London Borough of Hammersmith & Fulham

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

Agenda

Thursday 20 October 2016
7.00 pm
Courtyard Room - Hammersmith Town Hall

MEMBERSHIP

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

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Date Issued: 12 October 2016

London Borough of Hammersmith & Fulham

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

Agenda

20 October 2016

Item		Pages
1.	**MINUTES OF THE PREVIOUS MEETING**	1 - 10

(a) To approve as an accurate record and the Chair to sign the minutes of the meeting of the Health, Adult Social Care and Social Inclusion PAC held on Monday,12th September 2016; and

(b) To note the outstanding actions.

2. APOLOGIES FOR ABSENCE

3. DECLARATION OF INTEREST

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

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

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

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

4. CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH 'TRANSFORMATION PLAN' UPDATE 11 - 40

This report seeks to integrate the work and findings of the Hammersmith and Fulham CAMHS Taskforce with the Hammersmith and Fulham ***Future in Mind*** Transformation Plans which have been submitted to NHS England.

5. CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST - ACQUISITION OF WEST MIDDLESEX UNIVERSITY NHS TRUST: POST-ACQUISITION REVIEW 41 - 60

This report provides a post-acquisition review of the Chelsea and Westminster Hospital NHS Foundation Trust acquisition of West Middlesex University NHS Trust, one year after the formal integration of the two trusts.

6. ANNUAL PUBLIC HEALTH REPORT 2015-16 61 - 81

This report presents the annual report of the Director of Public Health 2015-16 for consideration by the Health, Adult Social Care and Social Inclusion Policy and Accountability Committee and was previously considered by the Health and Wellbeing Board, at it's meeting held on 7th September 2016.

7. WORK PROGRAMME 82 - 83

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

8. DATES OF FUTURE MEETINGS

Wednesday, 2nd November 2016
Monday, 12th December 2016
Tuesday, 31st January 2017
Wednesday, 8th March 2017
Monday, 10th April 2017

London Borough of Hammersmith & Fulham

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

Minutes

Monday 12 September 2016

PRESENT

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

Co-opted members: Patrick McVeigh (Action on Disability), Bryan Naylor (Age UK) and Debbie Domb (Disabilities Campaigner)

Other Councillors: Sue Fennimore, Vivienne Lukey.

Officers: Vanessa Andreae, Vice-chair, NW London CCG, Liz Bruce, Executive Director, Adult Social Care, Janet Cree, Managing Director, NW London CCG and Jane Wheeler, Deputy Director, Mental Health Strategy and Transformation Team, NW London CCG and Lucy Rumbellow, Primary Care Lead – Immunisations, NHS England.

83. MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 14th June 2016 were agreed as a correct record.

84. APOLOGIES FOR ABSENCE

Apologies were received from Councillor Sharon Holder.

85. DECLARATION OF INTEREST

Councillor Andrew Brown declared an interest as Managing Director of Santevis Limited, in Agenda Items 5 and 6.

86. NW LONDON SUSTAINABILITY AND TRANSFORMATION PLAN

It was noted that Members had previously been informed by email that Hammersmith & Fulham Council had not supported the draft STP as the plan endorsed the principle of downgrading Charing Cross hospital and A&E to which the Council is passionately opposed. This item was subsequently withdrawn.

87. CHILDHOOD IMMUNISATION - PERFORMANCE UPDATE AND PRIORITIES FOR 2016-17

Councillor Rory Vaughan welcomed joint presenters, Vanessa Andreae, Vice Chair of the H&F CCG and Lucy Rumbellow, Commisioning Lead – Immunisations, NHS England. Vanessa Andreae explained that the membership of Immunisation Network Group was drawn from several local organisations and agencies including the local authority and H&F CCG, amongst others. Councillors Lukey and Holder had attended events organised by the Group.

Lucy Rumbellow outlined briefly the programme which, during 2015/16, offered flu immunisation for children aged two and three years, and, school years 1 and 2. A review of flu rates amongst primary school children had resulted in targeted practices in two or more cohorts. A target of 40% take up would help ensure prevention and provided immunity for older members of the family by limiting transmission and thereby reducing rates in older people, concurrently. Practices were encouraged to develop action plans following national guidance.

Vanessa Andreae explained that approval for a pharmacy pilot project was due to be signed off, with the aim of administering vaccines to a 1000 children, aged 3-5 years, in Hammersmith & Fulham – although it was not yet certain. Feedback from a children's centres pilot project conducted in 2015 indicated ad hoc take up of vaccines from local pharmacies. The CCG were exploring service led agreements with pharmacies and identifying training needs, although the timing of when this could be delivered needed further consideration. Pharmacies had initially been identified in convenient locations such as shopping centres and high streets.

Councillor Vaughan commented that pharmacies had not previously been permitted to administer the vaccine to children and Vanessa Andreae clarified that this was more an issue relating to the porcine gelatine content of the vaccine, as opposed to actual administration. They were also consulting and working closely with community champions and faith leaders to address this.

Looking at the data from the Child Health Informatics Service (CHIS) reported to NHS England, Vanessa Andreae explained they were building in procedures which ensured that data could be extracted, when a carer had been contacted three times, without take up, as this was also useful in developing a targeted approach.

It was acknowledged that parents residing on the boundaries of two boroughs, had the benefit of living in one and obtaining services in another and that this potentially impacted on the data. Lucy Rumbellow confirmed that this was an issue that they were aware of, particularly in London. This was one of the reasons why GPs were asked to record data on babies registered with the practice and update records accordingly.

Councillor Joe Carlebach highlighted the problem of capturing accurate data to include vaccine take up from private practice, and similarly, "ghost patients" registered with NHS practices. Vanessa Andreae acknowledged that this was a complicated issue. She explained that they had considered ideas such as asking schools to request that parents included information about a child's immunisations record, as part of the application process on entering or registering for school.

In the detailed discussion which followed this suggestion, Members of the Committee were broadly supportive of the idea of capturing such data at the start of the admissions process but acknowledged that the execution and delivery method needed to be carefully considered. Councillor Lukey, suggested that officers from Children's Services were invited to attend future meetings of the Committee, to respond to policy questions that fall within their service remit.

ACTION: Children's Services / H&F CCG

Councillor Carlebach raised a concern about contrary guidance offered by GPs and schools, about the advice to keep children at home following infectious illness. Some schools asked that parents provided a medical certificate from a GP following three days of illness but school policies varied. Vanessa Andreae clarified that it was now possible to self-certify for up to five days and commented that if a child was off school for three days, they should see a GP. Discussing the wording about the need for a medical note, as posted on the LBHF website, it was acknowledged that this could be further clarified. Liz Bruce, Executive Director, Adult Social Care, commented that this had been raised previously with Children's Services and the Director of Public Health and concurred that greater clarity should be sought.

ACTION: Children's Services

Patrick McVeigh referred to the 40-60% target indicated in the report for immunisation rates amongst 2, 3 and 4 year olds. Lucy Rumbellow explained that there was evidence to show that the target was sufficient to reduce the spread of infectious diseases. Each new roll out for younger children would add another year group, each year. Two, three and four year olds would be picked up by GP's, and the cut-off point would be a child's 5th birthday, if it fell before 31 August.

Councillor Hannah Barlow referred to the top five and bottom five performing GP practices, what common factors identified them and what the mechanisms were for sharing learning amongst the better performing practices. Vanessa Andreae confirmed that the top five performers were also the larger practices, located in affluent areas. The bottom five were single partner practitioners,

serving a less affluent demographic. The lower performing practices were co-operating with the CCG to explore ways in which target rates can be achieved, without resorting to more formal methods to facilitate improvement. Based on the model of centralised hubs, practices that did not have a dedicated nurse practitioner, could book immunisation appointments accordingly. Although lower performing practices would be accountable if rates showed no sign of improvement, Members acknowledged that parents too, had a responsibility to follow up appointments.

Councillor Natalia Perez enquired about Meningococcal B vaccine for under two's and the Meningitis ACWY vaccine for university students, particularly, the wider availability of the vaccine. Dr Mike Robinson, Director of Public Health, explained that the Department of Health co-ordinated the introduction of new vaccines. Meningococcal B was introduced as a new vaccine for babies born on or after 15 July 2015, and its restricted expansion included certain age groups. Data spikes in young children and young adults indicated that a targeted approach was warranted and that it was not cost effective to vaccinate everyone.

Vanessa Andreae explained that it was important to stress the wider community benefits of the vaccination programme as it contributed to the overall reduction of this strain of meningitis. It was also explained that GPs could not charge for administering vaccinations available on the NHS from their own practice without breaching their terms of service. Most parents would not be able to cover the cost of paying for single vaccinations and it was further explained that Department of Health guidance stated that single vaccines would not be available on the NHS, due to their lack of efficacy when administered individually. It was accepted that parents would be anxious but given the current work being undertaken, the outlook was much improved compared to previous years. It was noted that parents who considered private vaccinations or vaccinating abroad should ascertain the origin and quality of the vaccines being administered.

Councillor Brown queried whether the data received was a reliable indicator of immunisation rates, highlighting the difference between practice figures and figures from NHS England. Dr Robinson expressed the view that the figures were a true representation and it was noted that data could be slightly skewed, given that they precluded vaccines administered in private practice or abroad. Councillor Vaughan queried specifically, data which had declined significantly over a three-year period (MMR – 24 months 80.8% to 73.4%). Lucy Rumbellow speculated that there were local issues around GP System One TTP data in in different practices. She outlined the complex process undertaken to extract and cleanse the data by the Child Health Informatics Service (CHIS), which was then submitted to NHS England for analysis. Data for Quarter 1 2016/17 was yet to be published and it was noted that there was a recognised concern that London cover data was lower than the data reported. It was also recognised that there were discrepancies between the system models, for which there was no available solution therefore they should be looking at both.

ACTION: H&F CCG / NHS England

Councillor Carlebach responded that it would be helpful to look at data from other boroughs, referring to the high number of private, paediatric GPs in RBKC and drawing comparisons with for example, Ealing. Vanessa Andreae confirmed that this was the case in RBKC and that the data was not available. It was recognised that that there was no pan London schedule to monitor if these figures improved. Outer and inner London figures were combined, with the outer London boroughs tending to record higher rates of immunisations. They were optimistic but clear about the significant amount of work required to meet target rates.

Councillor Sue Fennimore, Cabinet Member for Social Inclusion, acknowledged that the data around childhood vaccination indicated an increased impact on educational attainment and stated that she welcomed joint initiatives that would benefit communities. H&F CCG welcomed the offer of support, to help improve performance on take up rates and suggested that information could be included in council literature to raise awareness, highlighting the need to expand this across all forms of Council communication.

Councillor Vaughan referred to the four pilot sessions held in two local schools in 2015 and enquired if learning acquired through the pilots had been taken forward. It was acknowledged that whilst the pilot had been effective, there were financial and resource implications that needed to be considered. Vanessa Andreae confirmed best practice arising from the pilots was shared and referred to the Pan London Steering Board as another excellent forum for discussion. Although the model of consent was harder to achieve in different age groups, the process of administering vaccines in schools must be made more robust.

Vanessa Andreae continued, observing that communicating the importance of childhood vaccinations being routinely administered was acknowledged as a challenge. It was explained that the schools programme had been given to a newly appointed provider so there was currently no historic information to compare, year on year. The yearly improvements in rates of flu immunisation would result in a corresponding effect on younger siblings. Children were vectors in terms of their capacity to transmit infections to young children vulnerable or elderly family members.

Councillor Vaughan enquired as to what might be the suggested approach to mandate schools, and capture data at the point of admission, sharing the information with the Department of Health or Education, as appropriate. Liz Bruce expressed support for the concept and suggested that development work be undertaken to further explore the possibilities.

During the discussion which followed, the coordination of implementing a mechanism for collecting immunisation data at a single point of admission highlighted issues around the design of the form, local authority schools (it was noted that private schools already request this information), transfer dates and how parents sourced the details. It was agreed that the Children's and Education, Policy and Accountability Committee (CEPAC) could further explore this. Councillor Fennimore, whilst broadly supportive of the idea,

expressed doubts about collecting the data at a single point of admission and how this would work in practice, given the requirement for a single, pan London admissions form, which operated between September and March. She speculated that it could be included in the information given to parents about the admissions process. In theory, it was possible for parents to provide the information when, for example, they registered their interest in a school. This was an identifiable "nudge point" and Councillor Fennimore was keen to ensure that any further discussions included officers from Children's Services.

ACTION: HASCSIPAC

Bryan Naylor expressed broad support for the report findings, which he felt had been well presented. He welcomed an approach which advocated the wider community benefit for older people, to encourage better take up of the vaccination by parents.

Councillor Vaughan was encouraged by the collaborative work being undertaken and welcomed the fact that shared learning was a significant factor in the improved rates. He reiterated that the Committee broadly supported the idea of exploring with schools, data collection at a single point of admission and anticipated that officers would take this forward, in addition to referring the suggestion to CEPAC. A further report was planned for May 2017, with a possible update in either January or February.

RESOLVED

1. That a further report be considered in approximately May 2017, with an update to be scheduled for early 2017; and

2. That the report be noted.

88. LIKE MINDED MODEL OF CARE FOR SERIOUS AND LONG TERM MENTAL HEALTH NEEDS

Janet Cree, Managing Director, NW London CCG and Jane Wheeler, Deputy Director, Mental Health Strategy and Transformation Team, NW London CCG, presented the case for change, which used an evidence-based model for care. This had been produced following investigated planned change and the business case scheduled for later this autumn and it was envisaged that this would also include feedback from forums such as this one. Jane Wheeler continued that there was good practice evidenced across the boroughs. Bringing this to the PAC meeting for the first time, Jane Wheeler explained that there was a whole system strategy, which set out issues and challenges but they aimed to make change happen locally.

The single point of access, 24 hours a day, seven days a week, was central to having this service, with referrals from LBHF, local agencies and the Police, although she advocated early interventions that would pre-empt the need for Police involvement. There existed good services on which to build upon and the Mental Health Team Strategy (MHTS) local targets reflected national targets for 2020. With regard to the graphic on page 89 of the report,

it was noted that the single box provided a useful framework highlighting priorities. Focusing on eating disorders (work stream for April 2016), this was just one of several work streams which had been previously endorsed.

The overall aim of achieving a holistic support system in place was to ensure continued improvement in the quality of care for those with Serious and Long Term Mental Health Needs (SLTMHN). It was explained that people were reviewed in different parts of our system. They should be identifiable on discharge and picked up by other parts of the service, as appropriate. Achieving integrated transformation across social care was necessary to achieve an integrated approach. The impact on service users and carers in LBHF would be to simplify care journeys, making it easier to access services that emanate from a single point of contact.

In responding to a query about beds not being available and the alternative service options in that scenario, how this would really work in terms of service change and whether this was the right configuration to rapidly access services, Janet Cree outlined that the CCGs were pleased to engage closely with local services provided by organisations such as MIND and Mencap, which they viewed as critical friends. Councillor Brown congratulated them on the report, which he felt did much to challenge the stigma surrounding mental health and to ensure that these were addressed with equal assurance as physical issues.

Patrick McVeigh briefly outlined the case of an acute patient who was a manic depressive and had committed suicide. Enquiring about monitoring methods, in the borough, this had not been picked up until the Coroner's Enquiry. Jane Wheeler explained that sharing data was possible but there were inherent difficulties in suicide prevention that made it very difficult to share data. In this case, there would have been a time lapse in receiving the data from the Coroner's office. Dr Robinson added that although these numbers were relatively small, it did not preclude learning points being identified. Patrick McVeigh enquired what the actual number of cases were and it was agreed that the data from the Coroner's office could be shared.

ACTION: H&F CCG

Bryan Naylor commented that within an aging local population, it was hard to identify mental health needs before they became acute. There was a need to work more closely with services to address the fear that many older people had about illnesses such as Alzheimer's or dementia. He highlighted concerns about obtaining diagnosis and early intervention. Jane Wheeler accepted that this aspect of social isolation needed to be addressed and would form part of the Sustainability and Transformation Plan (STP). Citing Brent as a good example of this practice, she explained that there was a NW London steering group meeting to address this, consisting of local community groups, working throughout the local community to support themselves and the wider community. Councillor Fennimore commented that this was an important aspect of adult safeguarding work and should form part of the work programme. The opportunity to meet with members of Age UK to discuss their concerns was accepted.

ACTION: H&F CCG / Age UK

Janet Cree stated that there was joint dementia review being undertaken, working across dementia services, and recognised that there was an issue around post diagnostic support. She concurred that the focus had been on process and that there was a need to improve the diagnostics in terms of clinical pathways, with a view to redesigning them. Reiterating concerns by some Age UK members, Bryan Naylor highlighted issues such as memory loss and forgetting words, as being early warning signs and that GPs did not have sufficient time or resources to allay fears. Vanessa Andreae explained briefly the process by which GPs drew initial conclusions by asking three questions: name and address, time on the clock, and to remember three words given to them at the start of the conversation. A referral was then made if the answers were inadequate.

ACTION: H&F CCG

Councillor Barlow referred to the SLTMHN box diagram on page 90 of the report and enquired about the transition of children's services into the new modal of care. Jane Wheeler confirmed that this was a long standing issue and part of the work undertaken to address this in LBHF was with the Anna Freud National Centre for Children and Families. It was acknowledged that there were different points of transition. In terms of transition services such as out of hours provision of Children and Adolescent Mental Health services (CAMHs), it was noted that the 16/17 age group data was skewed towards young women. Councillor Barlow commented on the correlation between age and health need, and the resulting impact. She enquired whether other services within the borough were sufficiently integrated, to identify potential causes such as poor living arrangements. Jane Wheeler confirmed that they had tried to engage services jointly where children were transitioning, with a view to sharing solutions.

Highlighting the integrated model of care, Councillor Barlow asked about how information in such cases could be shared, for example, where a patient presents at the GP practice. It was understood that sharing of patient information between primary and secondary care was a complicated area, although this had improved.

Councillor Barlow enquired about the eating disorder work stream and what the criteria was. The requirement to work across boroughs, indicated a need to ensure that they demonstrated resilience to operate in this way, was acknowledged.

Enquiring about the single point of contact, Councillor Natalia Perez asked about improvements to the referral process, potential first contact and referral pathways in the voluntary sector, with organisations such as Mind and Mencap. In the case of individuals with low incomes or on benefits, there were inherent challenges in evidencing mental health need. Jane Wheeler explained that the number of Police referrals was high and not necessarily an ideal way of identifying need. This was illustrative of the current difficulties that they were seeing and that ideally, they would not want people to be identified through contact with the criminal justice process before accessing the services they needed. This also concerned raising awareness about how

to improve access to services and the sharing of information. The single point of contact in terms of urgent care response within 4/12 hours of being seen, was a gateway to voluntary sector services.

Councillor Perez enquired about what the challenges were to the new model of care and if this would reduce the number of beds required. It was confirmed that there were no plans to close beds although it was noted that some patients did refuse beds, preferring to access services from within the community. If this provision could be correctly configured, then funding for beds could be diverted to community based solutions. Responding to Councillor Perez's point about the lack of availability of local beds and the need to transfer out of the borough, it was explained such a transfer would be counterproductive, resulting in higher re-admission rates. The aim was to keep people healthy and out of beds and this required tight management on bed numbers. Liz Bruce confirmed that the Borough did have to find beds outside of the borough, when necessary. The CAMHs service was highlighted as an example of one service where they were struggling to provide sufficient, long term specialist bed care.

Janet Cree continued that few referrals were made by sheltered housing associations, illustrating poor sharing of information between housing and social care. She gave an example where an elderly woman had repeatedly locked herself out of her sheltered housing accommodation and had been subsequently fined. It was noted that there was a need to improve the existing configuration of services before adding new services, if the whole system was going to work in a conjoined and uniform way. Councillor Brown endorsed the need for a better interface between health and housing, citing the example of young addict who, following a transfer for treatment outside the borough, had returned to the area and had found it very difficult to be placed in local accommodation.

Councillor Vaughan enquired about the process of consultation and engagement. It was confirmed that this had been presented across the boroughs by the collaboration of CCGs and would only go to formal consultation if there were an impact on the number of beds or significant service redesign. Noting the various actions that had arisen out of the discussion, Councillor Vaughan thanked the presenters for the report.

RESOLVED

That the report be noted.

89. WORK PROGRAMME

Councillor Vaughan briefly highlighted several items that were planned for the following two meetings taking place in October and November. These included an item on the Public Health report, adult safeguarding and the CAMHs report (received by CEPAC in June).

RESOLVED

That the work programme for the remainder of the municipal year 2016/17, be noted.

90. DATES OF FUTURE MEETINGS

The Committee noted that the date of the next meeting will be Thursday, 20th October 2016.

Meeting started: 7PM
Meeting ended: 10PM

Chair .....

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London Borough of Hammersmith & Fulham **HEALTH, ADULT SOCIAL CARE AND SOCIAL INCLUSION POLICY & ACCOUNTABILITY COMMITTEE** **20 October 2016**	
Hammersmith & Fulham CAMHS Taskforce Report and the Children and Young People's Mental Health 'Transformation Plan' Update	
Report of: **Janet Cree** - Managing Director of Hammersmith & Fulham Clinical Commissioning Group **Rachael Wright-Turner** - Director for Commissioning, Children's Services	
Open Report	
Classification: For Information **Key Decision:** No	
Wards Affected: All	
Accountable Directors: **Janet Cree** - Managing Director of Hammersmith & Fulham Clinical Commissioning Group **Rachael Wright-Turner** - Director of Children's Commissioning	
Report Author: Angela Caulder, CAMHS Joint Commissioning Manager	**Contact Details:** Tel: 020 3350 4324 E-mail: angela.caulder@nw.london.nhs.uk

1. EXECUTIVE SUMMARY

1.1. Following a critical report from the House of Commons Health Select Committee on young people's mental health provision, the Children and Young People's Health and Well Being Taskforce was established in September 2014 by Norman Lamb, Minister of State for Care and Support. In February 2015 the taskforce published its report ***Future in Mind*** which contained 49 recommendations for improvement. Publication of the report coincided with an undertaking by the Government to increase resources for young people's mental health by £1.25 billion for five years.

1.2. In the autumn of 2015 Clinical Commissioning Groups (CCGs) in collaboration with local authorities submitted 'Transformation Plan' proposals to improve local mental health services for young people. This resulted in additional funds being released to CCGs in December 2015 to:

a. Establish community eating disorder services for under 18s
b. To 'transform' local mental health services for young people in line with the recommendations made in Future in Mind.

1.3. Additionally, in Hammersmith & Fulham, a local Child and Adolescent Mental Health Services (CAMHS) Taskforce was established and led by Cllr Alan De'Ath. The taskforce met on five occasions during 2015 and heard from local young people, schools, the voluntary sector and mental health clinicians and published its findings in the spring of 2016.

1.4. This report seeks to integrate the work and findings of the Hammersmith and Fulham CAMHS Taskforce with the Hammersmith and Fulham ***Future in Mind*** Transformation Plans which have been submitted to NHS England.

2. RECOMMENDATIONS

2.1 The Health, Adult Social Care and Social Inclusion Policy and Accountability Committee (HASCSI PAC) is requested to note the findings of the Hammersmith and Fulham CAMHS Taskforce. The full report can be found in Appendix 1.

2.2 The HASCSI PAC is also asked to note and support the progress being made in implementing the Hammersmith and Fulham young people's mental health Transformation Plan, which is also being reported to the Hammersmith and Fulham Health and WellBeing Board on the 14th November.

3. REASONS FOR DECISION

3.1. The recommendations above acknowledge that work has commenced in Hammersmith and Fulham to improve mental health services for young people but 'transformation' in line with the expectations of ***Future in Mind*** has not yet been achieved. Further work is planed over the year ahead to tackle the national priorities set by NHS England as well as local priorities suggested by the Hammersmith and Fulham CAMHS Taskforce.

4. PROPOSAL AND ISSUES

4.1 Turning first to the work of the Hammersmith & Fulham CAMHS Taskforce, recommendations were made across five areas:

- Access to services, information and support
- Strengthening training
- Transition
- Hammersmith & Fulham Transformation Plans

- Mental Health Challenge

4.2 The detailed suggestions grouped under the five headings above have been endorsed by the Hammersmith & Fulham Children and Education Policy and Accountability Committee on the 13th June 2016. Both the Children and Education PAC and the HASCSI PAC commissioned the local CAMHS Taskforce, hence reporting to both committees. Each recommendation area is briefly described below in more detail.

4.3 **Access, Information and Support**: this included a number of ideas that are already being considered by the council: delivering council early help and health provision in a new integrated family support service and seeking opportunities to access support through young people friendly provision, e.g. leisure or activity centres. A commitment was also made to develop a guide to emotional and mental health services with young people and to use this work as the foundation for a clear 'local offer' and discussion with schools on mental health stigma. These strands of work to be overseen and steered by a new Hammersmith & Fulham Young People's mental health alliance or partnership.

4.4 **Training:** training opportunities for schools, allied health staff (health visitors and school nurses) and the voluntary sector need to be extended and provided in a sustainable framework. This is a priority in the Hammersmith & Fulham Transformation plan which is developed further below.

4.5 **Transition:** the Taskforce report calls on mental health providers (for Hammersmith and Fulham, West London Mental Health Trust) to take steps to be compliant with the recently published NICE Guidance on Transitions.

4.6 **Transformation Plan**: this recommendation makes the explicit link between the taskforce's work, services delivered by West London mental Health Trust and Transformation Plans, and specifically challenges the trust to contribute plans to improve access, flexible appointment opportunities and better outcomes for Hammersmith & Fulham young people.

4.7 **Mental Health Challenge:** signing up to the Mental Health Challenge commits the council to identifying an elected member as the local 'mental health champion' with a corresponding 'lead officer' who together seek to strengthen and improve local services and opportunities for residents facing mental ill health.

Progress 2015-16

4.1 The Hammersmith & Fulham 'Transformation Plan' was submitted to NHS England in October 2015 and the CCG was subsequently allocated £100,744 to establish a young people's community eating disorder service and a further £252,173 to 'transform' mental health services for young people.

4.2 The allocation was for 2015-16 and funds arrived with CCGs in December 2015. An uplift of 19% for CAMHS transformation funds, amounting to £68,530, has been confirmed for 2016-17. The recurrent community eating disorders resource remains at 2015-16 levels, giving a new total of £421,530

for 2016-17.

4.3 Funding was set against eight priority areas:

- Updating the local needs assessment
- Co-production with young people
- Training the workforce
- Community eating disorder service
- CAMHS redesign and pathways review
- Learning disability and neuro-developmental services
- Crisis Care including the OOH Pilot Project
- Embedding Future in Mind

There are clear common elements with the priorities identified in the Hammersmith and Fulham CAMHS Taskforce report summarised above: e.g. improving training, working with young people and co-production.

4.4 **2015-16 resource -** Given the late arrival of these funds, resources have been largely committed to short term projects or to provide immediate improvements delivered by West London Mental Health Trust (WLMHT). This has included tackling waiting lists and support for high needs placements.

Progress 2015-16

4.5 **Priority 1** - The Anna Freud Centre has been commissioned to update the North West London young people's mental health needs assessment (£27,541). Anna Freud's interim report suggested that improvements are needed in two significant areas: Transitions[1] and Learning Disabilities. Anna Freud staff organised cross borough seminars over the summer and early autumn for stakeholders to address these emerging themes. The final Anna Freud report will be available in November.

4.6 **Priority 2** - Rethink[2] have recruited further co-production young champions who have contributed to the evaluation of the new WLMHT Out of Hours crisis support service. Rethink have also been supporting young people to deliver a training programme for teachers and other professionals (£20,667).

4.7 **Priority 3** - Improving training to increase capability and capacity for CAMHS is a significant priority. This has included Anna Freud carrying out a workforce and training analysis and a series of 'training the trainers' seminars on attachment, loss, behaviour and emotional well-being, jointly delivered with the local authority and specialist teachers (£53,981).

[1] Already identified as a local priority in the Hammersmith and Fulham CAMHS Taskforce report.

[2] ReThink is a national charity which specialises in co-production with young people. The Children's Joint Commissioning Team have an existing relationship with Rethink who have successfully delivered several traing projects in Hammersmith and Fulham schools in 2014-15.

4.8 **Priority 4** - There was an initial underspend for the three WLMHT CCGs,[3] as they sought to implement the new community Eating Disorders Service because of national recruitment problems, (£30,485). The remaining resource was deployed to strengthen WLMHT's learning disabilities service.

4.9 **Priority 5** - Successful conferences for Early Years and Schools staff have been delivered, with input from local and national mental health experts[4] in collaboration with the Public Health Healthy Schools Team. Resources have also been used to support the Anna Freud Centre's work on service redesign and pathways (£40,816).

4.10 **Priority 6** – Funding has been utilised to improve waiting times for the Learning Disabilities and Neuro-developmental pathways (£79,174).

4.11 **Priority 7** - As investment in the Out of Hours pilot had already been confirmed by Hammersmith and Fulham CCG, in the short term further resources were not matched to crisis work, although sustaining improvements remains a long term objective. The pilot aims to strengthen out of hours assessments and follow up with a view to reducing inappropriate admissions to psychiatric units for young people. Following a six month evaluation the pilot is being extended until March 2017 and Hammersmith and Fulham young people are being seen at Chelsea and Westminster Accident and Emergency by staff from Central and North West London Mental Health trust (CNWL).

4.12 **Priority 8** – Funding has been used broadly to improve capacity including:

- investment with the local voluntary sector to deliver self-esteem and mental health awareness training for schools.
- funds for IT equipment for WLMHT clinicians to support mobile service delivery from alternative sites (£51,704).

5. Next Steps 2016 - 20

5.1 The outcome, discussion and conclusions that can be drawn from both the Anna Freud Centre's needs analysis and service redesign work will have an important impact on the longer term transformation funding priorities for local mental health services for young people.

5.2 The eight priorities cited above in the initial Transformation Plans are now being honed down to four:

- Community Eating Disorder Service
- Service re-design
- Crisis Care
- Learning Disabilities and Neuro-developmental Disorders

[3] Hammersmith and Fulham, Hounslow and Ealing
[4] NHS England, Young Minds, CNWL and WLMHT

The 'next steps' summarised below should be viewed within the context of the refocused priorities and the transformation redesign work which is about to be undertaken.

- **Community Eating Disorder Service**

5.3 WL MHT established a community eating disorder service for Hammersmith and Fulham young people in February 2016 in line with national standards[5]. The service has been developed in collaboration with Hounslow and Ealing CCG. The community eating disorder service operates a hub and spoke structure with a base in Ealing and local clinics in Hammersmith and Fulham.

5.4 The service will be formally evaluated in 2017 with input from young people.

- **Service Redesign**

5.5 A sustainable training programme will be available for 2017-18. Local authority, voluntary sector and Public Health will provide input, aimed at improving prevention and early intervention. This is a key Future in Mind recommendation.

5.6 The CAMHS School Link Pilot Project which involves 10 Hammersmith and Fulham schools working with WL MHT will be extended until March 2017. An additional four schools have been identified to join the project for six months due to sustained interest in the project from Head Teachers. MIND have also been delivering support to young people in several Hammersmith and Fulham schools focusing on transition to work or college, mentoring and group work.

5.7 Suggestions for further service changes include:

a. delivering more emotional wellbeing and mental health services through schools

b. integrating early intervention mental health support and the local authorities Early Help and School Nursing services

c. increasing the involvement of the voluntary sector.

- **Crisis Care**

5.8 So far crisis care improvements have been limited to strengthening out of hours support for young people presenting to emergency departments in the evening or at weekends. The ambition however is to review and improve the response to young people in crisis across the board. In practice this means looking at the emergency response during the day, how young people might be supported as an alternative to admission to hospital and building on the opportunities presented by established psychiatric liaison services.

[5] One week wait for first appointments and provision for self referrals from young people.

5.9 It is anticipated that advances in this area will also link to NHS England's initiative to return commissioning of in-patient psychiatric beds for young people to local control (See below for more details).

- **Learning Disabilities, Neuro-Developmental Disorders and Autism**

5.10 The multi-agency service pathways for young people with learning disabilities and autism require urgent review and this is currently underway with workshops planned to take place for mapping and exploring several different good practice clinical models of delivery.

5.11 Short term additional commissioning resource has been agreed to support the CAMHS transformation programme across Central, West London and Hammersmith & Fulham CCGs with a particular focus on learning disabilities and autism, commissioning co-production and the implications of service redesign.

Coproduction

5.12 Co-production with young people is now integrated into the four priorities summarised above. Examples of current co-production activities include:

- A **Young People's Mental Health Conference** is scheduled for **29th October 2016.**
- WLMHT have been allocated funding to support collaboration with the young champions, and to undertake co-production service improvements with their own service users.
- Training of school staff by young people supported by ReThink is continuing in 2016-17.
- A new project with young champions has recently begun to produce A **Guide to Young People's Emotional Wellbeing and Mental Health Services.**
- The **Hammersmith and Fulham Partnership/Alliance** will be re-launched in November 2016.

National Issues

5.12 The provision of inpatient beds for young people, commissioned by NHS England, continues to cause considerable concern. Following the publication of Tier 4[6] Review carried out by NHS England two year ago, it has been apparent that there is an insufficient bed supply.

5.13 To begin to address this issue NHS England plan to commission additional beds through a procurement exercise in 2017-18.

5.14 Furthermore, a joint proposal by CNWL[7] and WLMHT to develop a new

[6] Mental health inpatient provision for young people
[7] Central and North West London Mental Health Trust

model of care to commission London beds for young people has been approved by NHS England. The first meeting of a new NW London Implementation Board with NHS England has recently been held.

6. OPTIONS AND ANALYSIS OF OPTIONS

6.1 Options are not formally presented in this report as the steps required to meet the ambitions for the Hammersmith and Fulham transformation plan are still in development.

6.2 As well as taking forward the 'next steps' for young people's mental health services summarised above, local commissioners will also be drawing on the recommendations of the Hammersmith and Fulham CAMHS Taskforce to develop both national and local priorities further.

6.3 The priorities still needing further attention are to:

- Explore options to collaborate with council services in developing an integrated family and school support service, as well as looking at possibilities to provide emotional wellbeing and mental health services from alterative 'young people friendly' service points.

- Signing up to Mental Health Challenge developed by the Centre for Mental Health, Mental Health Foundation, Mental Health Providers Forum, MIND, Rethink, Young Minds and the Royal College of Psychiatrists.

- Appointing a 'lead elected member' for mental health and identifying a 'lead officer' for mental health in the council.

7. CONSULTATION

7.1 Both the developing CAMHS Transformation Plan and the earlier Hammersmith and Fulham Taskforce Report (see Appendix 1) have involved extensive discussion and consultation with input from young people, schools, the voluntary sector, service providers and partner agencies.

8. EQUALITY IMPLICATIONS

8.1 An equality impact report has not been completed for this update report. An equality impact assessment was completed as part of the Transformation Plan submission to NHS England signed off by Health and Wellbeing Chairs and/or Lead Members for young people.

9. LEGAL IMPLICATIONS

9.1 There are no legal implications

10. FINANCIAL IMPLICATIONS

10.1 There are no financial implications arising from this CAMHS update report.

11. IMPLICATIONS FOR BUSINESS

11.1 There are no business implications arising from this CAMHS transformation update report.

12. OTHER IMPLICATION PARAGRAPHS

12.1 There are no risk management issues arising from the Hammersmith and Fulham CAMHS Taskforce report or the young people's mental health Transformation update.

13. BACKGROUND PAPERS USED IN PREPARING THIS REPORT

None.

LIST OF APPENDICES:

Appendix 1 - Hammersmith and Fulham CAMHS Taskforce Report 2016

Appendix 1 – HASCSI PAC Report 20th October 2016

Hammersmith & Fulham

Child and Adolescent Mental Health Taskforce Report 2016

Introduction

In 2014 there was significant national criticism of mental health services for young people. Inpatient facilities commissioned by NHS England (NHS E) were found to be too far away from patient's homes with insufficient capacity to meet demand. Local community based Child and Adolescent Mental Health Services (CAMHS) were described by the Minister at the time, Norman Lamb, as 'not fit for purpose' and in need of 'a complete overhaul.' Additionally, the Health Select Committee criticised investment in the service and the poor state of the current needs data and demanded improvements.

These pressures led to establishing the national CAMHS Taskforce led by Dr Martin McShane (NHS England) and Jon Rouse (DoH). The work of the national CAMHS Taskforce concluded with the publication of its well-received report, 'Future in Mind' in February 2015.

In step with these national developments, across Hammersmith & Fulham, Kensington & Chelsea and Westminster, a CAMHS Task & Finish Group met and made recommendations[1] for improvements to all three Health & Well Being Boards. The Task & Finish Group findings were strongly influenced by and indeed presented to the HWBBs by local Young People's Champions supported by Rethink[2].

In response to the Task & Finish report and the presentations made to the H&F Health and Well Being Board, a Hammersmith & Fulham focused CAMHS 'Taskforce' was asked to:

- Summarise the local need for mental health and wellbeing provision.
- Assess the services available in Hammersmith and Fulham which support good mental health and emotional wellbeing for young people.
- Identify any gaps.
- Comment on whether Hammersmith & Fulham young people and professionals have access to the right provision and services that young people want to use?

Taskforce Members:

Cllr Alan De'Ath (Chair), Cllr Sharon Holder, Cllr Sue Fennimore and Cllr Caroline Ffiske.

[1] Reported Autumn 2014
[2] Rethinking Mental Illness is a national charity campaigning for improvement in mental health services

Dr Christine Elliot – GP H&F CCG

Georgina Bell – West London Action for Children

Harry Wills, Shahid Khan and Selena Grogan – Rethink Young People's Champions

Stuart Lines – Public Health Vijay Parkash, Mennal Sohani and Kassim Makorie – West London Mental Health Trust

Alex Tambourides – H&F MIND

Officer Support from: Kerry Russell, Steve Buckerfield, Andy Davies and Jacqui Wilson[3] (CAMHS Commissioner)

Process

The H&F Young People's Mental Health Taskforce met on five occasions:

Initial Planning	19th March 2015
Provider's Focus	30th April 2015
School's View	18th June 2015
Young People's Priorities	2nd September 2015
What have we learnt?	29th October 2015

Over the course of the Taskforce meetings members heard evidence from a variety of organisations, individuals and stakeholders including: Rethink Young People Champions, H&F Youth Council, Hammersmith & Fulham schools, West London Action for Children, H&F MIND, Health Watch, the Centre for Mental Health and West London Mental Health Trust.

The Taskforce chair, Cllr Alan De'Ath and several other members visited the innovative Brent Centre for Young People[4] on the 20th July 2016.

The Taskforce also heard the results of the Hammersmith & Fulham Youth Council survey[5] of 200 local young people who were asked about their knowledge of mental health and emotional wellbeing.

Reports from HealthWatch on Young People's Priorities; the results of a survey across Hammersmith & Fulham primary schools and work produced by ReThink, working with local young people on perceptions of mental health services, were all considered by the Taskforce.

[3] Jacqui Wilson has left the CAMHS commissioner post and has been replaced by Angela Caulder
[4] Laufer House, 51 Winchester Avenue, London, NW6 7TT
[5] June 2015

Needs in Hammersmith & Fulham

A snapshot of mental health needs across the UK shows that:

- 1 in 10 children and young people aged 5 – 16 suffer from a diagnosable mental health disorder – around three children in every class
- 75% of mental health problems in adulthood (excluding dementia start before 18 years
- Between 1 in 12 and 1 in 15 children and young people deliberately self harm
- More than half of all adults with mental health problems were diagnosed in childhood. Less than half were treated appropriately at the time.

Local Population

No of Children[6]	33,328
No of School Children[7]	20,071
Rate of LAC[8]	60

Up to date information on the health, educational and social care needs of children and young people with emotional and/or mental health needs is not available. This is a common issue across North West London. Hammersmith & Fulham CCG, in collaboration with neighbouring North West London CCGs, has committed to commissioning a new Joint Strategic Needs Assessment for young people mental health needs for 2016[9]. The Anna Freud Centre has been recruited to undertake this work, which is now underway and will report in the summer 2016.

Estimates across North West London suggest 25,000 5-16 year olds will have a mental health disorder. Public Health England (2014) estimates that for Hammersmith & Fulham:

1828 young people may have a mental disorder

723 may have an emotional disorder

1104 can have a conduct disorder

307 experience a Hyperkinetic disorder

Self harm is also more common amongst young people with mental health needs. Among 11-16 year olds, over a quarter of those with emotional disorders and around a fifth of those with conduct or hyperkinetic disorders or depression said that they had tried to harm

[6] ONS Mid-Year Projections: Table SAPE15DT8;Mid 2013 Population Estimates of wards in England & Wales
[7] DfE School Rolls 2015
[8] Looked After Children DfE SFR36/2014 LAC aged 0-17 per 10,000
[9] The Anna Freud Centre has been commissioned to complete this work which is now underway and will report in the summer of 2016.

themselves[10]. Deliberate self-harm is more common among girls than boys. Between 2001/02 to 2010/11, rates of hospital admission due to deliberate self-harm have increased nationally by around 3% among 11-18 year olds (to around 17,500 in 2010/11).

There are also a number of specialist mental health needs for some vulnerable populations. National research has found that among looked after young people, 38% to 49% (depending on age) have a mental health disorder. Mental health conditions are also more common among young offenders. This is thought to be associated with the offending behaviour in over three-quarters of the young people who had a full assessment in 2014/15.

Children with special educational needs with an Education, Health and Care Plan (EHCP) may also be at higher risk of developing mental health needs, including autistic spectrum disorders.

Current Services and Performance

West London Mental Health Trust (WL MHT) is contracted by H&F CCG to provide community mental health services for young people in the borough. A team of approximately 30 mental health clinicians provides a service from their main base in Glenthorne road. The team is comprised of psychiatrists (4), psychologists (6), family therapists (3.1), psychiatric nursing (1), primary mental health staff in reaching to local schools (5.8) and management and administration (6.6).

Funding

Hammersmith & Fulham CCG invest £2,010,863 in mental health services for young people.

Hammersmith & Fulham local authority invest £512,000 in young people's mental health services, primarily supporting CAMHS work in schools, local training, a liaison post in social care, support for looked after children and a family therapy project. The local authority contribution is currently not guaranteed beyond March 31st 2017.

The London Borough of Hammersmith & Fulham have also benefited from short term national investment to introduce systemic family therapy clinicians and techniques into social work teams through the successful Focus on Practice programme.

Both the council and H&F CCG also joint fund the specialist Multi-Systemic Therapy (MST)[11] team which works intensively with families where young people are at risk of custody, care or not engaging with education.

Performance

2014-15 897 referrals received

[10] ONS (2005) Mental Health of children and young people in Great Britain

[11] MST Team – 3 therapists and a coordinator offer 24 hours support to high risk families. Funding is provided by the 3 inner London CCGs and Hammersmith and Fulham, Kensington and Chelsea and Westminster local authorities.

748 accepted

662 young people had a first attendance

5,156 follow up appointments offered

Waiting Times (June 2015) – all referrals are triaged to assess the severity of the issues and to decide priority.

55.6% (15 young people) assessed within 4 weeks of referral

37% (10 young people) assessed between 5 to 11 weeks

7.4% (2 young people) waited for longer than 11 weeks

Assessment to Treatment

68% (17 young people) treated within 4 weeks of assessment

20% (5 young people) treated between 5 and 11 weeks

12% (3 young people) treated beyond 11 weeks

Outcomes

Outcome measures have been included in the WL MHT contact for 2015-16. Both the clinician and the young person complete a self-assessment which tracks improvement as a result of the intervention. The national Children & Young Peron's Increasing Access to Psychological Therapies (C&YP IAPT) programme provides a menu of condition specific measures to be completed at the beginning and conclusion of treatment. Completion of an outcome measure at the start and conclusion of an intervention is termed a 'matched pair.' On a year to date basis, 41% of young people discharged from the service have a 'matched pair' of outcome measures. Of that cohort, 68% record that improvement was achieved.

It is anticipated that compliance with these outcome measure key performance indicators will improve significantly in 2016-17 and this is currently being negotiated with WL MHT.

Admissions to In-patient units

NHS England is responsible for commissioning in-patient psychiatric beds for young people (Tier 4 provision). The provision is provided by a variety of predominantly private hospitals (e.g. the Priory Group). NHS E data for 2014-15 indicates that there were 45 admissions for young people in Hammersmith & Fulham or 13.4 per 10,000 population, the highest ratio across North West London[12].

On the 10th March 2016 NHS England announced its intension to relinquish control of tertiary mental health beds in 'selected areas.' The changes could mean CCGs, NHS mental

[12] Ealing 6.1 Hounslow 5.0 Hillingdon 7.9 West London 8.2 Central London 9.5 Brent 9.0 Harrow 5.4

health trusts and independent providers could band together to make local or regional bids to take on the commissioning of secure mental health services, tier four child and adolescent mental health services, and other specialist services such as eating disorder units.

North West London CAMHS commissioners are keen to restore local control of access and discharge from inpatient units and will be contacting NHS England to explore how this can be taken forward.

Taskforce visit to Brent Centre for Young People

The Brent Centre for Young People was founded in 1967 by psychoanalysts[13] who had developed their work initially through the Anna Freud Centre[14]. The centre has grown over the years developing talking therapies unique to the centre which include: Adolescent Exploratory Therapy, Group Therapy for Young Offenders and Sport & Thought, as well as more widely used therapies such as psychoanalytical therapy, art therapy, psychotherapy and family therapy.

The centre receives some funding from Brent CCG but also has strong links with ten Brent schools which commission 'on site' support for young people from the service. This includes providing a service to young people excluded from school.

The Taskforce members who visited the Brent Centre for Young People were particularly impressed with:

- Centre's ability to combine therapeutic support with practical problem solving: e.g. homelessness, debt and access to sports activities
- Close working relationships with schools, the Key Stage 4 Referral Unit and Youth Offending Service
- Vibrant and up to date website providing support to young people and families
- Capacity to see young people and families quickly

The Brent Centre explained that there were still challenges and that their offer did not resolve everything. For example, transition between children and adult services remains an issue, and they work hard to keep communication working well with the local CAMHS team provided by CNWL.

- In summary, the Taskforce members thought there were considerable advantages to the Brent Centre for Young People's model and that exploring opportunities to look for collaborative models with the voluntary sector and other council services should feature in the Taskforce's recommendations.

[13] Moses Laufer, Egle Laufer, Mervin Glasser, Myer Wohl and Child and Adolescent Psychiatrist Maurice Friedman.
[14] Originally known as the Hampstead Clinic

Taskforce Discussions with Hammersmith & Fulham Young People

The Taskforce considered contributions from young people presented by three organisations:

- Hammersmith & Fulham Youth Council
- HealthWatch Central West London
- ReThink (national voluntary agency)

Hammersmith & Fulham Youth Council identified mental health as a key issue and therefore incorporated mental health for young people into its Youth Parliament 2015 Mind the Gap Campaign. The Youth Council's 2015-16 manifesto includes the pledge:

> '***We will work to help reduce the stigma around mental health so that young people can access the support they need.'***

As part of their campaign the Youth Council asked 3,000 young people:

> '***Do you know where to access support if you're feeling down or stressed? If so where would you go?'***

This was followed up with a more details questionnaire discussion with 196 young people in Hammersmith & Fulham schools or youth projects. The key findings were that:

- Many young people did not know where to access support, either in or out of school
- In school, friends, school based counsellors, peer mediators and form teachers were mentioned, but the understanding varied enormously from school to school.
- Out of school young people mentioned family and friends, going on line and going to see their GP, although a number also specifically ruled out seeing their GP.

The Youth Council survey also asked young people about their understanding of '***mental health***' and '***emotional well-being***.'

- Most gave negative definitions portraying the negative stigma surrounding mental health e.g. *Psycho, Mad, Dangerous*
- Only a few offered positive definitions e.g. *Happiness, satisfaction and no stress.*

The Youth Council's conclusions were that schools should talk more openly and regularly about mental illness, including encouraging young people who have experienced mental health issues, to talk to others.

Hammersmith & Fulham Youth Council also recommended stronger promotion and advertising of services with schools being much clearer about what is available and how to find support (including web links etc.).

Young people told the Youth Council that videos in assemblies or PHSCEE were very effective, particularly if it was produced by young people and for young people.

There were also some 'great examples of counselling in schools' but other schools don't provide this. These good examples should be shared and encouraged.

Finally, the Youth Council wanted to see more emphacise on how important ***positive mental health*** is and ***good tips*** for ***emotional wellbeing***.

HealthWatch Central West London produced a helpful report; 'Our Perspectives…read our stories about young people and mental health' in July 2015 and this was shared with the Taskforce. The report summarised the views and opinions of young people in Hammersmith & Fulham, Kensington & Chelsea and Westminster[15], with input from parents, carers and professionals[16].

The HealthWatch report echoes the findings reported by the Youth Council:

- Stigma associated with mental health and fear of 'labelling' remains powerful for young people
- Very mixed understanding of mental health and emotional well being
- Parents complained that they often did not understand what we being said as 'jargon' was frequently used by health professionals

A large proportion of young people (78%) that HealthWatch spoke to reported that they would seek support from their parents in the first instance. School based services were also popular with both parents and young people.

Finding information on young people's local mental health services was patchy. National organisations and charities had better capacity to keep websites up to date and relevant.

Transitions between services were also seen as problematic and the findings from the 2014 CQC '***From the Pond to the Sea – Children's Transition to Adult Services'*** remained relevant:

- Parents still caught up in with both CAMHS and Adult Mental Health Services
- No one to 'co-ordinate' transitions
- Transitions should be tailored to the individual and started at least 18 months before the 18th birthday

The HealthWatch report concluded with 18 recommendations which included:

- Calls to improve training: general awareness, mental health responsibilities for front line staff, jargon free communication for professionals and support and information for parents

[15] Young people's involvement included a focus group at a West London school, 100 young people completing an on line survey and a further 150 attending two engagement events

[16] Two engagement events were held: Oct 2014 St Anne's Church Soho and March 2015 Westminster College. The in-patient Unit Collingham Gardens operated by CNWL was visited and professionals given the opportunity to complete a survey.

- Improve clarity on pathways to services, co-ordination with the voluntary sector, and inclusion of the referrer in the 'solution', early intervention, transition planning and liaison with schools.
- Work with young people to develop creative early interventions which can be delivered as a 'whole family approach, through schools or young people's homes.

ReThink, the national mental health charity, has been providing support to a group of Hammersmith & Fulham 'Young Champions' who have been promoting the 'co-production' approach to mental health services: active involvement and participation of young people in service re-design, rather than traditional 'consultation' events.

The Champions produced a summary report based on an on line survey of 115 young people aged between 14 and 25 years old. Almost half of the respondents lived in North West London and half of those in Hammersmith & Fulham. Three quarters were female. There were equal numbers of respondents with and without a psychiatric diagnosis. The questionnaire asked participants firstly had they sought support and then where did they look to find it?

Findings

64% of the sample had made efforts to find help for their emotional or mental health issues which was broadly in line with both NW London and London comparisons.

Of those seeking support:

23% approached mental health services

19% turned to their family

12% found help through school or college

11% asked their GP

10% looked to friends

5% had access to a private counsellor or therapist

3% found an unspecified 'other' solution

Approximately two thirds of those seeking supported received what they had hoped for, with 25 young people registering disappointment.

Respondents were then asked to rate the quality of the support they received.

On average family, friends and teachers were rated as the most supportive, whereas statutory mental health services, often accessed in a crisis (in-patient or Accident & Emergency) were rated poor. Most forms of support received at least one high score (10)

from at least one young person, but specialist mental health services (CAMHS, counsellor or in-patient) also received some very low scores (0).

ReThink Conclusions

- More can and should be done in schools to promote positive mental health, open discussion and knowledge of support services, including via the web.
- Young people do seek help from family, friends and teachers and highly rate its effectiveness
- There is more we can do to improve both the visibility, access and initial responses from crisis and specialist mental health services

Taskforce Discussions with Hammersmith & Fulham Schools

The Taskforce heard the results of a survey of Hammersmith & Fulham Primary Schools which raised a number of issues that were then discussed with school representatives. This included:

- Uncertainty about the 'early signs' of mental health issues to look for
- Concern about increasing incidence of mental health issues within school and waiting lists and 'high' thresholds for professional help
- Schools were buying in valued additional support including: art therapy, counselling (West London Action for Children) and family therapy. Provision across schools was however inconsistent.
- From the small number of primary schools contacted, there was little in the way of additional training for school staff.

In terms of improvements, schools asked for:

1. Improved sign posting (e.g. flow diagrams) to services and simplified explanations about how to find services and what they could offer.
2. Schools were concerned that the 'in school' support and services was very limited. They would like to see this improved.
3. Schools also asked for 'sustainable' and easy access to 'highly skilled practitioners' who could provide advice and guidance.

There were additional contributions from the Bridge Academy, Lena Gardens, Fulham Cross Girls, Brackenbury and Jack Tizzard Special School. The points that follow summarise the lively and robust discussion that took place.

1. The school representatives who were able to attend the Task Force were unanimous in their view that the impact of pupil and on some occasion's also parental mental health issues was a significant and escalating issue.

2. The Bridge Academy has engaged its own therapy team[17] as local CAMHS was unable to respond quickly enough to identified issues. Mental health input was seen to make a difference where it was delivered at school and in groups.
3. Considerable interest in establishing more 'school linked' mental health posts and emphacising an 'early intervention' approach.
4. Concern that there was no specific service for younger children with an eating disorder
5. Also, complaints that waiting lists for a community service from Hammersmith & Fulham CAMHS could be up to 12 weeks.
6. Primary Heads felt that they were identifying need early but had little or no resource to address this.
7. Additional training for school staff was seen as essential. The training delivered by Educational Psychologists (two day input) was praised but access and knowledge of the training offer varied. More specialist mental health training for school staff was requested (e.g. anxiety, attachment, neuro-science, loss at an early age, de-escalation and self-harm).
8. General concern that Council resources for young people's mental health services will be reduced. Some schools already buy in art and music therapy but resources to expand this are limited.
9. Parental mental health or refusal to engage with mental health services both complicates and frustrates interventions – often with the school involved being left to cope as best they can.
10. There are further complications for secondary schools with larger numbers of pupils living outside of Hammersmith & Fulham. Self harm and concerns about uncertain transition arrangements were also mentioned.

Clinicians from WL MHT explained that their resources are finite and agreed that demand was increasing. Most of the mental health resources are already focused on schools but the range of needs being identified is very broad. A duty officer is available each day at Hammersmith & Fulham CAMHS, but it can be challenging when asked to respond immediately in a 'crisis.'

Universal Services:

There was also discussion of the impact and effectiveness of universal services and support available to schools.

Personal, Health and Social Education (PSHE), Emotional Wellbeing (EWB) and Social and Emotional Aspects of Learning (SEAL) were all mentioned as positive contributions within schools. Although SEAL has come to an end a number of schools persist with the programme as it was seen to be very effective.

[17] Includes Multi-Systemic Therapy, Art and Music Therapy and the Healthy Touch Programme.

Young Minds, Mind Up, Horn Foundation and Take Ten were examples of interventions or lesson plans that schools could make use of.

Public Health's Healthy School Partnership was also seen as a continuing positive initiative. This had led to discussions within schools about: home life; impact of social media; body image; exam stress; panic attacks; staff wellbeing; role of social workers and positive relationships.

It was noted that families are increasingly travelling longer distances to access education. Jack Tizzard School was also concerned about changes in support packages for families and the knock on effects on siblings.

Both Educational Psychology and the School Nursing service were seen as helpful supports for school responding to pupils with complex needs but both disciplines are primarily focused on meeting statutory obligations (SEN and/or safeguarding conferences).

Video Interactive Guidance was mentioned as a positive tool which Jack Tizzard had found to be useful.

Conclusions - Ideas for Improvements

The discussion was summed up by: how to respond with 'less resources and rising demand.'

Ideas to make the best use of available services included:

- Exploring co-location for mental health and/or early help or social work services with schools. These could be shared by groups of schools and linked to a local medical centre or GP practice(s).
- WLMHT explained that their work would be more effective if family social issues were addressed social care or early help services, rather than included with the mental health referral.
- Several present felt it was time that young people's services embraced a truly 'whole system' approach to improve 'joined up' outcomes and to make the available resources go as far as possible. This approach is being followed in adult services with increasingly close working between health and adult social care.
- Encouraging quarterly 'cluster meetings' for schools was suggested as an effective means improving communication and inter-agency understanding and responses.
- Establishing a clear Single Access Point for mental health services which is capable of generating a swift response was seen as essential (more than just a great web site).
- Developing a coherent mental health promotion strategy for young people was seen as an important priority for Public Health to pursue.

Taskforce Discussions with mental health clinicians and professionals

The Taskforce's discussion with local mental health providers and professionals included contributions from Rethink, the Centre for Mental Health (charity), Hammersmith & Fulham

MIND, West London Action for Children, West London Mental Health Trust and Christine Elliot, Hammersmith & Fulham GP. As with the other discussions overseen by the Hammersmith & Fulham CAMHS Taskforce, what follows is a summary of the lively discussion that ensued.

Andy Bell from the Centre for Mental Health told the Taskforce that there was a national drive to encourage local authorities to seriously consider the impact of mental health issues on their populations and the consequences for local services. With as many as 1 in 10 young people experiencing some form of emotional or mental health issues in childhood, this was a significant issue that should not be ignored. Andy Bell went on to stress that the consequences and costs both for individuals and society were high in adulthood: poor outcomes, reduced income and contribution to society and the economy, as well as service costs for local authorities, prisons and the NHS.

Andy Bell argued that the Taskforce should strongly support early intervention, with support through pregnancy, parenting programmes and easy access to therapy as required for both parents and young people. The Future in Mind report from the national CAMHS taskforce endorsed this approach and when combined with the Governments undertaking to improve investment (1.25 billion over 5 years) this was an opportunity to be grasped with both hands.

Alex Tambourides from H&F MIND explained that there are 148 branches of MIND across the UK. H&F MIND sees approximately 2,500 people each year and offers support with counselling and mental health advocacy. Locally MIND has been involved with initiatives to improve perinatal services, support for carers and understanding the needs being picked up in primary schools.

H&F MIND have also been engaged with West London College which has been improving its offer to students with mental health issues. This has included training for college staff and input on sign posting to appropriate services.

From MIND's perspective, more could be done to ensure that voluntary sector groups and other local stakeholders had stronger links to CAMHS and plans to develop local services for young people with mental health problems.

Alex Tambourides thought that key issues included:

- Professional service was good for people with severe mental illness but there was a real lack of preventative services
- Teachers dealing with mental health questions generally lack confidence
- Support 'gap' between universal and specialist services
- Stigma continues to be a massive issue
- Local coordination of mental health support for young people could be improved be re-launching a Hammersmith & Fulham young people's mental health partnership (possibly on a pilot basis to test the appetite)

Georgina Bell from West London Action for Children (WL AFC) told the Taskforce that only 23% of the local group's income came from statutory bodies with the rest coming from fund raising programmes. WL AFC employs 8 therapists and 'lots of volunteers.' The service supports low income families in Hammersmith & Fulham and Kensington & Chelsea. As well as providing direct services to local families, WL AFC also supplies counselling staff to several primary schools.

WL AFC receives both self referrals and referrals from professionals. They operate their own evaluation rating scale to measure the impact of their work and have offered a variety of group based interventions over the years including:

- Pre-Primary and Primary for Parents
- Parents of Teens
- Dad's Matter
- Breathe (Mindfulness)
- Mighty Me (Pre-school)
- Year 6 'Cool Moves' for transition
- Outreach at Jigsaw

Other services include: Mindfulness, Family Therapy and Cognitive Behavioural Therapy (CBT)

WLAFC have 500 new cases each year. Their focus is often more on the parent than the child.

Dr Meenal Sohani and **Kassim MaKorie** presented the services provided by West London Mental Health Trust (WL MHT). WL MHT is a large provider of mental health services supporting a population of up to 800,000, both adults and young people across Ealing, Hounslow and Hammersmith & Fulham. WL MHT also provides tier 2 services in Brent and the Forensic Mental Health Service for Southern England.

At present in Hammersmith & Fulham CAMHS is organised in two sections: Tier 3 which offers a specialist mental health service to young people with complex or entrenched needs and Tier 2, which provides brief interventions to support young people who do not require specialist psychiatric input. Both services see young people up to the age of 18.

The Tier 3 service provides talking therapies, family therapy, CBT, Psychology and Psychiatric diagnosis. The service is based at Glenthorne road in Hammersmith and will see young people at home and also at school, as well as supporting Chelsea Westminster A&E during the day. Emergencies are seen within 5 working days and all referrals are seen initially within 6 weeks. There is a 9 to 5 duty system each day.

Areas to strengthen include:

- Support for young people with learning disabilities and mental health

- Crisis Care
- Shortage of in-patient beds

The Tier 2 service, locally called community CAMHS, employs psychotherapists, nurses and family therapists. There is a team of 8. Statistics for 2013-14 evidence 1700 consultations, with 1100 direct to schools. Locally schools do know how to access the service and the team regularly see pupils on school premises.

In addition, there is a worker based in the Youth Offending Service (Cobbs Hall base) who leads on care planning for young offenders with mental health needs. A lot of training is also offered to YOS professionals.

There is also a small service providing mental health support to looked after young children. As funding is only confirmed until April 2017 short term appointments have been made.

Vijay Parkash, WL MHT Service Director and Clinical Lead agreed that:

- Improvements were required to improve data on need, performance and outcomes
- Mental health services across the UK required 'rethinking' not just tinkering with what's already there.

Christine Elliot, Hammersmith & Fulham GP, explained that general practice had the advantage of a global oversight of the family and knowledge of historic mental illness, but will often see very little of the 'family' once children have turned five years of age. A GP has to be very proactive if they want to continue to check on a young person's development.

Dr Elliot agreed that schools were best placed to spot issues for young people 5 to 18 years. Concerns included:

- Information sharing and confidentiality issues can limit inter-agency communications
- GPs not being aware of the support services available locally

Discussion and Issues

- *Will shifting resources to the preventative side reduce demand?*

Both MIND and WL MHT agreed that any new resource should be aimed at the preventative, early intervention side of demand, but warned that this would not necessarily reduce the incidence of young people (young adults) with severe mental illness. Staff from the WL MHT community service argued that their service was simply 'too small' to meet the rising demand from Hammersmith & Fulham schools. SENCOs were also seen as a key group of school staff to 'up skill.'

Rethink, argued that young people did not want more CAMHS professionals, but much better equipped and skilled teachers and social workers who could respond confidently to mental health needs.

- *Accessing information and consultation?*

General concern that the 'local offer' of mental health support services was very hard to find with everyone complaining they 'don't know what's there or how to find it.'

Rethink pointed out that if you want to improve 'access' to information, ask lots of young people what works for them? Young people will often talk to each other and go on line before approaching A&E.

- *How might services be different?*

Andy Bell argued that local authorities were well placed to bring organisations together to combine resources and services with a view 'collectively' reaping longer term benefits.

Single Points of Contact and/or service hubs for young people were seen as attractive ideas. There were some concerns expressed about how a 'hub' might be achieved in the current funding climate. Others emphacised and any 'single point of contact' must link to staff who can respond in real time – not just by e mail.

Service 'hubs' for young people in Australia had been praised in the Future in Mind report, but would they be used and be sustainable?

Would piloting community mental health services (or integrated early help services) based in a local school be more likely to succeed?

Julie Pappacoda argued that we have to improve the general early help – early intervention offer and look at integration of services where duplication looked likely.

Cllr Holder reminded the Taskforce that any findings or recommendations would have to be supported by a very strong evidenced based business case.

- *Peer support has been suggested by local young people and the Future in Mind report!*

Vijay Parkash thought developing a peer support approach could be 'revolutionary' if we could get it right. H&F MIND had examples of peer support working well. Some concern that any 'on line' peer support would have to be 'actively' supported by professionals to minimise risks. Rethink pointed out that peer support initiatives could be supported and promoted by 'co-production' principles.

Transition:

Wide spread agreement that 'transitions' continued to be a challenging area. There were different transitions depending on the services and young peoples' circumstances. Thresholds for support from Adult Mental Health Services are evidently higher.

A brief snap shot taken by CNWL revealed large numbers of young people leaving mental health services between 16 and 18. It was very unclear whether this was appropriate, or whether some of these young people re-engaged with Adult Mental Health Services later in their twenties? Was this an issue to be concerned about?

NICE guidelines have now been published on Transitions: ***Transition from children's to adults' services for young people using health or social care services*** – NG 43 February 2016. The guidance calls on health providers to identify a senior clinician or manager to drive forward improvements in transitions between services.

Potential for Improvements

Towards the end of 2015 and as the Hammersmith & Fulham CAMHS Taskforce moved to conclude its enquiries, three significant and very positive initiatives have taken shape:

- **Improved Crisis Care**: earlier in 2015 North West London CCGs agreed that additional resources should be found to improve the support available to young people with a mental health crisis which occurred beyond office hours or over weekends and public holiday. WL MHT launched the new Out Of Hours service or young people in February 2016. This has introduced waking psychiatric nursing staff who operate in the evenings, weekends and bank holidays. This mobile and face to face service will see young people who present and Accident & Emergency and will be able to review young people admitted to paediatric wars at weekends. The nurses will be support by the existing on call CAMHSA supported provided by WL MHT. The new service will begin in April 2016.

- **CAMHS School Link Pilot:** Hammersmith & Fulham CCG has been awarded a place on the NHS England CAMHS Schools Link pilot. This initiative links ten Hammersmith & Fulham schools to WL MHT who have received short term funding (from the CCG, DfE and NHS E) to strengthen school and CAMHS links. Two training days have now been held with SENCOs and school mental health leads, with a further review scheduled for later in 2016. Designated CAMHS staff are now linked to the ten schools in the pilot.

- **Future in Mind Transformation Plans:** In October 2015, led by Hammersmith & Fulham CCG, a local Transformation Plan was submitted to NHS England and subsequently approved. The Hammersmith & Fulham Transformation Plan is part of the North West London 'Like Minded' Mental Health Strategy and seeks to address eight priority areas. An update on the local plan can be found at Appendix !. The eight priority areas are:
    1. Updating the local needs assessment
    2. Supporting co-production with young people
    3. Training

4. Establishing a community eating disorder service
5. Service re-design for young peoples' mental health services
6. Improving services for young people with Learning Disabilities and Neurodevelopmental disorders
7. Improving crisis care
8. Embedding ideas from 'Future in Mind'

For 2015-16 Hammersmith & Fulham CCG have been allocated **£100,744** to establish a community eating disorder service (to be developed collaboratively with Ealing and Hounslow CCGs) and a further **£252,173** to address 'transformation' priorities.

Hammersmith & Fulham CAMHS Taskforce - What have we learnt?

Young people and their representatives told the taskforce that:

- They often did not know where to turn to for help
- That family, school and friends were all potential sources of help and advice
- School based support is welcomed by both young people and parents
- That the stigma attached to mental health was still strong
- That peer support and co-production initiatives are popular and effective approaches

Hammersmith & Fulham schools told the Taskforce:

- That an urgent improvement in the scope and scale of training offered to school staff should be an immediate priority
- Primary schools required support as well as secondary schools
- Schools are interested in experimenting with more 'school based' services (mental health and/or early help)
- That the 'offer' to school on mental health should be clear with more readily available sign posting materials (flow charts, video and/or websites) for external services
- Mental illness of parents and/or parental refusal to engage was a significant issue

Mental Health clinicians and the Voluntary Sector told the Taskforce:

- Demand for services and support, particularly from schools was increasing
- There is a 'needs gap' between universal and specialist services
- Partnership working between CAMHS, voluntary agencies and social care requires effort and perseverance and could be improved.
- Crisis care and support for young people with learning disabilities and mental health issues should be stronger
- GPs also had knowledge gaps about local young people's mental health provision

- Transition between services can still be uncertain

Taskforce Conclusions and Recommendations

Taskforce members have been impressed by the passion and determination to make improvements demonstrated by the contributors to the discussions. Thanks are particularly due to the young people from the Hammersmith & Fulham Youth Council and the champions supported by Rethink, both of whom have contributed important insights and suggestions for improvements.

The main conclusions reached by the Hammersmith & Fulham CAMHS Taskforce are:

1. **Access to Services, Information and Support Needs to Improve:**

   The Taskforce recommends that the council, NHS mental health and voluntary sector providers and CCG commissioners pool their managerial and clinical expertise to:

   a. Clarify the services and support available to Hammersmith & Fulham young people who are emotionally vulnerable and/or at risk of mental illness. This should include considering whether integration, aligning or pooling of staff, or resources between council, NHS and/or voluntary organisations would improve support for young people and provide a sustainable service able to respond to the current high demand and expectations.

   b. Draw up a feasibility plan for developing a Hammersmith & Fulham Centre for Young People that seeks to combine opportunities for purposeful activities, sports and fun with the capability to also access emotional wellbeing, sexual health and other young people focused support services, similar to the Brent Centre for Young People.

   c. The Taskforce recommends that a Guide to Young People's Emotional Wellbeing and Mental Health Services is produced using the principles of 'co-production' with young people. Once available in several formats, (print, web and if applicable apps), this should be distributed to every Hammersmith & Fulham school, GP practice and youth setting.

   d. The material should also be used to support creative and informed debates across Hammersmith & Fulham schools to tackle the stigma and fear that can be associated with mental health.

   e. The 'guide' information should form the basis of a published 'local offer' to be promoted on the local authority, CCG, mental health provider and voluntary sector web sites.

f. The 'local offer' for young people's mental health services in Hammersmith & Fulham should also be informed by the Schools CAMHs Link Pilot and the endorsement of school based services report above in this report.

g. Re-launch on a pilot basis, the Hammersmith & Fulham young people's mental health 'partnership' forum, with young people's active involvement, to improve coordination, planning and innovation.

2. Training Needs to be Strengthened and Sustainable:

A comprehensive and sustainable training programme should be commissioned to support school based staff, but also with the capacity to meet the training and information needs of other important groups: GPs, parents, young people etc.

3. Transitions Arrangements:

Transition arrangements between services continue to defy attempts to bring about improvements. The Taskforce strongly recommends that health and social care providers take immediate steps to achieve compliance with the new NICE Transitions Guidance.

4. Hammersmith & Fulham Transformation Plan:

The Taskforce supports the work underway as part of the Hammersmith & Fulham 'Transformation Plan' submitted to NHS England in October 2015.

a. As the primary provider of mental health services to young people in Hammersmith & Fulham the Taskforce recommends that West London Mental Health Trust develop plans and options to realise the ambitions articulated in Future in Mind to:

- Improve access to services
- Offer flexible appointment times and settings
- Demonstrate improved outcomes for young people

b. Progress on developing and delivering these changes and improvements to be reported to the Hammersmith & Fulham Health and Wellbeing Board by WL MHT and commissioner in Sept/Oct 2016.

5. Mental Health Challenge:

To sign the Local Authorities' Mental Health Challenge run by Centre for Mental Health, Mental Health Foundation, Mental Health Providers Forum, Mind, Rethink Mental Illness, Royal College of Psychiatrists and Young Minds. We commit to

appoint an elected member as ‘mental health champion’ across the council. We will seek to identify a member of staff within the council to act as ‘lead officer’ for mental health.

Cllr Alan De’Ath
Hammersmith & Fulham CAMHS Taskforce

London Borough of Hammersmith & Fulham **HEALTH, ADULT SOCIAL CARE AND SOCIAL INCLUSION POLICY & ACCOUNTABILITY COMMITTEE** **20 October 2016**	
Chelsea and Westminster Hospital NHS Foundation Trust – Acquisition of West Middlesex University NHS Trust: Post-Acquisition Review	
External Report: Chelsea and Westminster Hospital NHS Foundation Trust	
Open Report	
Classification: For Policy & Advisory Review & Comment **Key Decision:** N/A	
Wards Affected: All	
Accountable Director: External Report – N/A	
Report Author: Dominic Conlin, Director of Strategy and Business Development, (CWFT)	**Contact Details:** Tel: 020 331 58198 Email:dominic.conlin@chelwest.nhs.uk

1. EXECUTIVE SUMMARY

1.1 The attached report has been prepared by the Chelsea and Westminster Hospital NHS Foundation Trust and provides a post-acquisition review of the integration with West Middlesex University NHS Trust, one year after the formal integration.

2. RECOMMENDATIONS

2.1. The Committee is invited to submit any formal comments and note the report.

3. BACKGROUND PAPERS USED IN PREPARING THIS REPORT

None.

1.0 Purpose

The purpose of this document is to provide for the Hammersmith & Fulham Health Adult & Social Care Scrutiny Committee:

1) A summary of the key achievements of the new organisation
2) A more detailed review of the progress of the Integration and Transformation programme, the Foundation Trust's *assurance to delivery*, which commenced on September 1st 2015 on completion of the acquisition. This is a five-year programme and was specifically developed to support delivery of a range of clinical, quality and financial benefits and will support the development of a thriving and sustainable organisation.
3) To respond to key points of enquiry from the Committee meeting in July 2015 including:
    - Evidence that the new organisation will retain its responsiveness to local population
    - Specific update on progress against the plans to deploy a new Electronic Patient Record (EPR) System which was identified as one of the key benefits and enablers of improved care and use of resource.
    - Evidence of reflection and lessons learned

2.0 Introduction

Chelsea and Westminster Hospital NHS Foundation Trust (CWFT) acquired West Middlesex University NHS Trust (WMUH) on 01st September 2015. The combination of the two trusts created a major, multi-site north-west London healthcare provider and teaching hospital of nearly 1,000 beds and almost £600m revenue. The new organisation offers sector-leading (and in some cases nationally and internationally leading) tertiary services, complemented by high-volume, high-quality secondary care services. It is the second-largest maternity unit by births (c. 11,000) in London, and one of the larger paediatric centres by inpatient spells (c. 20,000) in London. This enables it to provide a breadth of service that encompasses core local services and a more comprehensive offering to patients for more complex treatment. In time it is expected that the FT will further develop its research programmes for the benefit of future models of care.

CWFT, whilst historically successful, was one of the smallest acute FTs in London (operating expenditure of £370m) and operated in a fiercely competitive environment containing a number of large, multi-site, multi-specialty healthcare organisations. This created a series of risks to our strategic vision to strengthen our position as:

- A major health provider and teaching hospital in North West London – offering a mix of regional and, in some cases, national and international tertiary services and local secondary care – recognising our core role as a healthcare provider;

- A leader in the health system supporting the health of the population and developing the provision of Accountable (Integrated) Care – recognising our developing role as a partner in the emerging *New Models of Care* agenda.

The main focus for this strategic vision is the ambition to provide accessible, safe and high quality care for all patients and their carers. However, the Trust recognised that the healthcare provider landscape was (and is) changing dramatically and CWFT, along with a number of other providers, did not currently fit that profile in a sustainable way.

Starting from the first day of "operating" as a single legally constituted Trust, an approach was followed to realise the benefits of integration, whilst ensuring business continuity, legal compliance and safety of patients, staff and the organisations were maintained. The initial phase of integration commenced with the development of a new operating model followed by consultation across operations and nursing, leading to the subsequent introduction in early 2016. Detailed service line strategies to support clinical standardisation and improvements in clinical outcomes and productivity were progressed alongside the shaping of the operational model including alignment and embedding of relevant policies, Standard Operating Policies, performance standards, KPIs and other.

3.0 The New Organisation: Key Achievements and early progress of Benefits Realisation: September 2015-August 2016

- Performance: Despite the pressure on performance seen across the NHS the new organisation **has met the key operating standards on A&E 4 hour waits, 18 week Referral to Treatment and key Cancer Access standards**. It places the Trust in the highest levels of performance in London and nationally.
- Finance & CIP delivery: This supported overall delivery of the Trust's control totals. Despite the turbulence in the NHS more widely and the risks identified from other NHS acquisitions and mergers the post acquisition financial targets were met and **the Trust met its 2015/16 financial plan** and is on track to meet its 2016/17 plan **and achieve a surplus of £3m**.
- Corporate Synergies: A planned synergy was the reduction in corporate costs in moving to one set of management arrangements. **This delivered the planned saving of £1.3m in 2015/16** and is forecast to realise **a recurring £2.8m of benefit.** This covered areas such as Board and Executive Management, Operational leadership, Corporate Nursing leadership.

  Further savings have been achieved in 2016/17 with a second phase of back office corporate restructures including Clinical Admin review, Finance/Information/Procurement, Human Resources, Estates and Facilities and IM&T. **There have been no redundancies to date** and savings have been realised through redeployment and release of interim/temporary staff, procurement and other process improvements; and estate improvements such as cessation of off-site leases.
- Clinical Benefits: A key principle of the acquisition was to develop clinical services and improve local access for patients and this was set out in the legally binding Transaction Agreement. In year 1 the Trust has delivered the flagship development of the cardiac catheter laboratory (at West Middlesex). This has seen a capital investment of over £2m and is the first of the developments which are projected to deliver patient benefits over the 5YR programme. **The service went live in September 2016** and the first patients have been treated. This is set out in more detail in Appendix 1 where we outline two case studies. Other service developments are being planned through the same PMO and commissioner/contract sign off process and include:
  - Surgical Assessment Unit at West Middlesex
  - FT wide rotas (eg Neo-natal Intensive Care to better match patient need with staff expertise
  - Fetal Medicine at West Middlesex
  - Development of integrated care programmes with Imperial, West London Mental Health Trust and Federation of GP's in Hammersmith & Fulham
- Culture and Values Development, Leadership and Development: Reflecting on key lessons learnt from other Mergers & Acquisitions (NHS and other) a series of Clinical Summits were undertaken to begin the process of building the clinical community and clinical leadership in the period up to the 1st September day 1. This was a key enabler to the successful achievement of the new clinical and operational structures which were consulted up on the autumn and went live in January 2016

Post-acquisition and to continue the culture and organisation development there was a programme of engagement via a *Big Conversation* with staff*,* led by Executives. A review of that process was carried out after the first 100 days and allowed us to build in terms of strategy, communications and behaviours a new organisation's shared values framework, *PROUD*. This will be consulted on later this year.

- Staff Engagement: Prior to the acquisition a key risk was the impact on staff. This concern was noted and questioned by the Committee. In March 2016 the results of the NHS Staff Survey were released which were based on staff questionnaires from the post acquisition period and provide an early indication of staff engagement. Against the 2015 baseline the survey shows that the:

    1. ***Overall Staff Engagement*** **score for West Middlesex staff increased from 3.64 to 3.84** which the national benchmarks show is above (better than) the average compared to other Trusts. The DH analysis indicated this as a statistically significant increase.
    2. ***Overall Staff Engagement*** **score for Chelsea & Westminster staff increased from 3.81 to 3.84** which the national benchmarks show is above (better than) the average compared to other Trusts

- Patient Experience: The Trust was shortlisted by the national Family & Friends Test for 2 awards in March 2016. The Chelsea site for reducing waiting times in sexual health and the West Middlesex site for improving mealtimes and food experience on surgical wards. Our performance in the national survey showed that the trend of continuous improvement was maintained although it should be noted that this was in line with wider national trends.

Performance in national surveys is rightly used as key evidence of Patients and Staff satisfaction and the evidence shows that both groups recommend our new organisation as both a place to get treatment and a place to work. This positive engagement is also evidenced in our Star Awards ceremony for staff (with approximately 1,000 nominations submitted) and the huge numbers of local people who attend our Open Days (at each site) and the institution of *Perfect Days* where corporate members of staff – including the Executive Team - work in patient facing areas to sustain positive organisation development and support our most important services.

The early indicators are positive and the Foundation Trust is very proud that our new organisation has successfully met the cultural and system challenges that we set for our first year and – alongside the considerable challenge of integration – we have continued to provide NHS leading services. During the last 12 months we have been recognised for:

- Our world leading Sexual Health service continued to innovate (and alongside the opening of our new unit at 10 Hammersmith Broadway) the Dean Street Express won the *Best Product, Innovation or Service* at the national Patient Safety Congress;

- Our survivors of torture pain clinic won first prize in the Grünenthal Pain Awards, an innovative awards programme to recognise excellence in the field of pain management and significant improvement in patient care;

- We were awarded the Innovation award in Education across Primary and Secondary Care at Health Education North West London's first ever awards ceremony; and

- As a great place to work and develop your career:

    - One of the *Nursing Times* 'Best Places to Work in the NHS' 2015

- We were awarded two NHS Personal Fair Diverse Awards by the NHS Employers organisation and an Employers Network for Equality and Inclusion (ENEI) Benchmarking Diversity Silver Award 2015
- HPMA Excellence in HR Award 2015
- Shortlisted for ENEI Health and Wellbeing Award 2015 and for *Personnel Today* Health and Wellbeing Award 2015
- Ranked as one of the top 30 employers for working families in the UK by leading work life balance charity *Working Families*—**the only NHS organisation in this year's top 30 list**.

4.0 Electronic Patient Record

The Full Business Case (FBC) , approved by Trust Board in September 2016, details the scope for the replacement Electronic Patient Record (EPR) system to be implemented across the Trust. The recommendation of the FBC is to procure Cerner Millennium in a shared environment with Imperial College Healthcare NHS Trust (ICHT), contracting for a ten year period.

The forecast investment in Cerner Millennium is in excess of £37m and was negotiated as part of the Transaction Agreement. It includes:

- Total Capital cost c.£31.6m
- Total Revenue costs c.£5.6m
- Total Whole Life Costs c.£37.2m

These costs are now embedded within the Trusts Long Term Financial Model and are offet by a benefits framework that **provides a positive net impact of the Trust I&E position over the ten-year period of c.£13.1m;** and has a net impact on cash flow over the ten-year period of c.£43.5m and a net impact on the balance sheet over the ten-year period of c.£44.6m

The adoption of a shared environment with ICHT shares material cost savings as well as significant benefits to our patients, our staff, ICHT staff and stakeholders across the health and social care sector (primarily within our catchment area within H&F and across NW London). Some examples include:

Safer Care	Inpatient medication errors and near misses, Falls assessments, Tissue Viability and other safety assessments will be better systemised across the trust . The EPR system supports an audit trail and wider implementation of the latest guidelines on clinical care and safety to deliver and demonstrate *safer care* to our patients on an *Every Time* basis.
Effective Care	Supporting revised work-flow, automating pathways, scheduling and order management for outpatients, theatres and ward areas. Supports length of stay reductions and more efficient use of workforce.
Higher- quality care through shared best practices	Standardisation, using the best in clinical practices and high quality services from each site as a template, provides the opportunity to drive improvements in clinical outcomes and quality of patient care; and monitor compliance
Supporting Innovation	Patients will have greater access to high-quality, leading research programmes within the organisation, which will encourage innovation and improved quality of care for patients both locally and at a global level.

	To achieve this the CWFT research and development strategy will build on access to a wider populations base and emerging relationships with Accountable Care Groups; and include a service line component for Research and Innovation in annual business planning

The FBC addresses the national strategic objectives set out in the Five Year Forward View (5YFV), particularly in terms of interoperability and digitisation of records and the local strategic objectives detailed within the NW London Sustainability and Transformation Plan (STP) and associated Local Digital Roadmap, particularly in terms of Patient access to their records and ability to engage proactively with managing their care.

The shared governance approach (including a Joint Chief Information Officer) and external assurance are being considered and worked through in line with the high level implementation timeline and project phasing which will see an initial go-live at WMUH in autumn 2017 and on Chelsea site in late spring 2018, which is in line with the assumptions set out in the Acquisition Business Case.

5.0 Analysis of CWFT as a Provider of Local Services for Hammersmith & Fuham

The Foundation Trust provides a range of core acute, ambulatory and specialist services to the population of Hammersmith & Fulham. **Across the combined CCG, Borough and NHS England contract portfolio the total value of clinical service is in excess of £50m**.

A direct comparison of contract activity and costs between April – September 2015/16 (the pre acquisition period) and the corresponding position in 2016/17 shows that activity levels are broadly consistent but that costs are currently lower – although the largest variance is in specialised services where contract prices and costs can be subject to greater vioatility.

		April to September			April to September	
		CW 2015/16	Activity		CW 2016/17	Activity
Hammersmith and Fulham CCG		£19,759,715	55386		£17,605,840	56628
Hammersmith and Fulham GUM		£1,835,393	14196		£1,698,003	12776
NHS England Dental for H&F patients		£367,051	1221		£215,278	888
NHS England Specialised Services for H&F patients		£3,688,750	5664		£1,891,126	5535
Totals		£25,650,909	76467		£21,410,247	75827

Alongside the 'how many' and 'how much' KPIs, the Foundation Trust's compliance against the quality and performance standards provides assurance that the 'how well' metrics are also being delivered.

6.0 Integration & Transformation Programme Outline

The Integration & Transformation Programme has been developed to underpin the delivery of the organisation's strategy (see Appendix 1) and, specifically, the realisation of the £122m of financial benefits which reflects the commitments made under the Transaction Agreement to deliver core NHS efficiencies. The £122m is derived against the required efficiencies across the 5 year period (see Appendix 2 & 3) and is the 'golden thread' of the new organisation's Operating Plan.

The 5YR programme of work is based upon the following objectives and related benefits:

1. 'Cost Out' (CIPs & Synergies) - to deliver both a surplus and financial sustainability through delivery of CIPs & Synergies, Clinical standardisation and Corporate Synergies

2. 'One Organisation' (Integration) - to establish a Trust with a shared culture, ways of working and behaviours whilst delivering service developments and improvements

3. 'New Models of Care' (Transformation) - to transform clinical and corporate services for our patients and the communities that we serve, underpinned by investments in Workforce, Estate and IM&T

7.0 Benefits Realisation Plan

The projects that make up the Programme will together deliver a range of outcomes:

- Using our staff and capabilities more effectively, efficiently and economically
- Improving clinical and corporate processes throughout the organisation
- Integrating the structure of our organisation and developing a shared culture built around our vision of excellent experience and care
- Transforming clinical pathways to enhance experience and quality, whilst being more efficient and effective
- Developing new services, growing our income and capturing additional income.

These in turn drive five overarching benefits (See Table 1):

1. Financial benefits - **through delivering £122.4m financial savings** developed as part of the Integrated Business Plan and to successfully meet NHS Efficiency Requirements;
2. Staffing benefits - through higher retention and satisfaction rates;
3. Compliance/ Governance benefits - through exceeding expectations for all mandatory Trust indicators;
4. Patient benefits - including improved access, experience and patient advocacy for our communities served;
5. Clinical benefits - including improved quality of services (safety, effectiveness, experience), with better outcomes and reduced variation.

Table 1 – Integration & Transformation Programme Governance Structure: Objectives to Benefits

Programme Objectives	Projects within the Programme will deliver a number of outcomes:	The outcomes support the key benefits of the Programme
[1] Service improvement & efficiency "Cost out" **Objective** – to plan and deliver non-financial and financial benefits (including acquisition synergies & corporate synergies whilst delivering the governance for managing the CIPs across the new Trust)	**Staffing and staff mix** 1. Skill mix to be more efficient and/or effective 2. Decreased spend on temporary staffing **Process improvement** 3. Clinical / Corporate) standardised processes to address quality and regulatory requirements 4. Improved demand management of clinical support 5. More productive outpatient clinics 6. More productive theatres 7. Shorter length of stay	**Financial benefits** Delivering £122.4m financial savings in the Integrated Business Plan **Staffing benefits** Higher Staff retention rates and improved satisfaction scores **Compliance / Governance benefits** Trust is meeting all mandatory guidelines and performance indicators
[2] Integration "One Organisation" **Objective** – to plan and deliver the organisational integration to establish an integrated organisation and culture, and to deliver service development objectives and benefits in selected areas	**Income** 8. Income growth 9. Income capture	**Patient benefits** Improved access, experience and patient advocacy for the communities served by the Trust **Clinical benefits** Improved quality of services (safety, effectiveness, experience), with better outcomes and reduced variation
[3] Transformation "New Models of Care" **Objective** – to plan and deliver the clinical and corporate transformation of the organisation and the EPR to enable this	**Structure** 10. Organisation re-structure to enable integrated efficient and effective management **Pathways** 11. Clinical pathways redesigned to enhance experience and quality of care	

The benefits realisation process should facilitate the following:

- Support projects to ensure delivery of the desired benefit
- Confirm priorities given finite investment resources
- Create opportunity to learn what works and what doesn't

7.1 Tracking and Reporting

This is driven by the Programme Management Office (PMO) and, in line with best practice, reports on a monthly basis against project milestones; financial month end results; satisfaction; progress against CQC domains and scores and reduction in serious incidents. On some projects the frequency of measurement will be dictated by the completion timescales of the various integration projects. For example Staff retention rates will only truly be measured once remaining corporate restructures are completed; Satisfaction score for patient and staff surveys take place periodically and are built into a 12 month schedule for 2016/17. It is important to have direct qualitative feedback as well as the primary quantitative measures that have been identified and are shown in more detail (see Appendix 5).

It is important to note that this is an iterative process over the 5YR programme. For example the Electronic Patient Record benefits realisation process is currently being developed separately given its significance and scope; and these will be built into the central programme register over time.

8.0 Communications & Engagement

The Trust has developed integrated communications and engagement channels which are now firmly in place. There remains work to be done in order to deliver the vision and outcomes that can be realised by integration, for example:

- Supporting **our** understanding and ownership that we are now one organisation, with one joint identity and vision underpinned by the Clinical Services Strategy, which will deliver the best care and experience possible for patients and staff
- Ensuring **we** realise integration and transformation should be part of business as usual, as well as highlighting their personal responsibilities towards delivering the integration and transformation agenda
- Helping **us** to feel empowered to instigate changes in behaviours, clinical pathways and ways of working
- Flagging key longer term programmes of work to begin initial ground work for communications and engagement in these areas

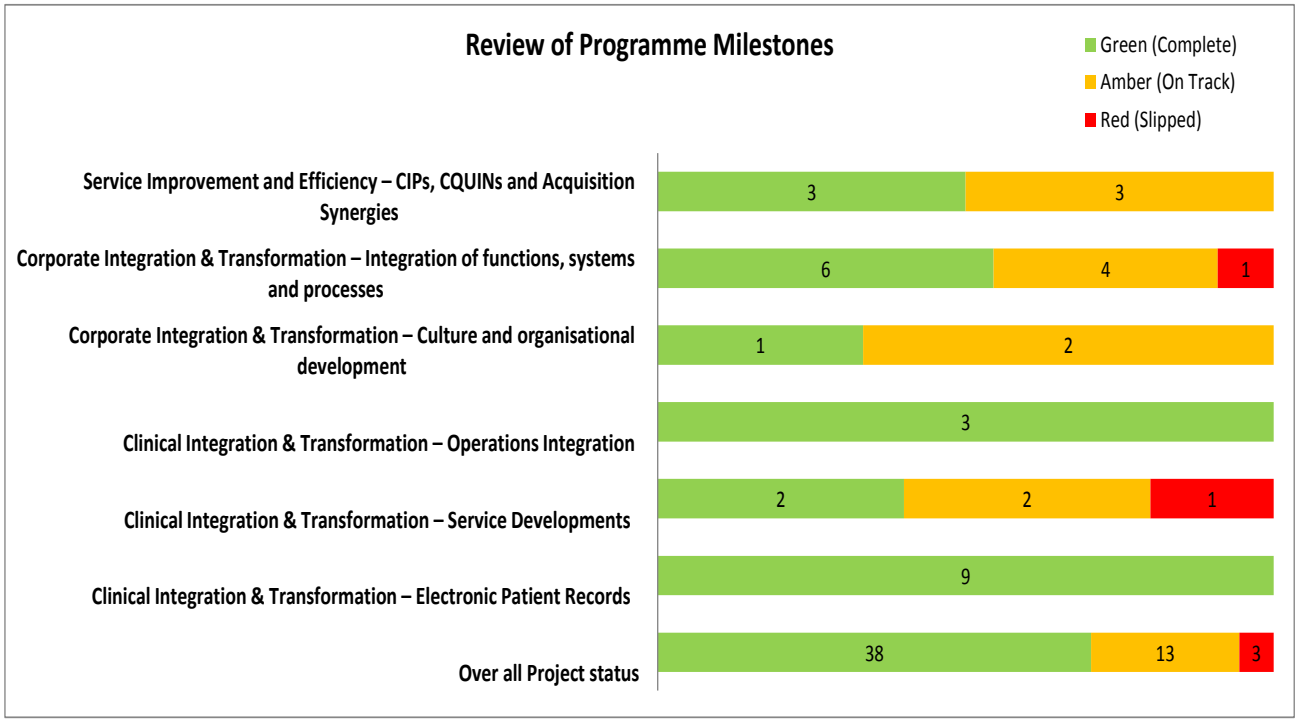
There has been some significant success in embedding the story of integration, setting the groundwork for transformation and identifying individuals and groups to support the programme.

9.0 Programme Governance and Budget

The Programme is governed by an Integration & Transformation Programme Board (ITPB). This is chaired by the Chief Executive and is tasked by the Trust Board with assuring the delivery of the Programme. Committees of the Trust Board such as the Quality Committee and Finance and Investment Committee provide additional scrutiny of the corresponding aspects of the Programme. Terms of Reference of the Board's committee structure include oversight for the delivery of benefits (see Appendix 6). It is linked to day to day structures through the 3 Divisions.

The Trust (supported by commissioners and set out in the legally binding Transaction Agreement) has committed significant resource to support delivery of the programme. The budget across the 5YR programme is £23.6 million.

Review of Programme Milestones (taken from year end review March 2016) and independently audited



2015/16 year end progress was achieved while delivering an underspend in 2015/16 of £1.8m (against plan of £6.4m). This underspend was achieved through reduced expenditure on external consultancy and slippage on some elements of standardisation (realisation of the finance single ledger and associated projects). Savings were redirected into future years to support large value projects including:

- Systems Development: Single Ledger, Integrated Data Repository, Single Staff Record (ESR);
- Electronic Patient Records: Clinical Design Authority: Procurement & Implementation Support (this will include external relationships in primary, community and social care);
- Support to a Recruitment & Retention Programme;
- Pathway Development;
- Legacy Projects e.g. Estates & Facilities.

10.0 Concluding remarks and lessons learned

Overall, excellent progress has been made in establishing the new organisation and delivering the Integration and Transformation Programme. Quick wins have been achieved against the 100 day plan around establishing cross-site teams, single governance structures (including for the programme itself) and agreeing a clear Design Authority and route to market for the procurement of an Electronic Patient Record programme. The regulator, Monitor, formally reviewed six month progress and:

- Has indicated approval of progress to date and high levels of assurance.
- Reported that CWFT is the only acute Trust in London to be 'green rated' at Q1 2016/17 on governance and finance

Executive buy-in to the programme remains strong, with clear responsibilities and accountability, and a strong leadership and line of sight to Board. This has been augmented through bi-weekly programme programme board meetings, attended by the entire executive team.

Against this overall position there has been reflection and the following lessons learned have been identified:

- Operational efficiency and effectiveness – continuation of delivery of national targets throughout the acquisition period has been a major achievement which will require ongoing focus and support to maintain the same high quality level of delivery.
- Communications – engaging with people at a time of change regarding the programme necessitates significantly more resource than was perhaps envisaged. This is currently under review, however the communications focus on Integration and Transformation plans now feature as a standing item in the monthly Chief Executive's Brief.
- Operational and Nursing restructure - delivered at pace and implemented within 100 days of acquisition. However, other areas, such as corporate (finance & HR) did not progress at the same pace and were not implemented until 2016/17 – which had implications for provision of suitably integrated back office support.
- IM&T – a key enabler of other workstreams, particularly ease of cross-site working. There was some slippage with the main challenge establishing the right forums and process for clinical engagement while the organisation went through restructure and a demanding 'business as usual' winter pressure period.
- Major projects e.g. Single Ledger did not evolve at the originally envisaged pace, although this particular project had specific issues. However, other areas where plans were put in place have not materialised potentially because they have been displaced by more immediate priorities such as CIPs & Synergies raising key risks around bandwidth
- Cultural change – used to cement new ways of working comes as a by-product of the ongoing work to create single teams and structures. This has been a key success of the Divisional Integration Groups (DIGs) and also Corporate Steering Groups. It will become an area of increasing focus to provide the 'glue' required to bind new structures and underpin transformation and delivery of related benefits going forward.
- CIPs and synergies – responsibility for the Trust's Cost Out agenda was transferred from a third party consultancy to an internally driven function within Chelsea & Westminster. This transfer combined with the need to extend the agenda to encompass a trust-wide approach has proven very challenging and has necessitated twice-weekly thematic 'deep dive' sessions with the Chief Executive
- Service developments - have had some success, such as the Cardiac Catheter lab at West Middlesex. However, other developments have been delayed owing to uncertainty in the national tariff changes, contracting round and the need to transition from commissioner support via Transaction Agreement to contract agreement.

Appendix 1

Case Study 1: Improving Access – Cardiac Catheterisation Service

Overview

On the 23rd of September, Chelsea and Westminster Hospital Foundation Trust saw the first patients in the new Cardiac Catheter Suite at the West Middlesex site. The lab itself is a purpose built and state of the art, with a modern designed day unit.

Background

As part of the implementing the Acquisition business case, the Trust negotiated capital from the Department of Health to improve local cardiac services. The impact of heart disease on the population was a recognised risk in local Health & Wellbeing Strategies. The Trust has taken forward an implementation case to implement the service at West Middlesex. After an options appraisal, which recognised that financial projections would be lower than the original acquisition assumptions due to changes in national tariff prices, it was decided that the lab could be situated in one of the underused theatres, with the day unit to be built co-adjacently. At the time of acquisition, patients requiring acute diagnostic or interventional cardiology care (including angiography, angioplasty, pacemakers, and ICDs) were transferred or referred to other Trusts, such as Hammersmith from West Middlesex, and the Brompton from Chelsea and Westminster. This need for patient transfer typically led to a delay in accessing diagnostics, an extended hospital stay and poorer patient experience and outcomes. Building a lab at West Middlesex allows us to treat our patients within 24 hours of admission and reducing the need for bed to bed transfer. It is slightly different for patients at Chelsea and Westminster Hospital as transfer is still required and we will maintain choice and offer the new lab or a choice of the existing units at Hammersmith or the Brompton .

A summary of the impact and benefits for patients is set out below using the example of a patient admitted as an emergency with chest pain and for whom the appropriate diagnostic test is procedure to get information about the heart and its blood vessels (angiography):

Patient Journey	Impact/Benefit
Patient is transferred to the daycase unit attached to the cath lab at West Middlesex within 24 hours of emergency admission.	This will: 1) Meet best practice for high risk patientsre access to diagnostic angiogram within 24 hours 2) Reduce length of stay by at least 24 hours compared to current
Post procedure the patient is transferred back to C+W the same day.	Against current benchmarks this reduces overall length of stay in hospital by between 24-48 hours
Patient remains under care of single clinician taking responsibility for co-ordinating care including arrangements in the community	Evidence shows that more than half of heart failure readmissions are preventable and prompt access to high quality rehabilitation reduces death rates by 20-30%.

	The reduced length of stay, quicker access and enhanced support improve her chances of recovery and quality of life. Improved pathway improves NHS financial effectiveness by approx £800,000 p.a.

The opening of the lab will also relieve pressures across London. As well as immediate transfer issues for CWFT patents this capacity should improve overall access to heart failure and treatment across North West London. We currently have good relationships with other Trusts and the development has been undertaken collaboratively. There are joint contracts in place between CW and Imperial for community cardiology and common pathways for rapid access chest pain and other conditions.

Workforce

One of the key risks identified in the business case was the ability to recruit appropriately skilled staff. Cardiac technicians in particular have proved difficult to recruit. We have been lucky to have internal support from the Physiology department at both our partner sites.

We have a full team of enthusiastic nurses and radiographers, and have also employed two new Cardiology Consultants, which means that there are five consultants running lists in the lab.

The service

The development has improved morale across the service and implementation has been a success with a very happy clinical team, and satisfied patients. Our first patient commented “I feel like a VIP! The service from everyone today has been faultless. I really can’t praise the team here enough. I was very nervous arriving here this morning but have been made to feel comfortable and put at ease.”

We are currently ramping up our activity through diagnostic and pacing cases, and in a few months will move onto the interventions.

Case Study 2: Improving Local Sexual Health Services – 10 Hammersmith Broadway

Background

The West London Centre for Sexual Health (WLCSH) was previously located in Charing Cross Hospital. It was a highly regarded clinical service in an extremely sub optimal Estate. The business case to move to 10 HB was predicated on improving access for patients, a more appealing clinical environment and an opportunity to develop improved pathways in line with other areas of the Directorate (eg bring benefits of Dean Street to a more local environment).

Implementation

A summary of key steps and timelines is outlined below:

Action	Date
New premises identified	03.04.2014
Business Case Approval	18.12.2014
Construction commences	15.10.2015
WLCSH Closes	24.03.2016
Planned date of 10 HB Opening	04.04.2016
Re-design of pathways, use of staff/estate and diagnostic flow – including use of local GPs to offer elements of the service	Ongoing
HIV Services open	04.04.2016
HIV/GUM (phased opening)/SRH/Express open	11.04.2016
HIV/GUM/10HB Express opened to 90% Capacity	10.08.2016
Continued mobilisation and joint scrutiny of kpi's with local commissioners	Ongoing

PATIENT EXPERIENCE

Patient feedback on the service, recorded through the trust PALS office:

- *'Very positive, personal and super quick service. Very glad, it took 5 times less time to be seen than it was at Charing Cross Hospital. Thank you.'*
- *'I had a very comfortable screening today and conversation with the doctors was really nice and friendly. More of his team should be like him, because it makes it easy to give my personal information. Overall it's just nice to make people feel comfortable'*
- *I have been here twice and think it's a really great place. Well done to the people who work here for not making it awkward and making it easy going, safe and a non-judgemental environment. Thank you for being a reliable service (my GP is always busy and appointments are hard to come by), so it's nice to know that in an emergency I can rely on this service.'*
- *I've a really nice and smooth experience regarding my STD test. The whole process went so smoothly and I was seen by two very friendly lady nurses and one male nurse. I must say this si my best experience so far even better than Dean Street (express clinic)'*
- *'I had an appointment today as an emergency, and want to say how happy I was with my experience. They made every effort to make sure I was seen on the day and made me feel extremely comfortable, were very informative and helpful on so many levels. Additionally the whole building was great and all the staff were friendly.'*

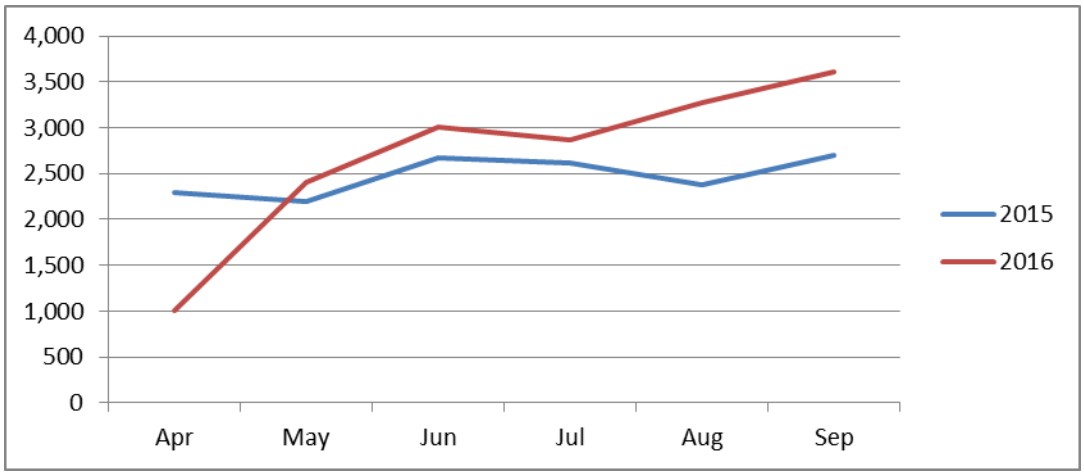
Overall patients are positive about the new clinical environment and very happy with the reduced time spent in clinic (previously an average of two hours, now reduced to 30 minutes).

Have improved access assumptions been reached?

Activity:

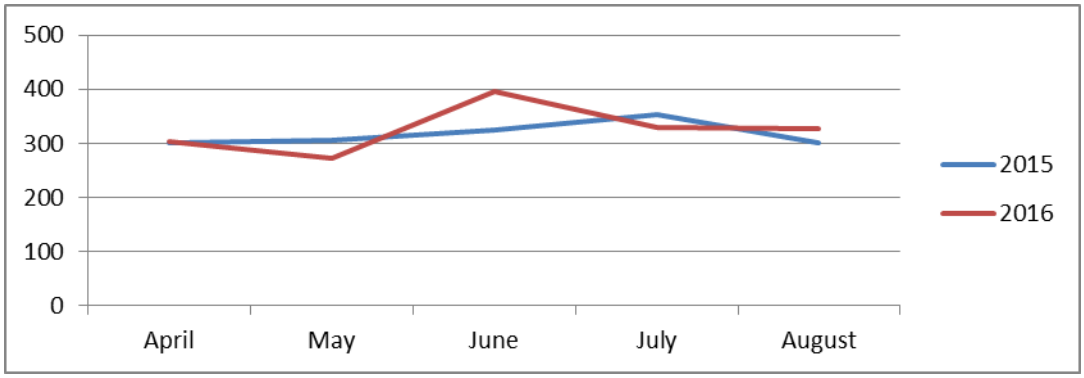
GU Activity – the GU Activity has been compared to the activity seen at the same time last year at the WLCSH.

	Apr	May	Jun	Jul	Aug	Sep
2015	2,300	2,196	2,670	2,612	2,374	2,706
2016	1,008	2,412	3,002	2,874	3,274	3,607
Movement	**(1,292)**	**216**	**332**	**262**	**900**	**901**
Target Activity	3,553	3,553	3,553	3,553	3,553	3,553
Variance	(2,545)	(1,141)	(551)	(679)	(279)	54



HIV Activity - HIV Activity has been compared to the number of booked appointments for HIV patients as seen at the same time as last year at the WLCSH.

Year	April	May	June	July	August	Total
2015	302	305	324	353	300	1584
2016	303	273	396	330	326	1624
Variance	1	-32	72	-23	26	40

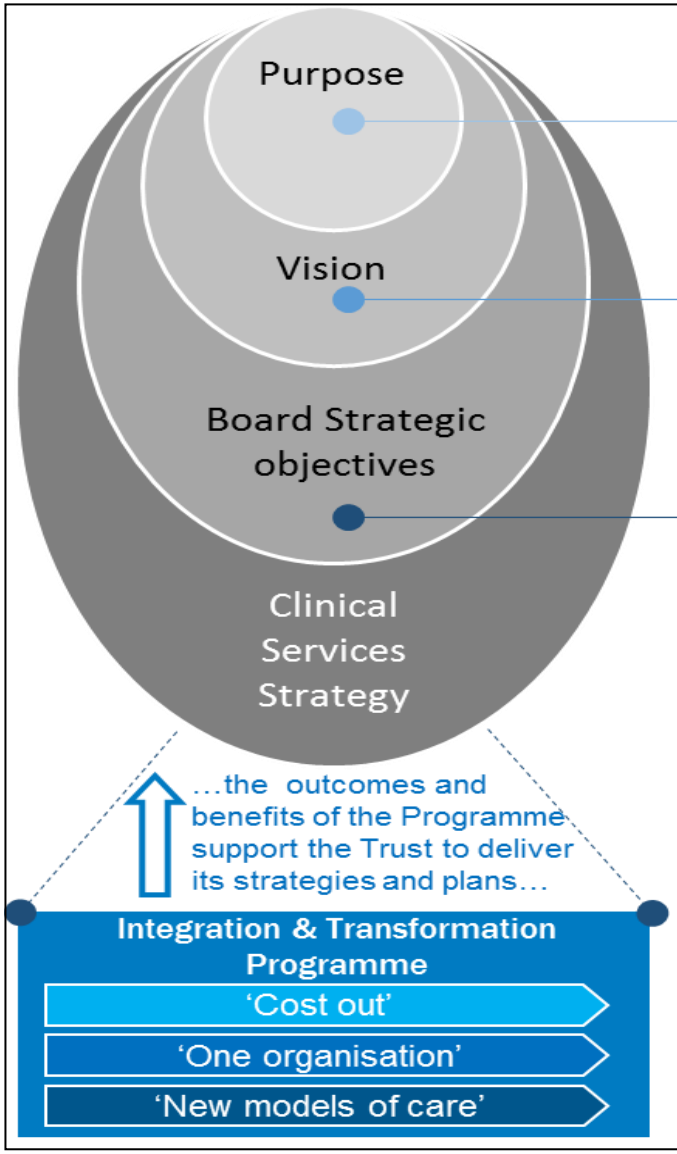


NB Activity is applied and billed to registered population and not to host.

Conclusion

Accepting that activity was lower than previous baselines during mobilisation there is now evidence that this locally focussed initiative is on trend to improve activity against previous levels and to improve user experience

Appendix 2 – Integration & Transformation Programme Outline in context of Trust Clinical Services Strategy



- Provide the best possible patient experience and care for the communities we serve

- Be the first choice for care and first choice to work for
- Be the highest quality local secondary care provider and a leading provider of women's, children's and sexual health services
- Be a champion of modern innovative healthcare

1. Excel in providing high quality, efficient clinical services
2. Improve population health outcomes and develop integrated care
3. Deliver financial sustainability
4. Create an environment for learning, discovery and innovation

i. Maintain quality standards and access to local acute care to our population (economically and at scale)
ii. Grow local elective care and protect access to specialised services for our local population (economically and at scale)
iii. Integrate care pathways and lay the foundations for community care through the accountable care programme
iv. Maintain and strengthen tertiary paediatric, women's and HIV services
v. Develop diverse income streams that ensure financial sustainability and enable investment in quality and innovation.

Appendix 3 – Integration & Transformation Programme Financial Benefits - £122m (Original submission to Monitor pre-acquisition)

	Value (£m, recurrent, nominal)			
Theme	**Years 1-2**	**Years 3-5**	**Total**	**Further information available in:**
Detailed standalone CIPS				
CWFT standalone	23.0		23.0	Kingsgate report, CWFT CIP tracker/PIDs
WMUH standalone	9.9		9.9	WMUH CIP tracker/PIDs
Acquisition synergies				
Corporate	5.7	0.4	6.1	Acquisition synergy summary/PIDs
Service developments	2.4	7.5	9.9	Acquisition synergy summary/PIDs
Clinical standardisation	3.0		3.0	Acquisition synergy summary/PIDs
IMT/EPR enabled savings		21.0	21.0	Acquisition synergy summary/PIDs
Inflationary impact	(0.1)	(0.2)	(0.3)	Acquisition synergy summary/PIDs
Further themes				
2m per year CW procurement savings		6.0	6.0	
1m per year CW estates savings		3.0	3.0	
£0.5m per annum CW temp staffing savings		1.5	1.5	
NWL pathology JV (3m WMUH, 4m CW)		2.7	2.7	Pathology business case
Balance from gross CIP opportunity		8.6	8.6	Kingsgate report
Further productivity opportunity CW and WM		6.0	6.0	OBC benchmarking
Sphere (economies of scale new members)		1.0	1.0	
Additional opportunities*		21	21	
Total	**44.0**	**74.3**	**122.4**	

Appendix 4 – Integration & Transformation Programme Financial Benefits - £122m (Updated for Finance & Investment Committee)

All figures taken from acquisition LTFM	15/16 £'k	TARGET 16/17 £'k	REVISED 16/17 £'k	CHANGE 16/17 £'k	17/18 £'k	18/19 £'k	19/20 £'k	Total £'k
Section 1: Service Improvement and Efficiency								
2015/16 and 2016/17 CIP								
CW two year CIP Plan	10,129	**12,809**						22,938
WM two year CIP plan	4,886	**5,031**						9,916
Years 1 and 2 CIP Plans	**15,014**	**17,840**			**0**	**0**	**0**	**32,854**
2017/18 to 2019/20 CIP								
Procurement Savings					2,000	2,000	2,000	6,000
Estates Savings					1,000	1,000	1,000	3,000
Temporary Staffing					500	500	500	1,500
NWL Pathology					1,996	365	369	2,730
Further productivity opportunity CW/WM					2,000	2,000	2,000	6,000
Sphere economies of scale							1,000	1,000
Additional opportunities					10,155	10,897	8,640	29,693
Years 3 to 5 CIP themes	**0**	**0**			**17,651**	**16,762**	**15,509**	**49,923**
Total Service Improvement and Efficiency	**15,014**	**17,840**	**19,150**	**1,310**	**17,651**	**16,762**	**15,509**	**82,777**
Section 2: Acquisition Synergies								
Clinical Standardisation	0	**3,045**	**3,045**	**0**	0	0	0	3,045
Corporate Synergies	1,275	**4,526**	**4,526**	**0**	198	38	188	6,226
Total Acquisition Synergies	**1,275**	**7,571**	**7,571**	**0**	**198**	**38**	**188**	**9,271**
Section 3: Service Developments								
Bariatric Surgery	0	**(227)**	**0**	**227**	23	503	0	299
Cardiology- Cath Lab	0	**2,104**	**248**	**(1,856)**	2,896	0	0	5,001
Ophthalmology	0	**(31)**	**0**	**31**	1,628	1,676	0	3,273
Physiological Measurement	0	**347**	**347**	**0**	411	0	0	757
Elective Orthopaedic Centre	0	**0**	**0**	**0**	0	(1,310)	1,078	(232)
Additional developments to be agreed			**500**	**500**				
Total Service Developments	**0**	**2,193**	**1,095**	**(1,098)**	**4,958**	**869**	**1,078**	9,099
Section 4: Transformation								
EPR enabled synergies	0	**0**	**0**	**0**	2,050	9,141	10,148	21,339
Total Transformation	**0**	**0**	**0**	**0**	**2,050**	**9,141**	**10,148**	**21,339**
Total Integration and Transformation Programme - 5 years	**16,290**	**27,604**	**27,816**	**212**	**24,858**	**26,810**	**26,923**	**122,486**
Cumulative total	*16,290*	***43,893***			*68,752*	*95,562*	*122,486*	

Appendix 5 – Board Assurance and Benefits Framework (inc measures of success)

CWFT Governance	Benefit Profiles	Benefit Category	Programme Workstream	Project Development Area(s)	Description	Programme Outcome	Programme Measures
Quality Committee	**Patient-Led Clinical Benefits**	Non-Financial	Corporate Integration	Quality Governance, Nursing & EPRR	Patient Care improves as the Trust creates Improved access, experience and patient advocacy for the communities it serves. Improved quality of services (safety, effectiveness, experience), with better outcomes and reduced variation.	2. Skill mix improved to be more efficient and/or effective	1) Increase in Patient Satisfaction scores
						4. Improved internal demand management of clinical support	2) Increase in Friends & Family Test (FFT) Scores
						5. More productive outpatient clinics	3) Reduction in Serious Untoward Incidents (SUIs)
						6. More productive theatres	
						7. Shorter length of stay	4) Increase in the number of, and usage of, digitised Patient Records as well as Individuals care plans.
			Clinical Transformation (including EPR)	Clinical Synergies (Standardisation)		8. Clinical pathways redesigned to enhance experience and quality of care and be more efficient and effective	
				Electronic Patient Record System (EPR)			
Finance & Investment Committee	**Financial**	Financial	Service Improvement & Efficiency	Cost Improvement Programme	Patient Care improves as the Trust is financially sustainable having reduced its deficit, increased its income and improved productivity to meet its goal of making a surplus as set out in the LTFM.	1. Decreased spend on temporary staffing	5) Increased Patient, Research, Commercial and Private Patient Income received during the 12 month period in comparison on last year.
						2. Skill mix improved to be more efficient and/or effective	
						3. Processes (clinical / corporate) standardised to be more efficient and effective and to address quality and regulatory requirements	

CWFT Governance	Benefit Profiles	Benefit Category	Programme Workstream	Project Development Area(s)	Description	Programme Outcome	Programme Measures
				Clinical Synergies (Standardisation)		4. Improved internal demand management of clinical support	
						5. More productive outpatient clinics	
						6. More productive theatres	6) A reduction in recurrent budgeted costs and a reduction in unplanned expenditure & Fines during the 12 month period in comparison on last year.
				Corporate Synergies		7. Shorter length of stay	
						8. Clinical pathways redesigned to enhance experience and quality of care and be more efficient and effective	
						9. Sustained Income growth	
						10. Sustained Income capture	
People & Organisation Development Committee	**Staff Benefits**	Non-Financial	Corporate Integration	Corporate Restructuring, Organisational/ Learning & Development	Patient Care improves as the Trusts' workforce is highly motivated, productive and goes above and beyond which leads to improved staff retention /satisfaction.	1. Decreased spend on temporary staffing	7) Increased staff satisfactions scores
						2. Skill mix improved to be more efficient and/or effective	8) Increase in staff retention rates (decrease in staff turnover)
Quality Committee	**Governance & Compliance Benefits**	Non-Financial	Corporate Integration	Corporate & Quality Governance	Patient Care improves Trust is meeting all mandatory guidelines and compliance performance indicators.	3. Processes (clinical / corporate) standardised to be more efficient and effective and to address quality and regulatory requirements	9) Greater compliance with the CQC 5 Domains
							10) Improvement in Monitor Risk Rating score

London Borough of Hammersmith & Fulham **HEALTH, ADULT SOCIAL CARE AND SOCIAL INCLUSION POLICY & ACCOUNTABILITY COMMITTEE** **20th October 2016**	
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 Health, Adult Social Care and Social Inclusion Policy and Accountability Committee and was previously considered by the Health and Wellbeing Board, at it's meeting held on 7th September 2016.

1.2. The Health, Adult Social Care and Social Inclusion Policy and Accountability Committee 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, Adult Social Care and Social Inclusion Policy and Accountability Committee 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, Adult Social Care and Social Inclusion Policy and Accountability Committee 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, the Health, Adult Social Care and Social Inclusion Policy and Accountability Committee members note and 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.

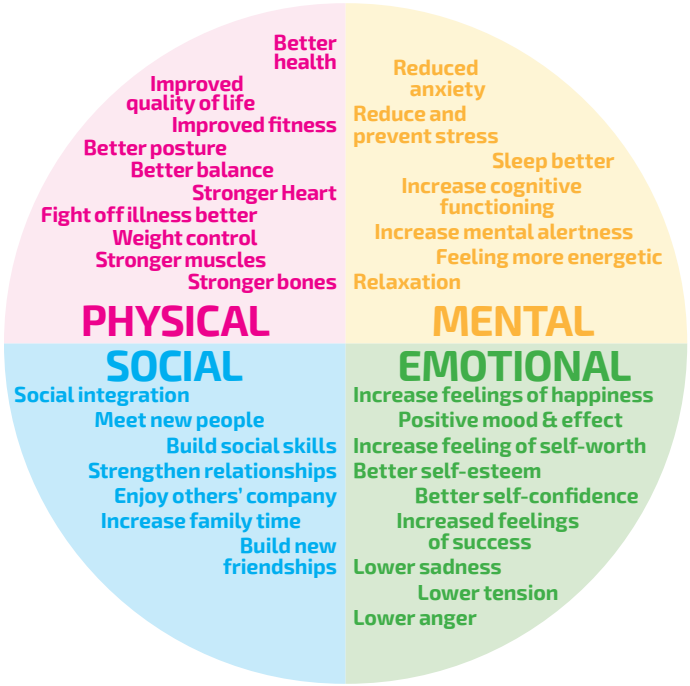
The more we move, the greater the benefit. Encouraging those who are inactive to embrace a significant level of activity would have the greatest benefit, but any shift helps.

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.

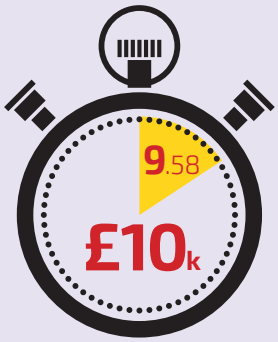
The benefits don't stop there. The figure below shows a wide range of health and wellbeing benefits to individuals.



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

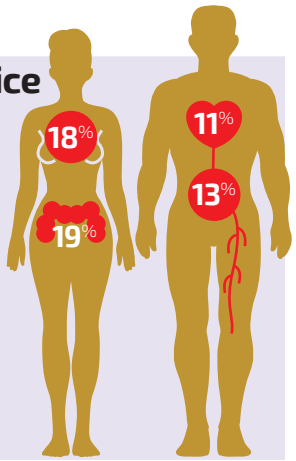


Table 1: Estimated costs to health care services attributable to physical inactivity [7]

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.

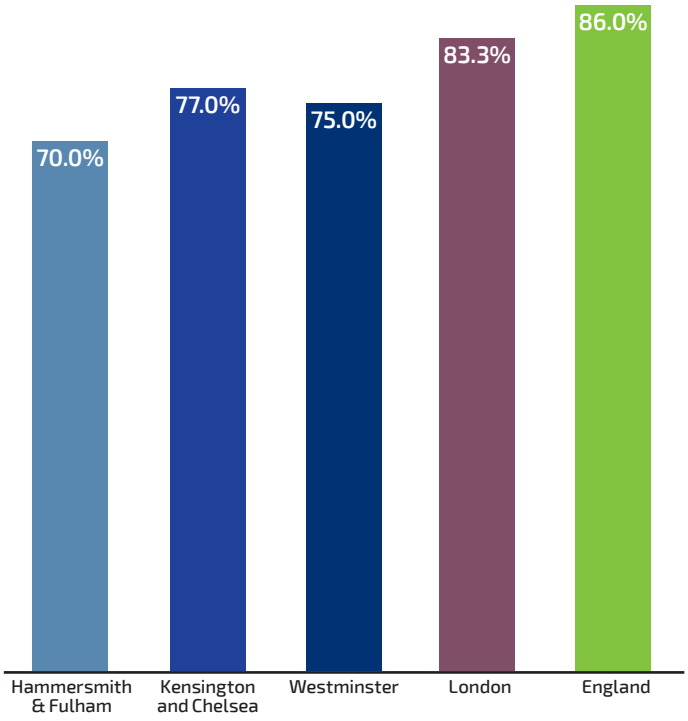


Figure 1: The percentage of state school children in Year 1-11 participating in at least two hours of high quality PE or school sport in a typical week (TNS Social Research, Annual Survey of School Sports Partnerships 2009/2010)

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.

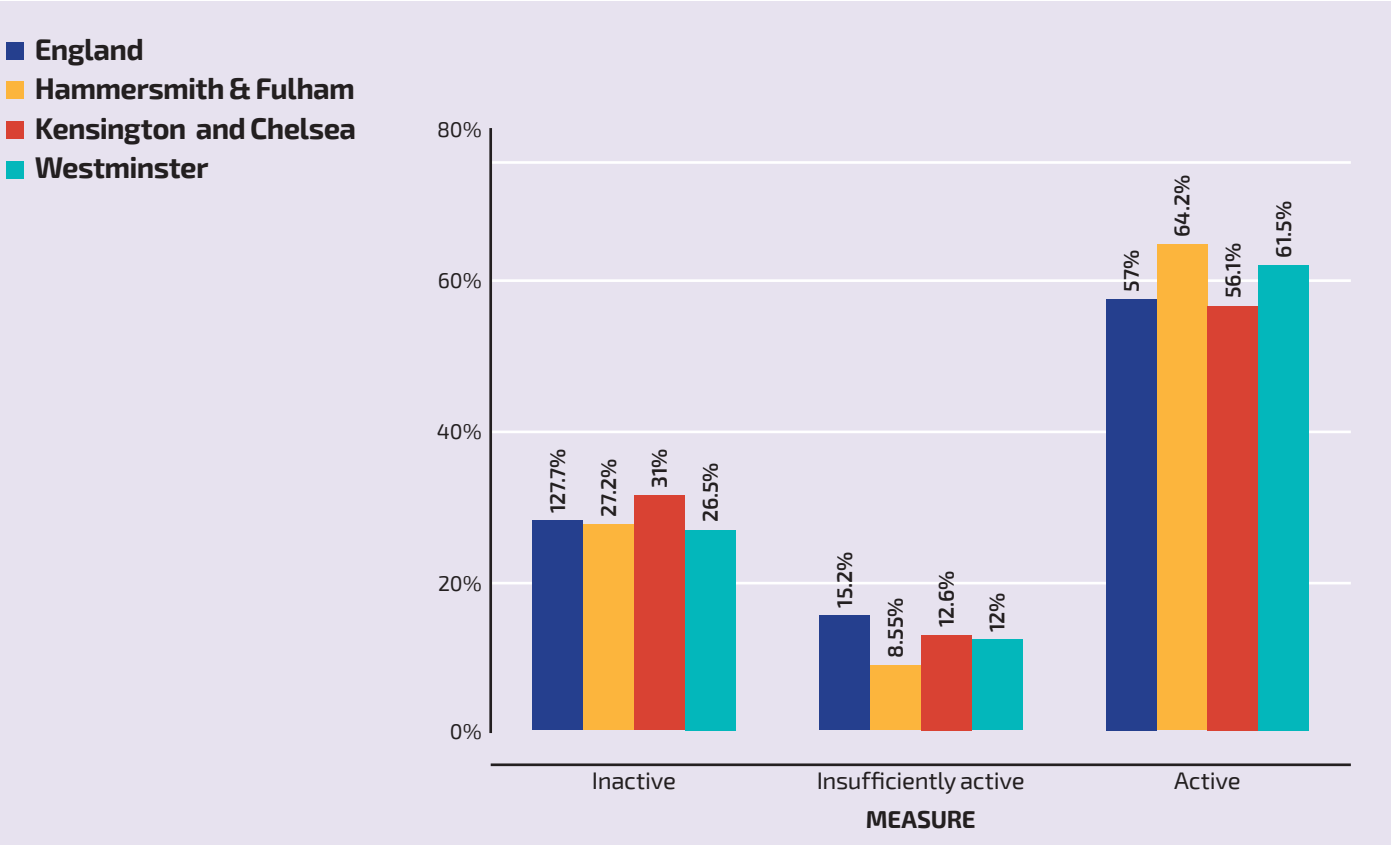


Figure 2: The percentage of adults (aged 16+) in the three Boroughs classed as Active, Insufficiently Active, and Inactive, compared with England (Source: Active People's Survey 2014/15)

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	Regional average^ / England Average / England Range (England Worst, 25th Percentile, 75th Percentile, England Best)	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

hammersmith & fulham

THE ROYAL BOROUGH OF
KENSINGTON
AND CHELSEA

City of Westminster

London Borough of Hammersmith & Fulham **HEALTH, ADULT SOCIAL CARE AND SOCIAL INCLUSION POLICY & ACCOUNTABILITY COMMITTEE** **20 October 2016**	
WORK PROGRAMME 2016-17	
Report of the Chair	
Open Report	
Classification: For review and comment **Key Decision:** No	
Wards Affected: All	
Accountable Executive Director: Kim Dero, Director of Delivery and Value	
Report Author: Bathsheba Mall, Committee Coordinator	**Contact Details:** Tel: 020 87535758 E-mail: bathsheba.mall@lbhf.gov.uk

1. EXECUTIVE SUMMARY

1.1 The Committee is asked to give consideration to its work programme for the municipal year 2016/17.

2. RECOMMENDATIONS

2.1 The Committee is asked to consider the proposed work programme and suggest further items for consideration.

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

None.

LIST OF APPENDICES:

Appendix 1 – Work Programme 2016-17

Appendix 1

Health, Social Care and Social Inclusion Policy and Accountability Committee

Item – Report Title	Report Author / service	Status
20th October 2016		
Chelsea and Westminster Hospital NHS Foundation Trust: Integration with West Middlesex Hospital	ChelWest and West Middx NHS Trust	
Listening To and Supporting Carers	TBC	
JOHSC Update	Governance and Scrutiny	
2 November 2016		
Digital Inclusion Strategy	Policy / Housing	
End of Life Care: JSNA and CLCH to Update on Action Plan		
12 December 2016		
West London Mental Health Trust: Update	WLMHT	
Community Independence Service		

Items for future agenda planning:

- Meal Agenda
- Impact of devolution on Local Health Services
- Commissioning Strategy: Providers
- Community Champions
- Customer Journey: Update
- Equality and Diversity Programmes and Support for Vulnerable Groups
- H&F CCG Performance
- H&F Foodbank
- Immunisation: Report from the HWB Task and Finish Group
- Integration of Healthcare, Social Care and Public Health
- Listening To and Supporting Carers
- Public Health Report
- Self-directed Support: Progress Update
- Antibiotic prescriptions