing boundary between commissioning and provision becoming increasingly blurred, with many traditional commissioning responsibilities falling under the remit of systems of care.

The case for strategic commissioning rests on the failure of commissioning to make a major impact in the NHS (**Mays *et al* 2011**; **Smith *et al* 2004**; Le Grand *et al* 1998) and the need to use scarce expertise as effectively as possible, not least to ensure that place-based provider collaborations are mirrored by a level of commissioning expertise that it is simply not possible to provide in more than 200 CCGs.

Strategic commissioning will require thoughtful evolution towards a system in which the clinical expertise and local knowledge of CCGs are retained and where NHS commissioning is based on footprints much bigger than those typically covered by CCGs today. The ability of CCGs in north-west London and Greater Manchester to collaborate over planning and working towards major reconfigurations of services illustrates one way forward, although these examples remain the exception rather than the rule. Recent developments in Staffordshire where six CCGs have agreed to work together in a regional commissioning group, alongside local authorities and NHS England, are a practical example of how this is being addressed (Renaud-Komiya 2015).

Strategic commissioning is quite different from how commissioning is understood and practised in the NHS today. It will no longer entail detailed contract specification, negotiation and monitoring, and the routine use of tendering. Instead, the focus will be on defining and measuring outcomes, putting in place capitated budgets with appropriate incentives for providers to deliver these outcomes, and using long-term contracts (for example, alliance contracts as used in New Zealand) extending over five to ten years. This will reduce transaction costs and free up some resources to invest in improving health and care.

We would add that place-based systems of care are likely to blur the distinction between commissioning and provision, as is beginning to happen in some of the new care models being developed under the *NHS five year forward view* (**NHS England *et al* 2014**). This means that systems of care will themselves take on some commissioning functions as they work to deliver the outcomes agreed with strategic commissioners. In practice, systems of care will need to decide how to use the budgets available to them, and the contracting and incentives required to ensure effective collaboration between providers.

5 Conclusion

Making these ideas happen will be neither simple nor easy, but in our view the direction that we have set out in the paper is far preferable to the alternative of the fortress mentality, which risks descending into a war of all against all, or another major restructuring of the NHS. Finding intelligent ways of making the existing system work better through rapid evolution, with the emphasis on locally devised arrangements within the broad framework we have described, is where we believe that attention now needs to be focused.

National bodies need to play their part in this process by both removing barriers to place-based systems of care and providing support to local leaders where there is a willingness to work in this way. The chief executive of NHS England, Simon Stevens, set out his thinking on how this might be done in a speech at The King's Fund in October 2015 (Ham 2015). He suggested that increases in NHS funding in 2016/17 would be held back until NHS organisations came forward with agreed plans for improving health and care in their areas.

If implemented well, this proposal could help to galvanise the leaders of NHS organisations to come together in place-based systems where this is not already happening, and it could accelerate progress where it is. There are, of course, many challenges in making Stevens' proposal work, including agreeing the boundaries of the systems that are bidding for funding where this is not clear, and securing agreement among organisational leaders on plans for the use of funding increases. Now is the time for these challenges to be grasped with the urgency demanded by the huge challenges facing the NHS.

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The King's Fund is an independent charity working to improve health and health care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

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Ideas that change health care

The NHS in England is facing growing financial and service pressures at a time of rising demand. It is seeking to tackle these challenges in the context of organisational arrangements that are more complex and fragmented than at any time in its history. How can these arrangements be adapted and made fit for purpose while avoiding another damaging reorganisation?

Place-based systems of care: a way forward for the NHS in England proposes a new approach. It looks at how the NHS can move away from the prevailing 'fortress mentality', whereby each NHS organisation acts to secure its own individual interests and future regardless of the impact on others, to place-based 'systems of care', whereby NHS organisations and services work together to address the challenges they collectively face.

The paper:

- sets out 10 principles to guide the development of place-based systems of care covering, for example, governance arrangements, financing and objectives
- examines the different options for collaboration between organisations to manage collective resources
- highlights the important role that national bodies and policy-makers have in removing obstacles to the development of systems of care and offering advice and support
- emphasises that commissioning needs to be strategic and integrated to enable greater collaboration between providers.

The main argument of the paper is that collaboration through place-based systems of care offers the best opportunity for NHS organisations to tackle the growing challenges that they are faced with and to improve the health and wellbeing of the populations they serve.

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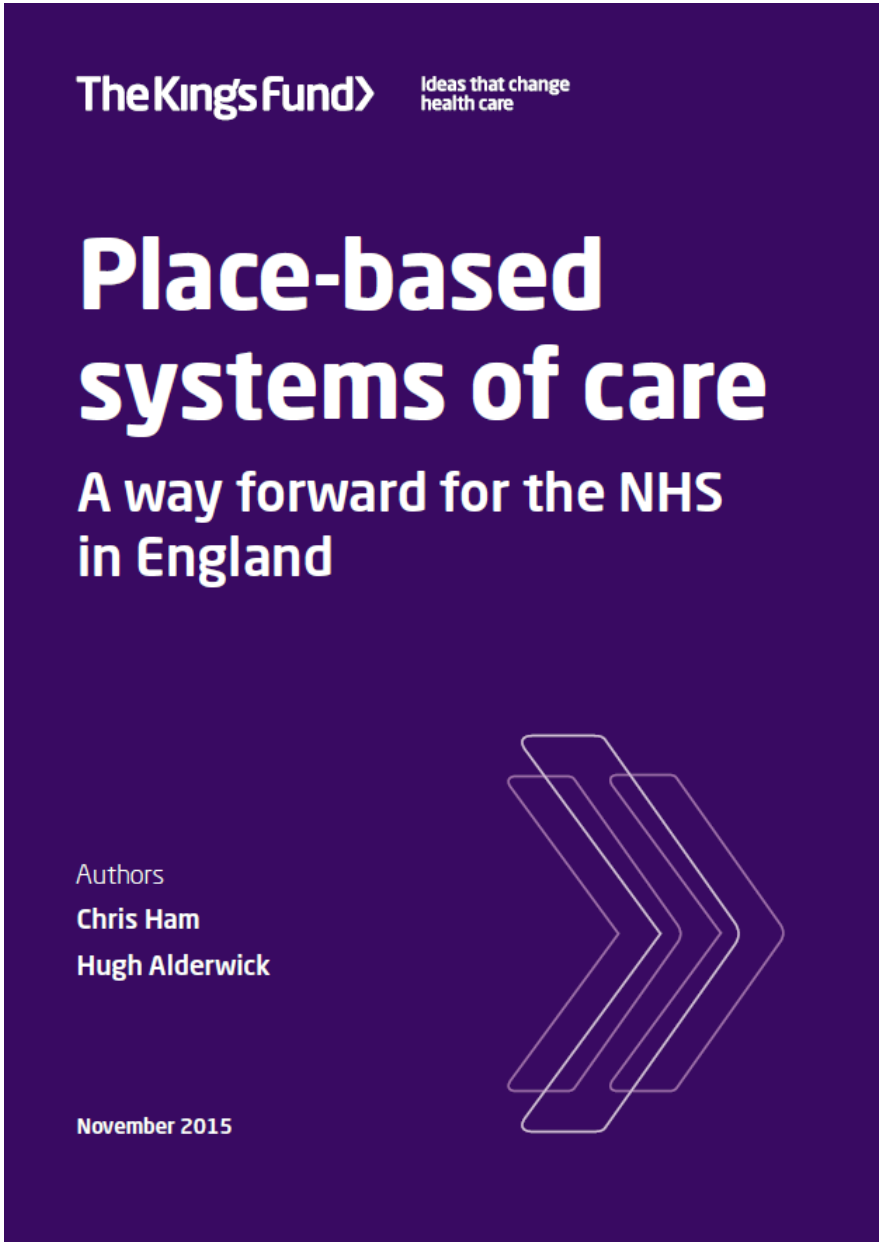
Place-based systems of care

Chris Ham
Chief Executive
21 March 2016

The King's Fund
Ideas that change health care



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Three versions of place based systems

- How the NHS is taking the idea forward through the new STPs
- Place based working led by local government, including in Greater Manchester
- Health and social care integration under the aegis of HWBs

The NHS version

- 44 footprints have been identified for the development of STPs
- Populations range from around 300,000 to 3 million
- Average population size in North and in London is 1.8-1.9m
- Each footprint will have a named senior leader
- Around half of senior leaders are providers and half are commissioners/local government leaders
- Some leaders have yet to be identified and may come from outside the NHS and local government
- Views on the footprints and process for developing STPs are mixed

Sustainability and Transformation Plans: purpose and scope

Planning by individual institutions will increasingly be supplemented with **planning by place** for local populations.

Every health and care system must come together to create its own ambitious **local blueprint** for accelerating its implementation of the Forward View. Local health and care systems should be **facilitating conversations about their footprints now.** Footprint proposals were submitted by end of January.

Plans will be place-based, multi-year, and show how local services should evolve and become sustainable over five years – providing clarity about how the locality will close all three gaps and deliver on national priorities between now and 2020/21. **STPs** will cover the period between **October 2016 and March 2021**, and will be subject to consideration in July 2016 following submission in **June 2016**.

The NHS must continue to **deliver core access**, **quality** and **financial standards** while **planning properly** for the next five years.

Emerging issues

- The size and complexity of some footprints
- The tight deadlines for delivering STPs
- Leadership and management capacity
- Time to plan when operational pressures are the priority
- The role of local authorities
- The worry that STPs could hold back local progress on smaller footprints
- How will national bodies assess the quality of plans?

Local government version

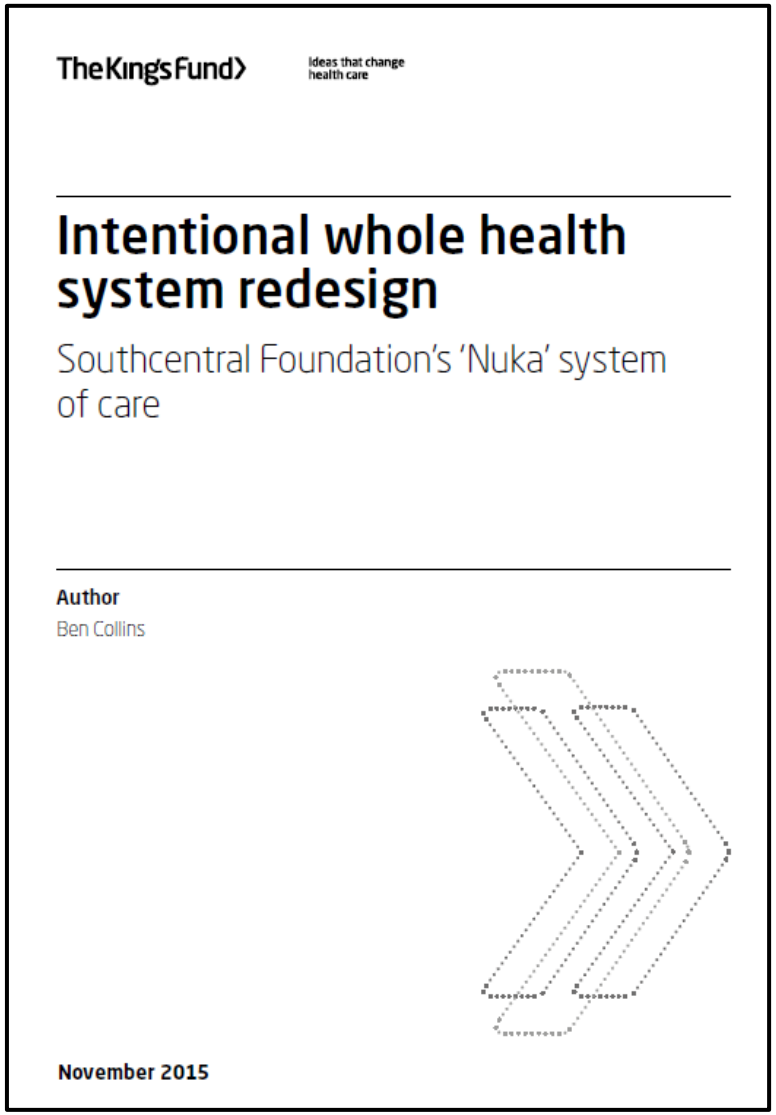
- Total place
- Community budgets
- Leeds integrated care pioneer
- Greater Manchester Devolution plans
- Focus on whole populations and public service budgets
- Priority for economic development as well as integration of services
- A bold vision for the ‘northern powerhouse’

Health and social care integration

- A growing number of examples from around England
- Torbay was an early example but there are now many more
- Integrated care pioneers have shown the way recently
- New care models under the NHS 5YFV are taking further
- The Isle of Wight is a good current example
- International experience is also relevant

Isle of Wight

- NHS organisations, the local authority and voluntary sector organisations are changing the way that they are organised as part of their work as a PACS vanguard (‘my life a full life’)
- Working under the health and wellbeing board, a joint commissioning board and joint provider board have been established, as well as a board that provides overall leadership for the transformation programme
- Emphasis has been placed on developing system leadership and a ‘one island £’, echoing the approach used in Canterbury, NZ
- Partners are also working together to integrate the various ‘support functions’ of the system, including IT, performance reporting and workforce development

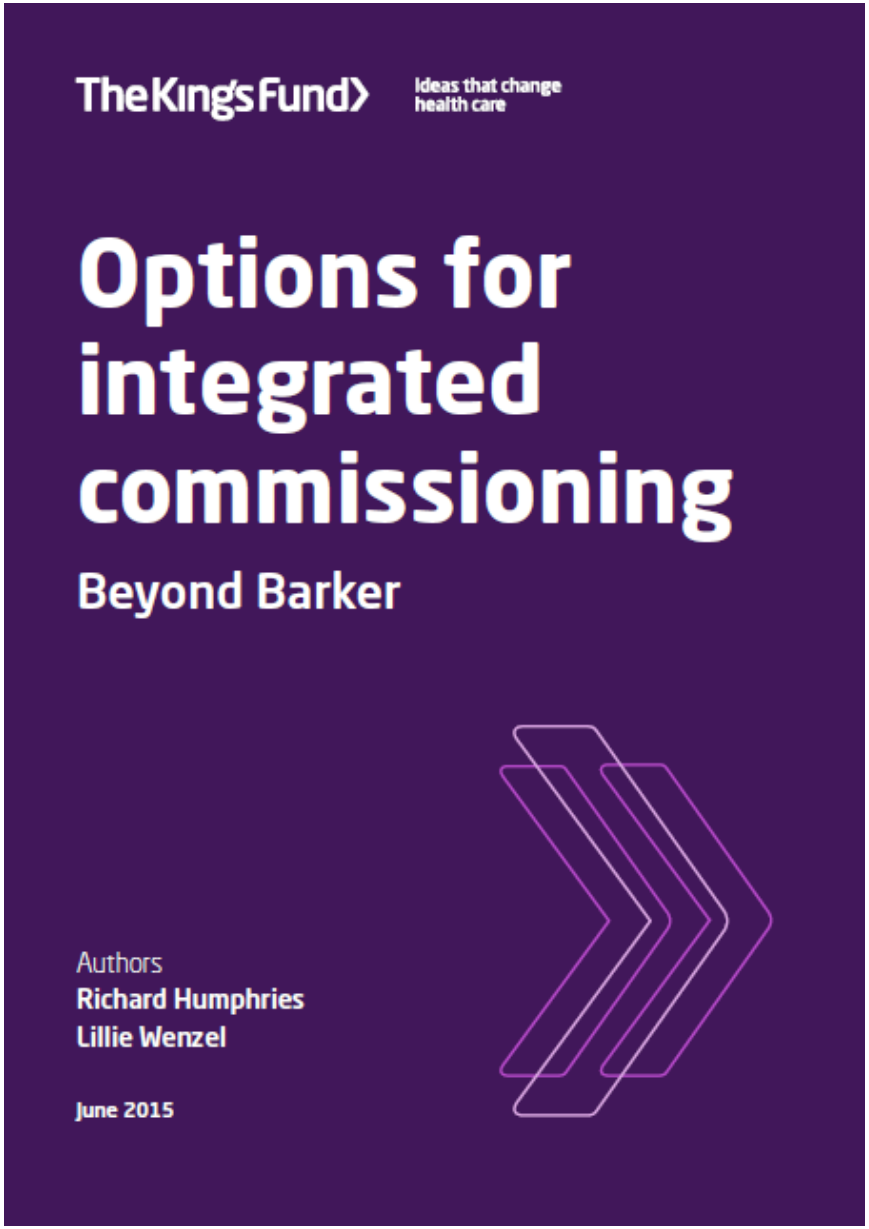


The Kings Fund

Ideas that change health care

Relationships

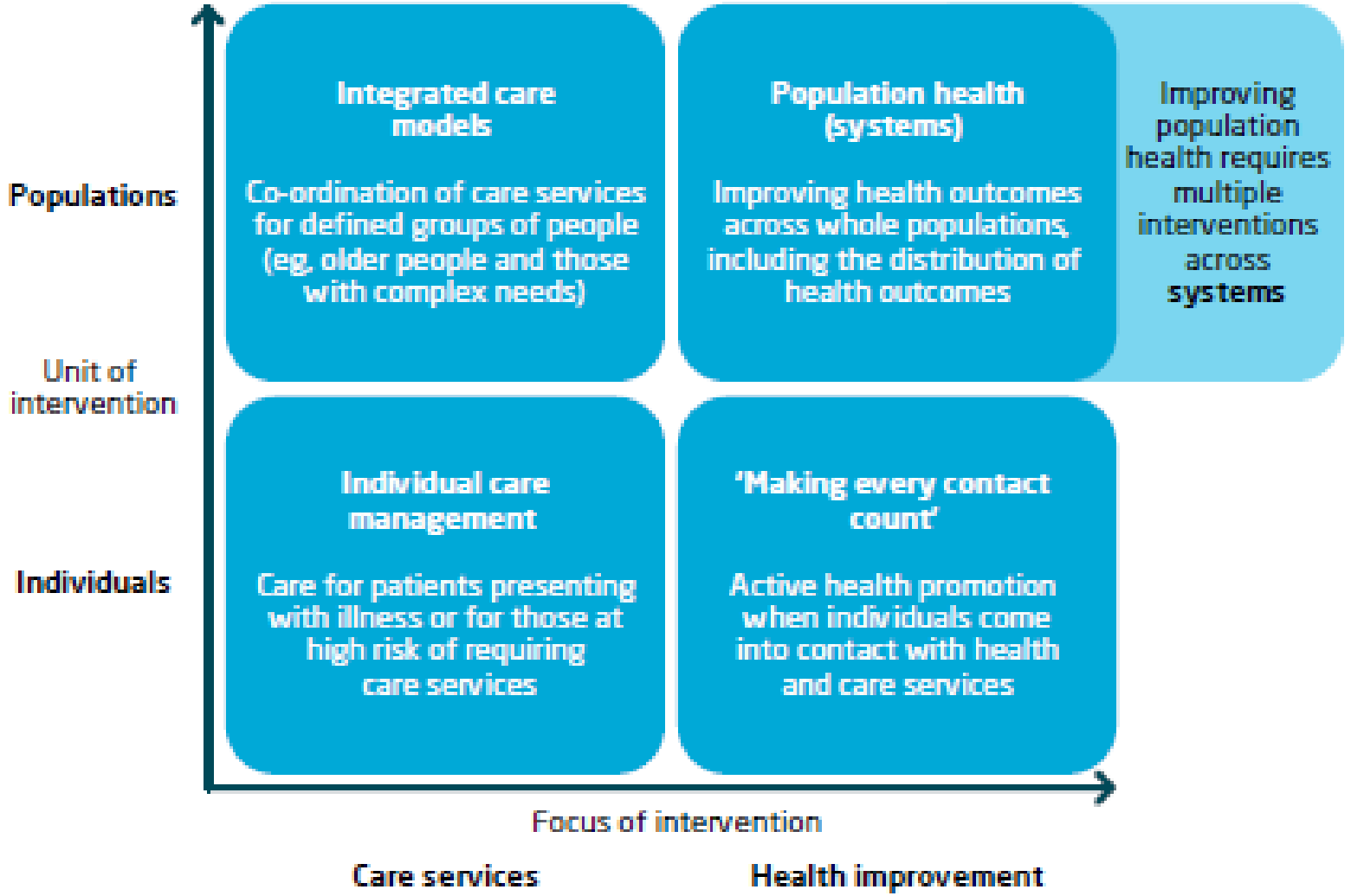
- Place based working and STPs depend on collaboration
- Collaboration depends on the quality of relationships
- Relationships rest on the behaviours of leaders
- System leadership is needed at all levels to realise the benefits
- Health and Wellbeing Boards have a role in providing system leadership


The King's Fund
Ideas that change health care
Options for integrated commissioning
Beyond Barker
Authors
Richard Humphries
Lillie Wenzel
June 2015

Implications for you

- The role of systems within systems: H&F, Tri Boroughs and NWL
- Different issues lend themselves to different footprints
- Specialised health services across NWL
- Local acute services across the three boroughs
- Community, primary and social care for H&F
- Population health at all levels

A broader shift in focus



Opportunities and challenges

- How to contribute to the STP and ensure progress in H&F?
- How to take forward health and social care integration?
- How to pool budgets and use expertise in different agencies, including the future of the Better Care Fund?
- How to go beyond health and social care into population health and economic development?
- What should be the role of the HWB in providing system leadership on these issues?

London Borough of Hammersmith & Fulham **HEALTH AND WELLBEING BOARD** **21 MARCH 2016**	
STRATEGIC PLANNING: REVIEWING PROGRESS AND LOOKING FORWARD TO THE REFRESH OF THE JOINT HEALTH AND WELLBEING STRATEGY	
Report of the Executive Director, Adult Social Care	
Open Report	
Classification - For Decision, Review & Comment **Key Decision: No**	
Wards Affected: ALL	
Accountable Executive Director: Liz Bruce, Executive Director, Adult Social Care	
Report Author: Harley Collins, Health & Wellbeing Manager	**Contact Details:** Tel: 0208 753 5072 harley.collins@lbhf.gov.uk

1. EXECUTIVE SUMMARY

1.1. This paper, which is in three parts, considers research into the effectiveness of health and wellbeing boards across the country, outlines the changing needs of the Hammersmith & Fulham population and sets out a framework for the refresh of the Joint Health and Wellbeing Strategy in 2016.

2. RECOMMENDATIONS

2.1. It is recommended that the board:

a) consider the position of Health and Wellbeing Boards across the country and reflect back on progress made to date.

b) Consider population health need in the borough, how needs and demography have changed and how they are expected to change in the future

c) Consider recent policy announcements and how the board will need to adapt to offer systems leadership in the future

d) Discuss early thinking about what the new Health and Wellbeing Strategies could cover;

e) Discuss a high level timeline for the development of the plans at this stage;

3. REASONS FOR DECISION

3.1. The board are invited to consider research into the effectiveness of health and wellbeing boards across the country, where it stands in comparison and where there is potentially room for further improvement and development.

3.2. Changing population health needs will inform the board's thinking in relation to the refresh of the Health and Wellbeing Strategy and potential priority groups and health conditions.

3.3. Recent policy announcements point to a potentially very different future health and care landscape with implications for the future role of health and wellbeing boards.

3.4. A high level outline of a health and wellbeing strategy is presented for the Board's consideration. The Board are asked to comment on the headings and agree an outline structure to enable Officers to begin the process of drafting the document

3.5. A high level timeline for development is also presented. The board are asked to comment on and agree this.

4. INTRODUCTION AND BACKGROUND

4.1. The meeting at which this paper is presently tabled offers the Board a time for reflection and consideration ahead of the refresh of the Joint Health and Wellbeing Strategy in 2016.

4.2. Health and Wellbeing Boards were established by the Health and Social Care Act 2012 as a forum where local leaders from across local health and social care systems could come together with the voluntary sector and other stakeholders to improve the health and wellbeing of the populations they serve and promote integrated services.

4.3. Many Boards met in shadow form in 2012 prior to being placed on a full statutory footing in April 2013. Research conducted by the King's Fund (October 2013) found that most Boards had used this shadow year well. Against a backdrop of complex organisational change and financial instability, most Boards made good progress building the relationships at the heart of a successfully functioning Board and fulfilling core statutory duties such as the development of Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies.

4.4. However, until very recently, research into Health and Wellbeing Boards has tended toward the consensus that whilst many Boards have made good progress and many had ambitions to assume a full systems leadership role, they are still on a journey and are very much a work in progress (London Councils, March 2015)

4.5. This has changed recently as a result of developments in Greater Manchester, Leeds and more recently London. *The Greater Manchester Health and Social Care Devolution: Memorandum of Understanding* (GMCA 2015) signals the delegation and ultimate devolution of health and social care responsibilities and funding worth £6 billion to accountable, statutory organisations in Greater Manchester.

4.6. The London Health and Care Collaboration Agreement (December 2015) signals the possibility of substantial devolved powers and funding for health and social care to London. (London Partners, December 2015). The five London Devolution pilots announced in December 2015 pave the way for further devolution of healthcare in London to local leaders.

4.7. Developments in Manchester, Leeds, London and elsewhere now offer local Health and Wellbeing Boards a model to aspire to. One where substantial funds, powers and responsibilities for health and social care are devolved to accountable

organisations and local leaders who are collectively responsible for improving the health and wellbeing of the populations they serve.

4.8. Part I of this paper invites the board to consider the findings of research into the ambitions and effectiveness of Health and Wellbeing Boards across the country and to reflect back on progress made in Hammersmith and Fulham to date. Having established where the Board stands, part II invites the Board to consider features of the borough's population including current health needs, how needs and demography have changed and how they are expected to change in the future. Part III recaps on recent significant policy announcements and invites the Board to consider how it will need to adapt to offer leadership in a potentially very different health and care landscape in the future. The paper concludes by inviting the Board to consider a potential answer to this question by setting out some key elements of a future Joint Health and Wellbeing Strategy for 2017 – 2020/21 and an approach and timetable for developing it.

5. PART I – THE POSITION OF HEALTH AND WELLBEING BOARDS NATIONALLY

5.1. There has been a not insignificant amount of research into and review of the ambitions and effectiveness of Health and Wellbeing Boards both in their shadow year and since they were set on a statutory footing in April 2013.

5.2. In 2012, shortly after Boards were established, the King's Fund published *Health and Wellbeing Board's: System Leaders or Talking Shops* which concluded that the single biggest test for health and wellbeing boards would be whether they could offer strong, credible and shared leadership across local organisational boundaries. (Humphries et al 2012).

5.3. In 2013, the King's Fund published *Health and Wellbeing Boards: One Year On (*King's Fund, Oct 2013*)* in which it followed up its first report by looking at what had changed, how Boards had used their shadow year, what they had achieved and whether they could provide effective leadership across local systems of care.

5.4. That research found that whilst there has been definite progress against a back drop of considerable organisational change and financial instability, particularly in areas such as relationship building and the delivery of core duties, Boards are still very much a work in progress.

5.5. Research has found that generally, reported relationships between CCGs and local authorities are good and improving and nearly all Boards have produced joint strategic needs assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWS). (October 2013).

5.6. Interestingly, public health and health inequalities tended to be the highest priorities in health and wellbeing strategies indicating that public health was exerting real influence and impact on local authorities. However, there was little sign in 2013 that boards had begun to grapple with the immediate and urgent strategic challenges facing their local health and care systems and the King's Fund report found that unless Boards did so, there was a real danger they will become a side show rather than a source of system leadership. (King's Fund, October 2013).

5.7. Despite important early progress, in-depth research conducted in 2015 by London Councils and Shared Intelligence found that the vast majority of London HWBs described their board as being on a journey, with very few claiming it was yet fulfilling its full potential. And although most Boards reported aspirations to do so, researchers found little evidence of London HWBs yet providing genuine systems leadership across the piece (*Conquering the Twin Peaks* London Councils, 2015).

5.8. This finding was replicated again in the Local Government Association's review of the second year of the national health and wellbeing board improvement programme which found that Boards nationally could all be located somewhere on a spectrum of maturity and ambition, with progress best represented by a bell-curve rather than a linear graph. (*Stick with it: A review of the second year of the health and wellbeing improvement programme* Local Government Association, February 2015*)*

6. WHAT ARE THE CHARACTERISTICS OF AN EFFECTIVE BOARD IN A CHANGING WORLD?

6.1. There is a high level of consensus amongst research findings and best practice guidance about the traits displayed by the more advanced and effective boards.

6.2. Firstly, HWB chairs were found to have the single biggest influence over a Board's focus and tone and the relationship between the council and CCG and between the chair (in most cases a senior councillor) and vice chair (often from the CCG) were also key markers of effectiveness.

6.3. The London Council's study suggested that effective boards: create the conditions in which there is genuine collaboration between key players in the local health and wellbeing system; ensure the existence of effective systems leadership; and ensure effective engagement with the public and other stakeholders. As a result, effective boards tend to display focussed, prioritised action which impacts on the wider determinants of health; a shared vision for the future of health and care in place, which has traction with the strategies and business planning processes of the key local organisations; and a work programme to deliver and monitor this (London Councils, 2015).

6.4. Factors enabling boards to operate effectively also included: a shared purpose and tight focus; a small number of priorities (typically between 3 and 5) with the discipline to stick with them; an explicit role in creating groups and forums for other related conversations and activities; effective sub-structures and time to meet in informal settings; an ability to influence all the key players; and a shared strategy which secures action by relevant organisations (London Councils, 2015).

6.5. The LGA (2015) found that the small number of boards who were ahead of the curve in their view had looked beyond tackling immediate 'problems' in the system and kept a disciplined focus on the bigger picture. Some of the key steps these Boards have taken included:

- Having difficult conversations about shifting money around
- Keeping a tight focus on long-term health issues and not getting distracted by other local and national 'noise'
- Having clarity on quick wins (first 100 days plans) and short to medium term gains in the first two or three years and longer term
- Maintaining focus on health and wellbeing, prevention and acute care
- Ensuring all board members and their organisations are brought into and acting upon board strategy

6.6 Features found to potentially impede board's progress include pressures to address issues that are not a priority; a tendency to focus on the board as a meeting rather than as an institution with a wider reach; failure to engage with, or seem meaningful to, providers; and being by-passed, with key discussions taking place in other forums outside the board's ambit (London Councils, 2015).

6.7 Table 1 captures a list of traits found by the Local Government Association to be markers of an effective Health and Wellbeing Board. Although not an

exhaustive list it offers a valuable tool for thinking about the Board's progress so far.

Table 1 – What are the characteristics of an effective health and wellbeing board?

best practice criteria	commentary	areas for discussion
Vision, ambition and role of the health and wellbeing board	• Is there demonstrable passion, ambition and enthusiasm displayed not only by the Chair but all Board members about what can be achieved locally and about the potential of the partnership to offer leadership and effect fundamental change? • Does the Board's Better Care Fund plan and Joint Health and Wellbeing Strategy display a clear focus on prevention, health inequalities, the wider determinants of health, and a recognition of the importance of 'big ticket' items such as health and care integration? • Does the Board have effective support and sub-structures?	• Does the Board's strategy have clear ties with the strategic objectives of providers and other stakeholders outside the partnership? • Has the Board articulated a clear and compelling narrative and road map for change setting out how the system can move from where it is now to where it needs to be?
System leadership and partnership working	• Are there strong and productive relationships between board members and do Board members feel comfortable offering critical challenge, holding each other to account and influence each other's organisations? • Do Board members have a good understanding of the major constraints and opportunities facing organisations in the local care system? • Are members clear about the role of the Board and the roles of scrutiny and Healthwatch. • Does the Board have productive relationships with external bodies (e.g. Council scrutiny, Safeguarding Boards)	• To what extent do board members have the right amount of authority to challenge and influence wider organisations not represented on the Board to secure action? • Is there an alignment between relevant partners' strategies and plans so they are focused on delivering shared priorities?
Delivery and impact	• Does the board ensure that the JSNA is updated regularly and informs partners' priorities and commissioning? • Does the board's strategy articulate clear milestones, performance indicators and outcomes and receive regular updates on progress?	• Does the Board have fit for purpose performance measures focused on the delivery of health and wellbeing outcomes? • Does the HWB effectively use a range of quantitative data such as financial,

	• Do board members and their respective organisations invest time outside of formal meetings developing relationships, trust and collaboration, purpose, roles and focus? • Is there parity between members with all afforded the opportunity to contribute at meetings and to the work of the board?	system performance and patient satisfaction, as well as qualitative evidence such as personal stories?
Communication and engagement	• Does the Board use mechanisms to ensure that community views are considered and represented in the deliberations and action taken by the Board, including the voices of seldom heard and hard to reach groups?	• Does the board have the appropriate mechanisms in place to engage with provider trusts (e.g. through representation on the board, attendance at relevant meetings, or through the development of appropriate sub-structures).
Integration and system redesign	• Is the Board enabling a shift of resources to make prevention and early intervention a priority? • Is the board thinking broadly about service integration across the public sector to maximise money? • Does the HWB focus on maximising community assets e.g. GP surgeries, children's centres and schools?	• Do board members display a willingness to learn from other boards, best practice and national developments?

7. PART II – THINKING ABOUT HOW HAMMERSMITH & FULHAM IS CHANGING

7.1. Hammersmith and Fulham is a small, densely populated borough. GLA 2015 projections estimate the population to be 189,850. It is common to other inner city areas in that it has a very large young working age population (73.9%) and smaller proportions of children (16.8%) and older people (9.3%). Compared with nationally, the proportion of people aged over 65 is almost half that of England. The borough has the 5th lowest proportion of children, 4th highest of young working age residents and 9th lowest of retirement age

7.2. The population is socio-economically and culturally diverse. 42% were born abroad and one third (32%) were from BAME groups in 2011, up from 22% in 2001. A range of European languages are spoken in the borough. A quarter of the borough's residents state their main language is not English and of these, 1 in 10 state they cannot speak English well (approx 3%). French, Arabic, Spanish and Polish are the most common languages other than English. The population is very mobile which can create significant challenges in providing health services and accurately recording population size.

7.3. Three quarters (75%) of the borough's housing stock is flats, compared to half in London. Many have limited outdoor space and nearly half have no ground floor entrance and some have no lifts potentially making it difficult for some people with mobility issues. A third of people (34%) live in private rented housing – the 5th highest in London – and a similar proportion (35%) are owner occupiers – 8th lowest in London. Just under a third (30%) live is social housing.

7.4. 38% of households are one person households and almost one in ten (8.8%) is a lone pensioner household. Almost half (43%) of older people live alone carrying a risk of social isolation.

7.5. Pressure on social housing stock and property prices in London has resulted in overcrowding particularly among families. Across all tenures, approx 13% of households are considered to be overcrowded, similar to the rate across London.

7.6. Despite house prices, Hammersmith and Fulham was classified as the 55th most deprived borough in the country in 2010 according to the index of multiple deprivation. Pockets of deprivation are spread throughout the borough but are particularly focussed in the north of the borough and usually correspond to areas of social housing and poorer than average health. Those living in areas of high density social housing are around twice as likely to report bad/very bad health compared to those in areas with low density, across all ages. This can make targeting of support easier, if areas of social housing in the borough are well defined

7.7. A third of children under 16 (29%) live in poverty according to official definitions, which is higher than London and England. The Job Seekers Allowance rate in November 2013 was 3.1%, similar to London (3.1%) and Great Britain (2.9%), but rates are almost double this in areas such as College Park & Old Oak and Wormholt & White City.

7.8. Men living in Hammersmith and Fulham have a lower life expectancy than London and England (79.1 years), and for women it is worse than London (83.3 years). Whilst many residents are affluent, there are significant areas of poorer health in the more deprived parts of the borough and therefore large health inequalities between rich and poor. The difference in male life expectancy between affluent and deprived areas in the borough – 9.2 years. The difference in female life expectancy is 3.9 years.

7.9. Most people (86%) in Hammersmith and Fulham consider their health to be good reflecting the younger age profile in the borough. The minority of people who

consider their health to be bad or very bad are more likely to have long term conditions that limit their ability to lead normal lives and are much more likely to be older. They also tend to be clustered around areas of deprivation and social housing.

7.10. The principle cause of premature (<75) and avoidable death in Hammersmith and Fulham is cancer, followed by cardiovascular disease (which includes heart disease and stroke). A significant number of people also die from COPD. Accidents and injuries are most common among younger residents. This is pattern is broadly similar to the rest of the country.

7.11. Tackling chronic diseases using a range of interventions, including support for lifestyle change and improved support for those already with chronic disease. Compared to a decade ago, around 135 fewer people die before the age of 75 each year, with differing levels of success across disease types.

7.12. The growing burden of disability also requires a co-ordinated response, with mental disorders, substance use, musculoskeletal disorders and falls all having a significant impact on the ability to lead a fulfilling life and contribute to society through stable employment up to retirement. Locally, mental health is the most common reason for long term sickness absence, and several of the wards in the deprived parts of the borough fall into the 20% highest in London for incapacity benefit/ ESA claimant rates for mental health reasons.

7.13. Although some of the causes of poor health and long-term conditions are easily identified – tobacco use, high blood pressure, being overweight, poor diet, and physical inactivity in particular – the public health challenge remains facilitating behaviour change amongst populations who may not be ready to change. Understanding and tackling the factors which prevent healthy choices includes tackling underlying issues around housing, the urban landscape, employment, and education.

7.14. The public health team have supplied further detailed supporting information at Appendix 1.

8. PART III – GETTING READY FOR THE FUTURE

8.1. Recent significant policy announcements and developments provide an indication of how health and social care systems might change in 2016/17 and beyond:

- The publication in December 2015 of *Delivering the Forward View: NHS Shared Planning Guidance 2016/17 – 2020/21* signals a radical shift in policy for the NHS over the next few years. The guidance requires NHS commissioners and providers to come together with local organisations, including local government, to develop five year *place-based* plans. The shift to a place-based approach to planning signals an acknowledgement that widespread deficits cannot be remedied by providers alone but instead require collective action and cooperation between commissioners, providers and local authorities managing common resources to secure a financially sustainable system (McKenna and Dunn. Feb 2016) The strongest place based plans will also unlock transformation funding from 2017/18 onwards, a recognition that funding is required to support transformation.

- Accompanying and consistent with the place-based approach to planning, has been the introduction of multi-year CCG funding allocations providing greater certainty to long-term planning and a shift toward looking at the

sum totality of allocations and aggregate financial balance across local systems (rather than individual organisational financial positions).

- the Government announcement in the 2015 Spending Review that it expects health and social care be fully integrated by 2020 with local plan for integration in place by 2017 is a recognition that health and care integration are central to the future sustainability of both systems and a desire to move at pace to achieve this.
- the ambition by more than 30 partners across North West London to become an Accountable Care Partnership by 2018 will require groups of providers to come together and assume clinical and financial accountability for delivering pre-agreed outcomes for particular segments of the population.
- The announcement of the five London devolution pilots which will road test new ways of working across London's health economy signal the prospect of a longer term aim for further devolution of London's healthcare to local leaders
- The *Greater Manchester Health and Social Care Devolution: Memorandum of Understanding* (GMCA 2015) signals the delegation and ultimate devolution of health and social care responsibilities and funding worth £6 billion to accountable, statutory organisations in Greater Manchester.
- The London Health and Care Collaboration Agreement (December 2015) signals the possibility of substantial devolved powers and funding for health and social care to London. (London Partners, December 2015). The five London Devolution pilots announced in December 2015 pave the way for further devolution of healthcare in London to local leaders.

8.2. The refresh of the Board's Joint Health and Wellbeing Strategy in 2016 will be a key vehicle for moving forward in this context and a key mechanism for grasping the opportunities presented by recent and ongoing developments.

9. REFRESHING THE JOINT HEALTH AND WELLBEING STRATEGY

9.1. The Health and Wellbeing Strategy is an opportunity to agree what is important for local people and how the whole system can take collective action to deliver those priorities. It also offers an opportunity to fulfil a systems leadership role across Hammersmith & Fulham with responsibility for all funding and decisions relating to the health and care of the population. To do this, the strategy would need to articulate the outcomes expected, say how commissioning and resources need to shift and how they would be managed over the short to longer term. This means:

- Delivering the framework within which accountable care partnerships could operate
- Providing the framework for commissioning across health and care
- Developing a vision and agreeing the outcomes which should be reflected in future commissioning arrangements
- Moving from an approach where the Board focuses on particular conditions and services, to one where it focuses on the needs of particular population

segments, enable a shift towards integration, prevention and early intervention
- Developing a governance structure involving the organisations involved in delivering health and care to take decisions in pursuit of agreed objectives
- Identifying the system enablers required to be able to manage the above such as developing the appropriate workforce, governance and IT.

9.2 The Health and Wellbeing Strategy could therefore set out:

- A high-level 5 year vision
- What has been achieved over the lifespan of the previous Health and Wellbeing Strategy
- The local context (e.g. demographic, economic, social, cultural), local assets and the key health and wellbeing challenges in Hammersmith & Fulham
- The strategic priorities for integrating health and care and taking a broader approach to supporting people in the community – including:
    - A plan for fully integrated health and social care services by 2020
    - Realising the benefits of outcomes based commissioning and accountable care from 2018
    - Taking advantage of new freedoms and flexibilities through devolution and the BCF
    - Working as a whole system to tackle the wider determinants of health
- Population group priorities (this is key to enable the move to capitated budgets which are a key aspect of the accountable care partnership model) – e.g.:
    - children and young people
    - looked after children
    - children with mental health needs
    - working age adults with episodic health needs
    - working age adults with enduring conditions (including mental health needs and learning disabilities)
    - older people
- Outcomes KPIs or key performance indicators to be measured in each population group.
- Key enablers to ensure delivery such as:
    - Integrated information and technology
    - Integrated workforce planning and organisational development
    - Governance and accountability arrangements
    - System leadership and delivery plans

9.3 A joint working group has been established to guide the development of the Joint Health and Wellbeing Strategy in parallel with the North West London Sustainability and Transformation Plan. A high level plan has been developed which proposes 3 phases of work:

Phase 1 (between now and end of March) – mobilisation, base case and local analysis

This includes:

- What has worked well/needs further development in the role of system leadership locally
- What the local evidence base suggests in terms of health and wellbeing in each of the areas
- The plan approach and plan structure

Phase 2 (between March and May) – setting population level priorities and engagement (including with residents)

This will include engagement with the Health and wellbeing Board on:

1. Defining the outcomes framework
2. Agreeing the priority population groups
3. Developing strategic priorities (overall and in population groups)
4. Engaging with subject matter experts in the creation of the plans (e.g. housing)
5. Developing the operational plans to underpin the STP and health and wellbeing plans
6. Creating the plans for system wide enablers

Phase 3 (May and July) – plan completion, further engagement and sign off

This will include:

1. Finalising the planning with Health and Wellbeing Boards
2. Engaging with residents and partners on the final draft plans
3. Mapping the plan outputs to operational plans
4. Agreeing the forward plan for delivery
5. Aligning resourcing plans

10. CONSULTATION

10.1. Under Local Government and Public Involvement in Health Act 2007 the Health and Wellbeing Board must involve the local community continuously throughout the JSNA and JHWS process. The duty to involve the local community covers people who live or work in the area, and includes children and adults. Extensive public, patient and professional engagement will be undertaken as part of the refresh and will be ongoing throughout the lifespan of the strategy. A detailed stakeholder engagement plan will be developed as part of the refresh programme and will be shared with Board members. The refreshed strategy will also draw on the JSNA and other strategic documents which themselves were formed on the basis of extensive public engagement**.**

11. EQUALITY IMPLICATIONS

11.1. *N/A*

12. LEGAL IMPLICATIONS

12.1. This report concerns the duty imposed by the Health and Social Care Act 2012 on the Local Authority and the CCGs to prepare a joint health and wellbeing strategy (JHWS) which is a strategy for meeting the needs included in the Joint Strategic Needs Assessment (JSNA).

13. FINANCIAL AND RESOURCES IMPLICATIONS

13.1. *None identified at this stage.*

11. IMPLICATIONS FOR BUSINESS

11.1 None identified at this stage.

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

Background papers:

Ham, C and Alderwick, H (November 2015) *Place-based systems of care: A way forward for the NHS in England* The King's Fund (available at: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Place-based-systems-of-care-Kings-Fund-Nov-2015_0.pdf)

Humphries et. al (October 2012). *Health and Wellbeing Board's: Sytem Leaders or Talking* Shops The King's Fund (available online at http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/health-wellbeing-boards-one-year-on-oct13.pdf)

Humphries, R. and Galea, A (October 2013). *Health and Wellbeing Boards: One Year On,* The King's Fund (available online at: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/health-wellbeing-boards-one-year-on-oct13.pdf)

(February 2015) *Stick with it: A review of the second year of the health and wellbeing improvement programme*, Local Government Association,

(February 2015) Health and wellbeing self-assessment tool, Local Government Association, (available online at: http://www.local.gov.uk/documents/10180/6101750/Stick+with+it+-+a+review+of+the+second+year+of+the+health+and+wellbeing+improvement+programme/5a54723b-d235-48c3-a499-327a29ba272b)

(March 2015) *Conquering the Twin Peaks*, London Councils (available online at: http://www.londoncouncils.gov.uk/our-key-themes/health-and-adult-services/health/health-and-wellbeing-boards/conquering-twin-peaks)

GMCA (2015) *Greater Manchester Health and Social Care Devolution: Memorandum of Understanding*, (available online at: https://www.greatermanchester-ca.gov.uk/downloads/download/40/greater_manchester_health_and_social_care_devolution_memorandum_of_understanding)

(December 2015) *London Health and Care Collaboration Agreement*, (available online at: https://www.london.gov.uk/sites/default/files/london_health_and_care_collaboration_agreement_dec_2015_signed.pdf)

(December 2015) Delivering the Forward View: NHS Shared Planning Guidance 2016/17 – 2020/21, NHS England, NHS Improvement, Care Quality Commission, Health Education England, National Institute of Care Excellence, Public Health England (available at: https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf)

McKenna, H. and Dunn, Phoebe (February 2016) *What the planning guidance means for the NHS: 2016/17 and beyond* The King's Fund (available at: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Planning-guidance-briefing-Kings-Fund-February-2016.pdf)

Health and Well-being strategy supporting information (Hammersmith and Fulham)

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AN OVERVIEW OF DIFFERENT CHARACTERISTICS OF LOCAL POPULATION

The borough at a glance…			
80,600	Households	8	Live births each day
£464,000	Median house price	2-3	Deaths each day
182,500	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%)
22%	Main language not English	22%	Local jobs in Public Sector
41%	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		

DEMOGRAPHY SUMMARY

- Population: 189,850 (GLA 2015)

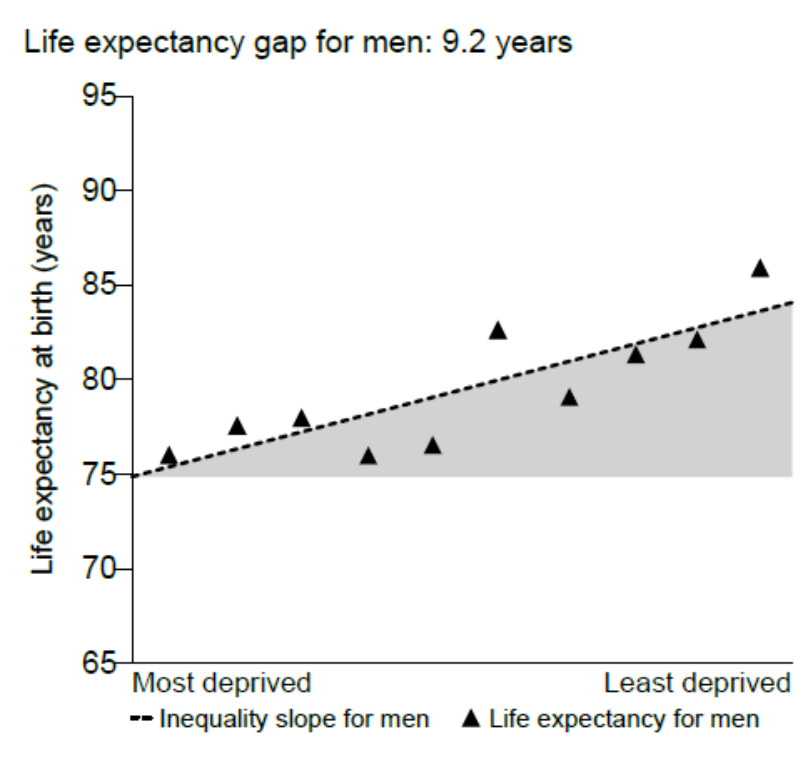
- Age GLA 2015)
  - Children – 16.8% *London - 20.0% | England 18.9%*
  - Working age - 73.9% *London - 68.6% | England 63.2%*
  - Older people - 9.3% *London - 11.4% | England 17.8%*

- % BAME (Census 2011) – 31.9%
  London – 40.2% | England – 14.0%

- % Not born in UK (Census 2011) – 42.6%
  London – 36.7% | England – 13.4%

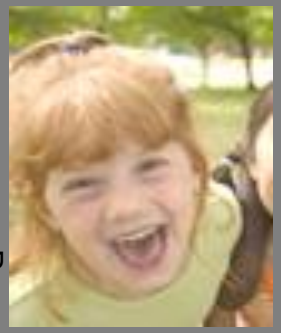
- % English is first language of no one in household (Census 2011) – 14.5%
  London – 12.9% | England – 4.3%

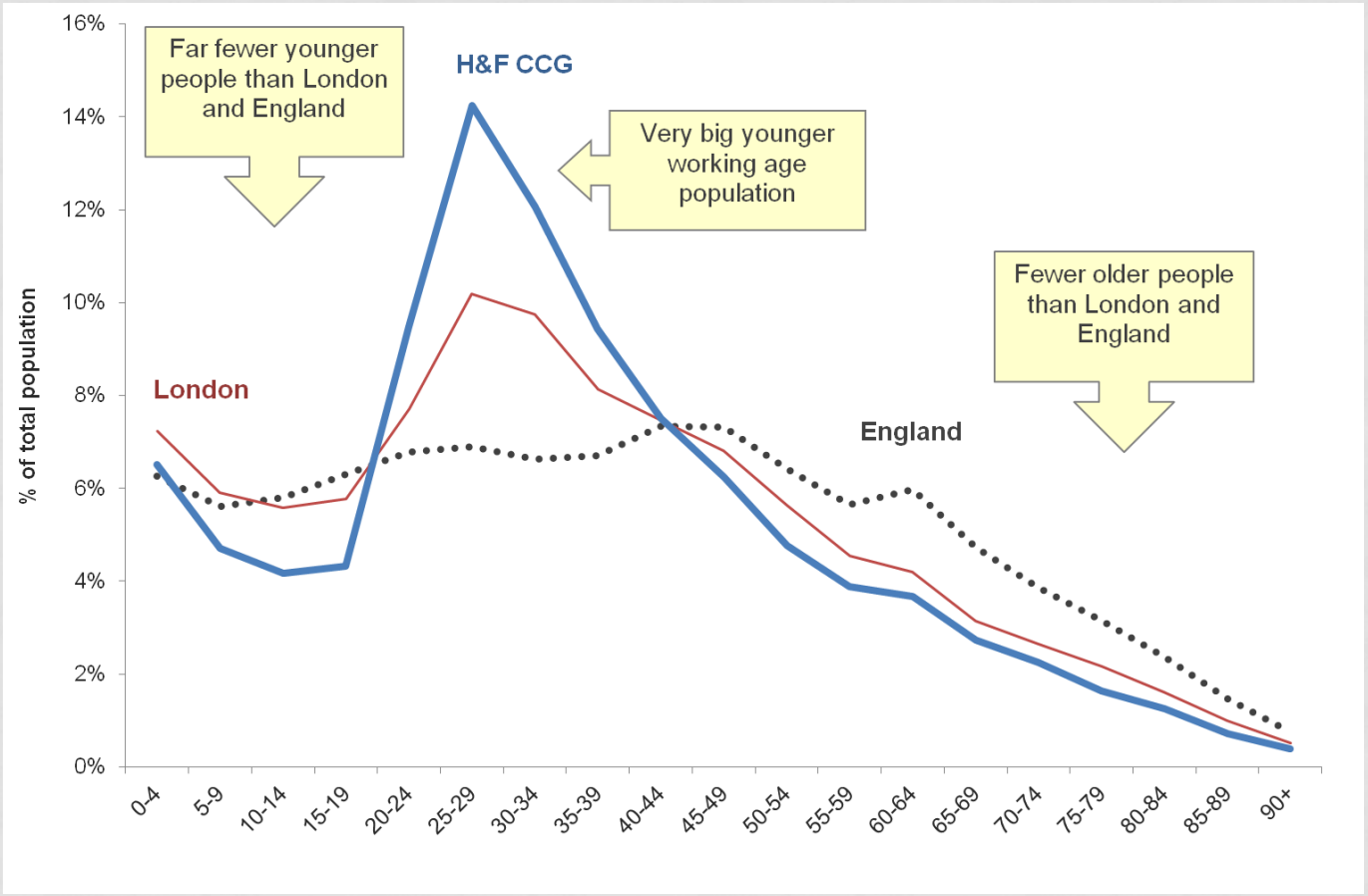
LIFE EXPECTANCY



Source: PHE Public Health Profiles 2015

AGE





The area has a very high working age population compared to London). – Data collected universally across all sources.

CHILD HEALTH

- In Year 6, 22.4% (253) of children are classified as **obese**, worse than the average for England.
- Levels of **GCSE attainment**, **breastfeeding** and **smoking at time of delivery** are better than the England average

Source: PHE Public Health Profiles 2015

ADULT HEALTH

- 13.3% of adults are classified as **obese**, better than the average for England. Estimated levels of adult excess weight and physical activity are better than the England average.
- The rate of **alcohol related harm** hospital stays was 657*. This represents 938 stays per year.
- The rate of **self-harm** hospital stays was 99.9*, better than the average for England. This represents 184 stays per year.
- The rate of **smoking related deaths** was 350*, worse than the average for England. This represents 191 deaths per year. Estimated levels of adult smoking are worse than the England average.
- Rates of **sexually transmitted infections** and **TB** are worse than average.

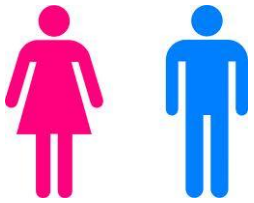
* rate per 100,000 population

Source: PHE Public Health Profiles 2015

Age	Health status	Healthcare access & quality
What do we know nationally?	• Poorer health and chronic disease with age • Greater levels of disability with age • Around a third of 80+ year olds likely to have dementia • Social isolation among older people • Increasing depression among older people	• Poorer dignity & respect in hospital for some older people • Instances of lower operation rates for cardiac procedures among older population • Younger people more likely to use A&E, not GP • Lower cervical screening uptake for younger women
What do we know in H&F?	• Poorer health and chronic disease with age • Greater levels of disability with age • High numbers of older people living alone – potential for social isolation • Increasing depression among older people	•Younger people more likely to use A&E, not GP • Lower cervical screening uptake for younger women • Older people have less success quitting smoking through local services (more long-term smokers?) • Slightly worse access to psychological therapies • Health Checks

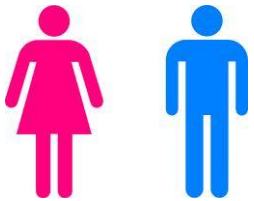
GENDER

H&F



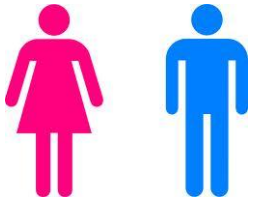
52% 49%

London (2011 Census)



51% 49%

England (2011 Census)



51% 49%

H&F area has a similar gender split to the rest of London and elsewhere in Great Britain, with the percentage of women being 1% greater and the percentage of men 1% lower .

Because women live longer than men, and the health inequalities between men and women, there are a much greater proportion of older women than older men among the H&F population.

Numbers for transgender and gender reassignment are not known locally.

Nationally, around 1500 people aged over 15 years old are presently undergoing treatment for gender dysphoria per year. There is also a rapid growth (15% per year) in the number of people, of all ages, who are seeking medical treatment for profound and persistent gender dysphoria.

Gender	Health status	Healthcare access & quality
What do we know nationally?	• Shorter life expectancy for men • Higher levels of smoking and low fruit & vegetable consumption among men • Higher suicide rate among men • Higher levels of substance abuse for men, including alcohol • Higher common mental illness for women • Lower levels of physical activity for women • Violence against women • Autism/ADHT higher among boys	• Lower use of GP services by men • Late presentation and diagnosis of cancer for men
What do we know in H&F	•Same as above, although little information around lifestyles (outside Westminster) and violence against women	•Smoking cessation among older smokers •Late presentation for cancer
GAPS	• Gender collected routinely, so good understanding of health status by gender • Data no consistently available from General Practice	• Good recording of gender, but lack or routine analysis around level of access across range of services commissioned

NUMBER OF FAMILY BREAKDOWNS

Little data is gathered around the number of family breakdowns and adoptions in the CWHH s area. The 2011 Census identifies **10.3% of the local adult population as separated or divorced,** which is lower than the London and national averages

The number of divorces in England and Wales in 2011 was 117,588, a decrease of 1.7% since 2010 , when there were 11,589 divorces

In 2011, 10.8% people divorced per thousand married population compared with 12.9% in 2001.

The number of divorces in 2011 was highest among men and women aged 40 to 44. Based on marriage, divorce and mortality statistics for 2010, it is estimated that the percentage of marriages ending in divorce is 42% compared with 45% in 2005.

The number of adoptions in England and Wales in 2011 was 4,734, an increase of 6 per cent since 2010 when there were 4,481 adoptions.

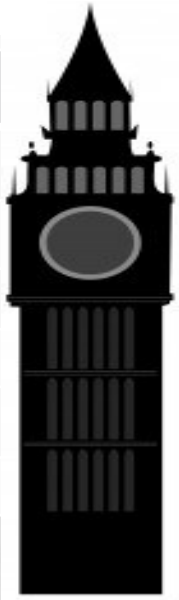
In 2011, most children adopted (62%) were aged between one and four years, rising from 58% in 2010.

The percentage of children adopted who were born outside of marriage increased slightly to 82% in 2011, up from 80% in 2010.

RACE ETHNICITY AND NATIONALITY

2001 Census data Ethnicity

	H&F area	London
White British	58%	60%
White Other	20%	11%
Black	11%	11%
Asian	5%	13%
Other/Mixed	6%	5%
BME	22%	29%



2011 Census data Ethnicity

	H&F area	London
White British	45%	45%
White Other	23%	15%
Black	12%	13%
Asian	9%	18%
Other/Mixed	11%	8%
BME	32%	40%

In the 10 years between the 2001 and 2011 Censuses, the percentage of people in black and minority ethnic groups has increased by 10% in H&F and 11% in London.

There has been a particular increase in the 'other ethnic' group in H&F, which may be partly a result of the creation of the 'Arab' category. The Asian group has increased due to a rise in 'Other Asian'. There has also been a rise in the 'White other' group. The numbers in the black ethnic group have remained relatively static

Note: Chinese grouped under 'Asian' in 2001 to be comparable to 2011

Race/ ethnicity	Health status	Healthcare access & quality
What do we know nationally?	• Poorer life expectancy for Pakistani/ Bangladeshi groups • Greater susceptibility to diseases such as diabetes for Asian and Black groups • Issues around refugee/asylum seeker health • Low birth weight babies among some groups e.g. Asians • Low physical activity/ high smoking for some groups e.g. Asians	• BME groups disproportionately using emergency services over routine/ GP services and some experience of challenges communicating with health professionals • Gypsies & travellers more likely to use emergency services over routine services • Black groups more likely to be detained under mental health act
What do we know in H&F?	• Poorer health among certain ethnic groups, from 2011 Census • Smoking rates high for Eastern European groups in Westminster • Issues around female genital mutilation for some Somali and Sudanese women • Speech and language therapy more common among BME children	• Conflicting evidence around breast and cervical screening uptake – lower uptake in some groups • Gaps in local knowledge around gypsies & travellers • High 'did not attend' rates among some ethnic groups for hospital services
GAPS	• Ethnic group not recorded on death certificates, hence some lack of local understanding of ill health by ethnicity • GP data not consistently available • Data not always collected accurately	• Sometimes poor data collection • GP data not consistently available • Small numbers in groups means methodological challenges around 'proving' access issues

RELIGION AND BELIEF

	Christian %	Muslim %	Hindu %	Jewish %	Buddhist %	Sikh %	Other religion %	No religion %	Religion not stated %
H&F	**54.1%**	10.0%	1.1%	0.6%	**1.1%**	0.2%	0.5%	**23.8%**	8.4%
London	48.4%	12.4%	5.0%	1.8%	1.0%	1.5%	0.6%	20.7%	8.5%
England	59.4%	5.0%	1.5%	0.5%	0.5%	0.8%	0.4%	24.7%	7.2%

According to the 2011 Census data, 54% of the population in H&F were Christian, higher than London (48%) but lower than England. A far smaller proportion of the H&F population were Hindu, Jewish or Sikh compared to the London average

DISABILITY

Limiting Long-term illness (LLTI), 2011:

Estimated 25,000 patients stated they had a LLTI
(12.6% of the population of H&F (London: 14.2%))

Visual Impairment:

840 registered blind or partially sighted.
(According to NHS statistics 2011)

Learning Disabilities:

385 on GP learning disability registers
(0.19% of the H&F GP population)

Working Age Disability:

Est 6,000 economically inactive due to long-term sickness or disability
(3.9% of working age population (London 3.7%))

Using a Mobility Aid:

Est 4,900 aged 65 or over using an aid.
(based on national population prev of around 29%) (HSE 2005)).

Hearing Impairment:

350 registered deaf or hard of hearing.
(According to NHS statistics 2014).

Those of working age with a disability are more likely to be living in areas of social housing.

Disability among older people is likely to rise due to improved life expectancy and ageing of post war baby boom.

Improved life expectancy at birth and better hospital care means increase in numbers with complex needs living in adulthood.

Limited information collected on patient disability.

Disability	Health status	Healthcare access & quality
What do we know nationally?	• Low life expectancy and high rates of obesity, heart conditions for those with learning disabilities • Mental health one of the primary causes of disability • Those with chronic diseases more likely to have a common mental illness • Working age disabled people twice as likely to be out of work and claiming benefits as non-disabled people	• Low rates of screening for learning disability population and 'diagnostic overshadowing'
What do we know in H&F?	• High rates of incapacity benefit for mental health reasons in deprived parts of INWL • Working age disability more likely in areas of social housing and deprivation (according to 2011 Census)	• Some evidence of low rates of screening and health checks for learning disability population • Limitations around accessibility of home care, given restrictions on adaptations to some housing (due to conservation area planning rules) • Challenges around accessibility and DDA compliance of primary care estate and restrictions to adapting premises • Low numbers on hearing and sight registers, compared to likely number in local population

SEXUAL ORIENTATION

Little data is gathered around sexual orientation in the CWHH s area. According to Stonewall, the size of the lesbian and gay population in the country may be in the region of 5-7% of the population. The Inner North West London area has among the highest rates in the country for HIV transmitted through sex between men, with very high **rates in surrounding areas suggesting that the gay population may be larger than elsewhere.**

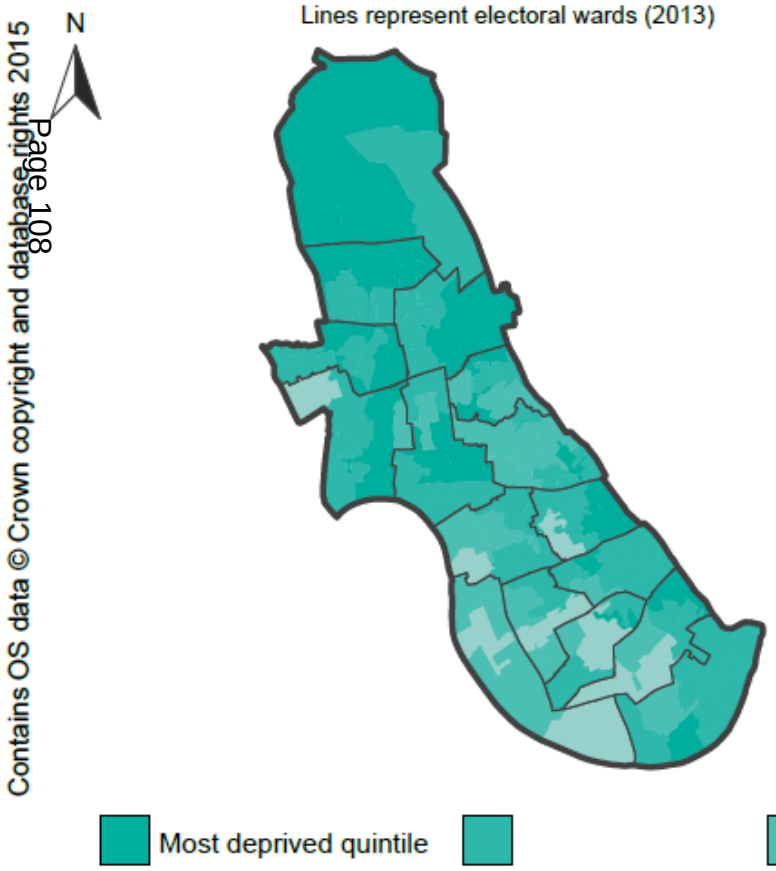
According to the 2011 Census, Hammersmith and Fulham has the 14th highest proportion of residents in same sex civil partnerships in the country (Westminster has the 6th highest and K&C has the 7th highest)

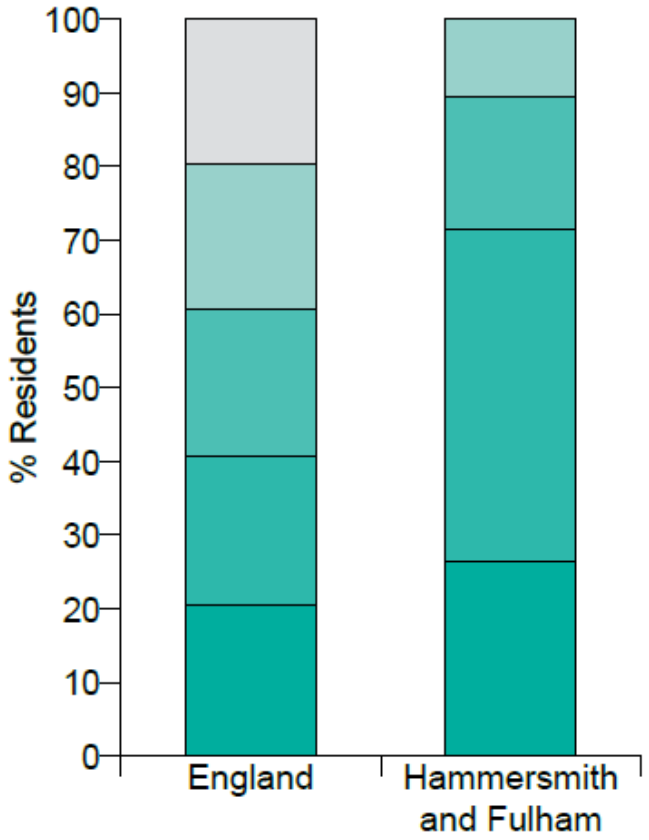
Nationally, lesbian, gay, bisexual and transgender (LGBT) groups are more likely to experience mental health problems and self-harm, as well as being more likely to engage in lifestyles harmful to health, such as drinking smoking and drug use. Locally the area is noted for a higher than average level of sexually transmitted diseases and a very high level of HIV transmission via sex between men.

Nationally issues have been highlighted around a lack if trust and/or understanding between LGBT groups and health professionals. National research has shown that 4 out of 10 men have not disclosed their sexuality to their GP. Local knowledge is restricted as data is not routinely collected around sexual orientation.

Sexual orientation	Health status	Healthcare access & quality
What do we know nationally?	• LGBT groups more likely to experience mental health problems and self-harm • More likely to engage in lifestyles harmful to health (e.g. drinking, smoking, drug use)	• Issues around lack of trust/understanding between LGBT groups and health professionals
What do we know in H&F?	• Very high levels of HIV acquired through sex between men • High levels of sexually transmitted diseases	• Good access to HIV clinics locally

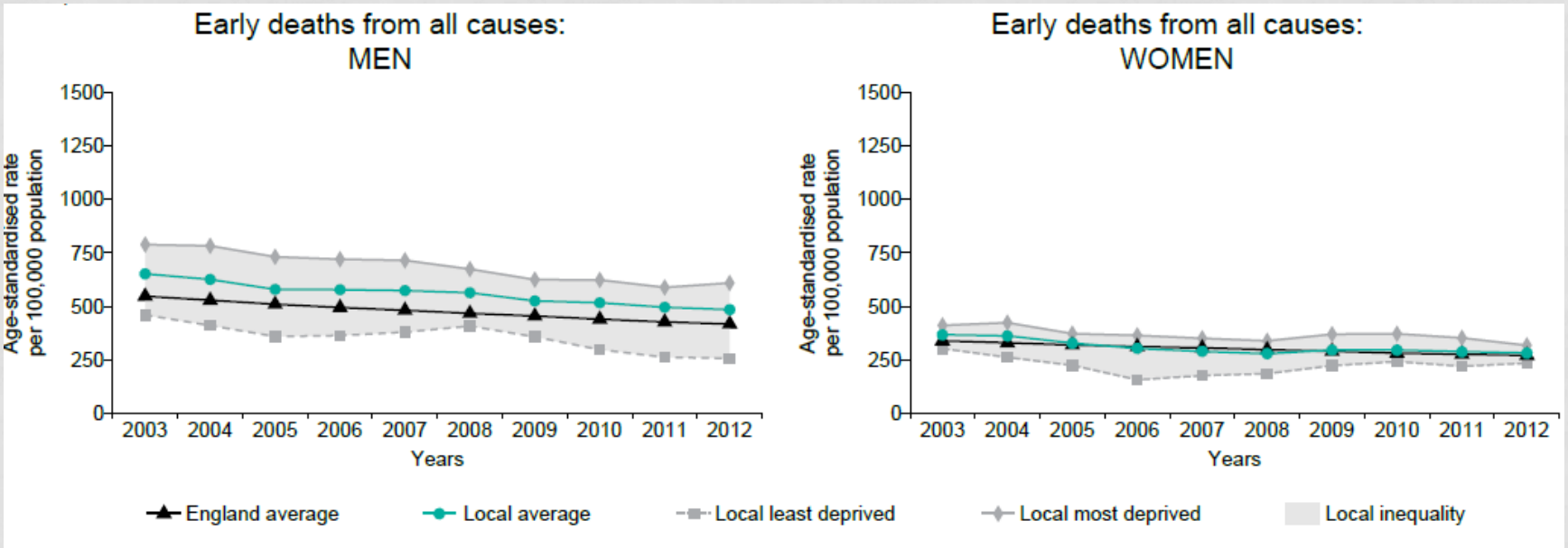
DEPRIVATION





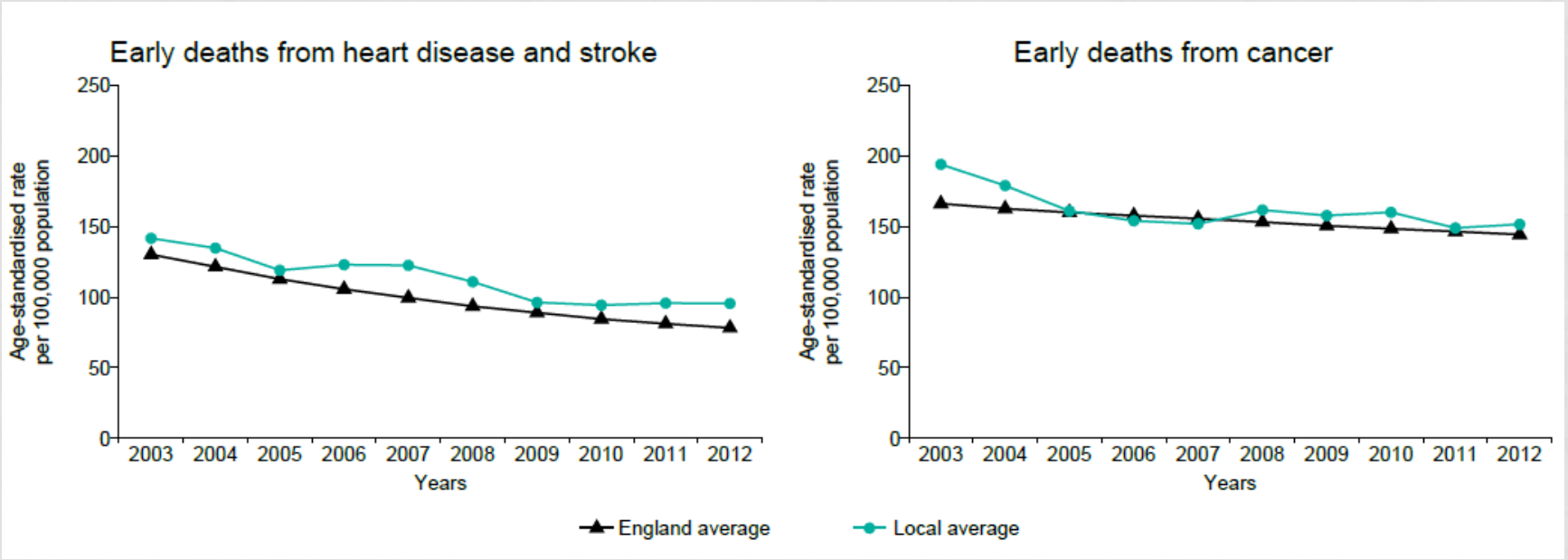
Source: PHE Public Health Profiles 2015

HEALTH INEQUALITIES – TRENDS (I)



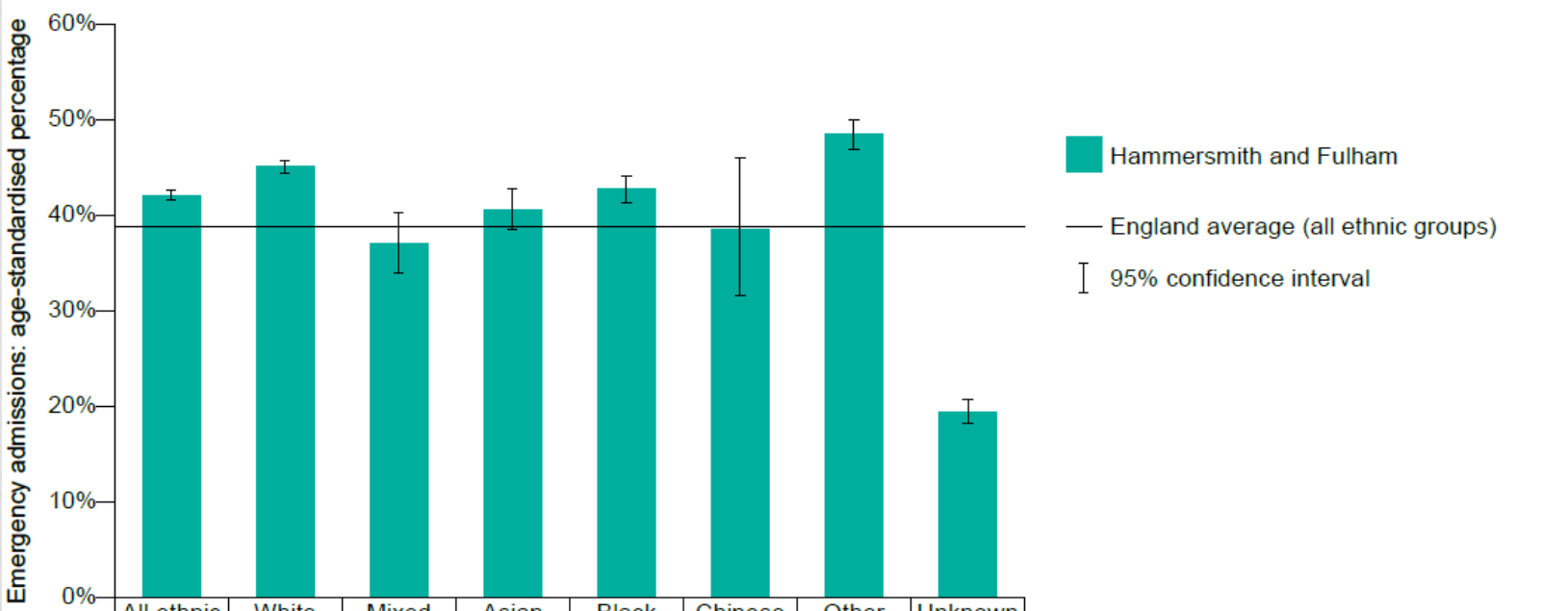
Source: PHE Public Health Profiles 20

HEALTH INEQUALITIES – TRENDS (II)



Source: PHE Public Health Profiles 20

HEALTH INEQUALITIES – ETHNICITY



All ethnic groups	White	Mixed	Asian	Black	Chinese	Other	Unknown	
16,540	10,386	352	833	2,155	66	1,976	772	Local number of emergency admissions
42.1	45.1	37.1	40.6	42.8	38.6	48.5	19.5	Local value %
38.8	39.2	38.3	43.0	42.5	35.2	44.9	30.1	England value %

Percentage of hospital admissions that were emergencies, by ethnic group, 2013

Source: PHE Public Health Profiles 20

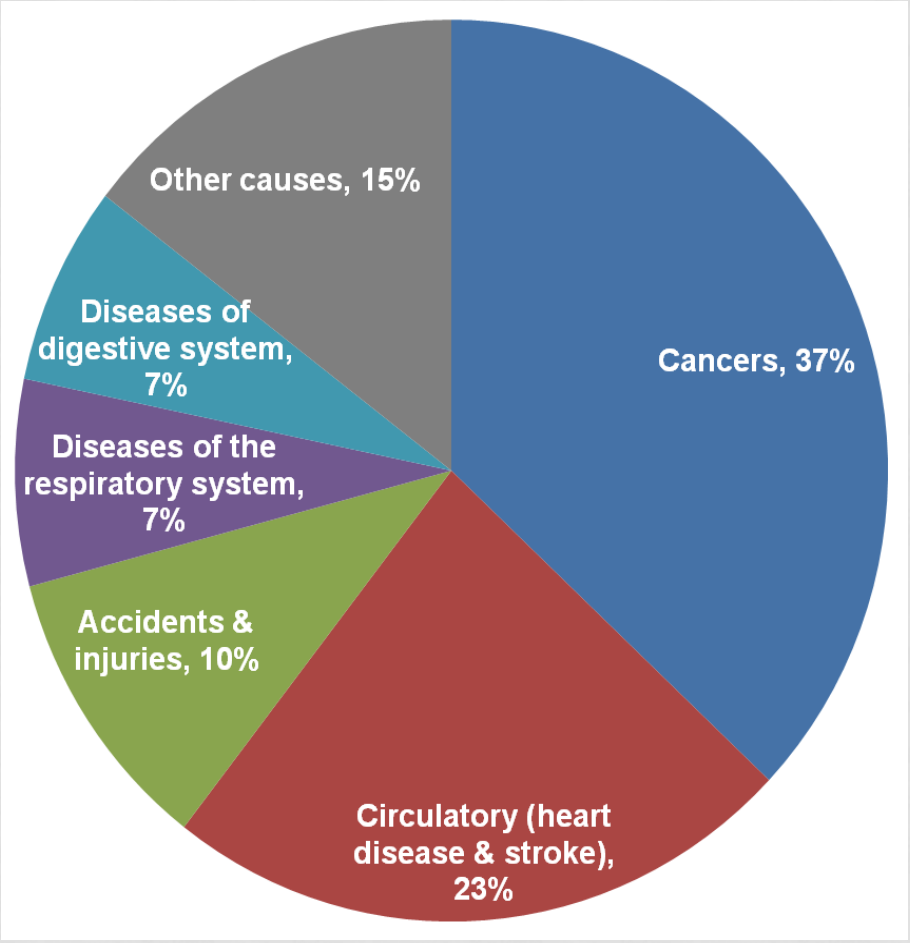
Socio-economic status	Health status	Healthcare access & quality
What do we know nationally?	For lower socioeconomic status: •Inequality in terms of life expectancy. • Much greater burden of chronic disease • More likely to smoke and less likely to eat fruit & vegetables or take regular exercise • Higher levels of common mental illness	• More frequent use of healthcare services (partly due to poorer health) • More likely to use A&E over GP, compared to more affluent groups • Greater 'did not attend' rates
What do we know in H&F?	• Large inequality in terms of life expectancy. See previous chart • Much greater burden of chronic disease • More likely to smoke and less likely to eat fruit & vegetables or take regular exercise (based on Major Health Campaign in Westminster)	• Evidence of 'inverse care law' in the past, where poorer quality services are located in poorer areas. No longer necessarily an issue • Greater 'did not attend' rates

HOUSING

- A third of people (34%) live in **private rented** housing – the 5th highest in London – and a similar proportion (35%) are **owner occupiers** – the 8th lowest in London. Just under a third (30%) live in **social housing**, which is more than is typical of London.
- Thirty eight per cent of households are **one person households**, higher than nationally. One in 10 households (8.8%) is a lone pensioner household, lower than London (9.6%) and England. Almost half (43%) of older people live alone, carrying a risk of social isolation.
- Pressure on social housing stock and property prices in London has resulted in **overcrowding**, particularly among families. Across all tenures, a similar proportion of households (13%) are considered to be overcrowded, compared to London (12%).

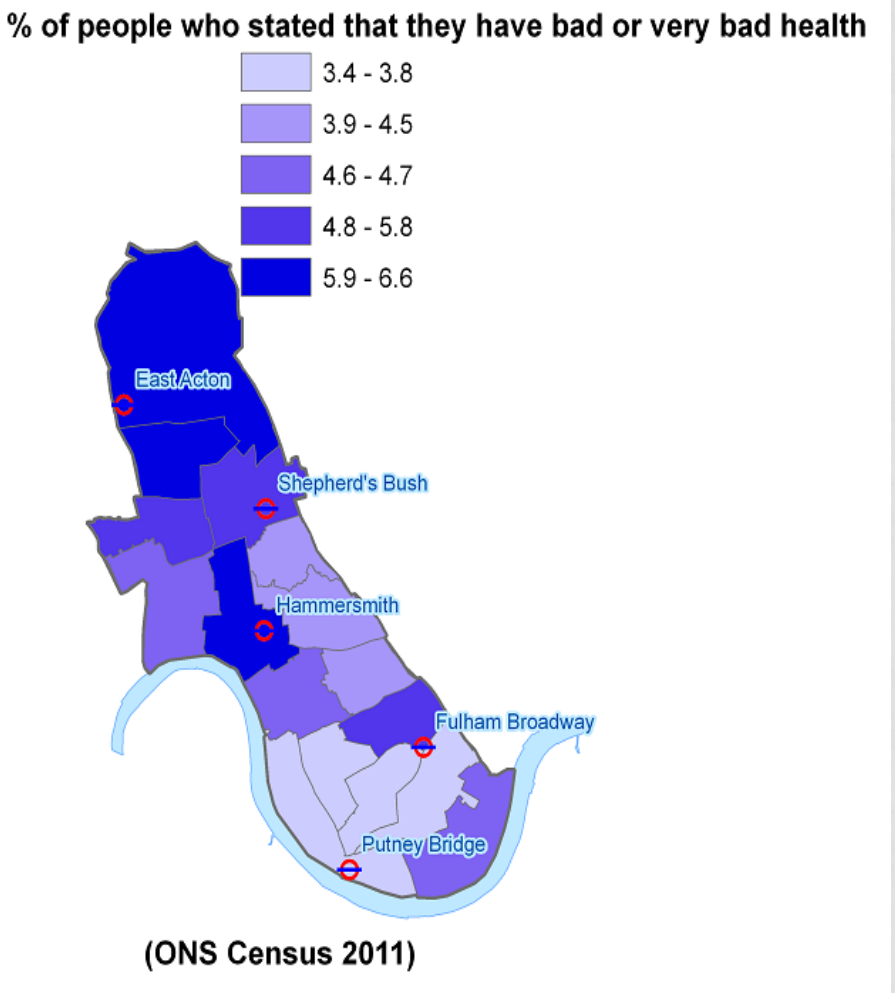
PATTERNS OF ILL HEALTH

- The principle cause of premature death in Hammersmith and Fulham is cancer, followed by cardiovascular disease (CVD) (which includes heart disease and stroke). A significant number of people also die from respiratory disease. Accidents and injuries are most common among younger residents. This is pattern is broadly similar to the rest of the country.



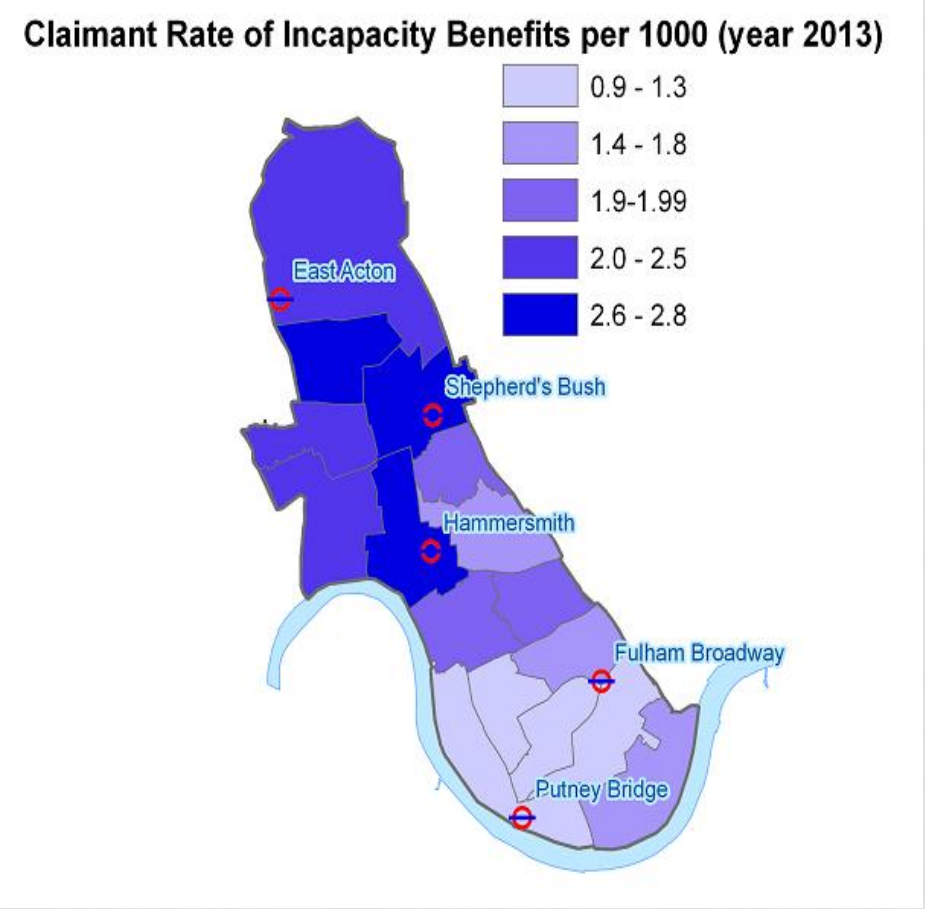
VULNERABLE GROUPS IN LONDON BOROUGH OF HAMMERSMITH AND FULHAM

- The overall premature (under 75) death rate higher than London and England and Shepherd's Bush Green, Askew, and Hammersmith Broadway wards fall within the 20% worst wards in London, with around 7-11 more early deaths a year than is typical for London. Furthermore, residents in those wards have stated that their health is either bad or very bad in the last census



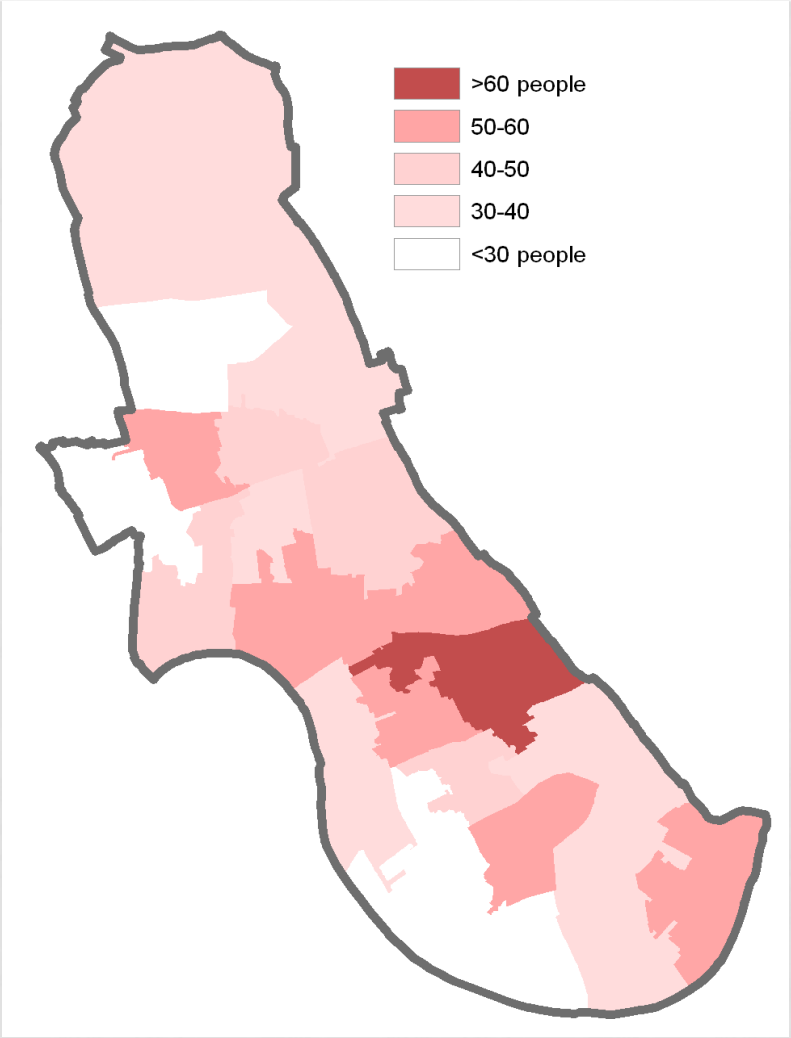
SERIOUS MENTAL ILLNESSES

- There are currently 2,395 patients in the borough on a GP register for severe and enduring mental illness (e.g. schizophrenia), the 8th highest in the country. These patients are spread relatively uniformly throughout the borough. Incapacity benefit claimant rates due to mental health and other medical reasons are high in Shepherd's Bush, Wormholt & White City and Hammersmith Broadway



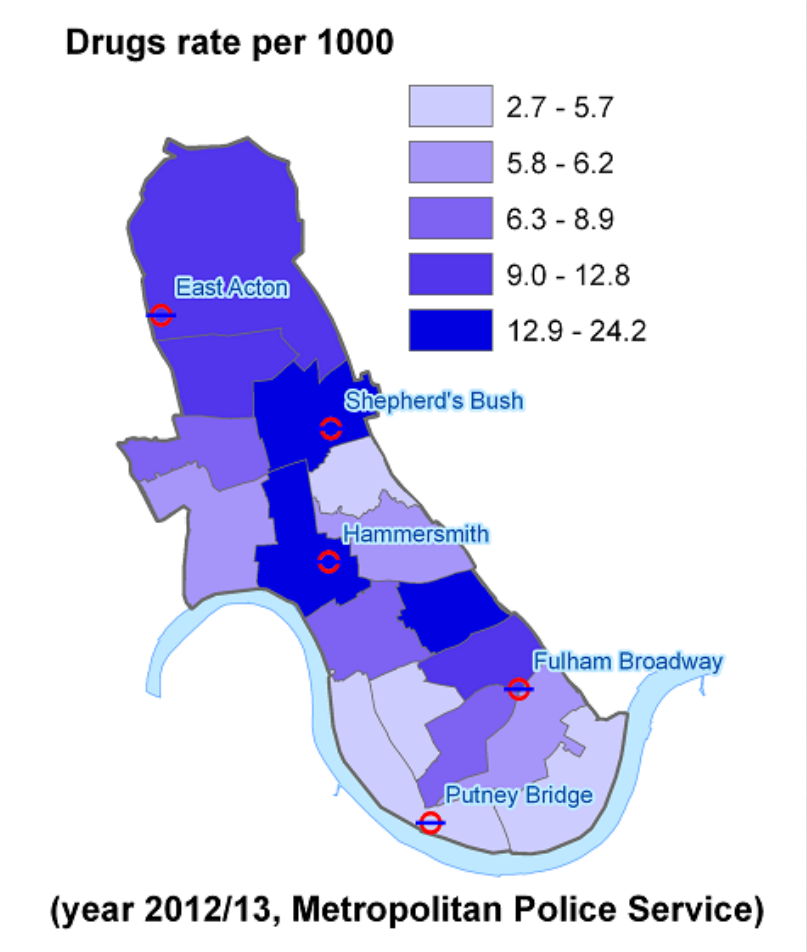
HIV

- There are currently 1,051 residents in Hammersmith and Fulham diagnosed with HIV, the 7th highest rate aged 15-59 in the country, with a higher proportion of cases contracted via sex between men.
- 19% of cases were diagnosed late, compared to the London average of 27%. Late diagnosis carries with it increased risk of poor health and death and increases chances of onward transmission.
- High rates of HIV/ AIDs patients known to services are residing in North End ward



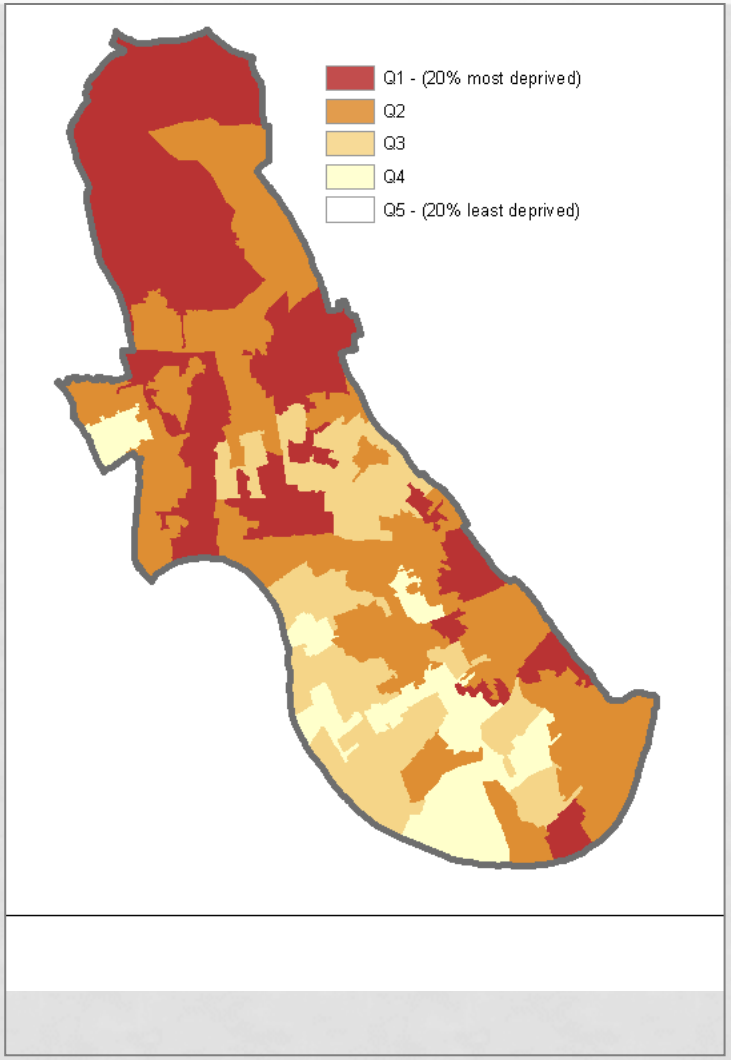
PROBLEM DRUG USERS

- The estimated number of problem drug users in Hammersmith and Fulham was 1,450, a rate of 11.5 per 1,000 population aged 15-64, the 9th highest rate in London. The cost to society of crimes associated with problem drug use in the borough may be as much as £60 million, (based on national estimates from the Home Office).Drugs offence rate per 1000 is high among Shepherd's Bush, Hammersmith Broadway and North End wards

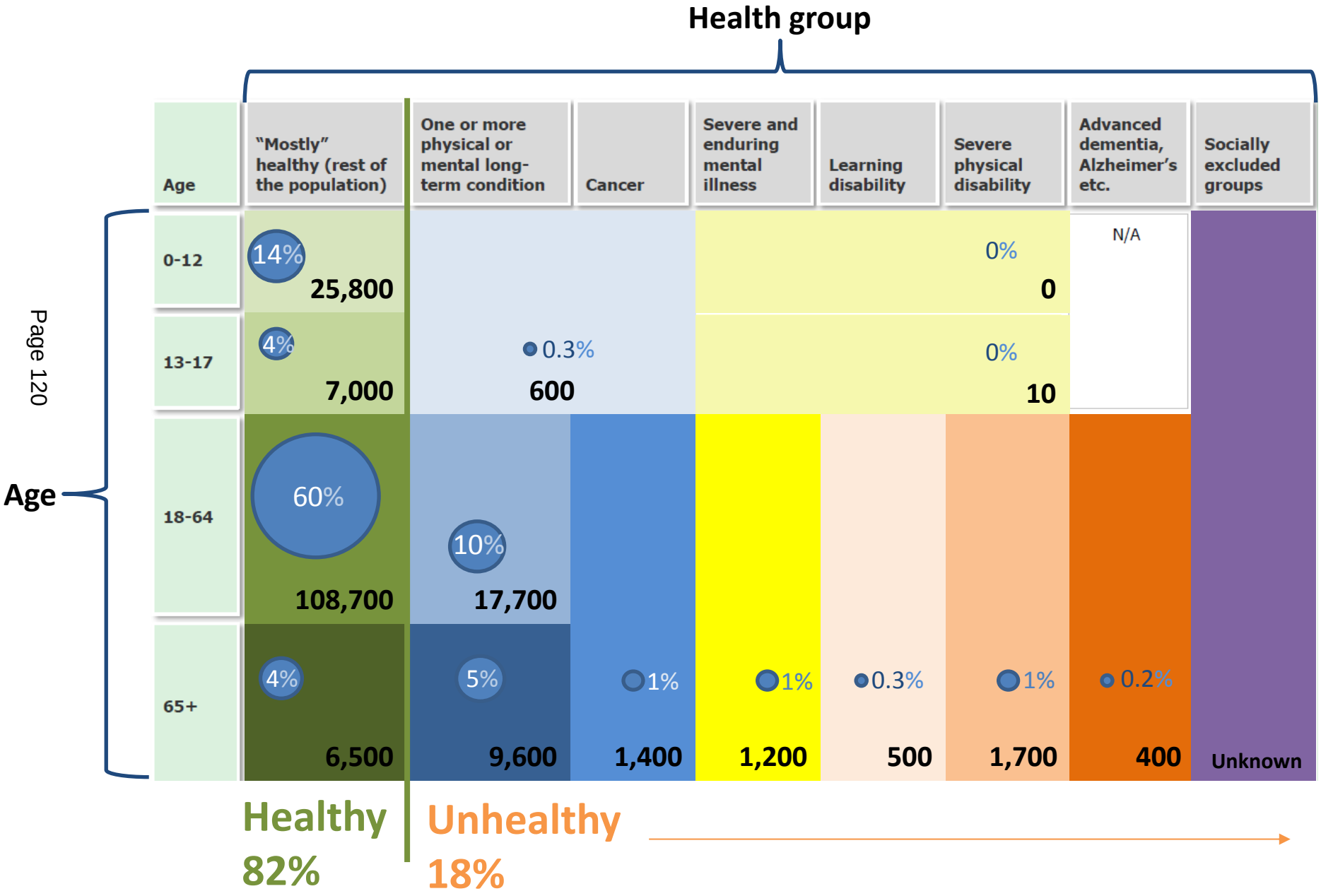


DEPRIVATION

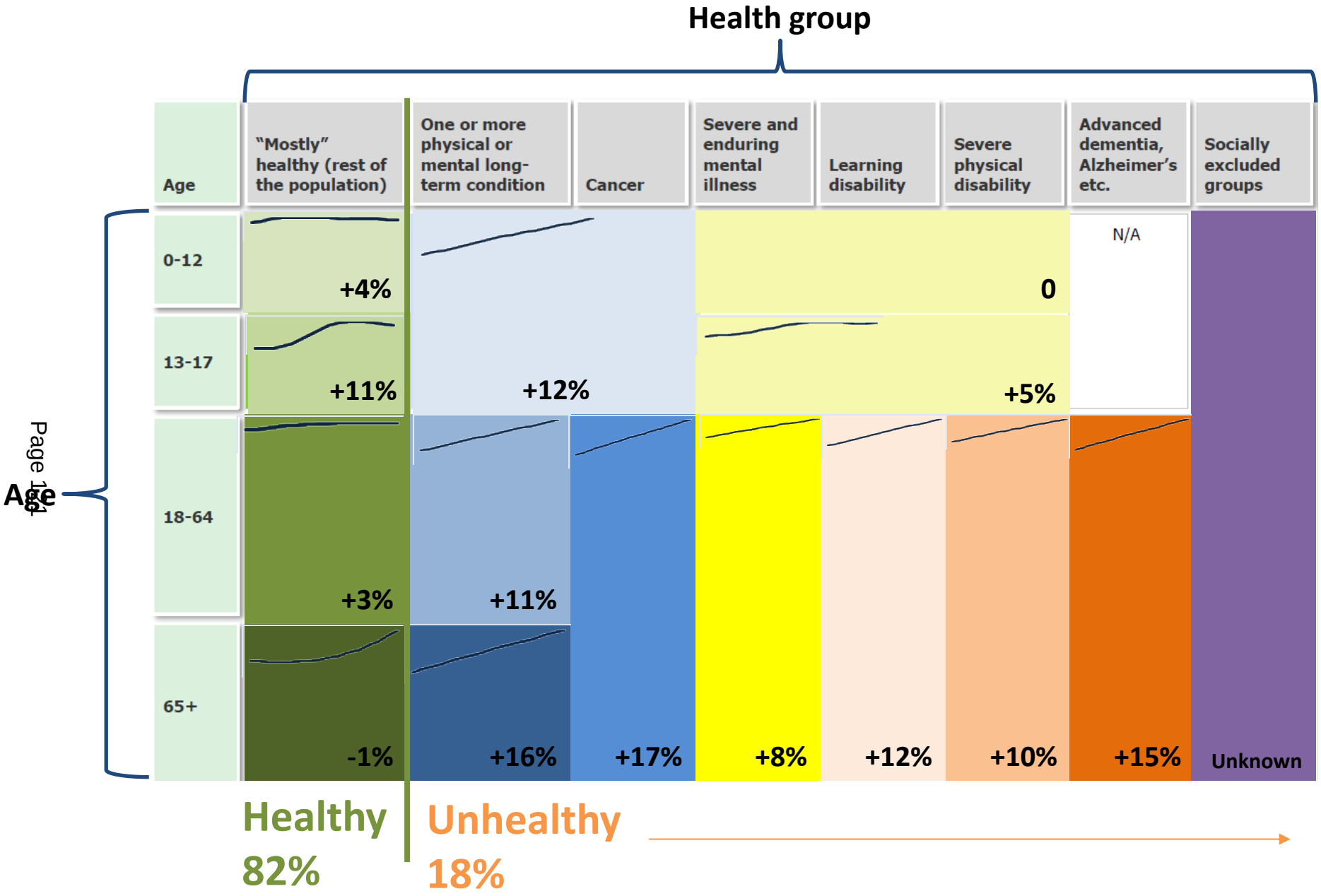
- Hammersmith and Fulham was classified as the 55th most deprived borough in the country according to the index of multiple **deprivation**, which is based on a range of economic, social and housing indicators. Pockets of deprivation are spread throughout the borough but are particularly focussed in the north of the borough. These areas usually correspond to areas of social housing and poorer than average health.
- A third of children under 16 (29%) live in **poverty** according to official definitions, which is higher than London and England. The **Job Seekers Allowance** rate in H&F are similar to London (3.1%) and Great Britain (2.9%), but rates are almost double this in areas such as College Park & Old Oak and Wormholt & White City.



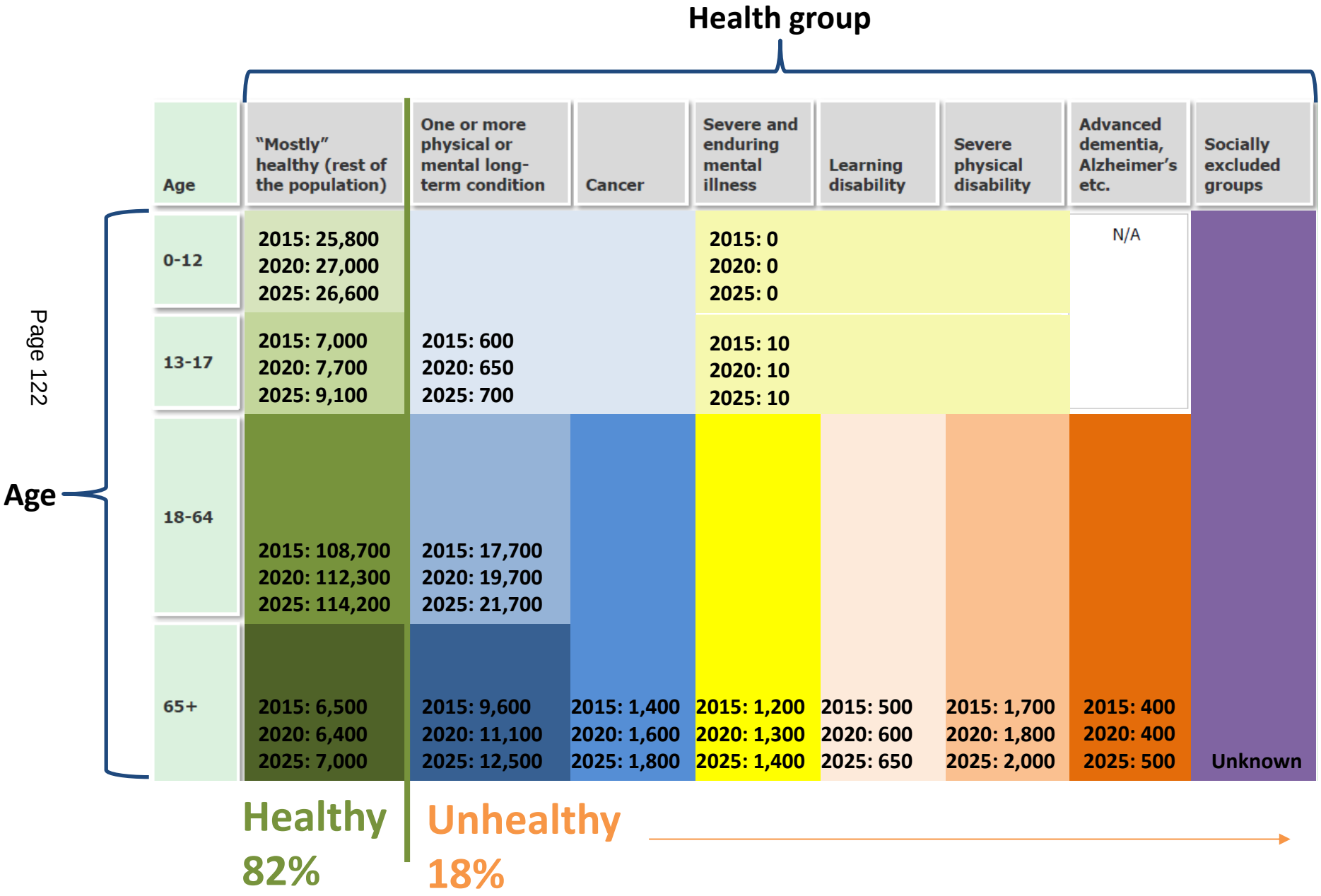
Number and percentage of the population in each group, LBHF 2015



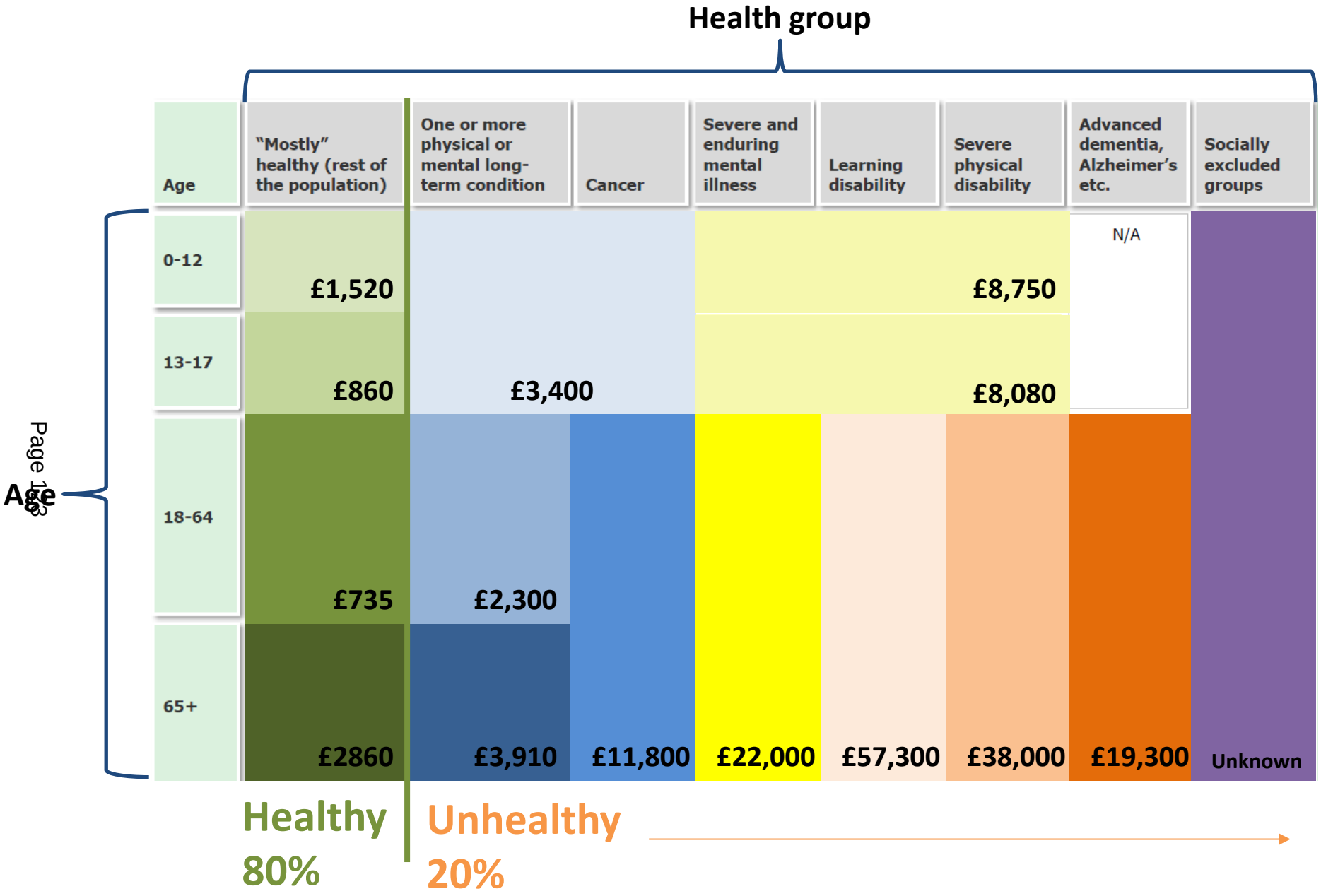
Percentage change in the number in each group and trend, LBHF 2015 - 2025



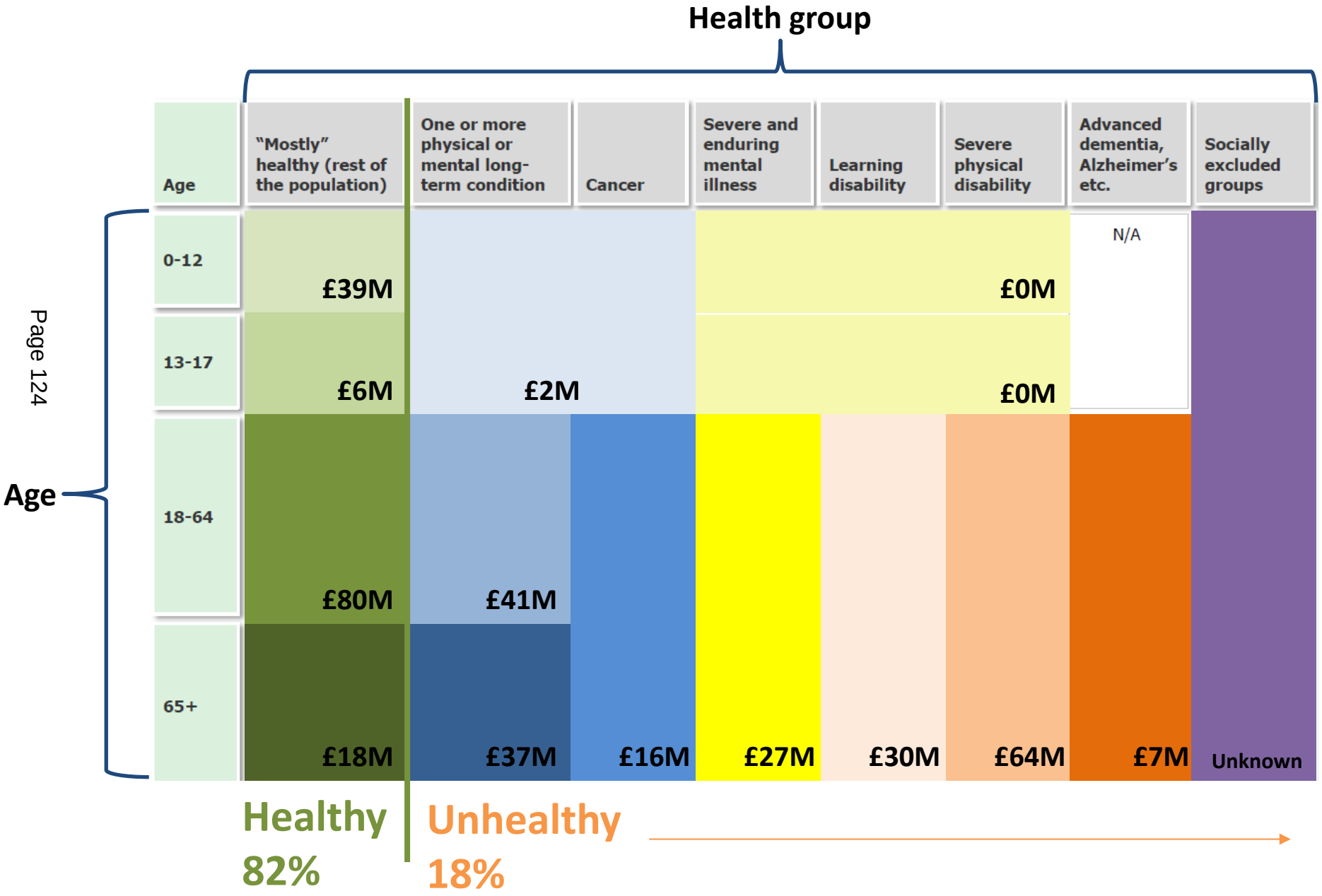
Number in each group, LBHF 2015 - 2025



Average annual cost of health care services per person in each group, London 2012/13



Total annual cost of health care services in each group in millions , LBHF 2015



CHANGING PATTERNS OF NEED

Child obesity in Hammersmith and Fulham state primary schools has been consistently higher than nationally for Year 6 pupils (aged 10-11) over a period of time. These higher rates may in part be a result of physical inactivity and poor diet, which is also reflected in poorer than average levels of tooth decay locally. In 2010/11, 158 children in reception and 275 children in year 6 were found to be at risk of obesity (BMI 95th percentile) and 99 and 188 were classified as clinically obese (BMI 98th percentile). 10% of the borough's primary school children live outside the borough.

Alcohol-related harm is an increasing public health issue and Hammersmith and Fulham is an 'outlier': it has more hospital admissions for alcohol-related and specific harm (e.g. liver disease) and alcohol-related crimes than the national average. Over the last decade, alcohol-related admissions have more than doubled, faster than nationally. 'Hotspots' for alcohol-related admissions include the White City and Shepherd's Bush area.

The number of older people is expected to rise considerably over the next two decades. Although the rise experienced locally may not be as substantial as the rise nationally, it will nevertheless have a dramatic impact on demand for services. At the same time, the number of those providing unpaid care in Hammersmith and Fulham was the 4th lowest in the country in 2001.

Illnesses such as dementia, primarily prevalent among very old populations, will become increasingly commonplace. Currently, there are likely to be around 1,250 patients in Hammersmith and Fulham with dementia. By 2025, there are likely to be in the region of 1,500 patients. Earlier diagnosis of dementia is associated with delayed admission to nursing care.

PROJECTIONS OF PREVALENCE OF SELECTED DISEASES IN H&F

Year	CMD	CVD	COPD	Dementia	Hypertension	Cancer
2015	25,464	13,259	5,807	1,249	36,841	4,659
2020	25,576	13,900	6,088	1,386	38,665	5,392
2025	25,847	14,733	6,409	1,579	40,661	6,316
2030	26,310	15,744	6,803	1,817	43,024	7,446

CMD= Common Mental Disorders
CVD= Cardiovascular Diseases
COPD= Chronic Obstructive Pulmonary Disorder

London Borough of Hammersmith & Fulham **HEALTH & WELLBEING BOARD** **21 March 2016**	
LIKE MINDED – UPDATE ON THE TRANSFORMING CARE PARTNERSHIP PLAN FOR PEOPLE WITH A LEARNING DISABILITY AND/OR AND CHALLENGING BEHAVIOUR	
Report of the Acting Deputy Director, Mental Health, Strategy & Transformation, NWL Collaboration of CCGs	
Open Report	
Classification - For Decision **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: Matt Hannant, Director Strategy & Transformation (Acting), NW London Collaboration of CCGs	
Report Author: Jane Wheeler, Acting Deputy Director, Mental Health, Strategy & Transformation, NWL Collaboration of CCGs	**Contact Details:** **Tel:** 07875 429320 **E-mail:** jane.wheeler2@nhs.net

1. EXECUTIVE SUMMARY

To provide an update to the HWBB on progress made to date within the North West London 'Transforming Care Partnership Plan'. We welcome and value your on-going input into this programme of work.

Attached to this cover sheet is information on the development of a Hammersmith and Fulham and the North West London Transforming Care Partnership Plan for people with learning disabilities, autism and challenging behaviour. These reports are for noting and comment. The HWBB is also asked to comment on the next steps for the plan's formal approved prior to submission to NHS England which is likely to be the 11th April.

2. RECOMMENDATIONS

It is recommended that the Board is:

2.1 To endorse the first draft North West London Transforming Care Partnership plan noting that further updates will be make to address the areas of underdevelopment;

2.2 To delegate authority to the relevant committee to approve the final local and NWL Transforming Care Partnership plan in order for this to be submitted to NHS England on 11th April 2016.

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

3. REASONS FOR DECISION

Guidance issued late in December 2015 includes planning guidance, a TCP plan template, and a financial template. These will require LAs and CCGs to work jointly and for there to be an agreement about sign-off.

4. INTRODUCTION AND BACKGROUND

In October 2015 NHS England, the Local Government Association and the Association of Directors of Adult Social Services published 'Building the right support'; this set out the national plan and the financial framework to support the closure of inpatient settings and develop community based services for people with a learning disability and/or autism with challenging behaviours and mental health conditions.

On 17th November, Jane Cummings wrote to all Clinical Commissioning Group Accountable Officers, Local Authority Directors of Adult Social Services and NHS England Regional Directors to suggest that NWL work collaboratively to form a single TCP. The letter included key actions and milestones to be achieved by each TCP, which are essential to ensure effective delivery of phase 1 of the mobilisation programme:

- Agree governance arrangements
- Appoint Senior Responsible Officer
- First Transforming Care Partnership Board meeting
- First cut of the Transforming Care Partnership plan submitted by the 8th February
- Final agreed Transforming Care Partnership plan to be submitted by 11th April

The first draft North West London Transforming Care Partnership plan with the local borough annexes was submitted to NHS England on the 8th February.

In developing the overarching North West London Transforming Care Plan, we have been working closely with the local learning disabilities joint commissioners in Hammersmith & Fulham. This collaboration is to ensure that there is alignment between the local plans and the overarching North West London.

Locally for Hammersmith & Fulham we want our Transforming Care Plan to help us to develop a model of care that will ensure that people with Learning Disabilities and/or Autism are able to live life with the same access to opportunities that any other member of our community is able to access. This will mean that individuals and their families are part of the decision making of where they live and what support they will access to live a meaningful and productive life.

We want this cohort to have:

- An opportunity to learn
- Appropriate employment or volunteering opportunities that may lead to work
- Choice and control
- A home to call their own
- Community participation
- A sense of being part of the local community
- Manage their health with the level and quality of support that they need

Our North West London plan builds on the progress already made in each borough and across NWL we are aligned on our plans to commission:

- **Community support** including the utilisation of more skilled staff to manage more complex/challenging behaviour
- Tailored **local housing options** for people with a learning disabilities and/or autism
- **Respite services** for families and carers, regardless of the age of person being cared for.
- **Crisis care**, available 24 hours a day 7 days a week that ensures that people with a learning disability and/or autism receive care and support that meets their needs in time of crisis
- An **all ages** service that removed the need to transition between children and adult services
- NWL service for people with **a forensic history** or Asperger's to provide the specialised psychological support required and manage the smaller number of cases over a larger geographical area
- **Co-ordinated** care across the health and social care pathways.

We will continue to develop the NWL plan building on our initial draft, addressing the areas which require in depth modelling, responding to NHS England feedback which was received on the 15th February and strengthening our implementation plans.

5. PROPOSAL AND ISSUES

The commissioning of support services for people with Learning Disability in Hammersmith & Fulham is governed by robust Section 75 arrangements.
The current provision does not always produce the best outcomes for this cohort and we need to "flex" our local offer to meet the changing needs of people currently using inpatient services.

We also intend to consider the needs of children and young people currently engaged (or needing to engage) with our CAMHS and residential educational placements, to ensure that our plan reflects future needs and assists us in meeting our target of reduced educational residential placements and future inpatient numbers that are avoidable.

We understand that a range of approaches will be required to meet the diverse needs of this cohort and this may include some short term intensive support and interventions in an inpatient setting, we expect that in the future this will be the exception and most people will have their physical and mental health needs met in the local community.

Further details are given in the full report below.

6. OPTIONS AND ANALYSIS OF OPTIONS

In Hammersmith & Fulham we want our Transforming Care Plan to help us to develop a model of care that will ensure that people with Learning Disabilities and/or Autism are able to live life with the same access to opportunities that any other member of our community is able to access. This will mean that individuals and their families are part of the decision making of where they live and what support they will access to live a meaningful and productive life.

NHS England feedback on the Transforming Care Partnership Plan was received on 18th February and was largely positive; it was felt it was a very strong submission which acknowledged areas for development, and further clarity will be given at the assurance meeting on 26th February. It was agreed that there were certain areas of the plan that we will continue to develop ready for final submission on 11th April.

Both Hammersmith & Fulham and our NWL Transforming Care Partnership plan builds on the progress already made in each of the boroughs; it brings together the best practices to share the learning and where it makes sense bring together resources, capabilities and expertise to develop collaborative solutions where there is agreement to alignment. Where there are differences and local nuances, these are outlined in each borough's local plans.

We will continue to develop the local and NWL wide Transforming Care Partnership plan to address some of areas of underdevelopment including estates, financial and activity modelling and implementation planning.

7. CONSULTATION

With Hammersmith & Fulham, there are arrangements in place with providers through existing mechanisms such as our Learning Disability Health Steering Group (LDHSG), Learning Disability Partnership Board (LDPB) and Learning Disability Executive Board (LDEB) which are all Tri-Borough.

In addition to this there is an Autism Partnership Board (APB) that includes people on the Autistic Spectrum who do not have a Learning Disability, which is also Tri-Borough.

Locally H&F has utilised the following meetings and forum's to engage a range of stakeholders including professionals, VCS, service users & carers in the development of their learning disability service developments:

- LD Partnership Board (next meeting in May)
- LD Executive board
- LD Health Steering Group
- Carers Partnership board
- Safeguarding Board
- Local offer group
- Preparation for Adulthood Steering Group
- Green Light toolkit meetings
- Accessible Mental health awareness events

Mary Dalton Head of Complex Needs Commissioning Tri borough Adult Social Care and Peter Beard, Senior Commissioning Officer Learning Disabilities and have been instrumental in developing the local and NWL Plan.

8. EQUALITY IMPLICATIONS

Tackling inequalities between individuals and communities is a theme throughout the entire Like Minded programme, as is the challenge to achieve parity of esteem between physical and mental health issues.

9. LEGAL IMPLICATIONS

None currently identified - we are finalising the overall model and assumptions underpinning the Transforming Care Partnership plan and this will be finalised and agreed in line with the delegated authority to approve the local and North West London plan.

10. FINANCIAL AND RESOURCES IMPLICATIONS

We are currently finalising the overall financial model and assumptions underpinning the Transforming Care Partnership plan and this will be finalised and agreed in line with the delegated authority to approve the local and North West London plan.

11. RISK MANAGEMENT

Risk	Mitigating actions
Not delegating authority for H&F approval of the NWL Transforming Care Partnership Plan would result in a lack of governance across NWL and may therefore result in this plan	H&F HWBB to identify appropriate sign off procedures for the Transforming Care Partnership Plan and delegate authority.

not receiving assurance from NHSE.	

12. PROCUREMENT AND IT STRATEGY IMPLICATIONS

None currently identified - we are finalising the overall model and assumptions underpinning the Transforming Care Partnership plan and this will be finalised and agreed in line with the delegated authority to approve the local and North West London plan.

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

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

LIST OF APPENDICES:

Appendix 1: Draft North West London Transforming Care Plan

1. North West London Whole Systems Mental Health & Wellbeing: Transforming Care Partnership Plan

Author(s): Kirsten Owen, Peter Beard, Mary Dalton

2.1 Background

In October 2015 NHS England, the Local Government Association and the Association of Directors of Adult Social Services published '***Building the Right Support.***' This set out the national plan and the financial framework to support the closure of inpatient settings and develop community based services for people with a learning disability and/or autism with challenging behaviours and mental health conditions.

Alongside the national implementation plan a '***service model'*** for commissioners of health and social care services was published. This builds on the previous Winterbourne View Concordat work that has been undertaken across the country. The overarching outcomes of work are:

- Reduced reliance on inpatient services, closing hospital services and strengthening support in the community
- Improved quality of life for people in inpatient and community settings
- Improved quality of care for people in inpatient and community settings.

The proposed outcome for the local interpretation of the national service model plan is to build up community capacity to support the most complex individuals in a community setting and avoid inappropriate hospital admissions.

'Building the right support' and the new '***service model'*** asks Local Authorities (LAs) and Clinical Commissioning Groups (CCGs) to come together to form Transforming Care Partnerships (TCPs) to develop community services and close inpatient provision over the next 3 years.

To support local areas with transitional costs, NHS England will make availability nationally up to £30million of transformation funding over three years with national funding conditional on *match-funding* from local commissioners. In addition to this, £15million capital funding will be made available over 3 years.

Locally in North West London (NWL), in November 2015, there was a well-attended North West London Learning Disabilities workshop with 76 attendees. The aim of the workshop was to explore ways to improve mental health services for people with a learning disability in North West London and increase knowledge and understanding of the wider mental health transformation programme, the NWL Like Minded Programme and the links to:

- Crisis Care;
- IAPT (psychological therapies);
- Perinatal mental health;
- Children and Young People's Mental Health Services (CAMHS)

2.2 Introduction

This report describes the role of NWL Transforming Care Partnership and its role in producing, developing, and implementing a regional plan to deliver against the national ambition to transform local services.

The output from the Kingswood workshop was an agreed action plan which will deliver change and improvement to ensure that people with learning disabilities in need of very specialist mental health services will get the support that they need. Additionally the workshop informed the emerging thinking about what is needed to support those with a learning disability and a forensic background to live safely in the community. This thinking has informed the development of our Transforming Care Plan.

The Hammersmith and Fulham Transforming Care Partnership Plan will focus on a local response and will consider what we can realistically achieve within our own capacity. The NWL Transforming Care Partnership will focus on specialist support (e.g. community forensic services), and support that cannot realistically be commissioned on a local basis. We have collaborated with all eight CCGs and LAs in the development of the NWL Transforming Care Partnership Plan.

The local Hammersmith and Fulham interpretation of the National Service Model plan has been attached to this paper and was submitted as an initial draft with the overarching NWL Transforming Care Partnership Plan to NHS England on 8th February 2016.

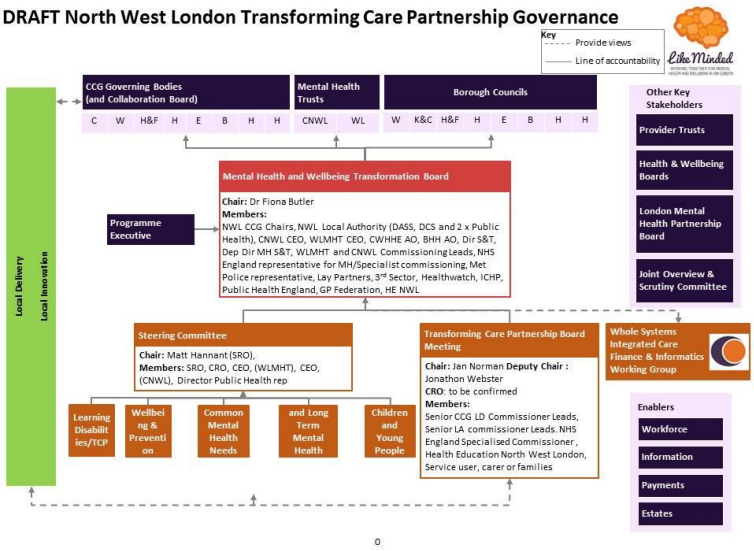
The plans will be scrutinised and an opportunity provided for amendments. A final plan will be submitted to NHS England in April 2016 and implementation will commence in April 2016.

2.4 North West London Transforming Care Partnership Board

The proposed foot print of the NWL Transforming Care Partnership was identified by NHS England and this partnership is consistent with the larger health transformation programme of “shaping a healthier future”.

The purpose of the Transforming Care Partnership Board is to ensure that within North West London there is collaboration on a single NWL wide plan to transform services for individuals with a learning disability and/or autism with challenging behaviours and mental health conditions who reside in the boroughs that make up NWL; Brent, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow, Kensington and Chelsea and Westminster.

The Transforming Care Partnership Board is chaired by the Senior Responsible Owner (SRO) Jan Norman Director of Quality and Safety for Brent, Harrow and Hillingdon Federation of CCGs. The deputy SRO is Jonathan Webster, Director of Quality and Safety for Central London, West London, Hammersmith and Fulham, Hounslow and Ealing CCGs.



The Transforming Care Partnership reports to the NWL Mental Health and Wellbeing Transformation Board which has senior executive and clinical leads from key partner organisations including representatives from West London Alliance, from Directors of Adult Services, Director of Children's Services and Directors of Public Health. Whilst it is acknowledged that Learning Disabilities is different to Mental Health, it was considered that the membership of the NWL Mental Health and Wellbeing Transformation Board would provide the right level of authority and governance for the Transforming Care Partnership.

2.4 Local Transforming Care Partnership Plan

London Borough of Hammersmith and Fulham (LBHF) and Hammersmith and Fulham Clinical Commissioning Group (HF CCG) are committed to the principles of ensuring people with a learning disability and/or autism have the same opportunities as other borough residents to be active residents that are supported within Hammersmith & Fulham to live full and rewarding lives.

Governance

LBHF and HF CCG have arrangements in place with Housing, providers through existing mechanisms such as our Learning Disability Health Steering Group (LDHSG), Learning Disability Partnership Board (LDPB) and Learning Disability Executive Board (LDEB).

In addition to this there is an Autism Partnership Board (APB) that includes people on the Autistic Spectrum who do not have a Learning Disability.

Stakeholder engagement

There has been engagement between LBHF, HF CCG Housing and a small number of family carers through the Boards identified in our Governance arrangements above, as well as ad hoc discussions with family carers who have raised the challenges that they face with mainstream general acute pathways outside of the Mental Health pathway. This includes the cohort with very complex health needs.

We have engaged with our Safeguarding Board which includes a wide range of providers across the health and social care economy and presented a progress report in relation to transforming care.

Current System

Within Hammersmith & Fulham; Queensmill School specialises in supporting pupils with autism. They provide satellite units and outreach support to other local schools. They are extending to provide post 19 education provision for young adults with autism.

The commissioning of support services for people with Learning Disability in Hammersmith and Fulham is governed by robust section 75 arrangements. The Learning Disability team is integrated with care management overseen by the Local Authority and clinical staff overseen by Central London Community Healthcare (CLCH) NHS Trust.

Support needs are identified through a holistic health and social care assessment and referred to appropriate support services within the team for specialist support via a wide range of clinical support including Nursing, Speech and Language Therapy, Physiotherapy, OT, Psychology and Psychiatry. A transition worker is embedded within the team and Learning Disability Nurses are involved in the assessment process.

The current provision does not always produce the best outcomes for this cohort and we need to "flex" our local offer to meet the changing needs of people currently using inpatient services.

We also intend to consider the needs of children and young people currently engaged (or needing to engage) with our CAMHS and residential educational placements, to ensure that our plan reflects future needs and assists us in meeting our target of reduced educational residential placements and future inpatient numbers that are avoidable.

We understand that a range of approaches will be required to meet the diverse needs of this cohort and this may include some short term intensive support and interventions in an inpatient setting, we expect that in the future this will be the exception and most people will have their physical and mental health needs met in the local community.

Aspiration

A model of care that will ensure that people with Learning Disabilities and/or autism are able to live life with the same access to opportunities that any other member of our community is able to access. This will mean that individuals and their families are part of the decision making of where they live and what support they will access to live a meaningful and productive life.

We want this cohort to have:

- An opportunity to learn
- Appropriate employment or volunteering opportunities that may lead to work
- Choice and control
- A home to call their own
- Community participation
- A sense of being part of the local community
- Opportunities to manage their health with the level and quality of support that they need in the community wherever possible
- Opportunities to avoid behaviours that will lead to the criminal justice pathway

For the Tri-Borough CAMHS there is currently a review being undertaken of the whole short break offer made to children, young people with disabilities and their families aged 0-18 across each of the three boroughs.

2.5 North West London Transforming Care Partnership Plan

NHS England feedback on the TCP was received on 18th February and was largely positive; it was felt it was a very strong submission which acknowledged areas for development, and further clarity will be given at the assurance meeting on 26th February. It was agreed that there were certain areas of the plan that we will continue to develop ready for final submission on 11th April.

At the date of submission of our first draft – 8th February 2016 - we are, as a system aware that our current plan does have a number of areas which we will continue to work on and develop over the next few months ahead of the final submission. We welcome the opportunity to receive feedback on our current plans to reshape services for people with a learning disability and/or autism away from institutional models of care and develop support in the community. Across North West London, there is agreement to continue to collaborate on knowledge sharing and working towards the same strategic vision rather than having a preconceived set solution in place to deliver care.

This plan contains a broad over-arching vision, developed through extensive discussion with the learning disability, disability, and mental health commissioning leads, housing teams, and finance colleagues in CCGs and Local Authorities across our 8 North West London boroughs. This builds on work at a local level to understand the views of service users and their families/carers

Our NWL Transforming Care Partnership plan builds on the progress already made in each of the boroughs; it brings together the best practices to share the learning and where it makes sense bring together resources, capabilities and expertise to develop collaborative solutions where there is agreement to alignment. Where there are differences and local nuances, these are outlined in each borough's local plans.

2.6 Next steps

We will continue to develop the H&F local and NWL wide Transforming Care Partnership plan to address some of areas of underdevelopment including estates, financial and activity modelling and implementation planning.

We will address any areas of feedback from this Board and address any areas of feedback from NHS England during the assurance process.

2.7 Recommendations

The HWBB is asked to:

- To endorse the first draft North West London Transforming Care Partnership plan noting that further updates will be make to address the areas of underdevelopment
- To delegate authority to the relevant committee to approve the final local and NWL Transforming Care Partnership plan in order for this to be submitted to NHS England which is likely to be on 11th April 2016.
- The final plans will come back to the HWBB in May. The plan will then be implemented from April 2016.

North West London Clinical Commissioning Groups and Local Authorities

Transforming Care Plan

In response to *Building the Right Support*

February 2016

Supported by Like Minded – The Mental Health and Wellbeing Strategy for North West London

Joint transformation planning template

Planning template – NORTH WEST LONDON

Executive Summary

This document sets out the vision of the North West London (NWL) Transforming Care Partnership (TCP) for improving the care and support available for the people of NWL with a learning disability and/or autism who also have, or are at risk of developing, a mental health condition or behaviours described as challenging. This is an all ages plan to address the needs of people with a learning disability, people with autism (including those with Asperger's syndrome) who do not also have a learning disability, and people with a learning disability and/or autism whose behaviour can lead to contact with the criminal justice system.

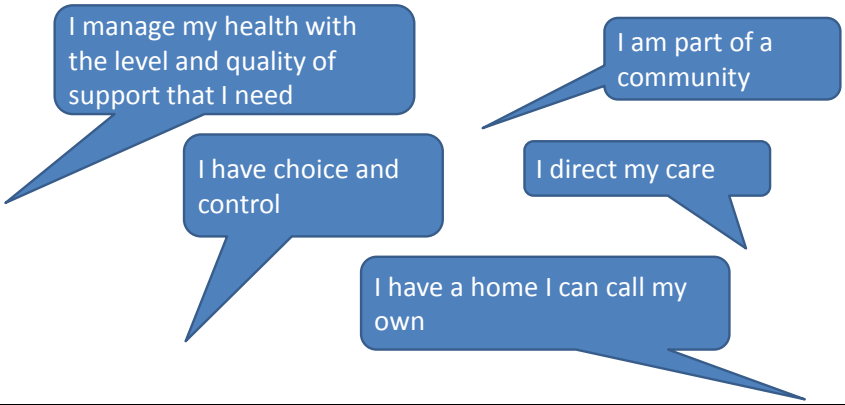
This draft plan provides a shared picture of:

- The North West London area
- The services currently commissioned and provided across our areas
- Our shared vision for how future services will be commissioned and provided
- What we need to change to achieve our vision and how we intend to do this

At the date of submission of our first draft – 8th February 2016 - we are, as a system aware that our current plan does have a number of areas which we will continue to work on and develop over the next few months ahead of the final submission on the 11th April. We welcome the opportunity to receive feedback on our current plans to reshape services for people with a learning disability and/or autism away from institutional models of care and develop support in the community. Across North West London, there is agreement to continue to collaborate on knowledge sharing and working towards the same strategic vision rather than having a preconceived set solution in place to deliver care.

This plan contains a broad over-arching vision, developed through extensive discussion with the learning disability, disability, and mental health commissioning leads, housing teams, and finance colleagues in CCGs and Local Authorities across our 8 North West London boroughs. This builds on work at a local level to understand the views of service users and their families/carers.

Our vision is that in North West London, people with a learning disability and/or autism and their families will be able to say:



We will achieve this vision by developing pathways and services that:

- Are community based where appropriate, with a reduced reliance on inpatient facilities;
- Have staff with the right skills and experience to manage complex cases, including managing the complexity of competing demands across health and social care;
- Provide respite for families and carers to maintain, wherever possible, at home placements and strong family relationships;
- House people with a learning disability and/or autism locally wherever possible and appropriate;
- Meet the needs of people of all ages – not defining support by age but instead responding to care and support needs and reducing the differences in services for children, young people and adults

These services and pathways will help us to achieve:

- Timely access to assessment and treatment for learning disability and/or autism;
- Reduced numbers of admissions to hospitals (both secure and non-secure), and shorter stays when admitted;
- Improved health and educational outcomes;
- Improved quality of life;
- Improved experience of services.

Our NWL plan builds on the progress already made in each of the boroughs; it brings together the best practices to share the learning and where it makes sense bring together resources, capabilities and expertise to develop collaborative solutions where there is agreement to alignment. Where there are differences and local nuances, these are outlined in each borough's local annex (attached to this plan). However across NWL we are aligned on our plans to commission:

- **Community support**, including the utilisation of more skilled staff to manage more complex/challenging behaviour. This may involve moving staff from inpatient facilities into community services, and vice versa, to share learning.
- Tailored **local housing options** for people with a learning disability and/or autism who have challenging needs. This will include short term housing options for people in crisis where there is a risk of placement breakdown.
- **Respite services** for families and carers, regardless of the age of the person being cared for. This will include short breaks, day centres, longer break provision and family support services.
- **Crisis care,** available 24 hours a day, 7 days a week that ensures that people with a learning disability and/or autism receive care and support that meets their needs in times of crisis, including when this crisis occurs outside of standard working hours.
- An **all ages service** that removes the need to transition between children and adult services.
- A NWL level **service for people with a forensic history** or Asperger's to provide the specialised psychological support required and manage the smaller number of cases over a larger geographical area.
- More services to support people with a learning disability and/or autism to access training, work experience, apprenticeships, and voluntary and paid employment.
- **Co-ordinated care** across the health and social care pathways, ensuring that primary care clinicians are involved in early identification and signposting, and all partners are engaged in on-going care and support.

In some areas it contains detailed proposals for how services will look different in the future but there is further work that will be required in a number of areas. In addition we know that it will take time to turn our vision in to reallty and that more detailed planning and clear measureable implementation plans will be needed. We have included within this document a more detailed plan of the next steps required and how we intend to agree the next level of detail.

Finally, as this is a draft plan the details contained in this document and appendices have been developed locally - but have not undergone a thorough assurance and governance process within each of the represented organisations. Further immediate assurance work is needed to test the finance assumptions and review of the finance in more detail. Equally there is immediate work to do on the implementation planning, for the April submission we will address the gaps in this draft of the document and ensure that the plan has been through the appropriate governance processes within North West London.

1. Mobilise communities

Governance and stakeholder arrangements

Describe the health and care economy covered by the plan

North West London Transforming Care Partnership covers all residents of North West London, and comprises eight CCGs and Local Authorities of: Brent, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow, Kensington and Chelsea and Westminster. The CCGs and Local authority boundaries are coterminous in 6 of our 8 boroughs. West London CCG covers the borough of Kensington and Chelsea, and the Queens Park and Paddington areas of Westminster. Central London CCG covers the remainder of Westminster. The geography covered by our Transforming Care Partnerships is shown in the diagram below:

Boroughs of NW London Transforming Care Partnership

To ensure an appropriate balance between economies of scale and the necessary local focus on the commissioning of health services, the eight CCGs manage their operations in two groups:

- BHH Federation of CCGs, covering the CCGs of Brent, Harrow and Hillingdon
- CWHHE Collaborative of CCGs, covering the CCGs of Central London, West London, Ealing, Hammersmith and Fulham and Hounslow.

NWL has four community health providers, two mental health trusts, and nine acute and specialist trusts. There are also a number of hospices, rehabilitation centres, residential care homes, and nursing homes. There are also a vast number of third and independent sector provided service.

The Kingswood Centre is an inpatient unit located in Brent that provides specialist learning disability service for people with acute mental health needs, autism and severe challenging behaviours, including forensic histories, and a recovery service. The majority of the CCGs spot purchase beds from Kingswood Centre; however Brent CCG has a contract with the Kingswood Centre.

There has been work undertaken in the last 6 months to review and develop a specification for the range of services provided by the Kingswood Centre with associated performance metrics and transparent pricing structure for the different aspects of the service.

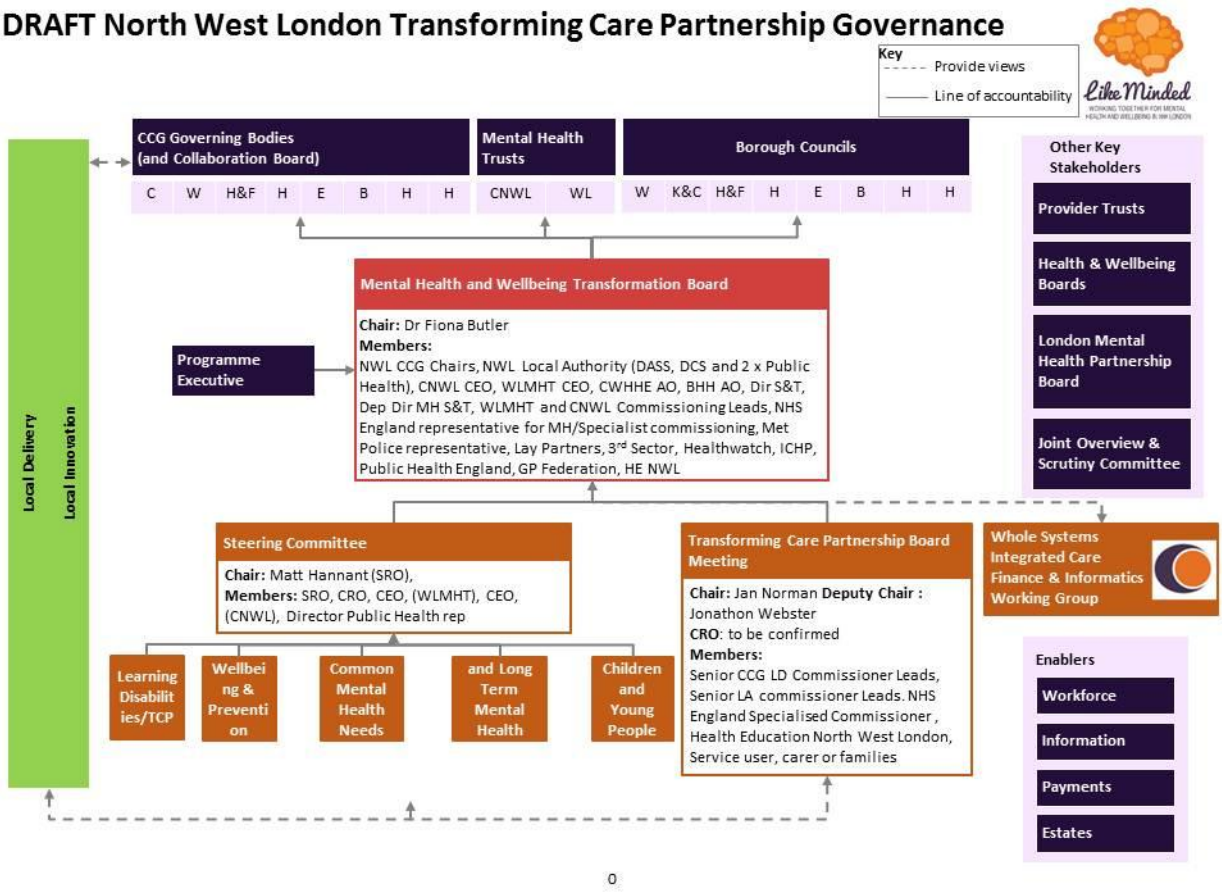
Out of area beds are commissioned by NWL CCGs on a case by case basis using spot purchase contracts, using a person centred, and needs-based approach.

There are a number of different approaches to collaborative commissioning arrangements; there are joint commissioning arrangements in place for Ealing, Hillingdon and Hounslow, and for the three boroughs of Hammersmith and Fulham, Kensington and Chelsea and Westminster with less formal relationships in Harrow. Brent CCG and Local Authority have just recently appointed a joint Leaning Disabilities commissioner.

This plan has been developed with considerable input from key representatives from our 8 North West London clinical commissioning groups (CCGs) and local authorities.

Describe governance arrangements for this transformation programme

The North West London Transforming Care Partnership Board provides leadership and assurance on the delivery of the TCP plan and will oversee progress of all the agreed work streams. The Transformation Board is chaired by the Senior Responsible Owner (SRO), Jan Norman, Director of Quality and Safety, Brent, Harrow and Hillingdon CCGs Federation. The Deputy SRO is Jonathan Webster, Director of Quality, Nursing and Patient Safety for Central London, West London, Hammersmith and Fulham, Hounslow and Ealing CCGs. Membership includes senior commissioning representation from learning disability, mental health, and children's commissioners from local authorities and CCGs.



In addition to the Partnership Board, a working group is being developed to drive implementation with fortnightly meetings scheduled. This will feed into the Partnership Board.

The NWL TCP Board is established as a strategic commissioning forum – with agreed routes for wider engagement across our provider base outside of the Board. The TCP Board reports to the NWL Mental Health and Wellbeing Transformation Board which has the senior executive and clinical leads from key partner organisations – including representatives from the West London Alliance from Directors of Adult Services, Directors of Children's Services and Directors of Public Health.

We welcome the membership of NHSE as a full partner and critical member of the Board.

Describe stakeholder engagement arrangements

In developing this plan, consultation has taken place with learning disability, disability, and mental health commissioning leads, housing teams, and finance colleagues in CCGs and Local Authorities across our 8 North West London boroughs. Meetings are on-going as we continue to develop our plans.

In November 2015 there was a well-attended North West London Learning Disabilities workshop with 76 attendees. The attendees included a user representative, representatives from Central North West London FT Learning Disabilities services. West London Mental Health Trust and from all the community learning disability services including LA and NHS

staff. CCG and Local Authority commissioners were also represented at the meeting alongside the quality and safeguarding leads and Health Education North West London.

The aim of the workshop was to explore ways to improve mental health services for people with a learning disability in North West London and increase knowledge and understanding of the wider mental health transformation programme, the NWL Like Minded Programme and the links to:

- Crisis Care; IAPT (psychological therapies); perinatal mental health; Children and Young People's Mental Health Services (CAMHS)

It also provided an opportunity for stakeholders to reflect on how the local Green Light Meetings can be used to take forward these improvements for people with a learning disability and mental health needs.

The workshop helped to identify the number and range of partners involved, from users and carers, commissioners from health and local authorities, the community providers of learning disabilities, mental health trust providers and the housing and community care providers.

The output from the workshop was an agreed action plan which will deliver change and improvement to ensure that people with learning disabilities in need of very specialist mental health services will get the support that they need. Additionally the workshop informed the emerging thinking about what is needed to support those with a learning disability and a forensic background to live safely in the community. This thinking has informed the development of our Transforming Care Plan.

In each of our boroughs, there are existing stakeholder engagement forums and groups, advocacy services and partnership boards that meet regularly and their feedback forms an important part of learning disability and/or autism service and pathway redesign. Before submission of our final plan in April, North West London colleagues will facilitate a number of workshops and events to co-produce this Transformation Plan. For now, the work done to date to influence our planning is outlined below.

Specific examples includes work during 2015 that Ealing and Hillingdon have both undertaken on consultations exercises with service users which highlighted a number of areas for development:

- Not knowing where to go for help
- First step is my GP – but they aren't always helpful
- My GP doesn't give me enough time to explain things, my appointment isn't long enough, I'm only allowed to talk about 1 issue at my appointment
- Being on the waiting list for counselling for a long time means things can change and get worse
- Not everyone can access all the services available
- Not being able to have a choice about where to meet for my support from CTPLD
- Not having a choice about what time I can meet
- Not having enough choice about what I can do in the day to help improve my mental health
- Staff don't always know how to best support someone with a learning disability, sometimes they see the way I am behaving as part of my learning disability, not a part of my mental health being bad
- I can't understand what is happening to me, people aren't explaining in a way that I can understand

- It makes things worse when I get ill as I find it all so overwhelming and difficult to understand what's going on
- I don't understand what my medication is for and why I should take it
- I was told I can't use Improving Access to Psychological Therapies (IAPT) because I have a learning disability – this is illegal and unfair

Within Hammersmith and Fulham, the Royal Borough of Kensington and Chelsea and Westminster, learning disability representatives of the joint partnership board have identified priority issues of health, housing, choice and control and transport. Within these broad themes key areas of importance to customers are: choice in housing; accessible communication to support decision making; person-centred planning and support; having a say in matching of support staff; employment and access to personal budgets.

A three borough market engagement event on 1st February shared these messages plus the need for skilled approaches to support positive outcomes for people with complex needs and behaviours. On-going engagement with providers will help shape the Transforming Care plan and in particular the responses to the needs of individuals.

These themes have been incorporated into our Transformation Plans – developing our themes of improving choice and control, person centred care, and specialist services.

Describe how the plan has been co-produced with children, young people and adults with a learning disability and/or autism and families/carers

The involvement of people with a learning disability and/or autism in the shaping of this plan is covered above. We will facilitate a number of workshops and events to co-produce this Transformation Plan during the coming months – we know that the right lead time is needed to allow for appropriate planning, preparation and transport arrangements.

Co-production is also a fundamental element of our Children and Young People's Mental Health Transformation Plan. We worked with stakeholders including children, young people, parents, clinicians, teachers, and youth services to develop that transformation plan. This ensured that our plans reflected what our service users and key partners wanted.

As part of our CAMHS plans, across the eight boroughs we are funding local organisations with particular relevance to local needs, and needs of specific under-served groups, to support young people, parents, and other key stakeholders to be involved in co-production. We aim to develop this further by reviewing co-production for different groups, learning from the work done in other boroughs across NWL and sharing our learning on the engagement approaches that work best for different groups of children, young people, and parents. We are building on the current approach in Hammersmith and Fulham with Rethink – training and supporting young people cross NWL to engage in all children and young people's (CYP) development projects. This will include a youth-led conference on Young People's Mental Health to be held in 2016.

On-going planning will also build on existing coproduction structures through partnership boards, sub-groups, and groups such as the Parents Reference Group and Carers groups. Engagement of care co-ordinators will be key to ensure a realistic focus on the holistic needs of the people they are planning with and the issues or barriers they are facing on the ground.

Please go to the 'LD Patient Projections' tab of the Transforming Care Activity and Finance Template (document 5 in the delivery pack) and select the CCG areas covered by your Transforming Care Partnership

Any additional information

Please see attached template.

The process of locally developing plans for the numbers of inpatient beds we will commission in the next 3 years - in compiling the NWL picture it is clear that we have a significant ambition to transform the experience of people – and our ability to support individuals outside inpatient settings. It is also clear that as a first submission we need to fully interrogate the data and define implementation plans for delivering this ambition. We anticipate that numbers will change It is acknowledged that there is more to do in order to strengthen the financial and activity modelling ahead of the submission on 11st April.

2.Understanding the status quo

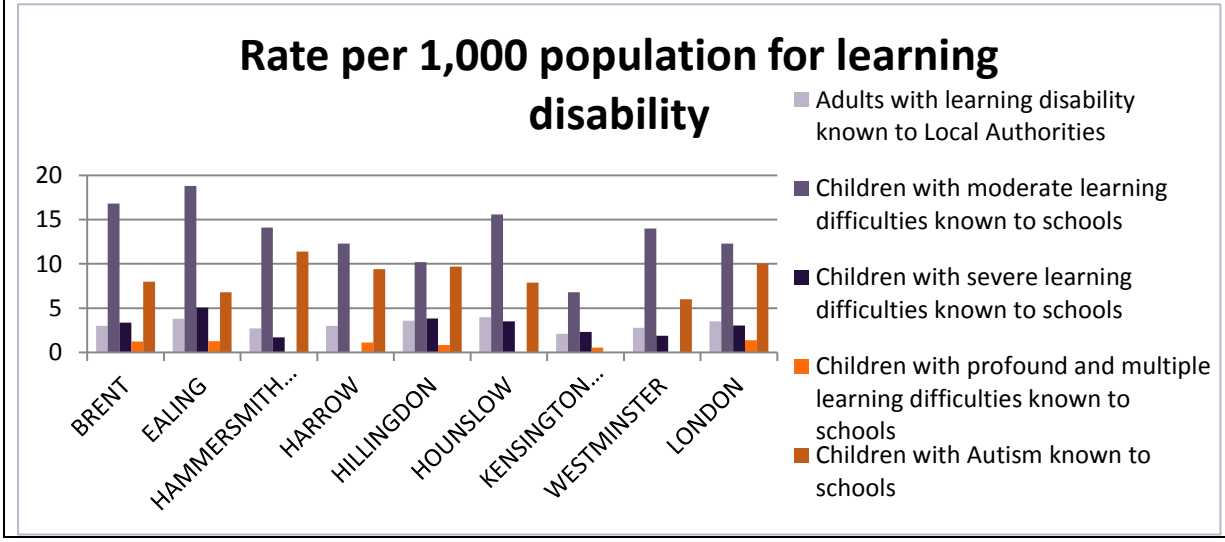
Baseline assessment of needs and services

Provide detail of the population / demographics

Learning Disability in North West London

The cohort of people with a learning disability and/or autism in NWL is diverse, and growing. The below graph shows the latest figures for learning disability prevalence across NWL and the rate per 1,000 population for the whole of London[1].

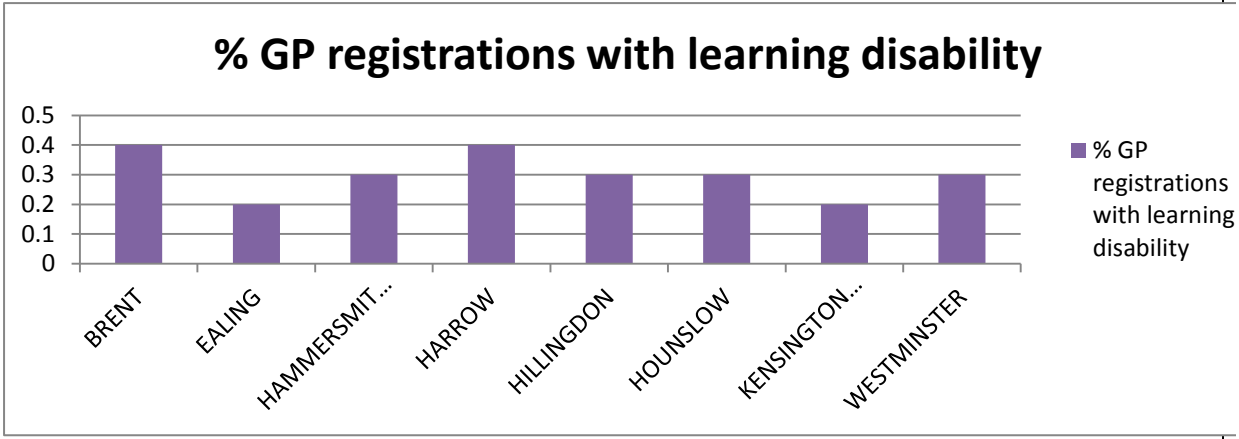
You can see that the rate per 1,000 population for children with moderate learning disabilities known to schools varies across the boroughs from 18.8 in Ealing to 6.8 in Kensington and Chelsea, with the London rate being 12.3[2].



[1] Public Health England Fingertips data 2013/14

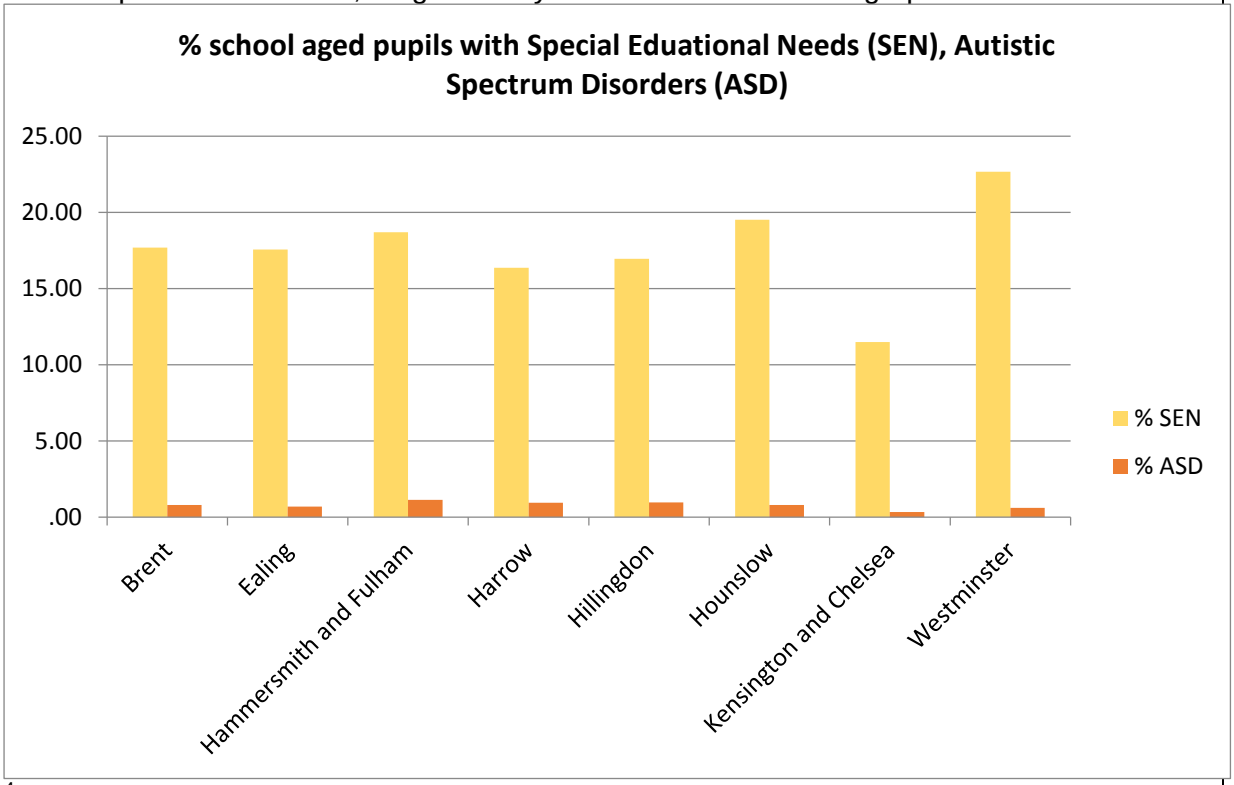
[2] http://fingertips.phe.org.uk/profile/learning-disabilities/data#page/0/gid/1938132702/pat/6/par/E12000007/ati/102/are/E09000020

We also know that the percentage of adults registered with a GP in NWL as having a learning disability varies across the boroughs from 0.2% to 0.4%[3].



In 6 out of our 8 NWL CCG areas, we do not have up-to-date information on the mental health and emotional well-being of our children and young people. We are therefore investing some of our CAMHS Transformation Plan funding in producing needs assessments to further guide our local priorities.

Across NWL, the percentage of school aged children with special education needs, including autistic spectrum disorders, ranges widely as demonstrated in the graph below.



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[3] HSCIC, 2014

[4] Public Health England Fingertips Tool (2014). Accessed at http://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh/data#page/9/gid/1938132753/pat/6/par/E12000007/ati/102/are/E09000005

Many of our NWL boroughs have undertaken LD JSNAs in the last few years. The details below provide a snapshot from these of some of the NWL specific challenges and opportunities:

- In Brent, 2.6% of school children had a learning disability (2014). This was slightly lower than the England average of 2.9%[5]
- Out of 600 individuals with learning disabilities known to local GPs in Hounslow, there are 296 females (45%) and 358 males (55%). The median age for females was 43 and for males was 37 years. Learning disabilities are more common in men than women (for severe learning disabilities an average ratio of 1.2:1, and for mild learning disabilities 1.6:1) and these figures are in keeping with that[6].
- Nearly 10% of adults with a learning disability are in paid employment in Ealing in 2011/12. This is statistically better than England average (6.1%) for the same period[7].
- Numbers in residential care of all ages in Hammersmith and Fulham have been steadily rising over time, with around 50-60 more 18-65 year olds in residential care than is typical for London and England[8].
- Kensington and Chelsea had experienced falls in numbers in residential care but this has risen sharply in recent years, and has 15-25 more than expected in residential care[9].
- Published figures on the spend on residential care suggest it was very high in Hammersmith and Fulham and high in Kensington and Chelsea by virtue of the higher proportion of clients in this type of accommodation[10].

Needs Grouping described in the National Service Model

The National Service Model identifies 5 groups of people with a learning disability and/or autism who:

- Have a mental health condition such as severe anxiety, depression, or a psychotic illness, and those people with personality disorders, which may result in them displaying behaviour that challenges;
- Display self-injurious or aggressive behaviour (not related to severe mental ill health), some of whom will have a specific neurodevelopmental syndrome where there may be an increased likelihood of developing behaviour that challenges;
- Display risky behaviours which may put themselves or others at risk and which could lead to contact with the criminal justice system (this could include things like fire-setting, abusive or aggressive or sexually inappropriate behaviour);
- Often have lower level support needs and who may not traditionally be known to health and social care services, from disadvantaged backgrounds (e.g. social disadvantage, substance abuse, troubled family backgrounds) who display behaviour that challenges, including behaviours which may lead to contact with the criminal

[5] Brent Learning Disability Brief JSNA 2014
[6] This is Hounslow, 2014
[7] Ealing JSNA 2012
[8] Tri borough Joint Strategic Needs Assessment 2013-2014
[9] Tri borough Joint Strategic Needs Assessment 2013-2014

[10] Tri borough Joint Strategic Needs Assessment 2013-2014

justice system;

- Adults with a learning disability and/or autism who have a mental health condition or display behaviour that challenges who have been in hospital settings for a very long period of time, having not been discharged when NHS campuses or long-stay hospitals were closed.

Currently, our CCGs and Local Authorities do not collect data that categorises people with a learning disability and/or autism into these distinct groupings. However, we will ensure that our Transformation Plans address the diverse and complex needs of each of these groups of people. We also plan to do further work on risk stratification of our population as part of the continuing development of our plans that will provide more detail on the numbers of people within each of these categories across North West London. This will also require close working with teams from the national criminal justice system, and local partners.

Analysis of inpatient usage by people from Transforming Care Partnership

Please see the attached Finance Template for detail on inpatient usage numbers for NWL.

The activity for our main inpatient unit, The Kingswood Centre, is shown below.

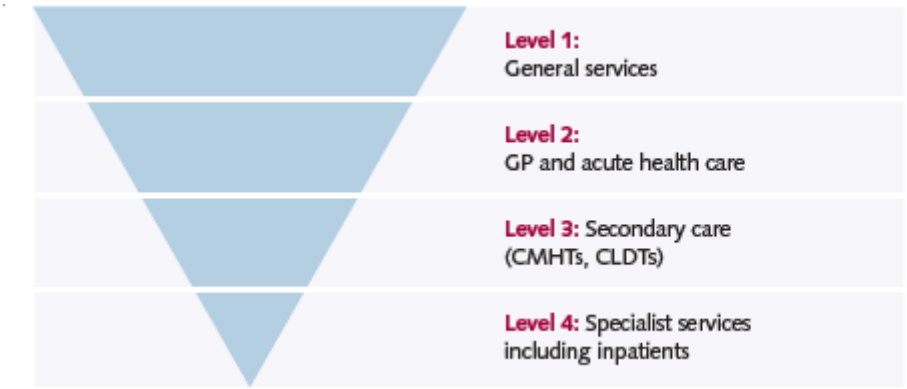
Admissions per year to The Kingswood Centre for NWL Boroughs – 2011 to 2015						
Borough	**2011**	**2012**	**2013**	**2014**	**Q1-2 2015**	**Total**
Brent	4	5	7	7	4	**27**
Hillingdon	2	0	2	4	4	**12**
Westminster	3	3	2	3	1	**12**
K&C	1	3	1	4	0	**9**
Hounslow	2	1	0	1	0	**4**
Harrow	1	5	0	5	1	**12**
Ealing	2	0	6	1	1	**10**
Hammersmith and Fulham	0	0	0	0	0	**0**

These numbers represent people with a learning disability and/or autism who have been an inpatient in our local NWL service. However we recognise that a large number of our NWL residents with a learning disability and/or autism are in inpatient units outside of our catchment area. This is in part due to the range of complex needs of these patients, and our limited estates to support these patients in community settings. Also, we are working with historical contracting arrangements that need to be updated.

The process of implementing our TCP allows us to address these issues as a collaborative across NWL.

Describe the current system

In North West London, people with a learning disability and/or autism can come into contact with a wide range of services. Services supporting people with a learning disability and/or autism can be described in the following ways:



Level 1 These services are primarily focused on improving the health of the whole population of people with learning disabilities. Good access to housing, leisure, education, transport and employment are known to have a positive impact on mental health. Other priorities include neonatal screening, early detection and treatment for conditions such as congenital hypothyroidism and phenylketonuria.

Level 2 People with learning disabilities and/or autism should have good access to mainstream health services. In primary care, this means regular health checks, advice and support on lifestyle factors such as diet, exercise, alcohol consumption and sexual health. Other services include health facilitation to improve access to primary care and health liaison to improve access to acute hospital-based care. Training and support for carers should be made available. Improving Access to Psychological Therapies is included at this level.

Level 3 Community mental health and learning disability teams which provide assessment, treatment and some on-going support for people with a moderate degree of mental health need (significant anxiety and depression, psychotic disorders, and cognitive impairment). These teams have expertise in dealing with perceived behaviour problems associated with these conditions, as well as the whole range of learning disability and coexisting autism and ADHD. In North West London, community services are provided by a range of providers including specialist learning disability providers (e.g. Craegmoor), community healthcare trusts (Central London Community Healthcare) and mental health trusts (Central and North West London Foundation Trust and West London Mental Health Trust). In Kensington and Chelsea there is a Positive Behaviour Support team and in Westminster there is a Flexible Response Service that also partners with a skilled support provider to provide in-reach for people with challenging behaviours.

Level 4 These services have expertise in dealing with people who are a severe risk to themselves and others, often with chronic severe treatment resistant mental illness, behaviour problems and offending behaviour. Services at this level include community-based assessment and treatment using a combination of crisis and home treatment teams, behaviour support services, forensic teams and experts in autism, ADHD, eating disorders, dementia and epilepsy. Inpatient services may also be required where 24 hour assessment and treatment would enable a safe return to well-resourced, community-based packages of care. The appropriate role for psychiatric hospital services for people with learning

disabilities lies in short-term, highly-focused assessment and treatment of mental illness. At present in North West London, these services are mainly provided by The Kingswood Centre with inpatient services being either block purchased (as is the case for Brent) or spot purchased (as is the case for all remaining areas in North West London). Spot purchasing of inpatient services also takes place in many other inpatient facilities across the country.

Residential and special schools also form part of the support available for children and young people with a learning disability and/or autism.

The services within these different levels include:

- Primary care
- Psychological therapies
- Community learning disability services
- Inpatient learning disability services
- Generic mental health services
- Services at the interface (transition services)
- Supported housing, residential care and continuing health care

The level of coordination between different service elements can vary, and can also lead to delay and duplication as well as high costs. These different services have a range of providers across NWL including a number of dedicated learning disability services:

- Integrated health and social care learning disability services (provided by the community health trusts; Central London Community Healthcare; Hounslow and Richmond community Healthcare; London North West Healthcare; Hillingdon) with social care staff from the relevant local authorities
- Autism Diagnostic Clinical Services (provided by Central and North West London Foundation Trust and West London Mental Health NHS Trust)
- CAMHS Learning Disability Services (provided by Central and North West London Foundation Trust and West London Mental Health Trust)

In addition, Local Authorities provide and commission a range of services for people eligible for support under the Care Act including residential care, supported living, respite, homecare, day opportunities, transport, advocacy and outreach, as well as special schools and a range of services and young people with learning disabilities and/or autism and behaviour that challenges.

What does the current estate look like? What are the key estates challenges, including in relation to housing for individuals?

A thorough picture of our current estate across residential and supported housing, clinical services, and community support is a gap within our current plan. We are working with our estates teams and providers to map the existing provision, including the areas where we are routinely accessing placements out of our North West London area.

In some of our boroughs, recent work on estates and residential support offers has taken place and there are strategies in place to develop and expand the offer to meet the needs of people with learning disabilities and/or autism. These strategies are included in each borough's appendix, where applicable.

Across many areas, in particular inner North West London, housing planning work has identified a shortfall of accessible property and lack of properties with the specification and

space to meet these needs of individuals and families. As inner London boroughs the cost of land and property is a huge challenge and as a result, there are many people in placements outside of their home boroughs. However there is on-going work to secure property through new build developments and improved pathways to access existing stock.

What is the case for change? How can the current model of care be improved?

The case for change across North West London is clear. The following challenges must be addressed:

- There is widespread recognition that those with a learning disability and/or autism and challenging behaviours are not best served by extended hospital stays, although admission for assessment and treatment will be required from time to time for some people.
- Despite this recognition, due to a lack of alternatives some people with a learning disability and/or autism and challenging behaviour are admitted to hospital in a crisis and remain in hospital for longer than necessary when they could have been supported in the community if 24/7 clinical support was in place.
- The ageing population of those with a learning disability and/or autism require more proactive support that also provides support and treatment for co-morbidities that are more common in later life;
- There is extensive reliance on families and carers to provide support. To prevent burn out and family breakdown, there is a need to ensure that there are both crisis and planned respite services available to avoid hospitalisation;
- There needs to be increased skills in the workforce to support people with a learning disability and/or autism most effectively and similar support for their families and carers;
- The population of North West London is increasing, as is the number of people with a learning disability and/or autism. Our systems and services need to be able to respond to this increase in demand in the most effective and efficient ways possible;
- The cost of housing in London is higher than anywhere else in the UK. This means that people with a learning disability and/or autism are often housed outside of London, which impacts on family and friend relationships and support. More needs to be done to ensure that people can stay in their own homes where possible, and where that is not possible, placements can be made closer to home to ensure support networks can be maintained.

To address these challenges, we need to develop a system and services underpinned by the following principles:

- The needs and preferences of people with a learning disability and/or autism should be at the heart of all we do. Care and support should be person-centred, planned, proactive and co-ordinated across health and social care, allowing people to have choice and control and lead good and meaningful lives;
- Substance Misuse services do not usually screen for learning disabilities – and vice versa – despite co-morbid needs frequently existing
- We need to further develop our system-wide approach across specialised and CCG commissioning, health and social care and other services (e.g. housing) for people in North West London with a learning disability and/or autism and challenging behaviours;
- Care and support services need to be redesigned to minimise inpatient care to when it is the best place for the person concerned. More often, care should be provided in community settings by skilled professionals who can support and maintain independence;

- A ‘whole life’ preventative approach is needed for care and support with a much greater emphasis on addressing or reducing the impact of challenging behaviours from a young age;
- Significant market development and provider liaison is required to achieve transformational change. The skills and capacity of providers must be increased to better support people with a learning disability and/or autism and challenging behaviour in the community to deal with high levels of complexity. Personalisation/ self-directed care, increasing employment opportunities;
- Advocacy forms part of the support available to people with a learning disability and/or autism to help uphold people’s rights and ensure their voices are heard.
- Within forensic pathways commissioned by NHS England there is a need to ensure the appropriate specialist input for service users with Learning Disabilities;
- The green light toolkit framework provides a means to focus on individuals and their needs and requires continued focus and resource to support;
- Court diversion schemes operate in NWL for people with Mental illness. The capability of all members of these teams to respond to the needs of people with a learning disability and/or autism could be strengthened.

Please complete the 2015/16 (current state) section of the ‘Finance and Activity’ tab of the Transforming Care Activity and Finance Template (document 5 in the delivery pack)

Any additional information

Please see attached template.

The process of locally developing plans for the numbers of inpatient beds we will commission in the next 3 years - in compiling the NWL picture it is clear that we have a significant ambition to transform the experience of people – and our ability to support individuals outside inpatient settings. It is also clear that as a first submission we need to fully interrogate the data and define implementation plans for delivering this ambition. We anticipate that numbers will change It is acknowledged that there is more to do in order to strengthen the financial and activity modelling ahead of the submission on 11st April.

3.Develop your vision for the future

Vision, strategy and outcomes

Describe your aspirations for 2018/19.

For North West London, Transforming Care is a programme that will help us develop our model of care and support for people with a learning disability and/or autism that promotes participation and an improved quality of life, whilst at all times maintains a person-centred approach that recognises and values difference and diversity.

In North West London, people with a learning disability and/or autism and their families will be able to say:

- I have choice and control
- I direct my care
- I have a home I can call my own
- I am part of a community

- I manage my health with the level and quality of support that I need

We will achieve this vision by developing pathways and services that:

- Are community based where appropriate, with a reduced reliance on inpatient facilities;
- Are skilled and experienced to manage complex cases, including managing the complexity of competing demands across health and social care;
- Provide respite for families and carers to maintain, wherever possible, at home placements and strong family relationships;
- Enable people to have choice in accommodation that is suitable to their needs and close to their communities and chosen networks; (acknowledging that for some people they may not choose this to be in their borough of origin);
- Meet the needs of people of all ages – not defining support by age but instead responding to care and support needs and reducing the differences in services for children, young people and adults

These services are pathways will help us to achieve:

- Timely access to assessment and treatment for learning disability and/or autism;
- Reduced numbers of admissions to hospitals (both secure and non-secure), and shorter stays when admitted through effective discharge planning;
- When required and community solutions are not appropriate, timely access to inpatient assessment and treatment;
- Improved health and educational outcomes;
- Improved quality of life;
- Improved experience of services.

How will improvement against each of these domains be measured?

In accordance with the national guidance, we will monitor progress on delivering against the overarching outcomes of the programme using the suggested measures.

For the aim of reducing reliance on inpatient services, we will use the Assuring Transformation Plan data set to monitor progress. This will include defining baselines and setting KPI trajectories and end states in collaboration with our providers and service users for the following:

- Registers of people with a learning disability and/or autism
- Numbers of patients on registers
- Numbers of patients with a care co-ordinator
- Numbers of patients who have had a formal care plan review
- Number of patients with a planned transfer date
- Awareness of Local Authority to up-coming transfers
- Number of patients with an independently appointed Advocate (family member, independent person, formal Independent Mental Capacity advocate (IMCA)
- Numbers of patients admitted to inpatient care
- Number not on at risk of admission registers prior to admission
- Numbers of patients transferred out of inpatient care
- Numbers of patients considered not appropriate for transfer to the community and the reasons why
- Number of readmissions

- Number of readmission resulting in Root Cause Analysis

For the aim of improving quality of life, we will use measures based on the Health Equality Framework tool. All these measures will be further refined as our plan developed. At present, we have some outline ideas on the quality of life areas we want to assess. These include:

- **Social determinants of health**: accommodation, employment, financial support, social contact, and safeguarding (e.g. 10% increase in the number of people with a learning disability and/or autism who are in employment by March 2019).
- **Genetic and biological determinants of health**: assessment and review of health needs, care plans, crisis plans, medication passports, and access to specialist services (e.g. 100% of inpatients in specialist learning disability services have a care plan that has been co-produced with the person and their family/carers).
- **Communication and health literacy**: body and pain awareness, communication of health needs, recognition by others of pain, recognition of health needs and response by others, understanding health information, and making choices (e.g. 100% of patient information leaflets in community learning disability and/or autism services are available in easy read format).
- **Behaviour and lifestyle**: diet, exercise, weight, substance use, sexual health, risky behaviours (e.g. 20% reduction in the number of people with a learning disability and/or autism who are overweight or obese).
- **Access to and quality of healthcare and other services**: reducing organisational barriers, understanding consent, managing transitions, uptake of health screening/ promotion, access to primary and secondary health services (e.g. 15% increase in uptake of cervical screening by women with a learning disability and/or autism).

For the aim of improving quality of care, we will use the suggested basket of indicators, where these are not covered by the measures above. As a start, this will include (but not be limited to) measuring and developing KPIs on:

- The number (and %) of people receiving social care primarily because of a learning disability who receive direct payments or a personal managed budget.
- Readmissions to hospital for people with a learning disability and/or autism.
- Waiting times for new psychiatric referrals for people with a learning disability and/or autism.
- The availability of accessible information in line with new accessible information standards.

In addition to these mandated measures, we will also use local measures to monitor progress against our local objectives. Co-production of these measures with people with a learning disability and/or autism and their families and carers will be an important component in the delivery of our Transformation Care programme.

For us, the most important measure of improvement will be patient reported experience and outcome measures (PREMS/PROMS). We are committed to embedding PREMS and PROMS into all services, drawing on the developing evidence base and guidance for using these measures appropriately for people with a learning disability and/or autism. We will ensure that people are allowed extra time to complete these measures, can complete them at home, and will have the support of someone they trust to complete each measurement tool. All questionnaires will also be provided in easy read formats. We will build on the work in NWL using Patient Knows Best to capture the improvements that matter at a local level.

Describe any principles you are adopting in how you offer care and support to people with a learning disability and/or autism who display behaviour that challenges.

The principles we are adopting in how we offer care and support to people with a learning disability and/or autism who display behaviour that challenges reflect the principles inherent in our current practice, and the ideals we are striving towards that are linked to the Transforming Care agenda. These are:

1. **Personalised**

Person centred care

- We will work with people with a learning disability and/or autism and their families to plan care and support that is focused on the individual and their unique circumstances.
- We will give people more influence over their care and will promote a culture of positive risk taking.
- We will be committed to achieving the outcomes that we co-produce with each person as part of their care planning or Education, Health and Care (EHC) plans. Overall, we will all be working towards supporting people to have good and meaningful everyday lives.
- We will provide people with a learning disability and/or autism, and their carers and families with the right information at the right time to enable them to make informed decisions about care and support. We will ensure that the ways in which this information is provided takes into account the communication needs of the person with a learning disability and/or autism.
- We will ensure people are supported to use personal budgets and direct payments to extend choice, control, and flexibility.

Support for families and carers

- We will provide support to families and carer to enable people with a learning disability and/or autism to live at home or in their community wherever possible.
- We will make training available for families and carers in managing challenging behaviour.
- We will develop our respite offer for families and carers through short term accommodation for people to use briefly in a time of crisis, and paid care and support staff who are trained and experience in supporting people who display behaviour that challenges including positive behaviour support.

Access to mainstream services

- We will encourage the use of mainstream services as a starting point, including employment and leisure opportunities. These services will be available and accessible for people with a learning disability and/or autism.
- We will monitor our mainstream services through quality checks using the Green Light Toolkit and evaluation by people with a learning disability and/or autism and their carers using peer evaluation and inspection where appropriate.
- Where mainstream services are not sufficient to meet a person's needs, we will provide specialist support service in a community setting wherever possible.

Choice and control

- We will ensure that people with a learning disability and/or autism have choice and control over how their health and care needs are met – with information about care and support in formats people can understand and the further development of advocacy services.
- We will provide a choice of housing options, including choice of type of accommodation and tenure, and support to live with families where that is the preferred arrangement.
- Plans and services will be co-produced and evaluated by people with a learning disability and/or autism, their families and carers. The opinions of people who use services will be listened to and their comments will initiate change.

2. Integrated

Co-ordinated care

- We will co-ordinate planning and commissioning of services across health and social care.
- We will encourage and promote cross organisation working.
- We will develop clear service specifications, pathways, protocols, and patient-centred outcomes.
- We will ensure discharge to community is well co-ordinated, guided by Care and Treatment Reviews.

Integrated to mainstream services

- We will improve access to mainstream services for people with a learning disability and/or autism by encouraging reasonable adjustments to services.
- We will work towards increasing access to education, employment and volunteering opportunities.

Lifelong approaches

- We will develop early intervention and preventative support programmes to address challenging behaviour from an early age.
- We will improve the continuity of care across different stages of life.

3. Localised

Community-based care and support

- We will develop local, multidisciplinary community support teams, consisting of a range of professionals to meet health and social care needs.
- We will build on existing services, incorporating evidence-based knowledge and skill development and expertise in the management of challenging behaviour and complex cases.
- We will work as a NWL collaborative to consider our options for developing more local housing options to ensure that our residents have the choice to be housed closer to their support networks.

4. Specialised

Specialist support

- We will ensure that people with a learning disability and/or autism are able to access specialist health and social care support in the community – via integrated specialist multi-disciplinary health and social care teams.
- We will develop the support that is available out of hours.
- We will develop the workforce so that all staff working with people with a learning disability and/or autism have the appropriate training, skills, knowledge and expertise to manage challenging behaviour in a supportive way.
- We will develop community forensic health and care across North West London so that people with a learning disability and/or autism have support to reducing their offending and/or antisocial behaviour.
- We will provide high quality assessment and treatment services in hospital settings for those people whose needs cannot be met in community. We will ensure that where a hospital admission is required, it is for the shortest time possible, and pre admission checks ensure that hospital care is the right solution and discharge planning is commenced from the point of admission or before.

Our Transformation Plan for people with a learning disability and/or autism forms part of our overall strategy to improve the mental health and wellbeing of people in North West London. Like Minded is the mental health and wellbeing strategy for North West London. It brings together service users, carers, clinical staff from the statutory services and voluntary groups and other experts to work together to improve mental health and wellbeing across North West London. By working together, our vision is for North West London to be a place where people say:

"My wellbeing and happiness is valued"
"I am supported to stay well"
"My care is delivered at the place and time that is right for me"
"The care and support I receive is joined up"
"I can access support to avoid crisis"

Please complete the Year 1, Year 2 and Year 3 sections of the 'Finance and Activity' tab and the 'LD Patient Projections' tab of the Transforming Care Activity and Finance Template (document 5 in the delivery pack)

Any additional information

Please see attached template.

Please note that without financial information from NHS England on the additional funding that will support this transformation programme, it is very difficult to project what finances will be allocated. The assumptions used to guide our planning are included in the spreadsheet.

The process of locally developing plans for the numbers of inpatient beds we will commission in the next 3 years - in compiling the NWL picture it is clear that we have a significant ambition to transform the experience of people – and our ability to support individuals outside inpatient settings. It is also clear that as a first submission we need to fully interrogate the data and define implementation plans for delivering this ambition. We anticipate that numbers will change It is acknowledged that there is more to do in order to strengthen the financial and activity modelling ahead of the submission on 11st April.

4.Implementation planning

Proposed service changes (incl. pathway redesign *and* resettlement plans for long stay patients)

Overview of your new model of care

Our new model of care will build upon the successful elements of our existing services to develop our community care and support offer and will look to address some of the challenges we face in NWL with finding suitable housing options. The fundamental elements of our new model of care are:

1. **Personalised: Care and support to meet each person's unique needs**

We recognise that no two people with a learning disability have the exact same care and support needs and preferences, and therefore we will work with each person with a learning disability and/or autism to ensure that they receive care and support that works most effectively for them and their families. When someone is referred to the service, they are offered a comprehensive assessment of their needs. People with a learning disability and/or autism and their family or carers will co-produce a shared care plan that covers their health, social care, and support needs as well as their goals for independent living.

To ensure that we are meeting the needs of all our population with learning disabilities and/or autism, including those who don't currently engage with services, we need to improve our registers. We will develop an all-ages learning disability register for individuals known to community services and inpatients facilities. We will build on this by cross-checking our registers with GP registers for adults and children, and local authority registers of children with additional needs.

To understand the future demand on our community services, we will work with our public health colleagues to understand our prevalence data based on national estimates and our improved registers. We will then work on risk stratifying our population to understand who is likely to need higher levels of support, either in community or inpatient facilities. This information will then inform our service implementation and market development plans.

2. Integrated: Co-ordinated care and planning

We will underpin our Transforming Care agenda with a co-ordinated approach to planning and commissioning of services across health and social care. Our communities have a long history of joint commissioning and integrated community team for people with learning disabilities. The local authorities work together within the West London Alliance. We have built on this approach with to develop this plan. We are committed to ensuring that support for people with a learning disability and/or autism is strengthened by cross organisation working. We are working together to develop clear service specifications, pathways, protocols, and patient-centred outcomes. We will continue to work together to monitor and evaluate services and new pathways to ensure our Transforming Care agenda delivers the outcomes we are aiming for. We will also work as a collaborative across North West London to tackle our local housing issues so that wherever possible our residents can live in housing close to their families, if that is their wish.

We will make best use of Care and Treatment Reviews to ensure all our resources are used effectively to avoid admissions where possible and to ensure a clear and on-going focus on well co-ordinated discharge to the community.

Planning of services will also stretch beyond health, social care and housing. We will ensure that people with a learning disability and/or autism are enabled to participate in society in meaningful ways. This means improving access to mainstream services for people with a learning disability and/or autism by making reasonable adjustments, utilising the Green Light Toolkit and other contractual levers. We will also work towards increasing access to education, employment, and volunteering opportunities.

3. Localised: Community care, close to home

At the centre of our model of care the multidisciplinary community support team consisting of psychiatrists, nurses, psychologists, social workers, and support workers. Support will also be available from other specialists including speech and language therapists, occupational therapists, physiotherapists, and creative therapists. The team will be built upon the existing services, incorporating evidence-based knowledge and skill development and expertise in the management of challenging behaviour and complex cases. The health services offered by the team will be integrated with social services and will have a single point of access.

Housing options suitable for people with a learning disability and/or autism are problematic in North West London. High land values and a shortage of space makes the development of housing more difficult than in other areas of the country. We are committed to working as a North West London collaborative to consider our options for developing more local housing options to ensure that our residents have the choice to be housed closer to their support networks.

4. Specialised: expert care and support

We recognise that specialist skills are required to provide high quality care and support for people with a learning disability and/or autism. These specialist staff are a fundamental element of our community care teams; we need to develop the expertise of these teams to manage more complex cases and challenging behaviour to reduce our reliance on inpatient facilities and residential school placements. Even with specialist community support, there will continue to be a need for inpatient care in some cases. Our aim is to reduce our reliance on inpatient admissions, and where they are required, to reduce length of stay and ensure that discharge planning commences at admission or before.

Across NWL we recognise the need for more specialised support for people with a learning disability and/or autism who are in contact with, or at risk of contact with, the criminal justice system. Our current community support teams could be further developed with more specialised psychological input for people who offend, linking closely with our court diversion and liaison services. This is one of the areas that we think could benefit from a NWL approach – pooling resource to support the small number of cases across NWL with specialised psychological support.

We also recognise the expertise that exists within the third sector for supporting people with a learning disability and/or autism and our NWL plan includes our third sector partners as an important part of our care and support pathways.

What new services will you commission?

Across North West London we are working towards to same strategic vision for people with a learning disability and/or autism. However, as we are describing a model across eight boroughs it is worth clarifying that in some cases these services will be new services in the boroughs where there is currently a gap; in other cases these services already exist and as such these services may be developed or updated within existing provision. Specifically we will commission:

- **Community support**, including the utilisation of more skilled staff to manage more complex/challenging behaviour. This may involve moving staff from inpatient facilities into community services, and vice versa, to share learning.
- Tailored **local housing options** for people with a learning disability and/or autism who have challenging needs. This will include short term housing options for people in crisis where there is a risk of placement breakdown, and access to shared living schemes.
- **Respite services** for families and carers, regardless of the age of the person being cared for. This will include short breaks, day opportunities, longer break provision and family support services.
- **Crisis care,** available 24 hours a day, 7 days a week that ensures that people with a learning disability and/or autism and their families and carers receive care and support that meets their needs in times of crisis, including when this crisis occurs outside of standard working hours.
- An **all ages service** that removes the need to transition between children and adult services.
- A North West London level **service for people with a forensic history** or Asperger's to provide the specialised psychological support required and manage the smaller number of cases over a larger geographical area.
- More services to support people with a learning disability and/or autism to access training, work experience, apprenticeships, and voluntary and **paid employment**.

- **Co-ordinated care** across the health and social care pathways, ensuring that primary care clinicians are involved in early identification and signposting, and all partners are engaged in on-going care and support.

What services will you stop commissioning, or commission less of?

We will commission fewer:

- Assessment and treatment inpatient beds – via both reduced numbers of admissions and reduced length of stay
- Residential school placements
- Out of area placements

This shift in commissioning will be heavily dependent on the development of specialist community support services that are able to manage the increasing demand and complexity of cases and sufficient suitable respite provision to enable families to cope. Therefore, we expect this decommissioning to be gradual over time as the community services embed. Our detailed implementation plan will describe the phasing of decommissioning – ensuring appropriate individual alternatives are in place as we reduce reliance on inpatient/residential care.

What existing services will change or operate in a different way?

Our existing services vary across North West London, so the detail of what will operate differently can be found in each borough's local annex. As general principles across North West London, existing services will change or operate differently in the following ways:

- Current community services will be developed, in terms of capacity, skill mix, and ability to manage complex cases and challenging behaviour. There will also be more in-reach into inpatient services to support discharge and more outreach to other health and social care teams to support more independent living and integration with mainstream services.
- Current day services will be remodelled to provide more respite options and more integration into the local community.
- Crisis response teams will be trained and supported to respond to people with a learning disability and/or autism in crisis.
- Mainstream services will, through training and support for staff and changes in protocols and procedures, have increased awareness of learning disabilities and autism and will be adjusted to provide appropriate care and support.
- Waiting times for an assessment for learning disability and/or autism in CAMHS will be reduced. Children and young people will receive a quicker assessment, diagnosis, and access to support and treatment.
- Quality assurance and service development will be fundamental elements of all services.
- More services will be able to be responsive to people's individual needs with direct accountability to individuals and their families through personal budget and individual service fund arrangements.
- There will be more effective links with the criminal justice system.

Describe how areas will encourage the uptake of more personalised support packages

Across NWL personal budgets are offered to people with a learning disability and/or autism. Currently, the uptake of these offers is generally low; however using a North West London approach we will share learning from areas where uptake is higher (such as Kensington and Chelsea). We recognise the importance of increasing awareness of the benefits of these packages of care, and are cognizant of the need to balance this against the additional support required to help people with a learning disability and/or autism and their carers manage these budgets.

Work has commenced with MENCAP in Brent to explore the barriers around these budgets and to develop guidance and support recommendations to increase uptake. We are committed to working with our local independent sector partners to ensure people with a learning disability and/or autism have access to independent advocacy support to help them understand their budgets and the options available to them.

Work is underway in Hammersmith and Fulham with a provider introducing Individual Service Funds to maximise accountability to personalised approaches and choice and control for customers with learning disabilities.

Each CCG has a commitment in their commissioning intentions to support Personal Health Budgets more widely. We can build on work in Kensington and Chelsea to introduce personal health budgets (supported by MIND) and the processes in place to support payments and appropriate advocacy. We will learn from the demonstrator sites for Integrated Personal Commissioning to plan for local implementation.

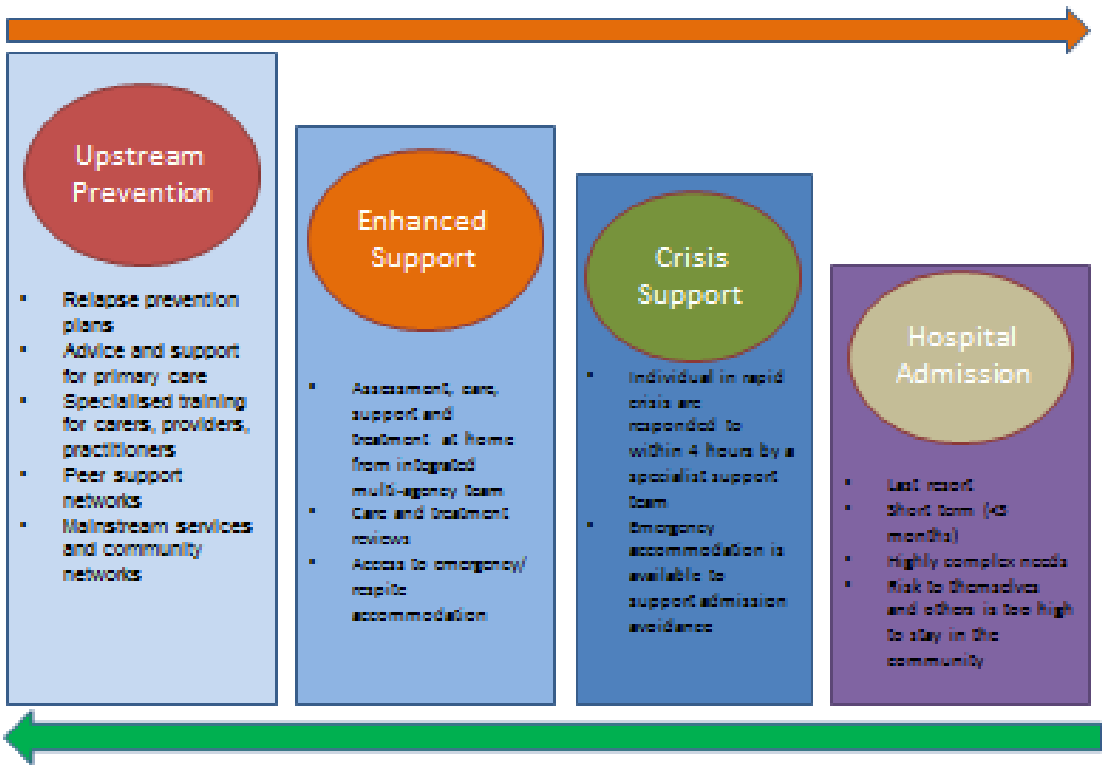
What will care pathways look like?

The overall objective of our TCP is to improve the experience of a small but vulnerable cohort of people across North West London. As we develop these plans we have been reminded frequently that the changes we want to see will be very individual to different people – reflecting the complexity of many of the needs of this population, and their families and carers. The care pathways we will further develop provide a framework but the reality is that each individual will require a tailored plan both for any immediate changes, but also to provide longer term support for the whole variety of needs – physical health, mental health, social care and education for example.

As noted in *Building the Right Support,* people with a learning disability and/or autism who display behaviour that challenges are a highly heterogeneous group. As a result, care pathways can be very diverse and will in every case be dependent on the individual and their family or carers. There are however some over-arching principles that will underlie every care pathway.

Our care pathways will be:

- Planned, in collaboration with the person with a learning disability and/or autism and their family and carers;
- Proactive, considering future care and support needs as well as the current situation;
- Co-ordinated, linking up health, education, social care, and the independent sector to provide a joined up approach to support that meets the range of needs of the person.



- Upstream prevention

Focusing resource, wrapped around the individual and their family and utilising the breadth of skill available in the community will support proactive planning and a holistic approach to avoiding exacerbation of need – and managing some of the drivers of worse outcomes. The GP remains a core member of this team with access to other team members who will be trained to ensure awareness of specific needs of this population

- Enhanced Support

Many of this population will require support at this level routinely. Supporting individuals to remain at home is key and the specialist teams to provide input at this stage in the pathway will focus on coordinating the range of services – to both the individual and the family/carers

- Crisis support

NWL through work on the crisis care concordat has improved access to urgent care for people with mental health needs. This model needs to be sensitive to specific needs of people with learning disabilities and provide pathways which re alternatives to admission

- Hospital Admission

Once admitted planning for discharge will be a priority with a focus on avoiding readmission and putting in place pathways which enable individuals to continue to be cared for in the least intensive setting.

How will people be fully supported to make the transition from children's services to adult services?

Our ambition is to develop an all ages offer for people with a learning disability, removing the need to "transition" from children's to adult services. The needs of service users do change with age; however the fundamental elements of support and care remain the same. In our proposed new model of care, all people with a learning disability and/or autism will have access to support for their health, education, and social care needs regardless of age. On turning 18 they will not be required to be reassessed according to different criteria or change services; instead needs will be assessed on an annual basis and will change with each individual rather than at pre-determined age points.

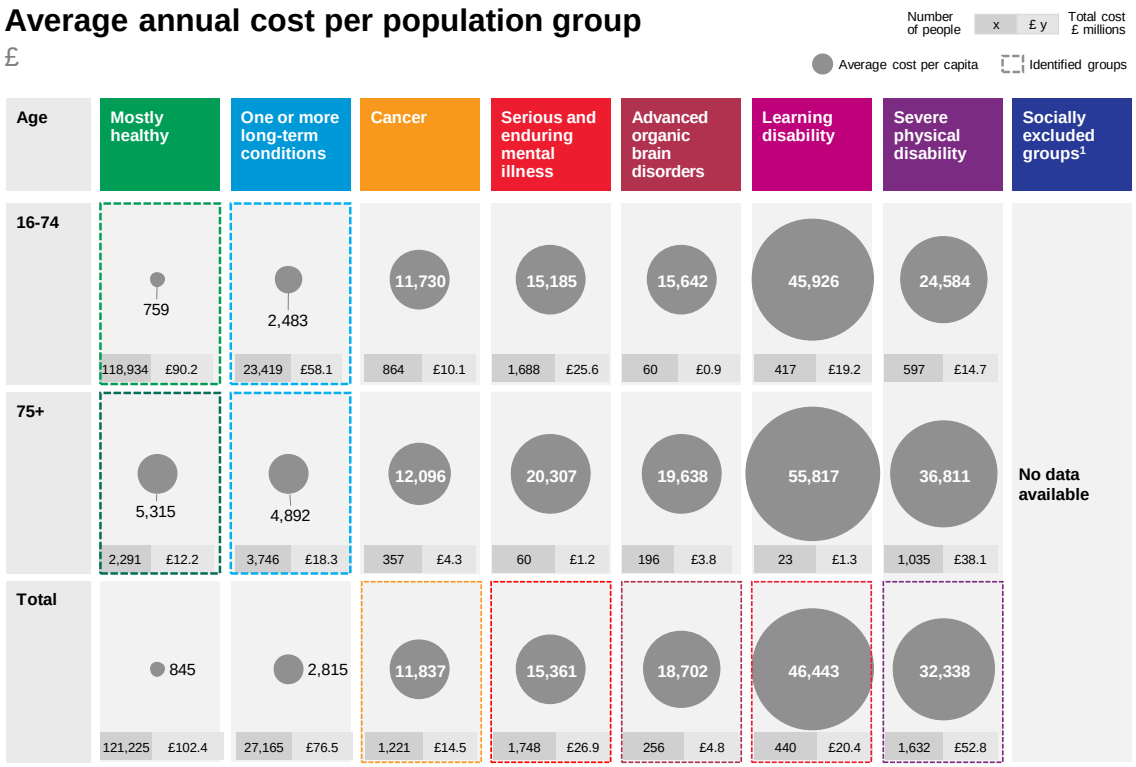
We will build on the Preparing for Adulthood principles and requirements of the Children & Family Act to ensure a local offer, raising aspirations of all young people with care and support needs with an emphasis on improving health, independence and employment outcomes.

As we move towards this new model of care, we will continue to support young people moving through the current system through careful planning and joined up working between social work teams. Our education, health and care plans also provide a bridging step between children's and adult services to assist with transition up to the age of 25.

How will you commission services differently?

Across North West London Local Authorities are working collaboratively with partners in health (commissioning and provision) to develop new models of care (in line with the 5 year forward views) which, whilst putting the patient at the centre, also enable funding to flow differently. Initially work began looking at the holistic needs of our elderly population with multiple long term conditions. In the current round of planning, and indeed with the driver of the Better Care fund and Sustainability and Transformation Plan, we are coming together to agree how we use the same lever for different populations – including those with serious mental illness, and those with learning disabilities. We are aided in this work as significant investment has been in made in the data systems which will enable us to collect the right information – on activity and funding initially, but in future on it comes, for the population segments as below (note the specific segment for learning disabilities).

We will also learn from and build upon the successes of our Section 75 arrangements in NWL to ensure that our commissioning partnerships across health and social care deliver improved outcomes for people with a learning disability and/or autism.



Note: The dataset includes a subset of the population of Hammersmith and Fulham; it represents ~90% of the population of that borough
1 For example, the homeless, people with alcohol and drug dependencies
Source: Integrated data-set from H&F, ICP data warehouse, FIMS 2012/13, CLCH budget, WLMHT budget, LA Budget, McKinsey analysis

How will your local estate/housing base need to change?

Across North West London we are developing our housing and estate plans, with each borough being at a different level of development. Local detail is outlined in the appendices. As we further develop our Transforming Care plan, we will develop a joined-up North West London estates plan that takes account of each borough's local position and uses a combined approach to deliver economies of scale and solutions that can be shared across North West London.

The general requirements for our estates for people with a learning disability and/or autism will include:

- accommodation with sufficient space internal and outdoor space
- consideration to any shared space that best supports people without aggravating or causing them stress
- support for families who want to stay living together but who may have outgrown their living space as a young person reaches adulthood
- location, close to support networks.

Alongside service redesign (e.g. investing in prevention/early intervention/community services), transformation in some areas will involve 'resettling' people who have been in hospital for many years. What will this look like and how will it be managed?

Across North West London, we have been supporting people with learning disabilities and/or autism to resettle into community placements after long periods in hospital for many years. We will build upon our existing step down protocols and procedures, offering more support

from the enhanced community team as part of this transition.

For people who have lived away for many years, additional consideration will need to be given as to their chosen place to settle if they no longer have links with their home borough. It should not be assumed that everyone would want to live in inner London nor leave new links they may have established elsewhere.

We will ensure that people with a learning disability and/or autism and their families and carers are involved in developing their care and support plans, including crisis action plans, well in advance of any resettlement. We will also ensure there is access to more suitable housing to make this transition easier. We are exploring the option of care navigators and support worker roles that will also assist with the resettlement process.

Our detailed implementation plans will address this area at the next submission. We know that to effectively support this population will take time. We can learn from work across NWL and wider – to involve the staff who support people currently, and the communities where people will resettle to. Utilising the key principles above we will take a person-centred approach and build on the breadth of experience of partners across the system.

How does this transformation plan fit with other plans and models to form a collective system response?

i. Local Transformation Plans for Children and Young People's Health and Wellbeing

Both this Transforming Care Plan and the North West London Children and Young People's Mental Health and Wellbeing Transformation Plan have been developed in collaboration with children's commissioners from CCGs and Local Authorities. In the CAMHS Transformation Plan 8 priority areas are identified, one of which relates to Learning Disabilities.

In this plan, one of our main ambitions is to develop an enhanced learning disability service within each of the 8 CCGs, streamlining the current service offering and filling the gaps. The design of the service locally will vary because the starting position is different and the needs of each borough differ somewhat based on prevalence and population. The NWL approach will ensure consistent quality and shared learning.

To achieve our ambition, we will **map local care pathways** for children and young people with learning disabilities and mental health difficulties to ensure a seamless experience of care for all children in their local area. This may involve reconfiguring services or commissioning additional local provision where there are gaps, commissioning an integrated service from CAMHS and Community Paediatrics.

As well as working closely with Community Paediatrics when screening referrals and undertaking assessments, there should be an **effective strategic link** between CAMHS learning disability (LD)/ neurodevelopmental disability (ND) services and special educational needs (SEN) departments, to ensure coordinated assessment and planning of education, health and care (EHC) plans where necessary, and effective transitions for young people with LD/ND across health and education. Multi-agency agreements and monitoring arrangements will be defined with close working amongst frontline services, clearly defined lead professionals and shared care plans.

We will **enhance the capacity of CAMHS** to meet the increasing demand for ASD and ADHD assessments. In some areas this will involve adding additional staffing resource to specialist neurodevelopmental teams.

Specialist support embedded in the network - In some areas such as Ealing the model of co-located services for children with disabilities enables fast access to specialist mental health practitioners for advice, consultation and joint working. This model should be explored in other areas and if physical colocation of entire services is not feasible we will consider embedding mental health practitioners in services that work closely with children and young people with LD.

Specialist mental health practitioners should be available to provide **advice and support to special schools and specialist units** to support early identification of mental health difficulties, advise on behavioural management strategies, and signpost to specialist support if needed.

Vulnerable groups including those with disabilities can find it more difficult **to access specialist services** when they need them, so it is crucial that all measures included in the wider plan to improve accessibility of specialist mental health services (such as single point of access, user involvement etc.) apply equally to young people with LD and neurodevelopmental difficulties.

We will ensure that specialist services for children and young people with learning disabilities, neurodevelopmental disorders and mental health difficulties are **sufficiently resourced** to enable efficient access in line with national waiting time targets, to a workforce with the right expertise to meet their needs.

The **crisis pathway** (Priority 7) developed through this NWL Transformation plan should ensure access to support from staff who are appropriately trained to work with young people with LD, whether through direct access or a consultation model. This will ensure that admissions to residential care are avoided wherever possible and that discharge back to the community is well supported.

There should be clear agreements in place between specialist services and primary care to **support shared care** for young people with LD/ND who require medication.

CCG and LA commissioners will connect with **local independent sector services** and support groups for young people with LD/ND and their families (e.g. parent-run ASD support group).

As part of our redesign of LD and ND services, we will ensure that the principles of Transforming Care are incorporated into our new pathway and service models. Explicitly, we will develop pathways that ensure that when a hospital admission is required for a person with LD or ND, all providers will first ensure that there is no other alternative to admission. Once this challenge has been passed, the person will have an agreed discharge plan developed at the point of admission to ensure they are discharged into community settings as soon as possible. We will also ensure that care and treatment reviews form a fundamental part of our LD and ND pathways and services.

Service Users, providers and commissioners recently came together at an all day workshop to look at adults Learning Disability provision – a key theme of the day is the need to ensure transition is well managed and supported. 35 of the participants volunteered to be part of a

network addressing transition issues – reflecting the commitment to change.

In year one (2015/16) the current service and interdependencies will be mapped out in detail and a service specification will be developed. In year two (2016/17), the service will be revised and redeveloped to become uniform across the 8 CCGs taking into account providers and models of commissioning. Year three (2017/18) to year five (2019/20) will be used to embed the model, develop sustainability and further refine according to borough need.

Our overall objectives for this priority area of our CAMHS Transformation Plan are:

- Children and young people access assessment and treatment for LD and ND in a timely manner.
- Children and young people with LD or ND achieve improved health and educational outcomes.
- Children, young people and parents report an improved experience of engaging with LD or ND services.

ii. Local action plans under the Mental Health Crisis Concordat

In November 2014, North West London became the first place in the capital – and only the second place across the UK – to have its action plan approved for the Mental Health Crisis Care Concordat. The declaration, signed by 25 partner organisations, outlines how organisations across North West London will work together to improve services for two million people, including the 32,000 living with serious mental illness.

This Transforming Care Plan aligns with our local plans to deliver the Mental Health Crisis Concordat. Specifically, the concordat implementation plan includes actions on providing community emergency assessments at home or in safe places 24/7, minimising the use of control and restraint used in inpatient facilities and transport services, and ensuring discharge planning and crisis care plans are routinely created and updated following an episode of crisis. We will also ensure that our crisis care teams are trained to respond appropriately to the needs of people with a learning disability and/or autism in times of crisis as part of our development of mainstream services.

iii. The 'local offer' for personal health budgets, and Integrated Personal Commissioning (combining health and social care)

Personal budgets are currently offered to people with a learning disability and/or autism, however uptake is low. As mentioned previously, some boroughs have plans to work with MENCAP and other local independent sector specialists to provide advocacy and information support services to increase understanding and utilisation of these budgets. We will build on learning from where there is higher uptake and also learning from the introduction of Individual Service Funds.

iv. Work to implement the Autism Act 2009 and recently refreshed statutory guidance

Work to implement the Autism Act 2009 and the updated 2015 guidance is on-going alongside the development of our Transforming Care plan. The awareness training on autism for all staff and specialist training for key staff dovetail with our plans to ensure all mainstream services make reasonable adjustments to meet the needs of people with a

learning disability and/or autism. Also, our development of clear pathways and protocols (including for assessment and diagnosis) will support the work already undertaken in accordance with the Autism Act 2009 in this area, providing an up to date pathway and diagnosis process across North West London in line with SAF submissions.

v. The roll out of education, health and care plans

Across North West London our local authorities have developed operational arrangements and service delivery which better meet the needs of children and young people with special educational needs or disabilities. Published local offers cover the support currently available to children and families with a learning disability and/or autism and these offers will be updated to reflect the changes initiated by this Transforming Care plan. As part of our commitment to transforming health, education, and social care for children and young people with a learning disability, we will work to reduce the waiting times for assessments and develop an all ages service that reduces the impact of transitioning from children's to adult care services. The focus will be on preparation for adulthood in planning for outcomes for well-being, health, independence and employment.

Any additional information

5.Delivery

Plans need to include key milestone dates and a risk register

What are the programmes of change/work streams needed to implement this plan?

We have identified a number of work streams that will be needed to implement this plan. We have summarised these below and will continue to develop the project plans and implementation groups for each of these work stream areas over the coming months.

1. **Pathways and Protocols**: as we co-produce new care and support services across North West London, it will also be important to develop clear service user pathways and protocols for transfer between services to reduce hand offs, share information (with consent) and provide a seamless journey for people with a learning disability and/or autism.
2. **Estates**: covering inpatient beds, community service delivery sites, community team office space, day centres, respite, residential schools, special schools, supported housing. Working closely across North West London to address the challenges with limited estate and high costs unique to London.
3. **Workforce Development**: up-skilling our community teams to manage challenging behaviour and complex cases, to support step down from inpatient care. Redistribution of staffing from inpatient services. In addition to community teams we need to make sure that our teams in urgent care services – including A&E are skilled to support people appropriately. Development of knowledge, understanding, and skills in mainstream services (particularly crisis teams) to make reasonable adjustments for people with a learning disability and/or autism.
4. **Market Development**: working with existing and potential future providers to develop service specifications, staffing requirements, and quality standards that improve the quality of care in the community for people with a learning disability and/or autism, allowing for the support and care of complex cases and challenging behaviour is community settings. This will involve developing the range of providers who are able to provide this care and support to increase quality and improve value for money. We will encourage innovation and tailored solutions for each individual.

5. **Specification of existing services**: work is already underway to update specifications for existing inpatient and community services to ensure clarity of existing offer and that this meets the needs of service users and their families and carers. This will also provide a foundation on which to develop services, providing an understanding of our starting point and any further developments that are required to deliver our Transforming Care Plan.
6. **Green Light:** this work stream will focus on ensuring that people with a learning disability and/or autism are able to access mainstream mental health services, and that mainstream services are able to adapt to meet the needs of people with a learning disability and/or autism. There will be a focus on training, leadership, and staff development.
7. **Communication and Engagement**: this work stream will ensure that a range of audiences are aware of the work being done to deliver our North West London Transforming Care plan. This will include communicating changes with referrers, people with a learning disability and/or autism, families, carers, and other professionals. There will also be a focus on awareness-raising with the general public, improving the understanding of learning disabilities and autism and reducing stigma.

Who is leading the delivery of each of these programmes, and what is the supporting team.

Leads for each of these programmes will be identified as a priority at the next Transforming Care Partnership Board meeting. Leadership will be based on subject area expertise, influence, and capacity to move this work forward.

1. **Pathways and Protocols**:

Each borough in NWL has nominated a lead for a specific area (see page 2) to lead on behalf of the 8 CCGs/boroughs on:

- community support
- local housing options
- respite services
- crisis care
- an all ages service
- service for people with a forensic history
- access to training, work experience, apprenticeships, and voluntary and paid employment
- co-ordinated care

2. **Estates**:

The NWL Estates team are leading this work as part of developing Strategic Estates Plans and working closely with Local Authority leads.

3. **Workforce Development**:

HENWL are supporting the NWL team to develop plans.

4. **Market Development**:

Work has commenced at a local level and the central NWL team will coordinate the implications of this across the wider patch.

5. **Specification of existing services**:

The central NWL team has commenced this work with clinical input from providers and commissioners.

6. **Green Light:**

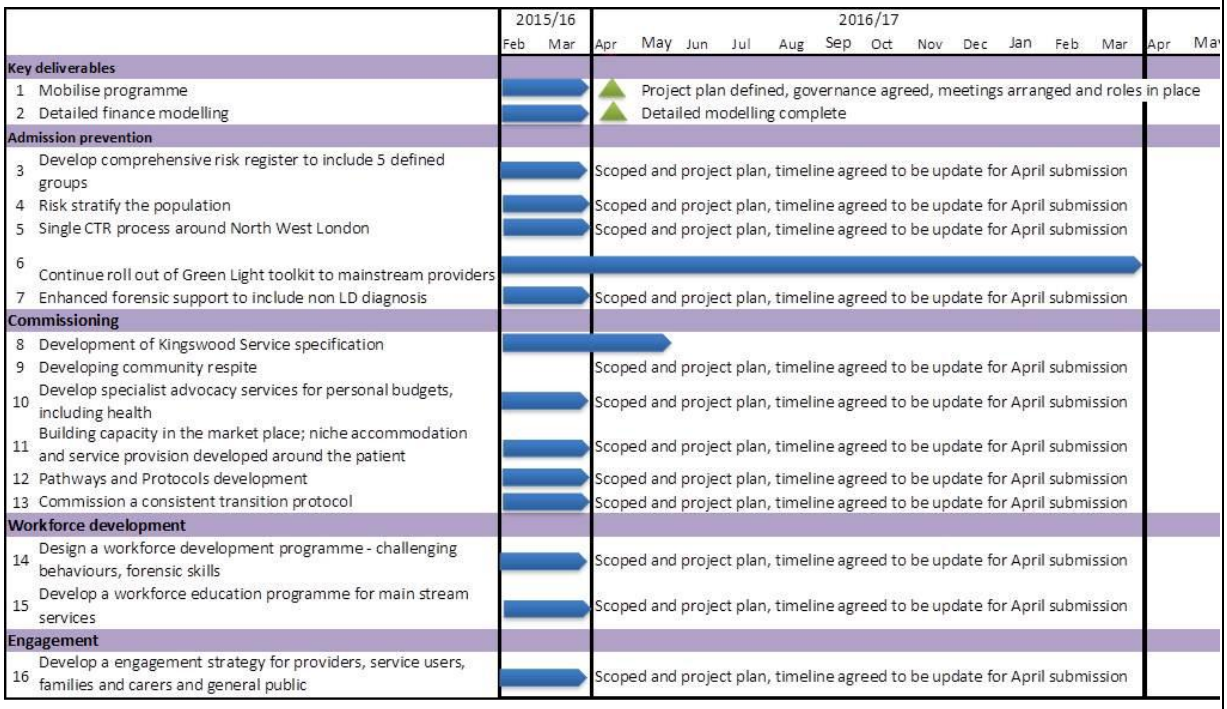
Work is being led at borough level.

7. **Communication and Engagement**:

The central NWL team are supporting development of plans in line with all change programmes.

What are the key milestones – including milestones for when particular services will open/close?

The key milestones for our Transforming Care plan are covered in the project plan below. As we develop clear implementation plans for each work stream, we will develop project plans with timescales for each key milestone.



What are the risks, assumptions, issues and dependencies?

Issues

The timescales to create the initial plans for the 8th February, has meant that we have not been able to undertaken as much focused engagement on the overarching Transforming Care Plan however, from detailed discussions in each of the Boroughs it is clear that local plans for learning disabilities have had service user, carers and family involvement. We do have plans in place to engage more widely with service users, providers and other key stakeholders prior to the next submission on the 11th April as we recognise that there is much more work to do to secure ownership of the plans and as such our plans may change depending on the feedback we receive.

Dependencies

The success of the plan will be dependent on a number of additional factors:

- National changes to allow budgets NHS England for specialised commissioning to be pooled with CCG budgets for non-forensic services for those with a learning disability and/or autism. (we need to test out if this is correct with the finance colleagues)
- CAMHS Transformation Plans: the work to transform CAMHS services has commenced across North West London and will include the redesigning of services for children and young people with a learning disability and/or autism. The Transforming Care plan will need to build upon the work done in CAMHS services to ensure that the new pathways and services align.

Assumptions

The following assumptions underpin our Transforming Care plan:

- Joint working across sectors and boroughs is achievable and sustainable.
- Savings will be released by transferring patients to community care settings, and that these savings will then be invested in community care.
- Additional funding will be provided by NHS England to support transformation, including double running of services during transition.

Risks

Risk description	Probability (High, Med, Low)	Impact (High, Med, Low)	Mitigation
Provider Response: The market does not develop as envisaged. The system may not support new entrant to any market development.	Med	High	Clear market position statements signalling commissioning intentions Good on-going provider engagement including actively working with providers to invite solutions, resolve issues and concerns.
Workforce skills: required workforce skills and capacity do not develop sufficiently. Staff not available/cannot afford to live in London.	Med	High	Clear workforce development plans Work with HENWL on workforce development models. Sufficient funding to develop workforce skills and recruit appropriate staff.
Mainstream services do not make the reasonable adjustment to accommodate LD/autism needs.	Med	Med	Senior leadership engaged so mainstream services make adjustments a priority, use contract levers where necessary.

Pooling budgets: nationally changes are not made to allow specialised commissioning spend to be pooled.	High	Med	Raise nationally as a key issue
Pooling budgets: locally there is still some reluctance to pool health and LA spend.	Med	Med	Leadership and use of the Better Care Fund and section 75 agreements
CCGs and LA are not able to afford new packages of care in the current financial climate with cuts to existing budgets.	High	High	Developing the market place and competition would lead to fairer pricing. Develop an effective pricing structure based on the care funding calculator. Consider risk sharing approaches with providers to encourage their investment.
Lack of commissioning leadership and operational service delivery capacity: business as usual (including CTR guideline recommendation and reporting requirements) takes up everyone's time and there is no availability to take forward the Transforming Care work.	High	High	Provide additional support and capacity via short-term funded posts to cover business-as-usual, allowing experienced staff with local knowledge to get involved in redesign and service development planning.
Population growth: the population of North West London is growing, as is the number of people with a learning disability and/or autism. This will impact on the capacity of services to respond to demand.	High	Med	Include modelling of population growth into service redesign and business case development. Delivering a community-based model will help mitigate by providing care at a lower cost than inpatient care.
High needs patients: the very high costs of high need patients may negate any savings made by transitioning patients into community settings.	Med	High	Realistic planning that accepts the non-standard needs of this population. Continued support for high needs patients factored into affordability models.
Culture change: lack of a single vision and aims across all organisations and team	Med	Med	Effective leadership of the TCP Stakeholder engagement to ensure building of positive and effective relationships.
Earlier discharge may result in more readmissions of patients who were not ready to transition to community.	Low	Med	Extensive discharge planning, to commence prior to admission, proactive care plans, coproduced with people with LD and/or autism and their carers, and monitoring of readmissions.

Negative publicity regarding the media coverage of closure of inpatient beds.	Med	High	Effective strategic communications plan which patient stories promoting better outcome for people.
Estates: lack of available, affordable local housing to develop community in Borough accommodation	Med	High	Look at change of use for existing health property. Consider widest range of solutions including private sector, shared lives etc.

What risk mitigations do you have in place?

See table above.

Any additional information

6.Finances

Please complete the activity and finance template to set this out (attached as an annex).

The process of locally developing plans for the numbers of inpatient beds we will commission in the next 3 years - in compiling the NWL picture it is clear that we have a significant ambition to transform the experience of people – and our ability to support individuals outside inpatient settings. It is also clear that as a first submission we need to fully interrogate the data and define implementation plans for delivering this ambition. We anticipate that numbers will change It is acknowledged that there is more to do in order to strengthen the financial and activity modelling ahead of the submission on 11st April.

End of planning template

London Borough of Hammersmith & Fulham **HEALTH & WELLBEING BOARD** **21 MARCH 2016**	
BETTER CARE FUND UPDATE: QUARTER 3 PERFORMANCE REPORT	
Report of the Cabinet Member for Adult Social Care and Health	
Open Report	
Classification - For Information **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: Liz Bruce, Executive Director Adult Social Care	
Report Author: Rachel Wigley, Deputy Executive Director and Finance Director, Adult Social Care and Health Chris Neill, Whole Systems Director for Adult Social Care and Health Janet Cree, MD of Hammersmith & Fulham Clinical Commissioning Group	**Contact Details:** Tel: 020 8753 5072 E-mail: chris.neill@lbhf.gov.uk

1. EXECUTIVE SUMMARY

1.1. As the Board will be aware, NHS England require regular updates against original BCF submission on benefits and performance. The quarter 3 BCF submission is included for information at Appendix 1.

2. RECOMMENDATIONS

2.1. It is recommended the Health and Wellbeing Board is asked to note and comment on progress to date and comment on the Quarter 3 Better Care Fund submission.

3. REASONS FOR DECISION

3.1. The Better Care Fund (BCF) creates a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their wellbeing as the focus of health and care services, and shifting resources into social care and community services for the benefit of the people, communities and health and care systems

3.2. The Better Care Fund reporting template for Q3 2015-16 which covers the period 1 October to 31 December 2015 was submitted to the national Better Care Support Team on midday on 26 February 2016. As the body with responsibility for endorsing Better Care Fund plans, the Health and Wellbeing Board were required to sign off the Q3 report. As timings did not align with HWB meeting dates, this was done via Chairs. The full Q3 report submitted is now provided here for information and so the Board can note progress.

4. INTRODUCTION AND BACKGROUND

4.1. The BCF is a single pooled budget for health and social care services to work more closely in local areas, based on a plan agreed between the NHS and local authorities. It is a national initiative to improve health and social care outcomes and cost-effectiveness, with an emphasis on more care at and near home.

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

- That the BCF will continue into 2016-17, maintaining the NHS's mandated contribution in real terms over the Parliament.
- That from 2017 the government will make funding available to local government, worth £1.5 billion in 2019-20, to be included in the BCF.
- Areas will be able to graduate from the existing BCF programme management arrangements once they can demonstrate that they have moved beyond its requirements.
- That there will be a commitment of over £500 million by 2019-20 for the Disabled Facilities Grant.

4.3. The Quarter 3 Reporting template was released in January. The timetable for completion was follows:

- 1st Draft completed - 10th February
- Consolidated return available for Senior Officer sign off - 17th February
- Final Submission (to be signed off by the Health and Wellbeing Board) - 26th February

4.4. As deadlines did not align with scheduled HWB meeting dates, Q3 returns went to Chairs and Vice-Chairs meetings for sign-off as detailed above with an agreement submitted reports would be received at the next HWB meetings.

4.5. The scope of the Q3 return was extended with further detail required on the use of NHS number across care settings, revised questions on plans for Personal Health Budgets and additional questions on Multi-Disciplinary/Integrated Care Teams in both non-acute and the acute settings.

4.6. The outstanding conditions in the three boroughs are as follows:

- Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?

- Is the NHS Number being used as the primary identifier for health and care services?
- Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care is there an accountable professional?

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 outline in this report discharges those duties.

6. FINANCIAL AND RESOURCES IMPLICATIONS

6.1. The 2015/16 Better Care Fund has been created from pre-existing NHS and Local Authority funding streams which were already being used to fund health and social care services. The Better Care Programme is focused on achieving improved outcomes through integration. The continuation of the pooled fund into 2016/17 will support continuity of services for customers as well as provide an opportunity for further improvements.

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

LIST OF APPENDICES:

Appendix 1 – Better Care Fund Q3 report template

Quarterly Reporting Template - Guidance

Notes for Completion

The data collection template requires the Health & Wellbeing Board to track through the high level metrics and deliverables from the Health & Wellbeing Board Better Care Fund plan.

The completed return will require sign off by the Health & Wellbeing Board.

A completed return must be submitted to the Better Care Support Team inbox (england.bettercaresupport@nhs.net) by midday on 26th February 2016.

The BCF Q3 Data Collection

This Excel data collection template for Q3 2015-16 focuses on budget arrangements, the national conditions, payment for performance, income and expenditure to and from the fund, and performance on BCF metrics.

To accompany the quarterly data collection Health & Wellbeing Boards are required to provide a written narrative into the final tab to contextualise the information provided in this report and build on comments included elsewhere in the submission. This should include an overview of progress with your BCF plan, the wider integration of health and social care services, and a consideration of any variances against planned performance trajectories or milestones.

Cell Colour Key

Data needs inputting in the cell
Pre-populated cells
Question not relevant to you

Throughout this template cells requiring a numerical input are restricted to values between 0 and 100,000,000.

Content

The data collection template consists of 9 sheets:

Checklist - This contains a matrix of responses to questions within the data collection template.
1) Cover Sheet - this includes basic details and tracks question completion.
2) Budget arrangements - this tracks whether Section 75 agreements are in place for pooling funds.
3) National Conditions - checklist against the national conditions as set out in the Spending Review.
4) Non-Elective and Payment for Performance - this tracks performance against NEL ambitions and associated P4P payments.
5) Income and Expenditure - this tracks income into, and expenditure from, pooled budgets over the course of the year.
metric in BCF plans.
7) Understanding support needs - this asks what the key barrier to integration is locally and what support might be required.
8) New Integration metrics - additional questions on new metrics that are being developed to measure progress in developing integrated, cooridnated, and person centred care
indicators.

Checklist

This sheet contains all the validations for each question in the relevant sections.
All validations have been coloured so that if a value does not pass the validation criteria the cell will be Red and contain the word "No" and if they pass validation they will be coloured Green and contain the word "Yes".

1) Cover Sheet

On the cover sheet please enter the following information:
The Health and Well Being Board
Who has completed the report, email and contact number in case any queries arise
Please detail who has signed off the report on behalf of the Health and Well Being Board.

template have been completed the cell will turn green. Only when all 9 cells are green should the template be sent to england.bettercaresupport@nhs.net

2) Budget Arrangements

This plays back to you your response to the question regarding Section 75 agreements from the Q1 and Q2 2015-16 submissions and requires 2 questions to be answered. Please answer as at the time of completion. If you answered 'Yes' previously the 2 further questions are not applicable and are not required to be answered.

they have?
If the answer to the above is 'No' please indicate when this will happen

3) National Conditions

This section requires the Health & Wellbeing Board to confirm whether the six national conditions detailed in the Better Care Fund Planning Guidance are still on track to be met through the delivery of your plan (http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/). Please answer as at the time of completion.

It sets out the six conditions and requires the Health & Wellbeing Board to confirm 'Yes', 'No' and 'No - In Progress' that these are on track. If 'No' or 'No - In Progress' is selected please provide a target date when you expect the condition to be met. Please detail in the comments box what the issues are and the actions that are being taken to meet the condition.
'No - In Progress' should be used when a condition has not been fully met but work is underway to achieve it by 31st March
Full details of the conditions are detailed at the bottom of the page.

4) Non-Elective and Payment for Performance

This section tracks performance against NEL ambitions and associated P4P payments. The latest figures for planned activity and costs are provided along with a calculation of the payment for performance payment that should have been made for Q4 - Q2. Two figures are required and one question needs to be answered:

Input actual Q3 2015-16 Non-Elective Admissions performance (i.e. number of NEAs for that period) - Cell O8
Input actual value of P4P payment agreed locally - Cell F19
If the actual payment locally agreed is different from the quarterly payment suggested by the automatic calculation in cell AR8 (which is based on your input to cell O8 as above) please explain in the comments box
Please confirm what any unreleased funds were used for in Q3 (if any) - Cell F34

5) Income and Expenditure

following information:

Forecasted income into the pooled fund for each quarter of the 2015-16 financial year
Confirmation of actual income into the pooled fund in Q1 to Q3
Forecasted expenditure from the pooled fund for each quarter of the 2015-16 financial year
Confirmation of actual expenditure from the pooled fund in Q1 to Q3

Figures should reflect the position by the end of each quarter. It is expected that planned income and planned expenditure figures for Q4 2015-16 should equal the total pooled budget for the Health and Wellbeing Board.

There is also an opportunity to provide a commentary on progress which should include reference to any deviation from plan or amendments to forecasts made since the previous quarter.

6) Metrics

This tab tracks performance against the two national supporting metrics, the locally set metric, and the locally defined patient experience metric submitted in approved BCF plans. In all cases the metrics are set out as defined in the approved plan for the HWB and the following information is required for each metric:
An update on indicative progress against the four metrics for Q3 2015-16
Commentary on progress against the metric

If the information is not available to provide an indication of performance on a measure at this point in time then there is a drop-down option to indicate this. Should a patient experience metric not have been provided in the original BCF plan or previous data returns there is an opportunity to state the metric that you are now using.

7) Understanding support needs

This tab re-asks the questions on support needs that were first set out in the BCF Readiness Survey in March 2015. These questions were then asked again during the Q1 2015-16 data collection in August. We are keen to collect this data every six months to chart changes in support needs. This is why the questions are included again in this Q3 2015-16 collection. The information collected will be used to inform plans for ongoign national and regional support in 2016-17.

The tab asks what the key barrier to integration is locally and what support might be required in putting in meeting the six key areas of integration set out previously. . HWBs are asked to:

Confirm which aspect of integration they consider the biggest barrier or challenge to delivering their BCF plan
support to take

There is also an opportunity to provide comments and detail any other support needs you may have which the Better Care Support Team may be able to help with.

8) New Integration Metrics

This tab includes a handful of new metrics designed with the intention of gathering some detailed intelligence on local progress against some key elements of person-centred, co-ordinated care. Following feedback from colleagues across the system these questions have been modified from those that appeared in the last BCF Quarterly Data Collection Template (Q2 2015-16). Nonetheless, they are still in draft form, and the Department of Health are keen to receive feedback on how they could be improved / any complications caused by the way that they have been posed.

For the question on progress towards instillation of Open APIs, if an Open API is installed and live in a given setting, please state 'Live' in the 'Projected 'go-live' date field.
For the question on use and prevalence of Multi-Disciplinary/Integrated Care Teams please choose your answers based on the proportion of your localities within which Multi-Disciplinary/Integrated Care Teams are in use.

9) Narrative

In this tab HWBs are asked to provide a brief narrative on overall progress in delivering their Better Care Fund plans at the current point in time with reference to the information provided within this return.

London Borough of Hammersmith & Fulham **HEALTH AND WELLBEING BOARD** **21 March 2016**	
END OF LIFE CARE JSNA	
Report of the Director of Public Health	
Open Report	
Classification - For Decision **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: Liz Bruce, Executive Director for Adult Social Care and Health	
Report Author: Colin Brodie, Public Health Knowledge Manager	**Contact Details:** Tel: 020 7641 4632 E-mail: cbrodie@westminster.gov.uk

1. EXECUTIVE SUMMARY

1.1. This report summarises the work and findings of the JSNA on End of Life Care, including the recommendations for key partners.

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

2. RECOMMENDATIONS

2.1. The Health and Wellbeing Board is requested to approve the End of Life Care JSNA for publication, and to note how the JSNA will be used to inform local strategic approaches to end of life care.

2.2. The Health and Wellbeing Board is invited to consider the recommendations arising from the End of Life Care JSNA, in particular Recommendation 3, and provide a steer on how this should be implemented locally:

- **Identify clear strategic leadership for end of life care across social care, health and the independent sector**. A lead organisation should be identified with responsibility for ensuring developments are cohesive and aligned. This is also reflected in the recent Ambitions for Palliative and End of Life Care recommended by the National Palliative and End of Life Care Partnership.

2.3. It is recommended that the Health and Wellbeing Board review progress against recommendations in 1 year from publication

3. REASONS FOR DECISION

3.1. A JSNA on End of Life Care was undertaken as part of the approved JSNA Work Programme in order to provide a comprehensive evidence base and information about the local population, to guide a future strategic approach to end of life care and inform commissioning intentions.

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

4. INTRODUCTION AND BACKGROUND

4.1. People approaching the end of their life experience a range of physical, emotional and spiritual symptoms. To manage these issues effectively requires integrated and multidisciplinary working between teams and across sectors regardless of whether the person is in their home, in hospital, a care home, or hospice.

4.2. Families and carers of people at end of life also experience a range of challenges and will have their own specific needs which must be addressed before, during and after the person's death.

4.3. While some people experience good and excellent quality end of life care, many people do not. To address the variation in end of life care, it is vital that end of life care is seen as 'everyone's business' and not limited to certain specialities such as palliative care services.

4.4. The focus on supporting people to receive care, and be supported to die in their preferred place of care, requires a future shift in culture which can only be achieved by upskilling the workforce in identifying the dying phase, having difficult conversations and managing end of life care needs and preferences.

4.5. Primary care teams in the community can deliver excellent palliative care for their dying patients and enable patients to die well where they choose when complemented by good access to specialist services, support, and expertise. As demand for community care increases, it is important to maximise the potential of primary palliative care and the use of frameworks or protocols with good collaboration with specialists.

4.6. Whole Systems Integrated Care (WSIC) and Shaping a Healthier Future (SaHF) strategies and respective local authority strategies provide opportunities to focus on community based care and enhance end of life care.

5. JSNA RECOMMENDATIONS

5.1. There are 5 recommendations, with each recommendation including a range of opportunities for consideration by commissioners for local implementation.

5.2. Recommendation 1 refers to an ambition for the local delivery of high quality, person- centred end of life care designed to improve the experience of the dying person and their families, carers and friends. Recommendations 2 to 5 describe the culture, governance, processes and systems that need to be in place in order to achieve this ambition

5.3. The recommendations are:

Recommendation	Summary
Recommendation 1: Maximise choice, comfort and control through high quality effective care planning and co-ordination	Everyone with a life limiting long term condition should have care plans which address their individual needs and preferences, particularly as they approach the last phase of life. Their care must be coordinated, with a clear oversight of the respective roles and responsibilities of all health, social care and third sector service providers.
Recommendation 2: Promote end of life care as 'everybody's business' and develop communities which can help support people	The overall focus of end of life care must be a community model, with input from specialist services when needed. Local leaders, commissioners, professionals and our populations should generate a culture where talking about and planning for the last phase of life is 'normal', and all practitioners are willing and able to give end of life care.
Recommendation 3: Identify clear strategic leadership for end of life care across both social care, health and the independent sector	A lead organisation should be identified with responsibility for ensuring developments are cohesive. Leadership should reflect a community based model across a range of services, with a clearly articulated end of life care vision and ambitions.
Recommendation 4: Develop a coordinated education and training programme for practitioners, the person	Formal and informal training and education programs for all frontline practitioners needs to be coordinated, systematic, visible and evaluated, in line with good practice guidelines.

dying, carers and for family and friends (if they wish)	
Recommendation 5: Everyone should have easy access to evidence and information	More information needs to be easily available. Accessibility in terms of language, style, culture and ability should be reviewed. Evidence and information must be available to commissioners and providers and used to actively improve services.

6. CONSULTATION

6.1. A workshop was held at the BME Health Forum in June 2015. Feedback from the workshop was incorporated into the findings, particularly the Policy and Evidence Review (Supplement 2)

6.2. A workshop was held at the End of Life Care Steering Group in September 2015 to inform the development of the recommendations. The End of Life Care Steering Group consists of CCG and GP End of Life Care leads as well as community and secondary care providers

6.3. The JSNA was presented to the Hammersmith and Fulham CCG Governing Body Seminar on 03/11/2015. In addition, CCG and GP End of Life Care leads were interviewed for the JSNA.

6.4. The draft JSNA was disseminated to key stakeholders in November 2015, including colleagues in Local Authority, Adult Social Care, CCGs, Central London Community Healthcare, Hospices, Specialist Palliative Care Teams, Healthwatch, and Community and Voluntary organisations. Feedback was collated and reviewed by the Task and Finish Group and informed the final report..

7. EQUALITY IMPLICATIONS

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

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

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

8. LEGAL IMPLICATIONS

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

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

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

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

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

9. FINANCIAL AND RESOURCES IMPLICATIONS

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

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

10. IMPLICATIONS FOR BUSINESS

10.1 None identified

11. RISK MANAGEMENT

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

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

12. PROCUREMENT IMPLICATIONS

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

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

13. IT STRATEGY IMPLICATIONS

13.1. Any future IT proposals identified as a result of the JSNA will be cleared by the relevant IT Officer.

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

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

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	End of Life Care Key Themes Report http://www.jsna.info/endoflifecare	Colin Brodie, Public Health Knowledge Manager Tel: 02076414632	Public Health
2.	End of Life Care JSNA Supplement 1 – Technical Document http://www.jsna.info/endoflifecare	Colin Brodie, Public Health Knowledge Manager Tel: 02076414632	Public Health
3.	End of Life Care JSNA Supplement 2 – Policy and Evidence Review http://www.jsna.info/endoflifecare	Colin Brodie, Public Health Knowledge Manager Tel: 02076414632	Public Health

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

KEY

FOR DECISION

FOR DISCUSSION

FOR INFORMATION

PLANNING

Agenda Item	Summary	Lead	Item
Meeting Date: 21 March 2016			
STRATEGIC PLANNING DISCUSSION			
STRATEGIC PLANNING DISCUSSION	comprising: • Place-based-leadership: Discussion facilitated by the King's Fund about place-based systems of care • Looking back: reviewing the position of health and wellbeing boards nationally and self-assessment of progress so far • Looking forward: reviewing the demographic and health challenges in the borough; recent policy developments and agreeing approach to refreshing the Joint Health and Wellbeing Strategy	**King's Fund** **ASC** **PH/ASC**	**For decision**
BUSINESS ITEMS			

NWL TRANSFORMING CARE PLAN	For review prior to final submission to NHS England on 11th April	**NWL CCG**	**For decision**
JSNA End of Life Care	For formal ratification	**PH**	**For decision**
BETTER CARE FUND Q3 REPORT	Report submitted on 26th February for information	**ASC**	**For information**
Meeting Date: 20 June 2016			
STRATEGIC ITEMS			
JOINT PLANNING	comprising: • Update on NWL Sustainability & Transformation Plan • Agree Joint Health & Wellbeing Strategy	**ASC/CCG**	**For decision**
ANNUAL PUBLIC HEALTH REPORT 2016/17 + ONLINE JSNA	For approval ahead of publication		**For discussion**
DISCUSSION ITEMS			
HOUSING JSNA	For approval ahead of publication		**For decision**
CHILDHOOD OBESITY: ONE YEAR ON	For approval ahead of publication		**For discussion**
Meeting Date: 7 September 2016			
STRATEGIC ITEMS			
INTEGRATION, ACCOUNTABLE CARE AND DEVOLUTION	including CCG commissioning intentions17/18 and beyond	CCG/ASC	**For decision**
TRANSFORMING PRIMARY CARE	Primary care transformation plans	CCG/NHSE	**for discussion**
MENTAL HEALTH	Update on tackling mental health in the borough	CCG/PH	**for discussion**
DISCUSSION ITEMS			
JOINT HEALTH & WELLBEING STRATEGY	discussion focusing on a particular aspect of the strategy	ASC/CCG/PH	**For discussion**
YOUNGER ADULTS 18-15 JSNA DEEP DIVE	to consider findings of the JSNA deep dive and approval ahead of publication	PH	**For discussion**

Meeting Date: 14 November 2016			
STRATEGIC ITEMS			
STP DELIVERY: 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**
JOINT HEALTH AND WELLBEING STRATEGY	discussion focusing on a particular aspect of the strategy tba	ASC/CCG/PH	**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**
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**