London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Agenda

Wednesday 7 September 2016
6pm
Courtyard Room - Hammersmith Town Hall

MEMBERSHIP

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

Ian Lawry – SOBUS (Co-Opted Member)

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Date Issued: 25 August 2016

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Health & Wellbeing Board
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9. ANNUAL PUBLIC HEALTH REPORT 2015-16 264 - 284

10. WORK PROGRAMME 285 - 288

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

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

11. DATES OF NEXT MEETINGS

The Board is asked to note that the dates of the meetings scheduled for the municipal year 2016/17 are as follows:

14 November 2016
08 February 2017
20 March 2017

London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Draft Minutes

Monday 20 June 2016

PRESENT

Committee members:
Councillor Vivienne Lukey (Chair) and Sue Macmillan, Cabinet Member for Education and Children
Councillor RoryVaughan, Chair, Health, Adult Social Care & Social Inclusion PAC
Vanessa Andreae, H&F CCG
Janet Cree, H&F CCG
Stuart Lines, Deputy Director of Public Health

Nominated Deputies Councillors: Councillor Sharon Holder, Lead Member for Hospitals and Health Care

Officers: Chris Neil, Adult Social Care, Wholes Systems Director; Rachael Wright-Taylor, Director for Children's Commissioning

51. SUE PERRIN - CONDOLENCES AND MINUTES SILENCE

The Chair informed members of the news that Sue Perrin, the Committee Coordinator responsible for supporting the work of the Health and Wellbeing Board, had sadly passed away, following a short illness. The Chair expressed her condolences to the family, friends and colleagues who had worked with her for a number of years. Sue had been a diligent, supportive and valued colleague and will be sadly missed. The Committee stood for a minutes silence to honour her passing.

52. APPOINTMENT OF VICE-CHAIR

The Chair invited nominations from members of the Committee for the appointment of Vice-Chair. Janet Cree, Managing Director, Hammersmith and Fulham Clinical Commissioning Group, proposed Dr Tim Spicer, Chair, Hammersmith and Fulham Clinical Commissioning Group, Vanessa Andreae, Hammersmith and Fulham Clinical Commissioning Group, seconded the proposal.

RESOLVED:

That Dr Tim Spicer be appointed Vice-Chair for the municipal year 2016/17.

53. MINUTES AND ACTIONS

Chris Neil, Whole Systems Director (LBHF) corrected a figure given under Item 4 as £159 million.

RESOLVED:

That subject to the above amendment, the minutes of the meeting held on 21 March 2016 be agreed as a correct record.

54. APOLOGIES FOR ABSENCE

Apologies were received from Dr Tim Spicer, Mike Robinson, and Liz Bruce. Apologies for lateness were received from Councillor Rory Vaughan.

55. DECLARATIONS OF INTEREST

None.

56. HEALTH AND WELLBEING STRATEGY 2016-17 AND NW LONDON SUSTAINABILITY & TRANSFORMATION PLANS

Janet Cree, Managing Director, H& Clinical Commissioning Group provided an update on the Sustainability and Transformation Plans (STP), setting out key evidence by the submission date, which was 30th June. Outlining briefly the main work, covering three delivery areas and categorising nine priorities, it was explained that this would be delivered over three boroughs, identifying actions in each one. These would also be planned with input from local working groups and with representatives from the CCG. It was noted that the key delivery area was radically updating prevention and early intervention and progress generally will be reviewed at national level, with a report back to the CCGs collectively. Janet Cree concluded by saying that the STP would continue to evolve.

Councillor Lukey enquired about the November deadline and Chris Neil, Whole Systems Director (LBHF) confirmed that this had now become adjustable. He also explained that there was new guidance about public consultation plans, highlighting concerns amongst local authorities about the democratic deficit and noting that this was not implied. Janet Cree responded that they were waiting on national guidance. The draft documents were not yet 'public'. Noting the correlation or overlap with the STP, they had used the local HWB strategy as a delivery vehicle. Local work had formed around the strategy and will feed into the STP, becoming part of the same workstream.

Councillor Lukey reaffirmed the Council's strong focus on public engagement and consultation but acknowledged that this would not be possible until the document became public. Moving forward, Councillor Lukey sought assurance that there were no references in the draft to the current debate on Charing Cross A&E services or the number of beds, voicing her concern that this discussion was occurring without local involvement. Vanessa Andreae,

H&F CCG, explained that there was a consolidation of strategies and this would not develop with that level of detail without local involvement. Janet Cree confirmed that there was clarity in the language used and that any reviews as to the number of beds will be clear.

Councillor Sharon Holder, Lead Member for Hospitals & Healthcare enquired at which point the STP would finally be signed off. It was noted that this would not be before The Leader, Councillor Stephen Cowen attended the next London Councils meeting and LBHF would be involved in further discussions on this. Chris Neil added that the process could be viewed from the base case but there was also a need to view the STP, locally and regionally.

Moving the discussion forward, Chris Neil provided an update on the Joint Health and Wellbeing Strategy 2016-2021. Referring to the survey data on the first page, January 2016 saw the strategy being refreshed and the STP amended. In March, Chris Ham, Chief Executive, The Kings Fund looked at integrated healthcare systems and on 24th May, there was a half day development session attended by stakeholders, NHS, public health providers and which was also attended by Councillor Holder. Engagement was important as a precursor to full public consultation.

Chris Neil went on to outline the timetable for consultation, with discussion and feedback by 10th July, and a public consultation period of 14 weeks, with final strategy approval by the Board on 16th November. With reference to the Joint Strategic Needs Assessment (JSNA) on page 3 and the wider determinants of health on page 4, the workshop held on 24th May discussed the close alignment of thinking on co-commissioning, for example, and the importance of technology and digital tools. Continuing, page 5 of the document referred to the priorities for delivering high quality health services, whilst page 6 outlined radical upgrades in prevention and self-care on independence work and capacity building. Joined up, frontline care, with clear access pathways was an important point. Chris Ham spoke in terms of public whole health approach, one that was more holistic and viewable across the systems, therefore able to move to increasingly preventative applications.

Stuart Lines, Deputy Public Health Director, commended the work undertaken on refreshing the strategy and the opportunity to revitalise key priorities for example, life expectancy and improving aspirations. Councillor Lukey added that targeted work would require evaluation and was keen to ensure that this would extend beyond adult social care. Vanessa Andreae suggested that it would be helpful to numerically align the priorities to avoid confusion and Chris Neil concurred with this approach. It was noted that the engagement process was timed to coincide with the summer holidays and part of the autumn term, and that it was important to encourage this. Councillor Holder reiterated that evidencing the format that the engagement took was essential for future analysis and auditing. Chris Neil confirmed that the consultation feedback would broadly inform the final draft and that further discussion on the strategy would include the Board. Continuing the discussion around consultation and engagement events, Councillor Sue Macmillan, Cabinet Member for Children and Education commented on the level of public

awareness, identifying what was working well and how to build on this, together with the need to make it relevant to the people.

Members of the Board considered the timeframe and agreed that the initial date for responses to the draft should be moved forward to 5th July to allow sufficient time to present it to the CCG governing body. Chris Neil agreed to slight amendments on the timetable and the Board commended the draft as a well-articulated document presented in an accessible language.

RESOLVED

1. That the content of the draft strategy, with the proviso that the date be moved forward to 5th July, as set out in Appendix 1, for public consultation, be agreed and approved;

2. That the 14 week period of public consultation on the draft strategy, from 20 July to 27 October 2016, be approved subject to minor amendment;

3. That further community engagement in the north, central and south of the borough during the public consultation period, be undertaken;

4. That, subject to the findings of the public consultation, a revised final Joint Health and Wellbeing Strategy, be considered for approval at the meeting on 14 November 2016; and

5. That the update on the Sustainability and Transformation Plans, be noted.

57. BETTER CARE FUND 2015-16

Chris Neil, Whole Systems Director, presented the report which set out arrangements for the Better Care Fund 2016/17. Focusing on continuing funding, the list of schemes referred to in the report identified a £159,327 million budget spread over three authorities. Briefly, it was noted that section 'A' schemes were implemented already.

Councillor Vivienne Lukey, Cabinet Member for Health and Adult Social Care, commented that beds were needed for dementia cases and it was noted that this was currently being considered by the joint executive teams. In terms of the timeframe, Janet Cree, Managing Director, H&F CCG, confirmed that the scoping of plans needed to identify resources from the delivery team, which was essential in order to understand need. It would be premature to set a timeframe as change will materialised according to the market and availability of beds but an update could be provided at the next meeting.

ACTION: Janet Cree

RESOLVED:

That the report be noted.

58. COMMUNITY INDEPENDENCE SERVICE PROCUREMENT

Chris Neil, Whole Systems Director, presented a brief outline of the report which sought to set out a key part of the Better Care Fund for older residents experiencing care issues or ill health. This was a nationally recognised service and illustrated what integrated care should look like. The plan was to implement a yearlong contract, with the CCG forming a partnership to recommission services. The following the procurement process (detailed in the report), the appointment of the preferred bidder was confirmed on 6th June, subject to contract.

In response to a number of points from Councillor Sharon Holder, Lead Member for Hospitals and Health Care, Chris Neil explained that the Better Care Fund (BCF) was under pinned by care measures split across different service areas. Key performance indicators were measured on a monthly/quarterly basis submitted by the lead provider group. In terms of written feedback from the Community Independence Service (CIS) this included very positive feedback on the service which was fed into the process. Chris Neil acknowledged the need to ensure high quality, accessible services and confirmed to Councillor Rory Vaughan that feedback through Healthcheck, directly to providers about patient experience, would be a positive benefit. It was noted that patient feedback, compliments and complaints should be acted upon consistently.

The Chair commented on Central and North West London NHS Foundation Trust (CNWL) in terms of the perception of the trust as a mental health service provider (providing a small element of nursing care) and how this now fitted with the role as provider for CIS. It was noted that the governance and accountability provisions for the Trust were tightly executed and that the Trust had managed to achieve a surplus last year. It was noted that the contract negotiation with the provider had taken place and following phased implementation would go live in September 2016, continuing to March 2018. The panel discussed options to evaluate the new service accepted that it would require a period of adjustment following mobilisation. It was anticipated that a review could be undertaken in either November or December to allow the Policy and Accountability (PAC) to examine in-depth. It was acknowledged that the transition may not impact at all particularly if it prevented residents from entering hospital and if they were in hospital, to discharge more efficiently. More information would be helpful and it was noted that acute hospitals were not engaging with service..

ACTION: Chris Neil

RESOLVED:

That the report be noted.

59. WORK PROGRAMME

The Committee discussed the agenda for the meeting planned for 7th September and noted the number of items on the agenda, exploring the possibility of allowing the Housing JSNA report to move to November and share the Annual Public Health report 2015/16 Vision Statements with the Board via email.

60. DATES OF NEXT MEETINGS

It was noted that the next meeting of the Board would be held on 7th September 2016.

Meeting started: 6pm
Meeting ended: 7.20pm

Chair .....

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London Borough of Hammersmith & Fulham **HEALTH AND WELLBEING BOARD** **7 SEPTEMBER 2016**	
NORTH WEST LONDON SUSTAINABILITY AND TRANSFORMATION PLAN (STP): JUNE SUBMISSION	
Report of the Managing Director of Hammersmith & Fulham CCG	
Open Report	
Classification - For Review & Comment **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: Liz Bruce, Executive Director of Adult Social Services	
Report Author: Harley Collins, Health and Wellbeing Manager	**Contact Details:** Tel: 020 8753 5072 E-mail: Harley.collins@lbhf.gov.uk

1. EXECUTIVE SUMMARY

1.1. This report gives an overview of the key messages and priorities detailed in the North West London STP submitted to NHS England in June. It updates on emerging governance arrangements that will oversee development and delivery of the STP, consultation and engagement plans and next steps including the deadline for submission of a final plan by 21 October.

2. RECOMMENDATIONS

2.1. The Health and Wellbeing Board is requested to:

- Discuss and provide comment on the June submission of the NW London STP which is included with this paper as Appendix 1. The Board's comments will be sent for incorporation into the final STP which NW London is required to submit to NHS England on 21st October.
- Once the outcome of October submission is known a further report will be presented to the Board on the service proposals and funding available in order to address the existing gap and ensuring that the costs of increased social care that will result from the delivery areas set out in the new plan.

3. REASONS FOR DECISION

3.1. To ensure ongoing involvement and input from the Health and Wellbeing Board and provide an opportunity for the Board to comment on the June submission prior to the final submission of the plan to NHS England on 21 October.

4. INTRODUCTION AND BACKGROUND

4.1 Sustainability and transformation plans (STPs) were announced in the NHS planning guidance published in December 2015 as a vehicle to support the delivery of the Five Year Forward View. NHS organisations in different parts of the country have been asked to come together to develop 'place-based plans' for the future of health and care services in their area. The emphasis on 'place' represents a shift in NHS planning policy from one where individual organisations act to secure organisational interests to one where organisations and services collaborate to jointly address challenges and improve the health of the populations they serve.

4.2 STPs are five-year plans covering all areas of NHS spending in England. A total of 44 areas have been identified as the geographical 'footprints' on which the plans will be based. The North West London footprint covers 8 boroughs[1] and 2.1 million residents.

4.3 STPs are local health and care systems' blueprints for accelerating implementation of the Forward View. Guidance from NHS England and other national bodies set out a series of questions for local leaders to consider in their plans, relating to the closure of three 'gaps':

1. Health and wellbeing – preventing people from getting ill and supporting people to stay as healthy as possible
2. Care and quality – consistently high quality services, wherever and whenever they are needed
3. Finances and efficiency – making sure services are operated as effectively as possible

4.4 Leaders have been asked to identify key priorities for their local area to meet these challenges and deliver financial balance. While the guidance focuses on NHS services, STPs also cover better integration with local authority services including public health and social care.

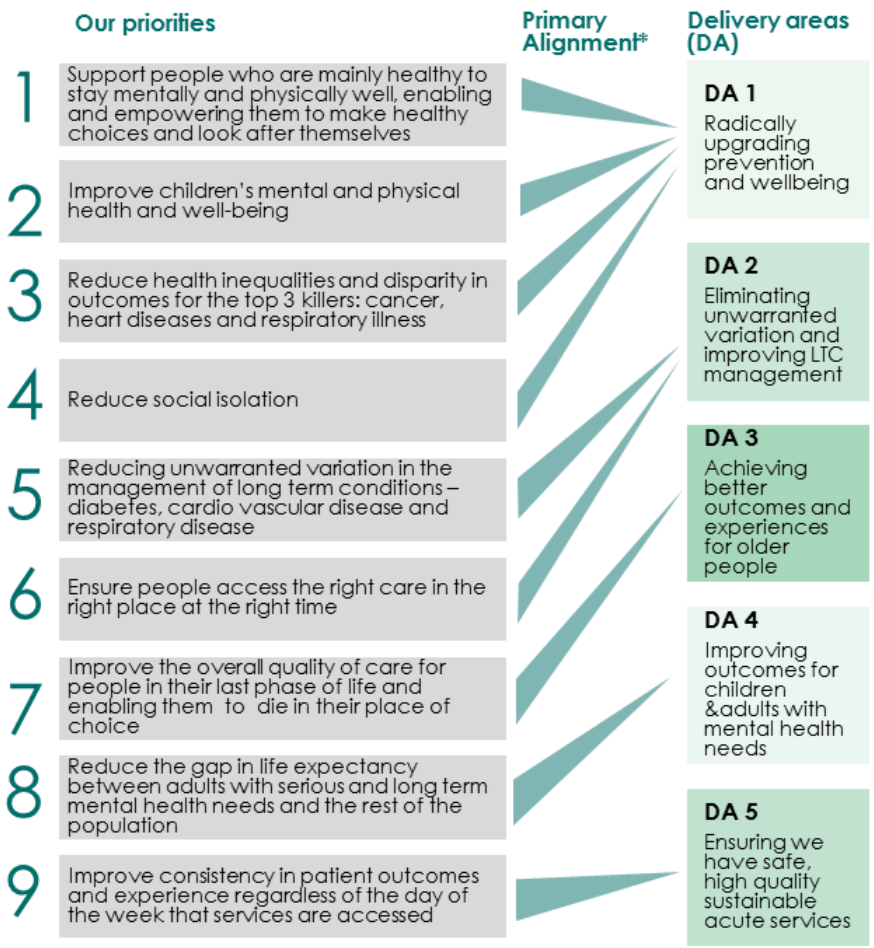
4.5 The NHS and local authorities across NW London have agreed to work together to deliver a better health and care system. Patient groups and other stakeholders have been involved in developing the plan. The NW London STP describes the shared ambition of partners across health and local government to create an integrated health and care system that enables people to live well and be well. A

[1] Brent, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow, Kensington & Chelsea and Westminster Councils

draft plan has been developed and was submitted to NHS England on 30 June. The key messages in the June submission were:

- To address the Triple Aim challenges, we must fundamentally transform our system.
- The vision for NW London involves 'flipping' the historic approach to managing care, turning a reactive, increasingly acute-based model on its head, to one where patients take more control, supported by an integrated system which proactively manages care with the default position being to provide this care in areas close to people's homes, wherever possible.
- We have developed 9 Priorities for NW London which we must address if we are to transform our system.
- From these priorities, we have identified 5 Delivery Areas that we need to focus on to deliver at scale and pace across NW London. Figure 1 below sets out how our Priorities align to the Delivery Areas
- Local areas have created 'Local Executive Summaries' which show how their plans are aligned to NW London priorities. These summaries also reflect local priorities and activities to address specific local challenges.

Fig.1 - Alignment of NW London's Priorities and Delivery Areas



4.6 The STP will determine how much money NW London is awarded from the Sustainability and Transformation Fund (STF). The strongest place-based plans will unlock funding from 2017/18 onwards to support their planned transformation. The STF is a national fund worth £1.8bn and is a major 'one-off' for sustainability, intended to bring NHS providers back to balance. The 44 STP footprints in England are competing for the funding and North West London is the 4th largest. The STF will gradually increase in size, rising to £3.4bn by 2020/21.

5. PROPOSAL AND ISSUES

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

5.2. An STP 'Base Case' was submitted to NHS England on 15 April setting out: the needs of NW London population, the emerging priorities, governance for implementing the plan and emerging delivery areas. Feedback received from NHS England was that NW London's plan is a good plan with strong patient engagement and a good relationship with local government.

5.3. A further iteration of the plan was submitted on 30 June. The London Boroughs of Ealing and Hammersmith & Fulham were not signatories to the June STP submission due to ongoing concerns around proposals developed through the Shaping a Healthier Future programme i.e. to reconfigure acute care in north west London. To move forward, the boroughs have agreed conditions (see Appendix 2 - STP Appendix A) that must be reflected in the STP document. Since submitting the plan NW London partners have met with NHS England to discuss the plans in more detail and are currently awaiting formal feedback.

5.4. The timelines for developing STPs and the process for approving them have been fluid. The original deadline for submitting plans to NHS England and other national bodies was 30 June 2016, but most plans will now be further developed and re-submitted by 21 October. The plans are likely to be assessed and approved in phases, depending on their quality. From April 2017, STPs will become the single application and approval process for accessing NHS transformation funding, with the best plans set to receive funds more quickly.

5.5. Governance

5.6. In order to work together across the system to deliver the transformation set out in the STP, partners need to develop an effective governance approach. Partners are in the process of developing a Joint Health and Care Transformation Group which will have representation from across local government and health, including commissioners, providers and patient representatives. The purpose of this group will be to oversee the development of the STP and its delivery and its first meeting will take place in late September. (A draft overview of governance arrangements and membership is attached as Appendix 3)

5.7. NW London is required by NHS England to re-submit its plan on 21st October (date is provisional at this time). Between now and October the priorities are:

- Completing the plan – incorporating feedback from local governance boards and from public and staff engagement
- Establishing governance arrangements to support the STP delivery
- Mobilising projects outlined in the STP and accelerate delivery
- Measuring and supporting 16/17 delivery and developing a detailed plan for 17/18

6. CONSULTATION

6.1. NW London have collaborated with people, service users and patients at all stages of the commissioning, mobilisation and delivery cycle.

6.2. NW London will be continuing these conversations with people in NW London during the development of the STP, and its implementation. There is joint governance and leadership across the communications and engagement space, with a work stream led by the CCG Director of Communications in partnership with communications leads from providers and local government. This group sets the overall direction for communications and engagement but working in partnership with colleagues from across all sectors involved in the STP.

6.3. North West London partners have followed best practice in their work guided by the principles of discussing early and listening. All work is in partnership with commissioners, providers, local government, Healthwatch, patients groups and residents associations.

6.4. **Having established the delivery areas in the checkpoint submission the purpose of this phase is to engage our partners, staff, patients and residents on whether our focus is right and what more they would like to see**

6.5. **At a local level we have already:**

- Held 22 face to face engagement events across all eight boroughs to help co-design the local plans, on top of regular meetings of the STP planning groups
- These events have included workshops, seminars and public meetings and been very popular with providers, patients, Healthwatch, carers and their families and lay partners
- We have also used Health and Wellbeing Boards along with CCG Governing Body meetings to engage people
- In Brent the Healthy Partners Forum had a turnout of around 100 people with table discussion focussed on the emerging priorities, while in Hillingdon over 100 people attended a STP focussed workshop
- We have promoted these events through our social media platforms to maximise attendance
- These local plans, co-designed with the local community, in turn form the basis for the full North West London STP.
- We have provided feedback to those attending so they can see how their work has fed into the plan

6.6 **At a pan North West London level we have:**

- Identified the key audiences we need to be engaging with over the next few months across the eight boroughs.
- Held joint health and local government meetings across NW London to contribute to the development of the STP.
- Hosted a co-production workshop with lay partners, Healthwatch and providers to help feed into the checkpoint submission and provide an early opportunity to shape the direction of the STP.
- Ideas from that session include the Peoples Health Charter which is an important part of our STP moving forward.
- Hosted a workshop with communications leads from across sectors to help co-design the engagement strategy
- Hosted sessions with clinicians to get their input into the priorities and delivery areas, ensuring our workforce is a driver and owner of change
- Clinicians have been enthused by the process and see the value that comes from the STP
- Created a shared slide deck/core narrative covering our health and social care challenges and opportunities, STP purpose, development, goals, strategic approach and priorities – ensuring it is in patient- focused and in accessible language

6.7 **Engagement from summer through to December 2016**

There are four strands to the work we are now doing:

(1) With partners:

- We are designing a programme of more deliberative-style events, looking at bringing together different groups in different ways – e.g. clinicians from across sectors/organisations; all those involved in care for older people – to more directly shape further development and implementation of the STP
- We ran a market stall event for our core partners (20 July) to showcase the range of work which is happening across North West London
- Working with local government partners we will continue to review the assumptions underpinning the changes to acute services and the delivery of local services
- We will hold a second market stall event for a wider audience of partners in the autumn

(2) With staff:

- Our best advocate for the STP is our staff, spread across multiple locations and in a range of different roles. Each of our partners – whether in health or local government – is working up plans for specific staff engagement.
- Across the STP footprint we are running a series of workshops with clinicians and local government officers to engage them on the STP
- STP updates are already a regular staple of all our internal communications materials and moving into the summer/autumn we will be promoting workshops and updating on progress through internal newsletters and bulletins, weekly/monthly updates from Chief Executives and Chief Operating Officers, and online through our intranets.

- We are also working in tandem with our GP federations to engage primary care providers

(3) And with our patients and residents – through face to face meetings:

- We will set out a programme of traditional town hall style meetings and other face to face events across the eight boroughs, working closely with Healthwatch and other patient groups and residents associations across the to ensure that we get real input from the local community
- As well as having events in each borough we will also hold pan north west London events, with at least one in the inner boroughs (CWHHE) and one in the outer boroughs (BHH)
- We will exploit the variety of networks available to us from patient representative groups to local authority engagement networks to maximise public involvement
- Feedback form all these events will be made available to help shape the discussion
- These public meetings will be co-hosted by NHS and local councils where possible in each borough in September to discuss the STP. The latest dates are set out below:

Brent	26 September
Ealing	20 September
Hammersmith and Fulham	21 September (TBC)
Hounslow	27 September
Kensington and Chelsea	14 September

(4) And online:

- We are developing an online engagement tool which will allow us to do targeted audience specific engagement so that we can reach those residents who want to get involved but won't attend face to face events
- We will promote the online engagement programme through our digital media channels – twitter, Facebook etc. – which already exist across both health and local government
- The focus of this engagement phase will be to test the nine priorities and five delivery areas.

7. LEGAL IMPLICATIONS

7.1. *The requirements in respect of the timing and content of Sustainability and Transformation Plans ("STPs") are set out in Delivering the Forward View: NHS Planning Guidance 2016/17. The Guidance was augmented by a Letter dated*

16th February 2016 which included additional information about the purpose of STPs and a timeline for the STP process, including key dates.

7.2. *The STP will cover the period October 2016 to March 2021. Deadline for submission of the final STP is 21st October 2016.*

7.3. *Implications verified / completed by Kevin Beale, Principal Social Care Lawyer, 0208 753 2740.*

8. FINANCIAL AND RESOURCES IMPLICATIONS

8.1. *As detailed in the report,* governance arrangements have commenced that will oversee development and delivery of the STP, in preparing the next steps including the deadline for submission of a final plan by 21 October 2016.

8.2. *The West London Alliance (WLA) Finance work stream recently met and has been tasked to review and update the financial modelling which was submitted in the June NW London STP submission. For H&F Adult Social care, the financial pressures estimated of £30.9m over the next 5 years will be updated and incorporated in the October submission.*

8.3. *Once the outcome of October submission is known a further report will be presented to the Board on the service proposals and funding available in order to address* the existing gap and ensuring that the costs of increased social care that will result from the delivery areas set out in the new plan.

8.4. *Numbers at this stage are draft and indicative pending completion of work by the finance work stream led by Steven Mair.*

8.5. Implications verified/completed by: (P. Daryanani, Head Of ASC Finance. 0208-753-2523.).

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

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

LIST OF APPENDICES:

- Appendix 1 - NW London Sustainability and Transformation Plan
- Appendix 2 - NW London Sustainability and Transformation Plan Appendices
- Appendix 3 – draft governance arrangements and membership of Joint Health and Care Transformation Group

NW London Sustainability and Transformation Plan

Our plan for North West Londoners to be well and live well

V1.0

30 June 2016

DRAFT

Foreword

The National Health Service (NHS) is one of the greatest health systems in the world, guaranteeing services free at the point of need for everyone and saving thousands of lives each year. However, we know we can do much better. The NHS is primarily an illness service, helping people who are ill to recover – we want to move to a service that focuses on keeping people well, while providing even better care when people do become ill. The NHS is a maze of different services provided by different organisations, making it hard for users of services to know where to go when they have problems. We want to simplify this, ensuring that people have a clear point of contact and integrating services across health and between health and social care. We know that the quality of care varies across North West (NW) London and that where people live can influence the outcomes they experience. We want to eliminate unwarranted variation to give everyone access to the same, high quality services. We know that health is often determined by wider issues such as housing and employment – we want to work together across health and local government to address these wider challenges. We also know that as people live longer, they need more services which increases the pressures on the NHS at a time when the budget for the NHS is constrained.

NHS England has published the Five Year Forward View (FYFV), setting out a vision for the future of the NHS. Local areas have been asked to develop a Sustainability and Transformation Plan (STP) to help local organisations plan how to deliver a better health service that will address the FYFV 'Triple Aims' of improving people's health and well being, improving the quality of care that people receive and addressing the financial gap. This is a new approach across health and social care to ensure that health and care services are planned over the next five years and focus on the needs of people living in the STP area, rather than individual organisations.

Clinicians across NW London have been working together for several years to improve the quality of the care we provide and to make care more proactive, shifting resources into primary care and other local services to improve the management of care for people over 65 and people with long term conditions.

We recognise the importance of mental as well as physical health, and the NHS and local government have worked closely together to develop a mental health strategy to improve wellbeing and reduce the disparity in outcomes and life expectancy for people with serious and long term mental health conditions. The STP provides an opportunity for health and local government organisations in NW London to work in partnership to develop a NW London STP that addresses the Triple Aim and sets out our plans for the health and care system for the next five years whilst increasing local accountability. It is an opportunity to radically transform the way we provide health and social care for our population, maximise opportunities to keep the healthy majority healthy, help people to look after themselves and provide excellent quality care in the right place when it's needed. The STP process also provides the drivers to close the £1.3bn funding shortfall and develop a balanced, sustainable financial system which our plan addresses.

We can only achieve this if we work together in NW London working at scale and pace, not just to address health and care challenges but also the wider determinants of health including employment, education and housing. We know that good homes, good jobs and better health education all contribute towards healthier communities that stay healthy for longer. Our joint plan sets out how we will achieve this aim, improve care and quality and deliver a financially sustainable system. We have had successes so far but need to increase the pace and scale of what we do if we are going to be successful.

Concerns remain around the NHS's proposals developed through the Shaping a Healthier Future programme i.e. to reconfigure acute care in NW London. All STP partners will review the assumptions underpinning the changes to acute services and progress with the delivery of local services before making further changes and NHS partners will work jointly with local communities and councils to agree a model of acute provision that addresses clinical quality and safety concerns and expected demand pressures. We recognise that we don't agree on everything, however it is the shared view of the STP partners that this will not stop us working together to improve the health and well-being of our residents.

Dr Mohini Parmar
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i. Executive Summary:
Health and social care in NW London is not sustainable

In NW London there is currently significant pressure on the whole system. Both the NHS and local government need to find ways of providing care for an ageing population and managing increasing demand with fewer resources. Over the next five years, the growth in volume and complexity of activity will out-strip funding increases. But this challenge also gives us an opportunity. We know that our services are siloed and don't treat people holistically. We have duplication and gaps; we have inefficiencies that mean patients often have poor experiences and that their time is not necessarily valued.

We are focused on helping to get people well, but do not spend enough time preventing them from becoming ill in the first place. The STP gives us the opportunity to do things much better.

The health and social care challenges we face are: building people centric services, doing more and better with less and meeting increased demand from people living longer with more long-term conditions. In common with the NHS FYFV, we face big challenges that align to the three gaps identified:

Health & Wellbeing	▪ Adults are not making healthy choices ▪ Increased social isolation ▪ Poor children's health and wellbeing	▪ 20% of people have a long term condition[1] ▪ 50% of people over 65 live alone[2] ▪ 10 – 28% of children live in households with no adults in employment[3] ▪ 1 in 5 children aged 4-5 are overweight[4]
Care & Quality	▪ Unwarranted variation in clinical practise and outcomes ▪ Reduced life expectancy for those with mental health issues ▪ Lack of end of life care available at home	▪ Over 30% of patients in acute hospitals do not need to be in an acute setting and should be cared for in more appropriate places[5] ▪ People with serious and long term mental health needs have a life expectancy 20 years less than the average[6] ▪ Over 80% of patients indicated a preference to die at home but only 22% actually did[7]
Finance & Efficiency	▪ Deficits in most NHS providers ▪ Increasing financial gap across health and large social care funding cuts ▪ Inefficiencies and duplication driven by organisational not patient focus	▪ If we do nothing, there will be a £1.3bn financial gap by 2021 in our health and social care system and potential market failure in some sectors ▪ Local authorities face substantial financial challenges with on-going Adult Social Care budget reductions between now and 2021

Segmenting our population helps us to better understand the residents we serve today and in the future, the types of services they will require and where we need to target our funding. Segmentation offers us a consistent approach to understanding our population across NW London. Population segmentation will also allow us to contract for outcomes in the future.

NW London's population faces a number of challenges as the segmentation below highlights. But we also have different needs in different boroughs, hence the importance of locally owned plans. We also need to be mindful of the wider determinants of health across all of these segments; specifically the importance of suitable housing, employment opportunities, education and skills, leisure and creative activities - which all contribute to improved emotional, social and personal wellbeing, and their associated health outcomes.

Please note that segment numbers are for adults only with the exception of the children segment

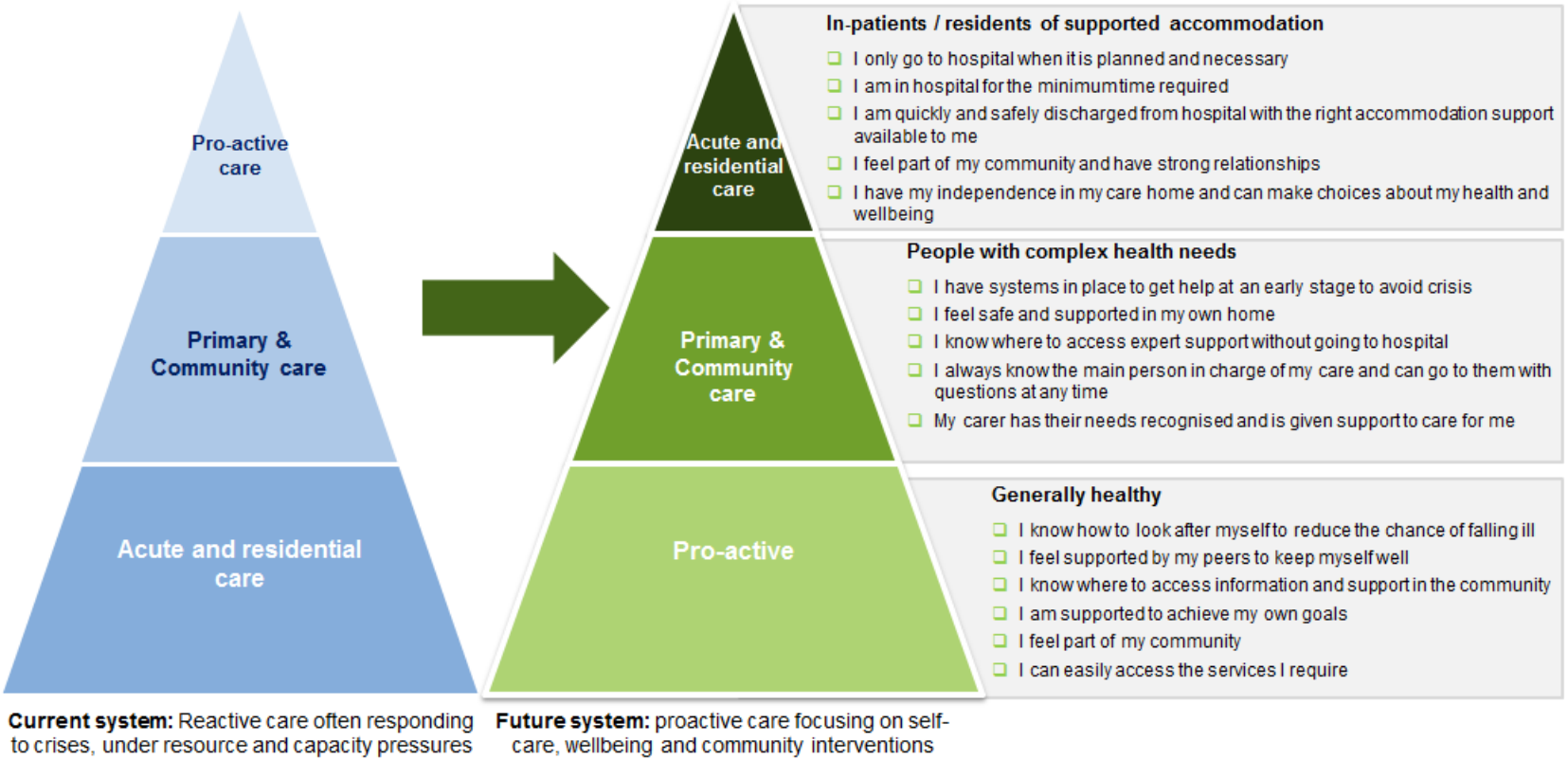
	Mostly healthy	One or more long-term conditions	Cancer	Serious and long term mental health needs	Learning disability	Severe physical disability	Advanced dementia / Alzheimer's	Children	Socially Excluded Groups
Current Population[8]	1,216,000	338,000	17,000	37,500	7,000	21,000	5,000	438,200	Nearly 3,500 people recorded as sleeping rough in the Three Boroughs
Future Population (2030)	1,264,00	458,000	26,000	37,900	9,000	27,100	7,000	463,200	
% Increase	4%	36%	53%	1%	29%	29%	40%	6%	

i. Executive Summary:
The NW London Vision – helping people to be well and live well

Our vision for NW London is that everyone living, working and visiting here has the opportunity to **be well and live well** – to make the very most of being part of our capital city and the cultural and economic benefits it provides to the country.

Our plan involves 'flipping' the historic approach to managing care. We will turn a reactive, increasingly acute-based model on its head, to one where patients take more control, supported by an integrated system which proactively manages care with the default position being to provide this care in areas close to people's homes, wherever possible. This will improve health & wellbeing and care & quality for patients.

Our vision of how the system will change and how patients will experience care by 2020/21



Through better targeting of resources our transformation plans will improve the finances and efficiency of our system, with the more expensive hospital estate and skills used far more effectively. This will also allow more investment into the associated elements of social care and the wider determinants of health such as housing and skills, which will improve the health & wellbeing of our residents.

i. Executive Summary:
How we will close the gaps

If we are to address the Triple Aim challenges, we must fundamentally transform our system. In order to achieve our vision we have developed a set of nine priorities which have drawn on local place based planning, sub-regional strategies and plans and the views of the sub-regional health and local government Strategic Planning Group. Having mapped existing local and NW London activity, we can see that existing planned activity goes a long way towards addressing the Triple Aim. But we must go further to completely close these gaps.

At a NW London level we have agreed five delivery areas that we need to focus on to deliver at scale and pace. The five areas are designed to reflect our vision with DA1 focusing on improving health and wellbeing and addressing the wider determinants of health; DA2 focusing on preventing the escalation of risk factors through better management of long term conditions; and DA3 focusing on a better model of care for older people, keeping them out of hospital where appropriate and enabling them to die in the place of their choice. DA4 and DA5 focus on those people whose needs are most acute, whether mental or physical health needs. Throughout the plan we try to address physical and mental health issues holistically, treating the whole person not the individual illness and seeking to reduce the 20 year disparity in life expectancy for those people with serious and long term mental health needs. There is a clear need to invest significant additional resource in out of hospital care to create new models of care and support in community settings, including through joint commissioning with local government.

Triple Aim		Our priorities	Primary Alignment*	Delivery areas (DA)	Target Pop. (no. & pop. segment)	Net Saving (£m)	Plans
Improving health & wellbeing	1	Support people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthy choices and look after themselves		**DA 1** Radically upgrading prevention and wellbeing	All adults: 1,641,500 At risk mostly healthy adults: 121,680 Children: 438,200 Learning Disability: 7,000 Socially Excluded	11.6	a. Enabling and supporting healthier living b. Wider determinants of health interventions c. Helping children to get the best start in life d. Address social isolation
	2	Improve children's mental and physical health and well-being					
	3	Reduce health inequalities and disparity in outcomes for the top 3 killers: cancer, heart diseases and respiratory illness		**DA 2** Eliminating unwarranted variation and improving LTC management	LTC: 347,000 Cancer: 17,000 Severe Physical Disability: 21,000	13.1	a. Improve cancer screening to increase early diagnosis and faster treatment b. Better outcomes and support for people with common mental health needs, with a focus on people with long term physical health conditions c. Reducing variation by focusing on Right Care priority areas d. Improve self-management and 'patient activation'
	4	Reduce social isolation					
Improving care & quality	5	Reducing unwarranted variation in the management of long term conditions – diabetes, cardio vascular disease and respiratory disease		**DA 3** Achieving better outcomes and experiences for older people	+65 adults: 311,500 Advanced Dementia/ Alzheimer's: 5,000	82.6	a. Improve market management and take a whole systems approach to commissioning b. Implement accountable care partnerships c. Implement new models of local services integrated care to consistent outcomes and standards d. Upgraded rapid response and intermediate care services e. Create a single discharge approach and process across NW London f. Improve care in the last phase of life
	6	Ensure people access the right care in the right place at the right time					
Improving productivity & closing the financial gap	7	Improve the overall quality of care for people in their last phase of life and enabling them to die in their place of choice		**DA 4** Improving outcomes for children &adults with mental health needs	262,000 Serious & Long Term Mental Health, Common Mental Illnesses, Learning Disability	11.8	a. Implement the new model of care for people with serious and long term mental health needs, to improve physical and mental health and increase life expectancy b. Addressing wider determinants of health c. Crisis support services, including delivering the 'Crisis Care Concordat' d. Implementing 'Future in Mind' to improve children's mental health and wellbeing
	8	Reduce the gap in life expectancy between adults with serious and long term mental health needs and the rest of the population					
	9	Improve consistency in patient outcomes and experience regardless of the day of the week that services are accessed		**DA 5** Ensuring we have safe, high quality sustainable acute services	All: 2,079,700	208.9	a. Specialised commissioning to improve pathways from primary care & support consolidation of specialised services b. Deliver the 7 day services standards c. Reconfiguring acute services d. NW London Productivity Programme

** Many of our emerging priorities will map across to several delivery areas. But we have sought to highlight where the main focus of these Delivery Areas are in this diagram*

i. Executive Summary:
Existing health service strategy

This STP describes our shared ambition across health and local government to create an integrated health and care system that enables people to live well and be well: addressing the wider determinants of health, such as employment, housing and social isolation, enabling people to make healthy choices, proactively identifying people at risk of becoming unwell and treating them in the most appropriate, least acute setting possible and reabling people to regain independence whenever possible. When people do need more specialist care this needs to be available when needed and to be of consistently high quality with access to senior doctors seven days a week. Too often people are being brought into hospital unnecessarily, staying too long and for some dying in hospital when they would rather be cared for at home.

The health system in NW London needs to be able to meet this ambition, and for the last few years doctors, nurses and other clinicians have come together as a clinical community across primary, secondary and tertiary care to agree how to transform health care delivery into a high quality but sustainable system that meets patients' needs. This is based on three factors:

Firstly, the transformation of general practice, with consistent services to the whole population ensuring proactive, co-ordinated and accessible care. We will deliver this through primary care operating at scale through networks, federations of practices or super-practices, working with partners to deliver integrated care (Delivery Areas 1-3).

Secondly, a substantial upscaling of the intermediate care services available to people locally offering integrated health and social care teams outside of an acute hospital setting (Delivery Area 3). The offering will be consistent, simple and easy to use and understand for professionals and patients . This will respond rapidly when people become ill, delivering care in the home, in GP practices or in local services hubs, will inreach into A&E and CDU to support people who do not need to be there and can be cared for at home and facilitate a supported discharge from hospitals as soon as the individual is medically fit. The services will be fully integrated between health and social care.

Thirdly, acute services need to be configured at a scale that enables the delivery of high quality care, 7 days a week, giving the best possible outcomes for patients (Delivery Area 5). As medicine evolves it can benefit from specialisation and the benefits of senior clinical advice available at most parts of the day. We know from our London wide work on stroke and major trauma that better outcomes can be delivered by consolidating the limited supply of specialist doctors into a smaller number of units that can deliver consistently high quality, consistently well staffed services by staff who are experts in their field. This also enables the best use of specialist equipment and ensures staff are exposed to the right case mix of patients to maintain and develop their skills. In 2012 the NHS consulted on plans to reduce the number of major hospitals in NW London from 9 to 5, enabling us to drive improvements in urgent care, maternity services and children's care. The major hospitals will be networked with a specialist hospital, an elective centre and two local hospitals, allowing us to drive improvements in care across all areas.

Our acute hospitals are under more strain than ever before. Some of this is due to increasing demand, and our STP sets out how we will manage demand more effectively through our proactive care model. We also have increasing expectations of standards of service and availability of services 24/7, driving financial and workforce challenges. We will partially address the financial challenges through our NW London Productivity Programme, but even if the demand and finance challenges are addressed, our biggest, most intractable problem is the lack of skilled workforce to deliver a '7 day service' under the current model across multiple sites. The health system is clear that we cannot deliver a clinically and financially sustainable system without transforming the way we deliver care, and without reconfiguring acute services to enable us to staff our hospitals safely in the medium term.

The place where this challenge is most acute is Ealing Hospital, which is the smallest District General Hospital (DGH) in London. The site currently has a financial deficit of over £30m as the costs of staffing it safely are greater than the activity and income for the site, meaning that the current clinical model cannot be financially sustainable. The vacancy rate is relatively high, and there are relatively fewer consultants and more junior doctors than in other hospitals in NW London, meaning that it will be increasingly challenging to be clinically sustainable in the medium term. We know that the hospital has caring, dedicated and hardworking staff, ensuring that patients are well cared for. We wish to maintain and build on that through our new vision for Ealing and for Charing Cross, serving the community with an A&E supported by a network of ambulatory care pathways and centre of excellence for elderly services including access to appropriate beds. The site would also host a GP practice and an extensive range of outpatient and diagnostic services meeting the vast majority of the local population's routine health needs.

The local government position on proposed acute changes is set out in Appendix A.

The focus of the STP for the first two years is to develop the new proactive model of care across NW London and to address the immediate demand and financial challenges. No substantive changes to A&Es in Ealing or Hammersmith & Fulham will be made until there is sufficient alternative capacity out of hospital or in acute hospitals.

i. Executive Summary:
Finances

Our population segmentation shows that we will see larger rises in the populations with increased health needs over the next 15 years than in the wider population. This increased demand means that activity, and the cost of delivering services, will increase faster than our headline population growth would imply. NHS budgets, while increasing more than other public sector budgets, are constrained and significantly below both historical funding growth levels and the increase in demand, while social care budgets face cuts of around 40%. If we do nothing, the NHS will have a £1,154m funding gap by 20/21 with a further £145m gap in social care, giving a system wide shortfall of £1,299m.

Through a combination of normal savings delivery and the benefits that will be realised through the five STP delivery areas, the financial position of the sector is a £50.5m surplus at the end of the STP period. The residual gap assumes business rules of 1% CCGs surplus, 1% provider surplus and breakeven for Specialised Commissioning, Primary Care and Social Care.

£'m	CCGs	Acute	Non-acute	Specialised Commissioning	Primary care	STF investment (see funding slide)	Sub-total NHS Health	Social Care	Total Health and Social Care
Do Nothing June '16	**(292.7)**	**(532.8)**	**(125.7)**	**(188.3)**	**(14.8)**	**-**	**(1,154.3)**	(145.0)	**(1,299.3)**
Business as usual savings (CIPS/QIPP)	127.8	339.1	102.7	-	-	-	569.7	-	569.7
Delivery Area (1-5) - Investment	(118.3)	-	-	-	-	-	(118.3)	-	(118.3)
Delivery Area (1-5) - Savings	302.9	120.4	23.0	-	-	-	446.3	62.5	508.8
STF - additional 5YFV costs	-	-	-	-	-	(55.7)	(55.7)	(34.0)	(89.7)
STF - funding	23.0	-	-	-	14.8	55.7	93.5	53.5	147.0
Other	-	-	-	188.3	-	-	188.3	63.0	251.3
TOTAL IMPACT	**335.4**	**459.5**	**125.7**	**188.3**	**14.8**	**0.0**	**1,123.7**	**145.0**	**1,268.7**
Residual Gap (with application of business rules)	**42.7**	**(73.3)**	**0.0**	**0.0**	**0.0**	**0.0**	**(30.6)**	**0.0**	**(30.6)**
Financial Position excluding business rules	**87.7**	**(37.3)**	**0.0**	**0.0**	**0.0**	**0.0**	**50.5**	**0.0**	**50.5**

The solution includes £570m of business as usual savings (CIPs and QIPP), the majority delivered by the acute providers, which relate to efficiencies that can be delivered without working together and without strategic change. Each of the acute providers has provided details of their governance and internal resources and structures to help provide assurance of deliverability.

Additional savings have been assessed across the five STP delivery areas, and require £118m of investment to deliver £303m of CCG commissioner savings and £143m of provider savings. These schemes support the shift of patient care from acute into local care settings, and include transformational schemes across all points of delivery. The work undertaken by Healthy London Partners has been used to inform schemes in all Delivery Areas, particularly in the area of children's services, prevention and well-being and those areas identified by 'Right Care' as indicating unwarranted variation in healthcare outcomes.

The financial modelling shows a forecast residual financial gap in outer NWL providers at 20/21, attributable to the period forecast for completing the reconfiguration changes that will ensure a sustainable end state for the providers. This could be resolved by bringing forward the acute configuration changes described in DA5c relating to Ealing.

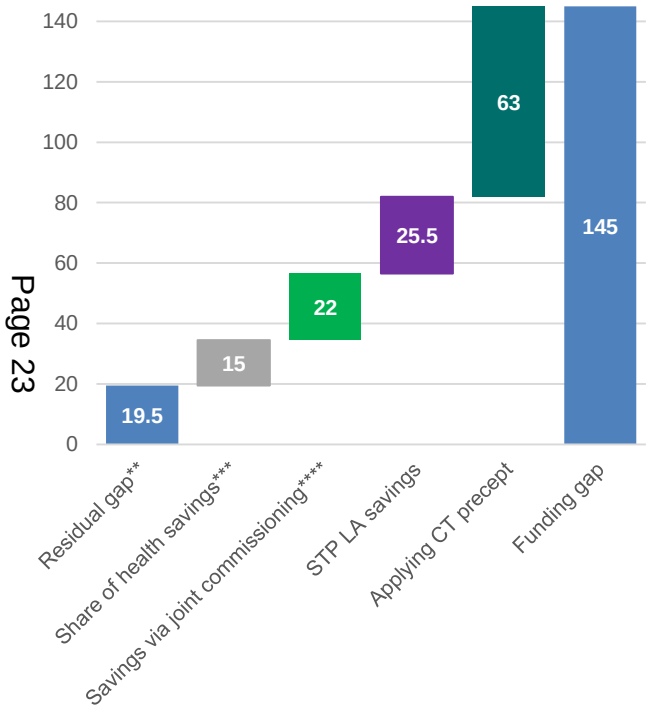
In order to support the implementation of the transformational changes, NWL seeks early access to the Sustainability and Transformation Fund, to pump prime the new proactive care model while sustaining current services pending transition to the new model of care.

NWL also seeks access to public capital funds, as an important enabler of clinical and financially sustainable services and to ensure that services are delivered from an appropriate quality environment.

i. Executive Summary:
Social Care Finances

Local government has faced unprecedented reductions in their budget through the last two comprehensive spending reviews and the impact of the reductions in social care funding in particular has had a significant impact on NHS services. To ensure that the NHS can be sustainable long term we need to protect and invest in social care and in preventative services, to reduce demand on the NHS and to support the shift towards more proactive, out of hospital care. This includes addressing the existing gap and ensuring that the costs of increased social care that will result from the delivery areas set out in this plan are fully funded.

The actions set out below describe how the existing gap will be addressed, through investment of transformation funding*:



Theme	STP delivery area	Savings for ASC (£M)	Savings for LG / PH (£M)	Total benefit for LG	Benefit for Health (£M)
Public Health & prevention	DA1	-	2.0	2.0	2.2
Demand management & community resilience	DA2	-	-	-	6.1
Caring for people with complex needs	DA3	-	-	-	5.1
Accommodation based care	DA3	7.7	-	7.0	2.0
Discharge	DA3	3.4	-	3.4	9.6
Mental Health	DA4	3.5	2.9	6.4	5.0
Vulnerable	DA1	3.0	3.0	6	-
Total savings through STP investments		**17.6**	**7.9**	**25.5**	**30.0**
Joint commissioning	DA3	22.0	-	22.0	TBC
Total savings		**39.6**	**7.9**	**47.5**	**30.0**

The following assumptions and caveats apply:

*To deliver the savings requires transformational investment of an estimated £110m (£21m in 17/18, rising to £34m by 20/21) into local government commissioned services

**The residual gap of £19.5m by 20/21 is assumed to be addressed through the recurrent £148m sustainability funding for NW London on the basis that health and social care budgets will be fully pooled and jointly commissioned by then.

***The share of savings accruing to health are assumed to be shared equally with local government on the basis of performance

****Further detailed work is required to model the benefits of joint commissioning across the whole system as part of Delivery Area 3

NB The financial benefits of the actions above represent projected estimations and are subject to further detailed work across local government and health.

i. Executive Summary:
16/17 key deliverables

Our plan is ambitious and rightly so – the challenges we face are considerable and the actions we need to take are multifaceted. However we know that we will be more effective if we focus on a small number of things in each year of the five year plan, concentrating our efforts on the actions that will have the most impact.

We have an urgent need to stabilise the system and address increasing demand whilst maintaining a quality of care across all providers that is sustainable. For year 1 we are therefore targeting actions that take forward our strategy and will have a quick impact. To help us achieve the longer term shift to the proactive care model we will also plan and start to implement work that will have a longer term impact. Our focus out of hospital in 2016/17 will therefore be on care for those in the last phase of life and the strengthening of intermediate care services by scaling up models that we know have been successful in individual boroughs. In hospital we will focus on reducing bank and agency spend and reducing unnecessary delays in hospital processes through the 7 Day Programme.

We are working together as partners across the whole system to review governance and ensure this work is jointly-led.

Areas with impact in 2016/17

Delivery area	What we will achieve	Impact
DA3	i. Single 7 day discharge approach across health, moving towards fully health and social care integrated discharge by the end of 2016/17 ii. Training and support to care homes to manage people in their last phase of life iii. Develop and agree the older persons (frailty) service for Ealing and Charing Cross Hospitals, as part of a fully integrated older persons service iv. Increased accessibility to primary care through extended hours v. All practices will be in a federation, super practice or on a trajectory to MCP vi. Deployed the NW London Whole Systems Integrated Care dashboards and databases to 312 practices to support direct care, providing various views including a 12 month longitudinal view of all the patients' health and social care data. ACP dashboards also deployed	i. Circa 1 day reduction in the differential length of stay for patients from outside of the host borough[9] ii. 5% reduction in the number of admissions from care homes, when comparing Quarter 4 year on year [10] iii. Full impact to be scoped but this is part of developing a fully integrated older person's service and blue print for a NW London model at all hospital sites iv. Aiming to move NW London average of 23mins/1000 people to 30mins/1000 people at pace v. Supporting sustainability, reducing unwarranted variation and preparing for Accountable Care Partnerships vi. Improved patient care, more effective case finding and risk management for proactive care, supports care coordination as integrated care record provided in a single view
DA4	i. All people with a known serious and long term mental health need are able to access support in crisis 24/7 from a single point of access (SPA) ii. Launch new eating disorder services, and evening and weekend services. Agree new model 'tier free' model.	i. 300-400 reduction in people in crisis attending A&E or requiring an ambulance[11] ii. Reduction in crisis contacts in A&E for circa 200 young people
DA5	i. Joint bank and agency programme across all trusts results in a NW London wide bank and reductions in bank and agency expenditure ii. Paediatric assessment units in place in 4 of 5 hospitals in NW London, Ealing paediatric unit closed safely iii. Compliance with the 7 Day Diagnostic Standard for Radiology, meeting the 24hr turn-around time for all inpatient scans	i. All trusts achieve their bank and agency spend targets All trusts support each other to achieve their control totals ii. Circa 0.5 day reduction in average length of stay for children[12]. Consultant cover 7am to 10pm across all paediatric units[13] iii. We will achieve a Q4 15/16 to Q4 16/17 reduction of 0.5 day LOS on average for patients currently waiting longer than 24hrs for a scan. This will increase to a 1 day reduction in 17/18[14]

i. Executive Summary:
How we will make it happen?

To deliver change at scale and pace requires the system to work differently, as both providers and commissioners. We are making four changes to the way that we work as a system in NW London to enable us to deliver and sustain the transformation from a reactive to proactive and preventative system:

1. Develop a joint NW London implementation plan for each of the five high impact delivery areas

We will establish jointly led NW London programmes for each delivery area, working across the system to agree the most effective model of delivery and accountable to a new model of partnership governance. We will build on previous successful system wide implementations within Health and Local Government to develop our improvement methodology, ensuring an appropriate balance between common standards, programme management, local priorities and implementation challenges. The standard methodology includes a clear SRO, CRO, programme director and programme manager, with clinical and operational leads within each affected provider, appropriate commissioning representation (clinical and managerial) and patient representatives. We have also developed a common project 'life cycle' with defined gateways. Models of care are developed jointly to create ownership and recognise local differences and governance includes clear gateways to enable projects to move from strategic planning, to implementation planning, to mobilisation and post implementation review. Examples of programmes that have been successfully managed through this process are maternity, seven day discharge and the mental health single point of access for urgent care.

2. Shift funding and resources to the delivery of the five delivery areas, recognising funding pressures across the system

We will ensure human and financial resources shift to focus on delivering the things that will make the biggest difference to closing our funding gaps:

We are reviewing the total improvement resources across all providers and commissioners, including the Academic Health Science Network (AHSN), to realign them around the delivery areas to increase effectiveness and reduce duplication

We have identified £118m of existing system funding and seek to secure £148m of transformation funding to support implementation of the five delivery areas.

We plan to use £34m to invest through joint commissioning with local government to support delivery of plans and to support closure of ASC funding gap.

We will undertake extensive system modelling of funding flows and savings through to 20/21 to inform future funding models and sustain the transformation.

3. Develop new joint governance to create joint accountability and enable rapid action to deliver STP priorities

NHS and Local Government STP partners are working together to develop a joint governance structure with the intention of establishing a joint board that would oversee delivery of the NW London STP. The joint governance arrangements would ensure there is strong political leadership over the STP, with joint accountability for the successful delivery of the plan, including the allocation of transformation resources and implementation of the out of hospital strategy.

We will also strengthen our existing governance structures and develop them where necessary to ensure that there is clear joint leadership for delivering the strategy across health and local government for each of the five delivery areas and three enablers.

Building on our ambitious STP plans, NW London will also develop options for a devolution proposition, to be agreed jointly across commissioners and providers. This could include local retention of capital receipts, greater local control over central NHS resources and greater flexibility over regulation to support delivery of long term plans.

4. Reshape our commissioning and delivery to ensure it sustains investment on the things that keep people healthy and out of hospital

We are moving towards primary care operating at scale with practices working together either in federation, supra-practices or as part of a multi-provider in order to ensure it responds to the needs of local communities, provides opportunities for sustainability and drives quality and consistency. Primary care, working jointly with social care and the wider community, is the heart of the new system.

By 17/18, we expect to see an expansion of local pooled budgets to ensure there is an enhanced joint approach locally to the delivery of care, within the new shared governance arrangements.

By 20/21 we will worked jointly across Health and Local Government to implement Accountable Care Partnerships across the whole of NW London, utilising capitated budgets, population based outcomes and fully integrated joint commissioning to ensure that resources are used to deliver the best possible care for residents of NW London. Some ACPs are planned to go live from 2018/19. Initial focus areas for ACPs will be based on the delivery areas set out within the STP.

1. Case for Change:

Understanding the NW London footprint and its population is vital to providing the right services to our residents

The NW London Footprint

Over 2 million people

Over £4bn annual health and care spend

8 local boroughs

8 CCGs and Local Authorities

Over 400 GP practices

10 acute and specialist hospitals

2 mental health trusts

2 community health trusts

NW London is proud to be part of one of the most vibrant, multicultural and historic capital cities in the world. Over two million people live in the eight boroughs stretching from the Thames to Watford and which include landmarks such as Big Ben and Wembley Stadium. The area is also undergoing major infrastructure development with Crossrail, which will have a socio economic impact beyond 2021.

It is important to us – the local National Health Service (NHS), Local Government and the people we serve in NW London – that everyone living, working and visiting here has the opportunity to **be well and live well** – to make the very most of being part of our capital city and the cultural and economic benefits it provides to the country.

In common with the NHS Five Year Forward View we face big challenges in realising this ambition over the next five years:

- Some NW London boroughs have the highest life expectancy differences in England. In one borough men experience 16.04 year life expectancy difference between most deprived and least[1]
- 21% of the population is classed as having complex health needs
- NW London's 16-64 employment rate of 71.5% was lower than the London or England average [2]
- If we do nothing, there will be a £1.3bn financial gap in our health and social care system and potential market failure in some sectors

The challenges we face require bold new thinking and ambitious solutions, which we believe include improving the wider determinants of health and wellbeing such as housing, education and employment, people supported to take greater responsibility for their wellbeing and health, prevention embedded in everything we do, integration in all areas and creating a truly digital, information enabled service.

We have a **strong sense of place in NW London, across and within our boroughs**. In the following pages of our Sustainability and Transformation Plan (STP) we set out our case for change, our ambitions for the future of our places and how we will focus our efforts on a number of high impact initiatives to address the three national challenges of 'health and wellbeing', 'care and quality', and 'finance and productivity'.

1. Case for Change:
Working together to address a new challenge

To enable people to **be well and live well**, we need to be clear about our collective responsibilities. As a system we have a responsibility for the health and well-being of our population but people are also responsible for looking after themselves. Our future plans are dependent upon acceptance of shared responsibilities.

Working in partnership with patient and community representatives, in 2016/17 we will produce a **People's Health & Wellbeing Charter** for NW London. This will set out the health and care offer so that people can access the right care in the right place at the right time. As part of this social contract between health and care providers and the local community, it will also set out the 'offer' from people in terms of how they will look after themselves.

Responsibilities of our residents

- To make choices in their lifestyles that enable them to stay healthy and reduce the risk of disease
- To use the most appropriate care setting
- To access self-care services to improve their own health and wellbeing and manage long-term conditions
- To access support to enable them to find employment and become more independent
- To help their local communities to support vulnerable people in their neighbourhoods and be an active part of a vibrant community

Responsibilities of our system

- To provide appropriate information and preventative interventions to enable residents to live healthily
- To deliver person-centred care, involve people in all decisions about their care and support
- To respond quickly when help or care is needed
- To provide the right care, in the right place, to consistently high quality
- Reduce unwarranted variation and address the 'Right Care' challenge
- To consider the whole person, recognising both their physical and mental health needs
- To provide continuity of care or service for people with long term health and care needs
- To enable people to regain their independence as fully and quickly as possible after accident or illness
- To recognise when people are in their last phase of life and support them with compassion

To support these responsibilities, we have a series of underlying principles which underpin all that we do and provide us with a common platform.

Principles underpinning our work

- Focus on prevention and early detection
- Individual empowerment to direct own personalised care and support
- People engaged in their own health and wellbeing and enabled to self care
- Support and care will be delivered in the least acute setting appropriate for the patient's need
- Care will be delivered outside of hospitals or other institutions where appropriate
- Services will be integrated
- Subsidiarity – where things can be decided and done locally they will be
- Care professionals will work in an integrated way
- Care and services will be co-produced with patients and residents
- We will focus on people and place, not organisations
- Innovation will be maximised
- We will accelerate the use of digital technology and technological advances

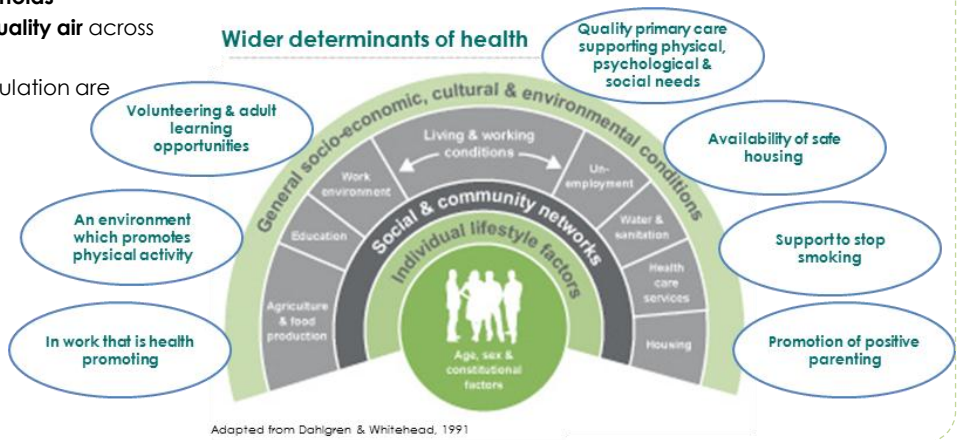
1. Case for Change:
Understanding our population

In NW London we have taken a population segmentation approach to understand the changing needs of our population. This approach is at the core of how we collectively design services and implement strategies around these needs. NW London has:

- 2.1 million residents and 2.3 million registered patients in 8 local authorities
- Significant **variation in wealth**
- Substantial **daytime population** of workers and tourists, particularly in Westminster and Kensington & Chelsea
- A high proportion of people were **not in born in UK** (>50% in some wards)
- A **diverse ethnicity**, with 53% White, 27% Asian, 10% Black, 5% Mixed, with a higher prevalence of diabetes
- A high working age population aged 20-39 compared with England
- **Low vaccination coverage** for children and **high rates of tooth decay** in children aged 5 (50% higher than England average)
- State primary school **children with high levels of obesity**

In order to understand the context for delivering health and social care for the population, it is critical to consider the wider determinants of health and wellbeing that are significant drivers of activity.

- High proportions living in **poverty and overcrowded households**
- High rates of **poor quality air** across different boroughs
- **Only half** of our population are **physically active**
- **Nearly half of our 65+ population are living alone** increasing the potential for social isolation
- **Over 60%** of our adult social care users **wanting more social contact**



Population Segmentation for NW London 2015–30[3]

Mostly healthy	One or more long-term conditions	Cancer	Serious and long term mental health needs	Learning disability	Severe physical disability	Advanced dementia / Alzheimer's	Children	Socially Excluded Groups
• 1,216,000 adults in NW London are mostly healthy • 58% of the total population • 24% of care spend in NW London In 2030: • 4% more adults • 31% more +65s	• 338,000 adults in NW London have 1 or more LTC • 16% of the population • 22% of the care spend in NW London In 2030 • 36% more adults • 37% more spend in NW London	• 17,000 adults in NW London have cancer • 0.8% of the population • 4% of care spend in NW London In 2030: • 53% more adults • 50% more spend in NW London	• 37,500 adults in NW London have serious and long term mental health needs • 2% of population • 7.5% of care spend In 2030: • 1% more adults • 21% more spend in NW London	• 7,000 adults in NW London have learning disabilities • 0.3% of the population • 8% of care spend in NW London In 2030: • 29% more adults • 35% more spend in NW London	• 21,000 adults in NW London have severe physical disabilities • 1% of the population • 18% of care spend in NW London In 2030: • 29% more adults • 26% more spend in NW London	• 5,000 adults in NW London have advanced dementia • 0.2% of the population • 2% of care spend in NW London In 2030: • 40% more adults • 44% more spend in NW London	• 438,200 children in NW London • 21% of the population • 14% of care spend in NW London In 2030 • 6% more children • 3% more spend in NW London	• Westminster has the highest recorded population of rough sleepers of any local authority in the country • There are nearly 3,500 people recorded as sleeping rough in the 3 Boroughs

Segmenting our population helps us to better understand the residents we serve today and in the future, the types of services they will require and where our investment is needed. Segmentation offers a consistent approach to understanding our population across NW London. NW London's population faces a number of challenges as the segmentation (left) highlights. But we also have different needs in different boroughs, hence the importance of locally owned plans.

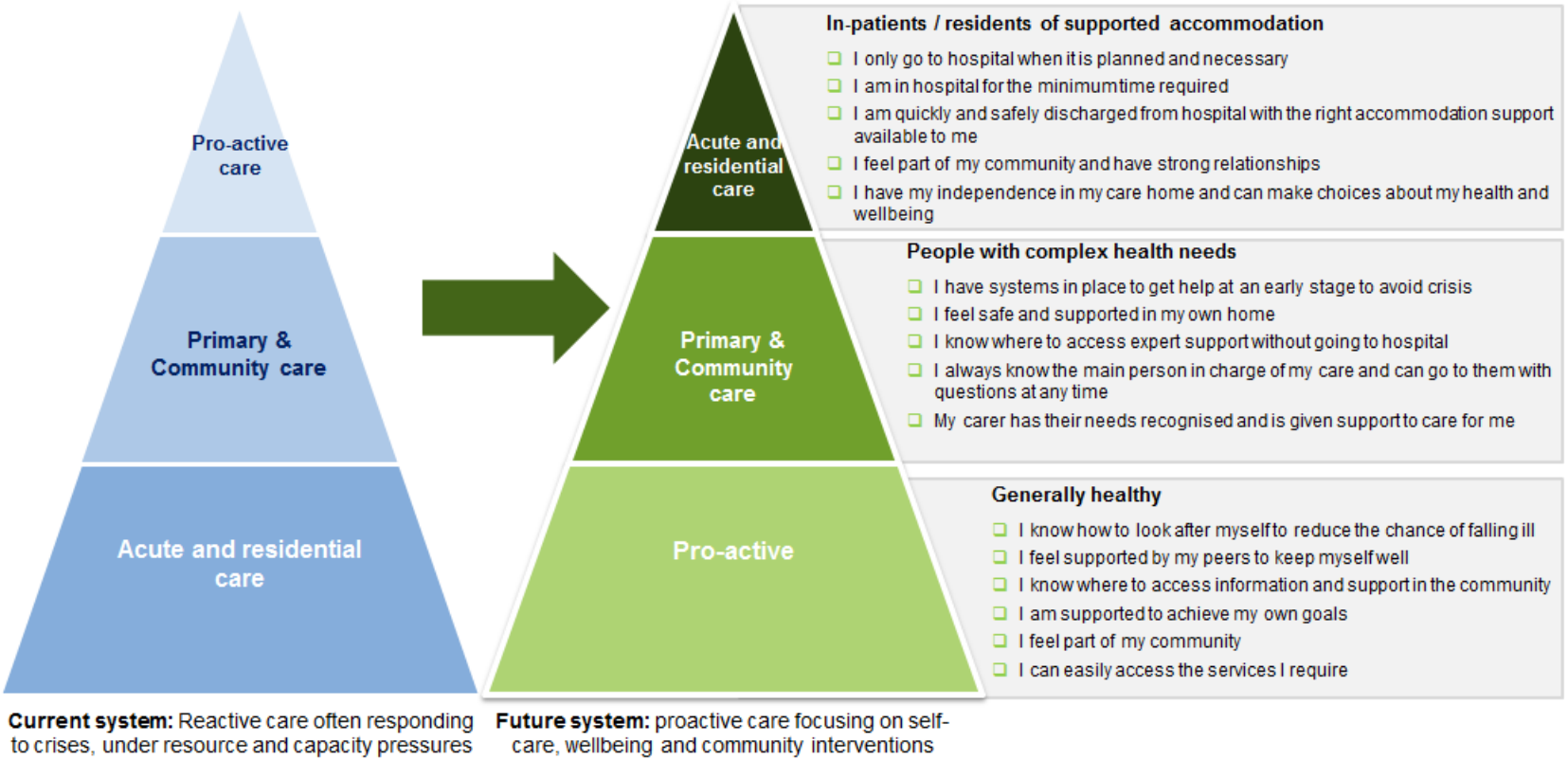
Please note that segment numbers are for adults only with the exception of the children segment

1. Case for Change:
The NW London Vision – helping people to be well and live well

Our vision for NW London is that everyone living, working and visiting here has the opportunity to **be well and live well** – to make the very most of being part of our capital city and the cultural and economic benefits it provides to the country.

Our plan involves 'flipping' the historic approach to managing care. We will turn a reactive, increasingly acute-based model on its head, to one where patients take more control, supported by an integrated system which proactively manages care with the default position being to provide this care as close to, or in people's homes, wherever possible. This will improve health & wellbeing and care & quality for patients.

Our vision of how the system will change and how patients will experience care by 2020/21



Through better targeting of resources to make the biggest difference, it will also improve the finances and efficiency of our system, with the more expensive hospital estate and skills used far more effectively. This will also allow more investment into the associated elements of social care and the wider determinants of health such as housing and skills, to improve the broader health and wellbeing of our residents.

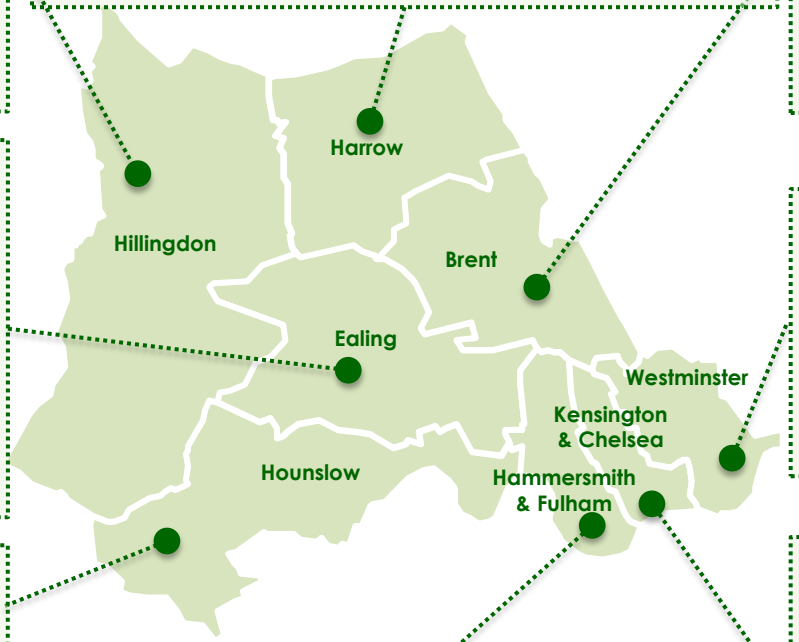
1. Case for Change:
Understanding people's needs

While segmentation across NW London helps us to understand our population we also recognise that each borough has its own distinct profile. Understanding our population's needs both at a NW London and a borough level is vital to creating effective services and initiatives[4].

- **Hillingdon** has the second largest area of London's 32 boroughs
- By 2021, the overall population in Hillingdon is expected to grow by 8.6% to 320,000
- Rates of diabetes, hospital admissions for alcohol-related harm and tuberculosis are all higher than the England average
- There is an expected rise in the over-75-year-old population over the next 10 years and it is expected that there will be an increase in rates of conditions such as dementia

- **Harrow** has one of the highest proportions of those aged 65 and over compared to the other boroughs in NW London
- More than 50% of Harrow's population is from black and minority ethnic (BAME) groups
- Cardiovascular disease is the highest cause of death in Harrow, followed by cancer and respiratory disease
- Currently 9.3% of Reception aged children being obese (2013/14) increasing to 20.8% for children aged 10 to 11 years old in year 6

- **Brent** is ranked amongst the top 15% most-deprived areas in the country
- The population is young, with 35% aged between 20 and 39
- Brent is ethnically diverse with 65% from BAME groups
- It is forecast that by 2030 15% of adults in Brent will have diabetes
- Children in Brent have worse than average levels of obesity – 10% of children in Reception, 24% of children in Year 6



- **Ealing** is London's third largest borough
- It is estimated that by 2020, there will be a 17.5% rise in the number of people over 65 years of age, and a 48% rise in the number of people over 85
- Ealing is an increasingly diverse borough, with a steady rise projected for BAME groups at 52%
- The main cause of death is cardiovascular disease accounting for 31% of all deaths
- In Ealing, cancer caused 1573 deaths during 2011-13. Over half (51.4%, 809) of cancer deaths were premature (under 75)

- **Westminster** has a daytime population three times the size of the resident population
- The principal cause of premature death in Westminster is cancer, followed by cardiovascular disease
- In 2014, Westminster had the 6th highest reported new diagnoses of Sexually Transmitted Infections (excluding Chlamydia aged < 25) rate in England
- Westminster also has one of the highest rates of homelessness and rough sleeping in the country

- **Hounslow** serves a diverse population of 253,957 people (2011 Census), the fifth fastest growing population in the country
- Hounslow's population is expected to rise by 12% between 2012 and 2020
- Hounslow has significantly more deaths from heart disease and stroke than the England average
- Due to a growing ageing population and the improved awareness and diagnosis of individuals, diagnosis of dementia is expected to increase between 2012 and 2020 by 23.5%
- The volume of younger adults with learning disabilities is also due to increase by 3.6%

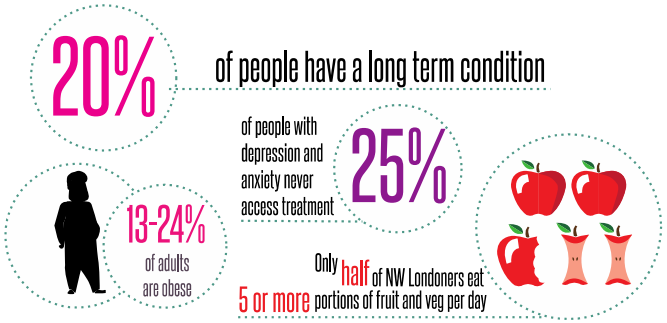
- **Hammersmith & Fulham** is a small, but a densely populated borough with 183,000 residents with two in five people born abroad
- More than 90% of contacts with the health service take place in the community, involving general practice, pharmacy and community services
- The principle cause of premature and avoidable death in Hammersmith and Fulham is cancer, followed by CVD

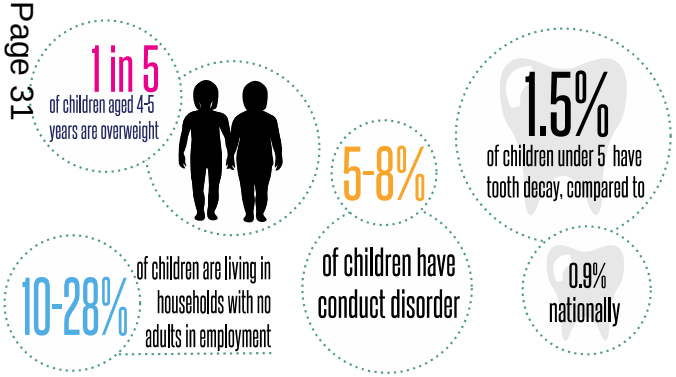
- **Kensington & Chelsea** serves a diverse population of 179,000 people and has a very large working age population and a small proportion of children (the smallest in London)
- Half of the area's population were born abroad
- The principal cause of premature death in the area is cancer
- There are very high rates of people with serious and long term mental health needs in the area

1. Case for Change:
Health and Wellbeing Current Situation

The following emerging priorities are a consolidation of local place based planning, sub-regional strategies and plans and the views of the sub-regional health and local government Strategic Planning Group. They seek to address the challenges described by our 'as-is' picture and deliver our vision and 'to-be' ambitions using an evidence based, population segmentation approach. They have been agreed by our SPG.

Our as-is…





1500 people under 75 die each year from cancer, heart diseases and respiratory illness.

If we were to reach the national average of outcomes, we could save 200 people per year.

Our to-be…

People live healthy lives and are supported to maintain their independence and wellbeing with increased levels of activation, through targeted patient communications – reducing hospital admissions and reducing demand on care and support services

Children and young people have a healthy start to life and their parents or carers are supported – reducing admissions to hospital and demands on wider local services

People with cancer, heart disease or respiratory illness consistently experience high quality care with great clinical outcomes, in line with Achieving World-Class Cancer Outcomes.

Our Priorities

1 Support people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthy choices and look after themselves

2 Improve children's mental and physical health and well-being

3 Reduce health inequalities and disparity in outcomes for the top 3 killers: cancer, heart diseases and respiratory illness

Our vision for health and wellbeing:

"My life is important, I am part of my community and I have opportunity, choice and control"

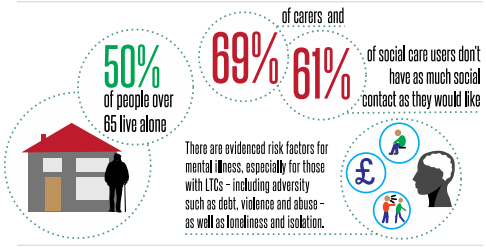
"As soon as I am struggling, appropriate and timely help is available"

"The care and support I receive is joined-up, sensitive to my own needs, my personal beliefs, and delivered at the place that's right for me and the people that matter to me"

"My wellbeing and happiness is valued and I am supported to stay well and thrive"

"I am seen as a whole person – professionals understand the impact of my housing situation, my networks, employment and income on my health and wellbeing"

1. Case for Change:
Care & Quality Current Situation

Our as-is…	Our to-be…	Our Priorities
		
People with long term conditions use 70% of all healthcare resources.	Care for people with long term conditions is proactive and coordinated and people are supported to care for themselves	5 Reducing unwarranted variation in the management of long term conditions – diabetes, cardio vascular disease and respiratory disease
Over 30% of patients in an acute hospital bed right now do not need to be there. **3% of admissions are using a third of acute hospital beds.**	GP, community and social care is high quality and easily accessible, including through NHS 111, and in line with the National Urgent Care Strategy	6 Ensure people access the right care in the right place at the right time
Over 80% patients indicated a preference to die at home but 22% actually did.	People are supported with compassion in their last phase of life according to their preferences	7 Improve the overall quality of care for people in their last phase of life and enabling them to die in their place of choice
People with serious and long term mental health needs have a life expectancy 20 years less than the average and the number of people in this group in NW London is double the national average.	People in this group are treated holistically according to their full range of mental, physical and social needs in line with The Five Year Forward View For Mental Health	8 Reduce the gap in life expectancy between adults with serious and long-term mental health needs and the rest of the population
Mortality is between 4-14% higher at weekends than weekdays.	People receive equally high quality and safe care on any day of the week, we save 130 lives per year	9 Improve consistency in patient outcomes and experience regardless of the day of the week that services are accessed
	People are empowered and supported to lead full lives as active participants in their communities – reducing falls and incidents of mental ill health	4 Reduce social isolation

Our vision for care and quality:

Personalised

Personalised, enabling people to manage their own needs themselves and to offer the best services to them. This ensures their support and care is **unique**.

Localised

Localised where possible, allowing for a wider variety of services closer to home. This ensures services, support and care is **convenient**.

Coordinated

Delivering services that consider all the aspects of a person's health bad wellbeing and is coordinated across all the services involved. This ensures services are **efficient**.

Specialised

Centralising services where necessary for specific conditions ensuring greater access to specialist support. This ensures services are **better**.

1. Case for Change:
Overall Financial Challenge – Do Nothing

Our population segmentation shows that we will see larger rises in the populations with increased health needs over the next 15 years than in the wider population. This increased demand means that activity, and the cost of delivering services, will increase faster than our headline population growth would imply. NHS budgets, while increasing more than other public sector budgets, are constrained and significantly below both historical funding growth levels and the increase in demand, while social care budgets face cuts of around 40%. If we do nothing, the NHS will have a £1,154m funding gap by 20/21 with a further £145m gap in social care, giving a system wide shortfall of £1,299m.

The bridge below presents the key drivers for the revised 20/21 'do nothing' scenario, as shown on the previous slide. The table below the bridge shows the profile of the 'do nothing' scenario over the five year period.

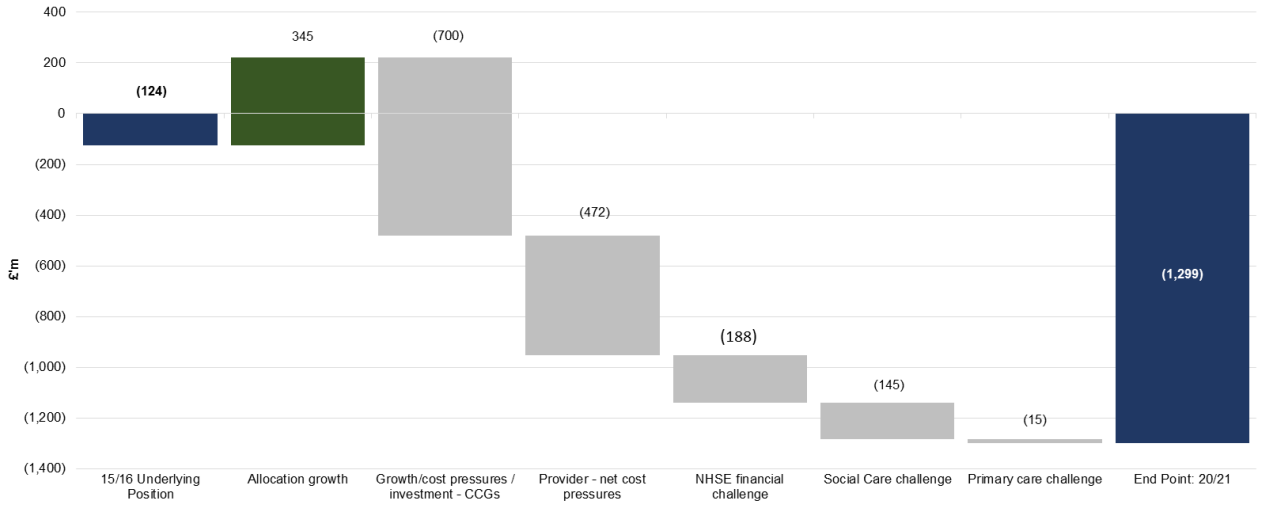


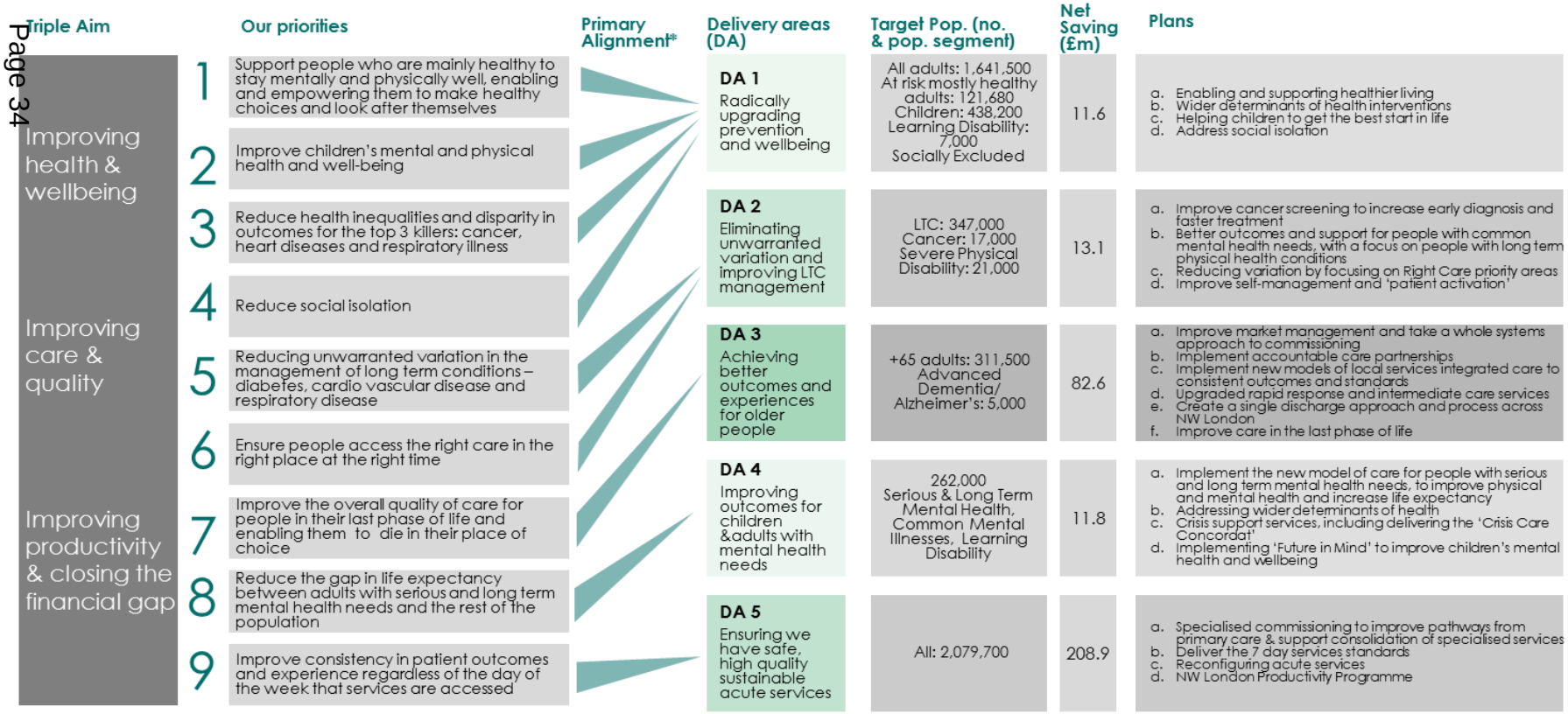
Table 1: Profile of the 20/21 Do Nothing financial challenge by organisation

£'m - Residual Gap	15/16	16/17	17/18	18/19	19/20	20/21
Providers	(190)	(304)	(374)	(462)	(544)	(659)
CCGs	60	(4)	(77)	(140)	(198)	(293)
Specialised commissioning	-	-	(44)	(90)	(138)	(188)
Primary care	-	2	(1)	(12)	(19)	(15)
Total NHS	**(130)**	**(306)**	**(496)**	**(704)**	**(899)**	**(1,154)**
Social Care	-	-	(36)	(73)	(109)	(145)
Total NWL Health and social care	**(130)**	**(306)**	**(532)**	**(776)**	**(1,007)**	**(1,299)**

2. Delivery Areas:
How we will close the gaps

If we are to address the Triple Aim challenges, we must fundamentally transform our system. In order to achieve our vision we have developed a set of nine priorities which have drawn on local place based planning, sub-regional strategies and plans and the views of the sub-regional health and local government Strategic Planning Group. Having mapped existing local and NW London activity, we can see that existing planned activity goes a long way towards addressing the Triple Aim. But we must go further to completely close these gaps.

At a NW London level we have agreed five delivery areas that we need to focus on to deliver at scale and pace to achieve our priorities. The five areas are designed to reflect our vision with DA1 focusing on improving health and wellbeing and addressing the wider determinants of health; DA2 focusing on preventing the escalation of risk factors through better management of long term conditions; and DA3 focusing on a better model of care for older people, keeping them out of hospital where appropriate and enabling them to die in the place of their choice. DA4 and DA5 focus on those people whose needs are most acute, whether mental or physical health needs. Throughout the plan we try to address physical and mental health issues holistically, treating the whole person not the individual illness and seeking to reduce the 20 year disparity in life expectancy for those people with serious and long term mental health needs. There is a clear need to invest significant additional resource in out of hospital care to create new models of care and support in community settings, including through joint commissioning with local government.



** Many of our emerging priorities will map across to several delivery areas. But we have sought to highlight where the main focus of these Delivery Areas are in this diagram*

2. Delivery Area 1:
Radically upgrading prevention and wellbeing

The NW London Ambition:

Supporting everybody to play their part in staying healthy

2020/2021

I am equipped to self manage my own health and wellbeing through easy to access information, tools and services, available through my GP, Pharmacy or online. Should I start to need support, I know where and when services and staff are available in my community that will support me to stay well and out of hospital for as long as possible

Target Population:
All adults: 1,641,500
Most Healthy Adults at risk of developing a LTC: 121,680
All children: 438,200

Contribution to Closing the Financial Gap

£11.6m

- **21% of NW Londoners are physically inactive[17] and over 50% of adults are overweight or obese[18]**
- **Westminster has the highest population of rough sleepers in the country[19]**
- **1 in 5 children aged 4-5 years are overweight and obese in NW London**
- **Around 200,000 people in NW London are socially isolated**

Why this is important for NW London

- NW London residents are living longer but living less healthy lifestyles than in the past, and as a result are developing more long term conditions (LTCs) and increasing their risk of developing cancer, heart disease or stroke. There are currently 338,000 people living with one or more LTC, and a further 121,680 mostly healthy adults at risk of developing an LTC before 2030[1].
- Those at risk are members of the population who are likely to affected by poverty, lack of work, poor housing, isolation and consequently make unhealthy lifestyle choices, such as eating unhealthily, smoking, being physically inactive, or drinking a high volume of alcohol. Our residents who have a learning disability are also sometimes not receiving the fully support they need to live well within their local community.
- In NW London, some of the key drivers putting people at risk are:
  - Unhealthy lifestyle choices - only half of the population achieves the recommended amount of physical activity per week[2]. 6 of the 8 Boroughs have higher rates of increasing risk alcohol drinkers than the rest of London and c.14% smoke[3].
  - Rates of drinking are lower in London than the rest of the UK overall. However, alcohol related admissions have been increasing across London. In NW London, there are an estimated 317,000 'increasing risk drinkers' (drinkers over the threshold of 22 units/week for men and 15 units/week for women) with binge drinking and high risk drinking concentrated in centrally located boroughs[10].
  - An increasing prevalence of social isolation and loneliness, which have a detrimental effect on health and well-being - 11% of the UK population reported feeling lonely all, most or more than half of the time[5].
  - Deprivation and homelessness, which are very high in some areas across NW London. Rough sleepers attend A&E around 7 times more often than the general population, and are generally subject to emergency admission and prolonged hospital stays[6].
  - Mental health problems - almost half the people claiming Employment Support Allowance have a mental health problem or behavioural difficulty[7]. Evidence suggests that 30% of them could work given the right sort of help[8].
- For NW London, the current trajectory is not sustainable. In a 'do nothing' scenario by 2020 we expect to see a 12% increase in resident population with an LTC and a 13% increase in spend, up from £1bn annually. By 2030, spend is expected to increase by 37%, an extra c.£370m a year[9].
- Targeted interventions to support people living healthier lives could prevent 'lifestyle' diseases, delay or stop the development of LTCs and reduce pressure on the system. For example, It has been estimated that a 50p minimum unit price would reduce average alcohol consumption by 7% overall[4].
- Furthermore, recent findings from the work commissioned by Healthy London Partnership looking at illness prevention showed that intervention to reduce smoking could realise savings over five years of £20m to £200m for NW London (depending on proportion of population affected)[10].
- This work also suggests that reducing the average BMI of the obese population not only prevents deaths (0.2 deaths per 100 adults achieving a sustained reduction in BMI by 5 points from 30), but also improves quality of life by reducing incidence of CHD, Stroke, and Colorectal and breast cancer.

Our aim is therefore to support people to stay healthy. We will do this by:

- Targeting people at risk of developing long term conditions and supporting them to adopt more healthy lifestyles – whether they are currently mostly healthy, have learning or physical disabilities, or have serious and enduring mental health needs. This group includes approximately 120,000 people who are currently well but are at risk of developed an LTC over the next five years[11]. This will also prevent people from developing cancer, as according to Cancer Research UK, cancer is the leading cause of premature death in London but 42% are preventable and relate to lifestyle factors[12].
- Working across the system at both NW London and London level to address the wider determinants of health, such as employment, education and housing.
- Enabling children to get the best start in life, by increasing immunisation rates, tackling childhood obesity and better managing mental health challenges such as conduct disorder. NW London's child obesity rates are higher than London and England - 1 in 5 children aged 4-5 are overweight and obese and at risk of developing LTCs earlier and in greater numbers[13]. Almost 16,000 NW London children are estimated to have severe behavioural problems (conduct disorder) which impacts negatively on their progress and incurs costs across the NHS, social services, education and, later in life, criminal justice system[14].
- Focusing on social isolation as a key determinant of physical and mental health, whether older people, single parents, or people with mental health needs. Around 200,000 people in NW London are socially isolated and it can affect any age group[15]. Social isolation is worse for us than well-known risk factors such as obesity and physical inactivity – lacking social connections is a comparable risk factor for early death as smoking 15 cigarettes a day[16].

2. Delivery Area 1:
Radically upgrading prevention and wellbeing

What we will do to make a difference

		To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)
A	Enabling and supporting healthier living	Develop NW London healthy living programme plans to deliver interventions to support people to manage their own wellbeing and make healthy lifestyle choices. Establish a NW London Primary Care Cancer Board which will look at improving public messaging/advertising around preventing cancers. Launch a NW London communications and signposting campaign to more effectively guide people to support, including voluntary and community, to improve care and reduce demand on services. As part of this we will: • Establish a People's Health and Wellbeing Charter, co-designed with patient and community representatives for Commissioning and Provider organisations to promote as core to health and social care delivery. • Sign up all NW London NHS organisations to the 'Healthy Workplace Charter' to improve the mental health and wellbeing of staff and their ability to support service users.	Together we will jointly implement the healthy living programme plans, supported by NW London and West London Alliance. Local government, working jointly with health partners, will take the lead on delivering key interventions such as: • Training GPs and other staff in Health Coaching and 'making every contact count' to promote healthy lifestyle choices in patients • Delivering an enhanced 111 service driven by a new Directory of Services which will signpost service users to the appropriate service • Rolling out systematic case-finding to identify and support people at risk of diabetes, dementia or heart disease, using our Whole system IT platform • Promoting a community development approach to improve health by identifying local needs and sign-posting through services, such as, information stalls, children's support sessions, health awareness sessions, debt management and maternity drop-ins • Supporting Healthy Living Pharmacies to train Champions and Leaders to deliver interventions, such as smoking cessation • Implement annual health checks for people with learning disabilities and individualised plans in line with the personalisation agenda	0.2	2.5
B	Wider determinants of health interventions	The healthy living programme plans will also cover how Boroughs will tackle wider determinants of health. In 16/17, local government already plans to deliver some interventions, such as: • Signing the NHS Learning Disability Employment Pledge and developing an action plan for the sustainable employment of people with a learning disability • Co-designing the new Work and Health programme so that it provides effective employment support for people with learning disabilities and people with mental health problems • Bidding for funds from the joint Work and Health Unit to support social prescribing of employment and interventions for those at risk of losing their employment	As part of the healthy living programme, local government, working jointly with health partners, will take the lead on delivering key interventions by 20/21 such as: • Introducing measures reduce alcohol consumption and associated health risks, e.g. licence controls, minimum pricing and promotions bans • Providing supported housing for vulnerable people to improve quality of life, independent living and reduce the risk of homelessness. Also explore models to deliver high quality housing in community settings for people with learning disabilities • Partner with organisations such as London Fire Brigade to jointly tackle the wider determinants of health such as social isolation and poor quality housing	3.3	6.5
C	Addressing social isolation	The healthy living programme plans will also cover how Boroughs will address social isolation. In 16/17, local government already plans to deliver some interventions, such as: • Enabling GPs to refer patients with additional needs to local, non-clinical services, such as employment support provided by the voluntary and community sector through social prescribing • Piloting the 'Age of Loneliness' application in partnership with the voluntary sector, to promote social connectedness and reduce requirements for health and social care services	As part of the healthy living programme, we will implement key interventions such as: • Ensure all socially isolated residents who wish to, can increase their social contact through voluntary or community programmes • Ensure all GPs and other health and social care staff are able to direct socially isolated people to support services and wider public services and facilities As part of the Like Minded programme, we will identify isolation earlier and make real a 'no health without mental health' approach through the integration of mental health and physical health support as well as establish partnerships with the voluntary sector that will enable more consistent approaches to services that aim to reduce isolation.	0.5	6.6

D	Helping children to get the best start in life	• NW London will invest part of its PMS premium income in increasing immunisation rates for key areas of need, such as the 5-in-1 Vaccine by 1 Year
		• Implement the 'Future in Mind' strategy, making it easier to access emotional well being and mental health services
		• Collaborate with the vanguard programme and the children's team at NHSE in the development of new care models for children and young people (C&YP)
		• Pilot a whole system approach to the prevention of conduct disorder, through early identification training and positive parenting support, focusing initially on a single borough
			• Share learning from the conduct disorder pilot across all 8 CCGs with the aim of replicating success and embed within wider C&YP work
			• Establish a Connecting Care for Children GP hub in the majority of localities where children live, building on 3 Borough work to:
			  • reduce high outpatient and A&E attendance numbers among C&YP
			  • promote healthy eating and obesity screening pathways (e.g. HENRY)
			  • Co-locating dental professionals and deliver dental hygiene training
			• Implement NW London wide programmes for overweight children centred on nutrition education, cooking skills and physical activity
				TBC	TBC

2. Delivery Area 2:
Eliminating unwarranted variation and improving Long Term Condition (LTC) management

The NW London Ambition:

- Everyone in NW London has the same high quality care wherever they live
- Every patient with an LTC has the chance to become an expert in living with their condition

I know that the care I receive will be the best possible wherever I live in NW London. I have the right care and support to help me to live with my long term condition. As the person living with this condition I am given the right support to be the expert in managing it.

2020/2021

Target Population: 338,000

Contribution to Closing the Financial Gap £13.1m

Case study – Diabetes

Risk of heart attack in a person with diabetes is two to four times higher than in a person without diabetes.

Diabetes accounts for around 10% of the entire NHS spend, of which 80% relates to complications, many of which could be prevented through optimised management. Around 122,000 people are currently diagnosed with diabetes in NW London.

An 11mmol/mol reduction in HbA1c (UKPDS) equates to a reduction of:

- 43% reduction in amputations
- 21% reduction in diabetes related death
- 14% reduction in heart attack

Multifactorial risk reduction (optimising control of HbA1c, BP and lipids) can reduce cardiovascular disease by as much as 75% or 13 events per 1000 person years – this equates to a reduction in diabetes related cardiovascular events of 2806 per year across NW London averaged over a five year period[9].

Why this is <u>important</u> for NW London

- Evidence shows that unwarranted clinical variation drives a cost of £4.5bn in England. Unwarranted variation covers all services, from the early detection of cancer, the management of long term conditions, and the length of stay in hospital to the survival rates from cancer and major surgery. Our STP aims to recognise and drive out unwarranted variation wherever it exists, across all five delivery areas.
- The key focus of this delivery area is the management of long term conditions (LTCs) as 75% of current healthcare spend is on people with LTCs. NW London currently has around 338,000 people living with one or more LTC[1] and 1500 people under 75 die each year from cancer, heart disease and respiratory illness – if we were to reach the national average outcomes, we could save 200 people per year:
  - Over **50%** of cancer patients now survive 10 years or more. There is more we can do to improve the rehab pathways and holistic cancer care[2]
  - **146,000** people (current estimation) have an LTC and a mental health problem, whether the mental health problem is diagnosed or not[3]
  - **317,000** people have a common mental illness and **46%** of these are estimated to have an LTC[4]
  - **512** strokes per year could be avoided in NW London by detecting and diagnosing AF and providing effective anti-coagulation to prevent the formation of clots in the heart[5]
  - **198,691** people have hypertension which is diagnosed and controlled – this is around **40%** of the estimated total number of people with hypertension in NW London but ranges from 29.1% in Westminster to 45.4% in Harrow. Increasing this to the 66% rate achieved in Canada through a targeted programme would improve care and reduce the risk of stroke and heart attack for 123,383 people

    There are ~20,000 patients diagnosed with COPD in NW London, but evidence suggests that this could be up to 55,000 due to the potential for underdiagnosis[6]. Best practices (pulmonary rehabilitation, smoking cessation, inhaler technique, flu vaccination) are not applied consistently across care settings
- There is a marked variation in the outcomes for patients across NW London – yet our residents expect, and have a right to expect, that the quality of care should not vary depending on where they live. For example, our breast screening rate varies from 57% to 75% across Boroughs in NW London.
- Self-care is thought to save an hour per day of GP time which is currently spent on minor ailment consultations. For every £1 invested in self-care for long-term conditions, £3 is saved in reducing avoidable hospital admissions and improving participants' quality of life. (If you add in social value, this goes up to £6.50 for every £1) [7]. The impact of self-care approaches is estimated to reduce A&E attendances by 17,568 across NW London, a financial impact of £2.4 m[8].

Our aim is therefore to support people to understand and manage their own condition and to reduce the variation in outcomes for people with LTCs by standardising the management of LTCs, particularly in primary care. We will do this by:

- Detecting cancer earlier, to improve survival rates. We will increase our bowel screening uptake to 75% by 2020, currently ranging between 40-52%.
- Offering access to expert patient programmes to all people living with or newly diagnosed with an LTC
- Using patient activation measures to help patients take more control over their own care
- Recognising the linkage between LTCs and common mental illness, and ensuring access to IAPT where needed to people living with or newly diagnosed with an LTC
- Using the Right Care data to identify where unwarranted variation exists and targeting a rolling programme across the five years to address key priorities.

2. Delivery Area 2: Eliminating unwarranted variation and improving Long Term Condition (LTC) management

What we will do to make a difference

		To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)
A	**Improve cancer screening to increase early diagnosis and faster treatment**	Our Primary Care Cancer Board will take the learning from HLP's Transforming Cancer Programme to create a strategy for how to improve early detection of cancer, improving referral to treatment and developing integrated care to support people living with and beyond cancer. As part of this we will share learning from the commissioning of a bowel cancer screening target in Hounslow and scale across NW London if successful. We will align our work to HLP's review of diagnostic capacity in 16/17 and work with HLP to develop an improvement plan for 17/18.	Through the Royal Marsden and Partners Cancer Vanguard, develop and implement whole system pathways to improve early detection and transform the whole acute cancer care pathway in NW London, thereby reducing variation in acute care and ensuring patients have effective high quality cancer care wherever they are treated in NW London	TBC	TBC
B	**Better outcomes and support for people with common mental health needs** (with an initial focus on people with [illegible]g term physical health conditions)	• Improve identification of people with diabetes who may also have depression and/or anxiety and increase their access to IAPT • Improve access to and availability of early intervention mental health services, such as psychosis services, psychological therapies supporting the emotional health of the unemployed and community perinatal services	• Address link between LTCs and Mental Health by specifically addressing impact of co-morbid needs on individuals and the wider system for all residents by 2020/21, delivering joined up physical and psychological therapies for people with LTCs • Ensure at least 25% of people needing to access physiological therapies are able to do so	TBC	TBC
C	**Reduce variation by focusing on 'Right Care' priority areas**	Identified and commenced work in 2016/17 in following areas: • Mobilisation of National Diabetes Prevention Programme (commencing August 2016) • Further development of diabetes mentor/champion role within communities • Extend diabetes dashboards to other LTC, improving primary care awareness of variability and performance • Increasing COPD diagnosis/pick up rate through more proactive screening of symptomatic smokers and reducing variability in uptake of pulmonary rehabilitation • Development of Right Breathe respiratory portal – 'one-stop-shop' to support decision-making for professionals and patients for asthma and COPD, enabling easy navigation through device-drug-dose considerations and supporting professionals and patients in reaching appropriate decisions and achieving adherence to therapy • The January 2016 Right Care Commissioning for Value packs showed a £18M opportunity in NW London. A joined up initiative is being launched in NW London to verify the opportunity and identify opportunity areas amenable to a sector wide approach. As a national 1st wave delivery site, Hammersmith & Fulham CCG has identified neurology, respiratory and CVD as priority areas for delivering Right Care.	• Patients receive timely, high quality and consistent care according to best practice pathways, supported by appropriate analytical data bases and tools • Reduction in progression from non-diabetic hyperglycaemia to Type 2 diabetes • Reduction in diabetes-related CVD outcomes: CHD, MI, stroke/TIA, blindness, ESRF, major and minor amputations • Joined up working with Public Health team to address wider determinants of health. This will also allow clinicians to refer to services to address social factors • Patients with LTC supported by proactive care teams and provided with motivational and educational materials (including videos and eLearning tools) to support their needs • Right Care in NW London will bring together the 8 CCGs to ensure alignment, knowledge sharing and delivery at pace. The Programme will ensure the data, tools and methodology from Right Care becomes an enabler and supports existing initiatives such as Transforming Care, Whole Systems Integrated Care and Planned Care within CCGs. The Programme will carry out analysis of available data to identify areas of opportunity as a sector. Deep dive sessions with clinicians and managers to determine the root cause of variation and implement options to maximise value for the system.	2	12.4
D	**Improve self-management and 'patient activation'**	• Identify opportunities for patient activation in current LTC pathways based on best practice – application for 43,920 Patient Activation Measures (PAM) licences in 2016/17 for people who feel overwhelmed and anxious about managing their health conditions	• Develop patients' health literacy helping them to become experts in living with their condition(s) – people diagnosed with a LTC will be immediately referred into expert patient training • Technology in place to promote self-management and peer support for people with LTCs • Increase availability of, and access to, personal health budgets, taking an integrated personal commissioning approach • PAM tool available to every patient with an LTC to help them take more control over their own care – planned increase in PAM licences to 428,700 • Enable GPs to address the wider social needs of patients which affect their ability to manage LTCs through provision of tools, techniques and time • Pro-active identification of patients by GP practices who would benefit from coordinated care and continuity with a named clinician to support them with LTCs	3.4	6.1

2. Delivery Area 3:
Achieving better outcomes and experiences for older people

The NW London Ambition:

Caring for older people with dignity and respect, and never caring for someone in hospital if they can be cared for in their own bed

There is always someone I can reach if I need help or have any concerns. I know that the advice and support I receive helps me to stay independent. There are numerous opportunities for me to get involved easily with my community and feel a part of it. I don't have to keep explaining my condition to the health and social care teams that support me; they are all aware of and understand my situation. I know that, where possible, I will be able to receive care and be supported at home and not have to go into hospital if I don't need to.

2020/2021

Target Population:

311,500

Contribution to Closing the Financial Gap

£82.6m

- **Over 30% of people in acute hospitals could have their needs met more effectively at home or in another setting**
- **4 in 5 people would prefer to die at home, but only 1 in 5 currently do**
- **17,000 days are spent in hospital beds that could be spent in an individual's own bed**
- **The average length of stay for a cross-border admission within NW London is 2.9 days longer than one within a CCG boundary**

Why this is important for NW London

Over the last few years there have been numerous examples of where the NHS and social care have failed older people, with significant harm and even death as a result of poor care. People are not treated with dignity and the increasing medicalisation of care means that it is not recognised when people are in the last phase of life, so they can be subject to often unnecessary treatments and are more likely to die in hospital, even when this is not their wish.

The increase in the older population in NW London poses a challenge to the health and care system as this population cohort has more complex health and care needs. The over 65 population is much more likely to be frail and have multiple LTCs. The higher proportion of non-elective admissions for this age group indicates that care could be better coordinated, more proactive and less fragmented.

- There is a forecast rise of 13% in the number of people over 65 in NW London from 2015 to 2020. Between 2020 and 2030, this number is forecast to rise again by 32%[1]
- People aged 65 or over in NW London constitute 13% of the population, but 35% of the cost across the health and care system
- 24% of people over 65 in NW London live in poverty, and this is expected to increase by 40%[2] by 2030, which contributes to poor health
- Nearly half of our 65+ population are living alone, increasing the potential for social isolation
- 42.1% of non-elective admissions occur from people 65 and over[4]
- 11,688 over 65s have dementia in NW London which is only going to increase[3]
- There are very few care homes in the central London boroughs, and the care home sector is struggling to deal with financial and quality challenges, leaving a real risk that the sector will collapse, increasing the pressure on health and social care services

Our aim is to fundamentally improve the care we offer for older people, supporting them to stay independent as long as possible. We will do this by:

- Commissioning services on an outcome basis from accountable care partnerships, using new contracting and commissioning approaches to change the incentives for providers
- Develop plans with partners to significantly expand pooled budgets and joint commissioning for delivery of integrated and out oh hospital care, especially for older people services, to support the development of the local and NW London market
- Increasing the co-ordination of care, with integrated service models that have the GP at the heart
- Increasing intermediate care to support people to stay at home as long as possible and to facilitate appropriate rapid discharge when medically fit
- Identifying when someone is in the last phase of life, and care planning appropriately to best meet their needs and to enable them to die in the place of their choice

2. Delivery Area 3:
Achieving better outcomes and experiences for older people

What we will do to make a difference

		To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)
A	Improve market management and take a whole systems approach to commissioning	• Carry out comprehensive market analysis of older people's care to understand where there is under supply and quality problems, and develop a market management and development strategy to address the findings alongside a NW London market position statement.	• Implement market management and development strategy to ensure it provides the care people need, and ensuring a sustainable nursing and care home sector, with most homes rated at least 'good' by CQC. • Jointly commission, between health and local government, the entirety of older people's out of hospital care to realise better care for people and financial savings	2	0
B	Implement accountable care partnerships	• Agree the commissioning outcomes and begin a procurement process to identify capable providers to form the accountable care partnership(s) • Support existing local Early Adopter WSIC models of care, including evaluation and ramp-up support	• Commission the entirety of NHS provided older people's care services in NW London via outcomes based contract(s) delivered by Accountable Care Partnership(s), with joint agreement about the model of integration with local government commissioned care and support services • All NHS or jointly commissioned services in NW London contracted on a capitation basis, with the financial model incentivising the new proactive model of care	0	25.1
C	Implement new models of local services integrated care to consistent outcomes and standards	• Continue to support the development of federations, enabling the delivery of primary care at scale • Develop and agree the older persons (frailty) service for Ealing and Charing Cross Hospitals, as part of a fully integrated older person's service and blue print for a NW London model at all hospital sites • Agree and publish clear outcomes for primary care over the next five years • Implement the first elements of the primary care strategic commissioning framework, with a focus in this delivery area on co-ordinated care	• Fully implement the primary care outcomes in each of the eight boroughs and across NW London • Implement integrated, primary care led models of local services care that feature principles of case management, care planning, self-care and multi-disciplinary working • Integrate mental health and physical health support so that there is a co-ordinated approach, particularly for people with dementia and their carers	18	26.3
D	Upgrade rapid response and intermediate care services	We currently have eight models of rapid response, with different costs and delivering differential levels of benefit. We will work jointly to: • Identify the best parts of each model and move to a consistent specification as far as possible • Improve the rate of return on existing services, reducing non elective admissions and reducing length of stay through early discharge • Enhance integration with other service providers	• Use best practise model across all 8 boroughs, creating standardisation wherever possible and investing £20-30m additional funding, including through joint commissioning with local government, creating additional capacity to enable people to be cared for in less acute settings, • Operate rapid response and integrated care as part of a fully integrated ACP model	20	64.9
E	Create a single discharge approach and process across NW London	• Implement a single NHS needs-based assessment form across all community and acute trusts, focusing on discharge into non bedded community services via a single point of access in each borough, reducing the differential between in borough and out of borough length of stay in line with the in borough length of stay • Move to a 'trusted assessor' model for social care assessment and discharge across NW London • Integrate the NHS and social care processes to form a single approach to discharge	• Eliminate the 2.9 day differential between in borough and out of borough length of stay • 100% of discharge correspondence is transmitted electronically; and the single assessment process for discharge is built into the shared care records across NW London • Fully integrated health and social care discharge process for all patients in NW London	7.4	9.6
F	Improve care in the last phase of life	• Improve identification and planning for last phase of life; - identify the 1% of the population who are at risk of death in the next 12 months by using advanced care plans as part of clinical pathways and 'the surprise test' - identify the frail elderly population using risk stratification and 'flagging' patients who should be offered advanced care planning - patient initiated planning to help patients to self-identify • Improving interoperability of Coordinate my Care with other systems (at least 4), including primary care to ensure that people get they care they want. • Reduce the number of non-elective admissions from care homes – demonstrate a statistically significant reduction in admissions and 0 day LOS (i.e. >10%)	• Every patient in their last phase of life is identified • Every eligible person in NW London to have a Last Phase of Life (LPoL) care plan, with a fully implemented workforce training plan, and additional capacity to support this in the community. • Meet national upper quartile of people dying in the place of their choice • Reduce non elective admissions for this patient cohort by 50%	4.9	7

2. Delivery Area 4:
Improving outcomes for children and adults with mental health needs

The NW London Ambition:

No health without mental health

2020/2021

Target Population:

262,000

Contribution to Closing the Financial Gap

£11.8m

I will be given the support I need to stay well and thrive. As soon as I am struggling, appropriate and timely advice is available. The care and support that is available is joined-up, sensitive to my needs, personal beliefs, and is delivered at the place that is right for me and the people that matter to me. My life is important, I am part of my community and I have opportunity, choice and control. My wellbeing and mental health is valued equally to my physical health. I am seen as a whole person – professionals understand the impact of my housing situation, my networks, employment and income on my health and wellbeing. My care is seamless across different services, and in the most appropriate setting. I feel valued and supported to stay well throughout my life.

Why this is <u>important</u> for NW London

Mental Health has been seen in a silo for too long and has struggled to achieve parity of esteem. But we know that poor mental health has catastrophic impacts for individuals – and also a wider social impact. Our justice system, police stations, courts and prisons all are impacted by mental illness. Social care supports much of the care and financial burden for those with serious and long term mental health needs, providing longer term accommodation for people who cannot live alone. For those off work and claiming incapacity benefit for two years or more, they are more likely to retire or die than ever return to work[1]. The '5 Year forward View for Mental Health' describes how prevention, reducing stigma and early intervention are critical to reduce this impact.

In NW London, some of the key drivers and our case for change are:

- **15% of people** who experience an episode of psychosis will experience repeated relapses and will be substantially handicapped by their condition and **10% will die by their own hand**.
- Those who experience episodes of psychosis have intense needs and account for the vast majority of mental health expenditure -nearly **90% of inpatient bed days, and 80% of spend in mental health trusts**.
- Mental health needs are prevalent in children and young people with 3 in 4 of lifetime mental health disorders starting before you are 18.
- The number of people with serious and long term mental health needs in NW London is double the national average
- Around **23,000 people in NW London** have been diagnosed with schizophrenia, bipolar and/or psychosis, which is double the national average
- The population with mental illness have **3.2 times more A&E attendances, 4.9 times emergency admissions**
- The contrast with physical health services is sharp and stark – access points and pathways are generally clear and well structured; the same cannot be said for mental health services which can be over-complicated and confusing.

Our aim in NW London is to improve outcomes for children and adults with mental health needs, we will do this by:

- Implementing a new model of care for people with serious and long term mental health needs, which includes investing in a more proactive, recovery based model to prevent care needs from escalating and reducing the number of people who need inpatient acute care
- Addressing wider determinants of health and how they relate to and support recovery for people with mental health needs
- Improving services for people in crisis and providing a single point of access to services, 24/7, so that people can access the professional support they need
- Transforming the care pathway for children and adolescents with mental health needs, introducing a 'tier free' model and ensuring that when children do need to be admitted to specialist tier 4 services they are able to do so within London, close to home. This includes Future in Mind and Transforming Care Partnerships work.

- People with serious and long term mental health needs have a life expectancy 20 years less than the average
- Social outcomes of people known to secondary care are often worse than the general population; only 8-10% are employed and only half live in settled accommodation
- In a crisis, only 14% of adults surveyed nationally felt they were provided with the right response
- Eating disorders account for nearly a quarter of all psychiatric child and adolescent inpatient admissions –with the longest stay of any psychiatric disorder, averaging 18 weeks

2. Delivery Area 4:
Improving outcomes for children and adults with mental health needs

What we will do to make a difference

		To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)

A	Implement the new model of care for people with serious and long term mental health needs, to improve physical, mental health and increase life expectancy	• More support available in primary care – supporting physical health checks and 35 additional GPs with Advanced Diploma in Mental Health Care and the non-health workforce is also receiving training
		• Embed addressing mental health needs in developing work in local services and acute reconfiguration programmes
		• Agree investment and benefits to deliver an NW London wide Model of Care for Serious & Long Term Mental Health Needs with implementation starting in 2016/17 to deliver a long term sustainable mental health system through early support in the community (investment of c£12-13m)
		• Rapid access to evidence based Early Intervention in Psychosis for all ages
			• Full roll out of the new model across NW London, including:
			  • Integrated shared care plans across the system are held by all people with serious mental illness with agreed carer support
			  • Comprehensive self management and peer support for all ages
			  • Collaborative working and benchmarking means frontline staff will have increased patient facing time, simultaneously reducing length of stay and reducing variation
			  • We will shift the focus of care, as seen in the 'telescope' diagram, out of acute and urgent care into the community
			• **The benefit to the patient will be tailored evidence based support available closer to home**
			 
				11	16

B	Addressing wider determinants of health, e.g. employment, housing	• Targeted employment services for people with serious and long term health needs to support maintaining employment • Support 'Work and Health Programme' set up of individual support placements for people with common mental health needs • Address physical health needs holistically to address mental health needs adopting a 'no health without mental health' approach • Ensuring care planning recognises wider determinants of health and timely discharge planning involves housing teams • Pilot digital systems to encourage people to think about their own on-going mental wellbeing through Patient Reported Outcome Measurements	• Employment support embedded in integrated community teams • Deliver the NW London Transforming Care Plan for people with Learning Disabilities, Autism and challenging behaviour – supporting c.25% of current inpatients in community settings • Implement digital tools to support people in managing their mental health issues outside traditional care models • Specialist community perinatal treatment available to all maternity and paediatric services and children centres • Personalisation – support individuals with mental health needs and learning disabilities to understand their choices about life and care • **The benefit to the patient will be a happier, fuller way of living**	TBC	5
C	Crisis support services, including delivering the 'Crisis Care Concordat'	• Embed our 24/7 crisis support service, including home treatment team, to ensure optimum usage by London Ambulance Service (LAS) LAS, Metropolitan police and other services – meeting access targets • Round the clock mental health teams in our A&Es and support on wards, 'core 24' • Extend out of hours service initiatives for children, providing evening and weekend specialist services (CAMHS service)	• Alternatives to admissions which support transition to independent living both in times of crisis and to support recovery • Tailored support for specific populations with high needs – people with learning disabilities/Autism, Children and Young People, those with dual diagnosis • **The benefit to the patient will be care available when it is most needed**	TBC	TBC
D	Implementing 'Future in Mind' to improve children's mental health and wellbeing	• Agree NW London offer across health, social care and schools for a 'tier-free' mental health and wellbeing approach for CYP, reducing barriers to access • Community eating disorders services for children and young people	• Implement 'tier-free' approach ensuring an additional c.2,600 children receive support in NW London • Clearly detailed pathways with partners in the Metropolitan Police and wider justice system for young offending team, court diversion , police liaison and ensure optimal usage of refurbished HBPOs (8 across NW London)	TBC	1.8

2. Delivery Area 5:
Ensuring we have safe, high quality sustainable acute services

The NW London Ambition:

High quality specialist services at the time you need them

Target Population:

All: 2,079,700[1]

Contribution to Closing the Financial Gap

£208.9m

2020/2021

I can get high quality specialist care and support when I need it. The hospital will ensure that all my tests are done quickly and there is no delay to me leaving hospital, so that I don't spend any longer than necessary in hospital. There's no difference in the quality of my care between weekdays and weekends. The cancer care I receive in hospital is the best in the country and I know I can access the latest treatments and technological innovations

Why this is <u>important</u> for NW London

Medicine has evolved beyond comprehension since the birth of the NHS in 1948. Diseases that killed thousands of people have been eradicated or have limited effects; drugs can manage diabetes, high blood pressure and mental health conditions, and early access to specialist care can not just save people who have had heart attacks, strokes or suffered major trauma but can return them to health. Heart transplants, robotic surgery and genetic medicine are among advances that have revolutionised healthcare and driven the increasing life expectancy that we now enjoy.

Better outcomes are driven in large part by increasing standards within medicine, with explicit quality standards set by the Royal Colleges and at London level in many areas. These require increased consultant input and oversight to ensure consistent, high quality care. Current standards include consultant cover of 112 hours per week in A&E; 114 hours in paediatrics; and 168 hours in obstetrics. Meeting these input standards are placing significant strain on the workforce and the finances of health services. We will continue to work with London Clinical Senate and others to evolve clinical standards that strikes a balance between the need to improve quality, as well address financial and workforce challenges. Many services are only available five days a week, and there are 10 seven day services standards that must be met by 2020, further increasing pressures on limited resources.

- In NW London A&E departments, 65% of people present in their home borough but 88% are seen within NW London. The cross borough nature of acute services means that it is critical for us to work together at scale to ensure consistency and quality across NW London[2]
- 3 out of our 4 Acute Trusts with A&Es do not meet the A&E 4 hour target[3]
- Our 4 non specialist acute trusts all have deficits, two of which are significant
- There is a shortage of specialist children's doctors and nurses to staff rotas in our units in a safe and sustainable way (at the start of 16/17) [4]
- 17/18 year olds currently do not have the option of being treated in a children's ward
- Previous consolidations of major trauma and stroke services were estimated to have saved 58 and 100 lives per year respectively[5]
- Around 130 lives could be saved across NW London every year if mortality rates for admissions at the weekend were the same as during the week in NW London trusts[6]
- There are on average at any one time 298 patients in beds waiting longer than 24 hours for diagnostic tests or results. [7]

We aim to centralise and specialise care in hospital to allow us to make best use of our specialist staffing resource to deliver higher quality care which will improve outcomes, deliver the quality standards and enable us to deliver consistent services 7 days a week. We will do this by:

- Reviewing care pathways into specialist commissioning services, identifying opportunities to intervene earlier to reduce the need for services
- Deliver the 7 day standards
- Consolidate acute services onto five sites (The consolidation of acute services to fewer sites is not supported by the London Boroughs of Ealing and Hammersmith and Fulham– see Appendix A, condition 5).
- Improve the productivity and efficiency of our hospitals.

There will be no substantial changes to A&E in Ealing or Hammersmith & Fulham, until such time as any reduced acute capacity has been adequately replaced by out of hospital provision to enable patient demand to be met. NHS partners will review with local authority STP partners the assumptions underpinning the changes to acute services and progress with the delivery of local services before making further changes and will work jointly with local communities and councils to agree a model of acute provision that addresses clinical safety concerns and expected demand pressures.

2. Delivery Area 5:
Ensuring we have safe, high quality sustainable acute services

What we will do to make a difference

		To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)
A	Specialised Commissioning	• Implement the national Hepatitis C programme which will see approximately 500 people treated for Hepatitis C infection in 2016/17 reducing the likelihood of liver disease. • Complete our service reviews of CAMHs, HIV, paediatric transport and neuro-rehabilitation and begin to implement the findings from these and identify our next suit of review work (which will include renal). • Using the levers of CQUIN and QIPP improve efficiency and quality of care for patients through a focus on: innovation (increasing tele-medicine), improved bed utilisation by implementing Clinical Utilisation Review and initiatives to reduce delays in critical care, cost effective HIV prescribing, and enhanced supported care at the end of life. • Be an active partner in the 'Like Minded' Programme	To have worked with partners in NW London and strategically across London to: • Identify the opportunities for better patient care, and greater efficiency by service such that quality, outcomes and cost-effectiveness are equal or better than similar services in other regions. • To have met the financial gap we have identified of £188m over five years on a 'do nothing' assessment; whether through pathway improvements, disease prevention, innovation leading to more cost effective provision or through procurement and consolidation. • To actively participate in planning and transformation work in NW London and Regionally to this end	TBC	TBC
B	Deliver the 7 day services standards	As a First Wave Delivery Site, working towards delivering the 4 prioritised Clinical Standards for 100% of the population in NW London by end of 16/17; we will: • develop evidence-based clinical model of care to ensure: - all emergency admissions assessed by suitable consultant within 14 hours of arrival at hospital - on-going review by consultant every 24 hours of patients on general wards • ensure access to diagnostics 7 days a week with results/reports completed within 24 hours of request through new/improved technology and development of career framework for radiographer staff and recruitment campaign • ensure access to consultant directed interventions 7 days a week through robust pathways for inpatient access to interventions (at least 73) in place 24 hours a day, 7 days a week	To have continued our work on 7 day services by being compliant with the remaining 6 Clinical Standards for 100% of the population in NW London: • Patient Experience • MDT Review • Shift Handover • Mental Health • Transfer to community, primary & social care • Quality Improvement We will also have continued work to ensure the sustainability of the achievement of the 4 priority standards, most notably we will: • Join up RIS/PACS radiology systems across acute NW London providers forming one reporting network • Build on opportunities from shifts in the provider landscape to optimise delivery of 7 day care • Deliver NW London workforce initiatives such as a sector-wide bank, joint recruitment & networked working	7.9	21.5

2. Delivery Area 5:
Ensuring we have safe, high quality sustainable acute services

What we will do to make a difference

		To achieve this in 2016/17 we will…	…and by 2020/21?	Investment (£m)	Gross Saving (£m)
C	Configuring acute services	Introduce paediatric assessment units in 4 of the 5 paediatric units in NW London to reduce the length of stay for children Close the paediatric unit at Ealing Hospital and allocate staff to the remaining 5 units Working to achieve London Quality Standards, including consultant cover of 112 hours per week in A&E; 114 hours in paediatrics; and 168 hours in obstetrics. But at the same time developed new outcome-focused standards with London Clinical Senate and others. Recruit approximately 72 additional paediatric nurses, reducing vacancy rates to below 10% across all hospitals from a maximum of 17% in February 2016 Design and implement new frailty services at the front end of A&Es, piloting in Ealing and Charing Cross ahead of roll out across all sites	Reduce demand for acute services through investment in the pro active out of hospital care model. Work jointly with the council at Ealing to develop the hospital in Ealing and jointly shape the delivery of health and social care delivery of services from that site, including: • a network of ambulatory care pathways; • a centre of excellence for elderly services including access to appropriate beds; • a GP practice; and • an extensive range of outpatient and diagnostic services to meet the vast majority of the local population's routine health needs Revolutionise the outpatient model by using technology to reduce the number of face to face outpatient consultations by up to 40% and integrating primary care with access to specialists.	33.6	89.6

D	NW London Productivity Programme	Implement and embed the NW London productivity programme across all provider trusts, focusing on the following four areas:
		• **Patient Flow**: address pressure points in the system that impacts on patient flow, patient experience and performance against key targets (e.g. 4 hour wait and bed occupancy).
		• **Orthopaedics**: mobilise and commence work around establishing a sector-wide approach to elective orthopaedics with the goal of improving both quality and productivity in line with Getting it Right First Time (GIRFT).
		• **Procurement**: assuming no mandation of the new NHS procurement operating model, establish the necessary enablers for collaboration to take forward sector-wide transformation in procurement and implement the Carter Review recommendations across the STP footprint[8]. These include establishing line of sight of sector-wide savings opportunities through agreed baseline reporting and on-going measurement of the benefits from collaborations, sector-wide visibility of contracts and establishing governance links to enable wider benefit of existing purchasing collaboratives (e.g. Shelford Group).
		• **Bank & Agency**: reduce agency spend across NW London; initiation of a range of workforce activities such as standardised pay and sector-wide recruitment. The sector is expected to reduce agency spend by £46m and deliver net savings of £32m.
			Single approach to transformation and improvement across NW London, with a shared transformation infrastructure and trusts working together through ACPs to constantly innovate and drive efficiency. Rolling programme of pathway redesign and patient flow initiatives to ensure trusts are consistently in the top quartile of efficiency. 17/18 plans against the initial delivery areas are set out below:
			• **Patient flow:** Implement system level initiatives in areas such as: improving access to GPs, better management of increasing volumes of ambulance attendances, integrated discharge processes from hospital and best practice A&E processing of patients.
			• **Orthopaedics:** Implement orthopaedics best practice based on Getting it Right First Time. Hip and knee replacements initial area of focus with estimated savings in the region of £2.6m to £4.0m across NW London, then roll out in full.
			• **Procurement:** 2016/17 will establish baselines enabling additional quantified benefits from 2017/18 onwards. Early impact areas include utilities, waste management, agency (linked with Bank & Agency workstream) and applying the GIRFT principles to commoditised purchasing for specific clinical areas.
			• **Bank & Agency:** build on work from 2016/17 , linking with South West London to share best practice. Key areas of focus are
			  • Strengthening recruitment to reduce vacancies
			  • Optimising scheduling to reduce demand
			  • Shifting usage from agency to bank to reduce costs
			  • Reducing unit costs for agency by increasing use of framework agencies and reducing rates through volume based contracts
				4.1*	143.4

*This is investment in the Delivery Architecture to achieve cross-provider CIPs – see Section 6

3. Enablers:
Supporting the 5 delivery areas

The 9 priorities, and therefore the 5 delivery areas, are supported by three key enablers. These are areas of work that are on-going to overcome key challenges that NW London Health and Social Care face, and will support the delivery of the STP plans to make them effective, efficient and delivered on time; hence they are termed 'enablers' in the context of STP. The following mapping gives an overview of how plans around each of the enablers support the STP: further detail is provided in the next section.

Delivery areas	By 2020/21, Enablers will change the landscape for health and social care:		
	Estates will…	**Digital will…**	**Workforce will…**
1. Radically upgrading prevention and wellbeing	• Deliver **Local Services Hubs** to move more services into a community setting • Increase the use of advanced technology to **reduce the reliance on physical estate** • Develop **clear estates strategies and Borough-based shared visions** to maximise use of space and proactively work towards 'One Public Estate' • Deliver **improvements to the condition and sustainability of the Primary Care Estate** through an investment fund of up to £100m and Minor Improvement Grants • **Improving and changing our hospital estates** to consolidate acute services and develop new hospital models to bridge the gap between acute and primary care	• Deploy our **shared care record** across all care settings to improve care, reduce clinical risk, and support transition away from hospital • **Automate clinical workflows and records** and support transfers of care through **interoperability**, delivering digital empowerment by removing the reliance on paper and improving quality • **Extend patient records to patients and carers** to help them to become more digitally empowered and involved in their own care, and supporting the shift to new channels • Provide patients with **tools for self-management and self-care**, further supporting digital empowerment and the shift to new channels • Use **dynamic data analytics** to inform care decisions and target interventions, and support integrated health and social care with whole systems intelligence	• **Targeted recruitment** of staff through system wide collaboration • Support the workforce to enable 7 day working through **career development and retention** • **Address workforce shortages** through bespoke project work that is guided by more advanced processes of workforce planning • Develop and train staff to '**Make Every Contact Count**' and move to **multi-disciplinary ways of working** • Deliver **targeted education** programmes to support staff to adapt to changing population needs (e.g. care of the elderly) • Establish **Leadership development forums** to drive transformation through networking and local intelligence sharing
2. Eliminating unwarranted variation and improving Long Term Conditions (LTC) management			
3. Achieving better outcomes and experiences for older people			
4. Improving outcomes for children and adults with mental health needs			
5. Ensuring we have safe, high quality sustainable acute services			

3. Enablers: Estates

Context

- The Estates model will support the clinical service model with a progressive transformation of the estate to provide facilities that are modern, fit for purpose and which enable a range of services to be delivered in a flexible environment.
- Poor quality estate will be addressed through a programme of rationalisation and investment that will transform the primary, community and acute estate to reflect patient needs now and in the future. This will require us to retain land receipts to invest in new and improved buildings.
- NW London has the opportunity to work across health and local government, promoting the 'One Public Estate' to leverage available estate to deliver the right services in the right place, at the most efficient cost. Key levers to achieve this are better integration and customer focused services enabling patients to access more services in one location, thus reducing running costs by avoiding duplication through co-location. We are keen to explore this as an early devolution opportunity.
- Some progress has been made towards estates integration, where local government and health have worked together to start to realise efficiencies. A notable example is in Harrow's new civic centre, where it is planned that primary care will be delivered at the heart of the community in a fit for purpose site alongside social care and third sector services. This will also enable the disposal of inadequate health and local government sites to maximise the value of public sector assets.

Key Challenges

- NW London has more poor quality estate and a higher level of backlog maintenance across its hospital sites than any other sector in London. The total backlog maintenance cost across all Acute sites in NWL (non-risk adjusted) is £623m[1] and 20% of services are still provided out of 19th century accommodation[2], compromising both the quality and efficiency of care.
- Primary care estate is also poor, with an estimated 240 (66%) of 370 GP practices operating out of category C or below estate[3]. Demand for services in primary care has grown by 16% over the 7 years 2007 to 2014[4], but there has been limited investment in estate, meaning that in addition to the quality issues there is insufficient capacity to meet demand, driving increased pressure on UCC and A&E departments.
- Our new proactive, integrated care model will need local hubs where primary, community, mental health, social and acute care providers can come together to deliver integrated, patient centred services. This will also allow more services to be delivered outside of hospital settings.
- In addition, NHS Trusts are responding to the Government's decision to act on the recommendations made by Lord Carter in his report of operational productivity in English NHS acute hospitals, to reduce non-clinical space (% of floor area) to lower than 35% by 2020, so that estates and facilities resources are used in a cost effective manner.
- Given the scale of transformation and the historic estates problems, there is significant investment required. However it is not clear if the London devolution agreement will support the retention of capital receipts from the sale of assets to contribute to covering the cost of delivering the change. Without this ability to retain land receipts we will not be able to address the estates challenges.

3. Enablers: Estates

Current Transformation Plans and Benefits

- **Deliver Local Services Hubs** to support shift of services from a hospital setting to a community based location
  - Business cases are being developed for each of the new Hubs, due by end 2016
  - The hub strategy and plans include community Mental Health services, such as IAPT
- **Develop Estates Strategies for all 8 CCGs and Boroughs** to support delivery of the Five Year Forward Plan and 'One Public Estate' vision with the aim of using assets more effectively to support programmes of major service transformation and local economic growth
  - Work is on-going to develop planning documents for delivery of the strategies
  - Continuing work with local authority partners to maximise the contribution of Section 106 and Community Infrastructure Levy funding for health
- **Develop Primary Care Premises Investment Plans** to ensure future sustainability of primary care provision across NW London
  - NW London will identify key areas to target investment to ensure future primary care delivery in partnership with NHSE primary care teams
  - CQC and other quality data is being used to identify potential hot spots in each Borough and develop robust plans to ensure a sustainable provision of primary care
- **Align Estates and Technology Strategies** to maximise the impact of technology to transform service delivery and potential efficiencies in designing new healthcare accommodation
  - NW London will optimise property costs by maximising use of existing space, eradicating voids and using technology to reduce physical infrastructure required for service delivery
  - Continuing work to identify opportunities for consolidation, co-location and integration to maximise the opportunity created by the Estates & Technology Transformation Fund to drive improvements in the quality of the primary care estate
- **Improving and changing the hospital estate** to address poor quality estates, improve consistency in care quality and overall system sustainability in the face of increasing demographic and clinical pressures
  - Consolidate services on fewer major acute sites, delivering more comprehensive, better staffed hospitals able to provide the best 7-day quality care (The consolidation of acute services to fewer sites is not supported by the London Boroughs of Ealing and Hammersmith and Fulham – see Appendix A, condition 5).
  - Develop new hospitals that integrate primary and acute care and meet the needs of the local population
  - Trusts are currently developing their site proposals, which will feed into an overall N W London ask for capital from the Treasury, contained in the strategic outline case to be submitted this summer.

Key Impacts on Sustainability & Transformation Planning

Delivery Area 1 - Prevention:
- Local services hubs will provide the physical location to support prevention and out-of-hospital care.
- Investment in the primary care estate will provide locations where health, social care, and voluntary providers can deliver targeted programmes to tackle lifestyle factors and improve health outcomes,

Delivery Area 2 - Reducing variation:
Local services hubs will support the implementation of a new model of local services across NW London. This will standardise service users' experiences and quality of care regardless of where they live, delivering 7/7 access to all residents

Delivery Area 3 - Outcomes for older people:
- Primary care estate improvements and local services hubs will enable the delivery of co-ordinated primary care and multidisciplinary working, enabling care to be focused around the individual patient
- Ealing and Charing Cross will specialise in the management of the frail elderly, with the ability to manage higher levels of need and the provision of inpatient care

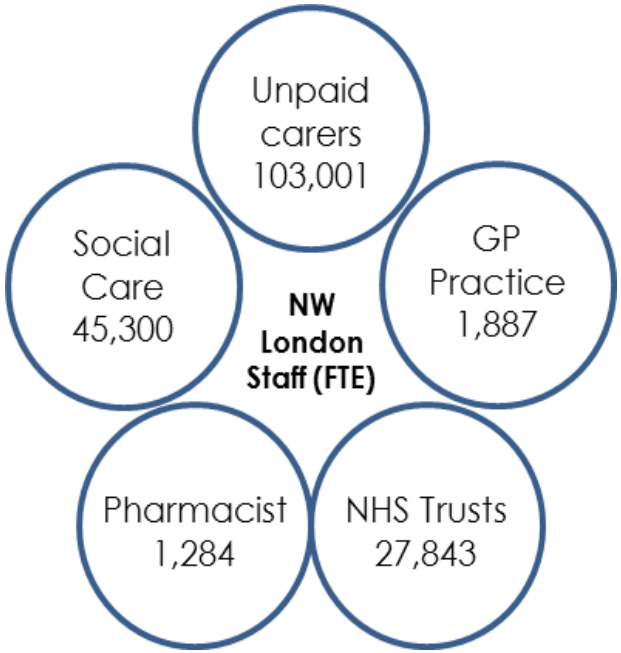
Delivery Area 4 - Supporting those with mental health needs:
Local services hubs will allow non-clinical provision to be located as close to patients as possible, e.g. extended out of hours service initiatives for children, creation of recovery houses and provision of evening and weekend specialist services to prevent self harming will facilitate the shifting model of care

Delivery Area 5 – Providing high quality, sustainable acute services:
- Addressing the oldest, poorest quality estate will increase clinical efficiencies and drive improved productivity
- Increasing the capacity of the major acute sites will enable consolidation of services, driving improved outcomes and longer term clinical and financial sustainability
- Enhanced primary and community capacity will support delivery of the vision of a new proactive care model and reduce pressure on major acute sites

3. Enablers: Workforce

Context

- Across NW London, our workforce is doing phenomenal, highly valued work and will be key to achieving our collective vision through delivering sustainable new models of care to deliver improved quality of care that meets our population's needs.
- There are currently over 30,000 healthcare staff, and c.45,000 social care staff supporting the population. Carers are a large, hidden but integral part of our workforce (NW London has more than 100,000 unpaid carers). Supporting and enabling service users to self-manage their conditions will also be crucial. We have an opportunity to focus on the health and social care workforce as a single workforce and particularly expand work across social care[1].
- We routinely fill over 95% of medical training places within NW London, and these trainees are making a highly valued contribution to service delivery.
- Appropriate workforce planning and actively addressing workforce issues is instrumental in addressing the five delivery areas in the STP
- In NW London significant progress has been made towards addressing workforce gaps and developing a workforce that is fit for future health care needs. The reconfiguration of emergency, maternity and paediatric services in 2015/16 is an example of successful workforce support and retention.
- Through close working with HEE NW London we have supported the workforce whilst implementing service change in primary, integrated and acute care**.** Nine physician associates currently work in NW London, with 32 commencing training in September. Through our development of clinical networks for maternity and children's services we have redesigned the model of care and formulated sector wide recruitment strategies that have enabled us to recruit 99 more midwives, 3 more obstetricians, 36 more paediatric nurses (37 more commence in September '16) and 3 consultants paediatricians (6 appointed to start in September '16, with plans to recruit 3 more).
- Building on this track record, **key enablers** will include the collaborative and partnership working between CCGs, Trusts, HEENWL and the CEPNs (Community Education Providers Network) to support workforce planning and development, and the HLP to utilise the established workforce planning infrastructure and expertise, build on strong foundations of on-going strategic workforce investment, and embed the findings outlined in HLP's London Workforce Strategic Framework.



What will be different in 2020[6]?

Our workforce strategy will address the following challenges to meet the 2020 vision:

Addressing workforce shortages

- Workforce shortages are expected in many professions under the current supply assumptions and increases are expected in service demand, therefore current ways of service delivery must change and the workforce must adapt accordingly. Addressing shortages and supporting our workforce to work in new ways to deliver services is fundamental to patient care.

Improving recruitment and retention

Modelling undertaken by London Economics in relation to Adult Nursing indicated that across London, over the next 10 years, the impact of retaining newly qualified staff for an additional 12 months could result in a saving of £100.7 million[2].

- **Turnover rates within NW London's trusts** have increased since 2011 (c.17% pa); current vacancy levels are significant, c.10% nursing &15% medical[3].
- **Vacancy rates** in social care organisations are high. The majority of staff in this sector are care workers, they have an estimated vacancy rate of 22.4%. **Disparity in pay** is also an issue (e.g. lower in nursing homes)[4].
- High **turnover of GPs** is anticipated; NW London has a higher proportion of GPs over 55 compared to London and the rest of England (28% of GPs and almost 40% of Nurses are aged 55+)[5]

Workforce Transformation to support new ways of working

- There will be a 50% reduction in workforce development funding for staff in Trusts, however workforce development and transformation including the embedding of new roles will be pivotal in supporting new ways of working and new models of care. To meet our growing and changing population needs, training in specialist and enhanced skills (such as care of the elderly expertise) will be required.

Leadership & Org. Development to support services

- Delivering change at scale and pace will require new **ways of working**, **strong leadership** and over arching change management. ACPs and GP Federations will be the frameworks to support service change, through shared ownership and responsibility for cost and quality.
- Wide scale **culture change** will require changes in the way organisations are led and managed, and how staff are incentivised and rewarded.

3. Enablers: Workforce

Current Transformation Plans and Benefits

Addressing workforce shortages

- Through workforce planning and extensive stakeholder engagement NW London is understanding and addressing key workforce issues. For example, NW London is leading a centralised Pan-London placement management and workforce development programme for **paramedics** with an investment of over £1.5m

Improving recruitment and retention

- NW London has plans to step up recruitment. For example, by October 2016, there is planned recruitment of over 100 additional **nursing staff** and 7 additional **children's consultant medical staff** leading to more senior provision of children's care. Further initiatives include:
  - **Scale recruitment drives**; leveraging the benefits of working in NW London.
  - Development of varied and **structured career pathways** and opportunities to **taper retirement**.
  - **Skills exchange** programmes between nurses across different care settings.
- **Promoting careers in primary care** by providing student training placements across professions to introduce this setting as a viable and attractive career option.
- Supporting the **implementation of 7 Day Services** by designing a framework to support career development and retention in radiology. Addressing workforce shortages will also support the development of the Cancer Vanguard.
- A **structured rotation programme** will support 200 nurses to work across primary and secondary care (including key areas such as mental health and care of the elderly).
- NW London's trusts will work collaboratively to **reduce reliance on agency** nurses (current spend: £172m pa on bank/agency[7])

Workforce Transformation across health and social care workforce to support integrated care

- Embedding **new roles** to support the system including: Physician's Associates, Care Navigators, Clinical Pharmacists, Peer Educators (support worker that can share experiences of mental health), and Nurse Associates.
- **Hybrid roles and developing career pathways** across health and social care will be important in the long term.
- Significant investment into Dementia, Community and Neonatal Nursing, Apprentices and the bands 1-4 workforce.
- **Optimising GPs' time** by understanding how we can develop the primary care workforce (including **practice manager development**) to redeploy GP workload where possible and increase the capability to deliver the business requirements of GP networks(Day Of Care Audit).
- **Supporting self-care** through use of patient activation measurements and Health Coaching training to help staff to have motivational conversations with patients, to empower them to set and achieve health goals, take greater responsibility for their health, and grow in confidence to self-manage conditions

Leadership and Organisational Development to support future services

- **Collective, system leadership**, will be key to the success of ACPs. Leadership development will be broader than senior leadership level; empowering MDT frontline practitioners to lead and engage other professionals and take joint accountability across services will be integral to success.
- Leadership and change management programmes will foster innovation, build relationships and trust across multi-disciplinary, cross organisational teams to deliver integrated new ways of working. The **Change Academy** will use an applied learning approach and will be underpinned by improvement methodology (38 leaders supported in phase 1)
- **Commissioning for outcomes** based programmes
- Leadership development forums will include the **GP Emerging Leaders** (providing NW London-wide workshops, mentoring, and sharing of local intelligence and education) and Transformation Network
- More effective ways of working achieved through the **Streamlining London Programme** across Trusts
- Adopting a collaborative approach to embed **health and wellbeing initiatives and ambassadorship** through the Healthy Workplace Charter

Key Impacts on Sustainability & Transformation Planning

NW London will deliver some general transformation plans that tackle the challenges faced and underpin all delivery areas to :

- Embed **new roles and develop career pathways** to support a system where more people want to work and are able to broaden their roles
- **Empower** MDT frontline **practitioners to lead** and engage other professionals and take joint **accountability across services**
- **Support staff** through change through training and support

Delivery Area 1 – Prevention and self management:

- **Health Coaching** training will help staff to have motivational conversations with patients to take greater responsibility for their health, and grow in confidence to self-manage conditions.
- To ensure carers, the largest proportion of our workforce, are supported, we will expand the programme in 2017/18, to build carers' skills around setting achievable health and wellbeing related goals for patients.
- The NW London **Healthy Workplace Charter** will embed staff health and wellbeing initiatives and ambassadorship
- Primary care and specialist community nurse workforce development

Delivery Area 2 - Reducing variation:

The framework to retain staff and support career development in radiology will help address shortages and support **implementation of 7 Day Services** and **Cancer Vanguard**. Growth in primary care and bespoke project work on LTCs prevalent in NW London such as diabetes and heart disease.

Delivery Area 3 - Outcomes for older people:

- Initiatives to attract and retain staff to work in integrated MDTs and new local services models will support the frail and elderly population. E.g.: Scale recruitment drives, promoting careers in primary care through training placements and skills exchange across different care settings
- **Optimising GPs' time** by developing the primary care workforce (e.g. **practice manager development**) will increase capability to deliver the business requirements of GP networks
- Leadership development forums will join up practitioners, providing NW London-wide workshops, opportunities to network and share local intelligence
- Building on the work of the early adopters

Delivery Area 4 - Supporting those with mental health needs:

GPs provided with tools, time and support to better support population with serious and long term mental health needs. 35 GPs will graduate in June 2016 with an Advanced Diploma in Mental Health Care and the non-health workforce is also receiving training.

Delivery Area 5 – Providing high quality, sustainable services:

- The **Streamlining London Programme** ; a pan-London provider group to achieve economies of scale by doing things once across London
- Reduce the reliance on agency nurses and thereby the cost of service
- The **Change Academy**, underpinned by improvement methodology and alignment to achieving productivity gains will support cross-boundary working and support financial sustainability of services.

3. Enablers: Digital

Context

- In terms of digital integration, the NW London care community already works closely together, co-ordinated by NHS NW London Informatics, and has made good progress with Information Governance across care settings. All of the eight CCGs have a single IT system across their practices and six of the eight CCGs are implementing common systems across primary and community care, and have a good track record in delivery of shared records, for example, through the NW London Diagnostic Cloud.
- The NW London Care Information Exchange is under way, funded by Imperial College Healthcare charity. This technology programme gives individuals a single view of information about their care across providers and platforms, allows sharing of information, and provides tools to improve communication with health and social care professionals. It has been integrated with acute Trust data but is currently constrained by the lack of interfaces with EMIS and SystmOne.
- There is good support from NHSE London Digital Programme in developing key system-wide enablers of shared care records, such as common standards, identity management, pan-London exchange, record locator, and IG register.

Key Challenges

- Over 40% of NW London acute attendances in Trusts are hosted outside their local CCG, 16% outside the footprint, making it difficult to access and retain information about the patient[1]. A potential mitigation is to share care records and converge with other Local Digital Roadmaps (LDR) via universal NHS systems.
- Due to different services running multiple systems, there is a dependence on open interfaces to deliver shared records, which primary and community IT suppliers have failed to deliver. This will require continued pressure on suppliers to resolve.
- There is a barrier to sharing information between health and social care systems due to a lack of open interfaces. This has led to a situation where social care IT suppliers have been looking to charge councils separately. Support is required from NHSE to define and fund interfaces nationally.
- Clinical transformation projects have in the past been very costly and taken a long time to deliver, which need to be allowed for in the LDR plans
- There is a lack of digital awareness and enthusiasm generally among citizens and professionals, requiring a greater push for communication around the benefits of digital solutions and education on how best to use it.

Strategic Local Digital Roadmap Vision in response to STP

1. **Automate clinical workflows and records**, particularly in secondary care settings, and support transfers of care through interoperability, **removing the reliance on paper** and improving quality
2. **Build a shared care record** across all care settings to deliver the **integration of health and care records** required to support new models of care, including the transition away from hospital
3. **Extend patient records to patients and carers,** to help them to become more **digitally empowered** and involved in their own care
4. **Provide people with tools for self-management and self-care,** enabling them to take an active role in their care, further supporting **digital empowerment** and the shift to new channels of care
5. **Use dynamic data analytics** to inform care decisions, and support integrated health and social care across the system through **whole systems intelligence**

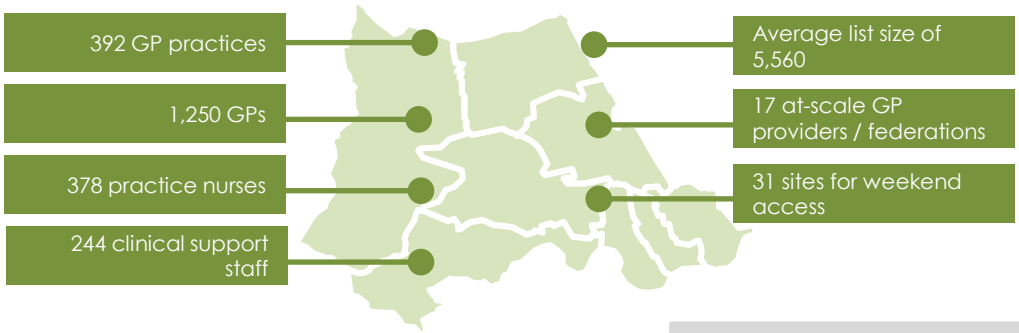
Enabling work streams identified:

- **IT Infrastructure** to support the required technology, especially networking (fixed line and Wi-Fi) and mobile working
- **Completion of the NW London IG framework**, where much work has already been done
- **Building a Digital Community** across the citizens and care professionals of NW London, through communication and education

3. Enablers: Digital

STP Delivery Area	Digital STP Theme	Key Impacts on Sustainability & Transformation Planning
1. Radically upgrading prevention and wellbeing	• Deliver digital empowerment • Integrate health & care records	**Enhancing self care:** • Give citizens easier access to information about their health and care through **Patient Online** and the NW London **Care Information Exchange** to support them to become expert patients • Innovation programme to find the right **digital tools** to help people **manage their health and wellbeing**; **create online communities** of patients and carers; and to get children and young people involved in health and wellness **Embedding prevention and wellbeing into the 'whole systems' model:** • Support integrated health and social care models through **shared care records** and **increased digital awareness** (e.g. personalised care-plans)
2. Eliminating unwarranted variation and improving LTC management	• Integrate health & care records • Whole systems intelligence • Deliver digital empowerment	**Improving LTC management** • Deliver Patient Activation Measures (PAM) tool for every patient with an LTC to promote self management and develop health literacy and expert patients • **Automate clinical workflows and records**, particularly in secondary care settings, and support transfers of care through interoperability and development of a share care record to deliver the **integration of health and care records and plans** • Patient engagement and self-help training for LTCs to help people manage their conditions and interventions **Reducing variation** • Integrated care dashboards and analytics to track consistency of outcomes and patient experience • Support new models of multi-disciplinary care, delivered consistently across localities, through shared care records
3. Achieving better outcomes and experiences for older people	• Deliver digital empowerment • Integrate health & care records • Whole systems intelligence	**Provision of fully integrated service delivery of care for older people** • Enable citizens (and carers) to **access care services remotely** through **Patient Online** (e.g. remote prescriptions) and NW London **Care Information Exchange**, **remote consultations** (e.g. videoconferencing) and **telehealth** • Support discharge planning and management, new models of out-of-hospital and proactive multi-disciplinary care through shared care records across health and social care • **Integrate Co-ordinate My Care** (CMC) with acute, community and primary care systems and promote its use in CCGs, where usage is currently low, through education and training and support care planning and management • **Shared information and infrastructure** to support new primary care and wellbeing hubs with mobile clinical solutions • **Dynamic analytics** to plan and mobilise appropriate care models • Whole Systems Integrated Care dashboards have been deployed to 312 GP practices to support co-ordinated and proactive patient care, with a plan to expand to all 400 practices by 2020/21
4. Improving outcomes for people with mental health needs	• Integrate health & care records • Whole systems intelligence	**Enabling people to live full and healthy lives** • Innovation programme to **find digital tools to engage with people** who have (potentially diverse) mental health needs, including those with Learning Disabilities **New model of care** • Support new care delivery models and shared care plans through **shared care records and care plans** **24/7 provision of care** • Support new models for out-of-hours care through **shared care records**, such as **24x7 crisis support services**
5. Ensuring we have safe and sustainable acute services	• Deliver digital empowerment • Integrate health & care records	**Investing in Hospitals** • Support new models for out-of-hours care through **shared care records and the NW London diagnostic cloud**, such as 24x7 on-call specialist and pan-NW London radiology reporting and interventional radiology networks in acute • **Investment to automate clinical correspondence and workflows** in secondary care settings to improve timeliness and quality of care. • Integrated out-of-hours **discharge planning and management** through shared care records • **Dynamic analytics** to track consistency and outcomes of out-of-hours care

4. Primary care in NW London



Primary care services in NW London deliver high-quality care for local people. These services, and general practice in particular, are at the centre of the local health and social care system for every resident. GPs are not only the first point of contact for the majority of residents, but also play a co-ordinating role throughout each patient's journey through a range of clinical pathways and provider organisations.

There are, nevertheless, significant challenges. These include:

- dramatic projected increases in the number of older people presenting with multiple and complex conditions, fuelling demand for GP appointments and a greater co-ordinating function within primary care – the number of people aged over 85 is expected to increase by 20.7% by 2020/21 and 43.8% by 2025/26;
- 27.1% of the GP and nurse workforce is aged over 55 and 7.4% aged over 65, which represents a significant retirement bubble;
- front-line delivery pressures that are contributing to recruitment and retention challenges, whilst lowering the morale of GPs and their primary care colleagues; and
- inadequate access to primary care, contributing to a patient-reported experience of GP services significantly below the national average.

These and other challenges require fundamental changes to the design and delivery of primary care, within the context of NW London's broader system transformation across health and social care. The NW London CCGs' plan for this is described in this document.

Some other statistics: achievements and challenges

- The NW London CCGs score above the London average for 6 out of 7 facets for co-ordinated care, based largely on the achievements made through the Whole Systems Integrated Care national pioneer programme
- The NW London CCGs score above the London average for 6 out of 13 facets for accessible primary care consultations (including telephone, email, and video consultations)
- 23% of the NW London practices so far inspected by the CQC ratings are performing below the national average
- 60% of people with a long-term condition feel supported to manage their condition – below the national average of 67%.

Some of our achievements so far

- NW London is the largest national pilot site for the Prime Minister's Challenge Fund, covering 365 practices and 1.9m people. This investment has improved patient access to general practice and supported the development of at-scale organisations in primary care. The CCGs are now working with NHS England to build on this achievement through the new Prime Minister's Access Fund investment announced in the GP Forward View.
- 280,000 patients can access web-based consultations .
- 60,000 patients can access video consultations.
- 97% of practices offer online appointment booking.
- Joint co-commissioning is embedded in NW London . Over recent months each joint committee has agreed its PMS review commissioning intentions, as a first instalment to equalising the patient offer in each CCG, and recommended estates bids to the Estates and Technology Transformation Fund
- Integrated care data dashboards have been piloted in eight practices, with a rollout plan prepared for 350 practices within 12 months. The dashboards link the past two years of patient-level data from acute, primary, community, and mental health, enabling patient journeys through the health system to be tracked and their care to be improved where appropriate.
- Contracts covering 19 services have been let at federation-level across five of the eight CCGs enabling a consistent service offering to the whole population.

Additional work already under way

- CCG self-care leads and lay partners across NW London have co-produced a self-care framework. This includes patient activation measurement that is to be piloted in approximately 200 GP practices by March 2017.
- 180 Healthy Living Pharmacies have been commissioned for 2016/17. They will train Health Champions and Healthy Living Pharmacy Leaders to support local communities with wellbeing interventions such as smoking cessation.
- Hillingdon and Ealing CCGs are providing a Minor Ailments Scheme, allowing patients to self-medicate when appropriate, reducing the impact on primary care. We plan to roll this scheme out across NW London by 2018/19.
- 32 Physician Associates places have been commissioned at Buckinghamshire New University and Brunel University, starting later in 2016.
- The Clinical Pharmacists in General Practice pilot is underway at 23 GP practices in NW London .
- The CCGs plan to make seven collective technology bids to the Estates and Technology Transformation Fund. These will cover areas including digitally-enabled patients, videoconferencing, integrated telecoms and patient management systems, and care home pilots.
- On-going work on local implementation of the 10 Point Plan for workforce includes: a recruitment evening session at Northwick Park Hospital for Foundation Year Doctors, the national thunderclap campaigns organised by HEE, and Joint work with the Foundation School and Medical School to attract new GP Trainers into local training programmes.

4. The future of primary care in NW London

NW London has a clear set of primary care outcomes that the CCGs will support providers to deliver over the next five years. These are shown below, along with how they map onto the five delivery areas to illustrate the crucial role that primary care has in delivering the NW London STP.

- Radically upgrading prevention and wellbeing
- Ensuring we have safe, high quality sustainable acute services
- Eliminating unwarranted variation and improving LTC management
- Achieving better outcomes and experiences for older people
- Improving outcomes for children and adults with mental health needs

Proactive care	
Co-design	- primary care teams will work with communities, patients, their families, charities and voluntary sector organisations to co-design approaches to improve the health and wellbeing of the local population
Developing assets and resources for improving health and wellbeing	- primary care teams will work with others to develop and map the local social capital and resources that could empower people to remain healthy; and to feel connected to others and to support in their local community
Personal conversations focused on an individual's health goals	- where appropriate, people will be asked about their wellbeing, including their mental wellbeing, capacity for improving their own health and their health improvement goals.
Health and wellbeing liaison and information	- primary care teams will enable and assist people to access information, advice and connections that will allow them to achieve better health and wellbeing, including mental wellbeing. This health and wellbeing liaison function will extend into schools, workplaces and other community settings.
Patients not currently accessing primary care services	- primary care teams will design ways to reach people who do not routinely access services and who may be at higher risk of ill health.

Accessible care	
Patient choice	- patients have a choice of access options (e.g. face-to-face, email, telephone, video) and can decide on the consultation most appropriate to their needs
Contacting the practice	- patients make one call, click, or contact in order to make an appointment, whilst primary care teams will maximise the use of technology and actively promote online services to patients (including appointment booking, prescription ordering, viewing medical records and email consultations)
Routine opening hours	- patients can access pre-bookable routine appointments with a primary health care professional at all practices 8am-6.30pm Monday to Friday and 8am-12 noon on Saturdays in a network
Extended opening hours	- patients can access a GP or other primary care health professional seven days per week, 12 hours per day (8am to 8pm or an alternative equivalent offer based on local need) in their local area, for pre-bookable and unscheduled care appointments
Same-day access	- patients who want to be managed (including virtually) the same day can have a consultation with a GP or appropriately skilled nurse on the same day, within routine surgery hours in their local network
Urgent and emergency care	- patients with urgent or emergency needs can be clinically assessed rapidly, with practices having systems in place and skilled staff to ensure these patients are effectively identified and responded to appropriately
Continuity of care	- all patients are registered with a named member of the primary care team who is responsible for providing an ongoing relationship for care coordination and care continuity, with practices offering flexible appointment lengths (including virtual access) as appropriate

Co-ordinated care	
Case finding and review	- practices identify patients, through whole systems data analytics, who would benefit from coordinated care and continuity with a named clinician, and proactively review those that are identified on a regular basis
Named professional	- patients identified as needing coordinated care have a named professional who oversees their care and ensures continuity
Care planning	- each individual identified for coordinated care is invited to participate in a holistic care planning process in order to develop a single shared electronic care plan that is: used by the patient; regularly reviewed; and shared with and trusted by teams and professionals involved in their care
Patients supported to manage their health and wellbeing	- primary care teams and wider health system create an environment in which patients have the tools, motivation, and confidence to take responsibility for their health and wellbeing, including through health coaching, future digital tools and other forms of education
Multi-disciplinary working	- patients identified for coordinated care will receive regular multidisciplinary reviews by a team involving health and care professionals with the necessary skills to address their needs. The frequency and range of disciplines involved will vary according to the complexity and stability of the patient and as agreed with the patient/carer. Care will be coordinated via shared electronic care records.

4. Delivering the ambitions of the primary care strategy

Following the NW London-wide development of ambitions and outcomes for primary care, the CCGs are now working with primary care providers to agree how this will be delivered in each borough in a way that meets the needs of their local populations. The draft process is shown below. This will be the basis of the design and delivery of annual commissioning intentions each year until 2020/21, with delivery of the SCF achieved by the end of 2018/19.

This will ensure that the increases to the NW London primary care medical allocations (shown in the table below) are invested in a way that delivers maximum benefits to patients, alongside the national programmes – such as the Prime Minister's Access Fund, from which NW London might be able to access approximately £12m in 2016/17 – announced in the GP Forward View.

NW London CCGs	2016/17	+£19.3m	2017/18	+£11.8m	2018/19	+£11.5m	2019/20	+£15.6m	2020/21
	£279.97m		£299.26m		£311.03m		£322.50m		£338.07m

SCF implementation

2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21

June, July

A two-month collaborative process led by CCGs and supported by the Local services team to define each CCG's model of care. The primary care component will include the outcomes and ambitions set out above.

August

The CCG primary care teams will, with the Local services team, then:

- undertake a gap analysis;
- translate the gaps into high-level prioritised annual commissioning intentions to 2020/21, based on confirmed allocations; and
- form a detailed plan for the design and implementation of 2017/18 priorities.

The Local services team will work with CCGs to design a standard process and format for this.

September

Governing bodies sign off:

- local model of care
- gap analysis
- prioritised annual commissioning intentions to 2020/21, based on SCF implementation by April 2019
- a detailed plan for the design and implementation of 2017/18 priorities, including business case and governance

The Local services team develops a pan-NW London plan to April 2017 to support consistency and alignment / 'develop and spread', based on detailed CCG plans and accounting for dependencies with enablers.

CCGs and the Local Services team will report on progress against this plan to the Local Services programme executive.

Shared CCG materials

HLP SCF costing and impact analysis

National programmes based on the GP Forward View and local programmes funded by the Sustainability and Transformation Fund

A **recurring annual cycle of primary care commissioning**: engagement, confirmed commissioning intentions, business case development, detailed planning, and implementation, based on the model of care and prioritisation approved by the governing body in September 2016.

Commissioning intentions that directly support the SCF will be prioritised before April 2019.

SCF commissioning intentions

SCF+ commissioning intentions

A **recurring annual cycle** of the Local services team building a NW London-wide plan against which all parties will report progress and be held accountable for delivery.

Support on enablers from Strategy and Transformation and other pan-CCG teams – including **federation development**

5. Finance:

Overall Financial Challenge – 'Do Something' (1)

The STP has identified 5 delivery areas that will both deliver the vision of a more proactive model of care and reduce the costs of meeting the needs of the population to enable the system to be financially as well as clinically sustainable. The table below summarises the impact on the sector financial position of combining the normal 'business as usual' savings that all organisations would expect to deliver over the next 5 years if the status quo were to continue with the savings opportunities that will be realised through the delivery of the 5 STP delivery areas, and demonstrates that at an STP level there is a surplus of £50.5m and there is a small, £31m gap to delivering the business rules (i.e. including 1% surpluses).

£'m	CCGs	Acute	Non-acute	Specialised Commissioning	Primary care	STF investment (see funding slide)	Sub-total NHS Health	Social Care	Total Health and Social Care	
Do Nothing June '16	**(292.7)**	**(532.8)**	**(125.7)**	**(188.3)**	**(14.8)**	**-**	**(1,154.3)**	(145.0)	**(1,299.3)**	**note 1**
Business as usual savings (CIPS/QIPP)	127.8	339.1	102.7	-	-	-	569.7	-	569.7	**note 2**
Delivery Area 1 - Investment	(4.0)	-	-	-	-	-	(4.0)	-	(4.0)	
Delivery Area 1 - Savings	15.6	-	-	-	-	-	15.6	8.0	23.6	
Delivery Area 2 - Investment	(5.4)	-	-	-	-	-	(5.4)	-	(5.4)	
Delivery Area 2 - Savings	18.5	-	-	-	-	-	18.5	-	18.5	
Delivery Area 3 - Investment	(52.3)	-	-	-	-	-	(52.3)	-	(52.3)	
Delivery Area 3 - Savings	134.9	-	-	-	-	-	134.9	33.1	168.0	
Delivery Area 4 - Investment	(11.0)	-	-	-	-	-	(11.0)	-	(11.0)	
Delivery Area 4 - Savings	22.8	-	-	-	-	-	22.8	6.4	29.2	
Delivery Area 5 - Investment	(45.6)	-	-	-	-	-	(45.6)	-	(45.6)	
Delivery Area 5 - Savings	111.1	120.4	23.0	-	-	-	254.5	15.0	269.5	
STF - additional 5YFV costs	-	-	-	-	-	(55.7)	(55.7)	(34.0)	(89.7)	**note 4**
STF - funding	23.0	-	-	-	14.8	55.7	93.5	53.5	147.0	**note 4**
Other	-	-	-	188.3	-	-	188.3	63.0	251.3	
TOTAL IMPACT	**335.4**	**459.5**	**125.7**	**188.3**	**14.8**	**0.0**	**1,123.7**	**145.0**	**1,268.7**	
Residual Gap (see note)	**42.7**	**(73.3)**	**0.0**	**0.0**	**0.0**	**0.0**	**(30.6)**	**0.0**	**(30.6)**	
Financial Position excluding business rules	**87.7**	**(37.3)**	**0.0**	**0.0**	**0.0**	**0.0**	**50.5**	**0.0**	**50.5**	
				note 5				**note 3**		

Specific Points to note are:

Note 1: The NWL 'Do Nothing' gap has changed since April '16 STP due to changes in the underlying position of organisations and social care, inclusion of 1% gap requirement on Trusts, NHSE spec comm gap for the Royal Brompton, removal of 16/17 CIP and the inclusion of Primary Care.

Note 2: BAU CIP and QIPP is those that can be carried out by each organisation without collaboration, etc

Note 3: See Social Care Finances gap closure slide (aligned to Delivery areas where applicable)

Note 4: £56m of STF funding has currently been assumed as needed recurrently for additional investment costs to deliver the priorities of the 5YFV that are not explicitly covered elsewhere. These costs are currently estimated

Note 5: Specialised commissioning have not yet developed the 'solution' for closing the gap, however it is assumed that this gap will be closed. This is a placeholder.

Note: The financial position of the sector is a £50.5m surplus at the end of the STP period. The residual gap assumes business rules of 1% CCGs surplus, 1% provider surplus and breakeven for Specialised Commissioning, Primary Care and Social Care.

The key financial challenge that remains at 2020/21 is the deficit at the Ealing site, where the on-going costs of safe staffing exceed the levels of activity and income and make delivery of savings challenging. This deficit could be eliminated if acute services changes were accelerated, generating a further improvement in the sector position of £62m.

The key risk to achieving sector balance is the delivery of the savings, both business as usual and the delivery areas. There will be a robust process of business case development to validate the figures that have been identified so far and the next section of the STP sets out the improvement approach and resources that we have put in place to ensure that our plans can be delivered.

The next page shows the information above in the form of a bridge from do nothing to post STP delivery.

5. Finance:
Overall Financial Challenge – 'Do Something' (2)

The bridge reflects the normalised position (i.e. excludes non-recurrent items including transition costs) and shows the gap against the delivery of a 1% surplus for the NHS.

BAU CIPs and QIPP The CIPs and QIPP that could be delivered by providers and commissioners in 16/17 – 20/21 (total £570m), including Carter, but without transformation (i.e. Status Quo)

Delivery Areas (1-5) - CCGs – The financial impact of the 5 delivery areas has been calculated and broken down between CCGs and providers. For CCGs they require £118m of investment to deliver £303m of savings.

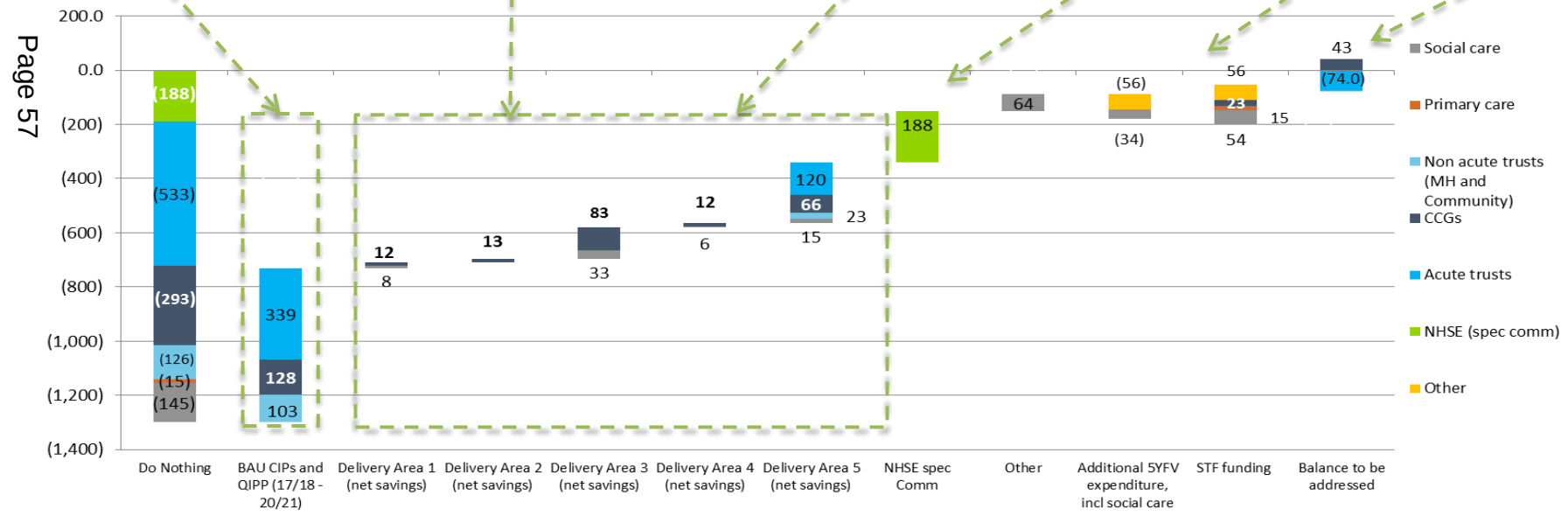
The work undertaken by Healthy London Partners has been used to inform schemes in all Delivery Areas, particularly in the area of children's services, prevention and well-being and those areas identified by 'Right Care' as indicating unwarranted variation in healthcare outcomes.

Delivery Areas (1-5) - Providers Quantum opportunity for trusts, delivered through cross sector collaboration, service change and other local opportunities

NHSE spec Comm NHSE spec comm have not yet developed the 'solution' for closing the gap, however it is assumed that this gap will be closed

STF and 5YFV expenditure See 'STP financial enablers – Sustainability and Transformation Funding

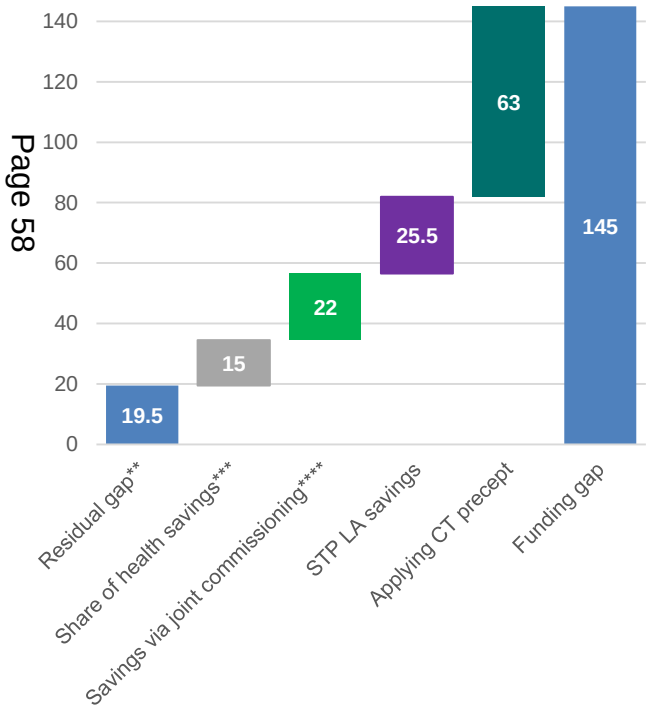
Balance to be addressed Remaining gap of £31m to be addressed – post 20/21.



5. Finance:
Social Care Finances

Local government has faced unprecedented reductions in their budget through the last two comprehensive spending reviews and the impact of the reductions in social care funding in particular has had a significant impact on NHS services. To ensure that the NHS can be sustainable long term we need to protect and invest in social care and in preventative services, to reduce demand on the NHS and to support the shift towards more proactive, out of hospital care. This includes addressing the existing gap and ensuring that the costs of increased social care that will result from the delivery areas set out in this plan
are fully funded.

The actions set out below describe how the existing gap will be addressed, through investment of transformation funding*:



Theme	STP delivery area	Savings for ASC (£M)	Savings for LG / PH (£M)	Total benefit for LG	Benefit for Health (£M)
Public Health & prevention	DA1	-	**2.0**	**2.0**	**2.2**
Demand management & community resilience	DA2	-	-	-	**6.1**
Caring for people with complex needs	DA3	-	-	-	**5.1**
Accommodation based care	DA3	**7.7**	-	**7.0**	**2.0**
Discharge	DA3	**3.4**	-	**3.4**	**9.6**
Mental Health	DA4	**3.5**	**2.9**	**6.4**	**5.0**
Vulnerable	DA1	**3.0**	**3.0**	**6**	-
Total savings through STP investments		**17.6**	**7.9**	**25.5**	**30.0**
Joint commissioning	DA3	**22.0**	-	**22.0**	**TBC**
Total savings		**39.6**	**7.9**	**47.5**	**30.0**

The following assumptions and caveats apply:

*To deliver the savings requires transformational investment of an estimated £110m (£21m in 17/18, rising to £34m by 20/21) into local government commissioned services

**The residual gap of £19.5m by 20/21 is assumed to be addressed through the recurrent £148m sustainability funding for NW London on the basis that health and social care budgets will be fully pooled and jointly commissioned by then.

***The share of savings accruing to health are assumed to be shared equally with local government on the basis of performance

****Further detailed work is required to model the benefits of joint commissioning across the whole system as part of Delivery Area 3

NB The financial benefits of the actions above represent projected estimations and are subject to further detailed work across local government and health.

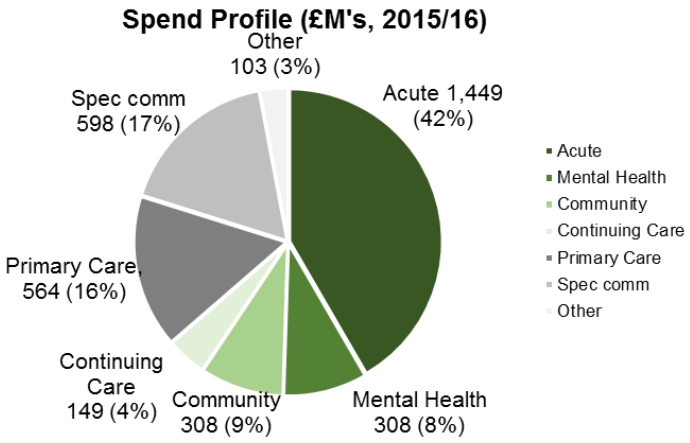
5. Finance:

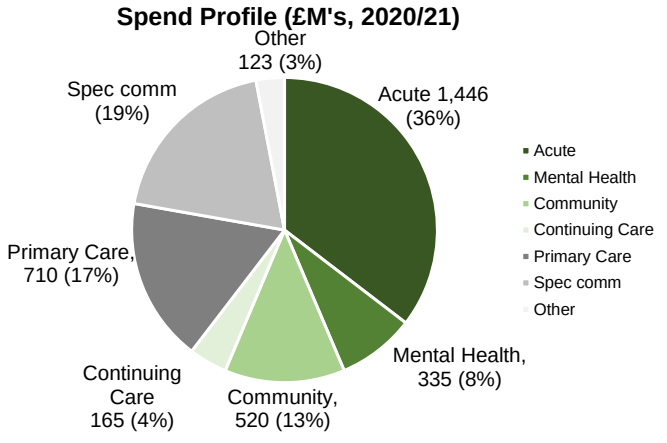
STP financial enablers – Sustainability and Transformation Funding

To drive the delivery of the STP at pace, we have made an initial assessment of the level of sustainability and transformation funding that we will need over the next 5 years to deliver the plan. This is set out below, and shows our expectation of where we expect to invest the funding recurrently from 2020/21.

	16/17	17/18	18/19	19/20	20/21	
	£m	£m	£m	£m	£m	
Sustainability funding	-	112.4	82.3	61.6	0.0	
Investment in prevention and social care	-	21.0	25.0	30.0	34.0	£53.5m
Social care funding gap	-	-	-	-	19.5	
Seven day services	3.0	4.0	7.0	12.0	20.0	
Mental health transformation and invetment in services - integrated care models	0.0	10.0	10.0	13.0	20.7	
Federation and primary care development	5.0	10.0	10.0	5.0	0.0	£55.7m
Support new payment models design and implementation	3.0	10.0	10.0	5.0	0.0	
Digital roadmap	-	3.0	10.0	10.0	15.0	
Improvement resources	2.0	2.0	2.0	0.0	0.0	
Additional investment in primary care services	0.0	1.0	12.0	19.0	14.8	
Uncommitted funding	0.0	0.0	0.0	0.0	23.0	
TOTAL	**13.0**	**172.4**	**156.3**	**136.6**	**147.0**	

The charts below show how the delivery of the STP will change the commissioner expenditure profile over the next 5 years as we move from a reactive system to a proactive care model. Acute spend by CCGs reduces from 42% to 36% of total spend, while primary and community care spend increases from 25% to 30%. Mental health spend stays the same as a percentage of the total but the expenditure increases and the way in which the money is spent shifts towards community based rather than acute based interventions, enabling increased demand to be managed. Some increased mental health spend is also included within the main primary care and community expenditure totals.





5. Finance:
STP financial enablers – Capital

The total capital assumed within the 'Do Nothing' position for Providers is £783m (funded by £573m from internal resources, £37m from disposals and £173m from external funding.) The table below shows the total capital requirements over and above the 'Do Nothing' Capital under the 'Do Something' scenario, over the five years of the STP planning period and the subsequent five years. This covers: acute reconfiguration proposals; development of primary care estate and local services hubs; as well as other acute and mental health capital investments.

Table 1: Do Something Capital

	Outer NWL	Inner NWL	OOH	Other - Additional Capital	Total
Up to 20/21					
Gross Capital Expenditure	75.2	247.4	219.2	206.1	**747.9**
Disposals and contingency	-	(330.0)	-	-	**(330.0)**
Total Net Capital Requirements	**75.2**	**(82.6)**	**219.2**	**206.1**	**417.9**
Post 20/21					
Gross Capital Expenditure	252.5	1,116.0	4.5	97.1	**1,470.1**
Disposals and contingency	29.0	(681.2)	23.0	-	**(629.2)**
Total Net Capital Requirements	**281.5**	**434.8**	**27.5**	**97.1**	**840.9**
Grand Total	**356.7**	**352.3**	**246.6**	**303.2**	**1,258.7**

Note: Projected costs, land sale receipts and affordability, particularly in the second five year period, are indicative and subject to detailed business case processes

Other Additional Capital – there are additional capital cases of £303m made up of: (1) £141m for LNWH for additional investment in NPH and CMH including, ICT and EPR and other IT; (2) £53m for backlog maintenance for THH relating to the tower; (3) £79m for CNWL for strategic developments; and (4) ETTF IT Digital roadmap of £31m.

To address the sustainability challenge at Ealing hospital would require the acceleration of the capital developments and approvals process (within the 'Outer NWL'. If that were achieved the capital profile would change, with the estimated position shown below :

Table 2: Accelerated timeline

	Outer NWL	Inner NWL	OOH	Other - Additional Capital	Total
Up to 20/21					
Total Net Capital Requirements	**249.9**	**(82.6)**	**219.2**	**206.1**	**592.6**
Post 20/21					
Total Net Capital Requirements	**106.8**	**434.8**	**27.5**	**97.1**	**666.1**
Grand Total	**356.7**	**352.3**	**246.6**	**303.2**	**1,258.7**

Note: The table shows the re-phasing without any assumed inflation saving (estimated to be c. £30m)

The funding for above capital ask will be a mixture of loans and PDC, which will modelled within individual business cases.

6. How we will deliver our plan:
Our NW London Delivery Architecture

To deliver this change at scale and pace will require the system, us, to work differently, as both providers and commissioners. At its heart, this requires shared commitment to an agreed vision, a credible set of plans and the right resources aligned to those plans. We know this both from the literature but more critically through our own experiences and track record of delivery change. Therefore we are making four changes to the way that we work as a system in NW London to enable us to deliver and sustain the transformation from a reactive to proactive and preventative system:

1. **Agree a joint NW London implementation plan for each of the 5 high impact delivery areas**
2. **Shift funding and resources to the implementation of the five delivery areas, recognising funding pressures across the system and ensure we use all our assets**
3. **Develop new joint governance to create joint accountability and enable rapid action to deliver STP priorities**
4. **Reshape our commissioning and delivery to ensure it sustains investment on the things that keep people healthy and out of hospital**

1. Develop a joint NW London implementation plan for each of the 5 high impact delivery areas

We will set up or utilise an existing joint NW London programme for each delivery area, working across the system to agree the most effective model of delivery. We have built upon previous successful system wide implementations to develop our standard NW London improvement methodology, ensuring an appropriate balance between common standards and programme management and local priorities and implementation challenges. This has been codified in the common project lifecycle, described below, with common steps and defined gateways:

Critical success factors of the standard methodology include a clear SRO, CRO, programme director and programme manager, with clinical and operational leads within each affected provider, appropriate commissioning representation (clinical and managerial) and patient representatives. Models of care are developed jointly to create ownership and recognise local differences, and governance includes clear gateways to enable projects to move from strategic planning, to implementation planning, to mobilisation and post implementation review. Examples of programmes that have been successfully managed through this process are maternity, 7 day discharge and the mental health single point of access for urgent care.

2. Shift funding and resources to the delivery of the five delivery areas, recognising funding pressures and complementary skills across the system

We will ensure human and financial resources shift to focus on delivering the things that will make the biggest difference to closing our funding gaps:

- We have identified £118m of existing system funding and seek to secure £148m of transformation funding to support implementation of the five delivery areas.
- We plan to use £34m to invest through joint commissioning with local government to support delivery of plans and to support closure of ASC funding gap.
- We will undertake extensive system modelling of funding flows and savings through to 20/21 to inform future funding models and sustain the transformation.

To further support the alignment of resources we are mapping and reviewing the total improvement resources across all providers and commissioners, including the AHSN, to realign them around the delivery areas to increase effectiveness and reduce duplication. The diagram on the next page also indicates where the various delivery areas are being supported:

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NW London Collaboration of CCGs Strategy & Transformation Team *Commissioner* ~ 80-100 staff	**West London Alliance Local Government** Work in progress to allocate key L G staff	**Academic Health Sciences Network (Imperial College Health Partners)** AHSN ~ 8 staff	**Provider Transformation/ Productivity (CIP)/ Integration Teams** *Providers* ~ 90 staff
DA1 a) Enabling and supporting healthier living			Business as usual CIP
	DA1 b) Wider determinants of health interventions		DA2 c) Delivering 'Right Care' priorities
	DA1 c) Helping children get the best start in life		DA4 c) Crisis support and Crisis Concordat
DA1 d) Addressing social isolation			DA5 a) Specialised Commissioning
DA2 a) Improving cancer screening			DA2 a) Improving cancer screening
DA2 b) Better outcomes and support for people with common MH			DA5 b) Delivering the '7 day standards'
DA2 d) Improving self management and patient activation			DA5 c) Configuring acute services
DA3 a) Improving market management and whole systems approach			DA5 d) NW London provider productivity programme
DA3 b) Implementing Accountable Care Partnerships (ACPs) by 2018/19			
DA3 c) Implement new models of local services			
DA3 d) Upgrade rapid response/IC services			
DA3 e) Creating a single discharge process			
			DA3 f) Improving last phase of life
DA4 a) New model of care for people with serious and long term mental health needs			
DA4 b) Addressing wider determinants of health			
DA4 d) Implement Future in Mind			
DA5 b) Delivering the '7 day standards'			
DA5 c) Configuring acute services			

Over time, we are seeking further alignment and integration between these teams, to avoid duplication and align the relevant people and skills to the most appropriate programmes of work

6. How we will deliver our plan:
Our NW London Delivery Architecture

3. Develop new joint governance to create joint accountability and enable rapid action to deliver STP priorities

NHS and Local Government STP partners are working together to develop a joint governance structure with the intention of establishing a joint board which would oversee delivery of the NW London STP. The joint governance arrangements would ensure there is strong political leadership over the STP, with joint accountability for the successful delivery of the plan, including the allocation of transformation resources and implementation of the out of hospital strategy.

We will also strengthen our existing governance structures and develop them where necessary to ensure that there is clear joint leadership for delivering the strategy across health and local government for each of the five delivery areas and three enablers.

Building on our ambitious STP plans, NW London will also develop options for a devolution proposition, to be agreed jointly across commissioners and providers. This could include local retention of capital receipts, greater local control over central NHS resources and greater flexibility over regulation to support delivery of long term plans.

4. Reshape our commissioning and delivery to ensure it sustains investment on the things that keep people healthy and out of hospital

- We are moving towards federated primary care primary care operating at scale with practices working together either in federation, supra-practices or as part of a multi-provider in order to ensure it responds to the needs of local communities, provides opportunities for sustainability and drives quality and consistency. Primary care, working jointly with social care and the wider community, is the heart of the new system
- By 17/18, we expect to see an expansion of local pooled budgets to ensure there is an enhanced joint approach locally to the delivery of care, within the new shared governance arrangements
- By 20/21 we will have implemented Accountable Care Partnerships across the whole of NW London, utilising capitated budgets, population based outcomes and fully integrated joint commissioning to ensure that resources are used to deliver the best possible care for residents of NW London. Some ACPs are planned to go live from 2018/19. Initial focus areas for ACPs will be based on the delivery areas set out within the STP.

Latest progress with the provider productivity programme

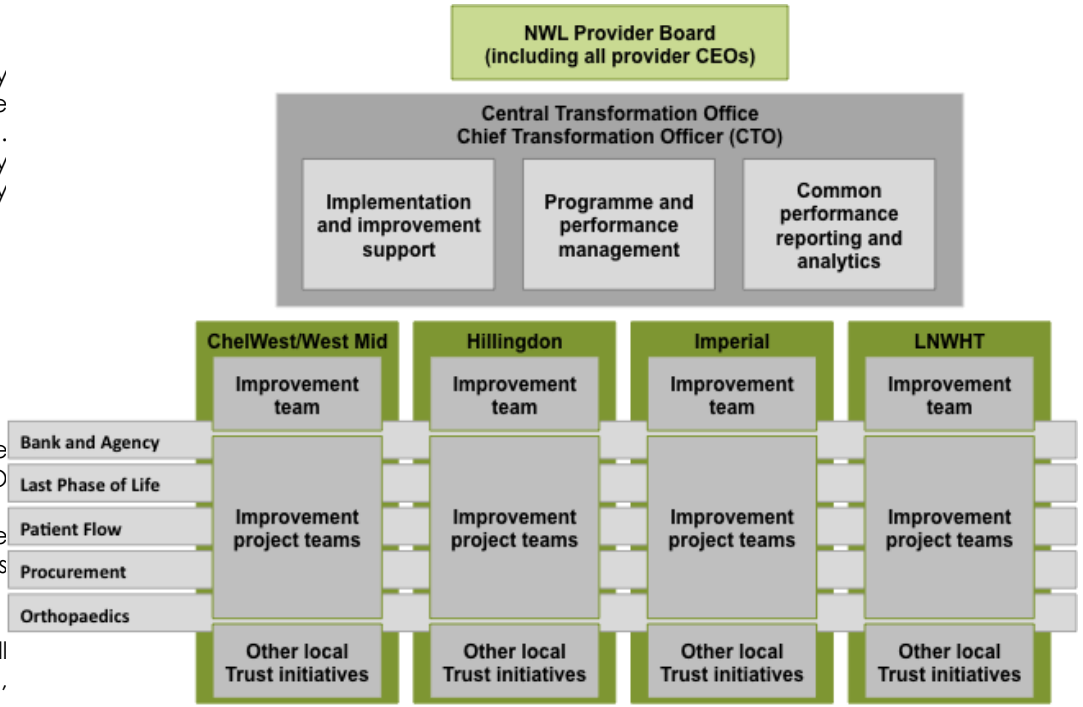
Providers in NW London have been collaborating to identify productivity opportunities from joint working, building from the recent Carter Review. These opportunities are detailed in the STP. Current progress is focused on mobilising a joint delivery capability across the providers, and then mobilising for delivery the priority projects of:

- Bank and agency
- Orthopaedics
- Procurement
- Patient flow

The schematic on the right sets out the end state.
To achieve this providers are working together to:

- Recruit a sector transformation director to lead the programme, with analytics funded by CCGs and PMO provided by ICHP.
- Programme directors are now in place for all but one programmes, programme directors and project managers funded by acute trusts.

As a result savings are expected in year from procurement, all trusts expecting to deliver their bank and agency targets, planning for a pan NW London bank by the end of the year.



6. How we will deliver our plan:
Risks and actions to take in the short term

We have described an ambitious plan to move from a reactive, ill health service to a proactive, wellness service, that needs to be delivered at scale and pace if we are to ensure we have a clinically and financially sustainable system by 2020/21. Unsurprisingly there are many risks to the achievement of this ambition, which we have described below. In some areas we will need support from NHSE to enable us to manage them.

Risks	Category	Proposed mitigations	Support from NHSE
We are unable to shift enough care out of hospital, or the new care models identify unmet need, meaning that demand for acute services does not fall as planned	Quality and sustainability	Development of a dashboard and trajectory, and regular monitoring of progress through joint governance Adoption of learning from vanguard and other areas	Access to learning from vanguards and other STPs
There is an unplanned service quality failure in one of our major providers	Quality and sustainability	On-going quality surveillance to reduce risk	
There is insufficient capacity or capability in primary care to deliver the new model of care	Quality and sustainability	Support development of federations Early investment in primary care through joint commissioning Identification and support to vulnerable practices Digital solutions to reduce primary care workloads	Clarity about future of and funding for GMS and PMS core contracts
There is a collapse in the care and nursing home market, putting significant unplanned pressures onto hospitals and social care	Quality and sustainability	Development of joint market management strategy On-going support to homes to address quality issues	
Can't get people to own their responsibilities for their own health	Self care and empowerment	Development of a 'People's Charter' Work with local government to engage residents in the conversation	National role in leading conversation with the wider public about future health models
We are unable to access the capital needed to support the new care model and to address the existing capacity and estate quality constraints	Finance and estates	Submit a business case for capital in summer 2016 Explore various sources of capital to deliver structural components of strategy, including the retention of land receipts for reinvestment.	Support for retention of land receipts for reinvestment, and potential devolution asks.
We are unable to access the capital required to increase capacity at the receiving hospitals quickly enough to address the sustainability issues at Ealing hospital	Finance and estates	Submit a business case for capital in summer 2016 that sets out the clinical and financial rationale to accelerate the timeline	Support for an accelerated timeline for the capital business cases
We are unable to recruit or retain workforce to support the old model while training and transforming to the new model of care	People and workforce	Development of workforce strategy, close working with HEENWL	

6. How we will deliver our plan:
Risks and actions to take in the short term

Risks	Category	Proposed mitigations	Support from NHSE
There is resistance to change from existing staff	People and workforce	OD support and training for front line staff Wide staff engagement in development of new models to secure buy in	
Providers are unable to deliver the level of CIPs required to balance their financial positions	Finance and sustainability	Establishment of new sector wide improvement approach to support the delivery of savings	
Opposition to reconfiguration by some partners prevents effective delivery of the rest of the plan	Partnership working	Establishing a new political relationship and reflecting this in enhanced joint governance, taking a 'whole systems view' to investment and market management	
IT systems aren't in place to enable shifts of activity through integrated care	Information and technology	Work within new national standards on data sharing to support the delivery of integrated services and systems.	NHSE/HSCIC to develop common standards for social care IT integration and provider requirements to enable system interoperability. Support to address the legacy conflict between the Duty to Share and the Duty of Confidentiality
Lack of interoperability in our primary and community IT systems, EMIS and SystmOne, which prevents shared care records which support integrated care	Information and technology	Keep pressure up on supplier to deliver open interfaces.	
Impact on the health sector and our workforce of 'Brexit'	People and workforce Finance and sustainability	Work closely with partners to understand the 'Brexit' implications and provide staff with support to ensure they feel valued and secure.	Early clarity of impact Political messaging to staff

7. References

Section	Slides	References
Executive Summary	4-11	[1] Health & Wellbeing of NW London population (2016). Triborough Public Health Intelligence Team. [2] ONS 2011 population figures 65+ accessed at https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/lowersuperoutputareamidyearpopulationestimates = 159,617. Living alone 2011 public health % of households occupied by a single person aged 65 or over accessed at http://fingertips.phe.org.uk/search/older%20people%20living%20alone#page/3/gid/1/pat/6/par/E12000007/ati/102/are/E09000002/iid/91406/age/27/sex/4) number = 75,058) [3] https://www.gov.uk/government/publications/child-poverty-basket-of-local-indicators [4] http://www.phoutcomes.info/search/overweight#pat/6/ati/102/par/E12000007 , Public Health Outcome Framework [5] System-wide activity and bed forecasts for ImBC [6] Chin-Kuo Chang et al (2011), Life Expectancy at Birth for People with Serious Mental Illness and Other Major Disorders from a Secondary Mental Health Case Register in London. PLoS One. 2011; 6(5): e19590 cited in https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/05/serious-mental-hlth-toolkit-may16.pdf) [7] National Survey of Bereaved People (VOICES 2014) [8] Health & Wellbeing of NW London population (2016). Triborough Public Health Intelligence Team. Serious and Long Term Mental Health needs figure comes from GP QOF register for Serious Mental Health Issues. [9] NW London high level analysis of discharging rates within/across borough boundaries. [10] Initial target for LPoL project [11] Estimate based on numbers of emergency referrals responded to by Single Point of Access in first six months of activity; extrapolated to cover both CNWL and WLMHT SPAs for full year [12] Initial activity analysis following service launch at West Middlesex University Hospital [13] London Quality Standard [14] Shaping NW London High Level Analysis of Inpatient Radiology Diagnostic Imaging and Reporting. Data extracts from Trust RIS systems for all inpatient radiology imaging
Case for Change	12-19	[1] Public Health Outcomes Framework data - Slope Index of inequality in life expectancy at birth using 2012-2014. 16.04 years relates to figures for Kensington & Chelsea. [2] NOMIS profiles, data from Office for National Statistics [3] Health & Wellbeing of NW London population (2016). Triborough Public Health Intelligence Team. Serious and Long Term Mental Health needs figure comes from GP QOF register for Serious Mental Health Issues. [4] Health & HSCIC, Shaping a Healthier Future Decision Making Business Case and local JSNAs

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Section	Slides	References
Delivery Area 1: Radically upgrading preventing & wellbeing	21-22	[1] Local analysis using population segmentation work from London Health Commission, and population projections from the Greater London Authority (GLA SHLAA 2014) [2] TBC – requested from Public Health [3] Commissioning for Prevention: NW London SPG: Optimity Advisors Report [4] Health First: an evidence-based alcohol strategy for the UK, Royal College of Physicians, 2013 [5] Siegler, V. Measuring National Well-being - An Analysis of Social Capital in the UK, Office for National Statistics (2015) http://webarchive.nationalarchives.gov.uk/20160105160709/http://www.ons.gov.uk/ons/dcp171766_393380.pdf [6] Westminster Joint Health and Wellbeing Strategy (2016). http://www.centrallondonccg.nhs.uk/media/45071/120-clccg-gb-part-i-westminster-joint-health-and-wellbeing-strategy-and-sign-off-processes-v2.pdf [7] DWP - Nomis data published by NOS [8] IPS: https://www.centreformentalhealth.org.uk/individual-placement-and-support [9] Local analysis using population segmentation work from London Health Commission, and population projections from the Greater London Authority (GLA SHLAA 2014) [10] Commissioning for Prevention: NW London SPG: Optimity Advisors Report [11] Local analysis using population segmentation work from London Health Commission, and population projections from the Greater London Authority (GLA SHLAA 2014) [12] Cancer Research UK [13] http://www.phoutcomes.info/search/overweight#pat/6/ati/102/par/E12000007 [14] Public Health England (2014) [15] Local analysis using population segmentation work from London Health Commission, and population projections from the Greater London Authority (GLA SHLAA 2014) [16] Holt-Lunstad, J, Smith TB, Layton JB. (2010) "Social Relationships and Mortality Risk: A Meta-Analytic Review" PLoS Med 7(7) [17] Commissioning for Prevention: NW London SPG: Optimity Advisors Report [18] http://www.phoutcomes.info/search/overweight#pat/6/ati/102/par/E12000007 , Public Health Outcome Framework [19] Westminster Joint Health and Wellbeing Strategy (2016). http://www.centrallondonccg.nhs.uk/media/45071/120-clccg-gb-part-i-westminster-joint-health-and-wellbeing-strategy-and-sign-off-processes-v2.pdf
Delivery Area 2: Eliminating unwarranted variation and improving Long Term Condition (LTC) Management	23-24	[1] Local analysis using population segmentation work from London Health Commission, and population projections from the Greater London Authority (GLA SHLAA 2014) [2] Cancer Research UK [3] http://www.hscic.gov.uk/catalogue/PUB02931/adul-psyc-morb-res-hou-sur-eng-2007-rep.pdf [4] Fund Naylor C, Parsonage M, McDaid D et al (2012). Long-term conditions and mental health: the cost of co-morbidities. London: The Kings Fund [5] Pan-London Atrial Fibrillation Programme [6] NHS London Health Programmes, NHS Commission Board, JSNA Ealing [7] Kings Fund, 2010 [8] Initial analysis following review of self-care literature [9] http://dvr.sagepub.com/content/13/4/268

7. References

Section	Slides	References
Delivery Area 3: Achieving better outcomes and experiences for older people	25-26	[1] Office for National Statistics (ONS) population estimates [2] Source: Index of Multiple Deprivation 2015 Income Deprivation Affecting Older People (IDAOPI); Greater London Authority 2015 Round of Demographic projections, Local authority population projections - SHLAA-based population projections, Capped Household Size model [3] https://www.england.nhs.uk/mentalhealth/wp-content/.../dementia-diagnosis-jan16.xlsx [4] SUS data - aggregated as at June 2016
Delivery Area 4: Improving outcomes for children and adults with mental health needs	27-28	[1] Tulloch et al., 2008 [2] Royal College of Psychiatrists, 2012 [3] http://www.publications.parliament.uk/pa/cm200506/cmhansrd/vo060124/debtext/60124-06.htm#60124-06_spmin1
Delivery Area 5: Ensuring we have safe, high quality sustainable acute services	29-31	[1] Health & Wellbeing of NW London population (2016). Triborough Public Health Intelligence Team [2] SUS Data. Oct 14-Sep15. [3] NW London CCGs - M11 2015-16 Acute Provider Performance Measures Dashboard [4] Shaping a Healthier Future Decision Making Business Case [5] Shaping a Healthier Future Decision Making Business Case [6] Shaping a Healthier Future Decision Making Business Case [7] Shaping NW London High Level Analysis of Inpatient Radiology Diagnostic Imaging and Reporting. Data extracts from Trust RIS systems for all inpatient radiology imaging. [7] Review of Operational Productivity in NHS providers – June 2015. An independent report for the Department of Health by Lord Carter of Coles.
Enablers: Estates	33-34	[1] ERIC Returns 2014/15 [2] NHSE London Estate Database Version 5 [3] NW London CCGs condition surveys [4] Oxford University's School of Primary Care Research of general practices across England, published in The Lancet in April 2016 [5] Lord Carter Report: https://www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/Commons/2016-02-05/HCWS515/http://qna.files.parliament.uk/ws-attachments/450921/original/Operational%20productivity%20and%20performance%20in%20English%20NHS%20acute%20hospitals%20-%20Unwarranted%20variations.pdf

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Section	Slides	References
Enablers: Workforce	35-36	[1] Trust workforce: HEE NWL, eWorkforce data, 2015. Not published Social Care Workforce: Skills for Care, MDS-SC, 2015 GP Workforce: HSCIC, General and Personal Medical Services, England - 2004-2014, As at 30 September, 2015 Unpaid Carers: ONS, 2011 Census analysis: Unpaid care in England and Wales, 2011 and comparison with 2001, 2013 Pharmacy Data: Royal Pharmaceutical Society of Great Britain, Pharmacy Workforce Census 2008, 2009 Maternity Staff: Trust Plans, 2015. Not Published Paediatric Staff: Trust Plans, 2015. Not Published [2] Conlon & Mansfield, 2015 [3] Turnover Rates: HSCIC, iView, retrieved 23-05-2016 [4] Vacancy Rates – NHS Trusts: HEE NWL, eWorkforce data, 2015. Not published Vacancy Rates – Social Care: Skills for Care, NMDS-SC, 2015 [5] GP Ages: HSCIC, General and Personal Medical Services, England 2005-2015, as at 30 September, Provisional Experimental statistics, 2016 [6] GP Appointments: Nuffield Trust, Fact or fiction? Demand for GP appointments is driving the 'crisis' in general practice, 2015 GP Practices: HSCIC, GPs, GP Practices, Nurses and Pharmacies, 2016 Providers: HSCIC, GPs, GP Practices, Nurses and Pharmacies, 2016 Skills for Care, nmds-sc online, retrieved 17-06-2016 [7] McKinsey, Optimising Bank and Agency Spend across NW London , 2015. Not published
Enablers: Digital	37-38	[1] Local Digital Roadmap - NHS NW London (2016)

Partnership organisations with the NW London STP Footprint

NHS Brent Clinical Commissioning Group

NHS Central London Clinical Commissioning Group

NHS Ealing Clinical Commissioning Group

NHS Hammersmith and Fulham Clinical Commissioning Group

NHS Harrow Clinical Commissioning Group

NHS Hillingdon Clinical Commissioning Group

NHS Hounslow Clinical Commissioning Group

NHS West London Clinical Commissioning Group

Brent

Harrow Council London

Hillingdon London

London Borough of Hounslow

The Royal Borough of Kensington and Chelsea

City of Westminster

West London Mental Health NHS Trust

Central and North West London NHS Foundation Trust

Chelsea and Westminster Hospital NHS Foundation Trust

London North West Healthcare NHS Trust

The Hillingdon Hospitals NHS Foundation Trust

Hounslow and Richmond Community Healthcare NHS Trust

The Royal Marsden NHS Foundation Trust

Royal Brompton & Harefield NHS Foundation Trust

London Ambulance Service NHS Trust

Imperial College Healthcare NHS Trust

Central London Community Healthcare NHS Trust

NHS Health Education North West London

NHS England

NHS National Institute for Health Research Clinical Research Network North West London

Imperial College Health Partners

wla West London Alliance

NW London Sustainability and Transformation Plan

Our plan for North West Londoners to be well and live well

APPENDICES – v1.0 20160630

List of appendices

Appendix A: Joint Statement on Health and Care Collaboration in NW London from Brent, Harrow, Hillingdon, Hounslow, Kensington & Chelsea and Westminster Councils

These six boroughs in NW London welcome the opportunity to improve the outcomes for local people and communities

- Local Government and Health partners in North West London (NWL) are committed to working together to design a sustainable health and care system that improves outcomes for our communities.
- We recognise the huge financial and demographic challenges facing public services over the next five years and acknowledge our duty to work together as system leaders to create a sustainable health and care system, whilst retaining our rights as sovereign organisations to help our communities get the outcomes they need.
- We support person-centred health and care that enables increased numbers of older people and those with disabilities to access clinical and social care in community settings whenever appropriate.
- We welcome joint working with the NHS to prevent health problems occurring and to improve the wellbeing of local people. We are committed to working together to deliver integrated health and social care systems that provide the highest quality out-of-hospital services for residents.
- The councils covering North West London will work closely with NHS partners to implement work in these areas, building on our strong track record of partnership delivery.

In order to deliver the ambitions of the STP, our six boroughs also agree that the following conditions must be reflected in the STP document itself:

1. Explicit reference to how the NHS will help to close the £145m social care funding gap, through investment in prevention and integration services
2. Explicit reference to the need to map and invest significant additional resource in out of hospital care to create new models of care and support in community settings, including through joint commissioning with local government
3. Explicit reference to plans to significantly expand pooled budgets and joint commissioning for delivery of integrated and out of hospital care, especially for older peoples services, to support the development of the local and NW London market
4. Explicit reference to a devolution proposition around local retention of capital receipts from estates and joint commissioning of all out of hospital care, with resources allocated to deliver it. This in no way infers any assumptions about acute reconfiguration.
5. There will be no substantive changes to A&E in Ealing or Hammersmith & Fulham until after of a review process, based on criteria to be agreed, led jointly by the six local authority partners and communities. All partners will work to significantly improve out of hospital provision to enable patient demand to be met.
6. A commitment from NHS partners to review with local authority partners the assumptions underpinning the changes to acute services and progress with the delivery of local services before making further changes
7. A commitment to work jointly with local communities and councils to agree a model of acute provision that addresses clinical safety concerns and expected demand pressures

Any changes to this agreement will be subject to joint review based on agreed criteria with the six local authority partners and their communities.

Concerns still remain around the government's proposals developed through the Shaping a Healthier Future programme i.e. to reconfigure acute care in north west London or downgrade the status of Ealing or Charing Cross hospitals, including A&E services.

We recognise that there is significant work still to do to develop a genuinely joint approach and reach agreement on any hospital changes in these areas. At the same time, the six boroughs recognise the significant opportunity to work together to invest in better care for local residents.

To move forward, our boroughs ask that NHS partners commit to work jointly to:

- develop an agreed approach to the delivery of the commitments , following the 30 June checkpoint
- develop an acceptable set of review criteria for any changes
- strengthen the supporting data and evidence base, and understand the financial risks and benefits and overall business case across health and care by October 2016
- agree a 'review point' in 2018 to review the agreed criteria
- co-produce the final plan with leaders, clinicians and the public from June through to October 2016

Appendix B: Leadership and governance

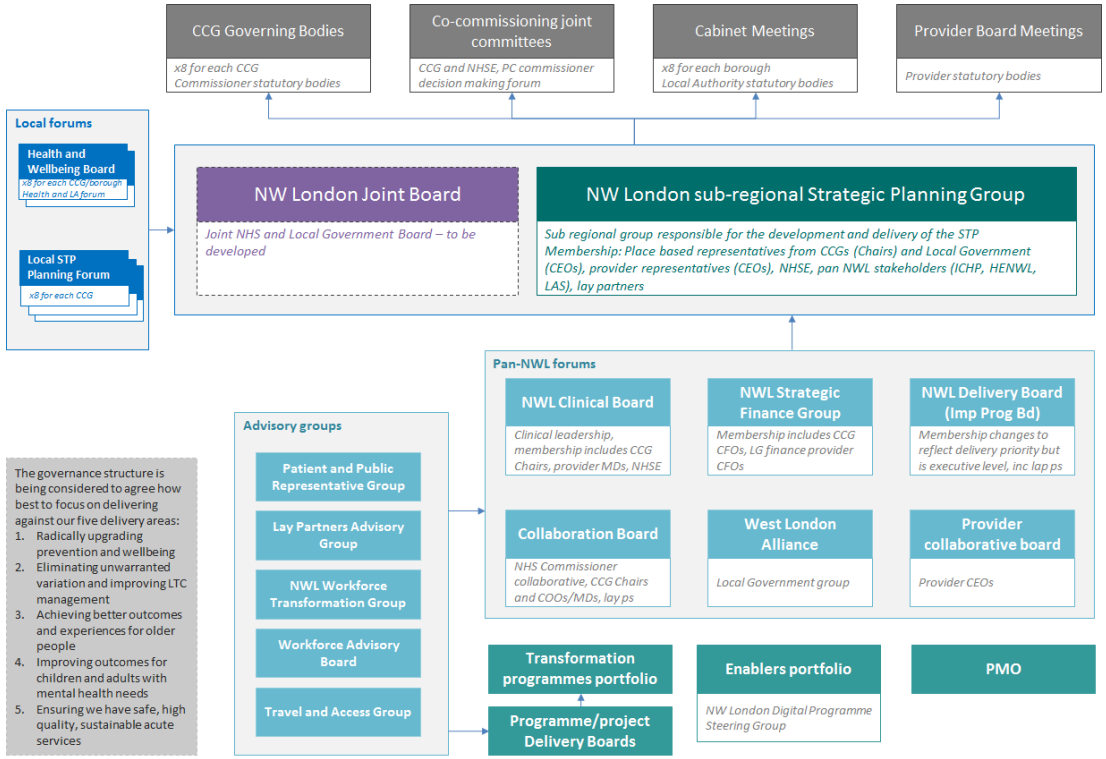
NW London has meaningful leadership and robust governance to drive transformational change

There is a history of collaboration at a sub-regional level in NW London across both health and local authorities. To help us work most effectively we have in place a robust governance structure and leadership arrangements.

NW London has one of the most established whole system partnerships in the country, with a strong history of pan-borough working through the long-established West London Alliance, NHS NW London and individual commissioners and providers as well as academic and workforce institutions. Lay partners are represented across the system and leadership.

With the development of the STP, we have strengthened our ways of working. NHS and Local Government partners are working together to develop a joint governance structure with the intention of establishing a joint board that would oversee delivery of the NW London STP. The joint governance arrangements would ensure there is strong political leadership over the STP, with joint accountability for the successful delivery of the plan, including the allocation of transformation resources and implementation of the out of hospital strategy. We will also strengthen our existing governance structures and develop them where necessary to ensure that there is clear joint leadership for delivering the strategy across health and local government STP partners for each of the five delivery areas and three enablers. Building on our ambitious STP plans, NW London will also develop options for a devolution proposition, to be agreed jointly across commissioners and providers. This could include local retention of capital receipts, greater local control over central NHS resources and greater flexibility over regulation to support delivery of long term plans.

Incorporating the individual's voice, clinical expertise and our managerial functions, we are operating in the following structure to develop and implement the STP:



STP Leadership Team

The STP is led by the appointed STP System Leadership Team, which meets weekly and includes representation from all of the key stakeholder groups in our system:

Dr Mohini Parmar *System Leader*
(Ealing CCG Chair)

Carolyn Downs *Local Authority Lead*
(Chief Executive, Brent Council)

Clare Parker *Joint NHS Commissioner SRO*
(Chief Officer CWHHE CCGs)

Dr Tracey Batten *Provider Lead*
(Chief Executive, Imperial College Healthcare Trust)

Rob Larkman *Joint NHS Commissioner SRO*
(Chief Officer BHH CCGs)

Matt Hannant *STP Programme Director*
(CCG Director of Strategy & Transformation)

Appendix C: How our priorities address the '10 big questions'

National priority areas	NW London Priority	Delivery Area (DA)	Section of NW London STP	Progress to date
1. How are you going to prevent ill health and moderate demand for healthcare?	**Priority 1:** Support people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthy choices and look after themselves	**DA1:** Radically upgrading prevention and wellbeing	**DA1:** Pages 21-22	• 5 of the 8 boroughs in NW London are part of the Diabetes Prevention Programme Pilot • PMS review - move to equitable provision of preventive screening and immunisation, targeting prevalence across CCGs potentially depending upon commissioning intentions • 6 of 19 primary care hubs up and running in NW London • Model of care work and federations - based on principle of commissioning for the whole population in order to address health inequalities • Risk stratification enabling care planning for high risk individuals • Patient activation measurement tool rolled out across NW London
2. How are you engaging people, communities and NHS staff?	**Priority 1:** Support people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthy choices and look after themselves **Priority 4:** Reduce social isolation	**DA1:** Radically upgrading prevention and wellbeing	**DA1:** Pages 21-11 **Enabler:** Workforce (Pages 35-36) **Enabler:** Digital (Pages 37-38) **Appendix C:** Co-production, communications and engagement with service users, partners and staff (Pages 5-6)	• Embedding co-production throughout our transformation, supported by the Lay Partner Advisory Group • Expert Patient Programmes in some CCGs • Federation commitment to engaging people and communities e.g. all practices have a Patient Participation Group • All CCGs signed up to healthy workplace charter • Change Academy has supported 4 multi-disciplinary teams to date as part of Phase 1 • Mental Health engagement events in collaboration with West London Collaborative
3. How will you support, invest in and improve general practice?	**Priority 6:** Ensure people access the right care in the right place at the right time **Priority 9:** Improve consistency in patient outcomes and experience based on the day of the week that services are accessed	**DA3:** Achieving better outcomes and experiences for older people **DA5:** Ensuring we have safe, high quality sustainable acute services	**DA3:** Pages 25-26 **DA5:** Pages 29-31	• Established federations to increase GP accessibility • Improvements to maternity and children's care across NW London by consolidating inpatient and emergency services onto 5 sites • 1.9m people have access to weekend primary care appointments • NW London CCGs score above London average for accessible and coordinated care dimensions • Primary care is working at scale – all eight CCGs have federation population coverage of above 75%
4. How will you implement new care models that address local challenges?	**Priority 6:** Ensure people access the right care in the right place at the right time **Priority 7**: Improve the overall quality of care for people in their last phase of life and enabling them to die in their place of choice **Priority 5**: Reducing unwarranted variation in the management of long term conditions – diabetes, cardio vascular disease and respiratory disease	**DA3:** Achieving better outcomes and experiences for older people **DA2:** Eliminating unwarranted variation and improving Long Term Condition management	**DA3:** Pages 25-26 **DA2:** Pages 23-24	• Joint commissioning of services (in particular rapid response) across health and social care • Whole Systems approach developed and in practice to segment the population and develop tailored services • Development of local models of care for urgent care, including 111 • There are urgent care centres at all A&Es in NW London • As part of the reconfiguration of paediatric services, a new model of care and paediatric assessment units have been developed
5. How will you achieve and maintain performance against core standards?	**Priority 3:** Reduce health inequalities and disparity in outcomes for the top 3 killers: cancer, heart diseases and respiratory illness	**DA5:** Ensuring we have safe, high quality sustainable acute services	**DA5:** Pages 29-31	• Performance is managed through a range of forums between providers and commissioners including quality meetings which feed into CCGs, Finance and Performance meetings and Contract meetings

Appendix C: How our priorities address the '10 big questions'

National priority areas	NW London Priority	Delivery Area (DA)	Section of NW London STP	Progress to date
6. How will you achieve our 2020 ambitions on key clinical priorities?	**Priority 2:** Improve children's mental and physical health and well-being **Priority 8:** Reduce the gap in life expectancy between adults with severe and long-term mental illness and the rest of the population **Priority 9:** Improve consistency in patient outcomes and experience based on the day of the week that services are accessed	**DA1:** Radically upgrading prevention and wellbeing **DA4:** Improving outcomes for children &adults with mental health needs **DA5:** Ensuring we have safe, high quality sustainable acute service	**DA1:** Pages 21-22 **DA4:** Pages 27-28 **DA5:** Pages 29-31	• Single point of access' and rapid response home treatment teams for urgent mental health needs launched across all 8 Boroughs Urgent care centres across NW London all operate to the same specification • Maternity – after the transition of maternity services at Ealing, there has been an improvement in: - midwife to birth ratio from 1:31 to 1:30 - midwife vacancy level from 8.1% to 7.2% - consultant ward presence from 108 hours to 122 hours • Signed up all North West London NHS organisations to the 'Healthy Workplace Charter' to improve the mental health and wellbeing of their staff. • launch of young people's eating disorder services. Providing quicker access for this vulnerable population
7. How will you improve quality and safety?	**Priority 9:** Improve consistency in patient outcomes and experience based on the day of the week that services are accessed	**DA5:** Ensuring we have safe, high quality sustainable acute services	**DA5:** Pages 29-31	• Launched seven day services programme • Implemented single discharge process • Psychiatric liaison in all A&Es and Urgent Care Centres (UCCs) in NW London • Maternity & Paediatrics – agreed quality standards which are tracked monthly across NW London • Mental health Crisis Care Concordat signed • Agreed clarifications on 7 Day Services standards on radiology
8. How will you deploy technology to accelerate change?	Underpins all priorities		**Enabler:** Digital (Pages 37-38)	• NW London Diagnostic cloud • Roll out of Electronic Prescribing Service (EPS2), Summary Care Record • Patient Online functionality available at all practices • Integrated Care data dashboards being piloted • In primary care 280,000 patients have access to web-based consultations and 60,000 patients have access to video consultations
9. How will you develop the workforce you need to deliver?	Underpins all priorities		**Enabler:** Workforce (Pages 35-36)	• Joint working with Health Education England (HEE NW London) • Care Coordinator and Care Navigator role developed, trained and in post (increasing numbers in the existing workforce) • Health and Social Care Coordinator role development (enhanced clinical skills) • CEPNs established across NW London which are improving ways of working across different parts of health and social care • PA programme in Hillingdon mobilised
10. How will you achieve and maintain financial balance?	Underpins all priorities		**Finance** (Pages 42-47)	• NW London financial strategy being implemented for the past few years • The Shaping a Healthier Future programme, by creating new unified clinical pathways and providing higher quality care across the system

Appendix D: Further information about our Mental Health and Wellbeing Transformation

Like Minded

WORKING TOGETHER FOR MENTAL HEALTH AND WELLBEING IN NW LONDON

Appendix D: The current picture

In North West London we have had a shared whole systems mental health programme (across health and social care) since 2012 reflecting a commitment to improving mental health and wellbeing for the 2 million residents of North West London. Since 2015 we have been working under the banner of Like Minded – with a Case for Change endorsed across all Health and Wellbeing Boards, and CCGs setting out our challenges and common ambition for change.

The programme coproduced the following 3 statements to articulate the overall vision our population. These statements are supported by a number of principles. Critically the Strategy, vision and principles describe the outcomes and experience we want to change – rather than focus on services.

My wellbeing and happiness is valued and I am supported to stay well and thrive

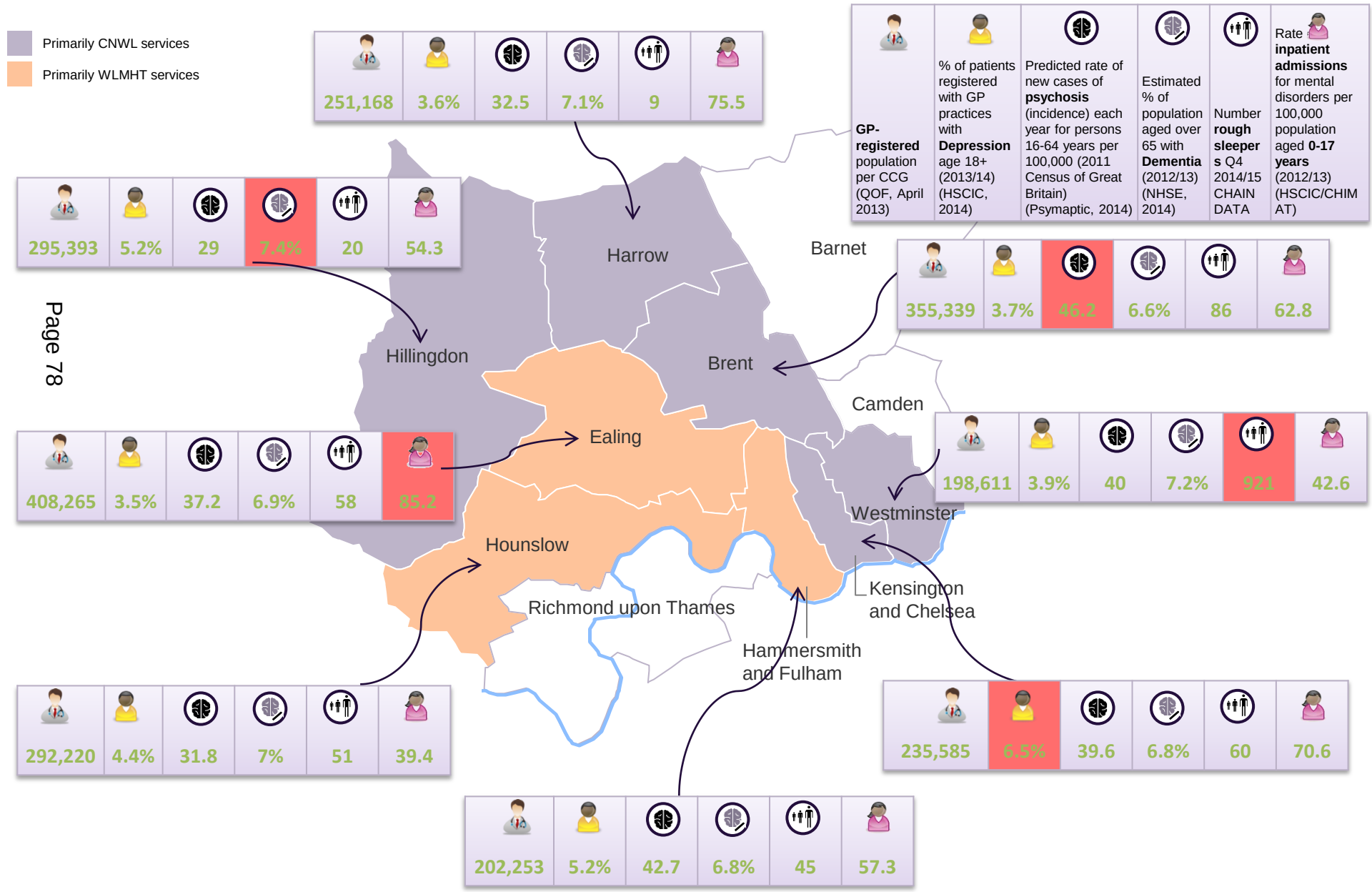
As soon as I am struggling, appropriate and timely help is available

The care and support I receive is joined-up, sensitive to my own needs, my personal beliefs, and delivered at the place that's right for me and the people that matter to me

Core principles

- My life is important, I am part of my community and I have opportunity, choice and control.
- My wellbeing and mental health is valued equally to my physical health
- I am seen as a whole person – professionals understand the impact of my housing situation, my networks, employment and income on my health and wellbeing
- My care is seamless across different services, and in the most appropriate setting
- I feel valued and supported to stay well for the whole of my life

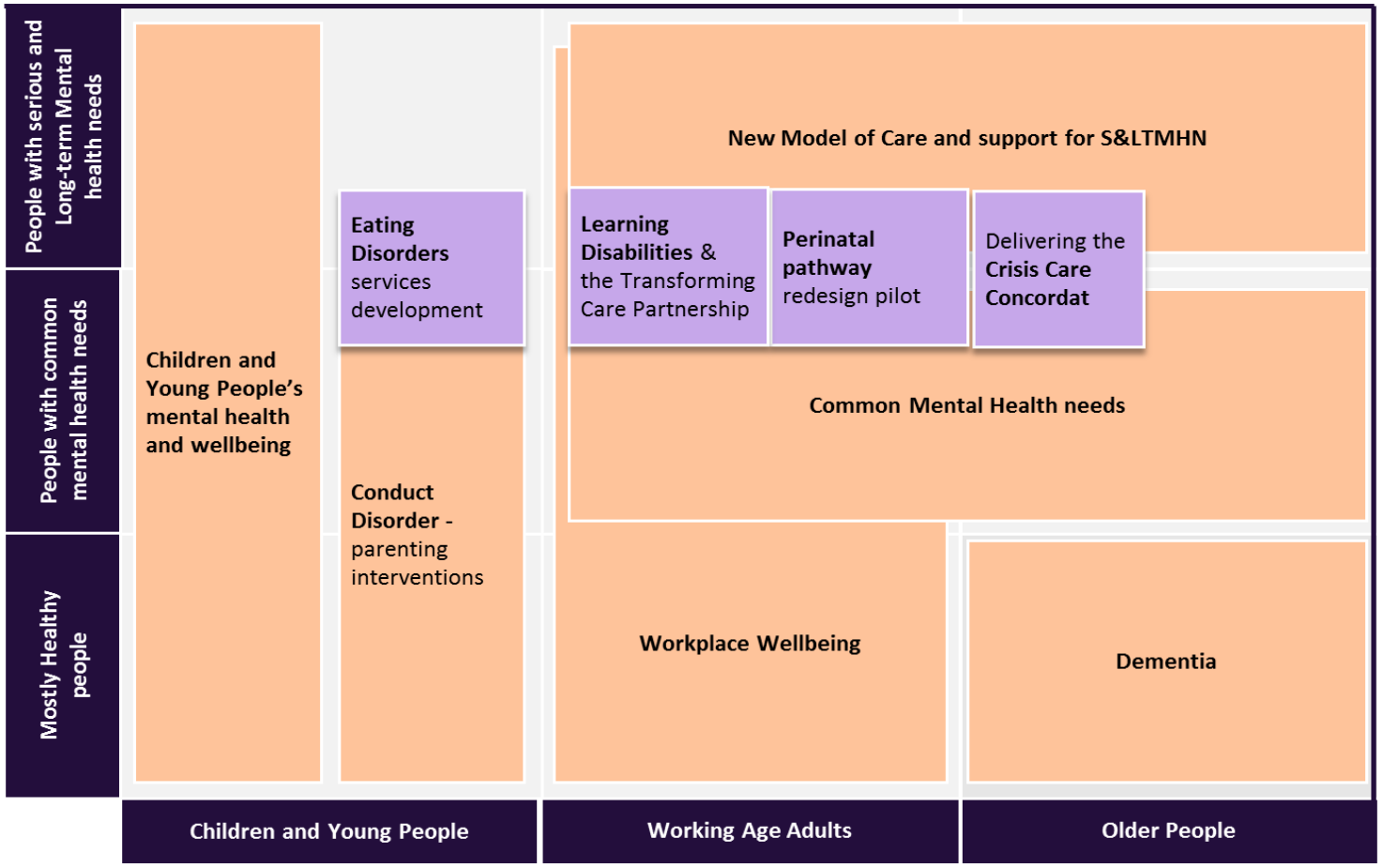
Appendix D: Case for change: there is still much we can do to improve outcomes and reduce variation



Appendix D: We use an approach across the life course, aiming to reducing mental health inequalities

In approaching mental health transformation in North West London we have considered an approach across the life course aimed at reducing mental health inequalities. Whilst we know that people are not defined by their diagnosis (we acknowledge that comorbidity is the norm) or demographics, this is a useful framework to prioritise and focus within an area of vast need.

We recognise that learning disabilities and mental health needs are not the same thing – but our work since 14/15 to address needs of our population who have both learning disabilities and mental health needs provided a spring board for wider work on learning disabilities under the Transforming Care Partnership Programme.



Appendix D: As a transformation programme with a wide remit we embed in NW London the sense that mental health is everyone's business

The Like Minded Strategy is a 'whole systems', all ages strategy. Throughout the programme we recognise the critical role that services and initiatives across the system have in supporting mental health and wellbeing. Our combined work across NWL naturally builds on the local transformation and co-production work within each Borough, and on work led by local mental health providers – CNWL and WLMHT. As a transformation programme with a wide remit we embed in NWL the sense that mental health is everyone's business – through supporting our own workforce to remain healthy, as much as focusing on supporting the mental wellbeing and recovery of our service users, carers and wider population.

As we have approached mental health transformation in North West London one key commitment has been to co-production – not just with service users and carers, but through a cross-system leadership approach to health, social care and the voluntary and community sector. Our work to date lends itself to a 'place based approach' - with no health without mental health we have to work with a wide range of partners and recognise the impact of mental illness on all statutory services and broader societal outcomes, such as employment and educational attainment.

The whole programme is focused on delivering the ambitions for Parity of Esteem, all transformation work rooted in a holistic approach to meeting the needs of the public.

We work closely with service users and carers, clinicians, professionals and experts across the system in health, social care, voluntary sector and public health and have held workshop events in specific areas, including children & young people, socially excluded groups, and mental ill health prevention.

We are not starting from scratch – our 24/7 urgent care pathway has been the critical development over the last year and unlocks the gateway to wider services for adults with serious and long term needs:

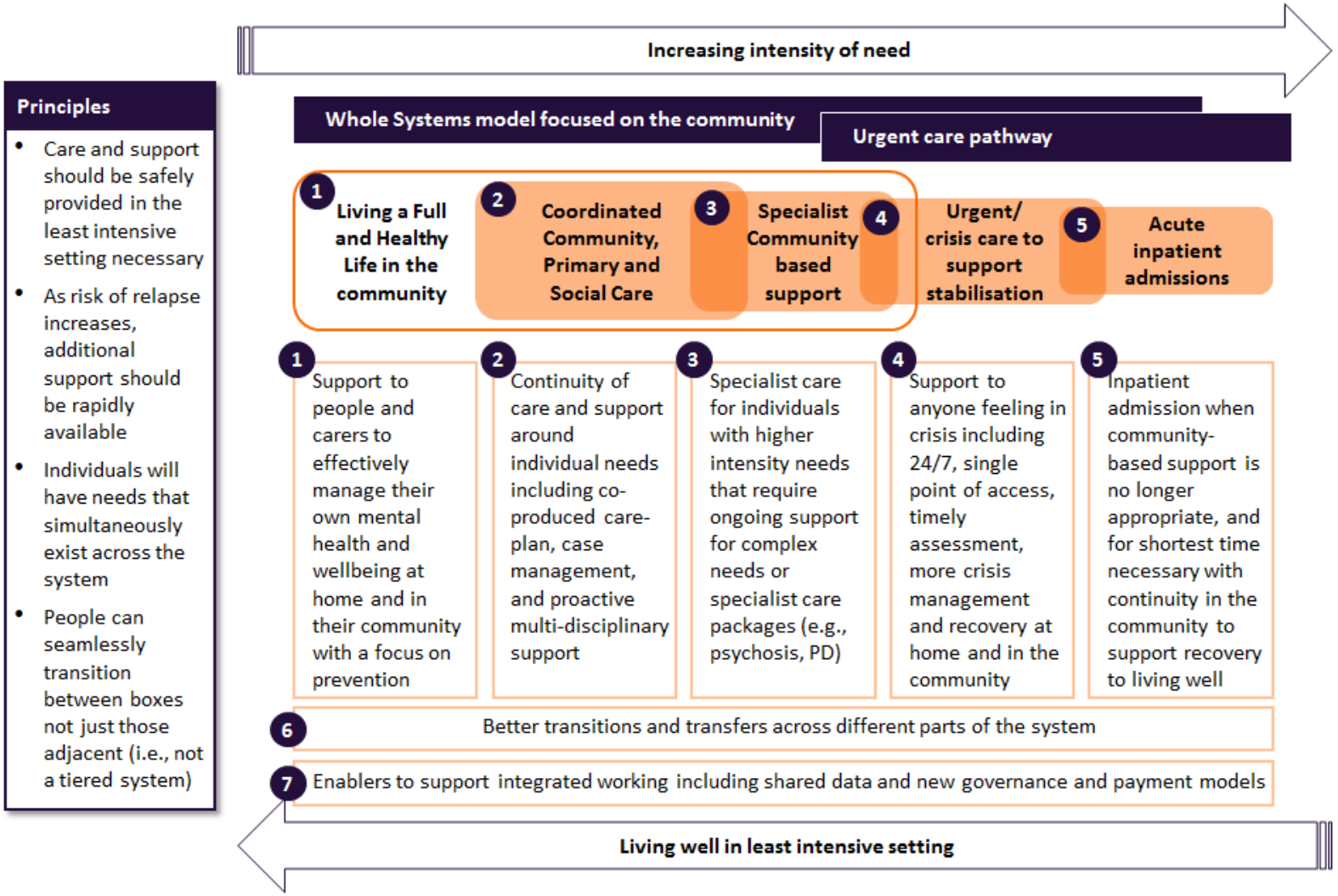
The 24/7 crisis line is the best anti-anxiety drug for GPs –we know we can get the right specialist support quickly for patients in the community

Appendix D: Like Minded new Model of Care and Support for people with Serious and Long Term Mental Health Needs (SLTMHN)

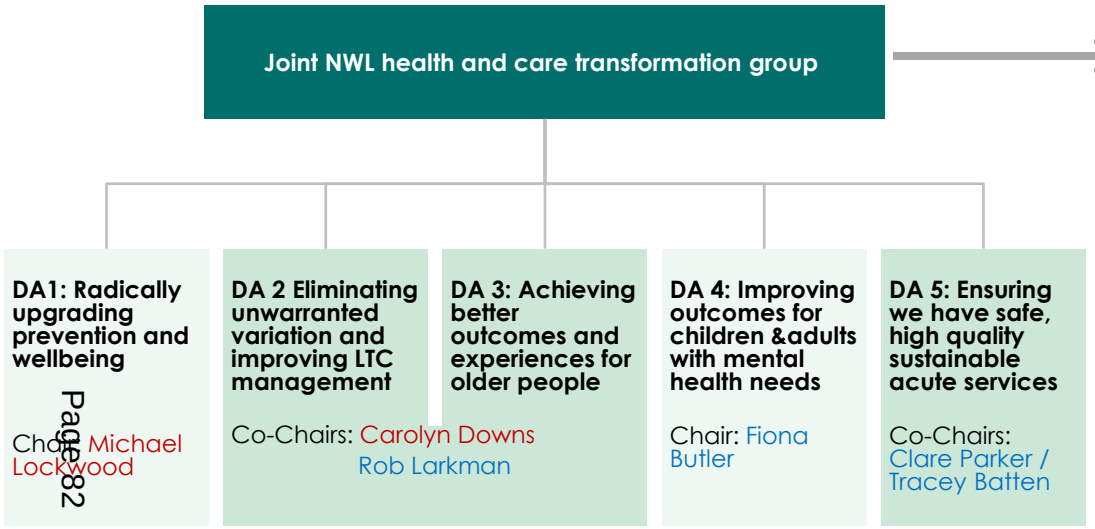
Like Minded has put much focus on the development of a model of care and support for people living with and experiencing SLTMHNs, as shown below. This model of care has been developed in conjunction with service users, CCGs, Trusts, and local authorities.

The model of care is designed to ensure care and support takes place in the least intensive setting possible, maximising independence and wellbeing.

Local business cases for the implementation of the model are still in development with the intention of these being agreed by governing bodies in September 2016.



Joint NW London Health and Care Transformation Group



	Membership		
	Role	**Name**	**Governance Link**
1	Co Chair (NHS)	Mohini Parmar	NHS/comm
2	Co Chair (LG)	Cllr Shah	LG
3	NHS Rep 2	Clare Parker	NHS/comm
4	NHS Rep 3	Rob Larkman	NHS/comm
5	NHS Rep 4	Tracey Batten	NHS/comm
6	NHS Rep 5	TBC	NHS/provider
7	NHS Rep 6	TBC	NHS/provider
8	Community/MH Trust Rep	Claire Murdoch	NHS/provider
9	Acute Trust Rep	Lesley Watts	NHS/provider
10	LG Rep 2 (Elected Member)	Cllr Curran	LG
11	LG Rep 3 (Elected Member)	Cllr Robathan	LG
12	LG Rep 4 (Elected Member)	Cllr Corthorne	LG
13	LG Rep 5 (Officer)	Carolyn Downs	LG
14	LG Rep 6 (Officer)	Michael Lockwood	LG
15	LG Rep 7 (Officer)	Liz Bruce	LG
16	Lay Partner Rep 1	Julian Maw	Citizen/patient
17	Lay Partner Rep 2	TBC	Citizen/patient
18	Finance & Estates Enabler	Charlie Parker / Keith Edmunds	NHS/LG

NHS members	LG members	Lay Partner	Finance Rep	**Total**
8	7	2	1	**18**

'Joint transformation group', principles and planning assumptions

- **Initial role:**
  - Oversight of STP development and recommendation to statutory orgs
  - Design and oversight of allocation of STF (driven through individual CCGs)
  - Oversight of STP delivery
- No delegated decision-making authority (at this stage)

- Subsidiarity applies
- Annual review of leadership and membership arrangements
- Terms of Reference to be determined
- Members of the Group only represent one role/function, i.e. either a place, type of organisation, population group, or a DA, not multiple roles

Mapping of SROs, CROs, and leadership resources to STP delivery areas and programmes

Delivery Area	Description	LG SRO	NHS SRO	CRO	Project	Project Sponsors	PD
DA 1	**Radically upgrading prevention and wellbeing**	Michael Lockwood (Chair)	Ethie Kong	Fiona Butler, Jan Norman, LG?	a. Enabling and supporting healthier living		
					b. Wider determinants of health interventions	Michael Lockwood	Penny Emerson
					c. Helping children to get the best start in life	Jan Norman	Jane Wheeler
					d. Address social isolation	Matt Hannant	Jane Wheeler
DA 2	**Eliminating unwarranted variation and improving LTC management**	Carolyn Downs (Co Chair)	Rob Larkman (Co Chair)	Fiona Butler, Jonathan Webster, Mohini Parmar LG?	a. Improve cancer screening to increase early diagnosis and faster treatment		Lizzy Bovill
					b. Better outcomes and support for people with common mental health needs, with a focus on people with long term physical health conditions	Matt Hannant	Jane Wheeler
					c. Reducing variation by focusing on Right Care priority areas		Penny Emerson
					d. Improve self-management and 'patient activation'	Rob Larkman	Penny Emerson
DA3	**Achieving better outcomes and experiences for older people**			Nicola Burbidge, Neville Purssell, Susan LaBrooy, Tim Spicer, Mohini Parmar, LG?	a. Improve market management and take a whole systems approach to commissioning	Phil Porter	
					b. Implement accountable care partnerships	Clare Parker/Liz Bruce	David Freeman
					c. Implement new models of local services integrated care to consistent outcomes and standards	Rob Larkman	Penny Emerson
					d. Upgraded rapid response and intermediate care services	Rob Larkman	Penny Emerson
					e. Create a single discharge approach and process across NW London	Rob Larkman	Penny Emerson
					f. Improve care in the last phase of life	Lesley Watts	Alison Kingston
DA 4	**Improving outcomes for children & adults with mental health needs**		Fiona Butler (Chair)	Fiona Butler, Sarah Basham, LG?	a. Implement the new model of care for people with serious and long term mental health needs, to improve physical and mental health and increase life expectancy	Matt Hannant	Jane Wheeler
					b. Addressing wider determinants of health		
					c. Crisis support services, including delivering the 'Crisis Care Concordat'		Jane Wheeler
					d. Implementing 'Future in Mind' to improve children's mental health and wellbeing		Jane Wheeler
DA 5	**Ensuring we have safe, high quality sustainable acute services**		Clare Parker (Co-Chair) Tracey Batten (Co Chair)	Susan LaBrooy, Tim Spicer, Mark Spencer, Mohini Parmar, LG ?	a. Specialised commissioning to improve pathways from primary care & support consolidation of specialised services	Tracey Batten	Hazel Fisher
					b. Deliver the 7 day services standards	Clare Parker	Simon Cook
					c. Reconfiguring acute services	Clare Parker	Simon Cook
					d. NW London Productivity Programme	Shane Degaris	Merav Dover
Enabling workstream		**LG SRO**	**NHS SRO**		**Project**	**Project Lead**	**PD**
Workforce			Ethie Kong		Workforce	Ethie Kong	Delvir Mehet
Digital			Ian Goodman		Digital	Ian Goodman	Sonia Patel
Finance & Estates		Charlie Parker	Keith Edmunds		Finance and Estates		Sue Hardy

Missing Name | >1 SRO | Key

	London Borough of Hammersmith & Fulham **HEALTH & WELLBEING BOARD** **7 SEPTEMBER 2016**
HAMMERSMITH & FULHAM CCG COMMISSIONING INTENTIONS 2017/18 DEVELOPMENT PROCESS AND EMERGING INTENTIONS	
Report from Hammersmith & Fulham CCG	
Open Report	
Classification - For Information & Comment **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: Janet Cree, Managing Director, H&F CCG	
Report Author: Janet Cree, Managing Director, H&F CCG	**Contact Details:** E-mail: janet.cree@nw.london.nhs.uk

1. INTRODUCTION

1.1 The Health and Wellbeing Board is requested to review and comment on the overview of the North West London CCGs' process for developing commissioning intentions for the 2017/18 contracting round.

1.2 Commissioning intentions are published annually, by the end of September, to providers of healthcare - to indicate our priorities and joint deliverables in the following contracting year.

1.3 We are in a different position from previous years for the contracting round in 2017/18, for the following reasons:

- NHSE have indicated that they wish us to develop two year contracts rather than the traditional one-year contract
- We have already developed, in collaboration with a wide variety of stakeholders, the North West London five-year Sustainability and Transformation Plan (STP). The STP content will form the narrative for our intentions.
- There are a number of ongoing national initiatives that will also inform our 2017/18 plans – for example Right Care (reducing unwarranted

variation/maximising value) and Demand Management Programmes (mitigating increasing system demand).
- Contracts need to be signed by December 2016, in order to facilitate mobilisation January – March 2017.

1.4 NHS England have indicated that that they will issue the following guidance in September:

- activity projections for 2017/18 and 2018/19, based on historical analysis, with the expectation that CCGs commission on that basis
- operating plan guidance
- a revised national contract
- an updated acute tariff (currently out for consultation)

1.5 The plans will need to:

- Deliver all constitutional standards (for example, 18 week referral to treatment, A & E four hour target, cancer targets)
- Align with emerging Accountable Care Partnership plans
- Ensure a consistent approach to the planning round across contracts
- Improve and sustain operational performance
- Accelerate the extension of local services
- Deliver financial balance

2. APPROACH

Given the collaborative approach adopted in the development of the STP – which included over thirty organisations across the North West London footprint – we have a solid foundation for our intentions. A number of CCG leads have been identified for key workstreams:

- Finance& Activity
- STP (Commissioning Intentions)
- STP Delivery Areas
- Communications (synonymous with STP communications
- Provider Engagement Contract Standardisation
- Data Quality
- QIPP & Demand Management
- Right Care
- Governance
- NWL Priority Areas
- Primary Care (including out of hospital GP services)
- Learning Disabilities
- Mental Health
- Operating Plan (constitutional standards)

The leads are meeting weekly and a structure and governance process is being established. An indicative high level timetable is shown at Appendix 2.

3. OVER-ARCHING THEMES

The STP described the triple aim, our priorities and delivery areas: the Executive Summary slide from the STP is attached as Appendix 1.

4. ENGAGEMENT

We had lay representation on the Integration and Collaboration Working Group – the weekly multi-provider group that met across the three boroughs from May to July 2016, and included representation from the Local Authority. One task of that group was to ensure that the STP was congruent with the emerging Health and Wellbeing Strategy for Hammersmith & Fulham.

The STP was also discussed at Governing Body seminars on: 5 April, 3 May, 7 June, with Chair's action taken to approve the 30 June submission, which was then reported by the CWHHE CCG Chief Officer at the Governing Body meeting in public on 12 July.

A website was launched 17 August inviting stakeholders to give feedback on the key elements contained within the STP. It can be found at https://www.healthiernorthwestlondon.nhs.uk/news/2016/08/05/north-west-london-sustainability-transformation-plan. We have sent the link to the Patient Reference Group and to SOBUS and Healthwatch for them to share with people and organisations on their lists. An event is planned in September/October which will be an opportunity for local people to hear about the STP and to feed back thoughts and ideas. This will form part of an on-going engagement process to talk about what sits beneath the strategic headlines of the STP, ahead of submission of the next iteration in October.

5. NEXT STEPS

The Health and Wellbeing Board is asked to:

- Review and comment on the paper
- Agree how they will receive future updates as the commissioning intentions develop over the next five weeks

6. BACKGROUND PAPERS USED IN PREPARING THIS REPORT – LOCAL GOVERNMENT ACT 2000

None.

7. LIST OF APPENDICES:

Appendix 1 - DRAFT STP 30 JUNE Executive Summar
Appendix 2 - Table showing an indicative high level timetable

Appendix 1: DRAFT STP 30 JUNE Executive Summary (slide 7)

If we are to address the Triple Aim challenges, we must fundamentally transform our system. In order to achieve our vision we have developed a set of nine priorities which have drawn on local place based planning, sub-regional strategies and plans and the views of the sub-regional health and local government Strategic Planning Group. Having mapped existing local and NW London activity, we can see that existing planned activity goes a long way towards addressing the Triple Aim. But we must go further to completely close these gaps.

At a NW London level we have agreed five delivery areas that we need to focus on to deliver at scale and pace. The five areas are designed to reflect our vision with DA1 focusing on improving health and wellbeing and addressing the wider determinants of health; DA2 focusing on preventing the escalation of risk factors through better management of long term conditions; and DA3 focusing on a better model of care for older people, keeping them out of hospital where appropriate and enabling them to die in the place of their choice. DA4 and DA5 focus on those people whose needs are most acute, whether mental or physical health needs. Throughout the plan we try to address physical and mental health issues holistically, treating the whole person not the individual illness and seeking to reduce the 20 year disparity in life expectancy for those people with serious and long term mental health needs. There is a clear need to invest significant additional resource in out of hospital care to create new models of care and support in community settings, including through joint commissioning with local government.

Triple Aim		Our priorities	Primary Alignment*	Delivery areas (DA)	Target Pop. (no. & pop. segment)	Net Saving (£m)	Plans
Improving health & wellbeing	1	Support people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthy choices and look after themselves		DA 1 Radically upgrading prevention and wellbeing	All adults: 1,641,500 At risk, mostly healthy adults: 121,680 Children: 438,200 Learning Disability: 7,000 Socially Excluded	11.6	a. Enabling and supporting healthier living b. Wider determinants of health interventions c. Helping children to get the best start in life d. Address social isolation
	2	Improve children's mental and physical health and well-being					
	3	Reduce health inequalities and disparity in outcomes for the top 3 killers: cancer, heart diseases and respiratory illness		DA 2 Eliminating unwarranted variation and improving LTC management	LTC: 347,000 Cancer: 17,000 Severe Physical Disability: 21,000	13.1	a. Improve cancer screening to increase early diagnosis and faster treatment b. Better outcomes and support for people with common mental health needs, with a focus on people with long term physical health conditions c. Reducing variation by focusing on Right Care priority areas d. Improve self-management and 'patient activation'
Improving care & quality	4	Reduce social isolation					
	5	Reducing unwarranted variation in the management of long term conditions – diabetes, cardio vascular disease and respiratory disease		DA 3 Achieving better outcomes and experiences for older people	+65 adults: 311,500 Advanced Dementia/ Alzheimer's: 5,000	82.6	a. Improve market management and take a whole systems approach to commissioning b. Implement accountable care partnerships c. Implement new models of local services integrated care to consistent outcomes and standards d. Upgraded rapid response and intermediate care services e. Create a single discharge approach and process across NW London f. Improve care in the last phase of life
	6	Ensure people access the right care in the right place at the right time					
Improving productivity & closing the financial gap	7	Improve the overall quality of care for people in their last phase of life and enabling them to die in their place of choice		DA 4 Improving outcomes for children &adults with mental health needs	262,000 Serious & Long Term Mental Health, Common Mental Illnesses, Learning Disability	11.8	a. Implement the new model of care for people with serious and long term mental health needs, to improve physical and mental health and increase life expectancy b. Addressing wider determinants of health c. Crisis support services, including delivering the 'Crisis Care Concordat' d. Implementing 'Future in Mind' to improve children's mental health and Wellbeing
	8	Reduce the gap in life expectancy between adults with serious and long term mental health needs and the rest of the population					
	9	Improve consistency in patient outcomes and experience regardless of the day of the week that services are accessed		DA 5 Ensuring we have safe, high quality sustainable acute services	All: 2,079,700	208.9	a. Specialised commissioning to improve pathways from primary care & support consolidation of specialised services b. Deliver the 7 day services standards c. Reconfiguring acute services d. NW London Productivity Programme

** Many of our emerging priorities will map across to several delivery areas. But we have sought to highlight where the main focus of these Delivery Areas are in this diagram*

Appendix 2: The table below shows an indicative high level timetable

Time Line	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
STP Translation into local CCG contracting intentions	■							
Iterative versions presented to GB seminar and GB in public in Sept	■	■						
CCG Contracting intentions developed to reflect borough priorities	■	■						
Contract Notices issued for significant contract variations	■	■						
2 Year Finance and Activity profiles developed	■	■	■	■	■			
QIPP Plans developed	■	■	■					
Implications of Level 3 Delegation (Primary Care) understood	■	■	■	■	■			
Information Schedule agreed			■	■				
Quality Schedule agreed			■	■				
Prospectus & Public communications						■	■	■
Contracts Signed					■			
Contract Mobilization						■	■	■

London Borough of Hammersmith & Fulham **HEALTH AND WELLBEING BOARD** **7 SEPTEMBER 2016**	
CHILDREN AND FAMILIES ACT IMPLEMENTATION AND PREPARATION FOR LOCAL AREA INSPECTION	
Report of the Director of Education	
Open Report	
Classification - For Review & Comment	
Wards Affected: All	
Accountable Executive Director: Clare Chamberlain, Executive Director of Children's Services	
Report Author: Steve Comber, Strategy, Partnership and Organisational Development.	**Contact Details:** Tel: 07739 317 307 E-mail: steve.comber@rbkc.gov.uk

1. EXECUTIVE SUMMARY

1.1 Following the implementation of the Children and Families Act in September 2014, the Special Educational Needs Service has been working in partnership with Children's and Adults' Social Care, Health partners, Parent Carer Forums and education settings to deliver the transformation needed to implement this legislation by April 2018.

1.2 We are also preparing for an upcoming local area inspection by Ofsted and the Care Quality Commission, which will test the effectiveness of our delivery of the new legislation.

2 RECOMMENDATION

2.1 The Health and Wellbeing Board should consider the contents of this paper, particularly with regards to how their organisation can contribute to (or is effected by) the implementation of the Children and Families Act and the Local Area Inspection:

2.2 1. That the Health and Wellbeing Board consider the contents of this paper; and

2. That the Health and Wellbeing Board note the report.

3 IMPLEMENTING CHILDREN AND FAMILIES ACT CHANGE PROGRAMME

3.1 The requirements of the Children and Families Act, which came into effect from 1 September 2014, represent some of the most significant changes to the way that services are delivered for young people with special educational needs (SEN) in the past 30 years.

3.2 The changes aim to improve cooperation between **all education, health and social care services** and introduce a person-centred approach to supporting children with special educational needs and disabilities and their families

Education Health and Care Plans

3.3 'Statements' of SEN have been replaced with a new outcome focused 'Education, Health and Care plan', which may be maintained by the Local Authority for an extended age range (from birth to 25).

3.4 The decision as to whether to issue an Education Health and Care Plan is made as part of a joint assessment process which considers the education, health and social care needs of the child or young person. If a plan is required, the full 20-week assessment process is undertaken to establish the outcomes that the child or young person will be working towards, the support that is required and the resources that will deliver this.

3.5 During the first full year of operation (January 2015 – December 2015), Hammersmith and Fulham has processed 25 new Education Health and Care Plans. Of these, the national SEN2 data shows that 54.2% were completed within 20 weeks, compared with 59.2% nationally.

3.6 Local authorities have to undertake 'transfer reviews' for all children and young people who currently have statements that were issued under the previous legislation. These reviews are undertaken to establish whether an EHC Plan should be issued under the new legislation and, if required, to agree the support and resources that are included in the new plan. It is

expected that all children who have a statement of SEN will have an EHC Plan, unless the young person is no longer in education.

3.7 All transfer reviews have to be completed by April 2018 and, as of December 2015, Hammersmith and Fulham had completed 2.3% of their total, compared with a national average of 18.2%. We are currently putting additional interim resource in place to ensure that future transfer reviews are completed in a timely fashion and to a high standard.

The Local Offer

3.8 It is a statutory requirement for all Local Authorities to publish a 'Local Offer' that outlines the services that are available to children with Education, Health and Social Care needs.

3.9 Following the launch of an initial local offer as part of the LBHF website in September 2014, we have undertaken significant consultation and worked closely with parents and young people from across the borough to develop a new site, which offers clearer, more comprehensive and accessible information for children and young people with SEN and their families. The local Parent Carer Forum, Parentsactive have been a key partner in helping to develop this. The site is currently available via a soft-launch[1] with full implementation being planned for later this year.

3.10 Consultation with young people themselves is crucial for the development and improvement of our Local Offer. While we have collated feedback from local children and young people, particularly via engagement undertaken via local schools, our priority is to capture more feedback from children and young people with additional needs to ensure the Local Offer directly supports those that it is intended for. We are currently planning further engagement via schools and colleges to work with young people groups to capture their views.

Co-production

3.11 Co-production is a key aspect of the new legislation and it is the responsibility of the local authority to ensure that the views of parents and young people are included in any strategic planning and decision making.

3.12 We are committed to this approach and the development of the SEN Service has been predicated on this model. We have worked closely with the local Parent Representative Group, Parentsactive, in order to provide opportunities for parents to actively inform the development of services for children with special educational needs and disabilities. including the development of a Parent Reference Group, which was set up in April 2014.

3.13 The group contains representatives from local support groups for parents of children with disabilities along with employees from the Information Advice and Support Service and Independent Supporters from third sector

[1] http://search3.openobjects.com/kb5/lbhf/fis/localoffer.page?localofferchannel=0

organisation, Barnado's. This group has been instrumental in enabling parents to contribute to the development of new systems for the delivery of the Children and Families Act. The feedback of parents has been helpful in shaping the local implementation of the Act since September 2014.

3.14 An example of where the group has been particularly effective has been the development of the initial online Local Offer of services for children with special educational needs and disabilities and subsequent feedback that has enabled us to continually work on improving the presentation and quality of information that is provided on this.

3.15 Members of the group have also recently provided feedback from the first cohort of parents and young people to have gone through the new joint education, health and care assessment process.

3.16 Furthermore, our practice when assessing young people and drafting their Education Health and Care Plans has been designed to incorporate an individualised co-production approach. This includes the scheduling of 'drafting meetings' whereby parents, carers and young people come together with key workers to discuss the outcomes that they would like to achieve and the best means by which these can be achieved within the local offer.

Working with schools, colleges and other educational settings

3.17 Schools are key partners in supporting the local authority to implement the reforms. Although we have headteacher representation on the Children and Families Act Executive Board and on the new multi-agency decision making panels, we still need to ensure that the 150 schools across the three boroughs are informed about the changes and able to implement new processes effectively.

3.18 The SEN Service has developed a toolkit for local schools and education, health and social care practitioners. This explains the new Education, Health and Care assessment processes and has been well received.

3.19 Training has been delivered to SENCOs, Special School Headteachers and key workers around person centred approaches to planning and this is being embedded via a peer-to-peer training model.

3.20 Furthermore, under the requirements of the Children and Families Act, all schools are required to publish an SEN Information Report, which outlines how they identify, support and monitor the progress of children with special educational needs.[2] It is the responsibility of school governors, the senior leadership team and school SENCO to ensure that the report is made available on the school website and that it is updated annually. When the requirement for the development of the report was announced, the local authority provided guidance to schools and SENCOs regarding how the report

[2] For the regulations regarding this report, please follow this link: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/251874/Consultation_on_draft_0_to_25_Special_Educational_Needs__SEN__-_SEN_information.pdf

could be structured, but we are aware that more work is required to continue improvements in this area.

4 JOINT COMMISSIONING STRATEGY

4.1 A Commissioning Strategy is being developed as part of a joint commissioning project with Children with Disabilities Services, Health and Adult Social Care. The work to develop the SEN strand of this strategy has been supported by the Management Consultancy, Ernst and Young.

4.2 The work to develop the SEN Commissioning Strategy was driven by data analysis, qualitative discussion and feedback from the service and the outputs of previous and/or existing projects and reviews.

4.3 Delivery of this work was split into three strands:

- Initial high level assessment of key service areas
- Analysis of current and projected future demand for services
- Development of a Commissioning Strategy to identify opportunities in response to the identified demands

4.4 The analysis, undertaken by Ernst and Young for the SEN Service, highlighted the following key priority areas for focus across, Hammersmith and Fulham, Kensington and Chelsea and Westminster around demographics, the type of needs and cost of provision:

- The proportion of the SEN cohort at secondary age will increase over five years. The number of 11-15 year olds will grow by 18% by 2020
- Autistic Spectrum Disorder is the primary need for 29% of all current statements / EHCP and demand for this support will remain high
- Speech, Language & Communications Needs in Three Boroughs is double the national proportion of statements / EHCPs
- Independent and non-maintained school provision outside of the local area costs 3.5 times more than state funded local provision

4.5 On the basis of these key priority areas, opportunities are being developed on the basis of the following priority areas:

- Increased demand
- A wider age range
- Autism spectrum disorder needs
- Speech Language and Commination needs
- High cost places

4.6 We are currently finalising the plans for taking these opportunities forward jointly with colleagues in Health and Adult Social Care. The identified priority areas to be addressed are as follows:

- Therapies (Speech and Language Therapy, and Occupational Therapy)
- Early Identification Pathways
- Personal Budgets
- SEN Outreach
- Externally commissioned short breaks
- Residential placements

5 TRANSITION TO ADULTHOOD

5.1 The extension of some Education Health and Care Plans to the age of 25 means that there is a need for local authorities to quantify the number of young people in a local area who are approaching transition at 16 and at 19 years of age and will qualify for an Education Health and Care Plan and, on the basis of this demand, will need to develop the education, health and social care local offer to support the transition to adulthood, including planning for young people's employment and independence in or near their local community.

Planning for adulthood

5.2 In order to ensure that the Special Educational Needs Service, the Children with Disabilities Service and Adult Social Care are working together in order to develop robust transition plans for all young people age 14 and above, a Young Person's Tracking Meeting has been established. The meeting will review cases across Hammersmith and Fulham as well as Kensington and Chelsea and Westminster. The key activities the group are as follows:

- To identify all young people who are aged 13-25 years old and may be eligible for adult's services
- To identify what services young people may be requiring and to identify gaps in service provision and ensure that these are considered in strategic planning
- To ensure that the health needs of young people in transition are planned for and ensure they have a Health Action Plan, or Continuing Healthcare assessments, as appropriate.
- To ensure that young people get advice and or support from an appropriate resource
- To establish eligibility for specialist adult services in line with the Care Act 2015

Developing local employment opportunities for young people with special educational needs and disabilities

5.3 An internal working group has been established across Children's Services, Adult Social Care and Public Health to agree Terms of Reference and key milestones for a Supported Employment Provider (SEP) Network.

5.4 Membership of the SEP Network will include parent/carers, Schools, Colleges, Supported Employment Providers, Job Centre Plus, Housing, Economic Development, Volunteer Centre and Education Business Partnership and first meeting to take place at end of July 2016.

5.5 Four key priorities for the SEP Network will be;

- Developing a 'Supported Employment Pathway' on the Local Offer (who to go to get support in looking for a job, benefits advice whilst working and job coaching support). This work will be developed with young people and their families.
- Finalising the Supported Employment Strategy across Education, Health and Adult Social Care
- Developing data systems and recording processes for all education and training providers which enable us to give a meaningful and accurate picture of numbers of young people with SEND into employment and of our improvement year on year
- Jointly develop performance indicators for all providers involved in the supported employment pathway so we can continue to improve our Local Offer for young people with SEND and their families

5.6 Progress to date;

- We have a new provider - Alexandra College (based in Camden, providing a regional offer) which provides an education pathway for young people with more complex needs to support the development of skills for independence and enabling access to opportunities for supported employment whenever possible.
- Queensmill, a special school in Hammersmith for children with autism, will be extending its recent 19-25 years education pilot offer from September 2016. This will be delivered at Options Day Centre and will jointly develop their work experience and internship model to benefit both young people with complex autism and the adults utilising the Day Centre.

5.7 Furthermore, a supported internship scheme has been set up by the Council. This scheme has created six job role opportunities across the Council initially in a 12-month programme entitled the Supported Employment Initiative. This programme will support LBHF residents, aged 18-25 into employment, from September 2016.

5.8 The Supported Employment Programme will provide a structured study programme, initially for six young people with Special Educational Needs and/or Disabilities with an Education, Health and Care Plan (EHC). The young people have been identified at a recruitment event at Ealing, Hammersmith and West London (EHWL) College.

5.9 The majority of the learning will take place in the workplace (4 days a week) with support from Job Coaches (employed by Action on Disability) and will be aligned to a complementary programme of study provided by EHWL (1 day a week).

6 PREPARING FOR THE LOCAL AREA INSPECTION OF PROVISION FOR 0-25 YEAR OLDS WITH SEND

Context

6.1 Following the implementation of the Children and Families Act, the Department for Education has requested that Ofsted and the CQC inspect local areas on their effectiveness in fulfilling their new duties. The inspections are resourced by additional funding provided specifically for the purpose and are part of the DfE's broader national accountability framework.

6.2 The inspection is **not** an inspection of individual providers or settings but rather makes a judgment on how well education, health and social care services work together as a 'local area', to improve outcomes for children and young people aged 0 – 25 years with a special educational need and/or disability. As such it incorporates a wide range of stakeholders including early years settings, schools & colleges, community and specialist health services, the Disabled Children's Team and third sector organisations.

6.3 Furthermore, it is not just an inspection of the provision for young people with EHC Plans, but will encompass the offer for young people with broader needs for SEN support – including the impact of Early Intervention Provision in the local area.

6.4 The current arrangements are that an inspection team of three inspectors (1x Ofsted, 1x CQC and 1x Local Authority Peer) will be on site for five days. There will be a five-day notice period for an inspection, with the following arrangements for an announcement:

- The lead HMI will normally contact the local authority's director of children's services (DCS) by telephone to announce the inspection. This notification call will normally take place between 9am and 10am. The lead HMI will make arrangements to speak with the director's nominated officer for the inspection as soon as possible in order to make the necessary arrangements for the inspection. The nominated officer should be the single point of contact for the lead HMI. Together, they will manage the coordination of the inspection.
- Once the lead HMI has contacted the local authority, the CQC inspector will contact the chief executive(s) of the clinical commissioning groups (CCG) to inform them of the inspection and to make necessary arrangements for the local health services' contribution to the inspection.

6.5 The inspection will not result in a graded judgement. Instead, the local area will receive a narrative report of what is working well and what needs to improve. This report will name specific organisations, such as the LA, the CCGs and other local stakeholders if necessary.

6.6 The focus of the inspection is threefold:

1. How effectively does the local area identify children and young people who are disabled and/or have special educational needs?
2. How effectively does the local area assess, plan for and meet the needs of these children?
3. What is the evidence that services are having a positive impact on improving outcomes for these children and young people and helping them making a successful transition to adult life?

6.7 These judgements are to be made about the performance of the local area since the implementation of the reforms in September 2014.

6.8 We are currently in a five-year cycle of inspections, and the expectations on the progress that local areas will have made will increase between 2016 and 2021. The table below sets out how the DfE propose to measure success at a national level:

	Positive experience of the SEND system for children, young people and their families	**Positive outcomes for children, young people and their families**	**Effective preparation for adulthood**
What does success look like?	- Parents, children and young people get right support at right time; feel that they are listened to and in control - Planned and well-managed transition at key points - A joined-up, transparent and accountable system	- Improved progression and attainment at all ages - Clear and appropriate expectations and aspirations leading to fulfilled lives - More resilient families	- Increased employment - Choice and control over living arrangements / Independent living - Participation in the community - Health outcomes based on need and aspiration
Examples of data and intelligence	- SEN appeals and outcomes - Education, Health and Care Plans (EHCPs) completed on time - Local authority and parent survey data - Children and young people's Personal Outcomes Evaluation Tool (POET) pilot - Feedback from Independent Supporters	- Attainment data - Outcomes for looked after children - Destinations after Key Stage 4 & Key Stage 5 - School absence and exclusion rates	- Employment status for adults with learning difficulties and disabilities (LDD) - Accommodation status for adults with LDD
When do we expect to see an impact?	**Short/medium term:** From Sept 2014 to Sept 2017	**Medium/long term:** 3 to 5 years' time	**Fully emerge:** 5 to 10 years' time

6.9 Inspectors will start the inspection expecting that the local area has a good understanding of how effective it is, including of any aspects of its responsibilities that require further development.

6.10 Inspectors will test out the evidence that the local area uses in its **self-evaluation of how effectively it meets its responsibilities**. Inspectors will report where evidence collected during the inspection supports the area's own evaluation, and where this is not the case. They will also report on where the local area does not have a good enough understanding of its effectiveness in identifying needs, and in meeting these needs and improving outcomes.

Local preparation

6.11 Work is underway to prepare for the SEND Local Area inspection including:

- The establishment of a SEND Quality Assurance Board to oversee the local implementation of the Children and Families Act, and planning for inspection. The Board includes representation from service mangers and commissioners across children's and adults Health and social care, Head teachers and parent representatives.
- An analysis of the risk of an early inspection of the local area based on current performance against key indicators set out by Ofsted/CQC: results of previous inspections, educational and other outcomes for children and young people with SEN, rates of attendance and exclusion, success in meeting statutory timescales for assessment and level of appeal to tribunals.
- Assurance of key datasets about children and young people with SEN or a disability and defining clear procedures and responsibilities during the inspection process.

6.12 The priority over the coming months is to build our understanding of the strengths and areas for improvement in services for children with special educational needs and/or disabilities:

- Producing a summary self-evaluation of effectiveness and ensuing action plan for each borough. We will consult on this with key stakeholders including parents' groups, schools and health partners.
- Working with parents and carers to review how well current arrangements support their meaningful involvement in decisions about local services as set out in the Children and Families Act.

6.13 A dedicated project manager is in place (working within the wider Children and Families Act Implementation Programme) to manage the preparation for the inspection.

6.14 Preparation is proceeding on the assumption that all three boroughs will be inspected at the same time (to be confirmed) and that we will need to plan on this basis, whilst ensuring that we maintain a focus on the particular strengths and weaknesses in each borough.

7 EQUALITY IMPLICATIONS

7.1 As this report is for information only, there are no equality implications to be considered at this stage.

8 LEGAL IMPLICATIONS

8.1 As this report is for information only, there are no legal implications to be considered at this stage.

9 FINANCIAL AND RESOURCES IMPLICATIONS

9.1 As this report is for information only, there are no financial and resources implications to be considered at this stage.

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

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

LIST OF APPENDICES:

None.

London Borough of Hammersmith & Fulham **HEALTH AND WELLBEING BOARD** **07 SEPTEMBER 21016**	
HAMMERSMITH & FULHAM TACKLING CHILDHOOD OBESITY TOGETHER UPDATE AND ANNUAL REPORT	
Report of the Director of Public Health	
Open Report	
Classification - For Information **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: Eva Hrobonova ehrobonova@westminster.gov.uk	
Report Author: Catherine Brice, Programme Manager	**Contact Details:** Tel: 020 7641 1432 E-mail: cbrice@westminster.gov.uk

1. EXECUTIVE SUMMARY

1.1 The attached annual report outlines the progress and achievements of the]Tackling Childhood Obesity Together (TCOT) Programme during its first year. The Health and Wellbeing Board are asked to note and sign off the report so it can be published on the JSNA website.

2. RECOMMENDATIONS

That, the Health and Wellbeing Board consider and agree the attached annual report for publication on the JSNA website; and

That, the Health and Wellbeing Board celebrate the success of the initiatives to date and further publicise the good news and the services.

3. REASONS FOR DECISION

3.1. Publication of the annual report is required to be published on the JSNA website.

4. INTRODUCTION AND BACKGROUND

4.1 Childhood obesity is one of the most serious public health challenges of the 21st century. An estimated 4000 children between the ages of 4 – 15 are currently obese in LBHF. Obese children are at an increased risk of developing social, psychological and other health problems, with 79% of obese children becoming obese adults resulting in long term personal ill health, lower life expectancy, social stigmatisation, lower chances of employment, increased social care costs, reduced productivity and increased sickness absence.

4.2 Drawing on local, national and international evidence, the five year Tackling Childhood Obesity Together programme (TCOT) has been designed to systemically address the wide range of contributory factors. The approach crosses the whole system of our society, its environment and its culture and involves a partnership between local government and the NHS and the science, business and community sectors. It encompasses all children and family public health services relevant to nutrition provided previously across the three boroughs such as Healthy Start and Healthier Catering and works particularly closely with relevant partner services such as Healthy Schools, School Nursing and Health Visiting to maximise effect and avoid duplication of effort.

4.3 The key aim of the programme is to halt and reverse the rising trend in childhood obesity across the three boroughs. In 2015/16 it had the following three components:

- **Family healthy weight services** - the implementation of a family healthy weight care pathway, workforce training and family healthy lifestyle services across the three boroughs, led by the London Borough of Hammersmith and Fulham (LBHF).

- **Whole system approach** - working with internal partners within Westminster City Council (WCC) and external partners across Westminster to change the environment so that healthy choices become easy choices for residents.

- **Community healthy lifestyle pilot** - a community-led healthy lifestyle project, Go Golborne, focusing on the ward of Golborne in the Royal Borough of Kensington and Chelsea (RBKC).

5. PROPOSAL AND ISSUES

5.1 Approval is sought to proceed with publishing the TCOT Annual Report on the JSNA website.

Update on Hammersmith and Fulham Healthy and Fit

5.2 Progress has been initiated with an analysis of existing locations suitable for an "outside green gym" which resulted as the winning idea of the community led event "Hackathon".

5.3 Following a successful recruitment campaign a suitable candidate has been identified to lead on delivery of the Hammersmith and Fulham whole community approach to health and fitness.

5.4 Initial designs and ideas have been put forward for what the outside gym could involve and how it can be launched with a potential sports day event for the whole community to be involved.

Update on community healthy lifestyle pilot

5.5 A bespoke pilot project has been initiated in the Golborne ward of RBKC to test a system-wide multi-strategy approach to tackling childhood obesity with the view of establishing a transferrable model of effective community-based intervention. Entitled 'Go Golborne' the healthy lifestyle initiative launched across the Golborne area of RBKC in May 2015 to increase opportunities for children and families living in and around the Golborne area to eat well and keep active. It aims to engage the local community in supporting consistent and best practice approaches to healthy eating and physical activity in all settings where children and families live, learn and play.

5.6 Go Golborne has a unique methodology that has been developed in line with research evidence on what is needed to effectively prevent childhood obesity at a local level. The model is being developed and piloted in Golborne with a view to extending its reach to other areas once we have gained sufficient insight into its impact and effectiveness. Key activities include:

5.7 A communication campaign across the area that uses social marketing techniques to promote key messages about healthy lifestyles and relevant local services. This includes a website, Twitter stream, local events, and the wide dissemination of posters, postcards and other bespoke information resources across the local area A comprehensive 5ADAY fruit and vegetable campaign took place across the area between November 2015 and March 2016, and a campaign entitled Unplug & Play will launch later in July to encourage children to reduce the amount of time they spend on screens and promote physical activity and active play (for details see www.rbkc.gov.uk/gogolborne).

5.8 Training and professional development opportunities for staff and volunteers from local agencies. A multi-agency network of local voluntary and statutory organisations has been established and meets regularly to share good practice, promote relevant services and events, and help inform the development of Go Golborne campaigns.

5.9 A scheme of small grants for local organisations to support activities and events that focus on promoting healthy eating and physical activity. So far over £10,000 has been invested in local organisations to run activities to increase access to fruit and vegetables and awareness of the 5ADAY message. This includes food growing activities, family cooking workshops, themed story and craft sessions, and pop-up healthy snack stalls.

5.10 Capacity building work with local schools including additional input from school health professionals, an extended National Child Measurement Programme (NCMP), small grants to support the implementation of Healthy Schools plans and the promotion of Go Golborne campaigns across the school community. This has enabled schools to invest in a range of complementary activities and equipment including new cookery kits, pedometers to enhance 'walk to school' activities, and external input from the Food Explorers and to run healthy eating events.

5.11 Collaborative work with other council departments to maximise links with existing services and explore opportunities to use policy levers to create healthier environments for children and families i.e. targeting fast food outlets in Golborne for the Healthy Catering scheme led by Environmental Health, and working with RBKC Markets to encourage market traders to start accepting Healthy Start vouchers for fruit and vegetables.

5.12 To give focus to this broad and ambitious programme of work a different 'headline' theme is being introduced every six months to frame activities, alternating between one focused on healthy eating theme and one focused on physical activity.

5.13 A close research partnership has been developed with Academic partners from the University of Kent to systematically measure and evaluate progress. The University will be producing their first report in October 2016, which will include an overview of initial progress, outcomes, and initial thoughts on how the model could be adapted/ replicated in other areas of the borough.

<u>Update on whole-system approaches</u>

5.14 This strand of work has initially been focused in Westminster and aims to embed a whole-council approach and cross-department commitment to tackle childhood obesity and create healthier environments for children and families. Wider societal and environmental changes are vital to enable families to put healthy lifestyle messages into practice, sustain newly learned behaviours, and help make healthy choices easy choices.

5.15 The council's statutory responsibility for improving the health and wellbeing of residents is a collective responsibility that requires improved coordination and joint working across all departments. We are tackling the 'obesogenic'

environment by working gradually with every council department to consolidate and strengthen activities that contribute to the prevention of childhood obesity by:

- Understanding work already underway across the council that contributes to preventing childhood obesity;
- Identifying actions to be included in departmental business plans to deliver the corporate strategy;
- Understanding the areas where the council currently has limited control or opportunity to influence; and
- Identifying opportunity areas for further development.

5.16 So far this work has led to the following activities: Strategic work with WCC's sports, leisure and wellbeing team to maximise physical activity opportunities for children, with a particular focus on areas in the borough with higher levels of deprivation and obesity. This includes ensuring children have access to at least one hour of physical activity a day (part of the Active Westminster Strategy (2015-2020)). A range of competitive opportunities have been made available to primary and secondary schools, including festivals and multi-skill fun days that promote engagement and participation in physical activity. Plans to develop a 'Westminster Standard' for participation in PE and school sport and further development of the Active Westminster passport scheme to engage more children from target areas.

5.17 Strategic work with the Environmental Health Service to extend the reach and impact of the Healthy Catering Commitment.

5.18 The Healthier Catering Commitment aims to supports food businesses to make straightforward changes to ingredients and preparation techniques in order to offer healthier food to customers. To date, 19 businesses have successfully achieved Healthier Catering Commitment status and there is an agreed target of awarding a further 20 businesses with the Healthier Catering Commitment award in 2016/2017. The introduction of a tiered scheme will be explored to encourage businesses to achieve the highest standard.

5.19 Work with the Transport, Planning and Housing team to develop new food growing schemes in regeneration areas. Three schemes have been initiated to develop sustainable and well-utilised garden resources to grow fresh produce and improve skills, knowledge and confidence in food growing, with a particular focus on children and families. Building on the success of these school and estate-based projects, options are currently being considered to develop a borough-wide food growing programme.

5.20 Learning from this work across Westminster City Council will directly inform plans to develop similar work across RBKC and LBHF in 2017/2018.

5.21 To ensure quality assurance of our innovative programme we have applied for and become the first local authority in England to gain membership of the prestigious EPODE European network of cities and places that systematically address childhood obesity. This membership offers learning and networking opportunities that enrich our programme and establishes our reputation as a borough that systematically addresses one of the most pressing global public health issues.

6. CONSULTATION

6.1. All of the initiatives are underpinned by research, evaluation and evidence. Our approach crosses the whole system of society, its environment and its culture and involves partnership between local government, the NHS and the science, business and community sectors. It encompasses all relevant children and family public health services. We work particularly closely with relevant partner services such as Healthy Schools, School Nursing and Health Visiting to maximise effect and avoid duplication of effort.

6.2. It is our intention that the TCOT programme is, where possible, evidence basedand that when evidence is lacking, the programme will generate evidence locally. With this in mind, we are piloting different approaches in different boroughs and using our learning to inform practice as the programme progresses.

7. EQUALITY IMPLICATIONS

7.1 Not applicable.

7.2 Implications verified / completed by report author.

8. LEGAL IMPLICATIONS

8.1 Not applicable.

8.2 Implications verified / completed by report author.

9. FINANCIAL AND RESOURCES IMPLICATIONS

9.1 Not applicable.

9.2 Implications verified / completed by report author.

10. IMPLICATIONS FOR BUSINESS

10.1 Not applicable.

10.2 Implications verified / completed by report author.

11. RISK MANAGEMENT

11.1 Not applicable.

11.2 Implications verified / completed by report author.

12. PROCUREMENT IMPLICATIONS

12.1 Not applicable.

12.2 Implications verified/ completed by report author.

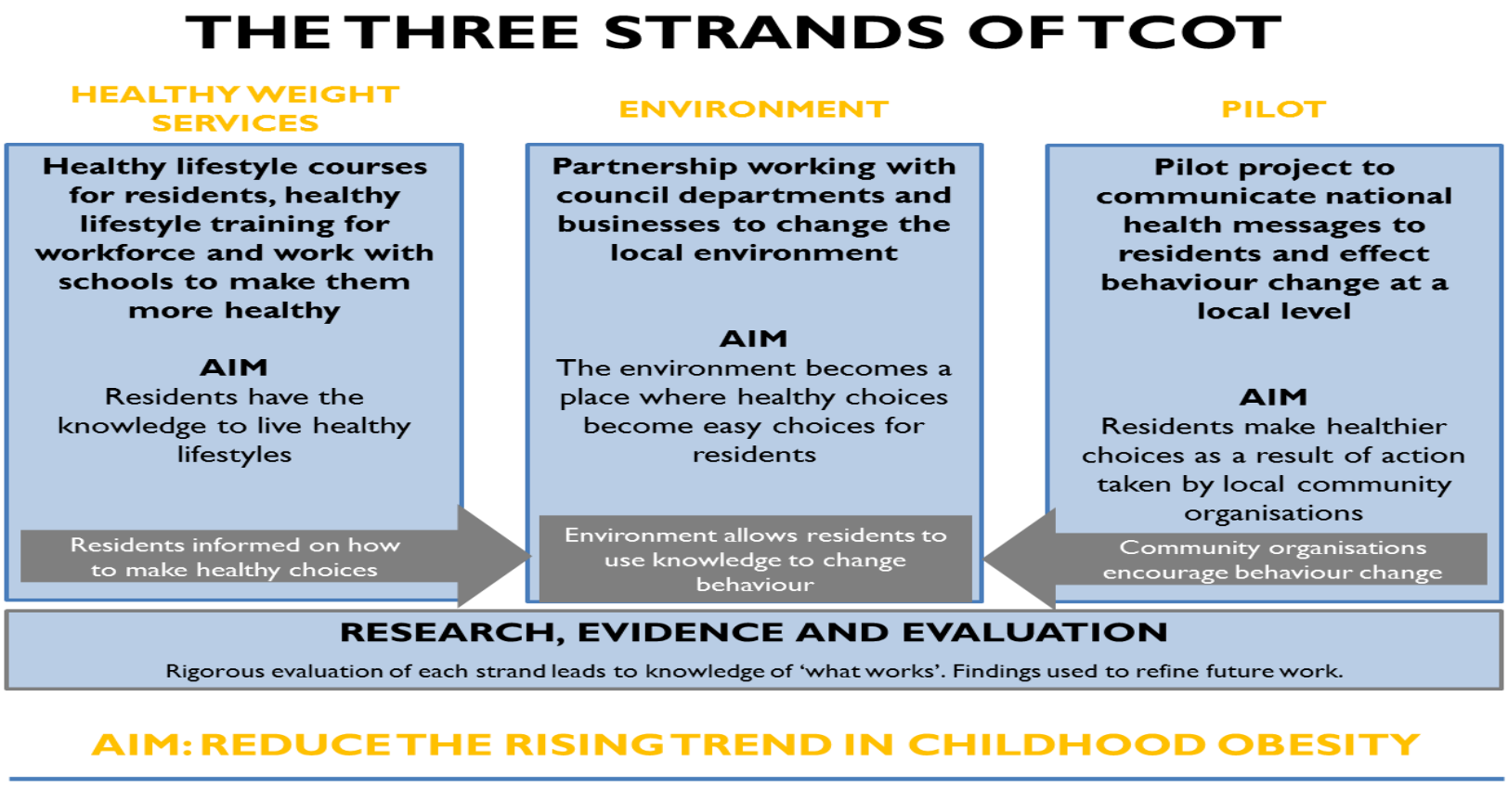
13. IT STRATEGY IMPLICATIONS

13.1 Not applicable.

14. LIST OF BACKGROUND PAPERS – LOCAL GOVERNMENT ACT 2000

14.1 None.

The three strands of TCOT 2015/16



Tackling Childhood Obesity Together

ANNUAL REPORT

2016

Produced by the Public Health department covering the London Borough of Hammersmith and Fulham, the Royal Borough of Kensington and Chelsea and the City of Westminster

Tackling Childhood Obesity Together (TCOT)

ANNUAL REPORT, 2016

Produced by the Public Health department covering the London Borough of Hammersmith and Fulham, the Royal Borough of Kensington and Chelsea and the City of Westminster

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June 2016

CONTENTS

Introduction

The World Health Organization (WHO) regards childhood obesity as one of the most serious global public health challenges for the 21st century. There are a number of potential health consequences associated with childhood obesity including impacts on mental health, type 2 diabetes and the likelihood of continuing obesity into adulthood, which is linked to a range of unfavourable health conditions. The current UK government is committed to publishing its childhood obesity reduction strategy, which is expected in the summer of 2016. Speaking on the subject in February 2016, Health Secretary Jeremy Hunt said "we have got to do something about this. I've got a one-year-old daughter, and by the time she reaches adulthood a third of the population will be clinically obese. One in 10 will have type 2 diabetes. It is a national emergency."

Across the boroughs of Hammersmith and Fulham, Kensington and Chelsea and Westminster nearly one in four children in reception (four to five-year-olds) and one in three children in year six (10 to 11-year-olds) are overweight or obese (National Child Measurement Programme (NCMP) 2014/2015). Each council is committed to tackling childhood obesity and as such the five year Tackling Childhood Obesity Together programme (TCOT) has been developed.

With no single effective solution identified to tackle childhood obesity, TCOT, drawing on local, national and international evidence, has been designed to systemically address its wide range of contributory factors. The approach crosses the whole system of our society, its environment and its culture and involves a partnership between local government and the NHS and the science, business and community sectors. It encompasses all children and family public health services relevant to nutrition provided previously across the three boroughs such as Healthy Start and Healthier Catering and works particularly closely with relevant partner services such as Healthy Schools, School Nursing and Health Visiting to maximise effect and avoid duplication of effort.

Introduction

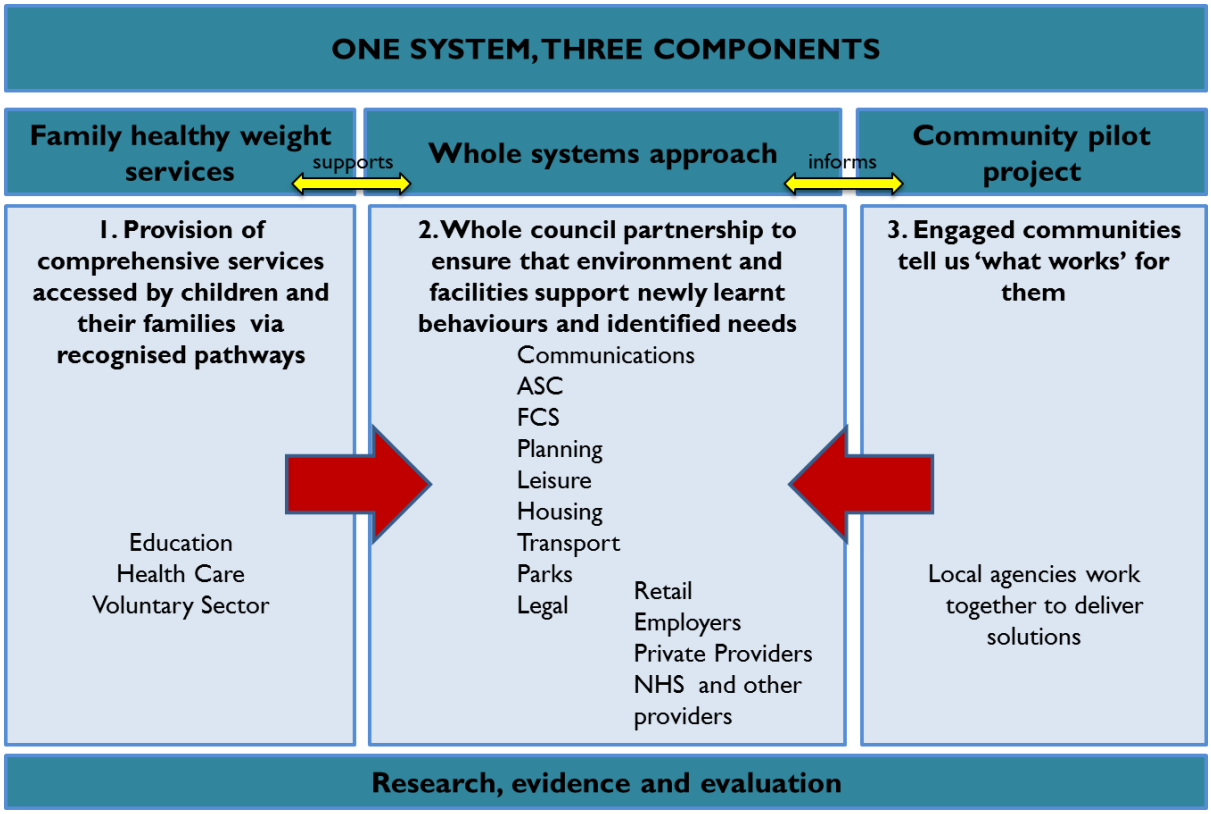
Figure 1: Vision of the TCOT programme

The key aim of the programme is to halt and reverse the rising trend in childhood obesity across the three boroughs.

It has three components:

- Family healthy weight services - the implementation of a family healthy weight care pathway, workforce training and family healthy lifestyle services across the three boroughs, led by the London Borough of Hammersmith and Fulham (LBHF).
- Whole system approach - working with internal partners within Westminster City Council (WCC) and external partners across Westminster to change the environment so that healthy choices become easy choices for residents.
- Community healthy lifestyle pilot - a community-led healthy lifestyle project, Go Golborne, focusing on the ward of Golborne in the Royal Borough of Kensington and Chelsea (RBKC).

Figure 2: The relationship between the three components of TCOT



These three programme components operate in close synergy and lessons learned are transferred and utilised across the three boroughs as they emerge. It is envisaged that, during the lifespan of the programme, different boroughs will test different approaches while rigorously evaluating them to inform future implementation of effective elements across the local geography to gradually achieve marked change in the environment, social norms and behaviours. We believe our approach is innovative, comprehensive and evidence-based where evidence exists.

Due to its comprehensive methodology, in November 2015 TCOT became the first UK local authority intervention to be accepted as a member of the EPODE International Network, a global network of community-based obesity prevention programmes.

This report describes the progress that has been made during the first year of the programme.

Eva Hrobonova, Deputy Director of Public Health

FAMILY HEALTHY WEIGHT SERVICES

INTRODUCTION

Aim and summary

The aim of the family healthy weight services is to ensure that children and families in need are motivated and able to attend evidence-based, appropriate and acceptable preventative services to improve their chances of maintaining or regaining a healthy weight. With this in mind, a significant investment has been made by all three councils in a number of healthy lifestyle services for local families and a programme of workforce training and development. Additionally two care pathways have been designed in wide partnership to facilitate access, knowledge and uptake of these services.

What evidence is there to suggest that this approach will help to reduce childhood obesity?

The evidence base for childhood obesity prevention services for children aged up to 12 years is well established and includes the comprehensive Cochrane review[1], the Foresight report[2], the McKinsey report, Overcoming obesity: An initial economic analysis[3] and the National Institute for Health and Care Excellence's (NICE) guidance on nutrition and physical activity. In April 2014, the public health department covering Hammersmith and Fulham, Kensington and Chelsea and Westminster completed and published the Child Obesity Prevention and Healthy Family Weight Services Review [4], which clarified that service provision, as it stood then, was inadequate and unequal and that there was no overlap or duplication of relevant provision from any other part of the organisation/s. It also pointed out that a gap in evidence exists for teenage obesity prevention interventions, despite a clearly identified need for services targeted at this age group.

Findings from both the Child Obesity Prevention and Healthy Family Weight Services Review and the locally conducted 2013-14 Children and Families' Early Help Services' Compare and Contrast Review reinforced the need to include outreach services and taster activities in local community settings to engage more vulnerable children and families and to increase access to services.

The Child Obesity Prevention and Healthy Family Weight Services Review also highlighted the need to develop an integrated childhood obesity care pathway with clinical commissioning groups (CCGs) and health service providers to generate appropriate referrals to services. Additionally, the review identified a need to improve the skills of the children's, NHS and other family service providers' workforce in understanding obesity prevention, motivational interviewing and delivering brief health promotion.

[1] Waters et al (2011), *Interventions for preventing obesity in children (Review), The Cochrane Collaboration*

[2] Butland et al (2007), *Tackling Obesities: Future Choices – Project Report, Government Office for Science*

[3] Dobbs, R and Sawers, C et al (2014) *Overcoming obesity: An initial economic analysis, discussion paper, McKinsey Global Institute*

What process was taken to develop the approach?
Initially, a review of current service provision of the public health department, which included an evaluation of current service provision, a health needs analysis, mapping of relevant activities and a consultation exercise, was undertaken. This resulted in the publication of the Child Obesity Prevention and Healthy Family Weight Services Review.

This review, together with evidence of the size of the problem locally, was shared with lead politicians to establish childhood obesity prevention as a local priority for action. This has resulted in a mandate to plan and commission local services that will have the capacity and ability to effectively address the issue of individual behaviour change. It was also acknowledged that to maximise the effect of these interventions locally and to gain return on our investment, changes to the wider living environment and relevant policies will need to happen simultaneously.

In line with the evidence base, a holistic approach was taken to design the new services. This process brought together a number of essential partners and stakeholders to design locally tailored services procured through an open, competitive tendering exercise where quality of service was the paramount consideration. The successful service provider, MyTime Active (a social enterprise that currently delivers lifestyle preventative health services across the UK), commenced delivery of these services on 1st August 2015 under a three year contract.

A range of stakeholders from the public health and children's services departments that cover Hammersmith and Fulham, Kensington and Chelsea and Westminster, local CCGs, acute and community NHS trusts, obesity prevention and weight management services and consumer champions, Healthwatch, worked together to produce a holistic, evidence-based and system-wide care pathway to maximise appropriate referrals and uptake of the new services. Engagement with these stakeholders ensured their sense of ownership of the pathways, as well as their familiarity with the referral process.

MEND (MIND, EXERCISE, NUTRITION…DO IT!)

Aim and summary

Following the Child Obesity Prevention and Healthy Family Weight Services Review in 2013/14, a range of new childhood obesity prevention and family healthy weight services have been commissioned by the public health department in close collaboration with the children's services department and local CCGs from across Hammersmith and Fulham, Kensington and Chelsea and Westminster. These aim to:

- Address the inequitable provision of services across the area.
- Provide effective evidence-based services to support families to make healthier choices for their children and themselves.
- Increase access to services through outreach activity to engage more vulnerable children and families in greater need.
- Ultimately result in a greater proportion of local children and families with a healthy weight.

The commissioned services delivered by MyTime Active are part of its MEND (Mind, Exercise, Nutrition…Do it!) programme and include:

- MEND Mini and MEND Mums - a universal tier-one parent and child obesity prevention course delivered in community settings to assist children aged up to four to maintain a healthy body mass index (BMI).
- MEND 5-7 and MEND 7-13 - an accessible tier-two family healthy lifestyle child weight management course to assist children and young people aged between five and 12, who are on or above the 91st BMI centile, to reach and maintain a healthier BMI.
- MEND in Schools - an intensive programme of activities for primary schools whose pupils have a higher risk of obesity involving all children in years one and four and their parents.

The above services aim to support families to make healthier choices easier through fun, interactive courses with sessions that cover healthy eating, physical activity and behaviour change in order to establish healthy patterns of eating and physical activity during the formative years. A pilot tier-two service for children aged 13 and over, to be co-designed by young people, is also planned.

These services are underpinned by a comprehensive workforce development programme and support to deliver the Healthy Schools and Healthy Start programmes and the Healthier Catering Commitment as described on pages 18-20.

Evidence of need

The number of places on MEND courses available to residents is based on the number of children in each borough (see Table 1 below). The courses for children aged up to four and their parents/carers were modelled on providing places for 30% of resident children and their parents/carers by the end of the third year of delivery. The courses for

Case study – MEND Mini

The MEND Mini course teaches parents creative ways to encourage children to taste and enjoy fruit, vegetables and other healthy snacks and to take part in active play. Each week children enjoy crèche-style activities while adults take part in discussion; topics include fussy eating, portion sizes and positive parenting. The following quotes, taken from parents who attended the course, demonstrate the positive impact of the programme:

- *"I now have more ideas for playing with Louis and I have gained good and interesting advice on nutrition. Louis now initiates games from MEND, such as walking like giants and crabs, at the park with his dad. I had to explain to Louis' dad what he was doing!"*
- *"I totally recommend MEND Mini! I have already recommended it to two other people. It's a really interesting programme and my child is always learning new things when we come to the programme. The children learn fun games and they develop new skills. I now use the traffic light game at street crossings to help Mikey follow commands."*

children aged 5 to 13 were modelled on providing places for 70% of children identified as obese by the NCMP by the end of the third year of delivery. Place numbers for both sets of courses increase each year to reflect the time it will take to generate demand to fill places.

Table 1: Projected numbers of places on MEND courses by the end of the third year of delivery

Local authority	Children aged 0-5	30% of one year group	Children aged 6-12	Children identified as obese annually in reception and year six classes (NCMP)	70% of children identified as obese annually in reception and year six classes (NCMP)
LBHF	13,854	831	1,642	469	328
RBKC	10,827	649	1,268	362	253
WCC	14,797	887	1,931	552	386

For more detail on the evidence of need and effectiveness of the chosen interventions, see page 9.

Process
The process of needs assessment, political support, wider stakeholder engagement, service design, procurement and implementation is described in detail on pages 10-11.

Benefits
To date, six months after the new services commenced, the MEND courses (Mini, Mums, 5-7 and 7-13) have received overwhelmingly positive feedback from participants. 109 families participated in courses from September to December 2015. 100% of families rated the courses 'good' or 'excellent' for their suitability to their needs, for meeting their goals and objectives of positive food behaviours, increased physical activity and self-efficacy and decreased sedentary activity and were 'very likely' to recommend them to friends or relatives. There will be 21 courses, held in children's centres, schools and community centres, on offer across Hammersmith and Fulham, Kensington and Chelsea and Westminster during the forthcoming term (summer 2016).

MEND in Schools has proven popular with most available places already filled. In RBKC, all 10 places have been filled with participation from eight schools (reaching 444 children) and two more commencing in September. In LBHF, six schools (reaching 345 children) are currently participating with four more commencing in September and a further five to be recruited. In WCC, nine schools (reaching 538 children) are currently participating with four schools commencing in September and five more to be recruited. Evaluation of the impact of MEND in Schools will take place at the end of the school year with early indications showing increases in water consumption, active play and reductions in confectionery consumption.

Next steps
Efforts will focus on increasing awareness of the services among families and the children's workforce, which will help to increase referrals and

self-referrals to the programmes. Furthermore, schools will be recruited to the remaining available spaces on the MEND in Schools programme. Finally, a pilot programme for teenagers, which will be designed, delivered and fully evaluated, will be developed in full with local young people. Insight from focus groups held with young people so far indicates that the programme needs to consider the following elements:

- Choices of activity are important.
- Parental presence should be at the discretion of the participants.
- Weekend programmes would be better than weekdays.
- Tone and approach must be carefully managed and consideration should be given to whether schools are the right setting for the programme.
- Location needs to be 'safe'.
- Social media content needs to generate enough interest to warrant further self-motivated interaction.

Table 2: The key milestones for family healthy weight services from years one to three

	Year 1	Year 2	Year 3
0-4 child obesity prevention programme places and one-to-one appointments	Maximum 900	Maximum 1,600	Maximum 2,420
5-13 child obesity treatment programme places	Maximum 384	Maximum 600	Maximum 968
Teenage pilot programme	• Focus groups and other engagement • Design of programme • Pilot first programmes in the summer term • Review of first programmes – additional co-design and adaptation	• 11 programmes delivered and evaluated • Additional co-design and adaptation	12 programmes delivered and evaluated
MEND in Schools programme	Recruitment of schools with 50% commenced by January 2016	43 schools participating	43 schools participating

Figure 3: children take part in a MyTime Active MEND physical activity session

SCHOOL MEALS

Aim and summary

The provision of free school meals is a statutory provision within the Education Act 2003. Each governing body has a duty to provide free lunches for eligible pupils and to provide the opportunity for other pupils to buy lunch. Approximately 21,000 school meals are provided daily within 112 schools through contracts managed by the Children's Services Commissioning directorate.

When the Children's Services Commissioning directorate was formed, an opportunity was recognised to undertake a shared approach to procurement for school meals across Hammersmith and Fulham, Kensington and Chelsea and Westminster. It was recognised that this process would maximise the opportunity to achieve financial efficiencies and savings relating to contract spend and delivery. Schools in the area were in support of councils procuring sovereign borough contracts on their behalf for the delivery of school meals. Schools have the opportunity to opt in to borough-wide contracts or to make their own arrangements.

Evidence of need

A successful school meal service has the potential to help children and young people enjoy their school lunches, educate their palates and embed positive eating habits for life. It will also enable them to get the most out of their learning in school by aiding concentration.

Healthy eating and being physically active are particularly important for children and adolescents. This is because their nutrition and lifestyle influence their wellbeing, growth and development. The nutritional requirements of children and adolescents are high in relation to their size because of their demands for growth, in addition to the requirements for body maintenance and physical activity.

In England only 1% of the packed lunches children bring to school meet the current school food standards. Therefore the school meal service has a vital contribution to make to the health of children and young people by improving the nutritional quality of their diet. Provision of school meals also plays a role in the overall strategy to help children maintain a healthy weight. Essential to this is not only the quality of the food and beverages available throughout the school day but also the work done to encourage the enjoyment and consumption of the whole lunch.

Schools are supported to take a 'whole school approach' to healthy eating by the Healthy Schools Partnership. A key part of that approach will be partnership working between the school and its catering provider.

Opportunities for school meal providers to contribute to health

- Maximise uptake of all school meals and free school meals in particular.
- Participation in School Nutrition Action Groups.
- Consultation with children as to how to improve the school lunch experience.

- Ensuring that children have time both to eat lunch and play by minimising queuing.
- Sharing facilities with breakfast clubs.
- Getting involved in teaching cooking skills.
- Engagement with parents to show them the school lunch, share recipes children enjoy at school etc.
- Support the national Change4Life campaign and any other relevant local campaigns.

Process
The school meals procurement was informed by the School Meals Working Party, which contained representation from schools and the public health and children's services departments. Schools were given the opportunity to shape questions on the specification, technical quality evaluation and presentation topics to best reflect local priorities. The quality factors were weighted according to their importance with a greater percentage of the allocated 40% based on meeting the specification and service outcomes to ensure that catering provision was of the highest quality and to mitigate risks associated with health and safety, food hygiene and nutritional quality. The process of evaluating the food and its quality from a nutritional point of view and to ensure adherence to nutritional guidelines was strongly emphasised and reflected by weightings. The tender evaluation process included supplier presentations as well as the sampling and scoring of set meals produced by suppliers at the 'cook-off' session.

In developing the specification, consideration was given to provision of halal and non-halal meat within menu choices. The sample menus provided reflected the racial and cultural mix of pupils, including the requirement to provide a vegetarian option every day.

Benefits
The procurement exercise has delivered the best possible outcome for schools from both quality and financial perspectives. The procurement process was extremely competitive, resulting in strong bids. The new service will provide consistently high quality meals and maximise value for money to achieve efficiencies. There has been active involvement from schools throughout the commissioning process to ensure that local priorities shape subsequent service delivery.

Next steps
Following consultation with the Schools Heads Forum and Heads Executive Group it was agreed that RBKC would be first to call-off from the Framework Agreement, followed by WCC and then LBHF. The call-off and contract start dates are January 2016, April 2016 and June 2016 respectively.

The public health department and its Healthy Schools Partnership will be working closely with the Children's Services Commissioning Directorate and the new school meals providers to maximise the opportunity these new contracts provide to drive improvements in the nutrition of children attending schools in the boroughs.

WORKFORCE DEVELOPMENT

Aim and summary

In addition to the family healthy lifestyle services detailed on pages 12-15, a second programme of work was commissioned to equip those working with children to further support efforts to tackle childhood obesity. It aims to:

- Improve settings such as schools and food outlets to make healthy choices, easy choices for children and families.
- Support the workforce to understand its role in obesity prevention and to have the skills and confidence to discuss children's weight with parents/carers, motivate them towards a healthy lifestyle and signpost them to relevant services.

More specifically, the commissioned services:

- Provide training, guidance and support to all state-maintained schools to work towards achieving the relevant Healthy Schools awards (bronze, silver or gold). The awards recognise schools for supporting the health and wellbeing of their pupils. This will be delivered in collaboration with the Healthy Schools Partnership, the organisation which administers the awards.
- Provide training, guidance and support for early years settings (nurseries, nursery classes and children's centres) to take a 'whole settings approach' to healthy eating, which includes meeting the Children's Food Trust Eat Better/Start Better guidelines. In addition they will provide support for the physical development aspects of the Early Years Foundation Stage Framework for Physical Development in order to attain the Healthy Early Years Award.
- Provide a rolling programme of training to priority members of the children's workforce on how to support children, young people and their families to achieve positive healthy eating and physical activity habits and subsequent healthy weight management. Examples of courses available include nutritional guidelines, active playtimes and cooking in the curriculum.
- Support the implementation of the Healthier Catering Commitment through the provision of specialist nutrition support.
- Provide training on the NHS's Healthy Start programme, which provides free vouchers to some pregnant women and parents of children aged up to four to buy healthy food and drink and coordinates the distribution of vitamins locally.

In addition to these commissioned services a care pathway that supports professionals to refer children to relevant services was developed.

Evidence of need

Evidence was gathered from national sources such as NICE's Obesity Prevention guidance and WHO's Population-Based Approaches to Childhood Obesity Prevention and local sources such as the Child Obesity Prevention and Healthy Family Weight Services Review and the Healthy Early Years Westbourne project in 2011-12. Findings strongly

Case study – Essendine Primary School

Essendine Primary School in north Westminster has achieved the Healthy Schools silver award for the priority area of healthy weight. MyTime Active is currently working with the school on the following activities to progress them towards achievement of their gold award:

- *Lunchbox audit – following an audit of 49 children's lunchboxes, recommendations were made to the school to improve the quality and variety of food items within them.*
- *Cooking in the curriculum – practical training sessions for school staff demonstrating how to deliver effective and safe cooking lessons.*
- *Active playtimes – practical training sessions for school staff, particularly teaching assistants and midday supervisors, to support them to encourage children to be active during play times.*

Support has been well received by teachers and pupils and the school is on track to achieve the Healthy Schools gold award this year.

indicated the need to equip frontline staff with the knowledge and skills to approach the issue of weight with families and children in an effective manner and the need to improve settings to make healthy choices easier for children and families. The previously commissioned training did not offer sufficient capacity to cover the extent of identified need. For more detail, see pages 10-11.

Process

The process of needs assessment, support and wider stakeholder engagement, service design, procurement and implementation is described in detail on pages 10-11.

Benefits

Workforce training

Up to the end of January 2016 training has been delivered to 228 people across Hammersmith and Fulham, Kensington and Chelsea and Westminster. Training is offered either as a rolling programme in a central location or bespoke to a group within their own setting, e.g., Community Champions, school or children's centre staff or school nurses. Modules on offer include obesity: the whole picture, nutritional guidelines, cooking in the curriculum, active playtimes, obesity: raising the issue and delivering physical activity.

Advice and guidance for schools and early years settings

Mytime Active has successfully built relationships with schools across Hammersmith and Fulham, Kensington and Chelsea and Westminster. In the first term they were working with 24 schools and will be working with a further 26 in the spring term. Mytime Active's nutritionists have been supporting schools in evaluating themselves against the healthy eating criteria of the Healthy Schools bronze award and advising on changes that schools need to make to attain the award, such as reviewing school food policies. It has also been supporting schools to improve lunchtimes, carrying out lunchbox audits and running workshops for parents as well as running healthy eating sessions with children including fruit and vegetable tasters, a sugary drinks activity and a session discussing the Eat Well plate.

Family healthy weight care pathways and toolkit

Two family healthy weight care pathways (one for children aged up to four and one for children aged between five and 19) and an accompanying toolkit have been developed, distributed and are available online. These resources provide a consistent set of messages, information about a range of universal preventative services and appropriate referral guidance for professionals to refer those who are already overweight or obese. They also reinforce the opportunities to intervene at key life stages from before birth until early adulthood and again during pregnancy.

Next steps

Training will continue to be offered with a greater focus on planned engagement with the wider children's workforce. This will include:

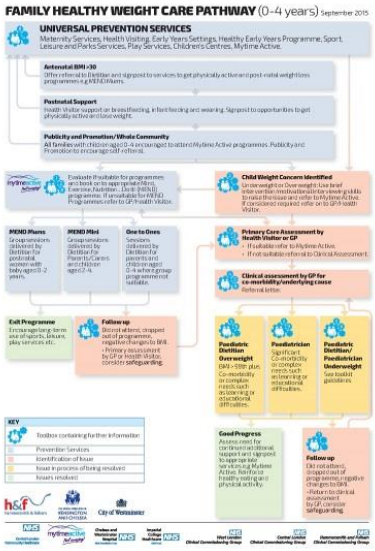
- Further work with the children's services department to ensure the training offer is visible to all staff.

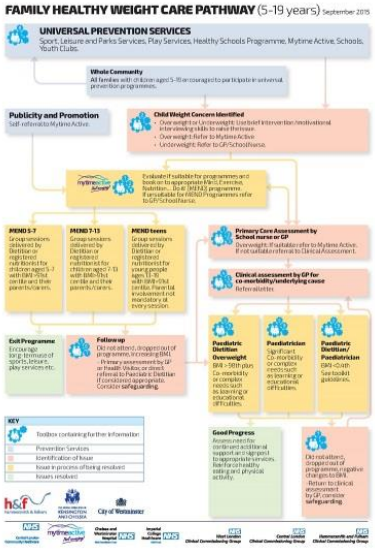
- Ensuring that the school nursing and health visiting workforce has had relevant training modules.
- Mytime Active including tracking of who is attending training in their reporting.
- Mytime Active attending borough community sports and physical activity networks to enable them to promote both its training offer and MEND programmes.

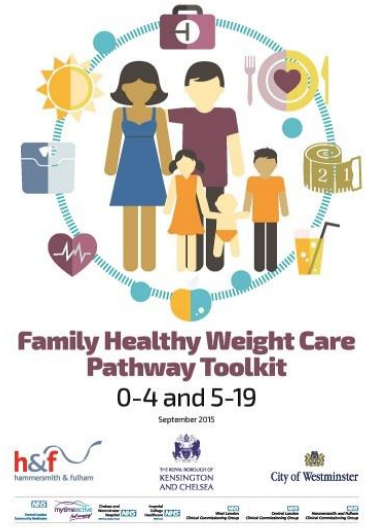
Work with schools and early years settings to support them to achieve Healthy Schools and Healthy Early Years awards will continue.

The family healthy weight care pathways working group will reconvene to review the pathways and evaluate them. The pathways will continue to be promoted at GP locality meetings and other means of promoting the use of them will be investigated, including laminated copies for all GPs and practice nurses and other health professionals.

Figure 4 (left, top to bottom): Family Healthy Weight Care Pathway (0-4), Family Healthy Weight Care Pathway (5-19) and the Family Healthy Weight Care Pathway Toolkit







WESTMINSTER WHOLE SYSTEM APPROACH

INTRODUCTION

What is the 'whole system approach' and what are its objectives?

To ensure that the environment across Hammersmith and Fulham, Kensington and Chelsea and Westminster is conducive to healthy lifestyles, we have been working with numerous partners within WCC to test and evaluate the effects of a whole system approach.

Our aim is to identify opportunities, first within the council and then across external networks, to work with partners to make positive changes to the wider environment within the borough that contribute to reducing childhood obesity.

We want to ensure that children and young people, their families and whole communities as well as visitors to the borough benefit from an orchestrated effort to collaborate, co-design and implement changes to the current obesogenic environment. This effort will involve work between our colleagues in other departments, for example sport and leisure, planning and housing, children and family services, as well as partners across the local geography and economy including the NHS, education, academia, catering and retail.

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

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

This approach is being developed in Westminster initially before being taken forward in Hammersmith and Fulham and Kensington and Chelsea..

What evidence is there to suggest that this approach will help to reduce childhood obesity?

In 2014 McKinsey published a discussion paper that aimed to start a global discussion on the components of a successful societal response to overcome obesity. One of the main findings of the paper concluded that no single solution creates sufficient impact to reverse obesity; only a comprehensive systemic programme of multiple interventions is likely to be effective.[5]

This approach has been at the heart of our programme design. The evidence of behavioural change interventions at an individual level (our significant investment into the preventative behaviour change services)

[5] Dobbs, R and Sawers, C et al (2014) *Overcoming obesity: An initial economic analysis, discussion paper, McKinsey Global Institute*

necessitating interventions at a societal/living environment and policy environments (our whole system approach). [6]

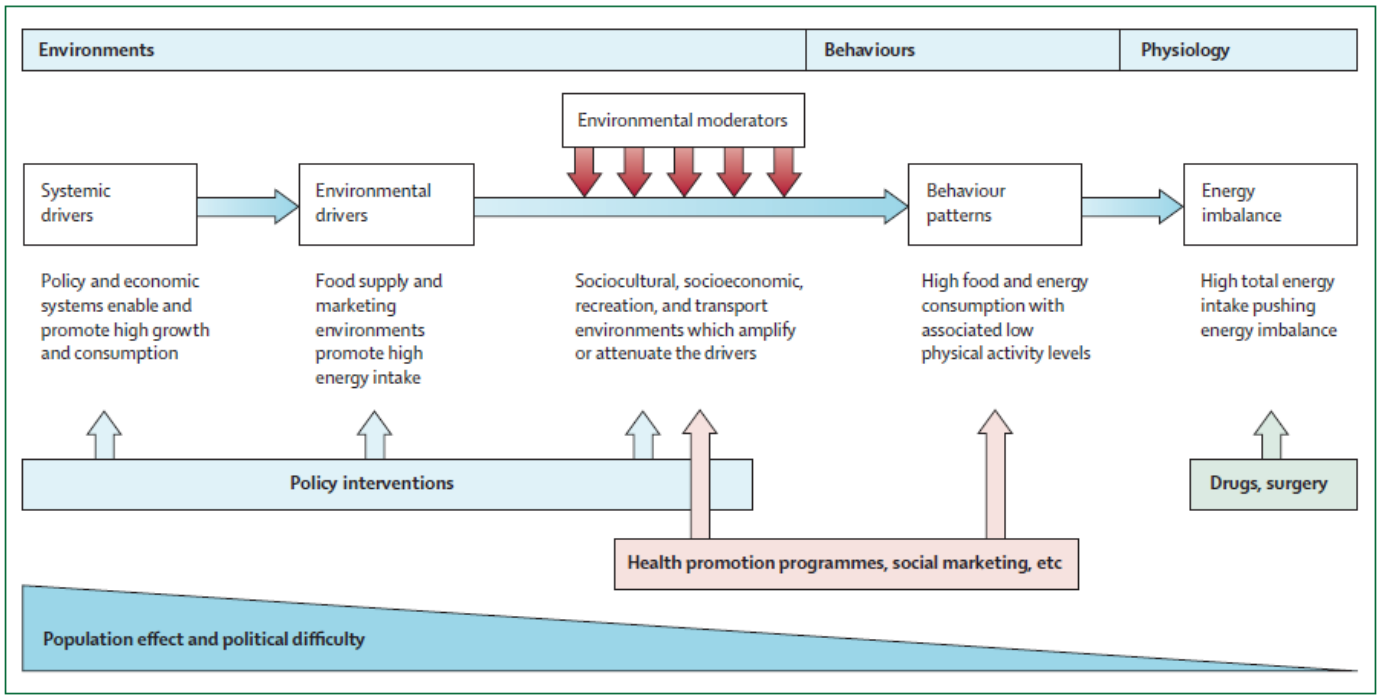


Figure 4: **A framework to categorise obesity determinants and solutions**
The more distal drivers are to the left and the environmental moderators that have an attenuating or accentuating effect are shown, along with some examples. The usual interventions for environmental change are policy based, whereas health promotion programmes can affect environments and behaviours. Drugs and surgery operate at the physiological level. The framework shows that the more upstream interventions that target the systemic drivers might have larger effects, but their political implementation is more difficult than health promotion programmes and medical services.

What process was taken to develop the whole system approach?

Initial scoping work identified the most relevant partner departments, followed by engagement with senior managers to discuss aims, recognise synergies, current work and identify future opportunities. Early cross-service workshops developed the first tranche of action plans signed off by members and officers. These cover:

- Food growing and education - pilot food growing projects in two schools and a housing estate in a regeneration area.
- Increasing physical activity - working with priority schools to engage with the school sports development team membership offer and services.
- The Healthier Catering Commitment - working with food premises to improve the nutritional content and quality of their food.

The progress against each action plan is described in more detail over the following pages. Further developments with other departments are also highlighted.

[6] Swinburn et al (2011), *The global obesity pandemic: shaped by global drivers and local environments, The Lancet*

FOOD GROWING

Aim and summary

Three different food growing schemes were identified for Westminster, all of which aimed to develop sustainable and well-utilised garden resources to grow fresh produce and improve skills, knowledge and confidence in food growing, with a particular focus on children and families. The three schemes identified were 1) school food growing and education, 2) community food growing in Church Street and 3) a temporary pop-up community food growing resource at Lisson Street Community Gardens.

Evidence of need

The benefits of gardening and community food growing for both physical and mental health are well documented[7]. In schools, food growing has been shown to increase the take-up of school meals, support higher educational attainment, improve attitudes to healthy eating and develop employment skills[8]. In the community further benefits include a stronger sense of community developed through positive interaction between neighbours and the creation of safer environments.

The Social Return on Investment (SROI) of the Master Gardener programme, a report produced by the University of Gloucestershire, indicates that for every £1 invested in gardening initiatives, on average £10.70 is returned to society in the form of social, economic and environmental outcomes including health and wellbeing, community participation and training[9].

Process

A successful food growing programme is well established in RBKC, therefore initial stages of the project focused on sharing best practice and developing a toolkit to support the development of the schemes. Additionally, a steering group was formed to oversee the process and ensure that relevant perspectives were addressed.

Scheme 1 – School food growing and education

King Solomon and Gateway academies were chosen as pilot sites for this project. Key members of staff were identified and plans tailored to each school according to need and opportunity. For example, a successful gardening club was already established at Gateway Academy so the focus was to maximise use of the existing garden resource. At King Solomon Academy there was very little existing provision but space to expand, therefore this was the initial focus.

Hammersmith Community Gardener's Association (HCGA) was commissioned to provide community gardener support at both school sites. This included 'teach the teacher' sessions, the development of lesson plans, weekly gardening sessions for pupils and the setting up of gardening clubs for pupils and parents.

Case study – The Fisherton Estate community pilot

Despite initial engagement being slow due to delays that led to the project beginning during Ramadan, take-up of and interest in the Fisherton Estate plots has been good. The project began with a 'getting started' workshop in which participants were provided with seedlings and given advice on other plants to grow. One participant brought her daughters, who were very keen to get started and plant the bed, with her. Watching them, she commented how wonderful it was and that they would never have got their hands dirty before the project! Over the next few weeks, attendance rates at the workshops increased as the weather improved and plants started to grow.

During the school holidays the community gardener encouraged lots of interest and participation from a wider range of children from the estate by holding child-focused workshops that included a smoothie bike activity in which 20 children took part, enjoying the healthy smoothies they created.

[7] Shmutz et al., 2014 The benefits of gardening and food growing for health and wellbeing

[8] Orme et al., 2011 Food for Life Partnership Evaluation

[9] Schmutz, P, Ulrich, B, and Courtney, E (2014) *The Social Return on Investment (SROI) of the Master Gardener Programme.* technical report.

Over the winter months, when food growing activity was reduced, HCGA arranged a series of 'keeping in touch' days to retain momentum of the project and strengthen community cohesion. These were a great success and saw increased attendance rates with visits to Columbia Road Market, Spitalfields City Farm and Kew Gardens.

Scheme 2 – Community food growing in Church Street
In collaboration with the Church Street futures steering group (an established resident group), the Fisherton Estate was chosen as the community pilot site as it had nine existing plots and the space and demand to expand. 11 new plots were installed and residents were invited to apply for a plot, with priority for families. CityWest Homes agreed to install an additional water point close to the plots.

HCGA was commissioned to provide community gardener support and set up a series of regular gardening sessions for both plot holders and other residents of the estate.

Scheme 3 - Temporary food growing pilot at Lisson Street Community Gardens
It was decided not to pursue a project at this site as it was considered too dark for food growing and proposals exist to significantly alter the site within the next two years as part of the wider redevelopment of the area.

Benefits
The number of participants who benefited from the projects is estimated at 288 pupils at King Solomon Academy and 112 pupils (including 10 who regularly attend a gardening club) at Gateway Academy. There are 20 community plots in the Fisherton Estate with 70% allocated to families. Many plot holders involve their whole families in their maintenance. Attendance at the regular gardening sessions has fluctuated; however, as the project has gained momentum, there have been attendances of up to 22 at sessions.

Initial surveys have been carried out at all sites to understand participants' knowledge and attitudes towards healthy eating and food growing at the start of the project. These results will be compared against those of the follow-up survey, which is anticipated to be completed in May 2016, one year after the projects were established.

Ongoing qualitative evaluation has taken place and examples are provided below:

- Feedback from staff at King Solomon Academy suggests that they value the expertise HCGA provides and that they are committed to offering food growing to as many children in school as possible. To date they have focused resources on younger children, as they have more flexibility in their timetables and food growing fits well with foundation core outcomes. They are looking to extend this to older age groups next term.
- An observation from the community garden was made by one parent of two girls saying how wonderful it was that her daughters were digging in the soil and that they would never have got their hands dirty previously.

Next steps
Community gardener support in the two schools will continue to be offered until July 2016. The current focus for HCGA is to support the schools to embed food growing into their school programme to ensure the project is sustainable in the long term.

HCGA will continue to offer support to the residents of the Fisherton Estate until May 2016, at which point the Church Street Neighbourhood Upkeep Project is due to launch. It is anticipated that gardening support at Fisherton Estate will be continued beyond this point.

Throughout 2016, eight further sites will be identified and prioritised for implementation before March 2017. These will comprise a combination of school and community sites and will include sites in the south of the borough. Particular care will be taken to choose sites based on their long-term viability to ensure projects are self-sustainable after March 2017.

Building on the success of these initial projects, it is anticipated that a borough-wide food growing programme can be developed across Westminster and be sustained beyond the life of the current funding. Options for how the programme can be taken forward in the future, including sponsorship or business partnership, are being considered.

Political support to progress any of these options is vital. There is a line in the Capital Programme over the coming years to support the WCC's Open Space Strategy, which is designed to improve the quality, management, accessibility and usage of parks and other open spaces in the city and provide new facilities where there are deficits in provision. Although this has to be secured on a year-by-year basis, there is potential to support the food growing programme to achieve one of the strategy's emerging aims: to encourage food growing within communities to contribute to healthy lifestyles (and the sustainability agenda).

Figure 5 (left, top to bottom): Plots at the Fisherton estate, children with smoothies created using a smoothie bike, proud plot holders

HEALTHIER CATERING COMMITMENT

Aim and summary

The Healthier Catering Commitment is based on the principle that small changes can make a big difference. It aims to supports food businesses to make straightforward changes to ingredients and preparation techniques in order to offer healthier food to customers. Once businesses have met certain criteria they are awarded different levels of the Healthier Catering Commitment award.

In Westminster, this project aimed to support 20 small and medium-sized food premises in 2015/16 in the borough's most deprived areas to successfully achieve the award.

Evidence of need

The increasing consumption of fast food is thought to be one of a number of contributory factors leading to rising levels of obesity[10]. Fast food tends to be more energy-dense and has a higher fat content than meals prepared at home[11]. Furthermore, outlets are often concentrated in areas of deprivation, where obesity levels are highest[12].

Process

This project was open to all independent point-of-sale food businesses in Westminster, with a particular focus on those in the most deprived wards including Harrow Road, Queens Park, Edgware Road and Churchill.

Prior to engaging businesses, five environmental health officers successfully completed Healthier Catering Commitment training, which covered the aims of the project, award criteria and how to support businesses to implement the changes needed. Later, three officers went on to complete the Chartered Institute of Environmental Health (CIEH) level 2 award in healthier food and special diets.

Following identification of eligible businesses, a letter was sent out to 163 businesses inviting them to consider their involvement in the project. The letter explained what the Healthier Catering Commitment was, including the key points of the project and the benefits of joining the scheme.

Shortly after, visits were made to the 100 most eligible businesses with the intention of engaging the relevant person at the business to explain the project, the criteria of the award and to begin audits. The amount of time taken to engage businesses varied depending on whether managers worked on site or not, perceived relevance of the Healthier Catering Commitment by staff and the food hygiene rating of businesses.

[10] GOS, 2007 Tackling Obesities: Future Choices Government Office of Science, Department for Innovation, Universities and Skills, London

[11] Prentice, A & Jebb S (2003) Fast foods, energy density and obesity: a possible mechanistic link. Obesity Review 4(4) 87-94

[12] Fraser et al (2010) The geography of fast food outlets: a review. International Journal of Environmental Research and Public Health. 7 (5) 2290-2308

As described by CIEH (PDF), for a business to achieve the Healthier Catering Commitment award, it must conform to a minimum of eight criteria from a list of 22, which include conditions in relation to the use of fats, oils, salt, availability of lower sugar drinks and snacks, fruit and vegetables. Joint visits between environmental health officers, dieticians and nutritionists supported businesses to implement the necessary changes.

Furthermore, a selection of food samples from businesses who had signed up to the scheme was submitted for nutritional analysis. The reasons for this were twofold: firstly to support engagement of businesses and secondly to evaluate the success of the Healthier Catering Commitment by comparing results from samples of food before and after the business had implemented the changes needed to achieve the award (the latter results are currently being awaited).

Benefits

Over the course of the project, 23 businesses in Westminster signed up to work towards achieving the Healthier Catering Commitment award.

To date, 19 businesses have successfully achieved Healthier Catering Commitment status and their efforts to serve healthier food were recognised at an awards ceremony at Westminster City Hall on 23rd February 2016.

The main catering changes made by businesses include:

- Use of grilling and baking methods rather than frying wherever possible.
- Use of low fat fillings for sandwiches.
- Use of semi-skimmed milk as a default for hot drinks.
- Removal of high sugar drinks from prominent displays.
- Offering smaller portion sizes.
- Actively promoting healthier choices to customers.

A survey with businesses to gather views on the Healthier Catering Commitment and recommendations for its future is due to be conducted in April 2016. A further follow-up survey will be undertaken to review the number of changes implemented by businesses that have been maintained.

Next steps

Support will continue to be offered to all businesses signed up to the scheme to date and a target of awarding a further 20 businesses in target areas in 2016/2017 has been set. We will however continue to work closely with colleagues in the city management department to explore opportunities to extend this initiative on a larger scale, as well as to seek opportunities for a better balance of retail on our streets.

The Healthier Catering Commitment award is valid for up to two years. Therefore monitoring reviews will be incorporated into future food hygiene inspections for those businesses who have been awarded to ensure they are maintaining their commitment, while minimising environmental health officer time to review this. The introduction of a

Case study - Fishing for a healthier option

Little Venice Fish Bar is located on Harrow Road, W9, and is situated on the corner directly opposite Westminster Academy and beside the Harrow Road Health Clinic. The business is owned by a local, Mr Nawid Aiobi, who was keen to be involved in the scheme from the start. Most customers are children and local residents with whom the business has a good relationship and it was evident from visits that the business plays an important part in the community.

Through working with environmental health officers and dieticians throughout the year, Little Venice Fish Bar has made subtle healthier alterations to the food they provide to improve the health and wellbeing of its customers. The business does not add salt to its chips, instead giving the option to its customers. The salt shaker used has a smaller number of holes, which prevents too much salt being added to a portion of chips. Further changes include using rapeseed oil, which has a lower amount of saturated fat compared to other oils, for deep fat frying and where soft drinks are sold the business positions healthier fruit drinks and water in a more prominent position to encourage its customers to choose the healthier option.

tiered scheme will be explored to encourage businesses to achieve the highest standard.

The Healthier Catering Commitment and successful businesses who have achieved the award will be further promoted to the public through the development of a page on WCC's website and social media presence.

The Healthier Catering Commitment in RBKC and LBHF

The Healthier Catering Commitment is well established across the other two boroughs. In RBKC, 99 businesses have successfully achieved the award to date with many premises located in the most deprived wards in the north of the borough. RBKC's environmental health team has targeted specific businesses in Golborne in order to support the Go Golborne project.

In LBHF, nearly 30 businesses have successfully achieved the Healthier Catering Commitment award. Similarly, many of these premises are located in the most deprived wards in the north of the borough.

Environmental health departments across all three boroughs have been supported by nutritionists from MyTime Active as part of its work to improve settings within the commissioned services.

Figure 6: Businesses are presented with the Healthier Catering Commitment awards at a ceremony at Westminster City Hall on 23rd February 2016

INCREASING PHYSICAL ACTIVITY

Aim and summary

The aim of this project is to increase opportunities for children and young people to participate in high quality physical activity, with a particular focus on areas in the borough with higher levels of deprivation and obesity.

The public health department in collaboration with WCC's sports, leisure and wellbeing team has worked to maximise physical activity opportunities for children.

Evidence of need

Regular physical activity is a key contributor to energy balance, helping to prevent excess weight and obesity[13]. The Department of Health recommends that children and young people (aged five to 18) should engage in moderate- to vigorous-intensity physical activity for at least 60 minutes every day. However, the proportion of those meeting the recommendations is low; among five-to-15-year-olds, only 24% of boys and 22% of girls in London achieve the guidelines[14].

Westminster is faced with high levels of inactivity that are even more prevalent in areas of high deprivation. There is also mounting evidence that participation in PE and school sport has plateaued, if not decreased, in some areas. In addition to quantity, the quality of physical activity offered, particularly in PE and school sport is also an important consideration[15].

The Physical Activity Joint Strategic Needs Assessment (JSNA), produced by the public health department, highlights that there is good evidence that school-based interventions are effective in increasing the duration of physical activity but not in increasing the levels of physical activity in leisure time. Multi-component school-based strategies are the most effective and should encompass physical education, classroom activities, after-school sport, active transport and a family/home component.

Process

Active Westminster is a partnership of organisations with an interest in physical activity in Westminster that works to improve opportunities that encourage those who live, work and study in Westminster to participate in sport and physical activity. The sports, leisure and wellbeing team (part of WCC's City Management and Communities department) is responsible for developing and promoting Active Westminster's sport and physical activity strategy through sports development and PE and school sport for all those that live, work and study in Westminster.

[13] Butland B, Jebb S, Kopleman P, McPerson K, Thomas S, Mardell J et al., (2007) Tackling obesities: future choices – project report, London

[14] British Heart Foundation (2015) Physical Activity Statistics 2015 file:///Q:/bhf_physical-activity-statistics-2015feb.pdf

[15] Ofsted (2012) Beyond 2012 – outstanding physical education for all

One area of cooperation has been the re-procurement of the new leisure service contract. The new service will come into effect in July 2016. As part of the revision and development of the service specification, the team has worked closely with colleagues in the public health department and WCC's procurement department to incorporate key areas identified in the action plan.

Another key area of work has been the development of the Active Westminster Strategy (2015-2020) in collaboration with a wide range of partners across the council and its external networks. The strategy highlights the links between physical activity and childhood obesity and emphasis has been placed on creating better connections at a local level through the Active Communities programme, which aims to develop opportunities for formal/informal and everyday activity in less traditional and more accessible locations, and maximising public health opportunities.

Benefits

Increasing physical activity opportunities for children

Active schools - we will work closely with our schools and partners to ensure all schoolchildren in Westminster have access to at least one hour of physical activity a day.

Active communities - the new programme will include over 130 hours of free activities, which will take place in a variety of community venues including parks and open spaces, city estates, schools, colleges and community halls, every week. Delivery of the programme has been approved through the new leisure centre contract, which commences on 1st July 2016 for 10 years.

School sport competitions - a range of competitive opportunities have been made available to primary and secondary schools, including festivals and multi-skill fun days that promote engagement and participation in physical activity.

World beating events - the Westminster Mile is set to become the largest and most inclusive event of its type in the world, attracting 10,000 participants in 2016.

Quality of PE in school

Approved by all schools in Westminster, the Continuing Professional Development programme is currently training teachers to understand the importance of increasing levels of physical activity through efficient delivery plans and techniques. Work is underway to integrate key messages from the Making Every Contact Count concept and youth volunteering programme, Active Champions, into training.

Forest Schools

The Forest Schools process focuses on child-led learning, allowing children to be independent, explore the environment and discover nature. A pilot scheme is being delivered at Paddington Recreation Ground in collaboration with St. Saviours, Edward Wilson and Essendine Primary Schools. The pilot is working with nine classes (250 children) from nursery to year four.

Physical activity strategy
The Active Westminster Physical Activity Strategy 2015-2020 is currently in development and will include priority work that links to TCOT.

Next steps
One of the key areas of focus will be strengthening links with the Healthy Schools Partnership programme and prioritising those schools with the highest prevalence of overweight and obesity to develop individual physical action plans as part of achieving the Healthy Schools bronze award.

Work will also focus on engaging partners within the council and its external networks to scope the possibility of developing a 'Westminster Standard' for participation in PE and school sport to ensure all children and young people have the opportunity to be active for at least five hours per week.

Further development of the Active Westminster passport scheme to engage more children from target areas will also be considered. The scheme offers free and discounted access to leisure services to young people resident in Westminster.

ENGAGEMENT WITH SERVICES

In addition to the three initial action plans agreed with council departments, a number of other activities have been initiated and some delivered to maximise the levers offered by the council. These more informal pieces of work, which are at different stages, have been summarised below.

Social supermarket application for funding to the Greater London Authority (GLA)

The social supermarket model works by securing high-quality residual food from retail and manufacture supply chains that would otherwise be sent as waste to landfill and sells this food to social supermarket members at a reduced price. Membership is carefully targeted at residents on the lowest incomes. Members are also supported by a range of on-site support services, including financial advice, employability and vocational skills training and courses on healthy eating and cooking on a budget.

In July 2015, the GLA invited applications from London boroughs to bid for capital funding to support the development of a social supermarket. A joint bid was developed with WCC's economic regeneration department, together with a number of partners in the voluntary sector, with potential premises identified on Harrow Road. Although unsuccessful on this occasion, other opportunities to implement this model in Westminster are being explored.

Planning and regeneration

The public health department is working with colleagues to maximise opportunities to promote health within large scale regeneration projects, including Church Street and Harrow Road.

The Church Street renewal programme has commenced and incorporates a work stream around the public realm. A key element of this work stream is the development of a 'green spine' running north to south across the neighbourhood, connecting green spaces such as children's play areas and community gardening projects. The intention is to encourage active travel around the neighbourhood and active play/leisure for residents and visitors of all ages.

The Harrow Road management plan is at an earlier stage in its development. Drivers for change include the high level of obesity among young children but also poor environmental air quality, traffic and congestion, poor public realm and a reduced retail offer, all of which deter active travel and leisure in the area. Renewal of Harrow Road therefore affords a set of opportunities including improvements to the canal frontage and to footpaths and cycle ways to encourage active travel and leisure and an improved surrounding area to create an appealing and genuine local retail offer, potentially including the above mentioned social supermarket model.

Housing and social landlords

A series of discussions are underway with Westminster housing provider CityWest Homes to explore how they might engage with their residents to improve health and wellbeing. The emphasis of the

engagement is on prevention, supporting residents to engage with their own health and wellbeing and to choose healthier lifestyles, including increasing physical activity levels and eating well.

Similarly registered social landlords are recognised as having a vital connection with residents who might not engage with other services. A number of providers are engaged with the Community Champions programme and we are keen to build on existing partnership work to explore other opportunities for engagement with their residents, many of whom are vulnerable.

Strategy development
The public health department is also working with colleagues across the council to maximise public health opportunities as part of the development of new strategies, including walking, cycling, open spaces and biodiversity strategies and the air quality action plan.

Procurement
Initial discussions have taken place with WCC's procurement department to incorporate quality standards and assurance for vending machines and other food provision within council contracts.

Beat the Street
The Beat the Street project aims to inspire people to walk and cycle more by engaging the whole community in a physical activity game over a period of six weeks. Participants compete for points by walking or cycling around the local area and scanning smart cards onto sensors known as 'Beat Boxes' to record their journeys. We have worked closely with Central London CCG to develop a proposal for this programme in Westminster.

COMMUNITY HEALTHY LIFESTYLE PILOT – GO GOLBORNE

GO GOLBORNE
eat happy · move · play

INTRODUCTION

What is Go Golborne and what are its objectives?

Go Golborne is a healthy lifestyle initiative that launched across the Golborne area of RBKC in May 2015. It aims to support a 'whole system' approach to promote healthy lifestyles by supporting a network of local agencies and groups to increase opportunities for children and families to make healthy choices.

The objective of Go Golborne is for children and families in Golborne to increase their awareness, knowledge and skills of how to live healthy lifestyles leading to increased levels of physical activity and healthy eating. It aims to do this by maximising the use of assets in the area, making changes to the local environment and providing consistent healthy lifestyle messages. Local stakeholders will be supported and trained to implement healthy lifestyle activities in Golborne. Additionally, the initiative aims to contribute to the evidence base on community-led approaches to tackling childhood obesity.

What evidence is there to suggest that this approach will help to reduce childhood obesity?

Go Golborne is a unique model developed as a result of a review of international evidence on the best methods to effectively prevent childhood obesity at a local level. Evidence suggests that effective strategies need to include action on multiple levels across a wide range of domains. Given the complex number of factors that influence a child's ability to eat well and keep active it can be difficult to understand and adequately address them at scale. Emerging evidence from research suggests there is much to be gained from developing 'whole system' approaches in smaller geographical areas so that actions can be shaped to meet the unique needs of local communities.

We also consulted local children, families and community organisations through workshops and creative consultation activities at local festivals and events to identify what is needed locally and inform our plans. The model is being piloted in Golborne with a view to extending its reach to other areas of the borough once there is sufficient insight into its impact and effectiveness.

Evidence suggests that preventative interventions targeting children and young people pay off – the upfront costs of most preventative interventions will usually be small in comparison with the future health benefits and long term cost savings across the economy from reductions in type 2 diabetes, cardiovascular disease and some cancers[16].

Figure 7 (left, top to bottom): Logo created for the Go Golborne project, learning how to grow herbs at the 5 A DAY family fun day, Go Golborne 5 A DAY Your Way shopping bags

[16] National Institute for Health and Care Excellence (2006) Obesity: *Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children* (NICE)

What process was taken to develop Go Golborne?
The area of Golborne was chosen as a test bed for this initiative as it is one of the most deprived areas of RBKC and levels of childhood obesity are high relative to more affluent areas of the borough. Furthermore, there was potential to reach a large number of children (around 2,000) and a range of local amenities that provide opportunities to explore how the local environment can help support healthy lifestyles.

A scoping exercise took place to map out the organisations and key stakeholders operating across Golborne that support children and families and play a role in shaping the local environment. Meetings and workshops took place to build a multi-agency network of relevant colleagues. A Go Golborne 'supporter pack' was developed to set out the scope of the project and the benefits of getting involved.

A small steering group was established to oversee the development and implementation of the project. It includes senior level representatives from key council departments (such as leisure services and community engagement), a local councillor and leads from the local school nursing team, nutrition service and voluntary sector. This group acts as a 'sounding board' to critically appraise project plans and progress against key aims and objectives.

Following considerable consultation with partners, it was agreed to develop a range of activities that include a comprehensive social marketing campaign, a small grants scheme for local organisations to deliver activities, continual growth of the community network to inform the development of the campaign and collaborative work with other council departments to influence the environment.

It was agreed that the programme should feature a different 'headline' campaign every six months, which are as follows:

- Five a day - to increase consumption of fruit and vegetables.
- Sugar swaps - to reduce consumption of sugary drinks and snacks.
- Snack check – to encourage healthy snacking habits.
- Active travel – to encourage walking and cycling.
- Screen time – to reduce the amount of time children spend on screens.
- Active play – to encourage physical activity.

How will Go Golborne be evaluated?
The University of Kent's Centre for Health Service Studies is conducting an independent evaluation of Go Golborne to assess the extent to which the project achieves its aims and objectives. It includes both quantitative and qualitative methods including an annual child and parent survey administered via schools and interviews with key stakeholders involved in the project. The university will also look at information gathered via an extended version of the NCMP to investigate if and how this work correlates to any significant increase in the number of local children who are a healthy weight.

5 A DAY YOUR WAY

Aim and summary

The objective of 5 A DAY Your Way, the first of Go Golborne's six campaigns, was to promote fruit and vegetable consumption among children in Golborne. The campaign aimed to do this by increasing the access, availability and affordability of fruit and vegetables and improving children and parents' attitudes, awareness and skills towards eating healthily.

The campaign incorporated a range of different activities, including:

- The creation of new materials to communicate key five a day messages such as a song written by a local musician with the help of local children, a family healthy eating magazine, a wallchart encouraging children to take part in a challenge to eat five portions of fruit and vegetables every day for 20 days, the design of cartoon superhero characters to inspire children to complete the challenge and collateral including shopping bags, posters, flyers and fridge magnets with positive healthy eating messages.
- A series of family events delivered in collaboration with community partners to reinforce messaging including:
  - A family fun day.
  - Pop-up fruit and vegetable snack stalls in school playgrounds.
  - Healthy cooking workshops.
  - Themed rhyme time sessions in the local library.
  - 'Create and play' workshops at a local play centre.
  - An 'eat the rainbow' photo competition in conjunction with RBKC's markets department that culminated in a pop-up healthy eating event for children at Portobello Market Square.
- Themed assemblies at five schools in Golborne.
- Work with partners across the council to explore other opportunities to increase access to fruit and vegetables – such as identifying local food outlets to join the Healthy Catering Commitment scheme and supporting local market traders to accept Healthy Start vouchers for fruit and vegetables.

Case study: 5 A DAY Your Way Family Fun Day

A family fun day was held at the Venture Centre, a community centre in Golborne, in November 2015 and was attended by over 200 families. Many local organisations and volunteers helped run the event that featured a host of fun activities that encouraged children to experiment with fruit and vegetables – from making soup with smoothie bikes to blind tasting games. Fruit and vegetable physical activity games took place in the outside play area and local musician Alexander D Great performed the song commissioned by the project, which includes healthy eating messages, with local children. Free health checks, recipe cards and information on the local services that support healthy lifestyles for families were available to parents.

Process

A systematic social marketing process was used to develop the campaign. Initially, desk research was conducted to identify key learning from other similar initiatives and relevant local reports. Two multi-agency workshops with local organisations were delivered to shape the mini-campaign. The Food Access Model[17] was used as a framework for discussion, which encouraged the group to consider factors including access, affordability and awareness. Children and families were also consulted through local events.

Figure 8 (left): Logo created for Go Golborne's 5 A DAY Your Way campaign

[17] Dowler EA, Dobson BM, (1996) Nutrition and poverty in Europe: an overview

Evidence of need
Eating five portions of fruit and vegetables a day plays a key role in maintaining healthy weight. However, very few children (or adults) manage to achieve it: among 11-to-18-year-olds only 10% of boys and 7% of girls meet the recommendation. Children in lower income groups eat up to 50% less fruit and vegetables than those with a higher income[18]. This was also considered to be a high priority by partner organisations during consultation.

Benefits
To date around 1,500 children have taken part in the 20 day challenge, approximately 200 people attended the family fun day and 2,500 magazines were distributed in the community. Social marketing activities have been further developed to enhance messaging. Channels include dedicated content on the Go Golborne website, social media engagement and print advertising.

The impact of the 5 A DAY Your Way campaign will be explored by the University of Kent as part of the wider evaluation of Go Golborne. As part of this, levels of fruit and vegetable consumption among local children will be analysed. Positive feedback about the campaign has been received with some quotes from local parents below:

- *"My daughter has been trying really hard with her wallchart – she loves the superpower characters!"*
- *"Thanks, it was a lovely event. My son enjoyed the art and crafts and the 'make your own fruit and veg' activity. I loved the face painting. I will make more soups at home."*
- *"Jibril made a special wrap - it was a really good experience, especially the bike blender soup. That was something new. Thank you."*
- *"(the fun day) was the first time my son tried to eat vegetables."*

Next steps
Planning for Go Golborne's 2nd campaign will commence in March 2016. The theme will focus on reducing 'screen time' and increasing levels of physical activity. Five a day messages will continue to be promoted and reinforced throughout.

[18] Public Health England (2011), National Diet and Nutrition Survey

Figure 9: Local songwriter, Alexander D Great, and local children perform his healthy eating song, 5 A DAY Your Way, written specially for Go Golborne at the 5 A DAY Family Fun Day

THE CHILDHOOD OBESITY JOINT STRATEGIC NEEDS ASSESSMENT

THE CHILDHOOD OBESITY JOINT STRATEGIC NEEDS ASSESSMENT

Aim and summary

The Childhood Obesity JSNA was published in February 2016. It explores the causes and consequences of childhood obesity and provides a local picture of its prevalence in our local communities, identifying those groups most at risk. The JSNA also aims to capture a range of existing programmes of work that support the development of healthier environments and identify further opportunities that can further focus our joint efforts to tackle this issue.

Evidence of need

The JSNA was developed in order to provide a baseline against which progress of TCOT will be measured. In addition to quantitative data regarding the prevalence of childhood obesity, existing programmes of work both within the council and through its external partners were to be identified in order to capture the wide range of work currently being delivered.

Process

Following an initial application to the JSNA steering group and subsequent approval, a comprehensive literature review was undertaken, as well as extensive data analysis and service mapping. Drafts were circulated to a range of internal and external partners. The JSNA was taken to the governing bodies and/or transformation redesign groups of the three local CCGs, as well as a range of voluntary sector forums including the BME forum and Kensington and Chelsea Children and Youth Forum for feedback.

Three stakeholder workshops were held with partners to identify any further gaps in the JSNA and to develop recommendations. The JSNA was taken back to the JSNA steering group, before being signed off by the Health and Wellbeing Boards in each borough.

Next steps

Key recommendations from the JSNA highlighted that every department and organisation has a role to play in creating and supporting increasing healthier environments and all engagement opportunities with partners should be used to achieve shared understanding of the need to address this issue collectively.

Additionally, the importance of developing clear and consistent messages that are readily understood by all audiences and delivered though the optimal communication channels for each audience was emphasised, in addition to a particular focus on early years. Finally, the need to act on and increase the evidence base and contribute to and keep abreast of national and regional developments was also raised.

NEXT STEPS FOR TCOT

NEXT STEPS FOR TCOT

Westminster – whole system approach

Three specific areas of work likely to be pursued in Westminster during the next year will be:

- Improving accessibility to water – to counter the effects of widespread consumption of sugary drinks, we will explore the introduction of water fountains to residential areas to provide free, healthy refreshment to residents.
- Increasing accessibility to low-cost, nutritious food – we will explore the idea of creating a social supermarket in Westminster. Social supermarkets provide members with cheap, nutritious food by redistributing surplus food.
- Promoting health-supporting built environments – utilising the opportunity of large developments such as Harrow Road and Church Street to improve play and recreation environments as well as street layouts to encourage physical activity and active travel.

Existing areas of work including food growing projects and the Healthier Catering Commitment will also be expanded upon during the next year. Additionally, Creating Healthy Places – a whole system approach to food and active living framework - will be used to identify further areas of work across the council that create healthy eating- and physical activity-supporting environments within neighbourhoods, high streets, new developments, connecting routes and institutions.

Hammersmith and Fulham

Details of the next steps to be taken in Hammersmith and Fulham are being considered following the outcomes of the H&F Healthy and Fit Hackathon, which took place in May 2016. The ideas, energy and enthusiasm of the day were captured in mini films and by a graphic illustrator, as below:

- Better at it – an inter-school challenge to help young people improve their skills at physical activities.
- Fitness Phood – an app that calculates the amount of physical activity you'd need to do to burn off the food you're about to eat. (the people's choice)
- My Lifestyle – an app to help improve fitness.
- Fun Free Fitness – a programme of free activities and sessions that take place around existing facilities such as parks.
- Cook Local – an app that helps people cook healthy food.
- Shake It, Make It – an app that gives people ideas for healthy lunches.
- Breast Friends – a social movement and initiative to support women to breastfeed in public.

- Real Beauty – a marketing campaign to improve people's attitudes to body image.

Figure 10 (above): graphic mural created during the H&F Healthy and Fit Hackathon that represents the creativity and ideas that were generated throughout the day

Kensington and Chelsea – Go Golborne

The Go Golborne initiative will launch two further campaigns, following 5 A DAY Your Way during the next year. The first, Unplug and Play, will be launched in June 2016 and will encourage children and families to reduce the amount of time spent using screens such as phones, laptops and televisions and increase the amount of time spend participating in physical activity. The main focus of the following campaign is to be decided but will focus on changing food habits. The initiative is also looking to expand work with local retailers and shoppers to understand the barriers to buying and selling fresh produce and prioritising this when it comes to e.g. shop offers.

LESSONS LEARNED FROM TCOT YEAR ONE

LESSONS LEARNED FROM TCOT YEAR ONE

The following is a series of lessons that have been learned throughout the first year of the TCOT programme.

- Political support at a local level is crucial.
- Taking time to engage communities is well spent.
- Developing partnership and exploring synergies with our own and partner's services pays off in creating a whole system.
- Using positive language and looking for suitable changes in asset-based approach is key to engagement.
- There can never be enough communication.
- The NHS engages willingly but more capacity is needed to promote the programme and the Family Healthy Weight Care pathways in particular.
- Space is a real limitation, especially for schools.
- Synchronisation of activities could be improved to boost uptake of activities, e.g., NCMP timing and recruitment to MEND programmes.
- Where connections/synergies have been made, effect is beginning to show.
- Creativity, flexibility and engaging children and families as early in the planning process as we can is essential in order to gain their interest and to align activities with local unmet needs.
- Where and when presented to experts, the programme has been highly commended for its comprehensive, systematic and evaluative approach.
- Robust evaluation must continue and where possible external partners should be engaged to enhance the process and increase credibility.
- Setting up an expert advisory body may be beneficial.

EVALUATION

EVALUATION

TCOT takes a complex, novel and somewhat experimental approach to a difficult problem and as such warrants rigorous evaluation.

To this end, the public health department has developed a number of partnerships with leading academic institutions and individuals. These include the University of Kent, public health physician, Harry Rutter, Professor of Nutrition and Childhood Obesity at Leeds Becket University, Pinki Sahota, and the Department of Primary Care and Public Health at Imperial College, London. Additionally, the department has partnered with social enterprises such as MyTimeActive and other institutions including Public Health England to deliver a high quality evaluation of the programme.

MyTime Active

An important part of evaluation is collection of the right kind of data. In collaboration with MyTime Active we are collecting data on skills, attitude and confidence following workforce training with their trainers. This includes data on their knowledge of childhood obesity and their strategies to broach the topic with parents and children and motivate them towards a healthy lifestyle and signpost them to relevant services. We collect extended NCMP data to include all school years and repeat measurements for four years to monitor change, as well as collecting data on healthy eating, physical activity and behaviour change. We will be able to look at the uptake of MEND courses and whether particular parents and children need extra help to change, if there are gaps in service and if so, what ways there are to remedy them. We are also looking at ways health professionals can help. The evaluation of MEND in Schools will be carried out at the end of each school year measuring increases in water consumption and active play and reductions in the consumption of unhealthy food.

Whole system approach

We are evaluating the impact and costs of collaborative initiatives between council departments that support healthy lifestyles to identify future opportunities to create maximum impact on health. The approach is currently being piloted in Westminster with a view to rolling out across Kensington and Chelsea and Hammersmith and Fulham in future.

The public health department is working with colleagues in the business intelligence and adult social care departments in an effort to unify the way strategies are evaluated for impact on council targets as well as public health outcome framework indicators.

Go Golborne

The University of Kent's Centre for Health Service Studies is conducting an independent evaluation of Go Golborne to assess the extent to which the project achieves its aims and objectives. The public health department and the University of Kent have developed a 'theory of change' framework to guide the evaluation.

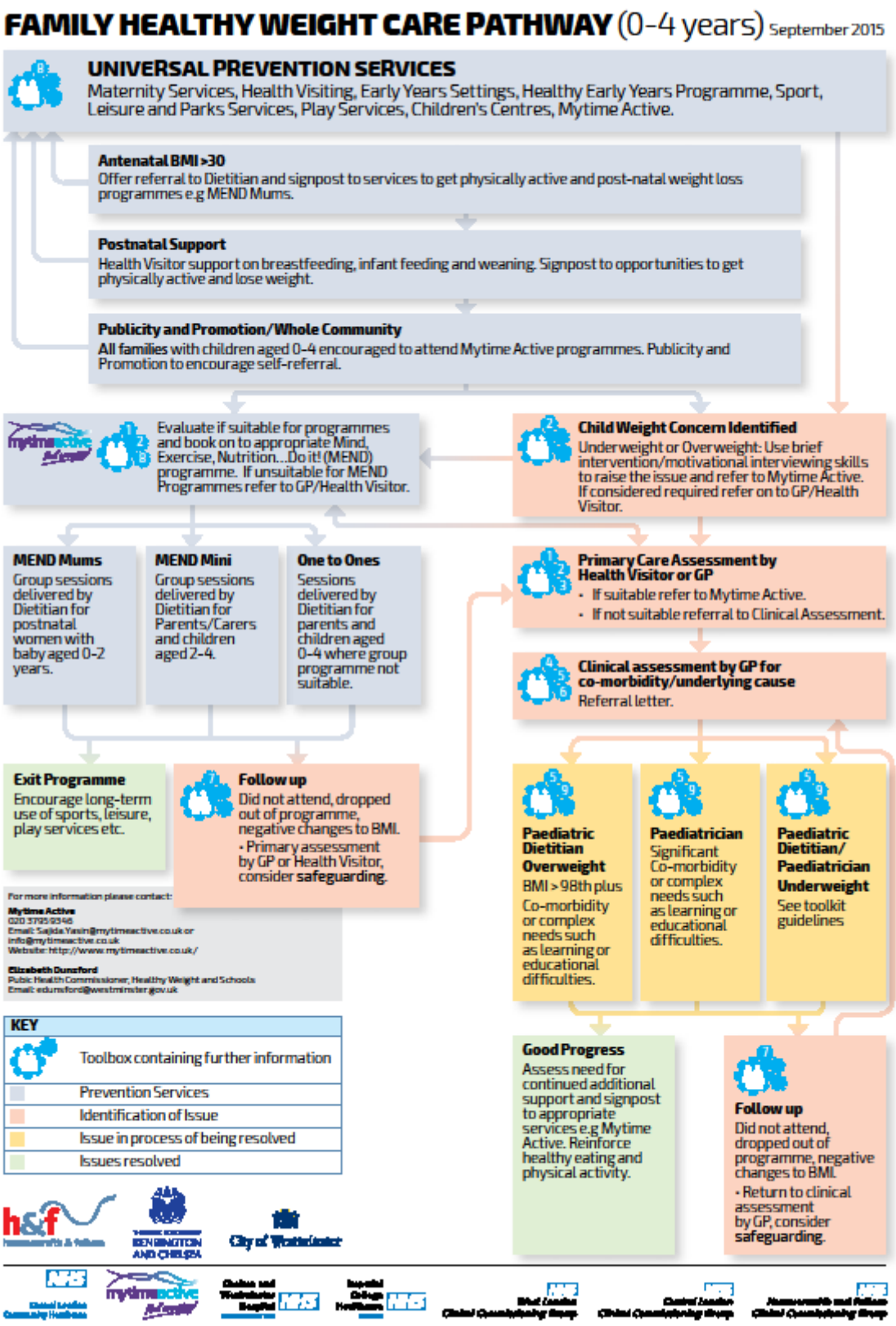
Baseline data on diet, physical activity and screen time is currently being collected and follow-up questionnaires will be repeated annually. NCMP

data will help correlate information and tell us whether changes in lifestyle happen in the children outside of the healthy weight range.

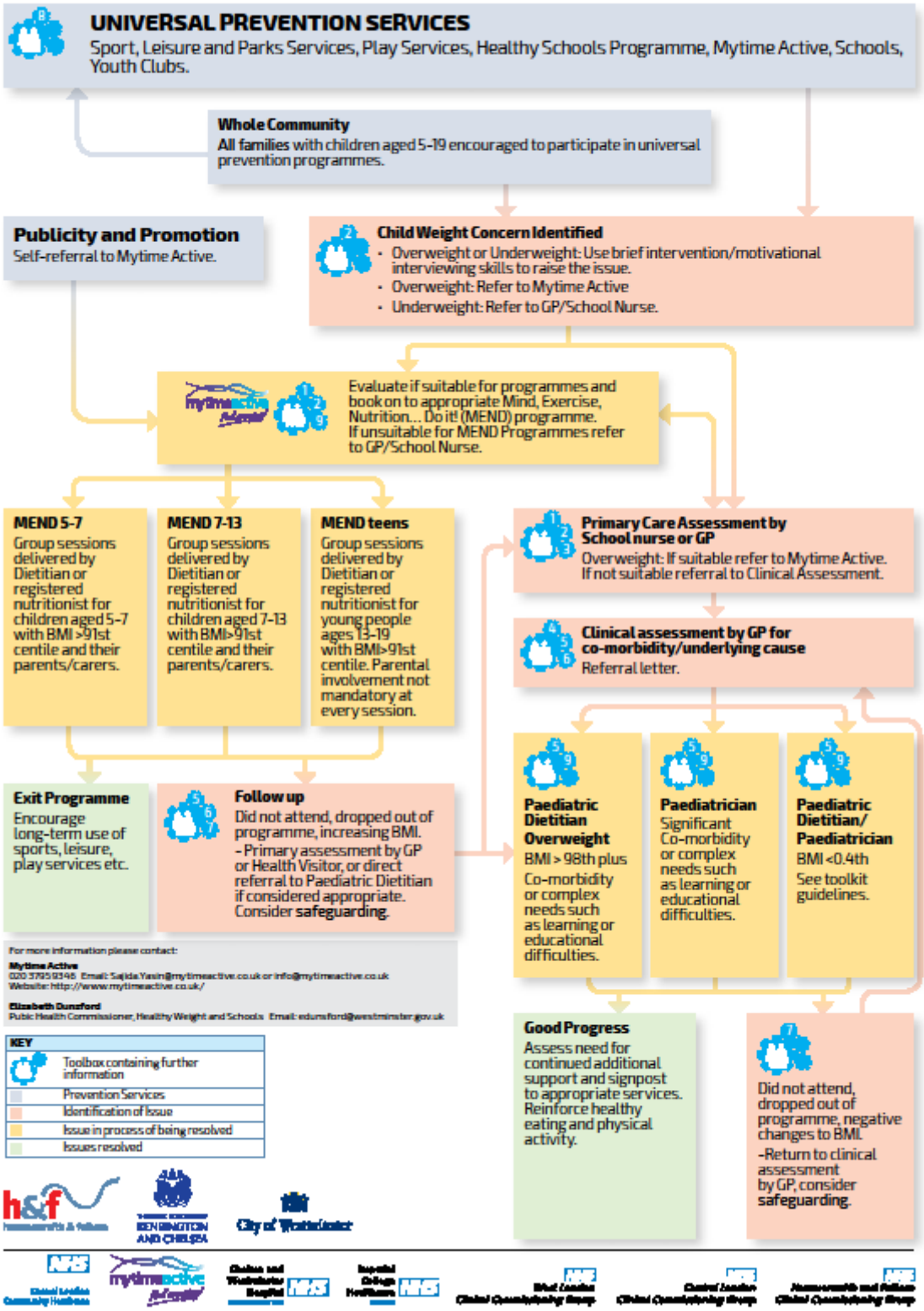
Qualitative data will also be collected with stakeholders to give rich context to the findings and identify the main drivers of any change. Process and cost data will also be collected in order to develop a toolkit to help other communities run similar programmes to implement sustained change.

APPENDIX I

The family healthy weight care pathways and toolkit (click to open PDFs)


FAMILY HEALTHY WEIGHT CARE PATHWAY (0-4 years) September 2015
UNIVERSAL PREVENTION SERVICES
Maternity Services, Health Visiting, Early Years Settings, Healthy Early Years Programme, Sport, Leisure and Parks Services, Play Services, Children's Centres, Mytime Active.
Antenatal BMI >30
Offer referral to Dietitian and signpost to services to get physically active and post-natal weight loss programmes e.g MEND Mums.
Postnatal Support
Health Visitor support on breastfeeding, infant feeding and weaning. Signpost to opportunities to get physically active and lose weight.
Publicity and Promotion/Whole Community
All families with children aged 0-4 encouraged to attend Mytime Active programmes. Publicity and Promotion to encourage self-referral.
Evaluate if suitable for programmes and book on to appropriate Mind, Exercise, Nutrition...Do it! (MEND) programme. If unsuitable for MEND Programmes refer to GP/Health Visitor.
Child Weight Concern Identified
Underweight or Overweight: Use brief intervention/motivational interviewing skills to raise the issue and refer to Mytime Active. If considered required refer on to GP/Health Visitor.
MEND Mums
Group sessions delivered by Dietitian for postnatal women with baby aged 0-2 years.
MEND Mini
Group sessions delivered by Dietitian for Parents/Carers and children aged 2-4.
One to Ones
Sessions delivered by Dietitian for parents and children aged 0-4 where group programme not suitable.
Primary Care Assessment by Health Visitor or GP
If suitable refer to Mytime Active.
If not suitable referral to Clinical Assessment.
Clinical assessment by GP for co-morbidity/underlying cause
Referral letter.
Exit Programme
Encourage long-term use of sports, leisure, play services etc.
Follow up
Did not attend, dropped out of programme, negative changes to BMI.
• Primary assessment by GP or Health Visitor, consider safeguarding.
Paediatric Dietitian Overweight
BMI > 98th plus
Co-morbidity or complex needs such as learning or educational difficulties.
Paediatrician
Significant Co-morbidity or complex needs such as learning or educational difficulties.
Paediatric Dietitian/ Paediatrician Underweight
See toolkit guidelines
For more information please contact:
Mytime Active
020 3795 9346
Email: Sajida.Yasin@mytimeactive.co.uk or info@mytimeactive.co.uk
Website: http://www.mytimeactive.co.uk/
Elizabeth Dunsford
Public Health Commissioner, Healthy Weight and Schools
Email: edunsford@westminster.gov.uk
KEY
Toolbox containing further information
Prevention Services
Identification of Issue
Issue in process of being resolved
Issues resolved
Good Progress
Assess need for continued additional support and signpost to appropriate services e.g Mytime Active. Reinforce healthy eating and physical activity.
Follow up
Did not attend, dropped out of programme, negative changes to BMI.
• Return to clinical assessment by GP, consider safeguarding.

FAMILY HEALTHY WEIGHT CARE PATHWAY (5-19 years) September 2015



Family Healthy Weight Care Pathway Toolkit

0-4 and 5-19

September 2015

h&f hammersmith & fulham

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

City of Westminster

Tackling Childhood Obesity Together, Annual Report 2016

Produced by the Public Health department covering the London Borough of Hammersmith and Fulham, the Royal Borough of Kensington and Chelsea and the City of Westminster

London Borough of Hammersmith & Fulham **Health and Wellbeing Board** **7 SEPTEMBER 2016**	
HOUSING SUPPORT AND CARE JOINT STRATEGIC NEEDS ASSESSMENT	
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 of Adult Social Care and Health	
Report Author: Anna Waterman, Strategic Public Health Advisor	**Contact Details:** Tel: 020 76414651 E-mail: awaterman2@westminster.gov.uk

1. EXECUTIVE SUMMARY

1.1. This report presents the key findings and recommendations from the Joint Strategic Needs Assessment (JSNA) on housing support and care. The JSNA focuses on integrated solutions to shared problems.

1.2. There is considerable activity already in place in Hammersmith and Fulham which seeks to address the challenges of providing housing support and care. The recommendations in this JSNA build on this activity and draw on national, regional and local evidence. They have been drafted in collaboration with key stakeholders and endorsed by them (see appendices 1, 2 and 3) to ensure that the right services are delivered in the right place at the right time, with a focus on improving outcomes for those most in need.

2. RECOMMENDATIONS

1. That the Health and Wellbeing Board consider and approve the Housing support and care JSNA and its recommendations for publication;

2. That the Health and Wellbeing Board members ensure that the report's recommendations are reflected in delivery plans for related strategic documents, including Sustainability and Transformation Plan, the Joint Health and Wellbeing Strategy and the Older People's Housing Strategy;

3. That the Health and Wellbeing Board champion progress on the 'foundation stones' outlined in section 8, particularly:

    a) Joint commissioning and pooled budgets (8.1);
    b) IT data sharing protocols and information governance (8.2);
    c) Smooth customer journeys between services; and

4. That the Health and Wellbeing Board review progress against recommendations in 1 year from publication.

3. REASONS FOR DECISION

3.1. A JSNA on Housing support and 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, services and stock, to guide a future strategic approach to housing support and care and inform strategy implementation and commissioning intentions.

3.2. The report is complementary to existing programmes across the Council. Key ones include the Housing Strategy, the Older People's Housing Strategy, a delivery plan for which is currently being developed, and Adult Social Care's prevention offer. The Housing support and care JSNA will build on existing commitments, and shape and facilitate their delivery.

3.3. A particular strength to be drawn from this JSNA is greater strategic partnership between housing, adult social care and the CCG, which can lead to robust joint initiatives.

4. INTRODUCTION AND BACKGROUND

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

4.2. This deep dive JSNA considers integrated approaches which support the provision of housing support and care for residents of Hammersmith and Fulham, focussing on challenges which can only be addressed through collaborative working. It explores the ways in which collaboration can improve customer journeys and value for money, and prevent or delay deterioration in health and wellbeing, and mitigate the impact of such deterioration.

4.3. The JSNA offers recommendations that support and enable the delivery and implementation of local and national strategy and policy, including:

- The draft **Joint and Health Wellbeing Strategy** makes a commitment to address poor quality and inappropriate housing and to mainstream prevention into everything that we do.

- The **Older People's Housing Strategy** outlines how the Council will work with partner agencies to improve housing options for older people and to promote independence and a preventative approach (see appendix 2). The JSNA complements the Strategy and there will be a number of joint initiatives across Health and Adult Social Care. For example, improving sheltered housing and housing options for older people is a key priority for the LBHF administration. The strategy sets out a commitment to work with partners and key stakeholders to examine what housing options are required to meet future demand and changing needs, picking up and building on the work of the JSNA.
- The **Whole Systems Integrated Care** and **Like Minded** CCG programmes focus on integrated partnership working and joined up services Hammersmith and Fulham CCG have identified the opportunity to incorporate a number of the recommendations into these programmes (see appendix 3).
- **The Care Act 2014** and the **NHS 5 Year Forward View** have shifted the focus for health, housing, and social care to prevention as demand for services is expected to increase.

5. PROPOSAL AND ISSUES: Key themes of the JSNA

5.1. There is a strong evidence base for the links between housing, health and wellbeing: good quality and appropriate housing is crucial to enabling people to stay healthy and well. Poor quality housing and homes which do not lend themselves to care at home can give rise to and exacerbate health and social care needs.

5.2. The JSNA makes a series of recommendations with a view to ensuring that the right services are delivered at the right time, with a focus on improving outcomes for those most in need. They have been drafted in consultation with key stakeholders to ensure the JSNA provides a number of levers for building strong partnership work.

Themes

5.3. There are a number of themes or 'foundation stones' which cut across and underpin the recommendations:

Joint commissioning and pooled budgets,	Recognising the links between housing, health and social care, commissioners need to increase the use of pooled budgets as a way of enabling closer collaboration, with investment weighted towards 'upstream' prevention and earlier intervention. Greater collaboration might also enhance opportunities to build on the provisions within the Public Services (Social Value) Act 2012.
IT data sharing protocols and information governance	Collaborative work to facilitate and enable information exchange between organisations, in a way that respects patient preferences and information governance protocols, is required if cost effective personalised prevention and early intervention are to be realised.
Smooth customer journeys, supported by referral rights and referral pathways	Work building on existing best practice is required to ensure that, regardless of where a resident makes first contact, the offer is consistent and secures optimal impact.

Quality services and facilities, appropriately tailored and targeted	This report seeks to highlight services which secure positive outcomes for some of our most vulnerable residents and which might play a greater role in facilitating cost effective provision than may previously have been recognised.
Asset based approaches (for individuals and for communities)	This report advocates the development of strategies which explicitly seek to strengthen community resilience and practices which utilise residents' own strengths.
Workforce development	Ensuring that staff teams are skilled up and supported to address the challenge is essential if positive outcomes are to be achieved.
Local intelligence	This foundation stone refers to securing greater understanding of the local landscape. Two specific areas highlighted are Fuel Poverty and those in severe and multiple disadvantage.

5.4. A more detailed explanation of the foundation stones can be found in Section 8 of the full report, pp 83-84.

5.5. **JNSA Report Recommendations**

The recommendations are summarised in the table below, and appear in more detail in the full report in section 7, pp 77-80.

Theme	Recommendation
Strengthening prevention and early intervention	Recommendation 1: Increase the number of homes in the boroughs which offer residents easy access and manoeuvrability. Recommendation 2: Invest in improving housing conditions, cross tenure, to facilitate efforts to maintain residents' health and wellbeing. Recommendation 3: Ensure that resources and arrangements are in place to support people to maximise their range of life skills and confidence, enabling them to live independently in the community. Recommendation 4: Ensure that strategies are in place to promote community cohesion and prevent and alleviate social isolation. Recommendation 5: Ensure the development of an asset based approach to the delivery of robust front-of-house, information, advice and outreach services, which promote independence and self-reliance and are tailored and targeted to secure best impact. Recommendation 6: Extend the reach of front line services by embedding the 'Making Every Contact Count' (MECC) approach.

Delivering personalised housing support and care	Recommendation 7: Establish data sharing appropriate protocols and governance processes across council departments, NHS partners and other front line provider agencies working to support vulnerable residents. Recommendation 8: Ensure support and care pathways, between front line staff in Housing (including REHS & RPs), ASC, health services, Children's Services and voluntary sector partners, facilitate smooth customer journeys and effective care. Recommendation 9: Consider undertaking a multi-agency evidence review of options for increasing the supply of move-on accommodation within the challenging landscape.
Strengthening collaborative approaches to supporting carers	Recommendation 10: Ensure that appropriate strategies are in place to increase the proportion of informal carers who are known to services and in receipt of appropriate support.
Improving the offer for those in severe and multiple disadvantage	Recommendation 11: Building on existing innovative approaches, develop models, potentially using pooled budgets, to deliver more cost effective, integrated health, housing and social care solutions.
Improving housing options in later life	Recommendation 12: Councils must use every opportunity to increase the range of desirable housing options for older people in both the social and private sectors, using innovative partnerships, and ensure their take-up.

5.6. The Health and Wellbeing Board is invited to consider the foundation stones and key recommendations arising from the Housing support and care JSNA (shown together in full in Section 7, p.82). Many of the recommendations include a range of opportunities for consideration by partners for local implementation.

6. CONSULTATION

6.1. Stakeholder engagement has been central to this JSNA. Public Health has held a co-ordinating role, brokering cross-departmental and cross-agency discussion on the shared challenges identified. The engagement and intelligence offered by a wide range of stakeholders has ensured that the report is rooted in the local landscape.

6.2. The consultation has included:

- Two Stakeholder Engagement Workshops, held in November 2015 and June 2016, with representation from Housing, Adult Social Care, Public Health, the Community and Voluntary Sector, CCGs, Residential Environmental Health Services, and providers of social housing and supported accommodation
- Engagement workshops in January 2016 with representatives from voluntary sector organisations
- An online consultation on the key findings and draft recommendations took place following stakeholder event in June 2016

- A presentation and discussion at the CCG's Governing Body in July 2016
- The JSNA findings were fed into a consultation event organized by Adult Social Care to be incorporated into the design of the new tender for a carers service across the three boroughs
- Targeted engagement with various departments and agencies throughout the process. In June 2016 key stakeholders were invited to comment on particular sections and key recommendations of relevance to them.

6.3. Housing, Adult Social Care and the CCG have welcomed the JSNA and the recommendations, and have submitted written responses highlighting the recommendations they are keen to progress (see appendices 1-3).

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. 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.)

7.2. The focus of the JSNA is the housing support and care needs of residents who are vulnerable due to poor health and wellbeing and/or poor housing conditions. There is a high correlation between many of the protected characteristics and deprivation, and between deprivation and poor housing conditions. The recommendations of the JSNA can therefore be expected to make a positive contribution to reducing health inequalities and delivering of Hammersmith and Fulham's equalities objectives.

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: Richard Simpson, Finance Manager – Public Health, 020 7641 4073.

10. RISK MANAGEMENT

10.1. Public Health risks are integrated into the councils Strategic Risk Management framework and specific risks associated with the reduction to budgets 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 Management Team level and are referenced to in the periodic reports to Audit Committees.

10.2. The proposals contribute positively to the management of a number of risks on the council's Shared Services Risk Register most importantly by meeting the needs and expectations of services users and improving wellbeing of the local community whilst reducing inequalities for all ages. The assessments of the current and future health and social care needs of the local population facilitated through a developed series of local evidence-based priorities for commissioning and strategies, which will improve the public's health contribute strongly towards management of commissioning or market testing risk.

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

11. PROCUREMENT AND IT STRATEGY IMPLICATIONS

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

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

No.	Description of Background Papers	Name of holder of file/copy	Department/ Location
1.	Hammersmith and Fulham Older People's Housing Strategy	Helen McDonough	Housing
2.	North West London Sustainability and Transformation Plan	North West London Collaborative of Clinical Commissioning Groups	NHS
3.	Joint Health and Wellbeing Strategy [draft]	Harley Collins	Health and Wellbeing Board

LIST OF APPENDICES:

Appendix 1: Adult Social Care response to the JSNA
Appendix 2: LBHF Housing Department response to the JSNA
Appendix 3: H&F CCG response to the JSNA
Appendix 4: Housing support and care: Integrated solutions for integrated challenges: London Borough of Hammersmith & Fulham, JSNA

Appendix 1

Adult Social Care response to the JSNA

Adult Social Care endorses the recommendations of the Housing support and care JSNA. Officers were fully involved in the production of this JSNA and the recommendations align with the principles underpinning Adult Social Care as well as the current and proposed commissioning priorities.

One area for which Adult Social Care would be keen to use the report as a spring board for greater collaboration with immediate effect is to strengthen supported housing services to deliver improved outcomes and better value.

Appendix 2

LBHF Housing Department response to the JSNA

The Housing Department welcomes the production of the JSNA and supports the JSNA and its recommendations. Officers were engaged in each stage of the report's development and played a key role in shaping the commentary as well as the recommendations.

The Department has produced a response to the report (available on request) which includes notes against each recommendation and will help in the development of implementation plans. The response highlight's the report's complementarity to the borough's Older People's Housing Strategy and, as well as endorsing each recommendation, the response offers additional examples of good practice in Hammersmith and Fulham and highlights those recommendations for collaborative action which have particular resonance:

- Increasing access and manoeuvrability (recommendation 1)
- Improving housing conditions (recommendation 2)
- Enhancing community resilience (recommendation 4)
- maintaining and building on advice, information and outreach services (recommendation 5),
- improving housing options for older people (recommendation 12)

As with all partners, data sharing is identified as having central importance.

Appendix 3

Hammersmith and Fulham CCG response to the JSNA

Senior Personnel were engaged with the development of the commentary and key messages. The CCG's Governing Body formally received the report and the feedback (available on request) confirmed the following:

- Recommendations are well received and there is clear alignment with the North West London Sustainability & Transformation Plan
- Programmes already underway will both contribute towards delivery of the recommendations and be shaped by them
- Data sharing is of central importance
- Those recommendations which support delivery of the Like Minded Strategy are a particular priority.

JSNA
Joint Strategic Needs Assessment

Housing support and care: Integrated solutions for integrated challenges

London Borough of Hammersmith & Fulham

Joint Strategic Needs Assessment (JSNA)

July 2016

www.jsna.info

An introduction to JSNAs

The purpose of JSNAs is to improve the health and wellbeing of the local community and reduce inequalities for all ages by informing all relevant parties about the health and social care needs of the local population and how these may be addressed. They are assessments of the current and future health and social care needs of the local population, with the core aim of developing local evidence-based priorities for commissioning and strategies. The needs identified may be met by the local authorities, CCGs, NHS providers or others.

JSNAs are a continuous process of strategic assessment and planning and are an integral part of CCG and local authority commissioning and planning cycles. Their agreed priorities are used to help to determine what actions local authorities, the local NHS and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing.

The Health and Social Care Act 2012 placed the duty to prepare a JSNA equally and explicitly on local authorities and CCGs, exercised through the Health and Wellbeing Boards. Health and Wellbeing Boards are able to decide when to update or refresh JSNAs or undertake a fresh process to ensure that they are able to inform local commissioning plans.

This report

This JSNA considers integrated approaches which might better support the provision of housing support and care for residents of the London Borough of Hammersmith and Fulham. It explores the way in which the Council's departments and services might collaborate more closely with each other and with NHS partners to improve customer journeys and cost benefit ratios, thereby preventing unnecessary deterioration in health and wellbeing, delaying inevitable deterioration and mitigating the impact of deterioration when it occurs.

JSNAs consider borough based data[1] alongside that from other boroughs. The Public Health department, which leads the production of JSNA reports, services three boroughs. As this report explores challenges which are shared by all three, and as one of the key departments responsible for service delivery serves the same three boroughs, the material draws on data and activity across all three.

It is clear that there is much activity already in place which seeks to address the challenges of providing housing support and care. This report makes a series of recommendations which seek to build on this activity, to provide levers for extending existing good practice and existing partnerships and to try new approaches in close collaboration. These recommendations build on the findings of pre-existing local research and reports, and draw on national, regional and local evidence. They have been drafted in collaboration with key stakeholders. The intention is to stimulate where necessary a conversation centred around integrated efforts, to ensure

[1] Some data was drawn from the Borough Profile, a document produced on a regular basis and last updated in 2014.

that the right services are delivered in the right place at the right time, with a focus on improving outcomes for those most in need.

Equalities statement

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. The "local area" is the London Borough of Hammersmith and Fulham, the population living in or accessing services within the area, and those people residing out of the area for whom Hammersmith and Fulham CCG and the local services have responsibility. 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.).

The focus of the JSNA is the housing support and care needs of residents who are vulnerable due to poor health and wellbeing and/or poor housing conditions.

There is a high correlation between many of the protected characteristics and deprivation, and between deprivation and poor housing conditions. The recommendations of the JSNA can therefore be expected to make a positive contribution to reducing health inequalities and thereby contributing to delivery of Hammersmith and Fulham's equalities objectives[2].

Authors and contributors

This JSNA has been co-produced by Adult Social Care, the Housing department and Public Health. The report was written by Anna Waterman with Irene Fernow and Jessica Nyman.

Acknowledgements

We would like to thank all those who attend the various stakeholder engagement events and discussions for their involvement in the production of this report. We would particularly like to thank Mike Boyle, Colin Brodie, Lisa Cavanagh, Julia Copeland, Kim Dero, Steven Falvey, James Hebblethwaite, Connie Junghans, Jonathan Lillestone, Helen McDonough, Rebecca McKie, Chidi Okeke, Peter Smith, Sharon Thurley and Rianne Van Der Linde.

[2] https://www.lbhf.gov.uk/councillors-and-democracy/about-hammersmith-fulham-council/strategies-and-plans/equality-objective-2016

CONTENTS

1 Executive Summary

1.1 Introduction

There is a strong evidence base for the links between housing, health and wellbeing: good quality and appropriate housing is crucial to enabling people to stay healthy and well, and less likely to need more costly health and social care interventions. Poor quality housing and homes which do not lend themselves to effective delivery of care packages can give rise to health and social care needs, exacerbate existing needs and lead to early loss of independence.

While many residents live in homes which support their health and wellbeing, there are resident's cross-tenure who do not and residents who need supportive housing. The services which councils provide to address this are an important part of the package available to support residents in maintaining their independence. It is these on which this JSNA focuses, placing the resident at the centre.

1.2 Approach

This report focuses specifically on the shared challenges which can only be addressed through collaborative working, not on those which can be resolved largely within single departments.

It draws on local research and reports produced for other reviews, for example of specific housing solutions, a specific set of services, or the needs of a particular cohort of residents or patients. It presents data analysis, comparing local data with meaningful benchmarks, and evidence from a number of sources. It seeks to build on existing good practice locally and to learn from practice elsewhere.

The Public Health department, which leads the production of JSNA reports, services three boroughs. As this report explores challenges which are shared by all three, and as one of the key departments responsible for service delivery serves the same three boroughs, the material draws on data and activity across all three. This adds depth to the report, facilitating greater understanding of the challenges.

Throughout, stakeholder engagement has been central to this JSNA. Public Health has held a co-ordinating role, brokering cross-departmental and cross-agency discussion on the shared challenges identified, and offering analysis of data, evidence and the economic case for investment upstream. The engagement and intelligence offered by a range of stakeholders across the system, through workshops, team meetings, third sector forums and one to one discussions, has ensured that the report is rooted in the

local landscape and is able to offer recommendations which offer levers for meaningful change.

1.3 Aims

This JSNA has five overarching objectives:

- To present an overview of the impact of poor housing on residents' health and wellbeing;
- To articulate key strategic drivers and the constraints Local Authorities face in addressing the support needs of residents;
- To explore the economic case for integrated approaches and working 'upstream';
- To identify key issues which require integrated strategic planning by health, housing and Adult Social Care;
- To identify potential measures which might enable the local authorities to utilize their assets more effectively and enable residents to maintain their independence for as long as possible through providing the appropriate mix of support at the right time.

1.4 Main findings

There is a significant challenge facing the Local Authority. The borough is one of the most densely populated areas in the country and demand for accommodation is very high, as reflected in house prices. There is limited housing which is affordable by households on low incomes / benefits, and demand for social and affordable housing outstrips supply, leading to long waiting times for social housing. In addition, a large proportion of properties in the private rented sector are in poor condition.

Another challenge is the size and age of the stock available: the great majority is flats, the number of family sized homes is limited and space for further development also limited. As a result, people requiring larger properties or ones which meet the four accessibility features have limited opportunity. All of these characteristics can exacerbate pre-existing health and well-being issues and/or our ability to address them, through the timely delivery of care and/or re-housing.

Hammersmith and Fulham's housing department has strategies in place to address the challenges and there is much activity underway, however the characteristics of housing in the borough limit the capacity of the system to respond to demand.

New legislation such as The Care Act 2014 and direction such as the NHS 5 Year Forward View have shifted the focus of health, housing and social care closer to prevention as demand needs to be managed effectively. Indeed, the evidence

overwhelmingly shows cost effectiveness of prevention and early intervention far outweighs that of support packages further down the line and that, without significant investment in prevention and early intervention, councils face escalating costs.

A significant percentage of the working age population have a disability and/or mental illness, and enablement and capacity building is essential to reduce demand on services. The management and treatment of chronic disease is paramount, and maintaining quality of life and providing joined up, high quality services are crucial.

Evidence also demonstrates that effective prevention requires robust partnership work across council departments, with NHS partners and with other front line agencies. To respond effectively to the fiscal climate therefore, commissioners are seeking new ways of working. An increase in joint commissioning, potentially pooling budgets beyond the existing and planned arrangements between NHS and ASC to incorporate other agencies, such as housing and other council departments, may be the only realistic way forward.

Regional and local policy initiatives seek to meet the challenge of reconciling increased demand with reducing budgets through greater focus on prevention and early intervention, and securing best use of existing resources. This is captured in the borough's refreshed Joint Health and Wellbeing Strategy, which emphasises digitalisation, workforce development and greater integration. This JSNA contributes to the continued development of these themes.

1.5 Foundation stones

The recommendations highlight seven common interwoven threads which offer important messages for how systems might be better structured. They are referred to in this report as foundation stones on which cost effective personalised prevention and early invention might rest.

- Joint commissioning and pooled budgets: Recognising the links between housing, health and social care, and the restrictions on how specific budgets can be used, commissioners need to increase the use of pooled budgets as a way of unblocking solutions and facilitating closer collaboration. This might enable greater weighting towards 'upstream' prevention and earlier intervention.

- IT data sharing protocols and information governance: Collaborative work to facilitate and enable information exchange between organisations, supported by robust information governance protocols and initiatives to facilitate

patients' confidence in appropriate disclosure, is required if cost effective personalised prevention and early intervention are to be realised.

- Smooth customer journeys supported by referral rights and referral pathways: work building on existing best practice is required to ensure that, regardless of where a resident makes first contact, the offer is consistent and secures optimal impact.
- Quality services and facilities, appropriately tailored and targeted: This report seeks to highlight services which secure positive outcomes for some of our most vulnerable residents and which might play a greater role in facilitating cost effective provision than may previously have been recognised.
- Asset based approaches[3] (for individuals and for communities): This report advocates the development of strategies which explicitly seek to strengthen community resilience and practices which utilise residents' own strengths.
- Workforce development: Ensuring that staff teams are skilled-up, confident and supported to address the challenge is essential if positive outcomes are to be achieved.
- Local intelligence: This foundation stone refers to securing greater understanding of the local landscape. Two specific areas highlighted are Fuel Poverty and those in severe and multiple disadvantage.

[3] Communities that are more connected need fewer public services, create dynamic places to live, and improve outcomes for residents.

1.6 Recommendations

This JSNA seeks to identify integrated solutions to shared problems in areas of provision which rely on partnership working. These fall into five themes:

- Strengthening prevention and early intervention
- Delivering personalised housing support and care
- Strengthening collaborative approaches to supporting carers
- Improving the offer for those in severe and multiple disadvantage
- Improving housing options in later life

The recommendations are not exclusively addressed for the Housing department, for Adult Social Care or indeed other departments or agencies. They will need to be addressed in partnership by the relevant teams or departments and the lead may be different for each recommendation. Section 7 presents the full set of recommendations with a steer as to what success might look like. It also proposes which department or organisation might take a lead on each.

Strengthening prevention and early intervention

Recommendation 1: Increase the number of homes in the borough which offer residents easy access and manoeuvrability.

Recommendation 2: Improve housing conditions, cross tenure, to facilitate efforts to maintain residents' health and wellbeing.

Recommendation 3: Ensure that resources and arrangements are in place to support people to maximise their range of life skills and confidence, enabling them to live independently in the community.

Recommendation 4: Ensure that strategies are in place to promote community cohesion and prevent and alleviate social isolation.

Recommendation 5: Ensure the development of an asset based approach to the delivery of robust front-of-house, information, advice and outreach services, which promote independence and self-reliance and are tailored and targeted to secure best impact.

Recommendation 6: Extend the reach of front line services by embedding the 'Making Every Contact Count' (MECC) approach.

Delivering personalised housing support and care

Recommendation 7: Establish data sharing appropriate protocols and governance processes across council departments, NHS partners and other front line provider agencies working to support vulnerable residents.

Recommendation 8: Ensure support and care pathways, between front line staff in Housing (including REHS & RPs), ASC, health services, Children's Services and voluntary sector partners, facilitate smooth customer journeys and effective care.

Recommendation 9: Consider undertaking a multi-agency evidence review of options for increasing the supply of move-on accommodation within the challenging landscape.

Strengthening collaborative approaches to supporting carers

Recommendation 10: Ensure that appropriate strategies are in place to increase the proportion of informal carers who are known to services and in receipt of appropriate support.

Improving the offer for those in severe and multiple disadvantage

Recommendation 11: Building on existing innovative approaches, develop models, potentially using pooled budgets, to deliver more cost effective, integrated health, housing and social care solutions to those in severe and multiple disadvantage.

Improving housing options in later life

Recommendation 12: The Council must use every opportunity to increase the range of desirable housing options for older people in both the social and private sectors, using innovative partnerships, and ensure their take up.

1.7 Implementation

This JSNA will be discussed at the Health and Wellbeing Board meeting in September 2016. Discussion will be framed to ensure that the appropriate lead for progressing each recommendation is identified and a roadmap for delivery agreed which secures buy-in on the front line.

2 Introduction

This JSNA considers integrated approaches which might better support the provision of housing support and care for residents of the London Borough of Hammersmith and Fulham. It explores the way in which the Council's departments and services might collaborate more closely with each other and with NHS partners to improve customer journeys and cost benefit ratios, thereby preventing unnecessary deterioration in health and wellbeing, delaying inevitable deterioration and mitigating the impact of deterioration when it occurs.

The JSNA is being published at a time of great change, with current spending projections suggesting significant financial pressures on services for the next 20 years[4]. There is a growing desire and recognition across the UK for devolved power and in 2015, a health and care devolution agreement for London was signed[5] which would allow a place based approach, offering opportunities to do things differently, and there are suggestions that London should seek further devolved powers to help address the housing crisis[6]. Place based approaches, which seek to achieve better outcomes at a lower cost[7], are considered by some to be integral to public sector reform, bringing a greater number of partners together to work collaboratively[8] and offering an opportunity to address the broader drivers of poor health, including housing[9]. This context provides an important backdrop to the JSNA.

It is clear that there is much activity already in place which seeks to address the challenges of providing housing support and care. This report makes a series of recommendations which seek to build on this activity, to provide levers for extending existing good practice and existing partnerships and to try new approaches in close collaboration. These recommendations build on the findings of pre-existing local research and reports, and draw on national, regional and local evidence. They have been drafted in collaboration with key stakeholders. The intention is to stimulate where necessary a different kind of conversation centred around integrated efforts, to ensure that the right services are delivered in the right place at the right time, with a focus on improving outcomes for those most in need.

[4] The King's Fund 2012, Future Trends. http://www.kingsfund.org.uk/time-to-think-differently/trends
[5] Prtners to the agreement include: London Councils, PHE London regions, NHS England London Region, the GLA and London CCGs.
[6] London Assembly, 2016: At Home with Renting: Improving security for London's private renters https://www.london.gov.uk/sites/default/files/at_home_with_renting_march_2016.pdf
[7] The King's Fund, 2010: Place-based approaches and the NHS. Lessons from Total Place.
[8] http://www.local.gov.uk/c/document_library/get_file?uuid=8541bff1-fab7-413b-b2ef-d02ce743fcdb&groupId=10180
[9] http://www.nlgn.org.uk/public/2016/get-well-soon-reimagining-place-based-health/

2.1 Knowledge gaps and research questions

This JSNA has five overarching objectives:

1. To present an overview of the impact of poor housing on residents' health and wellbeing;
2. To articulate the strategic drivers, the constraints Local Authorities face in addressing the support needs of residents;
3. To explore the economic case for integrated approaches and working 'upstream';
4. To identify key issues which require integrated strategic planning by health, Housing and Adult Social Care;
5. To identify potential measures which might enable the local authorities to utilize their assets more effectively and enable residents to maintain their independence for as long as possible through providing the appropriate mix of support at the right time.

2.2 Scope

Given the scale and complexity of the challenge facing Local Authorities in relation to housing, a number of pieces of work have been undertaken or are underway to identify how best different housing solutions might be utilized.

This JSNA does not seek to duplicate this work, and analysis of need for particular types of housing is therefore outside scope. A brief outline of these reviews is included as appendix one.

The primary focus of this report is the way in which Local Authority departments and services might collaborate more closely with each other and with NHS partners to improve cost benefit ratios, preventing unnecessary deterioration in health and wellbeing, delaying inevitable deterioration and mitigating the impact of deterioration when it occurs.

2.3 Stakeholder engagement

This report has sought to take a 360^{O} view of housing and care in Hammersmith & Fulham. In order to achieve this, extensive engagement was undertaken with a broad range of stakeholders both to determine the scope of the JSNA and to identify the conclusions and recommendations. This engagement took the form of face to face interviews, group meetings and stakeholder workshops with council and NHS staff, and the third sector. Some of these were designed around the breadth of the scope, others considered specific issues in greater depth.

A brief outline of the larger engagement initiatives can be found as appendix two. A more detailed account of stakeholder engagement can be made available upon request.

3 The local landscape

3.1 Housing and health: the evidence[10]

Good quality and appropriate housing are crucial to enabling people to stay healthy and well, and less likely to need more costly health and social care interventions. Poor quality or inappropriate housing or accommodation can give rise to health and social care needs, exacerbate existing needs and can lead to early loss of independence: addressing housing thereby supports delivery of health and care outcomes[11].

There is a strong evidence base for the impact that inappropriate and poor quality housing has on health and wellbeing. In some instances this can lead to a quicker deterioration in residents' health[12], for example as a result of a fall, an inability to maintain personal hygiene or keep the home sufficiently warm. Risk factors for hospital admission and deterioration include cold and associated damp and mould as a precipitant for cardiovascular, respiratory, rheumatoid disease and mental illness for example, and exposure to hazards. The biggest and most costly housing hazards impacting on NHS costs include damp and mould, excess cold, falls, collision and entrapment hazards and fire or hot surfaces, as well as lead poisoning.

Similarly, once a care need exists, inadequate housing, inability to adapt the home for the persons need or mobility restrictions risk further deterioration as well as premature placement in a residential setting, which could have been avoided with adequate housing provisions. The services councils provide to address these issues are an important part of the package available to support residents in maintaining their independence.

3.2 The housing stock

i. Size

The London Borough of Hammersmith and Fulham is one of the most densely populated areas in the country. A fundamental challenge for the Council is the poor match between the accommodation available and the needs of residents, be these housing based needs, or care needs.

[10] Fair Society, Healthy Lives, The Marmot Review, Strategic Review of Health Inequalities in England Post 2010

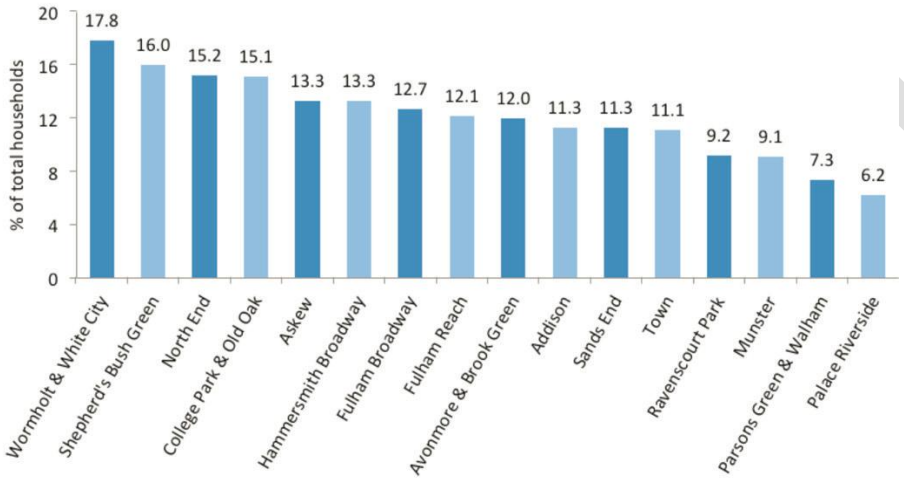
[11] Housing, health and care integration toolkit, Foundations, December 2013

[12] http://www.just-fair.co.uk/#!United-Nations-Austerity-policies-breach-the-UK%E2%80%99s-international-human-rights-obligations/qbw0c/577384fa0cf231749dc9f955

Hammersmith and Fulham has a high proportion of one and two bedroom properties, on a par with Inner London (66%)[13]. Occupancy rating provides a measure of whether a household's accommodation is overcrowded or under occupied. The proportion of the borough's households that have one fewer room than required was 27.6% compared with 21.7% in London and 8.5% in England and Wales. This is the eleventh highest proportion in England & Wales (Census 2011). Figure one shows this data by ward.

Children living in poor or overcrowded housing are more likely to have respiratory problems, be at risk of infections, and experience long-term ill health and disability. They are also more likely to experience mental health problems such as anxiety and depression. It can also affect nutrition and development, educational attainment and future life opportunities[*].

Figure 1: Households with fewer bedrooms than required, by ward



Source: Census 2011

The average waiting time for a 2 bed property in LBHF is currently 23 months, for a 4 bed property, 43 months[14]. Averages can be misleading, however, as households with different priority will wait different amounts of time.

Working with partners, the Council has delivered a number of successful projects aimed at mitigating the impact of overcrowding, including case workers offering a range of support and minor space saving adaptations. It is important for children in overcrowded homes to have access to open spaces and good quality safe outdoor play experiences. There are many good quality parks, open spaces and playgrounds in each of the local authority areas and there has been significant

[13] file:///Q:/1512RBKC_SHMA%20(1).pdf
[14] https://www.lbhf.gov.uk/housing/applying-council-housing
[*] Fair Society, Healthy Lives, The Marmot Review, Strategic Review of Health Inequalities in England Post 2010.

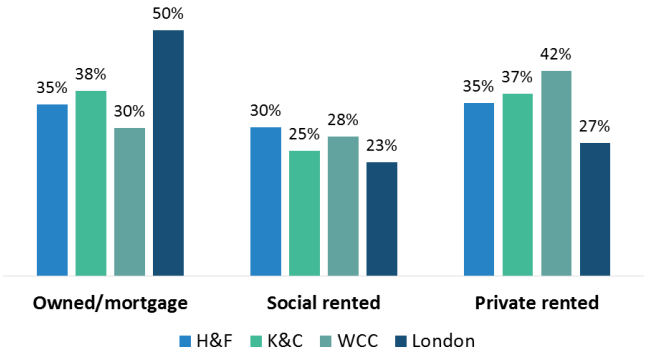
investment in playgrounds and parks in recent years. It is important that this legacy is maintained and that children and families can continue to access safe open spaces and playgrounds within their communities.

The mismatch between stock and need is exacerbated by under-occupancy, i.e. family sized accommodation housing single primarily older person households. While some residents simply value having the additional space, evidence suggests that among those aged over 60, 58% would move to more suitable accommodation but that there is reluctance due to a lack of suitable alternatives or fear of an unfamiliar environment, as well as a desire to retain the asset to pass on[15]. However, under-occupancy is present alongside overcrowding[16] and there is an incentive for Local Authorities to encourage under occupiers to move into more suitable accommodation in a way which frees up larger properties for use as social and/or intermediate housing (see section 6.5).

ii. Affordability

Hammersmith and Fulham is among the least affordable boroughs in London to buy a property, and private sector rents are high. There is a lower proportion of residents who are owner occupiers than the London average, and a higher proportion in the rented sectors, particularly the private rented sector. Due to the high value of properties, most are higher than the housing benefit maximum allowance.

Figure 2: Tenure of residents of all age by borough, 2011



Source: Census, 2011[17]

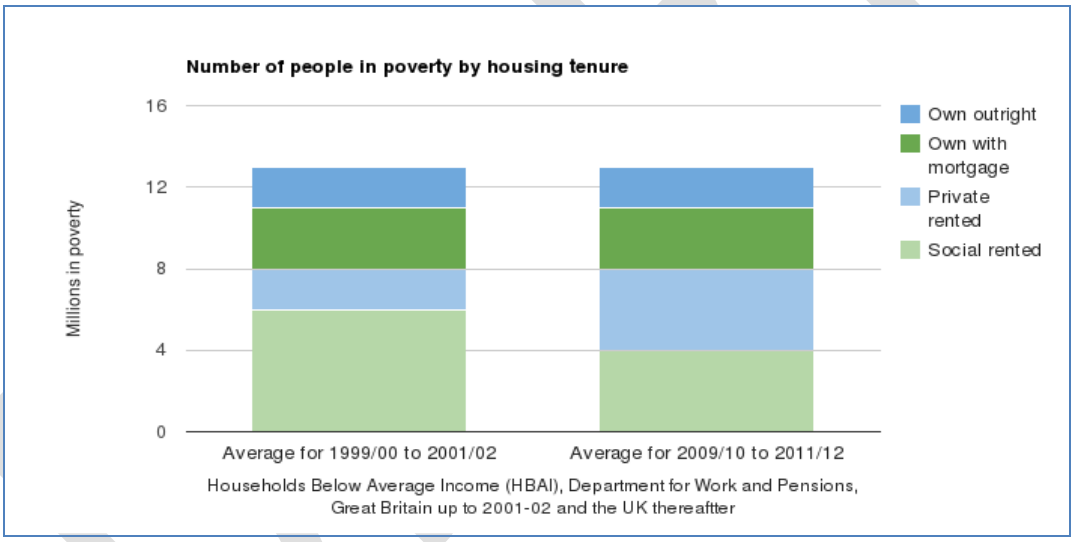
Hammersmith and Fulham has a higher proportion of stock in the social rented sector (31.1%) than the London average of 24.1%[18], however demand still far outstrips supply. High land costs make it hard for the Local Authority and

[15] Wood, C. *The top of the ladder.* DEMOS, 2013
[16] The impact of overcrowding on children particularly is discussed in the Child Poverty JSNA (2014).
[17] Strategic Housing Market Assessment for Hammersmith & Fulham 2014/15, Kensington and Chelsea Dec 2015 and Westminster Housing Market Analysis: Final Report Dec 2014, by Wessex Economics.
[18] 2011 Census: Tenure, local authorities in England and Wales, Table KS402EW

registered providers to develop new supported housing schemes and new sub-market or affordable housing. As a result, there are long waiting lists and the borough is increasingly dependent on temporary housing, which carries a heavy financial burden. The high value of properties is largely prohibitive for the Council when seeking to discharge homelessness applicants into the private rented sector and to procure temporary accommodation properties in-borough. Temporary accommodation can have a negative impact on health and wellbeing for a variety of reasons[19]. Properties are sourced for temporary accommodation from the lowest cost end of the market and the Councils enforce rigorous standards. However, the nature of temporary accommodation means that the properties are leased and the leases are not always renewed (when landlords wish to have their properties returned), which causes uncertainty.

Figure 3 below shows the number of people in the UK living in poverty, by housing tenure, highlighting that owner-occupiers account for 5 million of these.

Figure 3: Number of people in poverty by housing tenure



Source: DWP

A key consequence of increased life expectancy is that people will have to manage their retirement income and assets over a longer period than past generations[20]. Increased life expectancy, in combination with increased living costs and a tighter fiscal climate, is also leading to an increase in the number of older residents in the private sector living in family sized accommodation which they cannot afford

[19] Fair Society, Healthy Lives, The Marmot Review, Strategic Review of Health Inequalities in England Post 2010, page 79.
[20] Consumer Demand for Retirement Borrowing, Louise Overton and Lorna Fox O'Mahony, November 2015.

adequately to maintain, a situation compounded by a lack of appropriate and suitably priced property to facilitate downsizing.[21][22]

The combined impact of welfare reform and the Housing and Planning Act is likely to lead to a net loss in affordable housing locally, at least in the short term, and so greater reliance on the private sector for temporary accommodation and/or more permanent private rented offers.

iii. Quality and improvements

The condition and structure of housing and its amenities can significantly impact on health and well-being. Poor ventilation, energy efficiency, insulation, damp, condensation, and inefficient heating / excess heat can all have an impact on health and lead to and exacerbate long term medical conditions. The high proportion of housing stock comprised of flats, older properties and properties in conservation areas make many homes 'difficult to treat' with traditional methods such as cavity wall and loft insulation.

Hammersmith and Fulham has a high proportion of flats, representing 74% of dwellings. This presents challenges in ensuring appropriate access and safety, without which older people and those with life limiting illness and/or disabilities, who as figure four shows below represent 17% of the population, can be left feeling isolated and/or unable to leave their home unaided, as reported by voluntary/community sector stakeholders.

Figure 4: Long term health problem or disability by age

	H&F	London
Younger than 65 years, no limiting long term illness	83%	81%
Aged over 65 or with limiting long term illness	17%	**19%**
• ***Younger than 65 with limiting long term illness***	*8%*	*8%*
• ***Older than 65 years***	*9%*	*11%*
Total	100%	100%

Source: Census 2011

Recent analysis of the English Household Survey carried out by Future Climate shows that flats are less energy efficient than is commonly assumed and highlights that private sector blocks of flats and converted homes are being insulated at a significantly slower rate than houses[23]. There are a number of legal, practical and

[21] https://www.jrf.org.uk/press/home-cash-plan-help-income-poor-older-people-stay-their-own-homes
[22] Overton and Fox O'Mahony, Consumer-demand-for-retirement-borrowing, 2015
[23] http://futureclimate.org.uk/wp-content/uploads/2015/06/Futureproofing-Flats-Event-Report-Final.pdf

social barriers to improvements of common parts which can impede ability to carry out relevant adaptations and improvements[24].

The proportion of all homes subject to planning restrictions / conservation orders, which can prevent action to improve the quality and/or appropriateness of the stock, is high, at around 50% in Hammersmith and Fulham[25].

Vulnerable occupiers, such as older people and those with poor health and/or disability, are particularly at risk and also have the greatest exposure to a cold home environment due to the lengthy periods that they spend indoors. Older people are likely to be disproportionately represented in worst stock.

iv. Local responses

The Council's housing strategy discusses each of the issues above in greater depth, setting out priorities. They are outlined in section 3.4 below.

Hammersmith and Fulham has also identified five Regeneration Areas which are anticipated to be the key focus for growth in the borough over the next 20 years. Together, these regeneration areas have the capacity to deliver approximately 36,000 homes.

Finally, the Smarter Budgeting programme, which seeks to consider how best the Council might work in new ways to address more effectively the needs of its residents and secure greater value for money, has developed during production of this report. The programme identified a number of outcomes which mirror some of the findings in this report. These will need to be appropriately reflected in the implementation plans which arise from the recommendations (see section 7).

Headlines

There is a significant challenge facing the Local Authority, which covers one of the most densely populated areas in the country. Demand for social and affordable housing outstrips supply, leading to long waiting times for social housing. In addition, a large proportion of properties in the private rented sector are in poor condition.

The housing department has strategies in place to address the challenges and there is much activity underway, however the characteristics of the housing stock limit the capacity of the system to respond to demand.

[24] Wendy Wilson, Social Policy Section Disabled adaptations in leasehold flats & common areas, Standard Note: SN/SP/3133, 27 March 2012

[25] https://www.lbhf.gov.uk/planning/urban-design-and-conservation/conservation-areas

3.3 Fiscal climate

Local Authorities are facing significant financial challenges at a time when demand for housing, health and social care services is growing. NHS, Housing Services and Adult Social Care are under increasing pressure, through a combination of reduced budgets, an aging population, Housing and Welfare Reform and a requirement to implement significant reforms under the Care Act. Across North West London, it is estimated that if we continue to operate as we do now then by 2021 there will be a financial gap of between £500 million and £1.1bn in our health and care system[26].

It is widely recognised that to meet this gap, investment is needed in preventing poor health and wellbeing. However, finite resources render it difficult to shift resources upstream when demand on services among those with immediate needs is great. The nationally driven tightening of eligibility criteria for Adult Social Care recognises this demand but can mean that services are only able to provide care to residents once their wellbeing has decreased, rather than helping to prevent deterioration.

To respond effectively to the fiscal climate, commissioners need to increase the use of pooled budgets as a way of enabling closer health, housing and care collaboration with services weighted towards 'upstream' prevention and earlier intervention, and care in the community.

3.4 Strategic context and policy drivers

It is a period of uncertainty for the housing sector as significant changes to housing and welfare are underway through the Housing and Planning Act (2016) and the Welfare Reform and Work Act (2016) and changes to homelessness legislation are proposed. Although the full implications of these is unknown, affordable housing supply could decrease, at least in the short term, as homelessness presentations could go up.

Housing and Planning Act 2016[27]

The Housing and Planning Act 2016 contains a range of provisions on new homes, landlords and property agents, abandoned premises, social housing, planning, compulsory purchase, and public land (duty to dispose). It is a means of supporting delivery of the challenging targets for the London Mayor and central government to deliver large numbers of new properties across the country.

[26] Hammersmith and Fulham Joint Health and Wellbeing Strategy 2016-2021: Consultation Draft
[27] http://www.local.gov.uk/documents/10180/5533246/051316+LGA+Briefing+-+Housing+and+Planning+Bill+-+summary+at+Royal+Assent.pdf/669c7385-376a-45ea-b83b-2764c56a1d00

The Starter Homes provision that 20% of new supply on development sites should be Starter Homes, combined with the requirement on local authorities to make an annual payment to government based on the number of higher value voids that are likely to become vacant, could result in a decline in conventional affordable housing supply (i.e. social and intermediate housing) at least in the short term.

Welfare Reform and Work Act 2016

This legislation introduced reduced spending to lower the benefits bill and deficit. Amongst other things, the Act lowers the existing household benefit cap from £26,000 to £23,000 per annum (London) and freezes Local Housing Allowance rates for 4 years (supported housing is exempt). While the estimated number of residents leaving the borough as a direct result of previous welfare cuts has been lower than initially anticipated, possibly due to a combination of discretionary housing benefit payments and households making savings, the additional reductions are likely to increase the number of households presenting as homeless from the private sector, necessitating increased use of temporary accommodation.

The Act also introduces a requirement on registered providers of social housing in England to reduce social housing rents by 1% a year for 4 years. While this will benefit social tenants, the cost to the provider is to be covered through sales of assets which, in areas such as Hammersmith and Fulham should be expected to lead to a reduction in the amount of socially rented stock available within borough boundaries.

Anticipated housing legislation

The Government is considering changing homelessness legislation and a private members bill relating to this has been introduced to Parliament. This could place new legal duties on councils to prevent homelessness and to provide housing for a greater number of people when they are homeless.

The Care Act 2014

The Care Act primarily affects Adult Social Care, but is a duty on the entire local authority and specifically states that Housing and Adult Social Care must work together to prevent, delay or reduce individuals' needs for care and support. This is an important tool to address a common challenge for local service providers, that the Adult Social Care and Housing eligibility criteria are different, which can result in a number of vulnerable individuals falling into the gaps. It also states that local authorities should work with partners to identify unmet need and co-ordinate shared approaches to preventing or reducing such needs, developing joint commissioning arrangements to achieve health and wellbeing outcomes across the traditional service boundaries of housing, health, care and support.

There is a focus in the Act on enabling customers to live as independently as possible in the community including where appropriate in supported living schemes. There are, however, a number of people who may be vulnerable but are not eligible for adult care and support under the Care Act. This can result in multiple visits to different front line services, making delivery of positive outcomes challenging. Over time their needs commonly deteriorate and can result in anti-social behaviour, emergency admissions and greater reliance on public services. The most vulnerable among this group of residents are increasingly recognised as having 'severe and multiple disadvantage' and their needs are explored in section 6.4 of this report.

Better Care Fund

The Better Care Fund (BCF) is a single pooled budget to support health and social care services to work more closely together in local areas. It is a key delivery mechanism for promoting independent living in the community, enabling elderly or unwell people to stay out of hospital and recover their independence as quickly as possible. The Better Care Fund project locally includes the Community Independence Service (see appendix three), as well as other jointly funded initiatives.

The NHS Five Year Forward View (2014)

This document sets out a strategic vision and direction of travel for the NHS over the next five years including setting priorities and outcomes. It outlines the context in which the NHS and health and care services operate including variable quality of care, high levels of preventable illness and complex and deep-rooted health inequalities. Although it doesn't specifically discuss the role of housing, it sets a new direction for the NHS and makes clear that achieving 'a radical upgrade in prevention' will require new partnerships with organisations outside the NHS. It states that there is a broad consensus on what a "better future" for the NHS looks like, which includes:

- New partnerships with local communities, local authorities and employers
- A radical upgrade in prevention and public health
- Transformation to break down the barriers in how care is provided
- Opportunities to implement a range of service and delivery models – as opposed to a "one size fits all" policy.

NHS Planning Guidance – Delivering the Five Year Forward View (Sustainability and Transformation Plans) (2015)

The planning guidance asks all health and care systems (within self-defined geographies) to create comprehensive local blueprints for implementing and delivering the priorities of the Five Year Forward View, planning by place[28], rather than

[28] The King's Fund, 2010: Place-based approaches and the NHS. Lessons from Total Place.

planning by institution. Local places are asked to develop a shared vision which will support integration and service transformation. The Kings Fund's Place Based Systems of Care recommends that existing structures such as Health and Wellbeing Boards should be vehicle for leading the delivery of integrated and "place-based" care. It recommends services provide patient-centred, integrated and preventative care which is not only clinically informed but also informed by the partners delivering services that affect the wider determinants of wellbeing, specifically referencing housing.

North West London Sustainability and Transformation Plan

This document sets out the case for change, ambitions for the future in each of the eight boroughs covered and how efforts will be focused on locally identified priorities to address health and wellbeing, care and quality and finance and productivity. Among other characteristics, the document highlights the high proportion of residents living in poverty and overcrowded households, nearly half of the population aged over 65 lives alone, carrying the risk of social isolation, and the high proportion of Adult Social Care users wanting more social contact. The draft priorities include a local one which reads 'Ensure that no residents … are living in accommodation/homes that are making them sick'.

3.5 Local responses

ASC Business Plan

The H&F business plan sets out Adult Social Care's approach to care and support; delivering person-centred high quality, integrated care provided in people's homes and communities. The emphasis is on targeted prevention and support for vulnerable people to ensure they remain independent and healthy for as long as possible, delaying progression onto more intensive forms of care and ensuring appropriate care and support is available to patients as soon as they are medically fit for discharge from hospital. Key services, which provide care to support residents with tasks they cannot do themselves whilst enabling them to live as independently as possible, are the Community Independence Service, home care, telecare and meals on wheels. The Business Plan acknowledges that the suitability and safety of housing is central to enabling someone to be cared for in their home and of strategic importance to Adult Social Care and Health.

Local Prevention Offer

Prevention is critical to the vision of the Care Act: that the care and support system works to actively promote wellbeing and independence, and does not just wait to respond when people reach a crisis point. In response to this, the Adult Social Care team has developed a local prevention offer which applies to all adults, from those with no established need to those who need a lot of care and support in order to

prevent or delay need and deterioration of condition. The Council recognises that, although ASC plays a critical part, the responsibility for prevention is wider and approaches need to be integrated and aligned across departments and with other local partners. It identifies secondary and tertiary prevention as ASC's focus, in order to ensure that all services have a re-abling approach and encourage the customer to be as independent as possible. Being in suitable living accommodation, such as on the ground floor or in sheltered accommodation with outreach floating support, for example, can enable someone to continue safely to live independently. In relation to the development of preventative services we also take into consideration the 'Fs of Frailty'. This is seen as a good way to know when ASC can make an early intervention to prevent further needs as there is evidence that many of the conditions that can lead to frailty are amenable to preventative measures. These include: memory loss (**f**ailing memory), social isolation (loss of **f**riends and **f**amily), malnutrition (unhealthy **f**ood intake), **f**alls and living in cold damp homes (**f**uel poverty). These are each recurrent themes in this report.

Hammersmith & Fulham Housing Strategy

Hammersmith & Fulham's Housing Strategy 'Delivering the Change We Need in Housing' (May 2015) has three broad themes:

- Theme 1: Regenerating Places and Increasing Affordable Housing Supply
- Theme 2: Meeting Housing Need
- Theme 3: Excellent Housing Services for All

Under Theme 1, the Council sets out its aspiration to increase delivery of affordable housing, explore future options for council housing through the Residents' Commission and increase standards to the private rented sector. Theme 2 of the strategy sets out how the Council intends to adopt a new approach to eradicating homelessness through closer joint working with partners, its ambition to support older people to remain within their own homes for longer and highlights the importance of good joint working practices between Housing, Health and Social Care.

Theme 3 sets out a commitment to improve housing options for vulnerable groups including those with learning disabilities, mental health needs and physical disabilities, with support and resources to be focused on those with the highest and most complex needs. It is intended that the findings and recommendations within this JSNA will shape delivery of these aims within the strategy.

London Borough of Hammersmith and Fulham – Older People's Housing Strategy – 2016

In 2015/16 LBHF carried out an Older People's Housing Review to inform the development of Hammersmith and Fulham's Older People's Housing Strategy. The

Older People's Housing Strategy is a 'direction of travel' document setting out the key challenges and priorities for the authority. It includes actions and activities to address these challenges which will be developed in partnership with Health and the Third Sector and through closer working between Council Departments such as Adult Social Care and Housing.

The Older People's Housing Strategy will be published towards the end of 2016 and the priority areas for action are:
Priority 1 - Better understand what housing options older people need and want
Priority 2 - Maximise use of existing stock
Priority 3 - Increase housing options for older people
Priority 4 - Focus housing and support services around prevention to promote independence and reduce social isolation and loneliness.

Joint Health and Wellbeing Strategy (JHWS)

The JHWS is being refreshed for publication in Autumn 2016. It makes reference to the fact that 60% of health and wellbeing is attributable to the social determinants of health, housing being a major contributor. The vision places emphasis on person-centred and integrated prevention and early intervention and on supporting communities to stay healthy and independent in the community with choice and control over their lives.

The vision also commits to radically upgrading prevention and early intervention, mainstreaming prevention into everything that we do across the life course, and working across organisational and sector boundaries to achieve this. Housing is mentioned specifically as a key partner.

Headlines

New legislation such as The Care Act 2014 and direction such as the NHS 5 Year Forward View has shifted the focus of health, housing and social care closer to prevention as demand needs to be managed effectively.

Housing and Welfare reform is anticipated to lead to an increase in demand on already oversubscribed social housing with alternative suitable housing options limited.

The strong drivers to support residents to remain in their own home coupled with a challenging fiscal climate, render it imperative for Local Authorities to invest to best effect. This requires collaboration and integration.

Regional and local policy initiatives seek to meet this challenge, through increased focus on prevention and early intervention, best use of existing resources and levers.

4 Population need: supply and demand

4.1 Older People

Older people are the greatest users of health and social care services and are also the most complex to treat, often needing support with multiple conditions. The proportion of people aged 65+ living in Hammersmith and Fulham (9%) is slightly lower than the London average (11.1%).

Improved life expectancy and the ageing of the baby boom generation are expected to result in an increase in the number of people in London aged 65+ by 16% and aged 85+ by 35% over the next decade. Local figures are harder to predict and can be over-estimated, however modelling indicates an increase of 12% in Hammersmith & Fulham among those aged 65+[29]. These percentages are translated into numbers below.

Figure 5: Expected increase in the older population over the coming 20 year period

H&F	2014	2024	2034
65-74	9,824	10,322	13,231
75-84	5,523	6,837	7,439
85+	2,230	3,117	4,512
Total 65+	**17,577**	**20,277**	**25,182**

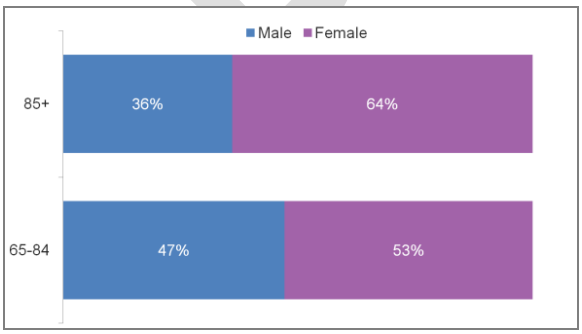
Source: Census 2011

As discussed in section 3.2ii, a key consequence of increased life expectancy is that people will have to manage their retirement income and assets over a longer period than past generations.

i. Gender

There are more women than men in the population of residents aged over 65 years, as is common in London and across England, and this becomes more pronounced with age. This is important for delivery of care, be this in the community or in some form of residential care.

Figure 6: Breakdown of residents by sex



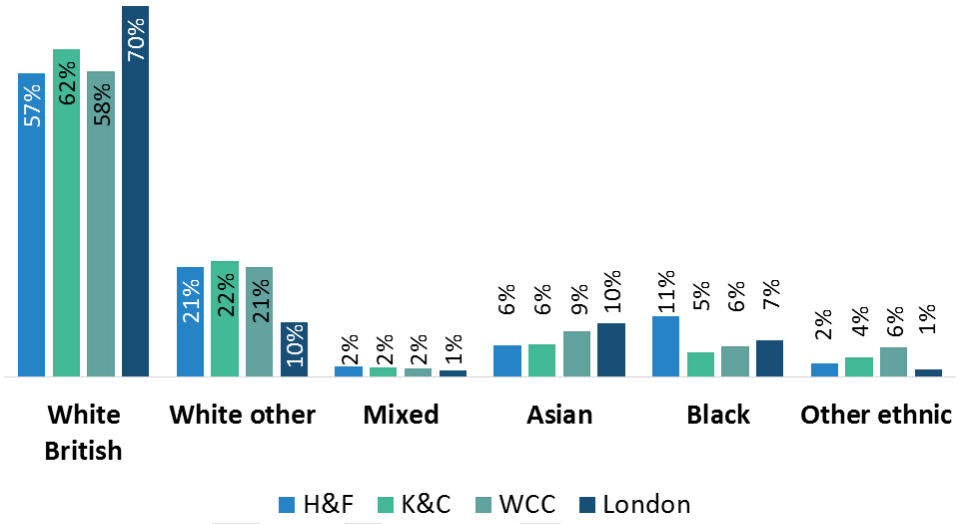
Source: Census 2011

[29] Tri-Borough Public Health Report, 2013-14

Data from ASC shows that men are under represented among their client base. 64% of older (65+ years) clients receiving homecare are women: there are twice as many older women than older men receiving homecare. There are similar trends in nursing/ residential care for older people and for direct payments. There are a number of potential reasons for this, including that women generally live longer than men and might provide unpaid care for their partners, delaying the need for Local Authority provision, and that men may be less likely to access services. Gender is an important consideration for service planning.

ii. Ethnicity

Figure 7: Percentage of residents aged 65 years and over by ethnic group, 2011



Source: Census 2011

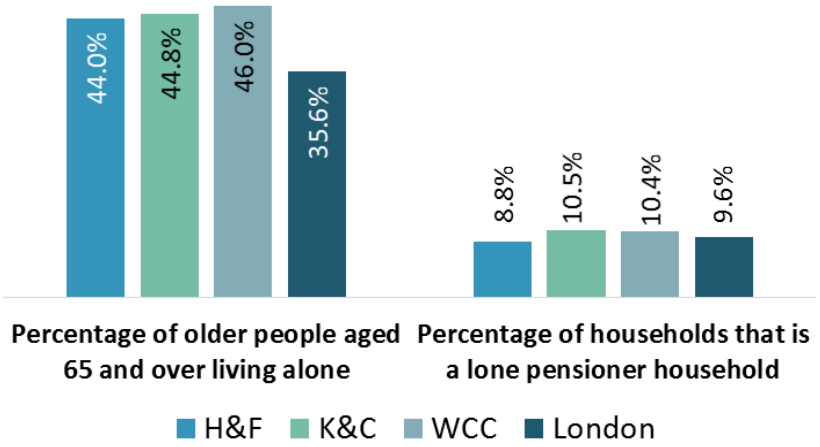
The proportion of clients of BAME origin can be expected to increase as the population ages. This will have implications for service delivery given that 3% of the population currently state they are not able to speak English well[30].

iii. Older people living alone

In Hammersmith and Fulham, 37.4% of older people live in single-person households[31], and 8.8% in a lone pensioner household. These figures are close to the London average (9.6%) but lower than that for England (12.4%)[32].

[30] JSNA Highlights Reports 2013/14
[31] Source: ONS, 2011 Census Table DC4404EW
[32] ONS, 2011 Census, Table KS105EW

Figure 8: Percentage of residents aged 65 years and over living alone in each of the three boroughs and London, 2011

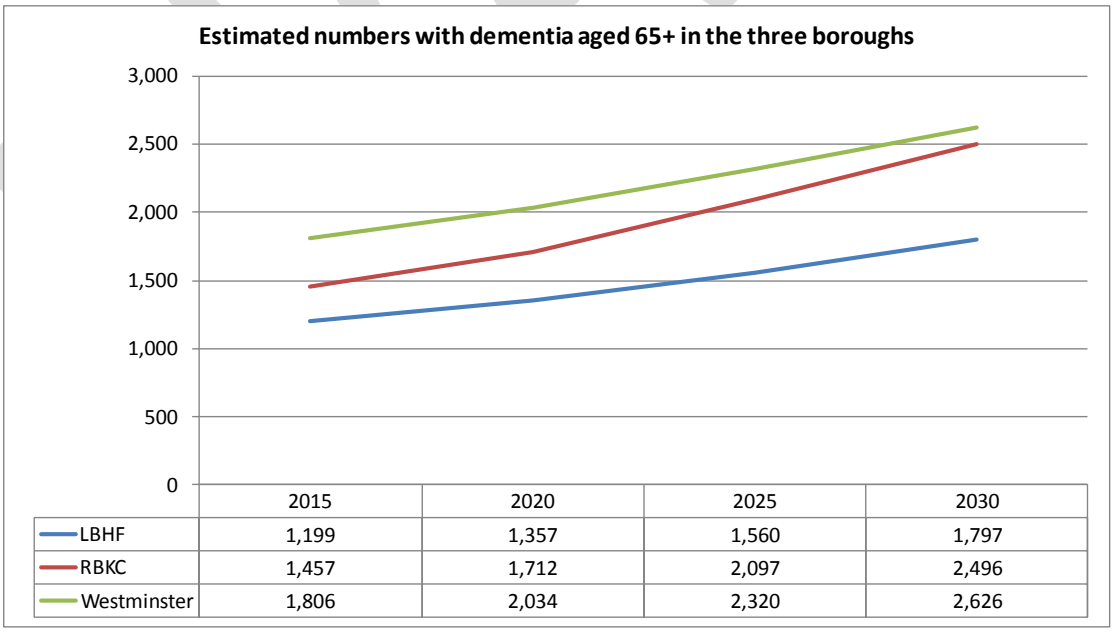


Source: Census 2011

iv. Dementia

The Dementia JSNA showed that the numbers of people living with dementia in the three boroughs is projected to increase by about 55% in the next 15 years, due to the greater number of older people age 80+. Around two thirds of those in care homes locally have a diagnosis of dementia.

Figure 9: Estimated numbers with dementia aged 65 years and older by borough



	2015	2020	2025	2030
LBHF	1,199	1,357	1,560	1,797
RBKC	1,457	1,712	2,097	2,496
Westminster	1,806	2,034	2,320	2,626

Source: GLA Population Projections http://data.london.gov.uk/dataset/gla-population-projections-custom-age-tables (accessed 1 July 2015, as referenced in the Dementia JSNA)

One of the themes of the Dementia JSNA is that whilst it is important to maintain independence, there needs to be an appropriate escalation of care when needed. Also, that there may be a need for increased training for paid and unpaid carers, residential care staff, and other appropriate professionals. Sections 6.1.6 Making Every Contact Count (MECC) and section 6.2 Personalised Housing Support and Care explore the themes around maximising opportunity and the importance of providing the right support at the right time.

The Dementia JSNA finds that Housing, Environment and Planning strategies do not specifically mention dementia or carers of people with dementia and recommends that the increasing numbers and needs of people with dementia and their carers are taken into account in wider local authority and health strategies, especially housing.

v. People aged over 65 on a low income

As shown in figure 10 overleaf, 28% of older people currently living in Hammersmith and Fulham are living in deprivation. If the percentage of older people living in poverty remains the same, this population is expected to grow over the next twenty years from 6,700 to 9,600 (42% increase) by 2030, due to population aging. The numbers for deprivation are important as they indicate need and the future burden on local authority housing and care.

Figure 10: Older people living in poverty in H&F

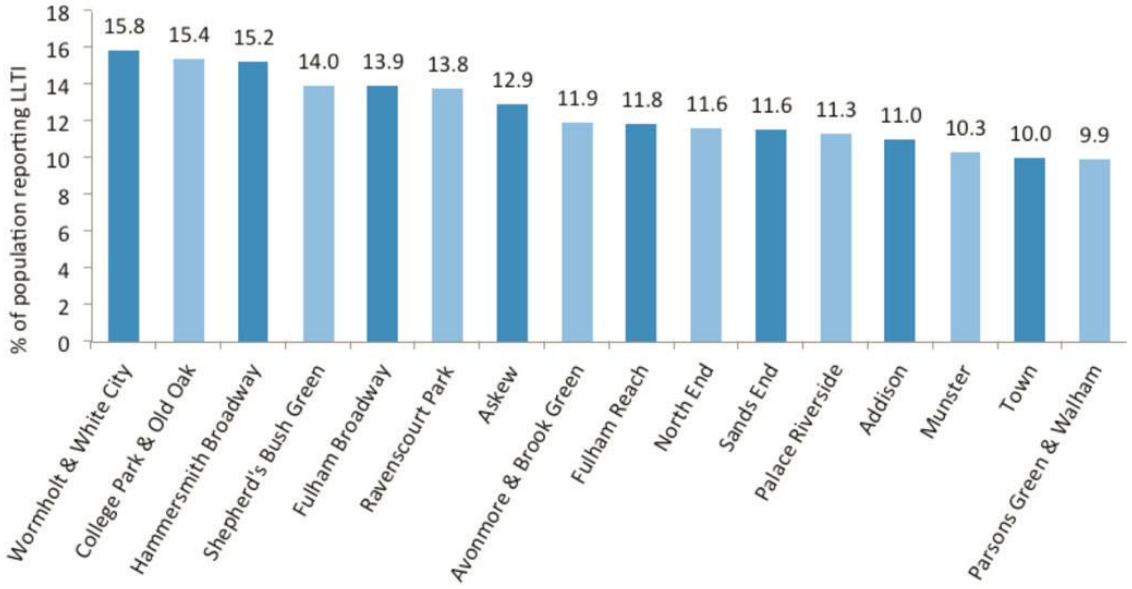
	Percentage of older people in poverty	Number of older people		Number of older people in poverty			Proportion of lower super output areas in most deprived 10% nationally	Rank
	2015	2015	2030	2015	2030	% change	2015	2015
H&F	28%	24,507	34,804	6,700	9,600	42%	19%	38
London Average	24%	1,329,292	1,867,204	313,700	440,600	40%		

Source: Index of Multiple Deprivation 2015 Income Deprivation Affecting Older People (IDAOPI); GLA 2015 Round of Demographic projections, Local authority population projections - SHLAA-based population projections, Capped Household Size model

4.2 Physical disabilities

In the 2011 Census, 12.6% of Hammersmith and Fulham residents reported having a long-term illness or disability that limits their day-to-day activities. The percentage by ward ranged from 9.9% in Parsons Green & Walham to 15.8% in Wormhold & White City.

Figure 11: Reported long term limiting illness, by ward



Source: Census 2011

Although the likelihood of having a disability increases with age, the large number of working age residents in the local area means the 45-64 year old age group has the largest number of people reporting a long-term illness or disability. This has implications for future demand, although it is not a straightforward picture due to population churn. There is a high correlation between disability and deprivation and historically it is the more deprived sections of the population who show less mobility, suggesting that the large proportion may be eligible for social housing earlier than might otherwise be the case. However, welfare reform might change this picture as more deprived population groups are forced to move out of the area.

Many people with long term conditions develop disabilities or mental health problems, which may require social care support, including the provision of care for their families and children.

National data[33] suggests that around 2,000 people in Hammersmith & Fulham aged 18-64 may suffer from a severe disability, with highest numbers in the older age groups[34].

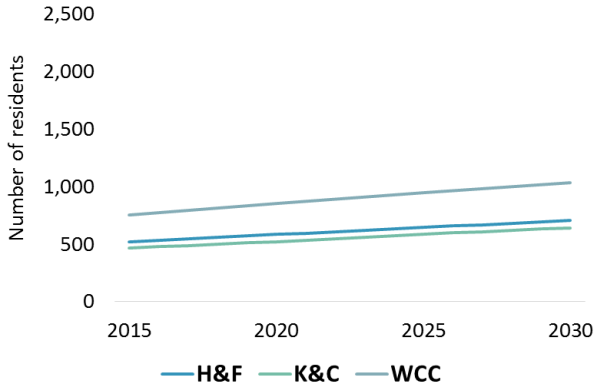
[33] Source: Projecting Adult Needs and Service Information (PANSI) and Projecting Older People Population Information (POPPI), national data from the Health Survey for England, 2001, applied to population estimates from the Office for National Statistics, 2014

[34] Numbers may differ to national trends, given the unusual socio-economic and demographic profile locally.

4.3 People with learning disabilities

The Learning Disabilities JSNA shows that there were 1014 people aged 18-64 with a learning disability known to Adult Social Care in 2013-14. Estimates suggest a prevalence rate of autism in adults with learning disabilities of between 20-30%, which is the equivalent of 69-104 adults in Hammersmith and Fulham. Of the 884 adult carers who responded to the 2014/15 carers' survey, 4% reported having a learning disability in LBHF.

Figure 12: Estimated number of residents with learning disability in Hammersmith & Fulham, Kensington and Chelsea and Westminster, 2015-2030



Source: Local analysis by the Public Health Intelligence Team using population segmentation from the London Health Commission, and population projections from the GLA (SHLAA 2014)

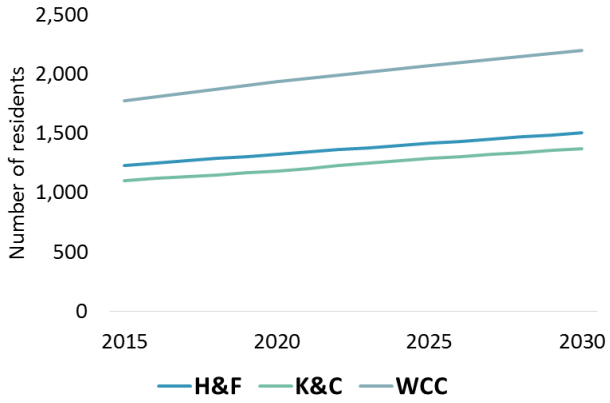
Of critical importance is the number of older people with learning disabilities requiring social care services. Better survival rates amongst the population are likely to have an impact on resources where carers become elderly and unable to provide continued support, and people with learning disabilities develop more complex needs such as dementia. In 2013/14, 14% of people with learning disabilities receiving a service from Adult Social Care were aged 65 or over.

4.4 Severe and enduring mental illness (SMI)

The population with mental illness who may be eligible for supported accommodation have severe and enduring mental health problems such as bipolar disorder and schizophrenia.

Rates of severe mental illness as recorded by GP practices are extremely high, with Hammersmith & Fulham CCG the twelfth highest out of 212 CCGs with 1,500 people registered with SMI. This is due in part perhaps to good GP identification and recording. Demand for mental health services looks set to rise in line with the population increase.

Figure 13: Estimated number of residents with severe and enduring mental illness in Hammersmith & Fulham, Kensington and Chelsea and Westminster, 2015-2030



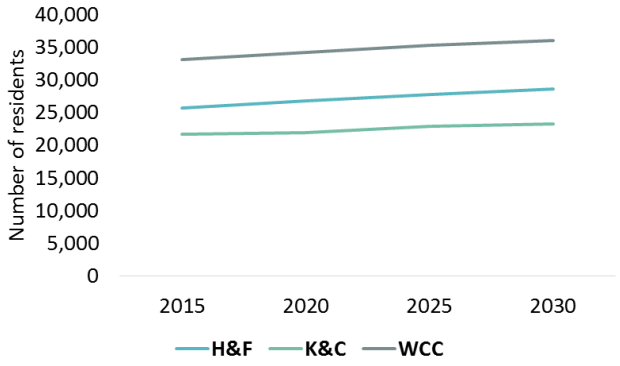
Source: Local analysis by the PH Intelligence Team using population segmentation work from London Health Commission, and population projections from the Greater London Authority (GLA SHLAA 2014)

Housing related support for people with severe mental illness ranges from floating support to low, medium and high supported housing. Residential and hospital placements are used to meet people's needs, support recovery goals and enable move-on where appropriate. Intensive services include NHS acute (inpatient) and Psychiatric Intensive Care Units, independent hospital provision and specialist placements for complex care. Residential and nursing placements are usually out of area.

4.5 Common Mental Illness (CMI)

Common mental illness covers the range of mental illnesses which can be treated through primary care services, such as anxiety and depression. Rates of common mental illness are likely to be similar to London, but numbers are substantial in absolute terms. Nationally, around 40% of years of life lost from a disability are from mental ill-health and a similar figure can be expected locally.

Figure 14: Estimated number of adults aged 16 years and over with a common mental illness in Hammersmith & Fulham, Kensington and Chelsea and Westminster, 2015-2030



Source: National estimates from 'Adult psychiatric morbidity in England, 2007: Results of a household survey' (Health and Social Care Information Centre, 2009) applied to population projections from the Greater London Authority (GLA SHLAA 2014)

Headlines

The London Borough of Hammersmith and Fulham can expect an increase in the proportion of their populations who have housing and care needs. Simultaneously the fiscal climate has led to a tightening of the Adults Social Care eligibility criteria and reduction in budget for non-statutory prevention services.

A significant percentage of the working age population have a disability and/or mental health illness and enablement and capacity building is essential to reduce demand on services. The management and treatment of chronic disease is paramount, and maintaining quality of life and providing joined up, high quality services are crucial.

Service planning needs to take account of increasing deprivation among the older population, increasing ethnic diversity and of gender.

The proportion of older people living alone has implications for service planning, given the link between this, social isolation and premature deterioration of health and wellbeing.

4.6 Local assets

There are assets available to Local Authorities seeking to improve the match between their stock and their population. These include a range of services which address the challenges vulnerable residents face, the majority of which are commissioned by Local Authority departments and NHS partners. They are provided by statutory sector agencies, voluntary/community sector organisation and other third sector or private bodies and include the Residential Environmental Health Service, Adult Social Care's Home care service, RSL and council estate teams, the Community Independence Service, Floating Support services and carers' services. Additional preventative services and more information about each one can be found as appendix three.

5 The economic case for prevention, early intervention and personalised support

Introduction

The preceding sections have established that, given the ageing population and people living for longer in ill-health, there will be an increasing need for the provision of health and social care among our population. This chapter seeks to offer analysis of the economic evidence for how best to address this need within available resources.

5.1 The cost of care

£15.5 billion nationally is spent by local authorities on Adult Social Care each year. For most older people with low to medium level need, enabling them to remain in their own homes has been shown to yield the best outcomes in terms of keeping people out of hospital and preventing escalation of care[35]. The gross weekly costs of nursing or residential care for clients in the three boroughs range from £458-950.

Councils provide re-ablement, provision of equipment and home adaptations as a means of preventing and/or delaying the need for increasingly intensive and costly care (such as home care, followed by institutional care in residential and nursing homes). Facilitating care at home also relies on the care giver to be able to detect changes in care need and to respond adequately and in a timely manner. For people with very high need, the costs of staying at home may be higher than costs of a home placement[36].

The Nuffield trust has been working on ways to combine health and social care data to predict the need for social care in order to focus re-ablement efforts. They showed that only 20% of people aged 85 or older moved into the intense social care category, emphasising the need for a targeted approach. However, the social care data available in the model was not accurate enough to support this, highlighting the need for high quality and joined up data. With such data in place modelling tools could further maximise value for money[37].

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[35] Your home or a home? Community Care *magazine 26 November 2009. Accessed July 2016.* http://www.communitycare.co.uk/2009/11/20/care-homes-v-care-at-home-council-spending-patterns-reveal-the-cost-equation-is-not-clear-cut/

[36] *Health and Social Care Cost information centre, Personal Social services Expenditure and Unit costs, England 2012-13.* Page 24

[37] http://www.nuffieldtrust.org.uk/sites/files/nuffield/Predicting-social-care-costs-Feb11-REPORT.pdf

Given the emphasis on keeping residents out of residential and nursing homes, Extra Care seems to be a cost effective alternative, being deemed to cost half of the alternative provision that would have otherwise applied[38]. However, more evidence needs to accrue to confirm the cost benefit of Extra Care and much depends on service models.

The health, social and economic value of informal care is huge. In 2000, around two thirds (65%) of the value of long-term care and support was provided by unpaid care, with a quarter (25%) from the state and 10% funded privately. If carers' support had to be replaced with provision from statutory services, it would cost the NHS, social services and other statutory bodies around £34 billion a year nationally, or around £140 million a year in Hammersmith and Fulham[39]. It is therefore of great importance to support carers, roughly 20% of whom provide in excess of 50 hours care a week and around 50% of whom have a co-morbidity themselves.

The majority of people who take up formal care services do so following discharge from hospital. In Hammersmith and Fulham, the three most common types of hospital admissions for those discharged to a care home (which account for one third of all admissions) are fractures (mostly due to falls), urinary tract infections and stroke, which have a major effect on mobility and functioning. Some could be avoided or delayed through a more preventative approach.

5.2 Integrated provision

Adaptations to the home and use of technology go a long way in reducing the need for escalation of social care in those with low and medium levels of need. However, adaptations are not enough and need to go hand in hand with other services such as occupational therapy, carers and medical professionals, and rely on joined up systems across agencies. Telecare is deemed to save £2,000 on average per installation but it also relies on supporting services functioning collaboratively.

5.3 The importance of data

The lack of data and data linkage is a major disadvantage to front line professionals seeking to provide smooth customer journeys and integrated care. It is also a major barrier to quantifying return on investment locally. For example, a project with CCG investment to remedy poor quality housing can only demonstrate return on investment using nationally recognised modelling tools (which suggest a probable

[38] Improving housing with care choices for older people. An evaluation of Extra care housing. http://www.pssru.ac.uk/pdf/dp2774.pdf
[39] http://jsna.info/document/carers-evidence-pack

saving of £1 million locally): it is unable to provide savings figures specifically for the CCG. Logic chains, collection of relevant data and careful informed evaluation will help close this evidence gap. Without them, existing data does not allow for this kind of detailed cost benefit analysis at present.

5.4 Homes and neighbourhoods: their role in prevention

The Care Act places a duty on local authorities to prevent, delay or reduce the need for care and support through provision or arrangement of services, facilities and resources. This duty extends to all residents, regardless of their present care needs. Prevention starts as early as childhood there are two major aspects which relate directly to housing:

i. Preventing the creation of care needs (through hazards and damp and cold homes, for example) and the deterioration of health and wellbeing through an enabling housing environment (ground level bathroom facilities, wheel chair accessibility) for example.

ii. The built environment surrounding the property and public realm.

5.3.1 Creating the right buildings to prevent care need

Poor quality housing has been calculated as costing the NHS at least £600 million a year nationally (roughly over £1 million locally) with a cost to wider society of more than £1.5 billion.

New homes

The least costly way to proactively delay or avoid need is through building new homes to the Lifetime Home standard, enabling people to stay in their own homes for longer, reducing the need for adaptations and giving greater choice to disabled people who are currently unable to live independently due to lack of suitable housing (e.g. wheel chair access to and within the house).

Cost benefit analyses on retro-fitting downstairs bathrooms compared with incorporating a lifetime home standard at build stage shows that the cost of retro-fitting would be in the region of £2000 while incorporating it up front would lower it to around £300[40]. Therefore it is important to not miss further opportunities to create lifetime homes despite the low number of new dwellings overall.

The case for all new housing to incorporate measures to enable life-long occupancy should include standards to withstand and mitigate the effects of climate change. As

[40] www.nihousingcouncil.org/CMSPages/GetFile.aspx?guid=95e1f58e-1f51-4cfc-823b-921ce882db8f

explored in 6.1.2, cold homes are linked to an increased risk of cardiovascular, respiratory and rheumatoid diseases, as well as hypothermia and poorer mental health. House building designs are evolving in recognition of climate change. A 'passive house' design enables passive heating of the house (for example by sunlight, residual heat from technical equipment and from those who enter the house) and prevents unnecessary heat loss. The design provides a 75% reduction in space heating requirements compared to traditional buildings, a warm and constant climate and reduces CO2 emissions[41]. An additional capital investment of 15% for passive houses would decrease in larger developments through economy of scale and is offset by savings in the long term. Suggestions for incentivising the construction of passive homes may be nothing more complicated than offering a government-backed low interest loan in line with the UKs Green deal philosophy whereby retrofit measures are financed 100% upfront[42].

Existing buildings

The Building Research Establishment calculated that the first year of treatment costs to the NHS of people living in the poorest 15% of the housing stock in England is around £1.4 billion. The cost of hospital, community and social care in the 12 months after admission due to a fall is deemed to be four times higher than the admission itself[43], including a 37% increase in social care costs. Falls patients, despite accounting for just over 1% of the over-65 population used 4% of the entire annual inpatient acute hospital spending in the year post fall and 4% of the entire local Adult Social Care budget in Devon[44].

Of the 75% of people aged over 55 in the UK who are owner-occupiers, many struggle to keep up with the costs of home improvements or maintenance. More than 20% of households with a person over 65 years of age failed to meet the Decent Homes standard in 2012, of which nearly 80% were owner occupiers. They failed most commonly on falls risk and excess cold[45].

41 http://www.seai.ie/Renewables/Renewable_Energy_for_the_Homeowner/SEI_Passive_House_A4.pdf Accessed 29/7/16

42 (http://www.bere.co.uk/sites/default/files/research/16PHT_Nick%20Newman%20submission.pdf)

43 http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/exploring-system-wide-costs-of-falls-in-torbay-kingsfund-aug13.pdf

44 Ibid

45 Off the radar. Housing disrepair and health impact in later life. Report by Care & Repair England 2016

The evidence presented in the DECC fuel poverty strategy suggests that tackling cold homes offers by far the best value for money[46]. Recent research suggests that the total benefits are 1.5 to 2 times the magnitude of retrofitting insulation when health gains, energy and emission savings are considered[47].

In addition to countering fuel poverty, cold and damp adaptations can be carried out to make a house suitable. National estimates scaled down to borough level, assuming that boroughs are similar to national figures, shows that proactively tackling the top 10 housing hazards definitely pays back in terms of local NHS costs and is likely to be much more favourable financially if social care costs are included. Payback is achieved in the shortest period of time for fixing stairs and levelling to prevent falls, removing collision and entrapment hazards and reducing excess cold.

Introducing adaptations to the house that facilitate coping at home not only enable the cared for person to stay at home, it has also been shown to reduce the actual amount of care needed, enabling the person to undertake tasks independently (curb-free shower compared with bath for example). Adaptations also present an opportunity to protect informal carers. On average, adaptations provided through the DFG grant are thought to delay relocation to a care home by 4 years[48].

The savings to local authorities through the Disabled Facilities Grant (DFG) are significant. Compared to a residential placement, which costs around £30,000 per annum, a DFG costs on average £7,000 as a one off intervention. To maximise the DFG, now within the Better Care Fund, it needs to be aligned with other services to offer a holistic and joined up approach. This can be achieved by bringing 'independence services' under one roof within a single team of occupational therapists, case managers, technical officers and other stakeholders. Local authorities have considerable flexibility in spending the DFG. For example, choosing not to means-test people has helped to avoid delays with adaptations in Ealing. Pre-emptive home modifications at relatively low cost have been shown to reduce falls that require medical treatment by 26%, bringing potential savings of £500m each year to NHS and ASC[49]. There may be financial benefits to providing a standard package of aids and

[46] Cutting the cost of keeping warm. DECC strategy 2015. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/408644/cutting_the_cost_of_keeping_warm.pdf

[47] Chapman, Howden-Chapman, Viggers et al 2009 J Epidemiological Community Health, Apr 63(4): 271-7

[48] http://www.foundations.uk.com/media/4210/foundations-dfg-foi-report-nov-2015.pdf

[49] http://www.communitycare.co.uk/2016/02/23/adaptations-already-cut-social-care-costs-heres-increase-impact

adaptations to prevent crisis and hospital admission upon request, rather than first requiring assessment[50].

Many issues make the current national system for adaptations sub-optimal. The assistance people receive depends on the tenure of their home rather than need, and on the financial contributions people are expected to make. Implementation of the national system also varies by authority, compromising equity. The majority of adaptations focus on existing problems, reacting rather than anticipating need. Yet the provision of adaptations at the point of crisis is less efficient than provision which plans ahead and might have averted the crisis. In times of budget constraints, the danger is that preventative approaches give way to the demands of reactive provision, which in turn means higher costs are incurred when people become eligible for help. A more strategic joint approach between housing, health and social care, which focuses on prevention and early intervention and is desirable, facilitated by joint commissioning[51].

One of the ways to join up agencies is to link DFG data and social care data via NHS numbers; while Hammersmith and Fulham makes DFG data available to ASC, it is not linked. The Whole Systems Integrated Care programme currently seeks to link ASC with health data, as stipulated by the Better Care Fund. Extension of this programme to incorporate wider determinants data, such as housing data, would greatly enhance capacity for care to be delivered cost effectively.

5.3.2 Creating the right built environment to prevent care need

There are many factors that influence the health of a person, but the single most cost effective focus for achieving preserved functionality, good health and mobility is physical activity. Physical activity preserves muscle and bone strength and balance into old age and thus prevents falls and frailty. Falls are multi-factorial and preventable; yet around 30% of people over 65 fall each year, 10% of those resulting in a fracture[52]. Combined hospital and social care costs, for patients with a hip fracture, amount to more than £6 million a day nationally: over two years, each hip fracture costs local authorities an estimated £3,879 for social care[53]. In 2014 there were 119 admissions in Hammersmith & Fulham for hip fractures.

[50] http://www.scie-socialcareonline.org.uk/the-cost-benefit-to-the-nhs-arising-from-preventative-housing-interventions/r/a11G000000DeS8yIAF; http://laterlife.ageing-better.org.uk
[51] http://www.foundations.uk.com/media/4210/foundations-dfg-foi-report-nov-2015.pdf
[52] Foundation, B.H., *Economic costs of Inactivity. Evidence briefing.* British Heart Foundation National Centre (BHFNC) for Physical Activity and Health, Loughborough University, 2013.
[53] Local HES data 2014

Physical activity has also been shown to be effective in preventing and treating dementia, one of the major predictors of care need[54] and being active five times a week significantly reduces stroke risk.

There is a strong business case for greater physical activity: a brief intervention for physical activity yields cost savings per quality adjusted life year of between £750 and £3,150.11[55]. In Hammersmith and Fulham, savings of over £1 million could be achieved if 100% of the resident population achieved just the minimum recommended levels of physical activity: 30 minutes of moderate activity, spread over the day. Further, this is likely to be an underestimate as it does not take into account costs associated with mental illness or dementia.

The Kings Fund recommends focussing on two themes with the highest yield in order to increase activity:

i. The reduction of car travel through improving cycling and walking provision and the urban realm, and
ii. Improving access to green spaces.

Getting just one more person to walk a day could recoup £768 a year in terms of health benefits, productivity gains and reductions in air pollution and congestion[56]. Having access to safe green spaces, walkable facilities such as shops and communal areas, proximity to public transport, street furniture such as benches and safety of the area all contribute to preventing deconditioning and social isolation[57]. In addition to facilitating individuals' independence and connections with the community, there are also benefits for broader community resilience[58].

The importance of dementia-friendly neighbourhoods cannot be overstated. The Dementia JSNA highlighted that the mainstay of management is to provide supportive care and an environment which allows people with dementia to function at their maximum capacity.

Many older people find that once they are outside the labour market, their environment presents an obstacle to a fulfilling old age in terms of social integration

[54] J. Eric Ahlskog, Y.E.G., Neill R. Graff-Radford, Ronald C. Petersen, *Physical Exercise as a Preventive or Disease-Modifying Treatment of Dementia and Brain Aging.* Mayo Clin Proc, 2011. **86**(9): p.8.

[55] http://webarchive.nationalarchives.gov.uk/20150116154742/http:/www.foodwm.org.uk/resources/Microsoft_Word_-_Cost_Effectiveness_Evidence_for_Physical_Activity_Programmes_-_Document_4.pdf

[56] Improving Publics Health. Active safe and Travel. Kings Fund. Accessed July 2016. http://www.kingsfund.org.uk/projects/improving-publics-health/active-and-safe-travel

[57] Healthy aging and the built environment. Centres of Disease Control. Accessed July 2016. https://www.cdc.gov/healthyplaces/healthtopics/healthyaging.htm

[58] Lawlor, E. The pedestrian pound. The business case for better streets and places. https://www.livingstreets.org.uk/media/1391/pedestrianpound_fullreport_web.pdf

and support and accessing resources. Suggested remedies include a focus on public transport with shelters and seats at bus stops and toilets at transport hubs; streets, footpaths and cycle routes that are clean, well lit and safe; adequate road-crossing points and affordable housing that meets the needs and aspirations of older people[59].

The cost effectiveness for Local Authorities of investment in the built environment is well-evidenced, associated with health and wellbeing at the community level, as well as improving satisfaction with 'place', increased social cohesion and interaction, increasing volunteering, creative 'play' among children and increased educational performance. Up to £23 is recouped for every £1 spent on increased walking and cycling facilities, parks and public gardens[60]. Improving open spaces can yield cost benefit ratios in the region of 2.7, meaning that any investment in open spaces such as local parks would be almost tripled in return. Similarly, improvement of the public realm is associated with a ratio of 1.4, and this does not include the wider benefits of increased physical activity and community resilience, as these are hard to quantify and likely to be locality-specific[61].

In a climate of shrinking resource and increasing reliance on community assets, the utilisation of planning requirements and the Community Infrastructure Levy for investment in the public realm are important tools for promoting health and wellbeing.

Key messages

Lack of data and data linkage is a major disadvantage to quantifying return on investment locally.

Integrated provision across front line services is critical to securing return on investment in those services and in provision such as telecare.

Evidence suggests that large scale savings can be achieved with a number of measures relating to housing, such as forward thinking planning to create life time, affordable, future proofed new housing stock and improvement of old housing stock.

Interventions to prevent deterioration of health and wellbeing extend as much to the built environment as to the buildings themselves.

[59] Kendig H, Phillipson C. Communities: New Approaches to Challenging Health and Social inequalities. Accessed July 2016. http://www.britac.ac.uk/sites/default/files/Hal%20Kendig%20and%20Chris%20Phillipson%20-%20Building%20Age-Friendly%20Communities%20-%20New%20Approaches%20to%20Challenging.pdf

[60] Marsh K, Bertranou E, Samanta K (2011). *Cost-benefit Analysis and Social Impact Bond Feasibility Analysis for the Birmingham Be Active Scheme*. London: Matrix Evidence. Available at: www.socialfinance.org.uk/sites/default/files/matrix_be_active_final_report_0.pdf Accessed 29/7/16

[61] Valuing the Benefits of Regeneration. Economics paper 7. Volume 1. Final Report. Accessed July 2016. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/6382/1795633.pdf

6 Priorities for strategic, cost effective provision

The material explored in the former chapters suggests five key lines of enquiry in which integration between Housing, Adult Social Care and health planning and delivery needs to be improved to enable cost effective interventions.

6.1 Strengthening prevention and early intervention

Introduction

Between Housing, Adult Social Care and Health, there are a number of opportunities to prevent and delay deterioration in health and wellbeing, and to reduce the support and care needs of residents. This section explores how ASC, Housing and NHS partners might facilitate best use of resources, working in partnership to improve the home environment, facilitate self-reliance and support the range of front line services to intervene earlier, thereby preventing and/or delaying deterioration.

Nationally:

- Over 20% all older householders live in a home that fails to meet the Decent Homes standard.
- 780,000 householders aged 55+ live in fuel poverty.
- 1.3m householders aged 55+ live in a home with at least one Category 1 hazard.
- The cost of poor housing to the NHS (first treatment costs) is £624m - costs dominated by excess cold hazards and those associated with falls
- One fifth of homes occupied by those aged 65+ years has none of the four accessibility features (level access, flush threshold, WC at entrance level, sufficiently wide doors and circulation space).

BRE/PHE 2013, p.5

6.1.1 Accessibility

Chapter 3 outlines the scale of the challenge facing the Council related to both the ageing population and the increasing proportion of the working age population who have life limiting illnesses and/or disabilities.

It is estimated that by 2030, the number of residents in the borough using a mobility aid will increase by 50%, (Health Survey for England 2013, Social care[62]). Section 3.2iii presents the significant deficit in the borough of properties which meet accessibility criteria and can cater for this growth, in both the private sector and social housing. Unless the deficit is addressed, the council will find it increasingly difficult to find appropriate

[62] Older people were asked whether they made use of a range of mobility aids, including elbow crutches, electric wheelchair, manual wheelchair, mobility scooter, walking stick, zimmer frame or other walking frame, or other mobility aid.

placements for its resident population, despite the fact that some of those in need of accessible homes will be owner occupiers able to commission adaptations to their own properties. Regardless of tenure, residents who are in accommodation which is no longer appropriate for their needs are at risk of earlier deterioration of their health and wellbeing, resulting in earlier loss of independence and reliance on the public purse. Provision for clients with particular accessibility issues is a key element of the preventative agenda[63].

Given our reliance on temporary accommodation, it is important to highlight that there are very few properties available to the council for this tenure which are able to accommodate accessibility requirements, presenting a significant barrier.

Accessible and adaptive dwellings

The Lifetime Homes Standard was a set of sixteen design criteria intended to make homes more easily adaptable for lifetime use at minimal cost. Until recently it was a mandatory requirement for new build properties under the London Plan (2011). The Government rationalised technical standards for new housing in 2015, applied through national Building Regulations rather than through planning policies. As a result the Lifetime Home Standards were replaced by Building Regulations (Part M4(2) (accessible and adaptable dwellings) and Part M4(3) (wheelchair user dwellings)) to ensure dwellings are accessible and adaptive. Local planning authorities have the option to require that the optional Building Regulations are met in new housing developments provided there is evidence to justify the need for them. The Minor Alterations to the London Plan (2015) updated the policy approach in response to revocation of Lifetime Homes and introduction of the optional Building Regulations. The London Plan policy is, therefore, that 90% of all new homes should be built to meet Building Regulation M4(2) and 10% should be built to meet M4(3).

The London Plan will certainly facilitate an increase in the number of properties which are accessible and adaptable, however of the homes we will inhabit in 2050, around 80 per cent are already standing today[64]. It is easier to meet the standard with new build than it is when you are providing housing within existing buildings (conversions or changes of use). Careful consideration should therefore be given to maximize opportunities for build of homes which meet the wheelchair accessible standard, above and beyond the GLA policy of 10%.

[63] Feedback from user groups and voluntary sector organizations challenge a commonly held assumption that people with disabilities desire ground floor units, suggesting instead that for some this heightens feelings of vulnerability.

[64] HOME TRUTHS: A Low-Carbon Strategy to Reduce UK Household Emissions by 80% by 2050 by Brenda Boardman, University of Oxford's Environmental Change Institute

Representatives of voluntary sector organisations engaged in this JSNA highlighted that too often it is assumed that people with disabilities wish to be on the ground floor; for some this will lead to a greater sense of vulnerability.

Adaptations

While some provision has to be designed appropriately from scratch, much can be achieved to ensure units' fixtures and fittings are appropriate for an ageing population and/or a greater proportion of working age population living with life limiting illness and/or disabilities. External sources of funding, such as the Disabled Facilities Grants (DFGs) and accident prevention grants, offer opportunities for adaptations that can increase the suitability of people's homes to meet their needs. While these are available cross tenure, there are very few installations in the private rented sector because you need permission from the landlord which may not be forthcoming, particularly for more invasive works. Also for some works, the process can take a lengthy period of time, beyond the resident's tenancy agreement.

However, stakeholder feedback in two boroughs suggested that these grants can be under-utilised, in part due to the staffing resource required to process each intervention. Similarly, feedback from the respective Housing departments highlights that securing approval for adaptations to be made takes too long, with planning restriction cited as a key barrier. In each borough, the DFG is administered by the residential environmental health service, with input from social care managers and/or health professionals. The customer journey from identification of requirement for modification, to assessment through to delivery might benefit from review to ensure that councils are able to expedite the process in the interests of cost efficiency (see section four highlighting the cost effectiveness of residential health intervention).

Local practice

- During the course of producing this JSNA, discussion held with one housing provider led to the development of policy which will ensure that, as units become available, a core set of measures will be implemented routinely to improve accessibility.
- Hammersmith and Fulham is increasing the number of front life staff trained as trusted assessors, enabling them to prescribe equipment which has no associated risks so that they can " make every contact count". The Advice Team, which is the "front door" into Adult Social Care, are all trusted assessors; they also issue replacement equipment for people with sensory impairments. The Adult Community Social Work Team also has social workers who are trusted assessors. As the equipment budget is a joint one with health partners, primary health care workers are also able to prescribe equipment.

Recommendation 1: Increase the number of homes in the boroughs which offer residents easy access and manoeuvrability, ensuring:

a) Strong emphasis on refurbishing existing homes to deliver a greater proportion of readily adaptable homes more quickly.

b) Expedient customer journeys for aids and adaptations, from identification of requirement to delivery which offer the best use of available resource.

6.1.2 Housing conditions

Healthy homes

The Council's residential environmental health services (see appendix three) are central to the improvement of housing conditions, including help with adaptations to improve independence and energy efficiency measures. This work has particular resonance in the private sector, which is characterized by the poorest quality homes, preventing unnecessary deterioration of health and wellbeing and the associated preventable reliance on more intensive local authority provision.

There are legislative powers which support the role of REHS teams, notably the Housing Health and Safety Rating System (HHSRS) and Houses in Multiple Occupation (HMO) standards. The Housing Health and Safety Rating System (HHSRS) enable risks from hazards to health and safety in dwellings to be assessed and removed or minimized. Introduced under the Housing Act 2004, it provides local authorities with enforcement duties (Category 1 hazards) and powers (Category 2 hazards)[65]. Excess cold is one of the highest scoring and most prevalent hazards. Dealing with excess cold hazards can help to reduce:

- Associated death and ill health
- Costs to the NHS for treatment
- Fuel poverty and CO2 emissions[66].

Local action

Public health has invested over £260k over the last two years in the Council's residential environmental health services to undertake proactive work to achieve the following outcomes in conjunction with ASC, GP practices and voluntary organizations:

- Improved housing conditions for vulnerable households.
- Integrated and streamlined care pathways among agencies supporting those 'at risk'.
- Greater engagement of community groups in addressing housing conditions.
- Integrated 'whole person' approach among those supporting vulnerable households.

[65] The Sector Skills Council for the places in which we live and work, Essential Information For Landlords and Agents HHSRS (Housing Health & Safety Rating System)
file:///Q:/Essential_Information_for_Landlords_and_Agents_-_HHSRS_-_Asset_Skills_2006.pdf

[66] CIEH guidance on enforcement of excess cold hazards in England, July 2011
file:///Q:/CIEH_guidance_on_enforcement_of_excess_cold_hazards_in_England_-_July_2011_(amended_May_2014).pdf

There are particular problems posed by the amount of older energy inefficient housing stock in England and Wales, particularly homes with solid walls in the private sector housing stock, many of which are hard to treat.

Local 'handyman' services offer simple and very low cost interventions to assist older people and those with disabilities with heating / plumbing / electrics / energy efficiency and minor adaptations. They can significantly enhance effectiveness of health and social care provision. As the population ages, there will be greater demand for such services, which allow residents to remain independent in their own homes for longer, experiencing greater levels of comfort and security.

Fuel poverty

A household is said to be in fuel poverty when its members cannot afford to keep adequately warm at reasonable cost, given their income; when a household's required fuel costs are above the median level; and when, if they were to spend what is required to warm the home, the household would be left with a residual income below the official poverty line. Cold homes are linked to an increased risk of cardiovascular, respiratory and rheumatoid diseases, as well as hypothermia and poorer mental health. Fuel poverty is caused by a convergence of three key factors:

- low income, which is often linked to absolute poverty
- high fuel prices, including the use of relatively expensive fuel sources (such as electricity as opposed to gas), aggravated by higher tariffs for low-volume energy users and/or use of pre-payment meters
- poor energy efficiency of a home, e.g. through low levels of insulation and old or inefficient heating systems

Figures from the Department of Energy and Climate Change (DECC), show that fuel poverty numbers across the borough are comparable to the England mean rate of 10.4%, but somewhat higher than the average for London of 9.8%. Notably there has been stagnation in fuel poverty numbers across England between 2013 and 2014, whereas the figure for London has increased by 0.8% and risen faster in Hammersmith & Fulham (3.3%).

Figure 15: Fuel poor households

LA Name	Estimated no. of Fuel Poor Households 2013	Proportion of households fuel poor (%) 2013	Estimated no. of Fuel Poor Households 2014	Proportion of households fuel poor (%) 2013	% change
H&F	8,500	10.3%	10,978	13.6%	+3.3%
London	32,6114	9,8%	348,215	10.6%	+0.8%
England	2.35 m	10,4%	2.38 m	10.4%	0%

Source: https://www.gov.uk/government/collections/fuel-poverty-statistics

The total number of excess winter deaths recorded for England and Wales in 2014/15 was 43,900 (the highest since 1999/00), with the majority of deaths amongst people aged 75 and over. Respiratory diseases were the underlying cause of death in more than a third of all excess winter deaths in 2014/15. Local authority data for excess winter deaths is not available for 2014/15 until November 2016, but a significant increase is expected on the previous year 2013/14. Following a dip in 2013/14, the number of excess winter deaths in London has more than doubled since.

Figure 16: Excess winter deaths

Excess Winter Deaths	2012/13	2013/14	2014/15
Hammersmith and Fulham	70	30	Tbc (Nov)
London	2,750	1,700	4,000
Nationally	31,200	17,460	36,300

Source: ONS Data, Excess Winter Mortality England and Wales

Furthermore, excess winter deaths can be under reported, as the cause will be recorded as heart disease or flu rather than hyperthermia or cold and 90% of the excess winter deaths occur before cold weather alerts are issued. The temperature only needs to drop below 6°C for death rates to rise and cold weather may span several days or weeks. Neither is the health impact of cold weather immediate; heart attacks peak in day two, strokes peak day 5 and respiratory disease day 12. NICE suggest that for every winter death there are eight non-fatal hospital admissions due to cold housing conditions. On top of these numbers are those experiencing poor health but not needing hospital treatment.

There is much more evidence to support interventions in the home than to support the action triggered by severe weather[67]. Fuel poverty can be alleviated through income maximisation initiatives for householders, such as benefits entitlement checks and winter fuel and cold weather payments, improved home energy efficiency through (grant funded) heating and insulation improvements and energy efficiency advice, and through reduced fuel costs through the warm homes discount, fuel switching, tariff switching and fuel debt grants. Each of these is incorporated into local initiatives to address the prevalence of cold homes.

Local Action

Peabody employs a sustainability team to visit residents and advise on ways of reducing fuel bills. They also run a Winter Warmers programme every year, visiting all residents over 75 years of age to give fuel advice and promote services to support health and well-being. The handyperson team offers free insulation and water usage advice on every visit and provides water saving measures and draught proofing free of charge.

[67] The evidence presented in the DECC fuel poverty strategy suggests that tackling cold homes offers by far the best value for money.

In March 2015, NICE published its guidance: "Excess winter deaths and morbidity and the health risks associated with cold homes". This makes recommendations for reducing fuel poverty and/or its impact, emphasizing the need for collaborative work between both the commissioning and provider arms of health, Adult Social Care and Housing and with other front line services, such as advice workers and heating installation companies. The recommendations focus on improving access to services, the need to identify and target vulnerable groups, to include clients and their carers in identifying tailored solutions, the need for improved connectivity with NHS providers, with discharge planning and on ensuring that 'every contact counts'. Despite the challenges for addressing fuel poverty in the three boroughs, outlined in section 3.2, there is much in the NICE guidance which is pertinent locally.

Overcrowding

The Child Poverty JSNA highlights the impact of overcrowding on the health and wellbeing of the family, particularly on children, and recommends three priority areas for action. These include the effective use of all planning, housing investment and housing allocation powers to respond to the need for good quality and affordable family sized housing, regardless of tenure, and greater integration between REHS and other front line services, particularly health and social care, to ensure that poor housing conditions are addressed, regardless of tenure.

Local action

LBHF seeks to alleviate overcrowding through bespoke space saving solutions such as sofa beds, fold away tables and chairs, bunk beds and shelving. The impact is reduced tension in the household, appropriate sleeping arrangements, improved sleeping patterns, facilities for doing homework. Families are also put in touch with other social support services.

Recommendation 2: Improve housing conditions, cross tenure, ensuring:

a) Residential environmental health teams are sufficiently resourced to address housing conditions across the three boroughs, taking a proactive approach and utilizing the HHSRS as appropriate to tenure.

b) A cost-effective handyperson scheme, potentially co-ordinated across three boroughs, to deal with a range of maintenance issues and minor adaptations.

c) Appropriate engagement of registered providers.

d) Integrated referral pathways for front line professionals working with vulnerable residents ensure that housing conditions are considered and concerns addressed through every resident contact (see also recommendation 6).

e) Full understanding of the shape and scale of fuel poverty in the borough and of the appropriate solutions and mitigation of impact, each Health and Wellbeing Board considering NICE's recommendation to undertake a fuel poverty JSNA. Action might include proactively lobbying central Government for policy solutions and revenue to improve hard to treat properties, including common parts of flats.

f) The reach of initiatives to alleviate the impact of overcrowding on children, e.g. homework clubs, active play space, ensures they are sufficient and appropriately tailored and targeted.

6.1.3 Maintaining independence in the community

The drive to maintain independence for as long as possible, ensuring 'the right support at the right time,' is dependent on the availability of interventions/services which can respond to episodes of greater dependence and focus on reablement. The aim is to provide, after a period of hospital admission or life changing illness, enabling support for people to re-build their range of life skills and confidence to be able to live independently in the community.

Recent work undertaken locally by Adult Social Care with its partner CCGs and Adult Social Care has considered the availability of step up and step down beds as a mechanism to avoid unnecessary hospital admissions and unnecessarily long hospital stays. Good practice elsewhere[68] provides limited stay accommodation (6-8 weeks) for patients who are medically fit for discharge but not yet ready to return home. It is important that these are time limited and explicitly focused on reablement

Good practice

Across the country sheltered schemes are allocating flats as step down accommodation - this should be a key component of any new builds and consideration should be given to implementing this across the piece.

[68] http://www.housingcare.org/service/list/s-38-intermediate-after-hospital-care/l-427-cambridgeshire.aspx or http://www.cambscommunityservices.nhs.uk/docs/default-source/news---press-releases/ccs-2015-legacy-document---april-2015.pdf?sfvrsn=0

[69]to ensure that the default position is a return home. The reablement period facilitates thorough assessment of the care package required and, where necessary, time for the patients, their carer, friends and family to consider alternative housing options. Without this mechanism, hospitalization can lead for some to premature and long term dependence on a number of services.

Assistive technologies offer an important tool in enabling people to live independently in the community in their own homes or supported housing. Take-up of this service is not as expected and feedback suggests that assistive technologies can be seen as an optional extra for some residents. This can lead to unnecessary hospital admissions or greater reliance on local authority services. ASC are looking into how to better incorporate assistive technologies into a range of their preventative services.

Local action

ASC's Community Independence Service provides a range of vital functions for up to 6 weeks including:

- Rapid response nursing services to prevent people with urgent care needs either attending or being admitted to hospital.
- Hospital In-Reach, to speed up discharge.
- Rehabilitation and reablement, which enables people to regain or retain their independence and stay in their own homes.
- As part of the rehabilitation programme, a range of community equipment is provided to enable people to live independently in a safe environment for as long as possible.

The NICE Guideline on Excess Winter Deaths, referenced above, includes in its recommendations the need to improve upon discharge planning arrangements, ensuring that care planning takes account of patients' home environments. Consistent feedback from Housing and Adult Social Care colleagues is the need for the home environment to be systematically built into routine discharge planning – not just to identify and address fuel poverty, but to consider the appropriateness of a patient's housing conditions more broadly. While such provision exists, process and practices need to be reviewed to ensure they are completed in the timely fashion required for any changes to be implemented in advance of discharge.

Delays in hospital discharge for over 65s accounted for 1.15 million bed days in 2015 costing around £820million[70] in the UK. Over 60% of all patients in hospital are over 65 years of age. Timely discharge relies on existing adaptations or fast tracked adaptations. Delays mean wasted hospital beds at high cost, and the risk of deconditioning and contracting infectious illnesses in hospital. It also means that the

[69] This is not an appropriate mechanism for securing timely discharge of homeless patients, for which there are separate mechanisms.
[70] National Audit Office 'Discharging Older Patients from Hospital'

lengthier the assessment the greater the likelihood of a change in need, rendering the original assessment less useful.

With hospital teams under substantial time pressures, serious thought should be given as to how early assessments could be completed through the wider social care and health systems. For example, consideration could be given as to whether this could be carried out by homecare agency staff under Adult Social Care's homecare contracts which will already see agency workers undertaking low level health tasks as part of whole systems working.

Recommendation 3: Ensure that resources and arrangements are in place to support people to maximise their range of life skills and confidence, enabling them to live independently in the community, including:

a) Sufficient investment in integrated community support services to enable 7 day provision.

b) Greater integration of assistive technologies in all care planning, and increased up-take.

c) Sufficient investment in localised, time-limited 'step up and step down' beds.

d) Discharge planning procedures and protocols which are commenced on admission and systematically and which routinely incorporate assessment of patients' home environments, ensuring the introduction prior to discharge of appropriate aids and adaptations.

6.1.4 Social isolation and community resilience

The Care Act 2014 establishes the "wellbeing principle", making promoting wellbeing the core purpose of local authorities' exercise of their care and support functions[71]. Wellbeing is defined as relating to a range of factors including social wellbeing, contribution to society and personal and family relationships. Given the links between loneliness and poor wellbeing, care and support functions must include action to address loneliness and isolation, as set out in the supporting statutory guidance.

The New Economics Foundation developed the framework 'Five Ways to Wellbeing: Connect (with the people around you), Be Active (keep moving), Take Notice (environmental and emotional awareness), Keep Learning (try something new at any age) and Give (help others and build reciprocity and trust). These actions promote

[71] http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted Section 1

wellbeing and refer to simple activities that individuals can do in their everyday lives[72]. Importantly there is a direct connection between these and reducing isolation.

Evidence from this JSNA's third sector engagement workshops suggests that loneliness is linked more to vulnerability than to age. Section 4.1iii presents Census data showing that an average of 44.0% of people living in the borough aged over 65 lives alone, carrying a risk of social isolation.

Local Action

The BME Health Forum has commissioned an emotional wellbeing project to support people who are going through a difficult time and who are not fluent English speakers. The project is delivered by six community organizations in five different languages. The BME Health forum trains staff and volunteers to support clients in 1:1 sessions offering emotional support and practical help. Outcomes include:

- Improved scores on the Warwick Edinburgh Mental Wellbeing Scale
- Improved scores on self-reported health
- Self-reported reduction in the use of health services
- Self-reported improvement in managing general health and long term conditions.

Adult Social Care is now embarking on a programme to transform its current model of care. This will see a shift of resources into effective prevention and early intervention, including reducing loneliness and social isolation, in order to focus more heavily on keeping independent, safe and well. The 'Fs of Frailty' framework for prevention, outlined in section 2.5, highlights the loss of friends and family as key drivers of deterioration. It promotes a more co-ordinated and joined-up approach to activity on frailty across council, NHS and third sector agencies.

A key challenge is to manage the demand for high cost services and sustain the focus on empowering people and developing stronger, resilient communities which will work together to maintain independence. This means unlocking the potential of local support networks and building community capacity to reduce isolation and vulnerability[73]. Services which offer opportunities for social contact and facilitate community cohesion, such as volunteer befriending services, health and wellbeing hubs, link up / connecting projects and the Community Champions are central to the preventative agenda. Despite this, these services can be reliant on short term funding which can undermine sustainability of outcomes and destabilise service provision.

Local action

Hammersmith and Fulham Council has established a Social inclusion Forum which brings together key officers from public, private, voluntary, community & faith sector organisations to deliver improved social inclusion outcomes for local residents. The Forum is currently developing a strategy on social isolation, which will focus particularly but not exclusively on Older People.

[72] The five ways to wellbeing were developed by NEF from evidence gathered in the UK government's Foresight Project on Mental Capital and Wellbeing to support dissemination of the key findings.
[73] A glass half full: how an asset based approach can improve community health and well-being, I&DeA 2010

The Council recognises the need to ensure that people are better placed to help themselves and each other; that when extra support is needed this is found within communities. Efforts to strengthen communities will focus on preventative actions which can help to keep people away from needing services delivered by the Councils, and very often the best and most sustainable help comes from neighbours and peers.

This means that we will look first at the strengths within people's lives – their family and community networks, their interests and their abilities, in order to link people with the right sources of support and help which build upon these strengths. Communities that are more connected need fewer public services, create good places to live, and improve outcomes for residents. People are not passive recipients of services – they have an active role to play in creating better outcomes for themselves and for others, and they themselves will be the starting point for tackling emerging issues.

Recommendation 4: Ensure that strategies are in place to promote community cohesion and prevent and alleviate social isolation. These should incorporate:

a) Recognition of community cohesion as a specific objective towards securing community resilience and promoting independence and self-reliance, with appropriate resourcing plans.

b) Plans for identifying residents at risk of social isolation and the appropriate mechanism(s) to best engage and support them.

6.1.5 Information, advice and outreach services

Information and advice is fundamental to enabling people to take control of, and make well-informed choices about, their care and support and how they fund it. Not only does information and advice help to promote people's wellbeing by increasing their ability to exercise choice and control, it is also a vital component of preventing or delaying people's need for care and support, including preventing homelessness.

The Care Act places a duty on local authorities to work with its partners to ensure the availability of information and advice services for all people in its area, regardless of whether or not they have' eligible care needs' (a wide definition including care and support related aspects of health, housing, benefits, and employment). Information and advice must be available at the right time for people who need it, in a range of accessible formats and through a range of channels.

ASC is developing a new 'front facing' service, with a bundle of 'front door' services which include signposting, information and advice. The aim is to give people the information they need at the earliest appropriate point, empowering people to direct their own care and support. Indeed, there are a number of local services which have

enhanced their traditional offer, to secure greater impact. One example is the Housing Options service, as outlined in the adjacent *Local action* box. Others are outlined below.

People First

People First is an easy to use website, www.peoplefirstinfo.org.uk, that provides a wealth of information and resources covering the whole of the private, voluntary and public sector across the borough. The site is aimed at the older adult population, people living with disabilities of whatever kind, and those who look after others. Its main purpose is to facilitate independence and wellbeing.

Care co-ordination service

In July 2016, the neighbouring Central London CCG launched the Care co-ordination service to support care planning by GP practices as they introduce a Proactive Care Management Specification. This requires GP Practices to proactively care plan for 30% of their population. The target groups are those aged over 65, anyone over 18 with one or more long term condition and anyone else that the GP thinks needs extra support, for example those nearing the end of their life, those recently bereaved and those transitioning between services. The new care plans will put the patients' goals and the actions they want to achieve at the heart of the plan. The Care co-ordination service will consider the wider support needs of the patients to inform care planning. Patients will be encouraged and supported to engage in activities to improve their health and wellbeing, making referrals as appropriate. Three clusters of practices will, in addition to the standard resource of one Care Navigator and one administrator, receive additional support as part of a trial group to test out the benefits for patient outcomes of having three clinical co-ordinators and a social prescriber[74]. The Social Prescribing element of the service will seek to connect patients with health and wellbeing activities delivered, largely by local and voluntary sector organisations, in a way which best suits their support needs.

Older People's Preventative Services

Adult Social Care has just refreshed its offer of prevention activities to those most in need of support around improvements in physical and mental health, and most at risk of social isolation. The activities seek to achieve the following outcomes:

- Control over daily life and preventing deterioration of health (including falls)
- Living independently at home
- Feeling respected and treated with dignity

[74] They will also trial use of Patient Activation Measures (PAM) - a 13 question test to ascertain people's confidence and interest in self-care. These will be used with high risk patients to ensure that tailored interventions to help them make positive lifestyle choices can be appropriately targeted.

- Feeling safe and secure
- Feeling a part of the community with improved social contact
- Good physical and mental health

Floating support services

Floating support services specifically seek to support vulnerable clients, including those who do not fit eligibility criteria for Adult Social Care but have clear support needs. They are an important part of the system available for vulnerable clients to support them maintain their independence and avoid residential care / hospital admissions, linking them with appropriate services and facilities. With tighter eligibility criteria, greater consideration may need to be given to how best to support those who do not meet the eligibility criteria but do have clear care needs (see section 6.4, Improving the offer to those in severe and multiple disadvantage).

In the current financial climate, many advice, information and outreach services are struggling to source adequate resources. The need to demonstrate cost effectiveness is paramount and the inherent difficulty of proving the impact of preventative initiatives makes this extremely challenging. Local commissioners will need to ensure both that social value is taken into account and recognise that for some vulnerable clients, tailored and targeted services are essential – that 'one size will not fit all'.

Recommendation 5: Ensure the development of an asset based approach to the delivery of robust front-of-house, information, advice and outreach services which promote independence and self-reliance and are tailored and targeted to secure best impact.

6.1.6 Making Every Contact Count (MECC)

Commonly residents in touch with one service or facility will benefit from others but may not find their way to that service in a timely fashion. The pressure on resources and the volume of residents needing some level of support requires local authorities and the NHS to secure greatest impact from each contact with a resident and patient, all contracted services and providers actively promoting and facilitating engagement with health and wellbeing – focusing on self-reliance, self-care or appropriate access to the right service at the right time. In some areas the fire service has offered a successful gateway for residents wary of contact with other services.

Local action

Hammersmith and Fulham's housing department is in the first wave for the roll out of the MECC programme.

Front line officers from the sheltered housing, neighbourhood housing, temporary accommodation and income collection services are all engaging in the programme. This will assist them to ensure that every resident contact is utilised to best effect, protecting and enhancing health and wellbeing.

The 'Making Every Contact Count (MECC)' approach provides an opportunity to optimize the current capacity and capability of the broad range of front line professionals across the public and voluntary sectors to actively support prevention and early intervention. The Public Health team is leading on developing the MECC approach across the three boroughs. The aim is for all frontline workers – be they from a council or NHS body, other public sector or voluntary / community sector organization - who have face-to-face interactions with residents to be trained and supported to have purposeful conversations with them about issues that can facilitate their improved health and wellbeing and to facilitate improved access to prevention and early intervention. Feedback from stakeholders highlighted the value of MECC, given that different residents access support from a variety of front line services which might not otherwise be able to address important issues.

Good practice: S.A.I.L[Ω]

Safe And Independent Living (SAIL) is a partnership of statutory and voluntary organisations able to identify an older person who is at risk or needs some help. Areas of concern which may be addressed through use of a checklist and referral process include:

- Health and well-being
- Mental resilience
- Isolation and social exclusion
- Financial inclusion
- Fire safety and wider home security issues
- Safeguarding concerns
- Personal safety and security

The transformation agenda is leading to consideration of which services might be brought together as hubs, the services which might be delivered through libraries; MECC offers an ideal framework to support this agenda.

Recommendation 6: Extend the reach of front line services by embedding the 'Making Every Contact Count' (MECC) approach. This will require:

a) The establishment of appropriate systems: MECC incorporated into specifications and contracts; front line workers having ready access to information; agreed referral routes; data sharing protocols and the IT infrastructure to support them (see recommendation 7).

b) Establishing MECC as a routine component of staff induction and regular training programmes in both the statutory and voluntary sectors, exploring links with other partners with front line workers, such as the fire service and refuse collection.

c) Providing training and support to formal carers and other commissioned agency workers to ensure they have the skills and information to contribute to the MECC approach as part of a quality care package.

6.2 Developing personalised housing support and care

Personalised support and care offers the best use of resources and the best experience for the resident. Increasingly policy documents and published strategy warn against 'one size fits all' approaches on the basis that, however strong or otherwise prevention and early intervention services might be, if they are not readily accessible and appropriate for the individual customer, their effectiveness might be expected to be compromised. Stakeholders consistently reported a number of barriers which mitigate against smooth customer journeys and compromise cost effectiveness. This section draws on national and local intelligence gathered and considers mechanisms for securing smooth customer journeys which respond to the range of support required.

6.2.1 Supported housing

Supported housing is an essential part of the system for enabling vulnerable people to be as independent as possible and maintain or improve their wellbeing. It is key to reducing the need for people to access higher supported housing/care packages or be hospitalized if needs are not met sufficiently early (see section 6.4 focusing on those with severe and multiple disadvantage).

Supportive housing is most effective where it can be sufficiently flexible to respond to customer's changing needs, house mixed communities to provide positive environments, where sufficient move-on accommodation is available, and residents' transition supported. These aims are difficult to achieve when there is a shortage of options. Schemes which are not flexible can lead to customer remaining in receipt in packages greater than is required, effectively blocking placements for those who do need that level of care.

Despite significant investment in move-on accommodation, and it being a key focus on of work within supported housing schemes and hostels, ensuring sufficient move-on accommodation remains a challenge. Move-on accommodation is central to reinforcing progress to greater self-reliance and reducing dependency on public services. However the cost of land makes it difficult for providers to develop schemes, high rents raise costs above the housing benefit cap, which can mean that independent housing is unaffordable to residents who might otherwise be ready for move-on, and commissioning approaches (contracts and service specifications) can provide too few incentives for providers to focus on pathways into more independent forms of accommodation.

In exploring this challenge, stakeholders identified a number of potential solutions:

- Ensure flexibility is built into contracts to enable more efficient use of placements, avoid unnecessary uprooting of residents (which could lead to deterioration of wellbeing) and improve cost effectiveness.
- Reclassification of schemes to enable residents to remain settled but reducing the level of support provided to allow greater independence and self-reliance, thereby reducing individuals' call on council resources. This approach must be twinned with re-investment to avoid a deficit of more intensive places in the system.
- Renewed emphasis on the provision of move-on accommodation, coupled with incentives in supported accommodation contracts for supported move-on, might facilitate independence and self-reliance and secure greater cost effectiveness.
- A review of classification systems, to ensure a focus on commonality of need and facilitating mixed communities, may help to ensure that residents can build their independence and reliance more effectively.
- Asset based commissioning[75] may provide a fresh perspective on how best to respond to the challenge, utilizing and building on communities' strengths.

6.2.2 Integrated assessment and placement

Personalized housing support and care requires strong partnerships between different Local Authority departments, registered providers and voluntary sector agencies. Services need to be integrated where possible, and effectively dovetailed where not, if they are to have best impact and thereby cost effectiveness. Stakeholders consistently report that a cultural shift in partnership working between Housing and Adult Social Care front line staff is required for efficient decision making and on-going support.

Stakeholders also consistently suggested that multi-disciplinary panels to consider/review cases have proved fruitful and should be considered for the routine, default position. A case-conference approach was seen as routinely producing positive outcomes, and is considered particularly beneficial where clients have complex needs and circumstances. They were also reported as contributing towards robust partnership work, facilitating improved mutual understanding of each-others' limitations and reducing inappropriate referrals between departments.

[75] A glass half full, I&DeA 2010

6.2.3 Data sharing

Chapter 5 made the economic case for data sharing. Stakeholder feedback consistently endorsed this, highlighting concerns that while progress has been made with data sharing between health and social care, Housing staff are often left without the intelligence they need to ensure they support residents with optimal effect. Registered providers need the intelligence gained from a risk assessment undertaken by Housing Options to ensure appropriate and person-centred care. Data sharing is an on-going challenge yet no party saw this as inherently the case. Concerted investment in bottoming out the barriers to data sharing protocols between housing, ASC, REHS, NHS providers (MH, SMS), RSLs, Children's Services was consistently requested.

6.2.4 Effective communication across support agencies

The work undertaken with vulnerable residents is complex and requires the effective engagement of a number of providers each with specialist skills. Services need to be familiar with each other and how they dovetail to be able to make effective referrals and undertake timely, effective assessments. Stakeholders suggested a multi-agency approach to promoting and facilitating secondments across teams to support front line workers in housing providers and in Adult Social Care to develop greater mutual understanding of respective responsibilities and constraints and identification as complementary parts of the same team.

Local action

The Community Champions initiative is developing effective partnerships across housing and health to support the delivery of champions projects across the three boroughs. These include the registered providers, many of whom co-fund the initiative out of recognition that the Champions are able to reach hidden and isolated individual and communities through the peer to peer approach.

The required cultural shift among front line practitioners across the system can only be achieved through a mutual understanding of roles, responsibilities and realistic expectations. The importance of multi-agency networking forums, promoting and facilitating skill mix and partnerships (across voluntary/community sector services and statutory services) was highlighted as an important tool in this and in improving and maintaining an understanding of the range of services available in the area.

Recommendation 7: Establish data sharing protocols and governance processes across council departments, NHS partners and other front line provider agencies working to support vulnerable residents.

Recommendation 8: Ensure support and care pathways, between front line staff in Housing (including REHS & RPs), ASC, health services, Children's Services and voluntary sector partners, facilitate smooth customer journeys and effective care.

Recommendation 9: Consider undertaking a multi-agency evidence review of options for increasing the supply of move-on accommodation within the challenging landscape. This would aim to inform future investment in and commissioning practice and include the options identified in 5.2.1.

6.3 Strengthening collaborative approaches to supporting carers

Introduction

The Department of Health defines a carer as a person who spends a significant proportion of their life providing unpaid support to family or potentially friends. This could be caring for a relative, partner or friend who is ill, disabled or has mental health or substance misuse problems. In addition to adults, some children under the age of 18 help to care for a parent or sibling: they are likely to be assuming a level of responsibility usually taken by an adult.

The support carers provide can enable the person they care for to remain living independently at home for longer and retain social networks. Their knowledge and understanding of the cared-for person's needs can also enhance care planning when remaining at home is no longer a realistic option[76]. The Care Act places upon Local Authorities a duty to provide for carers. Emphasis is placed on ensuring needs are assessed, information and advice provided and they are able to access services and pathways established for raising concerns. The carer is afforded rights independent of financial capabilities or needs of the dependant.

[76] Assessing the barriers to achieving genuine housing choice for adults with a learning disability: the views of family carers and professionals'. SCIE Social Care Online. Oxford University Press. British Journal of Social Work, 35(1), January 2005, pp.139-148.

6.3.1 The Local Picture

Nationally, studies have shown that 3 in 5 people will be a carer at some point in their lives, and that 600,000 people become carers each year. This would be roughly 1,000 in Hammersmith and Fulham.

The 2011 census estimated that in Hammersmith and Fulham there were 12,330 residents providing unpaid care, almost 21% of whom providing 50 hours or more care each week and that there will be an increase in need for a further 1,000 informal carers per borough over the next decade[77] to support the larger number of older people (resulting from better life expectancy and greater numbers born since World War II)[78]. However, just 735 such carers are known to Adult Social Care, according to 15/16 SALT returns. While others will be known to third sector carer support agencies and to GPs practices, this suggests a large majority of informal carers are not known to services and are not having their needs assessed and addressed by Adult Social Care or commissioned agencies. Given the role carers play in helping the cared-for person to remain independent, it is important that they are supported and that they are able to sustain this activity without their own health and wellbeing deteriorating.

6.3.2 Who does this affect?

An Adult Carers Survey is undertaken by Adult Social Care every two years and findings contribute to 5 indicators in the Adult Social Care Outcomes Framework. The response rate to the 2014/15 survey in Hammersmith and Fulham was 39.3%. Across the three boroughs, two thirds of all carers have been caring for five years or more and 38% are retired.

i. Gender

The large majority of carers known to Adult Social Care are women. This is reflected in the survey response, with 74% of respondents in Hammersmith and Fulham being female.

While caring responsibilities more commonly fall on women, consideration should be given to whether male carers are under-represented among known carers, perhaps as a result of being less likely to engage with services (Milligan

[77] http://jsna.info/document/highlight-reports-2013-14

[78] It has also been estimated that, as a result of new responsibilities set out in the Care Act 2014, a further 2,600 – 2,800 informal carers across the thee boroughs might come forward annually to be assessed/reviewed, although this increase has not yet materialised.

and Morbey, 2013) and, if so, how best to promote and facilitate uptake[79]. There appears to be no gender difference in carers' quality of life.

ii. Age

The largest age group among carers was the 55-64 age group, representing 26% of respondents. The numbers of respondents aged over 75 was c15%. This is a high proportion for a group which itself needs increasing support. There appears however to be no difference between the adult age groups in carers' quality of life.

The Child Poverty JSNA (2014) highlights that the number of residents aged under 15 providing unpaid care is estimated at 267. Young carers are in a position where they have to assume a level of responsibility that would normally only be asked of an adult. The stress and anxiety that this can cause can leave them feeling isolated and unsupported. Many miss out on their childhood and youth as time constraints make it impossible for them to attend school or take part in leisure activities with their peers. Young adult carers aged between 16 and 18 years are twice as likely to be not in education, employment, or training (NEET) [80]. The JSNA suggests that young carers are considered to be at risk of child poverty[81].

iii. Ethnicity

There was a slight under representation of the Asian group in the survey. This is consistent with anecdotal evidence that Asian groups may be less likely to identify themselves as carers and access services.

iv. Hours of care provided

The survey asks carers the number of hours of care per week they provide. In Hammersmith & Fulham, 92% of all unpaid carers provide over 20 hours of care every week. Furthermore, more than 4 in 10 respondents provide over 100 hours care each week. The average for Inner London is 1 in 3.

v. Location

The 2011 Census identifies highest levels of provision of 50+ hours a week in areas of relative deprivation and social housing. ASC assessed a higher proportion of the high intensity (50+ hours per week) carer population in these areas of deprivation: they are less successful at reaching more affluent areas,

[79] Older men who care: understanding their support and support needs, C Milligan & H Morbey, Lancaster University Centre for Ageing Research, December 2013 http://eprints.lancs.ac.uk/68443/1/Older_men_who_care_report_2013Final.pdf

[80] https://www.spurgeons.org/our-services/young-carers

[81] http://www.jsna.info/document/child-poverty

some of which have larger older populations. In part this may be due to successful targeting of initiatives in areas where a larger number of carers can be expected, including those who care for a larger number of hours per week. It may also be due to more affluent carers making private arrangements for care.

6.3.3 The human cost

Evidence shows that investing in carer support is a cost effective way of reducing ASC costs, yet the State of Caring report 2016[82] predicts that the financial strain on public services affects carers particularly adversely.

In the 2009/10 survey, carers reported several ways in which their caring responsibilities role had affected their health over the last 12 months. The most significant factors were disturbed sleep and stress, for roughly half of carers. Other factors included feeling depressed, physical strain, being irritable, loss of appetite, developing their own condition or making an existing condition worse[83].

The Census 2011 showed that carers caring for 50 or more hours a week are more than twice as likely to be in bad health than non-carers[84].

The 2014/5 survey sought responses about specific health conditions. In all three boroughs half the respondents had a health condition themselves, recorded as either a long standing illness, physical disability, sensory impairment, mental health problem, learning disability or 'other'[85]. 50% have co-morbidities – more than one long term condition[86].

A strong theme in the stakeholder feedback was the prevalence of loneliness and social isolation, with carers feeling trapped in their homes and unable to access support services due to their caring responsibilities.

Feedback also suggested that the way in which the primary service user has their needs assessed and provided has an impact on the carers' health and wellbeing, with carers' stress and anxiety being heavily linked to whether their views and experience are sufficiently taken into account in the development of the care plan for the cared-for person. Stakeholders reported that involvement of the carer in decision making about the primary users' needs and package of support can help them to feel supported and respected and better able to make effective assessments about their own support needs.

[82] https://www.carersuk.org/for-professionals/policy/policy-library/state-of-caring-2016
[83] Information on this survey in the JSNA Carers Evidence Pack.
[84] Census analysis (2013) Carers UK http://socialwelfare.bl.uk/subject-areas/services-activity/social-work-care-services/carersuk/166981carers-at-breaking-point.pdf
[85] Survey of Adult Carers in England 2014/5
[86] As yet unpublished ASC data

A report by Carers UK, 2014[87] , highlights that many carers only seek help once they actually reach a 'crisis' or 'breaking point'. At this stage their health and wellbeing needs will already have deteriorated and greater intervention will be needed – for example respite care for the cared-for person while the carer's needs are addressed. Carers whose needs are met and assessed at an earlier stage are less likely to reach this point as soon, some not at all. As recommended in the Dementia JSNA, carers need support and advice to empower them in fulfilling their caring role without detriment to their own quality of life.

6.3.4 Economic value

As outlined in chapter five, the health, social and economic value of informal care is huge. In 2000, around two thirds (65%) of the value of long-term care support was provided via unpaid care, with a quarter (25%) from the state and 10% funded privately. If carers' support had to be replaced with provision from statutory services, it would cost the NHS, social services and other statutory bodies around £34 billion a year nationally, or around £140 million a year in Hammersmith and Fulham.[88]

6.3.5 Identification of carers

Carers are often not known to services because they do not recognise themselves as carers (particularly in the early stages), may see it as fulfilment of family duties, or may be reluctant to make their needs known.

Even where they do self-identify, carers may be in contact with any of a number of services without presenting for an assessment of their needs on the basis of which a support package can be put in place. Their caring role might be known to their GP or social network, for example, or by hospital discharge staff, but not then subject of a referral to the appropriate service for assessment. This presents a challenge for those seeking to ensure carers are appropriately supported.

Local action

The specification for a new carers' support service is currently being designed. This will seek to ensure the following:

- an emphasis on ensuring care packages have a dual focus, on both the carer and the cared-for resident
- facilitation of the maintenance of a 'viable' home for both parties
- consideration of the totality of the impact of the caring role on the carer's wellbeing
- consideration of respite care as part of the cycle of care rather than solely at point of crisis
- tailored provision of respite care

This service will link with a wide range of partners to ensure that carers' diverse support needs are met.

[87] Carers at Breaking Point, Carers UK, September 2014 , http://socialwelfare.bl.uk/subject-areas/services-activity/social-work-care-services/carersuk/166981carers-at-breaking-point.pdf

[88] http://jsna.info/document/carers-evidence-pack

6.3.6 Carers' assessments / reviews

The national target for initial assessment / annual review of carers' needs is 95%. Unpublished data from Adult Social Care suggests Hammersmith and Fulham is falling short of this target. This reinforces feedback from stakeholders which suggests that experience of carers assessments is not consistent, some carers waiting much longer than others. The borough has made a marked improvement since the previous year.

6.3.7 Support packages

i. Carers' satisfaction with services and support

An unpublished finding from the ASC Carers' Survey 15/16 is that satisfaction with services and support is higher than the London average.

ii. Respite care

Stakeholder feedback stressed the need to ensure that respite care provides genuine rest and recovery for the carer as well as appropriate care for the cared-for person. Also that respite care must be seen as part of a cycle of care and be tailored appropriately, in a way which reflects the particular background to the caring relationship and the cultural context within which it operates.

iii. Housing related support

Although there is evidence and information on carers' general health and support needs of carers, there is a relative lack of research and information into specific housing related needs, and interventions which could facilitate and sustain their caring role. Those highlighted[89] include:

- Housing conditions: Carers who live with the person they care for may not have adequate space of their own, as a result of the storage of necessary equipment and/or having to use communal space as their bedroom. Carers who live elsewhere and need to stay overnight might end up regularly sleeping on a sofa. Engagement with voluntary sector agencies stresses that carers having their own space was seen as vital to their wellbeing. The prevalence of this stressor could become greater as a result of the under-occupancy cap, under which rooms used to house equipment or night-time carers who live elsewhere[90] can be defined as spare rooms, with a consequent reduction in the residents' housing benefit.

[89] Carers and housing: addressing their needs' by Princess Royal Trust. http://trustnet.carers.org/print/professionals/social-care/articles/carers-and-housing-addressing-their-needs,5878,PR.html

[90] Ibid.

- Household maintenance: carers can struggle to cope with these tasks on top of their caring role (and possibly their own frailty) and might not know how to access support.
- Equipment and adaptations: Feedback from stakeholder engagement, endorsed by the Dementia JSNA highlighted a common lack of understanding regarding the available aids, adaptations and assistive technology and their respective benefits. This can lead to health and safety risks for carers. In Australia, installation of home adaptations has led to a significant reduction in the number of care hours. Adaptations to assist with bathing reduced care giving hours by 60%, toileting by just under 50% and mobility equipment by 40%.[91] Technology such as tele-care might save up to £2,000 per year per installation[92].
- Security of home situation: whether owner occupiers or social or private tenants, carers can become vulnerable if the needs of a primary user of services deteriorate to the point of requiring residential care, either for financial reasons or where they are not named on the tenancy agreement. Anxiety relating to this can impact on their wellbeing before the event[93].

Recommendation 10: Ensure that appropriate strategies are in place to increase the proportion of informal carers who are known to services and in receipt of appropriate support. These should ensure:

a) The promotion of self-identification through tailored and targeted outreach which is sensitive to cultural conceptions of social roles, working with front line providers in a range of services, statutory and voluntary.

b) Referral mechanisms and smooth care pathways which ensure expediency and the provision of support for a range of needs from the right place at the right time and provide a fair and equitable experience for all carers.

c) Ready access to the breadth of advice and support necessary to ensure that carers' needs are addressed (see section 5.1.1 Prevention).

d) Care management protocol (including discharge planning) should identify how systematically to ensure that carers' views and needs are better taken into account.

[91] http://www.australianageingagenda.com.au/2016/04/07/home-modifications-reduce-reliance-care-study/
[92] http://www.kingsfund.org.uk/sites/files/kf/telecare-older-people-wanless-background-paper-teresa-poole2006.pdf
[93] Ibid.

6.4 Improving the offer for those in severe and multiple disadvantage (SMD)

Introduction

The term severe and multiple disadvantage (SMD) refers to individuals who present a range of challenging behaviors and needs which in isolation may not warrant specialist intervention but which in combination become highly significant. Further, where specialist interventions are put in place to manage one condition, these may fail or be less effective than anticipated as client barriers and multiple needs often reinforce and exacerbate each other.

National estimates suggest there are 4,440 residents experiencing Severe and Multiple Disadvantage (SMD) across the three boroughs[94]. They show a high prevalence of challenging behavior, homelessness, mental health issues and substance misuse and commonly suffer deep social exclusion. Individuals can lead chaotic and highly risky lives, experiencing poverty, stigma and discrimination[95]. Problems often develop after traumatic experiences such as abuse or bereavement and there is a high prevalence of challenging behavior, mental health issues and substance misuse issues[96].

Those in SMD can present a disproportionately high cost to the public purse through the repeated use of public services in an unplanned way. Individuals are often subject to a cycle of homelessness as housing placements become untenable. Rehousing is challenging due to the limited availability of appropriate social housing stock and the need to consider the potential impact on both the individual and the community (housing scheme) into which a placement is made. The provision of adequate and safe accommodation for individuals in the early and late stages of entrenched dependency has been highlighted as an issue in Hammersmith and Fulham.

Health and social care services are commonly designed either as generic services which address low level issues or to specialized services to address specific conditions, for example mental health conditions or learning disabilities. Many housing services currently work with individuals with a wide range of needs that go beyond requiring assistance with housing, and interact with health and social care. However, when an individual in SMD seeks help, the multiplicity of needs presented leads to challenges in providing services in the most effective way, which can lead to support being offered

[94] Hard Edges: Severe and Multiple Disadvantage in England, Lankelly Chase Foundation January 2015
[95] Hard Edges: Severe and Multiple Disadvantage in England, Lankelly Chase Foundation January 2015
[96] Alcohol and substance misuse is not within the scope of this JSNA, see 'Substance Misuse and Offender Health 2013/14 for local information http://www.jsna.info/document/substance-misuse-and-offender-health-2013-14

by multiple professionals from different services, overwhelming the individual and causing them to disengage.

Existing support services and pathways can be poorly suited to needs and, as a result, effectiveness in supporting recovery compromised. As a result, many become 'frequent flyers', individuals who repeatedly find themselves needing to return for additional assistance. In the face of multiple problems that exacerbate each other, and the lack of effective support from services, individuals can end up in a downward spiral of mental ill health, drug and alcohol problems, crime and homelessness. They become trapped, experiencing regular crises with no apparent realistic way out.

National evidence and best practice both support local findings that individuals experiencing SMD require person-centred and flexible care delivered in a timely fashion, and that appropriate care can generate significant cost savings. Evidence suggests that safe and suitable housing is a key enabler in recovery and stabilisation.

6.4.1 The local picture

Individuals who present with Severe and Multiple Disadvantage are predominantly white men, aged 25–44, with long-term histories of economic and social marginalisation and, in most cases, childhood trauma of various kinds[97].

As elsewhere, individuals who fall into the SMD cohort are not systematically identified and registered in Hammersmith and Fulham so the full prevalence is not known.

6.4.2 The human cost

The Multiple Exclusion Homelessness (MEH) survey[98] highlights increased prevalence of a range of physical health conditions including alcohol or drug related problems (85 times the incidence rate for the average population) epilepsy (five times), difficulty in seeing (3.4 times), stomach/liver/digestive complaints (3 times), chest/breathing problems, cancer and stroke (2 times). Individuals with SMD are also more likely to suffer from poor mental health. Nationally, 55% have a diagnosed mental health condition and 75% report common mental health problems and loneliness[99].

Of particular concern are older people with SMD, who often present with complex physical health and mobility issues. General community supportive accommodation

[97] Hard Edges: Severe and Multiple Disadvantage in England, Lankelly Chase Foundation January 2015
[98] A quantitative survey of people using 'low threshold' homelessness, drugs and other services in seven UK cities conducted in 2010.
[99] Hard Edges: Severe and Multiple Disadvantage in England, Lankelly Chase Foundation January 2015

may not be appropriate for them due to the level of risk they present, however neither do they meet the threshold for residential care. A small yet significant number of individuals within this cohort are experiencing early onset dementia, most likely brain damage as result of long term substance misuse.[100]

Almost 60% of individuals in SMD either live with children or have on-going contact with their children. Children in these families are potentially affected by chaotic lives, economic and housing insecurity, and social stigma and experience heightened risks of neglect, abuse and domestic violence. Focus and attention on how we address the negative impact of SMD on children's lives, possibly by joining up with Troubled Families initiatives and the plethora of good quality family services in the voluntary sector should be considered[101]. A recent report by IPPR, *Breaking Boundaries*[102], further sets out the case for government developing, alongside an expanded Troubled Families programme, a new 'Troubled Lives' programme based upon similar principles.

6.4.3 Financial cost (cost to society)

Despite making up a very small percentage of the population, the costs to services and society can be significant with failure to effectively support this client group often resulting in entrenched dependency. National estimates range from £16,000 a year for the average entrenched rough sleeper[103], to £21,180 a year for the average client facing substance misuse, offending and homelessness problems[104]. This is compared to average UK public expenditure of £4,600 per adult[105].

The Lankelly Chase research estimates that those accessing homelessness services in addition to criminal justice or substance misuse services or both, cost the public purse £4.3 billion a year[106]. Accumulated individual 'lifetime career' averages are also stark – ranging from £250,000 to nearly £1 million in the most extreme cases for the most complex individuals[107]. One recent study found that better coordinated interventions from statutory and voluntary agencies can reduce the cost of wider service use for people with multiple needs by up to 26% (Battrick et al 2014).

[100] Stakeholder feedback
[101] Hard Edges: Severe and Multiple Disadvantage in England, Lankelly Chase Foundation January 2015
[102] Breaking Boundaries, Towards a 'TROUBLED LIVES' programme for people facing multiple and complex needs, Clare McNeil and Jack Hunter, September 2015
[103] DCLG analysis, 2012 based on criminal justice and health costs for the average entrenched rough sleepers.
[104] Hard Edges: Severe and Multiple Disadvantage in England, op cit.
[105] Ibid.
[106] (Bramley and Fitzpatrick 2015).
[107] Hard Edges: Severe and Multiple Disadvantage in England

Figure 17: Annual costs of an individual with the most complex needs

Benefits	£6,020	28%
Prison	£5,053	24%
Psychiatric hospital	£3,094	15%
Hostels	£1,948	9%
Physical health	£1,603	8%
Rough sleeping services	£1,230	6%
Support services	£1,145	5%
Substance treatment	£763	4%
Criminal justice	£324	2%
Total annual cost:	**£21,180**	**100%**

Source: DCLG, Addressing complex needs, improving services for vulnerable homeless people 2015

6.4.4 Pressure on current housing and social care pathways

Key stakeholders and service providers fed back their experience of trying to support clients who 'fall into the gaps' between services[108], for example individuals in SMD to whom we have a housing duty but who do not qualify for ASC support and/or specialist housing. This can leading to highly vulnerable individuals being placed without an adequately tailored support package in place, despite best efforts[109].

Due to the limited supply of social housing stock, individuals in SMD may be placed in temporary accommodation for some time, awaiting permanent placements. The provision of appropriate support in TA can be challenging and individuals may fall into a cycle of homelessness as housing placements become untenable, with rehousing opportunities challenging. Floating support services have a particularly important role to play for individuals in SMD.

Local action

Family Mosaic's 'Health Begins at Home'* resident engagement initiative identified particular issues for SMD residents with both a human and financial cost. By putting in place tailored intensive health and wellbeing interventions they achieved a marked reduction in unplanned GP and hospital appointments and a significant improvement in health and wellbeing.

Tenancy Sustainment Officers at **Affinity Sutton** offer intense support at the start of tenancies for people identified as being high need/risk, particularly the under 25s, care leavers and ex-offenders).

There may also be a negative impact of those living around the resident in SMD, if they exhibit challenging behaviours. Further, the need to consider the potential impact on the community (housing block)

[108] JSNA stakeholder workshop December 2015
[109] JSNA stakeholder workshop December 2015
* www.familymosaic.co.uk/userfiles/Documents/Research_Reports/Health_Begins_At_Home_web.pdf
# http://www.affinitysutton.com/rent-a-home/supported/tenancy-sustainment/

into which a placement is made means that individuals experiencing SMD are often placed within the same housing block. Whilst existing accommodation schemes can manage a proportion of challenging clients at any one time, the mix is crucial also, as many residents with high support needs can, without the right interventions, cause the service to become unsafe and further exacerbate dependencies and issues.

It has been suggested that the Housing and Planning Act, together with welfare reform will not relieve the significant pressure on housing services across the borough and the following might be expected:

- continued upwards trends in homelessness applications;
- reduction in the overall availability of social housing stock;
- inability to procure suitable and affordable temporary accommodation within the borough or indeed London;
- further inability to discharge residents into affordable accommodation within the private rented sector

In combination this is expected to lead to longer waiting times with more residents being placed long-term in temporary accommodation, an increasing proportion out of the borough. Careful consideration of how this affects responsibilities of care and our ability to affect design of care is needed.

6.4.5 Current activity and good practice: *Housing First*[110]

Hammersmith and Fulham is currently undertaking an 18 month *Housing First* pilot. The *Housing First* model seeks to assist the most entrenched rough sleepers move off the streets and into their own accommodation. Crucially individuals are not required to be "housing ready" and there are no preconditions (e.g. for the individual to address wider social care or support needs) for access. Research has demonstrated the success and cost effectiveness of the model[111].

Traditionally, *Housing First* services target long-term entrenched rough sleepers who have lived in numerous hostels and have either been evicted or have abandoned their placement on multiple occasions. Many individuals will have a long history of anti-social behaviour, poor physical/mental health and substance misuse. Hammersmith & Fulham has achieved good results in reducing entrenched rough sleeping, however there is a small but not insignificant number of people in hostels who struggle to thrive in the hostel setting and are at risk of losing this

110

http://democracy.lbhf.gov.uk/mgReasonsRestricted.aspx?ID=76038&OID=40795&OT=A&RPID=89669278&BM=AI40795

111 'Housing First' or 'Housing Led'? The current picture of Housing First in England, June 2015 Homeless Link Policy and Research Team

accommodation, are often placing considerable demands on other statutory services such as the criminal justice system and through unplanned hospital admissions.

The purpose of the pilot is to assess whether the Housing First service model can deliver service improvements for homeless people with complex needs, and secure better value for money through reducing in the longer term the number of hostel places the council needs to commission.

6.4.6 Recommendations

Stakeholders in Housing and Adult Social Care across the borough expressed a desire to review how better individuals in SMD might be supported and whether there might be potential to secure cost savings as well as delivering real improvements in wellbeing and risk reduction both for these vulnerable clients and the wider public.

Recommendation 11: Building on existing innovative approaches, develop models, potentially using pooled budgets, to deliver more cost effective, integrated health, housing and social care solutions to those in severe and multiple disadvantage. These must include:

a) shared mechanisms for routine, earlier identification of those in SMD;

b) an integrated health and social care offer to those in SMD, in all housing settings;

c) integrated pathways into appropriate care and housing support.

6.5 Improving housing options for later life

Introduction

The English Housing Survey indicates that around three million households (53%) of those aged 65+ are under-occupying their home, with more space than they normally need[112]. The Joseph Rowntree Foundation identified a similar proportion, 57% of older households under-occupy, but also found that this differs with tenure: 68% of owner-occupiers compared to 19% of social renters. Of the 8 million households that under-occupy, just over half (4.2 million) are older person households[113].

Among those aged over 60, 58% express interest in moving to more suitable accommodation, however there is reluctance due to a lack of suitable alternatives or

[112] Savills UK - Housing an ageing population: spotlight

[113] Joseph Rowntree Foundation: *Older people's housing : choice, quality of life, and under-occupation*, 2012

fear of an unfamiliar environment, as well as a desire to maintain the asset to pass on[114]. This can lead to premature deterioration and loss of independence, as a result of inability to adequately maintain or heat the property and poor access to services where the property does not lend itself to adaptation, to unnecessary hospital admissions and/or premature removal into more residential care.

A review by the Joseph Rowntree Foundation[115] examines the housing options available to older people who may wish to move. They identified some key points which should be considered when considering schemes to encourage older people to down-size:

- Nationally, 75% of all older households are owner-occupiers, but only one quarter (23%) of specialist housing is for sale.
- Most older people want a home with at least two bedrooms (for visitors, carers) but most specialist provision has only one bedroom.
- Owner-occupiers are often reluctant to move from freehold to leasehold housing
- Many older people prefer to remain living in mixed-age housing and communities.

In the absence of a desirable alternative, the advantages which 'staying put' offers, such as maintaining social networks, access to support from neighbours and the local community and keeping pets may mean that 'staying put' is the right choice.

Releasing the 'spare capacity' in under-occupied housing stock could address some of the current and future challenges of housing supply for those in need, particularly for families. However, currently, death is a more significant contributor than downsizing in 'releasing' larger homes: 85% of homes with three or more bedrooms are 'released' by older people due to death rather than a move to a smaller home[116].

6.5.1 Support to 'stay put'

There may be scope for the fitter older population in their own properties and with spare capacity to take a 'lodger'. In Homeshare[117], someone who needs some help to live independently in their own home is matched with someone who has a housing need and can provide some support. Inspired by naturally-occurring, mutually beneficial relationships, Homeshare programmes seeks to facilitate such arrangements it in a way that maintains the non-contractual nature of the relationship while

[114] Wood, C. *The top of the ladder.* DEMOS, 2013
[115] Joseph Rowntree Foundation: *Older People's housing: choice, quality of life and under-occupation,* 2012
[116] Ibid
[117] Homeshare Practical Guide, Homeshare Plus http://sharedlivesplus.org.uk/images/publications/01-SL-HOMESHARE-GUIDE.pdf

increasing the clarity and safeguards around it. Local authorities may view this as a way of addressing the lack of intermediate housing and/or appropriate housing options for some vulnerable adults, for example those with mild to moderate learning disabilities.

Many larger properties will only become available for families, however, should the resident opt to move to alternative accommodation.

6.5.2 Support to move

The logistics of moving house can be a significant deterrent. Residents may need assistance with sorting through possessions for packing and/or passing on and properties may require some refurbishment as well as a facelift before they can be inhabited other residents. Councils are recognising that support, including financial assistance, with the preparation and arrangements associated with moving house, might be recognised as a cost effective investment.

Stakeholders reported that some boroughs (e.g. Croydon) are looking to property bonds as a mechanism to enable them to purchase homes on the open market, exploring the framing of such purchases as options for investment to support pension funds. Others have found this can serve to inflate house prices further, exacerbating issues they are seeking to resolve (e.g. Newham).

6.5.3 Providing desirable alternatives

While, in practical terms, the greatest leverage exists in relation to housing association and council tenants who are living in family-sized

Good practice elsewhere:

- support to 'downsize' to two bed as opposed to one bed properties (Islington), alleviating fears that friends and family will be unable to visit and carers unable to stay over as necessary without discomfort
- co-housing for over 55s (Haringey)
- through assistance with the preparations and logistics for moving and with the actual move[+], offsetting the cost with the benefits drawn from the move.

Local action:

- H&F's housing department is trialling offering residents help with renting out their home when they move into residential accommodation. The scheme provides a source of income which helps residents to cover their care costs, enables them to retain their asset and provides what is often family sized accommodation for social housing. The Council makes the necessary arrangements and covers the cost of necessary maintenance and decorating costs as part of the deal.
- SharedLives is an approach which supports family-based and small-scale ways of supporting adults. It has just been launched in all three boroughs by ASC.

housing, evidence suggests[118] that under-occupation should be discouraged across all housing tenures.

Perhaps the single most important barrier for older people who wish to move is the lack of a suitable and desirable offer. With only around 10% of the older population living in specialist housing nationally[119], there is significant scope, with the right investment and approach, in alleviating some of the pressure on the housing stock. Providers need to offer a range of attractive alternatives in order to offer a real choice[120].

A survey commissioned by the National Housing Federation in 2010 found people aged between 60 and 65 dreaded ending up in a care home or imposing themselves on relatives if they could no longer cope with living on their own[121]. The majority of respondents (80%) were positive about downsizing to a smaller, more manageable home. The research identified the following as central to older people's housing requirements:

- accessible
- spacious and attractive
- safe and secure
- age-friendly environment
- offers freedom, choice and flexibility
- has help at hand
- provides flexible, personalised support
- enables you to socialise and feel included
- allows you to make decisions

The HAPPI report[122] establishes principles which build on this and which have been used by developers and architect in providing housing schemes for people aged 55+ in the Royal Borough of Greenwich[123].

6.5.4 Challenges to providing desirable alternatives

[118] Kneale, D et al. *Downsizing in later life and appropriate housing size across our lifetime*. International Longevity Centre-UK, 2013
[119] International Housing Partnership. *Fit for the Future: Meeting the challenge of housing an ageing population*, 2013
[120] JRF, ibid
[121] National Housing Federation, "Breaking the mould : re-visioning older people's housing" 2011 + 'Support to Relocate' project, Stoke on Trent; 'Moving Experience' McCarthy and Stone
[122] Housing our Ageing Population: Panel for Innovation (HAPPI) https://www.gov.uk/government/publications/housing-our-ageing-population-panel-for-innovation
[123] Berrington, J. *Quality design attracts downsizers*. Housing LIN Case Study 77, 2013

Reasons why housing options for older people are limited nationally are significant[124]:

- A challenging housing market for developers
- There is limited public investment in new social rented housing
- Housing and planning issues, such as strategic vision and data on older people's housing or lack of imaginative ideas or innovation
- Developers offer limited models for specialist retirement housing
- General house-builders do not design for or target older people as a market segment.
- Limited use of creative partnerships between general house-builders, specialist retirement developers, housing associations and local authorities, although interest is growing.

Savills UK report[125] that without homes that meet changing lifestyle needs or financial incentives, such as stamp duty holidays for downsizers, it appears likely that we will see the majority of people staying in the family home for as long as possible. Typically people stay put until faced with a pressing health or social reason (e.g. bereavement, safety or health scare).

Extra care housing is one important response to the diverse needs of a growing older population and is part of the move towards age friendly communities, providing access to care services which are responsive to the changing needs of residents, provides unplanned care when required, and offers an emergency response, which can prevent unplanned hospital admissions.

Extra care is still evolving and various tenure and funding models are being tried and tested across the country. The borough currently has some socially rented extra care and plans to develop more but there is an increasing pressure to meet the needs of owner occupiers who do not wish move into social housing. There are now greater tenure options with more leasehold and shared ownership properties alongside social renting, which extend equity based choices[126]. These enable authorities to alleviate the pressure on their own extra care stock and may also offer wider benefits to communities in terms of economic and social wellbeing.

[124] Joseph Rowntree Foundation, op cit
[125] Savills UK. *Housing an ageing population: spotlight*. 2015
[126] Pannell, J & Blood, I. *Briefing 1: Quality and choice for older people's housing: what can a new Private Rented Sector offer?* Housing LIN, 2014.

Recommendation 12: Councils must use every opportunity to increase the range of desirable housing options for older people in both the social and private sectors, using innovative partnerships, and ensure their take-up. This must include:

a) the development of a broader range of options

b) the development of new approaches to providing housing options advice for older people, which promotes and facilitates early planning for ageing

c) the design or enhancement, as appropriate, of packages of support which respond to the barriers to the preferred housing solution, building on existing models of good practice.

7 Recommendations: reliant on robust partnership

7.1 Introduction

The recommendations are not exclusively addressed for the Housing department, for Adult Social Care or indeed other departments or agencies. They will need to be addressed in partnership by the relevant teams or departments and the lead may be different for each recommendation.

Any implementation plans which stem from this report will need to be produced in partnership and to consider the most appropriate, borough based response to each recommendation.

7.2 The recommendations

Strengthening prevention and early intervention

Recommendation 1: Increase the number of homes in the borough which offer residents easy access and manoeuvrability, ensuring:

a) Strong emphasis on refurbishing existing homes to deliver a greater proportion of readily adaptable homes more quickly.

b) Expedient customer journeys for aids and adaptations, from identification of requirement to delivery which offer the best use of available resource.

Recommendation 2: Improve housing conditions, cross tenure, to facilitate efforts to maintain residents' health and wellbeing, ensuring:

a) Residential environmental health teams are sufficiently resourced to address housing conditions across the borough, taking a proactive approach and utilizing the Housing Health and Safety Rating System (HHSRS) as appropriate to tenure.

b) A cost-effective handyperson scheme, potentially co-ordinated across three boroughs, to deal with a range of maintenance issues and minor adaptations.

c) Appropriate engagement of registered providers.

d) Integrated referral pathways for front line professionals working with vulnerable residents ensure that housing conditions are considered and concerns addressed through every resident contact (see also recommendation 6).

e) Full understanding of the shape and scale of fuel poverty in the borough and of the appropriate solutions and mitigation of impact, each Health and Wellbeing Board considering NICE's recommendation to undertake a fuel poverty JSNA. Action might include proactively lobbying central Government for policy solutions and revenue to improve hard to treat properties, including common parts of flats.

f) Initiatives to alleviate the impact of overcrowding on children, e.g. homework clubs, active play space, are sufficiently and appropriately tailored and targeted.

Recommendation 3: Ensure that resources and arrangements are in place to support people to maximise their range of life skills and confidence, enabling them to live independently in the community, including:

a) Sufficient investment in integrated community support services to enable 7 day provision.

b) Greater integration of assistive technologies in all care planning, and increased up-take.

c) Sufficient investment in localised, time-limited 'step up and step down' beds.

d) Discharge planning procedures and protocols which are commenced on admission and systematically and which routinely incorporate assessment of patients' home environments, ensuring the introduction prior to discharge of appropriate aids and adaptations.

Recommendation 4: Ensure that strategies are in place to promote community cohesion and prevent and alleviate social isolation. These should incorporate:

a) Recognition of community cohesion as a specific objective towards securing community resilience and promoting independence and self-reliance, with appropriate resourcing plans.

b) Plans for identifying residents at risk of social isolation and the appropriate mechanism(s) to best engage and support them

Recommendation 5: Ensure the development of an asset based approach to the delivery of robust front-of-house, information, advice and outreach services, which promote independence and self-reliance and are tailored and targeted to secure best impact.

Recommendation 6: Extend the reach of front line services by embedding the 'Making Every Contact Count' approach. This will require:

a) The establishment of appropriate systems: MECC incorporated into specifications and contracts; front line workers having ready access to information; agreed referral routes; data sharing protocols and the IT infrastructure to support them (see recommendation 7).

b) Establishing MECC as a routine component of staff induction and regular training programmes in both the statutory and voluntary sectors, exploring links with other partners with front line workers, such as the fire service and refuse collection.

c) Providing training and support to formal carers and other commissioned agency workers to ensure they have the skills and information to contribute to the MECC

approach as part of a quality care and support packages.

Delivering personalised housing support and care

Recommendation 7: Establish data sharing protocols and governance processes across council departments, NHS partners and other front line provider agencies working to support vulnerable residents.

Recommendation 8: Ensure support and care pathways, between front line staff in Housing (including REHS & RPs), ASC, health services, Children's Services and voluntary sector partners, facilitate smooth customer journeys and effective care.

Recommendation 9: Consider undertaking a multi-agency evidence review of options for increasing the supply of move-on accommodation within the challenging landscape.

Strengthening collaborative approaches to supporting carers

Recommendation 10: Ensure that appropriate strategies are in place to increase the proportion of informal carers who are known to services and in receipt of appropriate support. These should ensure:

a) The promotion of self-identification through tailored and targeted outreach which is sensitive to cultural conceptions of social roles, working with front line providers in a range of services, statutory and voluntary.
b) Referral mechanisms and smooth care pathways which ensure expediency and the provision of support for a range of needs from the right place at the right time and provide a fair and equitable experience for all carers.
c) Ready access to the breadth of advice and support necessary to ensure that carers' needs are addressed.
d) Care management protocol (including discharge planning) should identify how systematically to ensure that carers' views and needs are better taken into account.

Improving the offer for those in severe and multiple disadvantage

Recommendation 11: Building on existing innovative approaches, develop models, potentially using pooled budgets, to deliver more cost effective, integrated health, housing and social care solutions to those in severe and multiple disadvantage. These must include:

a) shared mechanisms for routine, earlier identification of those in SMD;
b) an integrated health and social care offer to those in SMD, in all housing settings;

c) integrated pathways into appropriate care and housing support.

Improving housing options in later life

Recommendation 12: Councils must use every opportunity to increase the range of desirable housing options for older people in both the social and private sectors, using innovative partnerships, and ensure their take-up. This must include:

a) the development of a broader range of options

b) the development of new approaches to providing housing options advice for older people, which promotes and facilitates early planning for ageing

c) the design or enhancement, as appropriate, of packages of support which respond to the barriers to the preferred housing solution, building on existing models of good practice.

7.3 Implementation

	Housing	RPs	ASC	REH	PI	CCGs	A&C HPs	GPs	OTs	CVS	ChS	PH	CPol	Sch	IG
Recommendation 1: Accessibility															
Recommendation 2: Housing conditions															
Recommendation 3: Maintaining independence															
Recommendation 4: Community resilience															
Recommendation 5: Info, advice & outreach															
Recommendation 6: MECC															
Recommendation 7: Data sharing															
Recommendation 8: Smooth customer journeys															
Recommendation 9: Move-on accommodation															
Recommendation 10: Carers															
Recommendation 11: Those in SMD															
Recommendation 12: Housing options for OP															

Key

	Lead department
	Key partner

Registered Providers	RPs
Adult Social Care	ASC
Residential Environmental Health	EH
Planning	Pl
Clinical Commissioning Groups	CCGs
Acute and community health providers	A&C HPs
General Practitioners	GPs
Occupational therapists	OTs
Voluntary & Community Sector	VCS
Children's Services	ChS
Public Health	PH
Parks and Leisure	P&L
Corporate policy	CPol
Information Governance	IG

8 Foundation stones

The recommendations, framed placing residents at the centre, highlight seven common interwoven threads which offer important messages for how systems might be better structured. These are consistent with themes identified in the refreshed Joint Health and Wellbeing Strategy. Each of these acts as a foundation stone on which cost effective personalised prevention and early invention might rest.

8.1 Joint commissioning and pooled budgets

NHS, Housing Services and Adult Social Care are under increasing pressure, through a combination of reduced budgets, an aging population, Housing and Welfare Reform and a requirement to implement significant reforms under the Care Act. It is widely recognised that investment in preventing the deterioration of health and wellbeing is needed. Recognising the links between housing, health and social care, and the restrictions on how specific budgets can be used, commissioners need to increase the use of pooled budgets as a way of unblocking solutions and facilitating closer collaboration. This might enable greater weighting towards 'upstream' prevention and earlier intervention.

8.2 IT data sharing protocols and information governance

The health and wellbeing strategy recognises that investing in information technology and data analytics will all be crucial to delivering an integrated health and social care system which provides patients with a good experience of care. Collaborative work to facilitate and enable information exchange between organisations, supported by robust information governance protocols and initiatives to facilitate patients' confidence in appropriate disclosure, is required if cost effective personalised prevention and early intervention are to be realised.

8.3 Smooth customer journeys, supported by referral rights and pathways

There are a number of examples of good practice in Hammersmith and Fulham where specific teams have sought to address broken customer journeys. Work to build on these is required to ensure that, regardless of where a resident makes first contact, the offer is consistent and secures optimal impact.

8.4 Quality services and facilities, appropriately tailored and targeted

Hammersmith and Fulham is characterised by quality services and facilities. In financially straitened times, the pressure to improve cost benefit ratios and to ensure that services and facilities reach those with the most to gain increases. This report seeks to highlight services which secure positive outcomes for some of our most

vulnerable residents and which might play a greater role in facilitating cost effective provision than may previously have been recognised.

8.5 Asset based approaches[127] (for individuals and for communities)

These look first at strengths rather deficits within a community or a person's life. Communities that are more connected need fewer public services, create dynamic places to live, and improve outcomes for residents. People are not passive recipients of services – they have an active role to play in creating better outcomes for themselves and for others, and they themselves will be the starting point for tackling emerging issues – their family and community networks, their interests and their abilities - in order to link people with the right sources of support and help which build upon these strengths. This report advocates the development of strategies which explicitly seek to strengthen community resilience and practices which utilise residents' own strengths.

8.6 Workforce development

The drive to achieve more for less has implications for our staff. Ensuring that staff teams are skilled up, confident and supported to address this challenge is essential if positive outcomes are to be achieved. If they are to be expected to 'make every contact count', staff working in front line services of different sectors will need the tools to do so. These will include referral rights and pathways but also learning opportunities to ensure that they are able to recognise signs of poor or deteriorating health/wellbeing and to know how best to address them.

8.7 Local intelligence

Distinct from IT data sharing protocols and information governance, this foundation stone refers to securing greater understanding of the local landscape. While much is known about the demographics of the borough and about needs, there remain sources of data which have not been drawn together to shed light on issues pertinent to prevention and early intervention and to the provision of personalised housing support and care. Two specific areas highlighted in this report are fuel poverty and severe and multiple disadvantage.

[127] A glass half full: how an asset based approach can improve community health and well-being, I&DeA 2010

Appendix 1: Related reports and reviews

Older People's Housing

Older People's Housing Strategy 2016, LBHF

In 2015/16 LBHF carried out an Older People's Housing Review to inform the development of Hammersmith and Fulham's Older People's Housing Strategy. The Older People's Housing Strategy is a 'direction of travel' document setting out the key challenges and priorities for the authority. It includes actions and activities to address these challenges which will be developed in partnership with Health and the Third Sector and through closer working between Council Departments such as Adult Social Care and Housing.

The Older People's Housing Strategy will be published towards the end of 2016 and the priority areas for action are:

Priority 1	Better understand what housing options older people need and want
Priority 2	Maximise use of existing stock
Priority 3	Increase housing options for older people
Priority 4	Focus housing and support services around prevention to promote independence and reduce social isolation and loneliness.

Review of Extra Care Housing

Customer engagement work took place in December 2015-February 2016 with all residents invited to one-to-one interviews and a number of focus groups for relatives, carers and friends.

Review of Mental Health Supported Accommodation, LBHF

Some placements had to be made outside of the borough as there wasn't suitable in borough accommodation types, or no availability. Customers requiring an out of borough placement could be broadly grouped as follows:

1. Complex but more routine needs; younger adults often with substance misuse issues requiring a robust rehabilitation and recovery approach. Possibility that with the right care and support individuals may be able to step down into in-borough supported housing in the future.
2. Individuals with forensic histories.
3. Very complex needs often with complex physical ill health issues. It is hard to envisage it being cost effective to commission in borough services case by case approach required to identify suitable placements.

Appendix 2: Stakeholder engagement

Multi-agency Workshops

An engagement workshop took place in November 2015 with around 40 attendees from Housing departments in each borough, Adult Social Care, Public Health, the Community and Voluntary Sector and each of the local Clinical Commissioning Groups as well as residential environmental health services and some providers of social housing and supported accommodation. This brought together the expertise from different parts of the system to identify issues and potential solutions. This was used to inform the key lines of enquiry in this report.

A second engagement workshop, attended by another 45 delegates from the same agencies, was held in June 2016. Discussion centred on the key messages of the report and a set of draft recommendations. The focus was on ensuring that they had resonance for attendees, captured the most pertinent issues and offered recommendations which might act as agents for change.

Carers' event

In February 2016, the JSNA findings were fed into a consultation event organized by Adult Social Care to be incorporated into the design of the new tender for a carers service across the three boroughs. This ensured that carers' views informed the report, particularly, but not exclusively, section 6.3.

Online consultation

An online consultation on the key findings and draft recommendations took place following June's stakeholder event. All those who had engaged in the production of the JSNA, were invited to give their feedback. The online survey had a distribution list of 150 people.

Targeted engagement

Targeted engagement with various departments and agencies took place throughout the process. In June 2016 key stakeholders were invited to comment on particular sections and key recommendations of relevance to them. The team meetings of the Housing department and the Wider Adults Leadership Team were part of this approach. A presentation was also given to the CCGs Governing Body.

Appendix 3: Core community services

1. Residential Environmental Health Service (private tenants)

- Make sure homes comply with the Housing Health and Safety Rating System (HHSRS) and Houses in Multiple Occupation (HMO) standards
- Help reduce the number of privately rented homes that lack modern bathroom and kitchen facilities, contain hazards or have poor thermal insulation
- Help residents who are experiencing fuel poverty, especially older residents who are at greater risk of poor health as a result of living in a cold home
- Deal with pest control and drainage problems
- Help people with a disability to adapt their homes to improve their independence

2. Council Neighbourhood Service teams, RSL estate teams and ALMO estate teams

Social housing providers, from the councils, ALMOs, and other registered social landlords such as Housing Associations and providers of supported housing have a team of Housing Officers who manage tenancies including anti-social behaviour. They are in frequent contact with residents across their patch, and often visit residents in their own homes.

Additionally, each estate has a team of caretakers. Some estates will also have a grounds maintenance person. They are familiar to residents, and are able to act as the eyes and ears of the estates.

3. Community independence Service (CIS)

CIS provides a range of vital functions for up to 6 weeks including:

- Rapid response nursing services to prevent people with urgent care needs either attending or being admitted to hospital.
- Hospital In-Reach, to speed up discharge.
- Rehabilitation and reablement, which enables people to regain or retain their independence and stay in their own homes.

The CIS is a key example of the three councils and three CCGs' commitment to a preventative approach and targeted interventions that promote independence and keep people out of hospital. It is a person-centred service, and is provided by a team of people working together including a case manager who puts together a care plan.

4. Floating support

Floating support services provide support to a range of vulnerable client groups including people with mental health issues, as well as older people, young people who are at risk or leaving care and families. The service helps people to maintain their independence in their own home, and in their wider life. Floating support is available across the three boroughs and people do not have to be eligible for care and support in order to receive it.

5. Housing options

The vehicle for accessing social housing the housing options service(s) provide a range of housing advice and support including assessment for social housing eligibility. The service also offers on-going support for residents in temporary accommodation awaiting permanent placement.

6. Befriending

A number of local third sector organisations offer befriending volunteer schemes, where a volunteer may be paired with a vulnerable adult. The relationship can be practical, such as providing assistance with letters, or simply improving their wellbeing by offering company.

7. ASC Care at home service

The population of people that are being supported to live at home now have a range of complex needs and long-term conditions, and this service includes hybrid health and social care workers who take a reablement approach to help people to live as independently as possible.

The service aims to achieve outcomes for people, moving away from 'time and task' focused provision, working more directly with customers to agree the details of their care and how the outcomes will be achieved.

8. Supporting People services

Supporting People is a programme of hostel and supported accommodation, predominately for people with a history of rough sleeping, mental health problems or substance misuse. Every scheme is different; residents will typically have a key worker who helps tailor their support package to their needs, and there is often target timeline for 'move-on' to help the individual to become more independent.

9. Meals on wheels service

The aim of the home meals service is to deliver a safe, reliable, nutritious service for customers who are unable to provide this for themselves. Malnutrition is a significant issue for maintaining good health. Good nutrition advice can help prevention, early intervention and reablement allowing people to stay healthy and at home for longer. It can also reduce hospital and potentially residential care admissions as well as keeping people well who are in these places.

10. Falls prevention services

Falls can have a serious impact on the quality of life of older people. They can undermine the independence of older people, cause multiple A&E attendances, inpatient stays and increase the level and cost, of social care services provided.

Falls may be caused by the person's poor health or frailty, or by environmental factors, such as cold homes and trip hazards inside and outside their home. There are a number of services for older people funded by the CCG, Public Health and Adult Social Care that

promote healthier active lifestyles and build confidence through physical activity, strengthening exercises and health talks.

11. District Nursing

CLCH provide a district nursing service is for housebound people aged over 16 who require nursing care in their home and local community. The service includes managing chronic long term conditions, caring for acutely ill patients in their own homes, caring for post-operative patients, delivering end of life care, and medication management.

12. Health Visiting

This is a universal service offering support for parents of children age 0-5, including the mental health of parents when this may affect their child's welfare.

Additionally, the Family Nurse partnership works with young parents (where the mother is under age 20 at conception) to improve aspirations the mothers, such as by encouraging further education.

13. Day services

Adult Social Care and the NHS commission a range of services for vulnerable adults including older adults, people with a learning disability, and people with mental health problems. These provide activities and outings, exercise and fitness sessions, classes, information and advice, social opportunities and spaces. Additionally, they offer services for people with complex needs who often require safe and accessible building environments and very close support, alongside personal care.

Many of these services are provided by the third sector.

14. Carers' services

The importance of providing services to carers to enable them to continue in their caring role is widely recognised, and reinforced under the care act with a duty to assess the needs of all carers.

Each borough provides a service to their carers. Part of their remit is to identify unpaid carers, and provide support to known carers through peer support groups, information and advice and promote awareness of carers' rights with other partners such as GPs.

If a carer is assessed as eligible, they may be entitled to a carers' personal budget, which enables carers to decide for themselves what they most need and what outcomes they would like to achieve. Desired outcomes may be related to health improvement or reducing loneliness. Things that carers may purchase include a holiday, gym membership or educational courses.

	London Borough of Hammersmith & Fulham **HEALTH AND WELLBEING BOARD** **07 SEPTEMBER 2016**
TITLE OF REPORT Annual Public Health Report	
Report of the Director of Public Health	
Open Report	
Classification - For Information **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: Liz Bruce, Executive Director of Adult Social Care and Health	
Report Author: Colin Brodie Public Health Knowledge Manager	**Contact Details:** Tel: 020 76414632 E-mail:cbrodie@westminster.gov.uk

1. EXECUTIVE SUMMARY

1.1. This paper presents the annual report of the Director of Public Health 2015-16 for consideration by the Health and Wellbeing Board.

1.2. The Health and Wellbeing Board is invited to consider how the report and key messages can support current and future programmes and interventions to promote physical activity levels in Hammersmith and Fulham

2. RECOMMENDATIONS

1. That, the Health and Wellbeing Board consider the annual report of the Director of Public Health and the three key messages on physical activity:

    a) Physical activity is good for both your mental and physical health and wellbeing;
    b) Any physical activity is better than none; and
    c) Simple, daily physical activity as part of everyday life is what we should aim for.

2. That, the Health and Wellbeing Board consider how the report and key messages can be best used to support programmes and interventions to promote physical activity levels in Hammersmith and Fulham; and

3. That, Health and Wellbeing Board members comment on the report.

3. INTRODUCTION AND BACKGROUND

3.1. There is a statutory duty for the Director of Public Health (DPH) to produce an independent Annual Public Health Report (APHR). This report is the DPH's statement about the health of local communities. The report:

- Contributes to improving the health and wellbeing of the local population
- Addresses health inequalities;
- Promotes action for better health through measuring progress towards health targets and
- Assists with planning and monitoring of local programs and services that impact on health over time.

3.2. For the 2015-16 report the APHR has focussed on the theme of physical activity, and particularly the importance of physical activity to those segments of the population who are physically inactive. It builds on the Physical Activity JSNA published in 2014.

3.3. Being active is good for our health and wellbeing, need not cost anything and is fun. The APHR promotes a number of key messages around physical activity:

- Physical activity is good for both your mental and physical health and wellbeing
- Any physical activity is better than none
- Simple, daily physical activity as part of everyday life is what we should aim for

3.4. The APHR describes:

- The benefits of physical activity
- The challenge and costs of physical inactivity and sedentary behaviour
- Levels of physical activity in our three boroughs
- The impact of physical activity on areas of local authority activity
- Interventions to promote physical activity and what assets/services are available across the three Boroughs

3.5. The key messages in the APHR are consistent with the focus on the prevention agenda outlined in recent national strategy, including the Care

Act 2014 and the NHS Five Year Forward View, and the development of Sustainability and Transformation Plans (STP). It is aligned with the Public Health England framework to embed physical activity into daily life Everybody Active, Every Day.

3.6. This themed report affords an opportunity to use the APHR not only to deliver information on the state of population health but as a call to action, and to promote interventions or programmes that can increase levels of physical activity in our communities.

4. PHYSICAL INACTIVITY: 'SITTING IS THE NEW SMOKING'

4.1. Physical inactivity presents a major public health issue. There is strong evidence that shows that physical inactivity and sedentary behaviour increases the risk of over 20 chronic conditions such as heart disease, type 2 diabetes, breast and colon cancers, mental health and musculoskeletal conditions.

4.2. Research also shows a three year difference in life expectancy between people who are inactive and people who are minimally active.

4.3. According to the latest data 64% of adults (16+) in Hammersmith and Fulham are classed as physically active, higher than the rate for England (57%). However, over a quarter (27%) are classed as physically inactive (less than 30 minutes per week of moderate physical activity). The biggest gains for communities are from encouraging the least active to become more active.

4.4. Data on physical activity levels in children is not routinely collected across the Borough. The latest figures that we have (for 2009/10) indicate that participation in high quality PE and sports among children in Hammersmith and Fulham (70%) is lower than London (83.3%) and England (86%).

4.5. Evidence from the Physical Activity JSNA also tells us that there are inequalities in terms of physical activity levels, with BME groups, women, people with long term conditions and people living in more deprived areas having lower participation rates.

4.6. Physical inactivity and sedentary behaviour presents an enormous and growing burden to society. The costs to the broader health and social care system are significant and there is a considerable impact on the economy as well as other public services. The costs of physical inactivity include:

- causes 11% of chronic heart disease, 19% of colon cancer, 18% of breast cancer, 13% of type 2 diabetes, and 17% of premature deaths
- in Hammersmith and Fulham the estimated costs per year to the health service attributable to physical inactivity is £2,331,126

- across the three Boroughs the local economy loses £84million each year due to sickness absence, and associated costs

4.7. The next phase of the implementation will be to continue to work with the Communications Teams in the local authority and Clinical Commissioning Group, and other key stakeholders to identify how the key messages from the APHR can be aligned with and support existing and future campaigns to promote physical activity levels in our communities.

5. EQUALITY IMPLICATIONS

5.1. The APHR builds on the Physical Activity Joint Strategic Needs Assessment (JSNA) published in 2014 which analysed participation in physical activity for population groups. The JSNA identified inequalities in physical activity levels: BAME groups, women, people with long term conditions and people living in the more deprived parts of the borough have low participation rates in moderate level of physical activity

6. LEGAL IMPLICATIONS

6.1. The Director of Public Health for a local authority must prepare an annual report on the health of the people in the area of the local authority Section (Section 31 (5) of the Health and Social Care Act, 2012). The London Borough of Hammersmith and Fulham has a duty to publish the report (Section 31 (6) of the Health and Social Care Act, 2012)

7. FINANCIAL AND RESOURCES IMPLICATIONS

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

7.2. Implications verified/ completed by report author.

8. RISK MANAGEMENT

8.1. No risks identified.

8.2. Implications verified/ completed by report author.

9. PROCUREMENT AND IT STRATEGY IMPLICATIONS

9.1. Any future contractual arrangements and procurement proposals identified as a result of the Annual Public Health Report and re-commissioning projects will be cleared by the relevant Procurement Officer.

9.2. Implications verified/ completed by report author.

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.		

Appendix 1 - Annual Public Health Report 2015-16

Appendix 1

‘Sitting is the new smoking’

Report of the Director of Public Health 2015-2016

h&f hammersmith & fulham

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

City of Westminster

Foreword

It's my pleasure to introduce the annual public health report covering the three boroughs of Hammersmith & Fulham, Kensington and Chelsea, and Westminster.

This report is an independent evidence based statement about the health of local communities. Its function is to highlight important issues that affect our population, and aims to:

- Contribute to improving the health and wellbeing of local people
- Reduce health inequalities
- Promote better health through measuring progress towards health targets
- Support better planning and monitoring of local programmes and services

The report complements the Joint Strategic Needs Assessment (JSNA) work programme which identifies the current and future health and wellbeing needs of the population.

This year's report explores physical inactivity across Hammersmith & Fulham, Kensington and Chelsea, and Westminster. Promoting physical activity is a public health priority and the report builds on the Physical Activity JSNA published in 2014. It shows what we can do to encourage the least active to be more physically active, with suggestions how we can make physical activity a part of daily life.

We know…

- Physical activity is good for both your mental and physical health and wellbeing
- Any physical activity is better than none
- Simple, daily physical activity as part of everyday life is what we should aim for

Being active is good for our health and wellbeing, need not cost anything and is fun. I hope this report gives our readers some ideas and inspiration for how we can all make simple, positive changes.

Together, let's move more, every day

Mike Robinson

Director of Public Health for
Hammersmith & Fulham, Kensington and Chelsea,
and Westminster

Contents

Introduction

> **"If medication existed which had a similar effect to physical activity it would be regarded as a wonder drug or miracle cure."**
>
> Chief Medical Officer, 2010

Being active matters at every age.

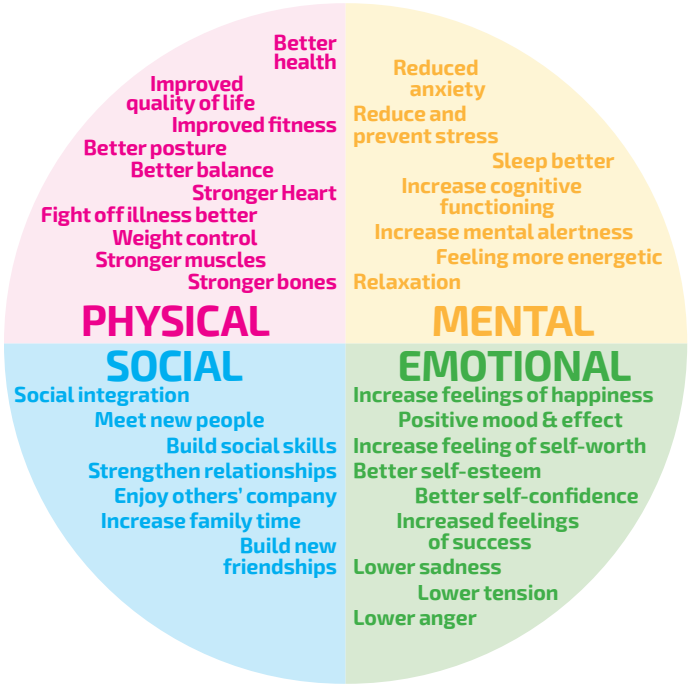
The more we move, the greater the benefit. Encouraging those who are inactive to embrace a significant level of activity would have the greatest benefit, but any shift helps.

Nationally, it's becoming increasingly recognised that physical activity as part of a wider wellbeing strategy can be integrated wherever we are: at work, school, home, and community settings. The Government funded Five Ways to Wellbeing draws particular focus to actions that can improve people's wellbeing. *Connect, Be Active, Take Notice, Keep Learning and Give are simple ways* that, when incorporated into our daily living, can have huge impact on our wellbeing.

In this report, we focus on the second of these – Be Active – but it's clear that moving and being physically active, especially when done in community, overlaps with other elements of the Five Ways to Wellbeing.

Research shows there is a three year difference in life expectancy between people who are inactive and people who are minimally active. Regular physical activity can reduce the risk of over 20 chronic conditions including coronary heart disease, stroke, type 2 diabetes, cancer, obesity, mental health and musculoskeletal conditions.

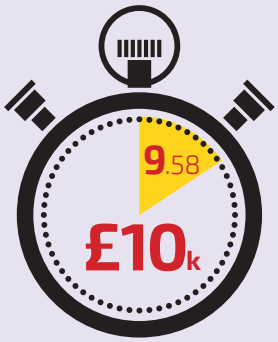
The benefits don't stop there. The figure below shows a wide range of health and wellbeing benefits to individuals.



Source: http://www.activegrand.ca/healthy-living-tips/benefits-regular-activity

Physical inactivity and sedentary behaviour have a considerable negative impact and cost for the individual, local communities and society.

In the time that Usain Bolt runs 100 meters (9.58 seconds) the **NHS spends around £10,000** on tackling preventable ill health. (Obesity £1,548, Diabetes £2,740, CVD £4,370, Depression and Anxiety Disorders £880 and Dementia £571).



Trends are not encouraging

If current trends continue, by 2030 the average number of hours we are sedentary each week will increase from 48 hours to 52 hours. There is an overall decline in physical activity, whether it is related to leisure, travel, domestic or occupation.

The challenge is how can we reduce that trend and be more active.

Sitting is the new smoking

So, how did we get here? One of the biggest challenges of sedentary behaviour and physical inactivity is that opportunities to be active are being designed out of our lives.

We drive more and further than ever, we sit for longer periods at our desks, and spend leisure on increasingly sedentary pastimes. The wonders of technology mean that even the simplest of tasks for daily living are becoming automated. Multiple car ownership has increased from 17% to 32% in the last 20 years and the number of journeys walked has declined by a third since 1995.

Physical inactivity – a cost too large to ignore

Physical inactivity presents an enormous and growing burden to society. The costs to the broader health and social care system are significant and there is a considerable impact on the economy as well as other public services. Physical inactivity is a cost we are all paying for nationally and in the three boroughs.

> **"Whatever our age, there is good scientific evidence that being physically active can help us lead healthier and even happier lives. We also know that inactivity is a silent killer."**
>
> Chief Medical Officer, 2011

Cost to the health service

- Physical inactivity causes 11% of chronic heart disease, 19% of colon cancer, 18% of breast cancer, 13% of type 2 diabetes. It causes 17% of premature deaths
- The estimated cost to the NHS of physical inactivity is £1.06 billion

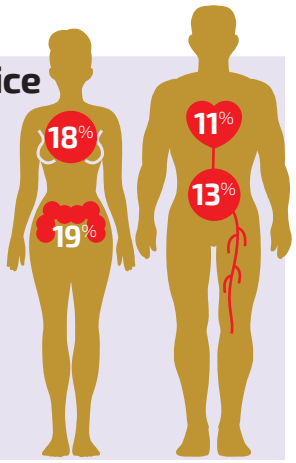


Table 1: Estimated costs to health care services attributable to physical inactivity [7]

Borough	Cost per year	Cost per 100,000 population
Hammersmith & Fulham	£2,331,126	£1,346,641
Kensington and Chelsea	£3,891,230	£1,933,313
Westminster	£6,270,360	£2,487,423

Cost to the local economy

- The local economy across the three boroughs loses £84million each year due to sickness absence, and associated employer, health and social costs and welfare
- Mental health problems and musculoskeletal problems are the two largest causes of sickness days, and physical activity has been proven to prevent both conditions.

Cost to Adult social care

£15.5 billion is spent nationally by local authorities on adult social care each year. Many of the conditions that affect mobility and functioning, such as dementia, depression, stroke, and falls, could be modified by greater levels of physical activity.

Cost to local authority

- A wide variety of issues can result from physical inactivity such as reduced readiness for school, lower educational achievement among school children and increased school sickness absence
- Greater car dependency contributes to air pollution which has an impact on people's health.

Meeting the challenge

The best opportunities for being active exist in all areas of daily life, whether in the workplace, at home, in neighbourhoods, in education or health settings. Physical activity need not cost anything; more importantly it can be a lot of fun and give us a sense of wellbeing.

Cost benefits of increasing physical activity

So, is there a business case for the councils to invest in encouraging physical activity? Yes, the cost benefits achieved through an increase of physical activity are substantial. The National Institute for Health and Care Excellence (NICE) established that a brief intervention for physical activity in primary care costs between £20 and £440 per quality-adjusted life year (QALY) with net costs saved per QALY between £750 and £3,150.

For Hammersmith & Fulham, Kensington and Chelsea, and Westminster savings of over £5 million could be achieved if 100% of the resident population achieved just the minimum recommended levels of physical activity. However, this is likely to be an underestimate as it does not take into account mental illness or dementia for example and only considers health care costs. If we add in costs to the council or society through improved work attendance, productivity and savings for social care or benefits, the savings could be far higher.

The King's Fund published useful guidance on interventions to increase physical activity. Their recommendations focus on two themes:

- reduction of car travel by improving cycling and walking provision and improving the urban realm, therefore encouraging active travel and
- improving access to green spaces which are associated with increased physical activity.

Here we explore the recommendations which could make an impact in the three boroughs:

Every pound spent on cycling provision recoups £4 in health care costs. **35p profit to the economy** is made with every mile travelled by bike instead of car.

Getting just one more person to **walk to school could recoup £768 a year** in terms of health benefits, productivity gains and reductions in air pollution and congestion.

Increasing use of parks and open spaces could reduce NHS costs of treating obesity by more than **£2 billion**.

Up to £23 is recouped for every £1 spent on leisure facilities in parks and public gardens in terms of better quality of life, reduced NHS use, productivity gains and more.

Free swimming initiatives attract a high proportion of people from disadvantaged backgrounds, thereby addressing health inequalities.

The solution - what should we be aiming for?

So, what do we mean by physical activity? Physical activity refers to all forms of activity. Everyday walking or cycling, active play, work-related activity, taking the stairs rather than the lift, working out in a gym, dancing, or gardening as well as organised and competitive sport – it all counts.

In 2011 new guidelines on the amount of activity recommended for health were published by the Chief Medical Officers of the four UK countries.

However, even small increases in physical activity have demonstrated health benefits, and so any activity is better than none.

Early Childhood (under 5 years)

1. Safe floor-based play and water-based activities from birth.
2. At least 3 hours of activity spread throughout the day for toddlers who can walk unaided.
3. Minimum amount of time being sedentary (being restrained or sitting) for extended periods (except time spent sleeping) in ALL children under 5

Adults (19 – 64)

1. Aim to be active daily. Over a week, activity should add up to at least 2½ hours of moderate intensity activity in bouts of 10 minutes or more – one way to approach this is to - for example do 30 minutes on at least 5 days a week.
2. Or 1 hour and 15 min of vigorous intensity activity spread across the week or a combination of moderate and vigorous intensity activity.
3. Undertake physical activity to improve muscle strength on at least two days a week.
4. Minimum amount of time spent being sedentary (sitting).

Children and Young People (5 – 18 years)

1. Moderate to vigorous intensity physical activity for at least one hour and up to several hours every day.
2. Vigorous intensity activities, including those that strengthen muscle and bone, at least three days a week.
3. Minimum amount of time spent being sedentary (sitting).

Older Adults (65 and over)

1. Minimum recommended activity is the same as in younger adults.
2. Any amount of physical activity in older adults will bring health benefits. Some is better than none, and more physical activity provides greater health benefits.
3. One hour and 15 minutes of vigorous intensity activity spread across the week or a combination of moderate and vigorous activity for those who are already regularly active.
4. Physical activity to improve muscle strength on at least two days a week is particularly important in the elderly.
5. Those at risk of falls should incorporate physical activity to improve balance and co-ordination on at least two days a week.
6. Minimum amount of time spent being sedentary.

How increased physical activity helps us all

High levels of physical activity benefit people, communities and society. When people move more, crime, pollution and traffic go down. Productivity, school performance, property values and health and wellbeing improve drastically.

Below we highlight how physical activity has a positive impact across the work and priorities of local government.

Health and wellbeing

Worldwide, physical inactivity is the direct cause of 10% of premature mortality. If inactivity could be reduced by only 10% it would prevent 1.3 million deaths every year globally

There is a **three-year difference in life expectancy** between people who are inactive and people who are minimally active.

Importantly, the length of time we are sedentary is also associated with ill-health. Even people who meet or exceed the recommended requirements for physical activity, but who sit for long periods of time, experience ill health.

Adult social care

Physically active residents can stay independent longer.

Older adults who are regularly active have a 30-50% lower risk of developing functional limitations

Physical activity can help to increase social interaction and tackle isolation and loneliness.

Children and family services

Physical activity can contribute to an increase in academic performance and attainment.

Sport and recreation can help to raise people's self-esteem and determination, both useful skills for learning and passing exams.

Employment and economic productivity

High levels of physical fitness are viewed favourably by employers, who associate fitness with greater productivity, potential to work longer hours and taking less sick leave.

Playing sport can help people build valuable skills like problem solving, communication and teamwork.

Climate change and air quality

Walking and cycling are pollutant free activities, and so increasing active travel can lower carbon emissions and reduce pollution. 75% of transport related emissions are from road traffic.

Planning, transport and the built environment

Getting the borough moving by tackling congestion, parking and traffic enforcement and developing road / cycle path capacity to support growth and regeneration

Increasing physical activity and active travel can help to lower carbon emissions.

Making walking and cycling safer and more enjoyable can contribute to fewer road traffic accidents.

Community safety

Physical activity can help to increase people's self-esteem and enable them to develop relationships and school skills, foster discipline and teach commitment. Cycling and walking have been shown to build a sense of community and belonging.

Social inclusion

Physical activity can foster community spirit and help to improve risk factors relating to crime and antisocial behaviour.

Active leisure can be used to reach out to at risk groups in society and the wider community and can play a role in promoting gender and disability equality.

Economic prosperity

Excessive dependence on motorised road transport has significant economic costs on society such as congestion; road casualties; physical inactivity; pollution and damage to the climate.

The average economic benefit-to-cost ratio of investing in cycling & walking schemes is 13:1.

Retail sales with a high quality cycle lane can increase footfall by up to 49%.

Physical Activity in the three Boroughs

In this next section, we explore what the local picture is, based on the national picture and incorporating local data where it is available.

Children

The national picture

In England, less than a quarter of children are classed as physically active. Overall, boys are more active than girls with 21% of 5-15 year old boys completing at least 1 hour of moderate intensity activity each day, compared to 16% of girls.

There is a decline in physical activity for both boys and girls as they get older. For boys, the numbers meeting the recommended levels of activity decline from 24% in 5 to 7 years olds to 14% in 13 to 15 year olds. For girls the decrease was from 23% to 8% respectively.

However, 41% of boys and 44% of girls do walk to and from school every day, and in school, most children participate in some type of physical activity (93% of boys and 92% of girls)

Children spent on average 3.3 hours each weekday on sedentary pursuits such as watching TV, reading etc. outside of school. This rises to around 4 hours on the weekend.

Children in the three Boroughs

Generally, children in the three boroughs have lower participation rates in high quality PE and school sport compared with their peers in London and England. For Hammersmith & Fulham this is 70% of pupils, Westminster is 75%, and 77% in Kensington and Chelsea.

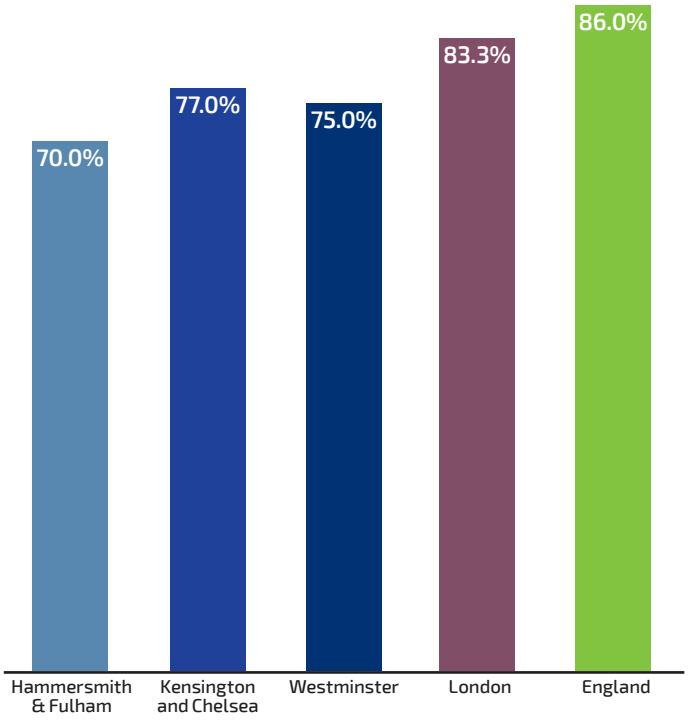


Figure 1: The percentage of state school children in Year 1-11 participating in at least two hours of high quality PE or school sport in a typical week (TNS Social Research, Annual Survey of School Sports Partnerships 2009/2010)

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

Unfortunately data on PE activity is no longer routinely available for all our Boroughs since the School Sport Partnerships came to an end. In order to monitor physical activity levels in children it is essential that data is collected across the three Boroughs.

Adults

The Active People Survey 2014/15 shows the most up to date data available nationally and locally on physical activity for people aged 16 and over.

The national picture

Nationally 67% of men and 55% of women aged 16 and over are classed as physically active. Over one in five men (20%) and one in four women (25%) are classified as inactive.

However, **over half of men and women spent four or more hours in sedentary time per day**, with men more likely than women to average six or more hours of total sedentary time on both weekdays (31% and 29% respectively) and at the weekends (40% and 35% respectively).

Activity decreases with age for men, from 83% in 16 to 24 year olds to 11% in those 85 years and over. The same is true for women, although activity levels peaks among 35 to 44 year old women (66%) before declining. After the age of 74 levels of decline in activity are similar in both sexes.

There is a link between physical activity and household income. 76% of men and 63% of women in the highest income group met the UK recommended levels of activity compared to 55% and 47% respectively in the lowest income group.

Physical activity rates are lower among those with a greater body mass index (BMI). 75% of men who are of healthy weight met physical activity guidelines, compared with 71% of overweight and 59% of obese men. Corresponding figures for women were 64%, 58% and 48%, respectively.

Adults in our three boroughs

The number of physically active people (aged 16+) stayed broadly similar from 2014 to 2015, with 56% in Kensington and Chelsea, 64% in Hammersmith & Fulham, and 62% in Westminster.

This appears to confirm a trend towards increasing inactivity, with the number of completely inactive people increasing in two boroughs and staying level in the other borough. Westminster and Hammersmith & Fulham are in line with the national average of 28% (27% in both) while Kensington and Chelsea has a higher level of inactivity (31%). Where data exists, the three boroughs are following national trends across sex, age, socio economic status, disability and employment status.

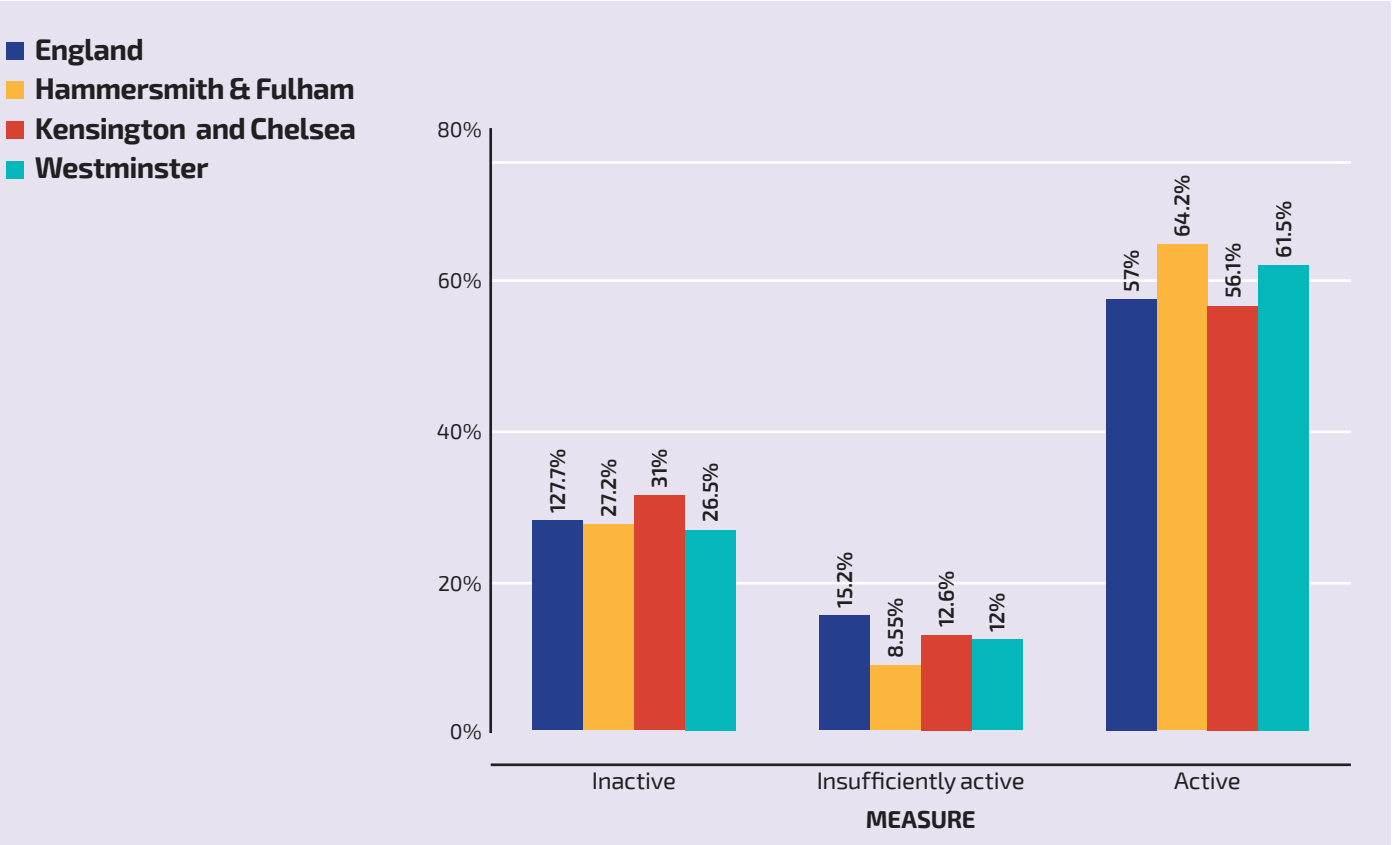


Figure 2: The percentage of adults (aged 16+) in the three Boroughs classed as Active, Insufficiently Active, and Inactive, compared with England (Source: Active People's Survey 2014/15)

Success stories

The best opportunities for keeping active exist in all areas of daily life, whether in the workplace, at home, in neighbourhoods, in education or health settings. Physical activity need not cost anything; more importantly it can be a lot of fun and give us a sense of wellbeing.

So how are we doing in the three boroughs when it comes to encouraging residents to get active? Below are some of our success stories.

London Borough of Hammersmith & Fulham - Bikeit Programme

Before April 2010, Tigist Negash, a 34-year old student and mum of three had never cycled in her life. For years Tigist spent the school run chasing after her two sons who liked to cycle to their primary school as their mum walked behind. Tigist was struggling to get to college on time in between dropping her sons at school and her daughter at nursery and couldn't rely on the bus or walk the distance quickly enough.

When Sustrans began working with her son's school to encourage more children to cycle, Tigist decided to take part in a cycling course, sponsored by the Council's Bikeit Programme. The course was created especially for parents and carers, to prove just how easy it is to cycle for short local journeys.

"Every morning, I cycle with them to school, then I go on to college in Hammersmith, about a mile away. I have to be there at 9.30am, and if I took the bus or walked I wouldn't be able to get there in time. Without being able to cycle, I wouldn't be able to go to college."

She now cycles every day and uses her bike to accompany her two sons to school and carry her daughter to nursery before going on to college to study English.

Royal Borough of Kensington and Chelsea: Charles Falope

Charles, a young man in his twenties, is a regular attendee at the weekly disability multi-sport session at Kensington Leisure Centre and he enjoys the activities that are on offer in the main sports hall like table tennis, volleyball, basketball, boccia and polybat. Charles has autism and can sometimes find it hard to play with others. This stops him from fully partaking in as many of the activities as he would like.

After discussions with Charles and with the support of Public Health funding and the Activate! Programme, it was decided he would benefit from attending a Disability Sports Coaching UK course, (a one day Adapted Sports Course). Charles had previously shown great interest in helping the coaches and the training has helped him engage more fully in the sessions. To make sure Charles continued to learn and develop into a proficient assistant coach, he received six weeks of mentoring.

Since Charles attended the course in November 2015 his progress has been amazing. Now he is helping the other coaches by setting up and setting down activities. By far the biggest change for him is that he now helps others take part in the activities. For example, at his last session he played Polybat with another participant, who has very little mobility and cannot communicate very well. Charles praised her every time she hit the ball back and this was very heartening to see. After this he invited her and another person to play bowls. Finally, the Head Coach made Charles responsible for the boccia match. He handed out the boccia balls and refereed the game in his referee's kit.

At the end of every session Charles asks the Head Coach 'How did I do?', 'How can I improve?' and each week the reply is 'You've done well Charles, keep up the good work'.

Active Westminster Walks for Health Scheme - Regents Park Walk Group

A Health Promotion Nurse from the Health Improvement Team leads a 60 minute health walk in Regents Park. The group, which has been running for several years, meets at the Clarence Gate, every Wednesday at 1.30pm. Adults of all ages, genders, abilities and backgrounds join in with the weekly walk. Some of the walkers have long standing mental health or social issues.

A female walker said that she feels secure in the group as the nurse is able to monitor the different health conditions the group participants may have and take action if needed. Especially concerned about her memory loss, she wanted to remain physically active without fear of getting lost. The group gives her a reason and confidence to get out of her flat, meet people and talk about different topics and interests such as gardening and dogs.

Group members are encouraged to choose a route as they enjoy walking varied routes and seeing beautiful locations within the park. The walking group provides support to socially isolated adults, with complex social, mental and physical health conditions, to participate in physical activity and connect with others. Next steps include plans to support some group members to complete Walk Leader training organised by the Health Improvement Team.

Looking forward

In the 5 year Forward View of the NHS, there is a clear emphasis on prevention and public health, as "...the health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on [it]". National action on obesity, smoking, alcohol, physical inactivity and other major health risks will now be in the spotlight.

Prevention starts at the earliest possible opportunity. Being physically active over the lifecourse means that we can enjoy a better quality of life through every age and stage. The solution to addressing these challenges – the miracle cure – is here.

We can meet the challenges, many of which are set out in this report, if we have the will and enthusiasm to do so.

Our hope is that the examples of good practice in our three boroughs, and the realities of what we face if we don't take action, will help to inspire us.

Together, let's move more, every day

Useful contacts

For information on ideas on how to be more active, and to access opportunities in your local area here are some helpful contacts and websites.

One You

One You is a national campaign to encourage us to move more, eat well, drink less and be smoke free. The website include ideas on how to include physical activity into our daily lives.

W www.nhs.uk/oneyou/moving

Get Active London

The Get Active London website provides a one stop shop for activities, clubs and venues across London.

W www.getactivelondon.com/

NHS Choices Live Well

The NHS Choices Live Well provides suggestions on how to build more physical activity into our daily lives for busy parents, families, young people, office workers, older people, and disabled people.

W www.nhs.uk/Livewell/fitness/Pages/Activelifestyle.aspx

People First

People First provides a wealth of information and resources covering the three boroughs, with a focus on older people, people living with disabilities, and those who look after others.

W www.peoplefirstinfo.org.uk/health-and-well-being/taking-care-of-yourself/exercise-and-sport.aspx -.

Hammersmith & Fulham

Community Sports Team

The Community Sports Team provides information on activities and facilities in Hammersmith & Fulham.

W www.lbhf.gov.uk/sport

E sportsdevelopment@lbhf.gov.uk

T 020 8753 3838

Get Going

The Get Going campaign brings together a range of free and low cost physical activity opportunities which help prevent long term illness and ageing.

W www.lbhf.gov.uk/getgoing

Kensington and Chelsea

Sports Development Team

The Sports Development Team provides information on activities and facilities in Kensington and Chelsea.

W www.rbkc.gov.uk/leisure-and-culture/sports-and-leisure

E SportandLeisure@rbkc.gov.uk

T 020 7938 8182

Go Golborne

Go Golborne is a new local campaign led by the Council that is all about supporting children and families to eat well, keep active and feel good.

W www.rbkc.gov.uk/subsites/citylivinglocallife/gogolborne/move.aspx

Westminster

Westminster Sports Unit

Westminster Sports Unit provides information on activities and facilities in Westminster.

W www.westminster.gov.uk/sports

E sport@westminster.gov.uk

T 020 7641 2012

Daily Mile

The Daily Mile is a simple and inclusive initiative to introduce daily physical activity into children's lives as part of everyday school life. Westminster is committed to rolling out this initiative to all schools within the city.

W http://thedailymile.co.uk/

Appendix 1: Health profiles

A purpose of the annual public health report is to report on the health of the local population. The health profiles that follow provide an overview for each Borough. Further information on the current and future health and wellbeing needs of our population can be found in the Joint Strategic Needs Assessment.

These profiles are provided from Public Health England, and are replicated here under the terms of the Open Government Licence. More information is available at www.healthprofiles.info and http://fingertips.phe.org.uk/profile/health-profiles.

Appendix 1: Health summary for Hammersmith & Fulham

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average

Domain		Indicator	Local No Per Year	Local value	Eng value	Eng worst	England Range (Regional average^ / England Average; England Worst – England Best; 25th Percentile – 75th Percentile)	Eng best
Our communities	1	Deprivation	47,048	26.3	20.4	83.8		0.0
	2	Children in poverty (under 16s)	7,575	25.6	19.2	37.9		5.8
	3	Statutory homelessness	385	4.8	2.3	12.5		0.0
	4	GCSE achieved (5A*-C inc. Eng & Maths)†	720	65.6	56.8	35.4		79.9
	5	Violent crime (violence offences)	3,100	17.2	11.1	27.8		2.8
	6	Long term unemployment	1,168	8.9	7.1	23.5		0.9
Children's and young people's health	7	Smoking status at time of delivery	71	3.1	12.0	27.5		1.9
	8	Breastfeeding initiation	2,065	89.4	73.9			
	9	Obese children (Year 6)	253	22.4	19.1	27.1		9.4
	10	Alcohol-specific hospital stays (under 18)†	n/a	-	40.1	105.8		11.2
	11	Under 18 conceptions	47	21.3	24.3	44.0		7.6
Adults' health and lifestyle	12	Smoking prevalence	n/a	21.4	18.4	30.0		9.0
	13	Percentage of physically active adults	279	64.0	56.0	43.5		69.7
	14	Obese adults	n/a	13.3	23.0	35.2		11.2
	15	Excess weight in adults	227	49.7	63.8	75.9		45.9
Disease and poor health	16	Incidence of malignant melanoma†	14.0	11.1	18.4	38.0		4.8
	17	Hospital stays for self-harm	184	99.9	203.2	682.7		60.9
	18	Hospital stays for alcohol related harm†	938	657	645	1231		366
	19	Prevalence of opiate and/or crack use	1,390	10.1	8.4	25.0		1.4
	20	Recorded diabetes	7,376	4.4	6.2	9.0		3.4
	21	Incidence of TB†	54.0	29.9	14.8	113.7		0.0
	22	New STI (exc Chlamydia aged under 25)	2,949	2195	832	3269		172
	23	Hip fractures in people aged 65 and over	99	591	580	838		354
Life expectancy and causes of death	24	Excess winter deaths (three year)	52.0	18.4	17.4	34.3		3.9
	25	Life expectancy at birth (Male)	n/a	79.1	79.4	74.3		83.0
	26	Life expectancy at birth (Female)	n/a	83.5	83.1	80.0		86.4
	27	Infant mortality	12	4.4	4.0	7.6		1.1
	28	Smoking related deaths	191	350.0	288.7	471.6		167.4
	29	Suicide rate	16	9.7	8.8			
	30	Under 75 mortality rate: cardiovascular	90	95.5	78.2	137.0		37.1
	31	Under 75 mortality rate: cancer	145	151.6	144.4	202.9		104.0
	32	Killed and seriously injured on roads	70	38.9	39.7	119.6		7.8

Indicator notes are included on page 15.

Appendix 2: Health summary for Kensington and Chelsea

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average

Regional average^ England Average

England Worst 25th Percentile 75th Percentile England Best

Domain		Indicator	Local No Per Year	Local value	Eng value	Eng worst	England Range	Eng best
Our communities	1	Deprivation	36,584	23.5	20.4	83.8		0.0
	2	Children in poverty (under 16s)	4,090	20.9	19.2	37.9		5.8
	3	Statutory homelessness	539	6.9	2.3	12.5		0.0
	4	GCSE achieved (5A*-C inc. Eng & Maths)†	552	74.4	56.8	35.4		79.9
	5	Violent crime (violence offences)	2,192	14.1	11.1	27.8		2.8
	6	Long term unemployment	629	5.7	7.1	23.5		0.9
Children's and young people's health	7	Smoking status at time of delivery	23	2.0	12.0	27.5		1.9
	8	Breastfeeding initiation	1,476	91.3	73.9			
	9	Obese children (Year 6)	187	21.3	19.1	27.1		9.4
	10	Alcohol-specific hospital stays (under 18)†	8.3	30.9	40.1	105.8		11.2
	11	Under 18 conceptions	33	19.0	24.3	44.0		7.6
Adults' health and lifestyle	12	Smoking prevalence	n/a	17.8	18.4	30.0		9.0
	13	Percentage of physically active adults	266	57.5	56.0	43.5		69.7
	14	Obese adults	n/a	11.2	23.0	35.2		11.2
	15	Excess weight in adults	192	45.9	63.8	75.9		45.9
Disease and poor health	16	Incidence of malignant melanoma†	12.7	9.9	18.4	38.0		4.8
	17	Hospital stays for self-harm	138	87.9	203.2	682.7		60.9
	18	Hospital stays for alcohol related harm†	607	433	645	1231		366
	19	Prevalence of opiate and/or crack use	1,065	9.2	8.4	25.0		1.4
	20	Recorded diabetes	6,422	4.2	6.2	9.0		3.4
	21	Incidence of TB†	38.3	24.5	14.8	113.7		0.0
	22	New STI (exc Chlamydia aged under 25)	2,107	1879	832	3269		172
	23	Hip fractures in people aged 65 and over	102	490	580	838		354
Life expectancy and causes of death	24	Excess winter deaths (three year)	45.8	17.7	17.4	34.3		3.9
	25	Life expectancy at birth (Male)	n/a	82.6	79.4	74.3		83.0
	26	Life expectancy at birth (Female)	n/a	86.2	83.1	80.0		86.4
	27	Infant mortality	6	2.8	4.0	7.6		1.1
	28	Smoking related deaths	159	252.4	288.7	471.6		167.4
	29	Suicide rate	11	7.5	8.8			
	30	Under 75 mortality rate: cardiovascular	60	54.9	78.2	137.0		37.1
	31	Under 75 mortality rate: cancer	127	116.3	144.4	202.9		104.0
	32	Killed and seriously injured on roads	80	51.3	39.7	119.6		7.8

Indicator notes are included on page 15.

Appendix 3: Health profile for Westminster

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average

Regional average^ | England Average | England Worst | 25th Percentile | 75th Percentile | England Best

Domain		Indicator	Local No Per Year	Local value	Eng value	Eng worst	England Range	Eng best
Our communities	1	Deprivation	53,263	23.5	20.4	83.8		0.0
	2	Children in poverty (under 16s)	9,120	30.7	19.2	37.9		5.8
	3	Statutory homelessness	716	6.5	2.3	12.5		0.0
	4	GCSE achieved (5A*-C inc. Eng & Maths)†	1,007	68.1	56.8	35.4		79.9
	5	Violent crime (violence offences)	5,871	26.2	11.1	27.8		2.8
	6	Long term unemployment	1,063	6.5	7.1	23.5		0.9
Children's and young people's health	7	Smoking status at time of delivery	50	1.9	12.0	27.5		1.9
	8	Breastfeeding initiation	n/a	-	73.9			
	9	Obese children (Year 6)	340	25.6	19.1	27.1		9.4
	10	Alcohol-specific hospital stays (under 18)†	10.0	28.4	40.1	105.8		11.2
	11	Under 18 conceptions	24	9.6	24.3	44.0		7.6
Adults' health and lifestyle	12	Smoking prevalence	n/a	18.5	18.4	30.0		9.0
	13	Percentage of physically active adults	262	57.4	56.0	43.5		69.7
	14	Obese adults	n/a	17.9	23.0	35.2		11.2
	15	Excess weight in adults	295	52.6	63.8	75.9		45.9
Disease and poor health	16	Incidence of malignant melanoma†	8.3	4.9	18.4	38.0		4.8
	17	Hospital stays for self-harm	161	71.2	203.2	682.7		60.9
	18	Hospital stays for alcohol related harm†	996	522	645	1231		366
	19	Prevalence of opiate and/or crack use	2,550	15.6	8.4	25.0		1.4
	20	Recorded diabetes	8,991	4.4	6.2	9.0		3.4
	21	Incidence of TB†	60.0	26.9	14.8	113.7		0.0
	22	New STI (exc Chlamydia aged under 25)	3,723	2246	832	3269		172
	23	Hip fractures in people aged 65 and over	118	438	580	838		354
Life expectancy and causes of death	24	Excess winter deaths (three year)	47.0	13.3	17.4	34.3		3.9
	25	Life expectancy at birth (Male)	n/a	81.7	79.4	74.3		83.0
	26	Life expectancy at birth (Female)	n/a	85.9	83.1	80.0		86.4
	27	Infant mortality	11	3.8	4.0	7.6		1.1
	28	Smoking related deaths	192	236.1	288.7	471.6		167.4
	29	Suicide rate	22	10.1	8.8			
	30	Under 75 mortality rate: cardiovascular	99	74.8	78.2	137.0		37.1
	31	Under 75 mortality rate: cancer	165	122.4	144.4	202.9		104.0
	32	Killed and seriously injured on roads	177	78.9	39.7	119.6		7.8

Indicator notes

1 % people in this area living in 20% most deprived areas in England, 2013 2 % children (under 16) in families receiving means-tested benefits & low income, 2012 3 Crude rate per 1,000 households, 2013/14 4 % key stage 4, 2013/14 5 Recorded violence against the person crimes, crude rate per 1,000 population, 2013/14 6 Crude rate per 1,000 population aged 16-64, 2014 7 % of women who smoke at time of delivery, 2013/14 8 % of all mothers who breastfeed their babies in the first 48hrs after delivery, 2013/14 9 % school children in Year 6 (age 10-11), 2013/14 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population, 2011/12 to 2013/14 (pooled) 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2013 12 % adults aged 18 and over who smoke, 2013 13 % adults achieving at least 150 mins physical activity per week, 2013 14 % adults classified as obese, Active People Survey 2012 15 % adults classified as overweight or obese, Active People Survey 2012 16 Directly age standardised rate per 100,000 population, aged under 75, 2010-12 17 Directly age sex standardised rate per 100,000 population, 2013/14 18 The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause, directly age standardised rate per 100,000 population, 2013/14 19 Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2011/12 20 % people on GP registers with a recorded diagnosis of diabetes 2013/14 21 Crude rate per 100,000 population, 2011-13, local number per year figure is the average count 22 All new STI diagnoses (excluding Chlamydia under age 25), crude rate per 100,000 population, 2013 23 Directly age and sex standardised rate of emergency admissions, per 100,000 population aged 65 and over, 2013/14 24 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 01.08.10-31.07.13 25, 26 At birth, 2011-13 27 Rate per 1,000 live births, 2011-13 28 Directly age standardised rate per 100,000 population aged 35 and over, 2011-13 29 Directly age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population, 2011-13 30 Directly age standardised rate per 100,000 population aged under 75, 2011-13 31 Directly age standardised rate per 100,000 population aged under 75, 2011-13 32 Rate per 100,000 population, 2011-13

† Indicator has had methodological changes so is not directly comparable with previously released values. ^ "Regional" refers to the former government regions.

More information is available at www.healthprofiles.info and http://fingertips.phe.org.uk/profile/health-profiles Please send any enquiries to healthprofiles@phe.gov.uk

h&f
hammersmith & fulham

THE ROYAL BOROUGH OF
KENSINGTON
AND CHELSEA

City of Westminster

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

KEY

FOR DECISION
FOR DISCUSSION
FOR INFORMATION
PLANNING

Agenda Item	Summary	Lead	Item
Meeting Date: 20 June 2016			
STRATEGIC ITEMS			
Joint planning	comprising: • Update on NWL Sustainability & Transformation Plan • Joint Health & Wellbeing Strategy	**ASC/CCG**	**For decision**
Community Independence Service Re-procurement		ASC/CCG	**For information**
Better Care Fund Update 2016/17		ASC/CCG	**For information**
Meeting Date: 7 September 2016			
STRATEGIC ITEMS			
Sustainability and Transformation Plan: June 'checkpoint' Submission		ASC/CCG/PH	**For discussion**
CCG Commissioning Intentions	including CCG commissioning intentions17/18 and beyond	CCG/ASC	**For decision**
DISCUSSION ITEMS			
Housing JSNA	For approval ahead of publication	PH	**For decision**

Child and Adolescent Mental Health Service (CAMHS) Task Force Report		CS	**For information**
Implementation of Children and Families Act and Preparation for Local Area Inspection	including an update on the SEN joint commissioning strategy	CS	**For discussion**
FOR INFORMATION ONLY			
Annual Public Health Report	For approval ahead of publication	PH	**For discussion**
Health Visiting Programme		PH	
Tackling childhood obesity together (TCOT)	For approval ahead of publication	PH	**For decision**
Meeting Date: 14 November 2016			
STRATEGIC ITEMS			
Approving the final Joint Health and Wellbeing Strategy	The Board is asked to approve the final JHWS post-consultation	All	**For decision**
STP planning update	update	NWL CCG	**For discussion**
Transforming primary care	Primary care transformation plans	CCG/NHSE	**For discussion**
Integrated Family Support Service		CS	**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**
Online JSNA highlights reports		PH	
Young adults JSNA		PH	
Meeting Date: 13 February 2017			
STRATEGIC ITEMS			

Better Care Fund Planning Update and Allocations 2017/18		ASC/CCG	**For decision**
Accountable Care Partnership		CCGs	
Joint Health and Wellbeing Strategy: Update on implementation	discussion focusing on a particular aspect of the strategy tba	All	**For discussion**
CAMHS transformation update		CS	**For discussion**
Meeting Date: 20 March 2017			
STRATEGIC ITEMS			
Health and Social Care Integration Planning	Update on planning for full integration by 2020	CCG/ASC	**For decision**
Learning from London Devolution Pilots	review of learning from first year of London devolution pilots	ASC	**For discussion**
The role of pharmacy in our health and care plans		PH	**For discussion**
BUSINESS ITEMS			
Joint Health and Wellbeing Strategy: Update on implementation	discussion focusing on a particular aspect of the strategy tba	ASC	**For discussion**
CCG Operating Plans 2017/18	operating plans for 2017/18	CCG	**For information**

Other possible items

- Update on tackling mental health in the borough and Mind briefing on the role of local community services in supporting people with mental health problems

KEY

STRATEGIC ITEMS – items concerning system level issues (e.g. health and care integration, devolution, primary care transformation)

DISCUSSION ITEMS – items of interest focusing on a specific part of the system such as a specific health condition, service or population group (e.g. JSNA deep dives)

BUSINESS ITEMS – items for the board's approval or information but which do not require a discussion (e.g. items that have been agreed offline but require formal approval by the Board)

INFORMATION ITEMS – items for information only and not requiring discussion