London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Agenda

Wednesday 8 February 2017
6pm
Courtyard Room - Hammersmith Town Hall

MEMBERSHIP

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

Ian Lawry – SOBUS (Co-Opted Member)

Nominated Deputy Members:

Councillor Rory Vaughan
Councillor Sharon Holder
Steve Miley, Director for Family Services (attending on behalf of Clare Chamberlain)

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Date Issued: 30 January 2017

London Borough of Hammersmith & Fulham

Health & Wellbeing Board
Agenda

8 February 2017

Item		Pages
1.	**MINUTES AND ACTIONS**	1 - 10

(a) To approve as an accurate record and the Chair to sign the minutes of the meeting of the Health & Wellbeing Board held on Monday, 14th November 2016.

(b) To note the outstanding actions.

2. APOLOGIES FOR ABSENCE

3. DECLARATIONS OF INTEREST

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

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

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

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

4. JSNA PROGRAMME UPDATE: YOUNG ADULTS JSNA, ONLINE JSNA HIGHLIGHT REPORTS AND JSNA FORWARD PLAN 11 - 101

This report provides an update on the current JSNA work programme and outlines proposals for future projects. The paper presents two JSNA products for consideration and approval by the Health and Wellbeing Board.

5. PHARMACEUTICAL NEEDS ASSESSMENT 102 - 108

This report outlines the responsibility of the Health and Wellbeing Board to publish a Pharmaceutical Needs Assessment (PNA) for Hammersmith and Fulham. The report also describes the purpose and requirements for the PNA and outlines local arrangements to produce the PNA.

6. HAMMERSMITH AND FULHAM JOINT HEALTH AND WELLBEING STRATEGY: DELIVERY AND IMPLEMENTATION PLANNING 109 - 146

This report provides an update on progress to date in relation to the development of a Delivery Plan for the Hammersmith and Fulham Joint Health and Wellbeing Strategy 2016-21. The Board is asked to endorse the proposed approach in taking this work forward.

7. BETTER CARE FUND 2017/18 147 - 150

This report provides an update to the Health and Wellbeing Board on progress towards developing the Better Care Fund arrangements for 2017/18.

8. DELEGATED PRIMARY CARE COMMISSIONING 151 - 153

This report provides an update to the Health and Wellbeing Board on primary care delegation. Members of the Health and Wellbeing Board are asked to note the paper.

9. QUALITY PREMIUM: 2016/17 UPDATE AND 2017/18 PLANNING 154 - 163

The Quality premium is intended to reward CCGs on the basis of achieving a number of key improvements and is paid to CCGs annually, based on performance against measures that incorporate a combination of national and local priorities. The submission date for the 2017/18 Quality Premium the date is to be confirmed but expected to be February or March.

10. WORK PROGRAMME 164 - 167

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

11. DATE OF NEXT MEETING

The Board is asked to note that the final meeting date scheduled for the municipal year 2016/2017 is as follows:

Monday, 20 March 2017

London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Minutes

Monday 14 November 2016

PRESENT

Committee members:
Councillors Vivienne Lukey (Chair)
Vanessa Andreae, H&F CCG
Janet Cree, H&F CCG
Dr Mike Robinson, Director of Public Health
Keith Mallinson, H&F Healthwatch Representative

Nominated Deputies Councillors:
Councillors Rory Vaughan and Sharon Holder

Officers: Helen Banham, Strategic Lead, Professional Standards and Safeguarding, Westminster City Council, Angela Caulder, Joint Commissioning Manager, and, Dr Meenal Sohani, Consultant Child Psychiatrist, Hammersmith and Fulham CAMHs, West London Mental Health Trust, Jean Daintith, Independent Chair, LSCB, Harley Collins, Health and Wellbeing Manager and Bathsheba Mall, Committee Co-ordinator.

72. MINUTES AND ACTIONS

The minutes of the meeting held on 7th September were agreed as a correct record.

73. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Sue Fennimore, Liz Bruce, Stuart Lines, Tim Spicer and Ian Lawry.

74. DECLARATIONS OF INTEREST

None.

75. DRAFT ANNUAL REPORT OF THE LOCAL SAFEGUARDING CHILDREN BOARD

Councillor Vivienne Lukey welcomed Jean Daintith, Independent Chair of the Local Safeguarding Children's Board (LSCB), accompanied by Emma

Biskupski, LSCB Business Manager. Detailing the background to the draft annual report, it was explained that there was a requirement for it to be submitted to several agency and organisational lead officers including the Chief Executive and the Health and Wellbeing Board (HWB). This was the 4th Annual Report of the LSCB, covering LBHF, RBKC and WCC. It was explained that the LSCB oversees a partnership arrangement, comprising of sub-groups and individual boards for each borough.

This year they had undertaken a range of activities including two task and finish short life working groups, one focusing on neglect, and a second on parental mental health, with lead officers from Children's Services and mental health colleagues working collaboratively to support the process. It had been a busy year, with 5 serious case work reviews being undertaken, together with a n inspection of children's services in the three boroughs and the LSCB received a "good" rating and given five recommendations. A different approach had been taken to producing the Annual Report for 2015/16 and partner organisations had each been invited to draft their own sections and account for themselves. The report also set out what has been achieved in the past year and future direction of travel in the context of the significant changes planned by government and the introduction of the children and social work bill, currently going through Parliament. These changes were not anticipated to be implemented prior to 2018 but police, local authorities and health agencies to would positioned to lead on child safeguarding.

Ms Daintith explained that this was her fifth year of chairing the LSCB and that she had taken a decision to step down. Interim arrangements had been made to begin the process of appointing a new independent chair.

Janet Cree commented that she would have had sight of the Annual Report through the CCG Quality Committee, as well as through the HWB, welcomed the report. However, she also recommended that the section on Ofsted recommendations be set out more clearly in a separate box, making them more accessible. Ms Daintith explained that prior to the inspection, she had been concerned about demonstrating a clear link both through the governance arrangement with the HWB but also a shared agenda. Going forward, they aimed to reduce the bureaucracy around having multiple meetings with the same individuals, a process which was already happening organically as they now worked across the partnership groups within the three boroughs, focusing on areas of local concern. Examples of reporting arrangements in other parts of the country had shown great synergy between the LSCB and HWB in term of taking forward key concerns. Ms Daintith felt that the LSCB was effective and benefitted from strong partnership arrangements, a sharing of good practice and an ability to work well together.

Councillor Rory Vaughan expressed interest in the case review and commented that it was helpful to add perspective by including more detail about the points of learning and how these are translated into practice. Referring to page 159 of the report and the LSCB training offer being amended where required to incorporate learning, did not offer a flavour of how that learning was implemented. Ms Daintith explained that the amount of time spent on serious case reviews was not reflected in the short paragraph.

Whilst it was accepted that the learning points were actively noted and followed up, Cllr Vaughan responded that their inclusion at the back of the report was meant they were hidden and that given the interest to the lay reader, these could be given greater prominence.

Councillor Lukey referred to the structure of the report and each section being written by individual agencies. She welcomed the fact that each had made reference to the joint working arrangement that they engaged in. Councillor Lukey also expressed interest in the section on "MASH" (Multi-Agency Safeguarding Hub) which, given its importance, could have been expanded. Councillor Lukey enquired about the level of joint working and also, what work had been undertaken to avoid duplication. Responding to the query about the MASH, Ms Daintith acknowledged that this was short and that the MASH that operated in the three boroughs was very good. The MASH was led by the police, and involved ASC and health colleagues. However, some weaknesses had emerged resulting from changes to the probation service and the community rehabilitation company (CRC) which worked with the largest number of offenders. The LSCB had undertaken some development work with the CRC to ensure that the new arrangements were picked up at a local level and that the CRC were on board with what the LSCB were trying to achieve. Ms Daintith continued, reporting that the that there was a good representation from all the statutory agencies, including the prison service and health colleagues, in particular. Any non-attendance was picked up at the Board sub-group. The changes to the Metropolitan Police at a local level will have an impact on the arrangements. The Police will need to be a lead in the future and from January 2017, will meet with the Director of Children's Services and Jonathan Webster from the North West London Collaboration of CCGs to embed strong partnership working during the transition period of her departure and the new temporary independent chair and the new arrangements becoming clear.

Steve Miley, Director of Family Services, responded to issue of possible duplication of services, and explained that the LSCB had brought together leaders from across the three boroughs partnership group, which overall, had ensured positive local discussion without duplication. This was understood to be less about duplication and more about seeking to reduce unnecessary bureaucracy, with the aim of creating more effective interventions by giving professionals greater freedom to work flexibly.

Sarah McBride, Director of Partnerships, ASC, referred to page 130, listing the component parts of the system (NHS England, CCGs, NHS trusts and other providers) and the section under which primary care was represented (currently referred to in part under NHS England). Primary care was a main touch point in the community and many were depended upon it as building block for future development. Ms McBride suggested that further thought be given as to how the report for next year could represent that sector more clearly. Jean Daintith explained that the LSCB had designated doctors and nurses from the acute trusts from the CCGs, respectively. At a local level there were GP's and there was additionally some attendance from NHS England. Several serious case reviews had involved looking at GP practice and whether this had been good enough, particularly if there had been co-

ordination around patient records and operational understanding of mental health referrals.

Councillor Lukey thanked Ms Daintith for an informative report and commended her for her work as the Independent Chair of the LSCB.

RESOLVED

That the report be noted.

76. CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH TRANSFORMATION - UPDATE REPORT

Councillor Lukey welcomed Angela Caulder, Joint Commissioning Manager, and, Dr Meenal Sohani, Consultant Child Psychiatrist, Hammersmith and Fulham CAMHs, West London Mental Health Trust. The report integrates the findings of Councillor Alan D'Aths Child and Adolescent Mental Health Taskforce Report 2016 (Appendix 1) and the development of the CAMHS transformation plan. In 2015, the CCGs in collaboration with local authorities, agreed proposals to improve mental health services for young people, which included establishing a community eating disorder service for under 18s, and, to 'transform' local mental health services for young people in line with the recommendations made in 'Future In Mind'. Angela Caulder highlighted the following 3 achievements and three next steps:

- The eating disorders service, established on 1st April 2016, in collaboration with Ealing and Hounslow CCGs, as a hub (Ealing) and spoke (Glenthorne Road, LBHF) model. This was as self-referral service, with cases being seen within four weeks, and, a one week wait for urgent cases and linked to the CAMHS national specifications for eating disorders. This was a national incentive with the CAMHs transformation money to develop services for children with eating disorders such as anorexia nervosa;

- Out of hours' service, working with 8 CCGs across North West London, involving both Central and North West London Foundation Trust (CNWLFT) and the West London Mental Health Trust (WLMHT). The service had recently been reviewed and evaluated by both the trusts and LBHF children and young people champions, and received positive feedback. Both services were now embedded and would be available across all 8 collaborative CCGs in 2017/19;

- The H&F schools pilot, a successful bid to become one of fifteen national sites. This linked ten schools together with CAMHS provision from the West London Mental Health Trust, with two hours per week in school (with a specially trained mental health lead in each school) and several young people seen in school, with a further four schools added to the programme, now extended to March 2017.

A related or linked achievement was the co-production work with local children and young people champions (aged between 16-20). These were young people who had either direct or indirect personal experience of living with mental health problems. They had been evaluating the services, delivering training with colleagues from WLMHT, in the successful LBHF schools pilot in 2016. In addition, Ms Caulder reported that a young peoples conference had been held at RBKC Town Hall, attended by children from LBHF with an opportunity to share experiences and meet young social media stars. Dr Meenal Sohani explained that as part of the national school links pilot project, H&F CCG were successful in their bid to work with WLMHT in developing links with 14 schools in the borough, both primary, secondary and alternative provision. Linking with the lead in each school, clinicians offered training and consultation to the staff, organising drop in sessions for pupils or guidance for parents. Feedback to date has been positive and the service well received.

In terms of next steps, Ms Caulder explained that they were keen to work with LBHF on the development work planned around integrated family support services. A second objective was to develop a sustainable training work programme for the children and young people work force, to be accessible through an online database offering training on a range of mental health issues, and would be available from April 2017. A third objective was a further increase in co-production activities, this time including parents and their feedback from children with complex needs. A resources guide using the experience of children was also being developed.

Dr Sohani added that the redesign of clinical pathways, applying some of the allocated transformation money to reduce waiting times and avoid duplication. A workshop with key partners was planned on how they could work together to achieve this. Ms Caulder referred to the plans to pilot a tapered transition model and would work closely with WLMHT.

Co-optee Keith Mallinson commented that he welcomed the report and expressed concern about the barriers to services. It was essential that parents were included in the process and hoped that H&F partnership working would help shape services become more accessible.

Councillor Sharon Holder commended the report but took the view that reported well on specific areas but there was concerned that feedback from the schools or the evaluation from the children and young people champions was not included. Ms Caulder explained that this had been because the pilot had not yet concluded so there was currently no local or national evaluation available. It was anticipated that this would be reported more fully around June 2017. A service users forum was also being set up to enable regular feedback.

Responding to a comment on transitioning from Vanessa Andreae, NW London CCG, Ms Caulder explained that research from Anna Freud showed that the small number of young people transitioning to adult mental health services do not often experience difficulties and that the process is usually

well co-ordinated. Referring to the tapered transition model, it was noted that the pilot would begin small, and start with a pooled budget next year.

Councillor Lukey referred to paragraph 6.20 of the report and enquired about the number of children currently occupying beds in adult facilities. It was confirmed that there was currently one young person, with complex and challenging needs currently placed in an adult facility, with appropriate safeguarding measures in place. Ms Caulder acknowledged that there were concerns about transition, social care and EHC (Education, Health and Care) plans to the age of 25 years but noted that there was a disconnect for plans to 18 years. The pooling of budgets to help address this might be the way forward and Ms Caulder was keen to engage with officers in Adult Social Care to develop this approach.

Dr Mike Robinson, Director of Public Health commented that the four priorities set out in the draft Health and Wellbeing Strategy were all relevant to work currently being undertaken through CAMHs. He observed that 75% of all long term conditions (LTC) in adults originated in childhood and that early intervention and prevention could mitigate against this. He asked what could the HWB do to help reduce the number of LTC relating to mental health in children and highlighted the need for a differently focused report that could explain which measures successfully addressed this. Ms Caulder referred to the "Future In Mind" (2016) report recommendations detailing early intervention and prevention. It was explained that much of the CAMHs transition plan was about building capacity with the aim of picking up referrals early and additionally, delivering very basic and effective interventions for children in frontline services, preventing the development of LTC in adult life.

RESOLVED

That the report be noted.

77. SAFEGUARDING ADULTS EXECUTIVE BOARD ANNUAL REPORT 2015/16

Councillor Lukey welcomed Helen Banham, Strategic Lead, Professional Standards and Safeguarding, Westminster City Council, who presented the third annual report of the SAEB, working across the three boroughs. Ms Banham explained that the report set out the operational arrangements for working with the key statutory agencies involved were: the local authority, police and health professionals including directors of public health, NHS trusts, including The Royal Marsden, Imperial, West London Mental Health Trust, Central and North West London and Central London Community Healthcare.

Thirteen cases serious (death or harm to an adult) safeguarding case reviews (Care Act 2014, S.45) had been conducted (with one predating 1st April 2016). Ms Banham explained that this was one of most important areas of work undertaken. This would not be possible without out the willingness of agencies to share information and there had not been a need to force compliance with S.45, which was well evidenced across the partnership.

The report focused on the accountability of health organisations and patient safety, and Ms Banham explained that residents were at the very heart of safeguarding. To illustrate, two consultation events were held (November 2015), with feedback used to inform and develop the House Strategy. The role of community champions was also essential to ensure local input. Whilst the role of community champion, it was important to be aware of how issues such as domestic violence and mental health concern, had a significant impact on the individuals who took on such roles. The SAEB has also focused on financial abuse and the scamming of older or vulnerable adults. Valerie Simpson from Trading Standards had recently been appointed to the SAEB.

Keith Mallinson expressed concern about safeguarding issues arising in Wormwood Scrubs prison. He commented that the conditions within the prison were disgraceful and that prisoners experiencing abuse and neglect were reluctant to come forward. He hoped that agencies that represented them such as the prison and the probationary services would be challenged. Ms Banham responded that this had been a priority for Mike Howard, Independent Chair of the SAEB. He had attended Wormwood Scrubs in order to secure representation from the prison on the SAEB, and whilst he was mindful of the seriousness of the concerns raised, there was currently no easy solution.

Councillor Vaughan commented that he had been impressed by the report when it had recently been presented to the Health, Adult Social Care and Social Inclusion Policy and Accountability Committee (HASCSIPAC, 20th October 2016) and welcomed the approach of focusing on a single theme throughout the year, which in this case had been financial scams and fraud. Councillor Lukey added that it would be helpful if there could be further exploration of cases of hoarding, as these had resulted in the case of two (unrelated) deaths in Earls Court. Ms Banham observed that adult safeguarding was a vast area of work and the report could only offer brief insight into the work undertaken. The focus this past year had been on those issues highlighted as important to residents. Referring to the hoarding cases, Ms Banham explained that worked closely with colleagues from housing and environment and the London Fire Brigade in terms of reducing the risk.

In terms of priorities, Ms Banham explained that what they had learned from serious case reviews was ensuring that individuals were in receipt of the right sort of care. To illustrate, behaviour that was difficult to manage in a care home such as dementia. It was essential to have early discussions to avoid having to make urgent decision during a crisis or episode.

Councillor Lukey thanked Ms Banham for the report, noting that the report had been presented to HASCSIPAC it was acknowledged the challenges involved in avoiding duplication.

RESOLVED

That the report be noted.

78. DEVELOPING THE JOINT HEALTH AND WELLBEING STRATEGY

Councillor Lukey welcomed Harley Collins, Health and Wellbeing Manager, who presented the report. This was a joint report between the Council and the CCG and set out the development details of the Joint Health and Wellbeing Strategy, 2016-21 and emerging priority areas including mental health, children, young people and families and long term conditions. The development process had been structured in three phases: The first, from January to March, involved a large scale review of the evidence of need; the second phase, covering April-May, included a series of workshops with patients and stakeholders; the third phase has included a fourteen-week period of public consultation during July-October.

It was explained that consultation and engagement has been a key principle throughout all stages of the work. During the public consultation, an online questionnaire was set up and sent to over 500 local organisations. 40 responses had been received from a mixture of businesses and individual residents. Responses indicated strong support for the four draft priority areas and for a preventative approach that sought to proactively keep people well rather than reactively treat people who are sick.

Feedback had been received as the report had navigated governance processes from within the Council. The report had been considered by the Business Development Team, which had sought greater reference in the report to the link with social inclusion, the Worklessness and Poverty Commission report and reference to the regeneration work undertaken in Children's Services and across the Council. HASCSIPAC (20th October 2016) had highlighted the lack of reference to older people as a separate, 5th priority, which was currently being considered. Further comments from the Committee included references to welfare reform and the need to formulate a communications strategy and implementation plan.

Vanessa Andreae commented that the strategy would require monitoring in terms of measuring precisely how it would impact on outcomes and make a difference. Councillor Lukey explained that this would be the next phase of work, to develop detailed operational and implementation plans, with examples of how we might deliver, key performance indicators and with more information about outcomes. Vanessa Andreae responded that the strategy was detailed and outward facing but that it was important to recognised that it should not be promising to deliver outcomes that had not been considered. Any statements would need to be clearly evidence based and benchmarked. Mr Collins confirmed that the next phase would more closely involve Public Health and commissioning colleagues in developing a 'dashboard' which would guide the work of the Board. Councillor Lukey added that this was intended to be a high level documents, with the next step being to translate it into a delivery plan.

Commenting on the governance arrangements, Ms Andreae highlighted the need to consider to properly signpost the reporting arrangements. Sarah

McBride responded that it was important to note that HWB was not the delivery vehicle for the JHWS, it's role was to monitor and ensure proper governance.

Councillor Vaughan recapped some of the points of the discussion around priorities. It was acknowledged that it was important to understand how services were making a difference and affecting the required outcomes. Councillor Vaughan concurred that the next phase would be prove more difficult and took the view that it worth reflecting on whether older people should be a 5th priority. He also expressed interest in applying indicators as to how outcomes had improved. Ms Andreae commented that children and young people were selected as a single priority (Giving children and families the best possible start), older people could be referenced in three of the other priorities, particularly LTC and social isolation and loneliness, which were key borough priorities. Ms Andreae speculated as to whether older people could be articulated into one of the existing areas. Ms McBride endorsed the comments, noting that the whilst there should be reference to prevention and treatment there was a risk that the strategy would be too broad. It was accepted that it would be helpful to set aside time in January to articulate a development plan. It was anticipated that the strategy would be signed off by the end of the year but it was recognised that some realignment was required to include the concerns of older people more clearly, whilst at the same time, not offer too much in terms of what was deliverable.

RESOLVED

1. That the Health and Wellbeing Board endorse the Joint Health and Wellbeing Strategy; and

2. That the report be noted.

79. WORK PROGRAMME

The Board noted that the date of the next meeting had been brought forward and would take place on 8th February and not 13th February. Harley Collins informed the Board that some updates to the forward plan would be required and that a date for a development session to discuss the JWBS would be scheduled.

RESOLVED

That the reported be noted.

80. DATES OF NEXT MEETINGS

The date of the next meeting would be 8th February 2017.

Meeting started: 6pm
Meeting ended: 8:20pm

Chair .....

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London Borough of Hammersmith & Fulham **Health and Wellbeing Board** **08 February 2017**	
JSNA Programme Update: Young Adults JSNA, Online JSNA Highlight Reports and JSNA Forward Plan	
Report of the Director of Public Health	
Open Report	
Classification - For Decision and Information **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: Liz Bruce, Executive Director of Adult Social Care and Health	
Report Author: Jessica Nyman, JSNA Manager	**Contact Details:** Tel: 020 7641 8461 E-mail: jnyman@westminster.gov.uk

1. EXECUTIVE SUMMARY

1.1. This report provides an update on the current JSNA work programme and outlines proposals for future projects. The paper presents two JSNA products for consideration and approval by the Health and Wellbeing Board:

- The Young Adults (18-25) JSNA report and recommendations
- The JSNA Highlights Report online version.

1.2. This paper also asks for the Board's endorsement of the JSNA programme's forward plan:

- Deep Dive JSNA on Children with Complex Needs
- The Pharmaceutical Needs Assessment (PNA) refresh, which will be expanded on in a separate paper.

2. RECOMMENDATIONS

2.1. The Health and Wellbeing Board is requested to consider and approve the Young Adults JSNA for publication.

2.2. The Health and Wellbeing Board are invited to comment on the content and user experience of the **JSNA Highlight Report** (Online JSNA), and

share within their respective organisations after the Board meeting.

2.3. The Health and Wellbeing Board are requested to approve that data in the JSNA Highlights Report (Online JSNA) is updated by the Public Health Intelligence team on a rolling basis as and when it becomes available, and provide an annual summary of changes made to the Health and Wellbeing Board.

2.4. The Health and Wellbeing Board is requested to consider and approve proposals for the future JSNA work programme for 2017/2018, incorporating the Children with Complex Needs JSNA and the refresh of the Pharmaceutical Needs Assessment for 2018, which will be explained in detail in a separate paper.

3. INTRODUCTION AND BACKGROUND

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

3.2. This report provides an update of the current JSNA work programme for 2016/17 and a look forward to the 2017/2018 work programme. Two JSNA products are presented for approval prior to publication:

- Young Adults (18-25) JSNA
- JSNA Highlights Report

4. CURRENT JSNA WORK PROGRAMME (2016/17)

Young Adults JSNA

4.1. This deep dive JSNA has looked at the health and wellbeing needs of young adults. The focus is on the needs of 18-25 year olds, but where appropriate has also looked at 16-17 year olds preparing for transition from children's services to adults services.

4.2. The key objectives of this JSNA are:

- To capture the unique health and wellbeing needs and issues affecting young adults age 18-25s.
- Identify the provision and gaps in provision of services for young people.
- To identify how to improve early interventions in issues which could affect people's long term outcomes.

4.3. While health and social care service provision has often focussed on children, older people and the very unwell, there is an emerging consensus that the needs of young adults are not always fully understood or being met.

4.4. Young adults (age 18-25) make up 12.5% of the population in Hammersmith and Fulham and 9.3% of Hammersmith and Fulham CCG's patients. Historically, very little evidence has been gathered about their needs and so a JSNA has been conducted on the health and wellbeing needs of 18-25 year olds locally.

4.5. The JSNA looks at how young adults use health and care services, and looks in detail at care leavers, eating disorders, substance misuse and sexual health which were identified as being key areas to establish an evidence base to improve commissioning.

4.6. Some of the key findings and themes of the JSNA are summarised below:

- Across a range of services the **age of 18 is an arbitrary cut-off point** for transition into adults services, and does not take into account the variation in needs of 18 year olds and young adults.
- The **model of care** in a traditional GP practice is not well suited to this cohort.
- Professionals who do not work solely with young adults may benefit from **training and awareness** on issues that particularly affect young adults.
- The young adult population is **transient** and has a **higher migration rate** in and out of the boroughs than the rest of the population.
- Effective **joined up working and communication** across services and sectors, is key to person-centred care. **Co-location of services** may benefit this age-group.

4.7. A full set of the recommendations from the Young Adults JSNA is included in Appendix 1 and Chapter 10 of the full report. The key recommendations are summarised below:

Theme	**Gap or challenge**	**Recommendation**	**Lead**
Primary care	The current model of primary care is not well suited to young adults, who are overall less satisfied with their GP than older adults and more likely to use walk-in centres and urgent care than other age groups. Young adults would benefit from GP services configured to their health needs, such	Pilot an integrated primary care model at one or more GP practice in each CCG with a high number of young adult patients. Consider services which could have a presence, such as sexual health services, eating disorder services and talking therapies. Offer training	Toby Hyde, Head of Strategy, Hammersmith and Fulham CCG

	as at The Well Centre in Lambeth.	for GPs in young adults' health.	
Eating disorders	A small fraction of the estimated numbers of young adults with eating disorders are receiving a service. Evidence shows better outcomes when ED is treated promptly, but waiting times locally are long. National and local strategies require the development of out of hospital services. There is currently only a service in secondary care. The exemplar primary care eating disorder service in Bristol provides cost-effective help before the patient's condition deteriorates.	Review the eating disorder pathway as part of Like Minded Serious and Long Term Mental Health Need population group Business Cases. Consider ways to provide an early intervention eating disorder service in primary care offering NICE recommended rapid triage and assessment by a skilled practitioner in partnership with GPs for those with emerging but not life-threatening Eating Disorders.	Julie Scrivens, Head of Planned Care and Mental Health
Care leavers	The greatest area of unmet health and wellbeing needs of care leavers is mental health needs which would not meet the threshold for Adult Mental Health Services.	Extend existing CAMHS or LAC CAMHS services to a tapered service for 16-25 year-old care leavers to give continuity to those with a relationship with the service, and extend the offer to include care leavers age 18-25 not already open to LAC CAMHS who are not eligible or suitable for Adult Mental Health services.	Steve Buckerfield, Head of Children's Joint Commissioning
Substance misuse	The majority of young adults in treatment for substance misuse are addressing cannabis and alcohol issues, however adult services cater predominately to crack and opiate users.	Allow flexibility in substance misuse services to provide for young adults up to the age of 25, based on a professional assessment of their need.	Gaynor Driscoll, Head of Commissioning of Substance Misuse and Sexual Health, Public Health
General	Young adults are particularly difficult to involve in participation and engagement exercises in the typical ways that	Coproduce the redesign of services with young people.	All commissioners and service providers

	services engage patients and users.		

JSNA Highlight Reports (Online JSNA)

4.8. The JSNA borough Highlight Report for Hammersmith and Fulham has been refreshed with the latest available data and is available **through this link.** The highlight report is in a more interactive online format than previous versions, and provides the supporting evidence to the Joint Health and Wellbeing Strategy as well as an overview of the health and wellbeing needs of local residents.

4.9. The Online JSNA uses national and local evidence sources in a format that links directly to the most recently available data and a variety of other publically available tools.

4.10. The key objectives of this project are:

- To describe the health and wellbeing needs of the local population for the council, NHS and community and voluntary sector in order to identify priorities and service planning.
- To enable staff and partners to easily find the rich and extensive data on the population of the Hammersmith and Fulham that is publically available but difficult to locate.
- To enable analysts to respond quickly to common questions or requests with the most up to date data without unnecessary duplication of work.
- To increase engagement with the JSNA through a more user-friendly format.

4.11. Previous JSNA Highlight Reports (most recently published March 2014) have been a static document that the Health and Wellbeing Board has signed off, which does not change until a full refresh is completed. The Online JSNA will give a date for all statements and figures, and can be easily updated when new key data becomes available in order to be more responsive to the needs of its users. This will require a change to the governance process for the Highlight Report.

4.12. **It is recommended that the Health and Wellbeing Board agree that data in the Highlight Report can be updated by the Public Health Intelligence team on a rolling basis as and when it becomes available, and provide the Board an annual summary of changes.**

4.13. The content for this online version of the Highlights Report is now in consultation. Health and Wellbeing Board members are invited to comment on the content and user experience at the Health and Wellbeing Board meeting and through the feedback survey in the Online JSNA, and share it within their respective organisations after the Board meeting.

4.14. Future JSNA Work Programme (2017/2018)

4.15. The review of the JSNA process and products undertaken early 2016 identified that the process for selecting topics for deep dive JSNAs should be changed. As reported in the paper to the Health and Wellbeing Board in May 2016 the following recommendations were made:

- The JSNA Review recommends the deep dive programme directly aligns to the new Joint Health and Wellbeing Strategies.
- The JSNA Review recommends that the exact shape of the deep dive programme should be determined with team managers from the main commissioning functions to have the maximum impact: Adult Social Care, Children's Services, The Joint Commissioning Team and the CCGs, in consultation with the Community and Voluntary Sector, and signed off at the Health and Wellbeing Boards.

4.16. These changes have been implemented and to date, the following topic for a deep dive JSNA has been identified:

Children and Young People with Complex Needs JSNA

4.17. The Children's Services Director of Commissioning and the Head of Children's Joint Commissioning have identified that the deep dive topic that would best support the Joint Health and Wellbeing Strategy priority 'Supporting children, young people and families to have the best possible start in life' is on **children and young people age 0-25 with complex health and care needs** as we do not currently have a jointly agreed robust dataset to underpin planning.

4.18. Under the Children and Families Act 2014, local authorities and CCGs are obliged to gain an understanding of this population in order to inform a joint commissioning strategy. A joint Ofsted and CQC inspection could take place imminently, and Ofsted will need to see evidence of the local need and how the local authority and NHS are planning to meet it.

Pharmaceutical Needs Assessment (PNA) – 2018 refresh

4.19. In addition, each HWB is required to publish a PNA by virtue of section 128A of the National Health Service Act 2006 (pharmaceutical needs assessments).

4.20. The current PNA was published in March 2015. The National Health Service (Pharmaceutical Services) Regulations 2012 require that the Health and Wellbeing Board publish a revised PNA within 3 years – in this instance, by the end of March 2018. **The Hammersmith and Fulham PNA will be delivered as part of the JSNA work programme.** Further detail will be provided in a separate PNA paper.

5. CONSULTATION

5.1. A wide range of stakeholders were consulted in the development of the Young Adults JSNA. This included professionals from the three boroughs who work with care leavers; professionals who work with people who misuse substances; and eating disorder professionals; Hammersmith and Fulham CCG's Governing Body seminar; the JSNA Steering Group; Hammersmith and Fulham Youth Council; and a group of care leavers. In addition, a draft of the JSNA was circulated to a wide range of stakeholders for consultation in November 2016.

6. EQUALITY IMPLICATIONS

6.1. JSNAs must consider the health, wellbeing and social care needs for the local area addressing the whole local population from pre-conception to end of life. The "whole local population" includes people in the most vulnerable circumstances or at risk of social exclusion (for example carers, disabled people, offenders, homeless people, people with mental health needs etc.)

6.2. The Online JSNA Highlight Reports considers the whole population including vulnerable groups.

6.3. The Young Adults JSNA focusses on the needs of young adults who are an often overlooked population group and include very vulnerable people such as care leavers and people with eating disorders. The recommendations of this JSNA can be expected to make a positive contribution to reducing health inequalities and delivering Hammersmith and Fulham's equalities objectives.

7. LEGAL IMPLICATIONS

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

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

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

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

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

8. FINANCIAL AND RESOURCES IMPLICATIONS

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

8.2. Implications verified/completed by: Richard Simpson, Finance Manager – Public Health, telephone 020 7641 4073.

9. RISK MANAGEMENT

9.1. Preparation of a Joint Strategic Needs Assessment is a statutory duty, risk number 8 on the Shared Services Risk Register. The assessment identifies 'the big picture' in terms of health and wellbeing needs and inequalities of the local population and informs future service planning, taking into account evidence of effectiveness.

9.2. The JSNA assesses the health, wellbeing and social care needs of the local community. It is an ongoing process that involves identifying present and future needs of the local population across a number of priority areas including health, education and housing. In doing so the process contributes directly to the management of Customer and Citizen risk, meeting local needs and expectations, risk number 9.

9.3. Implications verified/completed by: Michael Sloniowski, Shared Services Risk Manager, telephone 020 8753 2586

10. PROCUREMENT AND IT STRATEGY IMPLICATIONS

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

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

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.	Young Adults JSNA	Jessica Nyman	Public Health

LIST OF APPENDICES:

Appendix 1: Young Adults JSNA Recommendation
Appendix 2: Draft Young Adults JSNA

Appendix 1: Young Adults JSNA Recommendations

Topic	Gap or challenge	Potential solution/recommendation
Primary Care	The current model of primary care is not well suited to young adults, who are overall less satisfied with their GP than older adults. YA would benefit from GP services configured to their health needs, such as at The Well Centre in Lambeth. Co-location has come up across chapters as an effective way of increasing young adults' uptake of appropriate services, particular in hard to engage cohorts such as care leavers. Small changes that all GP practices can facilitate would make a positive difference.	1. Pilot an integrated primary care model at one or more GP practice in each CCG with a high number of young adult patients. Consider services which could have a presence, such as sexual health services, eating disorder services and talking therapies. Offer training for GPs in young adults' health. a. Consider opportunities for this approach in other contexts with target populations, such as co-location of health services at care leaver peer support groups. 2. Train local GPs and GP practice staff in the GP Champions for Youth Health Project's Toolkit for General Practice. CCGs should make use of the GP Champions for Youth Health Project's Commissioning Effective Primary Care Services for Young People.
Eating disorders	A small fraction of the estimated numbers of young adults with eating disorders are receiving a service. Additionally, evidence shows better outcomes when ED is treated promptly in the first 3 years of the illness, but waiting times locally are long. National and local strategies require the development of out of hospital services and an early intervention approach to protect mental and physical health and wellbeing. There is currently only a service in secondary care. The exemplar primary care eating disorder service in Bristol provides cost-effective and well received help before the	3. Review the eating disorder pathway as part of Like Minded Serious and Long Term Mental Health Need population group Business Cases. Consider ways to provide an early intervention eating disorder service in primary care offering NICE recommended rapid triage and assessment by a skilled practitioner in partnership with GPs for those with emerging but not life-threatening Eating Disorders. a. Such a service would then be capable of providing the leadership and momentum for the following recommendations.

Eating disorders	patient's condition deteriorates and requires treatment in secondary care.	
	The current NICE guidelines are from 2004, over a decade old, and are currently being updated with publication expected in 2017.	4. Review existing services against new NICE guidelines when available in 2017.
	Professionals outside of specialist ED services do not consistently understand what to do when an eating disorder is identified, and how to manage an eating disorder patient.	5. Map pathways and create a tool for professionals to use to enable appropriate and timely referrals. 6. Offer guidance to GPs and other health professionals to identify and then work constructively and appropriately with people with an eating disorder. a. Identify GPs with high numbers of young adults and low referral rates to eating disorder services as a target group for training.
	Looked after children have higher rates of mental illness than the general population; nearly half have a mental disorder. In consultation with care leavers, there was a lack of awareness and coping strategies. However, some may not want help in a clinical setting. National evidence suggests good outcomes for mentoring, which may be more appropriate where psychological therapies are not wanted.	7. Actively promote resilience, prevention and early intervention for good mental health for all in generic services for care leavers. a. Review current and past mentoring and peer mentoring schemes in the three boroughs for care leavers and / or young adults.

Care Leavers	The greatest area of unmet health and wellbeing needs of care leavers is mental health and emotional wellbeing that would not meet the threshold for Adult Mental Health Services. Nationally, 'Future in Mind' and locally, The Anna Freud Centre needs assessment for CAMHS recommend a tapered transition from age 16-25. LAC CAMHS see children over long time periods and specialise in trauma, which is most appropriate to this cohort. Some care leavers have existing relationships with LAC CAMHS staff which they would benefit from continuing; other are not ready to engage with counselling services until they are age 18 or above.	8. Extend existing CAMHS or LAC CAMHS services to a tapered service for 16-25 year old care leavers to give continuity to those with a relationship with the service, and extend the offer to include care leavers age 18-25 not already open to LAC CAMHS who are not eligible or suitable for Adult Mental Health services. a. The offer to care leavers should include flexibility if appointments are missed or service users don't want to be seen in a clinical setting.
	A significant proportion of local care leavers are former UASCs, and have specific health and care needs.	9. Professionals including Leaving Care teams to be fully trained on national guidance for unaccompanied asylum seeking and trafficked care leavers
	Consultation with care leavers identified that many sought advice from non-health professionals who they had a trusting relationship with e.g. their social worker. Although almost all are registered with a GP, most prefer to use walk in centres, A&E and urgent care. The needs and preferences of care leavers vary significantly from person to person,	10. Non-health professionals working with care leavers e.g. personal advisors and key workers should routinely take an active role in the health of care leavers, such as taking them to the GP and encourage seeking help in the appropriate setting. a. Pilot a personal budget for care leavers, where an assessed physical or mental health need is established, to allow them to choose a relationship with the professional that best meets their needs

Care leavers	meaning a specific service may not be appropriate.	
	A small number of care leavers have significant multiple complicated physical, mental and social care needs, and a large number of professionals become involved in their case.	11. Pilot a transitions panel similar to the disabled children's panel for cases of care leavers with multiple or complicated needs.
Substance misuse	The majority of young adults in treatment for substance misuse are addressing cannabis and alcohol issues, however adult services cater predominately to crack and opiate users.	12. Review adult and young people's service offer to ensure a flexible, responsive and coordinated service is available to meet the needs of young people who use a range of substances. Allow flexibility in the young people's substance misuse services to provide for young adults up to the age of 25, based on a professional appraisal of where their need can best be met.
	Vulnerable groups are more susceptible to harmful substance misuse.	13. Develop a local strategy to reduce substance misuse among vulnerable and disadvantaged under 25s as recommended by NICE (2007).
	Although numbers in services are relatively small, substance misuse is widespread amongst young adults. There is significant variation between the boroughs in their referral rates into substance misuse services from key partners.	14. Continue to develop awareness and training for a broad range of professionals in contact with young adults to enable conversations to be started earlier, rather than when a problem has taken hold. Training should include building resilience in young people to resist pressures in their social groups, schools and universities. a. Work with young people's services, GPs and hospitals to embed effective pathways and interventions which target those most at risk of substance misuse.
Sexual Health	Sexual health is a key health issue for the vast majority of young adults.	15. Ensure all commissioned sexual health services adhere to the You're Welcome standards.
	There is a strong link between substance misuse and risky sexual behavior.	16. Consider integration of substance misuse and sexual health services for young people.
	There are clear inequalities in sexual health, particularly in socio-economic status. Care	17. Work with young people's services to embed effective pathways and interventions which target high risk groups including care leavers.

	leavers have significantly higher rates of pregnancy than the general young adult population.	
	Young people consulted reported that adults and professionals over-medicalise what to them is a social issue.	18. Develop sexual health services to proactively address the psychosocial aspects of sexual health.
	The Framework for Sexual Health Improvement in England recommends the prioritisation of prevention and that all young people are informed to make responsible decisions, and are aware of the risks of unsafe sex.	19. Collaborate with other London boroughs to prioritise prevention and provide consistent health messages to enable young people to make informed and responsible decisions**.**
		20. Improve local prescription of Long Acting Reversible Contraception (LARCs).
General	There is existing good practice guidance for services working with young adults on transitions and service design.	21. Health and care services should self-assess against the NICE guidance on transition from children's to adults' services for young people using health or social care services, and services that young people access should adopt the Government's 'You're Welcome' quality criteria to be more suited to young adults.
	Young adults are particularly difficult to involve in participation and engagement exercises in the typical ways that services engage patients and users.	22. Coproduce the redesign of services with young people.

JSNA
Joint Strategic Needs Assessment

h&f
hammersmith & fulham

Young Adults Joint Strategic Needs Assessment

The Health and Wellbeing Needs of young adults age 18-25

healthwatch
Hammersmith
and Fulham

NHS
Hammersmith and Fulham
Clinical Commissioning Group

This report

This needs assessment on young adults supports the development of strategy and Local Authority (LA) and Clinical Commissioning Group (CCG) commissioning intentions to improve services for young adults.

It covers the health and wellbeing needs of young adults, focussing on 18-25 year olds but considering wider age groups where appropriate, in the London Borough of Hammersmith and Fulham and nearby boroughs with whom certain services are shared, The Royal Borough of Kensington and Chelsea, and the City of Westminster. The report focuses in particular on:

- Eating disorders
- Care leavers
- Substance misuse
- Sexual health
- Wider determinants of health

Data has been collected from a number of sources, including the 2011 census from the Office for National Statistics, and local data provided by stakeholders and providers. Workshops and interviews were conducted with key local stakeholders and providers.

Authors and contributors

This report was written by Jessica Nyman with support from Naomi Potter, Clare Lyons-Amos, Chrisa Tsiarigli, Toby Hyde, Colin Brodie, Matthew Mead, Steve Buckerfield and Rachel Krausz.

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Joint Strategic Needs Assessments (JSNAs)

The purpose of JSNAs is to improve the health and wellbeing of the local community, and reduce inequalities for all ages, by informing all relevant parties about the health and social care needs of the local population and how these may be addressed. They are assessments of the current and future health and social care needs of the local population, with the core aim of developing local evidence-based priorities for commissioning and strategies. The needs identified may be met by the local authorities, CCGs, NHS or others.

JSNAs are a continuous process of strategic assessment and planning, and are an integral part of CCG and local authority commissioning and planning cycles. Their agreed priorities are used to help determine what actions local authorities, the local NHS and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing. Past reports can be found at www.jsna.info.

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1 Executive summary

While health and social care service provision has often focussed on children, older people and the very unwell, there is an emerging consensus that the needs of young adults are not fully understood or being met (Care Quality Commission, 2014; Goddard, 2015). More information on the needs of this age group is needed to inform local commissioning and service design, but available data and evidence (and consequently the conversation) is often merged into wider age groups (e.g. 19-64 year olds). It is therefore difficult to obtain a more specific understanding of the needs of young adults.

It is important to understand the health and care needs of this population better in order to improve their immediate and long-term outcomes (not just health), particularly those with long-term conditions. This will ensure that services are configured to meet the particular needs of young adults, and to support the transition from children's to adults' services. This JSNA seeks to describe the local characteristics of this age group and address a number of their key health and care issues.

An interactive summary of the key data and findings can be found on the **Online JSNA**.

1.1 Key themes

A number of cross-cutting themes with this age cohort became apparent across the different chapters:

Age 18 cut-off and transitioning into adult services	Across service types, practitioners and evidence suggest that having a cut-off point at age 18 is arbitrary and unhelpful. The needs and 'emotional ages' of 18 years olds differ widely, and some young adults may receive more appropriate care in a young people service than an adult service. This is unlikely to be resolved via a change to a different cut-off, so services should move towards a model of being needs-led. Additionally, young people and professionals agree on the value of continuity and stability at age 18, especially given the changes happening in people's lives at this age. The interruption of having to transition before the person is ready can have a negative outcome.
Use of health services including GPs	The model of care in a traditional GP practice is not well suited to this cohort. Young adults are less likely to go to their GPs for a variety of reasons: one being a fear of their confidentiality being breached if they have a family GP, another being that they tend to seek help in a crisis, and so will use urgent care or A&E rather than waiting to see a GP. Additionally, young adults are more likely to disengage with services or be discharged for missing an appointment, particularly if they do not have a parent or carer to encourage them to seek help and attend.
Training and awareness	Professionals who do not work solely with young adults, such as GPs, may benefit from training and awareness to identify issues that particularly affect young adults, how to discuss these constructively, and work with parents, carers, family and friends where appropriate.
Transient populations	The young adult population has a higher migration rate in and out of the boroughs than the rest of the population. They are more likely to leave home during this time, such as for university. This can interrupt delivery of health or care services or treatment, and

	may require coordination between different boroughs and Clinical Commissioning Groups (CCGs). They are more likely to be registered with a GP in a borough they do not live in. This challenges the continuity and integration of care that local services can offer, and requires empowerment of this cohort to effectively manage their own health and seek advice when required.
Participation and user involvement	Young adults are particularly difficult to involve in participation and engagement exercises in the typical ways that services engage patients and users. Alternative methods should be explored such as online platforms, youth forums and community networks.
Joined-up working and co-location of services	The importance of effective communication across professional boundaries, in particular children's and adults' services but also between health, local authority and the voluntary sector, is key to person-centred care. This was highlighted as an area for improvement locally in some of the key chapters examined in this report. Co-location has been consistently identified as a way to make services more user-friendly for young people, making them more likely to engage. The Well Centre in Lambeth co-locates GPs and youth workers, with close working with other services such as sexual health and substance misuse services. This also makes it easier for professionals to discuss the needs of the person.
Service design	Common service design requirements for young adults include flexibility, evening and weekend hours. Alternative models such as telephone, text and online appointments are also recommended.
Gender	Differences in gender can be seen in young adults. Young women are three times as likely to have a common mental disorder and ten times as likely to have an eating disorder as young men. Young men are more likely to have problematic substance misuse and less likely to be seen in services in their expected numbers.

1.2 Summary of Key Recommendations

Chapter	Gap / challenge	Recommendation
Primary care	The current model of primary care is not well suited to young adults, who are overall less satisfied with their GP than older adults and more likely to use walk-in centres and urgent care than other age groups. Young adults would benefit from primary care services configured to their health needs, such as at The Well Centre in Lambeth.	Pilot an integrated primary care model at one or more GP practice in each CCG with a high number of young adult patients. Consider services which could have a presence, such as sexual health services, eating disorder services and talking therapies. Offer training for GPs in young adults' health.
Eating disorders	A small fraction of the estimated numbers of young adults with eating disorders are receiving a service. Evidence shows better outcomes when ED is treated promptly, but waiting times locally are long.	Review the eating disorder pathway as part of Like Minded *Serious and Long Term Mental Health Need* population group Business Cases. Consider ways

	National and local strategies require the development of out of hospital services. There is currently only a service in secondary care. The exemplar primary care eating disorder service in Bristol provides cost-effective help before the patient's condition deteriorates.	to provide an early intervention eating disorder service in primary care offering NICE recommended rapid triage and assessment by a skilled practitioner in partnership with GPs for those with emerging but not life-threatening Eating Disorders.
Care leavers	The greatest area of unmet health and wellbeing needs of care leavers is mental health needs which would not meet the threshold for Adult Mental Health Services.	Extend existing CAMHS or LAC CAMHS services to a tapered service for 16-25 year old care leavers to give continuity to those with a relationship with the service, and extend the offer to include care leavers age 18-25 not already open to LAC CAMHS who are not eligible or suitable for Adult Mental Health services.
Substance misuse	The majority of young adults in treatment for substance misuse are addressing cannabis and alcohol issues, however adult services cater predominately to crack and opiate users.	Allow flexibility substance misuse services to provide for young adults up to the age of 25, based on a professional assessment of their need.
General	Young adults are particularly difficult to involve in participation and engagement exercises in the typical ways that services engage patients and users.	Coproduce the redesign of services with young people.

The full recommendations are at the end of every chapter, and summarised together in Chapter 10.

2 Introduction

2.1 National picture

While health and social care service provision has often focussed on children, older people and the very unwell, there is an emerging consensus that the needs of young adults are not being met or fully understood (Care Quality Commission, 2014; Goddard, 2015). More information on the needs of this age group are needed to inform local commissioning and service design, but available data and evidence (and consequently the conversation) is often merged into wider age groups (e.g. 19-64 year olds). This makes it difficult to obtain a more specific understanding of the needs of young adults.

Consensus is emerging through legislation and guidance that the needs of children and young people do not end at age 18, and a number of recent legislative changes and likely future legislative changes use the upper age limit of 25. The Children and Families Act 2014 has made this legislation for children with Special Educational Needs and Disabilities (SEND). The government report *Future in Mind* (Department of Health & NHS England, 2015) advised the age limit of children's mental health services should extend to age 25. The *Keep on Caring* strategy (HM Government, 2016) will extend the government duty to care leavers up to age 25 (see chapter 6). A recent NSPCC report (Bazalgette, Rahilly, & Trevelyan, 2015) described the withdrawal of CAMHS at 18 as a "cliff edge", and recommended that local authorities and health services should work together to provide mental health support for care leavers up to the age of 25.

Young adulthood is a time of significant change in life. It is an important phase of development where individuals lay the foundations for their adult futures and set behaviour patterns. Both positive and negative experiences can have a long-lasting effect. It is a time of transitioning away from being a child towards independence; living away from family; moving from school to work or university. For those with health and social care needs it can involve moving from paediatric to adult health and care services, for which NICE have produced best practice guidance (NICE, 2016). Person-centred care is particularly important for this age group, given their range of needs and 'emotional ages'.

However, young adults report widespread difficulties in accessing care (Hagell, Coleman, & Brooks, 2015). Young adults are regular users of healthcare; although many are satisfied with their experiences, many are not, and the proportions saying they are not tend to be higher than in other age groups (Healthy London Partnership, 2015). Government guidance on young people friendly services – the 'You're Welcome' quality criteria (Department of Health, 2011) - is not widely known about or used consistently.

2.2 Young adults in Hammersmith and Fulham

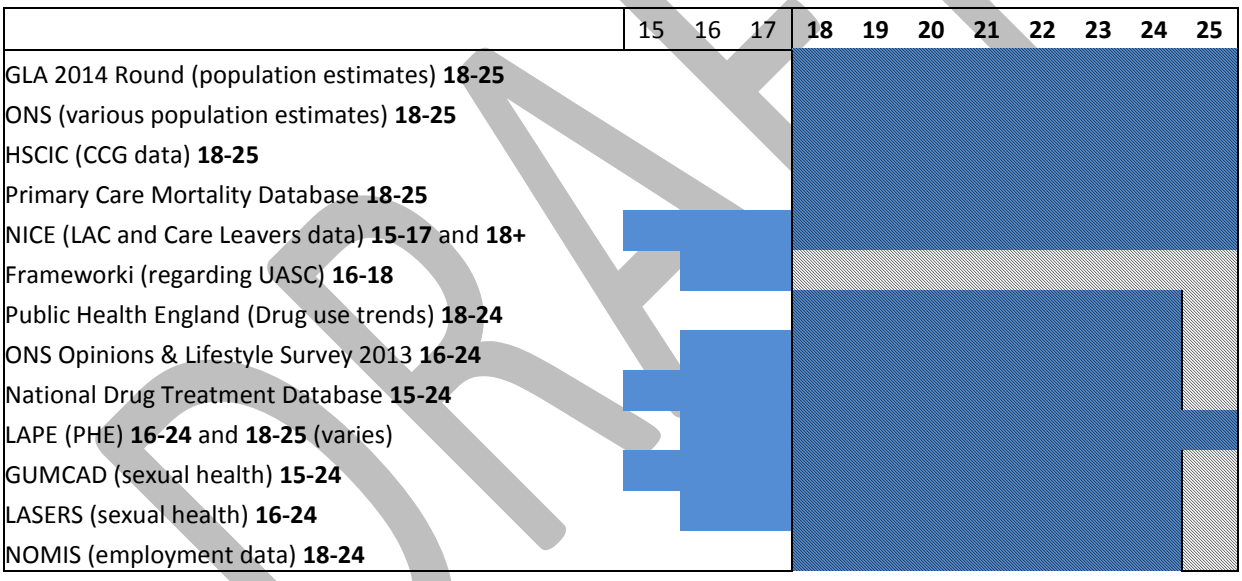
Young adults (age 18-25) make up **12.2% of the total population of Hammersmith and Fulham,** and a slightly smaller proportion of GP registered patients in **Hammersmith and Fulham Clinical Commissioning Group (9.3%).** Despite this, very little evidence has been gathered about their health and wellbeing needs.

Locally, there is an understanding that this age group is transient, culturally diverse, and includes a significant student population. This JSNA seeks to describe the local characteristics of this age group and address a number of their key health and care issues.

2.3 Definitions and scope of the Young Adults JSNA

This JSNA will focus on 18-25 year olds, and in some areas people about to turn 18. However, data is not being systematically collected in this exact age bracket, and so in some instances this report will cover broader age ranges. Where this occurs, it will be made explicit in the text. In addition, the diagram below shows which age groups are covered by the data sources we have used.

Table 1: Age groups covered by data sources



In agreement with key stakeholders, this report will seek to explore some particular issues which affect this age group where we are currently lacking a strong evidence base for commissioning:

- Eating disorders
- Care leavers
- Substance misuse
- Sexual health
- Wider determinants of health

This report will complement and build on other local projects, such as the needs assessment on Children and Young People's Mental Health undertaken by the Anna Freud Centre on behalf of the North West London Like Minded work programme.

The needs of young people with complex needs transitioning from Children's Services to Adult Social Care (such as children with a learning disability or autism spectrum disorder) are different to the needs described in this document. They are therefore out of scope and will be looked at in a further deep-dive JSNA on people age 0-25 with complex needs and disabilities. Additionally, the review of the wider determinants of health for this cohort – including crime and safety, housing, and employment – in chapter 9 will not go into as much detail as other chapters, as work in this area is covered in greater detail in other departments.

2.4 Relation to commissioning

This JSNA will highlight unmet need, which can inform CCG commissioning intentions, as well as the local authorities, providers of services and the community and voluntary sector.

The findings and recommendations in this report should be considered in relation to the opportunities arising in each borough.

Cross-borough/CCG programmes

- North West London Sustainability and Transformation Plan
- North West London Like Minded Strategy and Programme – mental health transformation (see Chapter 5 recommendations)
- Children and Adolescent Mental Health Services transformation (see Chapter 6 Recommendations)
- Development of policy and guidance for the issue of a personal budget for children and young people with an Education, Health and Care Plan with a focus on outcomes, which could be adapted into a consistent approach for care leavers (see Chapter 6 Recommendations).

Hammersmith and Fulham

- Old Oak redevelopment
- GP Practice Redesign at urgent care practices (see Chapter 4 Recommendations)
- Redesign of Urgent Care Centres (see Chapter 4 Recommendations)

2.5 Objectives

The key objectives of this document are:

- To capture the unique health and wellbeing needs and issues affecting young adults aged 18-25 years
- Identify the provision and gaps in provision of services for young people
- To identify how to improve early interventions in issues which could affect people's long term outcomes.

3 Population profile

This chapter will describe the young adult population in Hammersmith and Fulham, as well as Kensington and Chelsea and Westminster. The majority of the data available in the report is for 18-25 year olds; however, some data is not routinely collected for this age group. Whenever a different population age group is used, it is explicitly stated. The data used in the report is the latest available at the time of writing.

3.1 Summary

The young adult population of Hammersmith and Fulham is more ethnically diverse and more transient than the adult population. The areas most densely populated by young adults tend to be close to universities.

3.2 Behaviours and characteristics

3.2.1 Risk taking

Young adults are known to have higher risk-taking behaviours such as smoking, binge drinking, substance misuse and unprotected sexual intercourse.

3.2.2 Use of technology

In 2015, 90% of 16-24 year olds owned a smartphone (Ofcom, 2015). Adolescents and young adults use technology to access information in their daily lives, but services have not yet successfully adapted to this.

NHS Go app

Through the NHS's Healthy London Partnership patient engagement activities, it has been recognised that young people often lack basic knowledge of how to access healthcare services. Engagement with young people highlighted easier access to services, particularly ways to get support out of hours and at weekends, as a priority. This gap in providing more readily accessible information needs to be filled in a way that is inclusive to young people by using forms of technology that they already utilise.

Young people co-designed an app to enable easily access information about health services, as well as healthy lifestyle advice, via a 'youth friendly portal'. The app can be downloaded through mainstream app stores.

3.2.3 Students

There are a number of large universities in central London, and many students either reside in Hammersmith and Fulham, or are registered to GPs in the borough.

3.3 Demography

3.3.1 Numbers or resident and registered young adults age 18-25

The population figures below are projected estimates for 2016 produced by the Greater London Authority. These projections take into account new housing developments.

Table 2: Estimated resident and GP registered population age 18-25

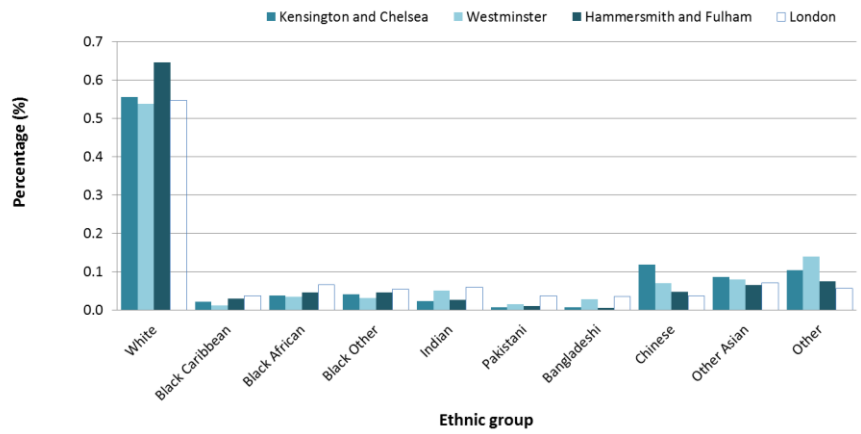
	Estimated Residents		CCG registered		
Local Authority / CCG	Resident	% of resident population	Registered	% of registered population	% of residents registered with CCG
LBHF / H&F CCG	22,294	**12.5%**	19,640	**9.3%**	88.1%
RBKC / WL CCG	15,582	**9.6%**	19,742	**8.1%**	126.7%
WCC / CL CCG	29,845	**10.7%**	34,338	**16%**	115.1%

Source: GLA R2014 SHLAA EGPP – capped, GP registered list size population (Jan 2016), HSCIC

Hammersmith & Fulham has the highest proportion (12.2%) of young adult residents of the three, however Hammersmith and Fulham CCG has fewer young adults registered with a GP than young adults in its resident population.

3.3.2 Ethnicity

Figure 1: Estimated young adult population by ethnic group, 2016



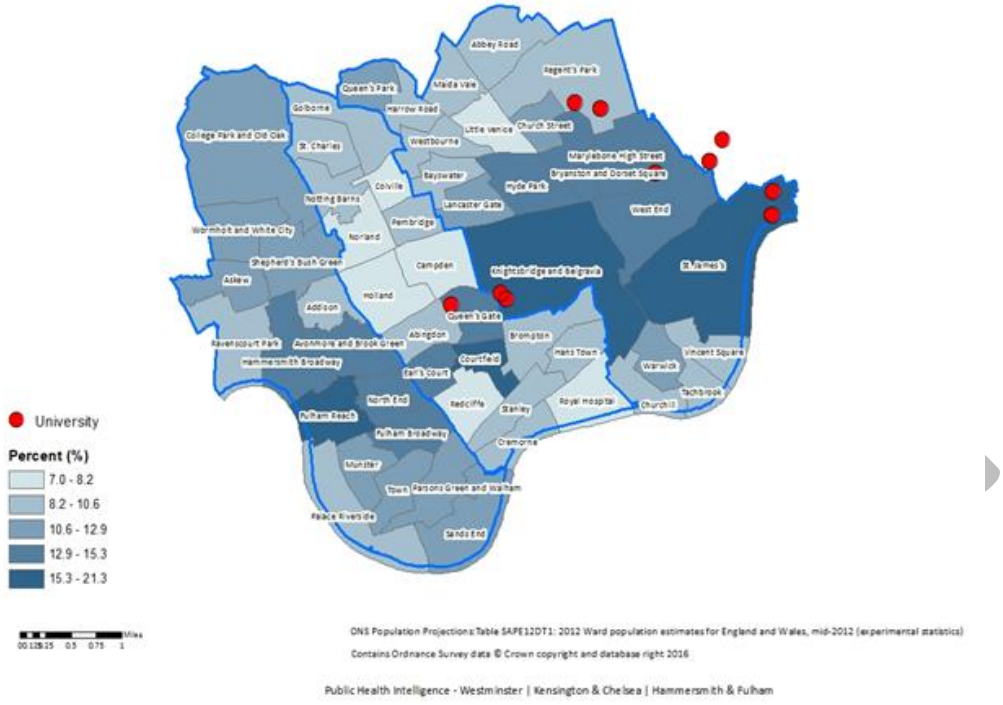
Source: GLA R2014 SHLAA EGPP – capped

The populations of each borough are predominately 'white', however there is a higher proportion of BME groups amongst 18-25s than the general population.

3.3.3 Location

The electoral wards with the highest proportion of young adults are Fulham Reach (18.3%) in Hammersmith & Fulham. Many of the wards with the highest concentrations of young adult population are those in which a university is located.

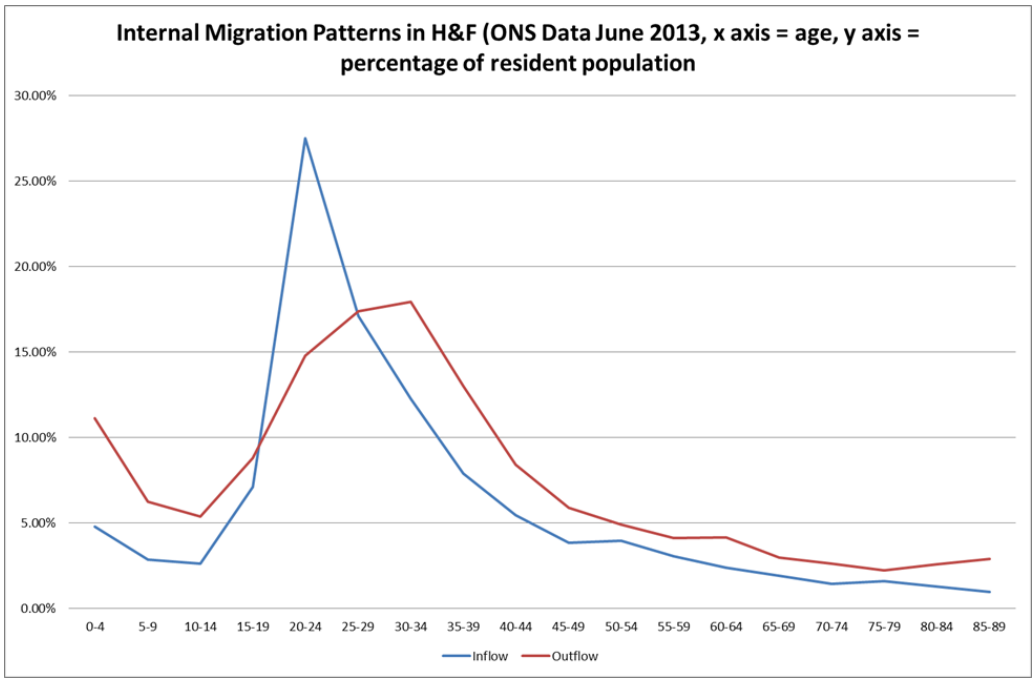
Figure 2: Map showing percentage of young adult population by ward, 2015



Source: ONS, 2015

3.3.4 Migration

Figure 3 Internal migration patterns, June 2013



The young adult population of Hammersmith and Fulham is significantly more mobile; they make up a far higher percentage of the estimated migration in and out of the borough than their percentage of the general population.

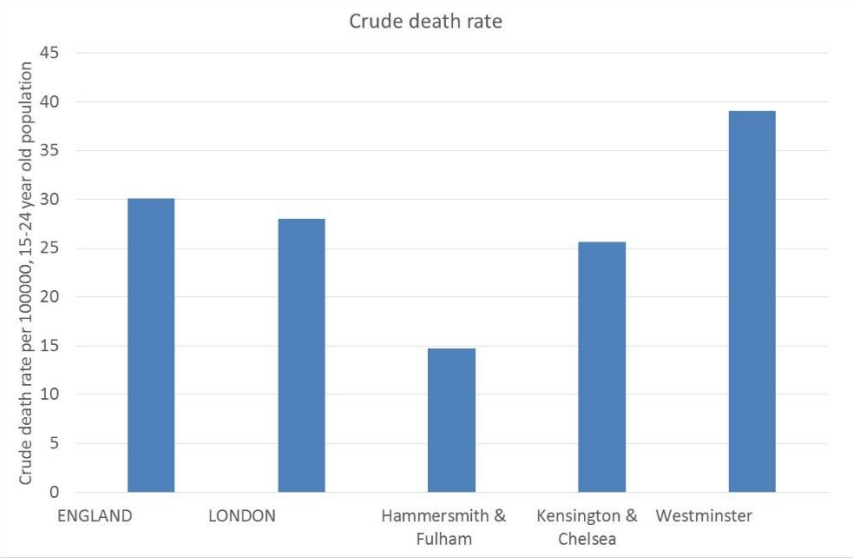
This shows that this age group is more likely to leave home during this time, such as for university. This can interrupt a health or care service they may be receiving, or require coordination between different boroughs and CCGs. They are also more likely to be registered with a GP where they no longer live. This challenges the continuity of care that local services can offer, and requires empowerment of this cohort to manage their own health and seek advice when required.

Transitions for university students, such as for mental health services, have extra complexity due to geographical relocation and transience of residence. Students may need access to mental health support at home and at university, from both primary and secondary care services. The production of best practice guidance for CCGs and GPs around student transitions, encouraging close liaison between the young person's home-based and university-based primary care teams, and promoting adherence to NHS guidelines on funding care for transient populations (Department of Health & NHS England, 2015), would be valuable to ensure seamless care.

3.3.5 Deaths

Numbers of deaths in 15-24 year olds are low, and in comparison with London and England Hammersmith and Fulham has a lower rate. **The most frequent cause of death is accidents and a significantly higher number are young men**, as is consistent nationally.

Figure 4 Crude mortality rates for young people age 15-24, 2010-14



Source: Office for National Statistics mortality data by age

4 Primary and Secondary Care health services

4.1 Primary Care

Nationally, 16–24 year-olds are less satisfied than older adults using GPs (Hagell et al., 2015). They have greater difficulty in booking GP appointments and are twice as likely to attend A&E or a walk-in centre.[1]

The Association for Young People's Health (AYPH) carried out the *GP Champions for Youth Health* project[2] from 2012-2015, funded by the Department of Health. This identified the issues adolescents and young adults experience with GPs, and through collaboration between GPs and the voluntary sector, developed new services and referral pathways for young people. The project produced the *Toolkit for General Practice*[3], a resource for all GP practices, and CCG guidance on *Commissioning Effective Primary Care Services for Young People*[4]. This includes taking sufficient time to understand underlying problems they may struggle to disclose, as well as practical elements such as drop-in appointments after college, and enabling online appointment booking.

The project explored GPs working jointly with the community and voluntary sector through the Youth Information, Advice and Counselling Services (YIACS) network to provide better health services for young people by: offering good health information through other services, supporting self-management of health needs, developing strong relationships, focussing on the holistic needs of young people, and more commonly working with people up to age 25 to support them through transition.

4.1.1 Issues with primary care

GPs provide a key universal healthcare service to people across the life course, and are a key referral point for specialist services. However, primary care was consistently highlighted as an area for improvement for young adults' health locally, in workshops relating to other chapters in this report such as substance misuse, eating disorders and care leavers, and in consultation with young people.

Confidentiality: An issue which has been raised consistently by young adults and professionals is a lack of trust in the confidentiality between GPs and young adults, particularly with a family GP.

[1] GP Champions for Youth Health Project. *Toolkit for General Practice (online)* http://www.youngpeopleshealth.org.uk/wp-content/uploads/2015/06/GPToolkit_ONLINE.pdf (accessed 14.12.16)

[2] AYPH. *GP Champions (online)* http://www.youngpeopleshealth.org.uk/our-work/young-peoples-participation/gp-champions (accessed 14.12.16)

[3] GP Champions for Youth Health Project. *Toolkit for General Practice (online)* http://www.youngpeopleshealth.org.uk/wp-content/uploads/2015/06/GPToolkit_ONLINE.pdf (accessed 14.12.16)

[4] GP Champions for Youth Health Project. (online). *Commissioning Effective Primary Care Services for Young People* http://www.youngpeopleshealth.org.uk/wp-content/uploads/2015/06/Commissioners_ONLINE.pdf (accessed 14.12.16)

Help seeking behaviour: In focus groups with local young people, they tend to seek help in a crisis, and so will use urgent care or A&E rather than waiting to see a GP.

Experiences at the GP: several young people reported negative experiences of GP practices from GPs and reception staff, particularly when they went without parents.

Care leavers: consultation with local care leavers raised the issue of continuity being important for care leavers, but them being unable to see the same GP and build a relationship. The group reported that they tend to use A&E, even for a check-up of a long term condition in one case. (See chapter 6 – Care Leavers).

Good practice case study: The Well Centre, Lambeth, provided by Redthread

The Well Centre in Lambeth is an example of the community and voluntary sector supporting good primary care for young people. It is a 'one-stop shop' providing GP services, youth work and nurse-led mental health services from one location attached to an existing youth centre. By providing healthcare in a youth-oriented environment, the Well Centre's founders – the Redthread youth work charity and the Herne Hill Group Practice – aim to address the common concerns of young people regarding primary care. This group frequently reports dissatisfaction with accessing healthcare, and often finds it difficult to speak to GPs over fears of breached confidentiality or being misunderstood. However, early intervention is vital: half of all lifetime cases of psychiatric disorders start by age 14 and three quarters by age 24.

Young people can either attend on a drop-in basis or by booking an appointment in advance, and as of December 2015 over 1400 had signed up. Well Centre staff also run workshops, lessons, and youth work outreach activities – including school assemblies, PHSE and regular counselling sessions in schools. Approximately 30% of the Well Centre's patients are aged 18 or over, and 43% visited from beyond the Lambeth CCG area, suggesting a wider demand for the service in terms of both age and geography.

A 2015 study (Hagell & Lamb, 2016) of the Well Centre suggested that it was accomplishing its goal of providing services to more vulnerable and socially excluded residents. Although outcome measures are still in development, 59% of young people have reported an improvement in their life satisfaction since first starting to attend. One-third of those studied in 2014 reported having no other doctor, while the proportion of those living in single-parent households was over double that of the general population. A disproportionately high number were not in education, employment or training. In terms of cost-effectiveness, a preliminary cost benefit analysis undertaken in May 2014 calculated that the Well Centre cost £450 per client; every case seen potentially saved the NHS £713 through avoided A&E visits and other long-term costs.

4.1.2 *Local primary care use: General Practitioners (GPs) Practices*

A few GP practices were identified as having a higher number of young adults on their patient list.

Table 3: List of GP practices with highest numbers of young adults by CCG

CCG	Practice name	18- 25: Male	18- 25: Female	18- 25 all persons
Hammersmith and Fulham CCG	**NORTH END MEDICAL CENTRE**	644	917	**1561**
	THE MEDICAL CENTRE, DR JEFFERIES & PARTN	565	716	**1281**
	THE BUSH DOCTORS	443	610	**1053**

4.1.3 *Common mental disorders (CMD)*

CMD includes depression, anxiety and sleep disorders, and are usually treated in primary care. Prevalence of mental health issues has not been measured at a local level. However, the national Adult Psychiatric Morbidity Survey (APMS) last conducted 2014 measures prevalence. Using these validated surveys, the estimated prevalence of CMD among 18- 24 year olds in our local population suggests that **1 in 5 18-24s (21.07%) suffered from CMD in 2014, compared to 17.1% amongst adults age 16-64 generally, showing that CMD is more of an issue for young adults.**

The APMS 2014 results showed that CMD symptoms were about **three times more common in women age 16-24 (26.0%) than men (9.1%). The gap has grown since 1993, when 16-24 year old women were twice as likely (19.2%) as 16-24 year old men (8.4%) to have symptoms of CMD.**

Figure 5 Common Mental Disorders prevalence in 18-24s, estimated using 2014 APMS and 2015 ONS population projections

Local authority	Male	Female
Hammersmith and Fulham	**890**	**2,616**
Kensington and Chelsea	**701**	**1,883**
Westminster	**1,255**	**3,133**

4.2 Recommendations

Gap / challenge	Potential solution / recommendation
The current model of primary care is not well suited to young adults, who are overall less satisfied with their GP than older adults and more likely to use walk-in centres and urgent care than other age groups. Young adults would benefit from GP services configured to their health needs,	1. Pilot an integrated primary care model at one or more GP practice in each CCG with a high number of young adult patients. Consider services which could have a presence, such as sexual health services, eating disorder services and talking therapies. Offer training for GPs in young adults' health. a. Consider opportunities for this approach in other contexts with target populations, such as co-

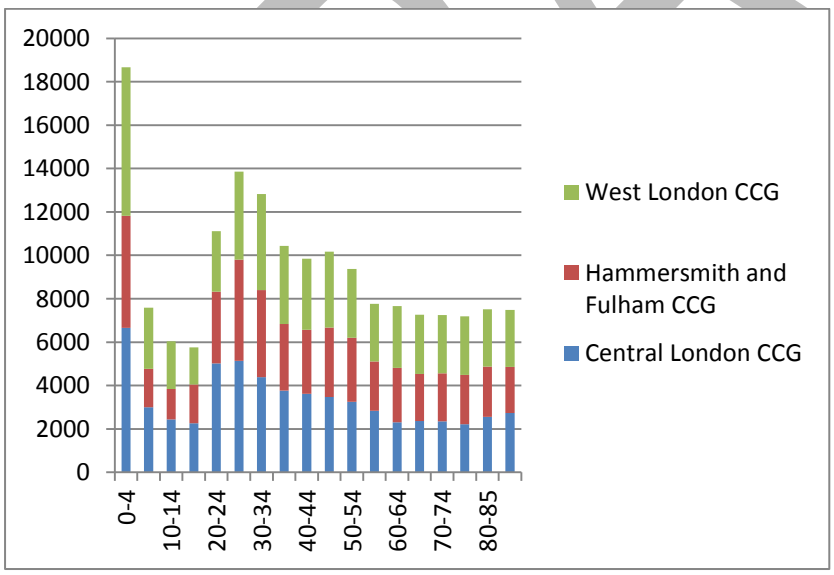
such as at The Well Centre in Lambeth. Co-location has come up across chapters as an effective way of increasing young adults' uptake of appropriate services, particular in hard to engage cohorts such as care leavers.	location of health services at care leaver peer support groups.
Small changes that all GP practices can facilitate would make a positive difference. The AYPH's primary care guidance has been endorsed by the Royal College of General Practitioners (RCGP) and contains actions all GPs could carry out to improve primary care services for young people.	2. Train local GPs and GP practice staff in the GP Champions for Youth Health Project's *Toolkit for General Practice*[5]. CCGs should make use of the GP Champions for Youth Health Project's *Commissioning Effective Primary Care Services for Young People*[6].

4.3 A&E and Urgent care use

4.3.1 Urgent care

There is a significant spike in Urgent Care Centre use at age 20-24 as shown in table 4 below. In consultation with young people, many said that they preferred to use A&E or urgent care than GPs.

Table 4 Non-elective Attendances of all Urgent Care Services in the Three Boroughs (2014/15)



[5] GP Champions for Youth Health Project. *Toolkit for General Practice (online)* http://www.youngpeopleshealth.org.uk/wp-content/uploads/2015/06/GPToolkit_ONLINE.pdf (accessed 14.12.16)

[6] GP Champions for Youth Health Project. (online). *Commissioning Effective Primary Care Services for Young People* http://www.youngpeopleshealth.org.uk/wp-content/uploads/2015/06/Commissioners_ONLINE.pdf (accessed 14.12.16)

When looking at the rates of use (per 1,000 people) of Urgent Care Centres (UCC), A&E and Walk-in Centres (WiC), urgent care is the preferred unplanned secondary care service for young adults. Table 5 shows that the rate of attendances at walk-in centres is significantly higher amongst young adults than all age groups, however urgent care centre use is even higher in young adults. A&E use is lower amongst young adults than the general population, as the older populations have more co-morbidities and so are frequent users of A&E services.

Table 5 Rate per 1,000 people of users among 18-25 year olds from the three boroughs compared with all age groups (2015/16)

	A&E		UCC		WiC	
	18-25	All other ages	18-25	All other ages	18-25	All other ages
Rate of attendances per 1000 population	**238.2**	287.1	**351.5**	243.5	**57.5**	31.1

4.3.2 Accident and & Emergency (A&E) use

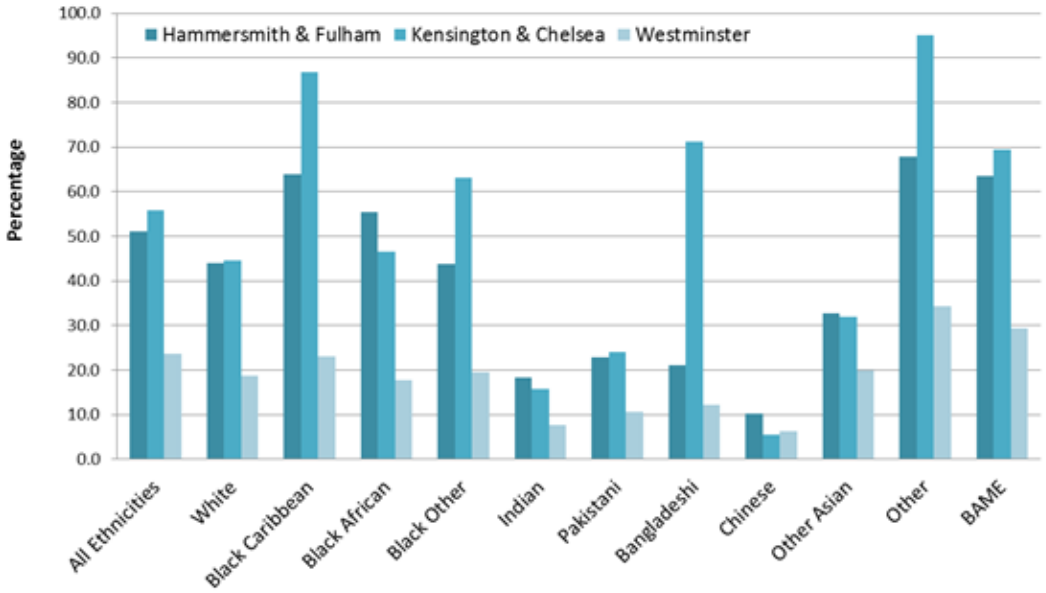
In 2015/16, there were 27,221 A&E attendances from the populations of the three boroughs aged 18-25, **11.5% of the total attendances.**

Figure 6: Numbers of A&E attendances in young adults age 18-25 by local authority and gender, 2015/16

The majority (80%) of A&E attendances in young adults were first attendances; 1% were follow-up attendances and 19% were not coded. **There was a higher number of females attending A&E.**

The chart below shows A&E attendances in young adults by ethnicity, as a proportion of the resident young adult population. There is a high proportion of young adult population in the Other, Black Caribbean and Bangladeshi groups that have attended an A&E department in the last year. However, the numbers may be skewed by individuals with high attendance rates in those ethnic groups.

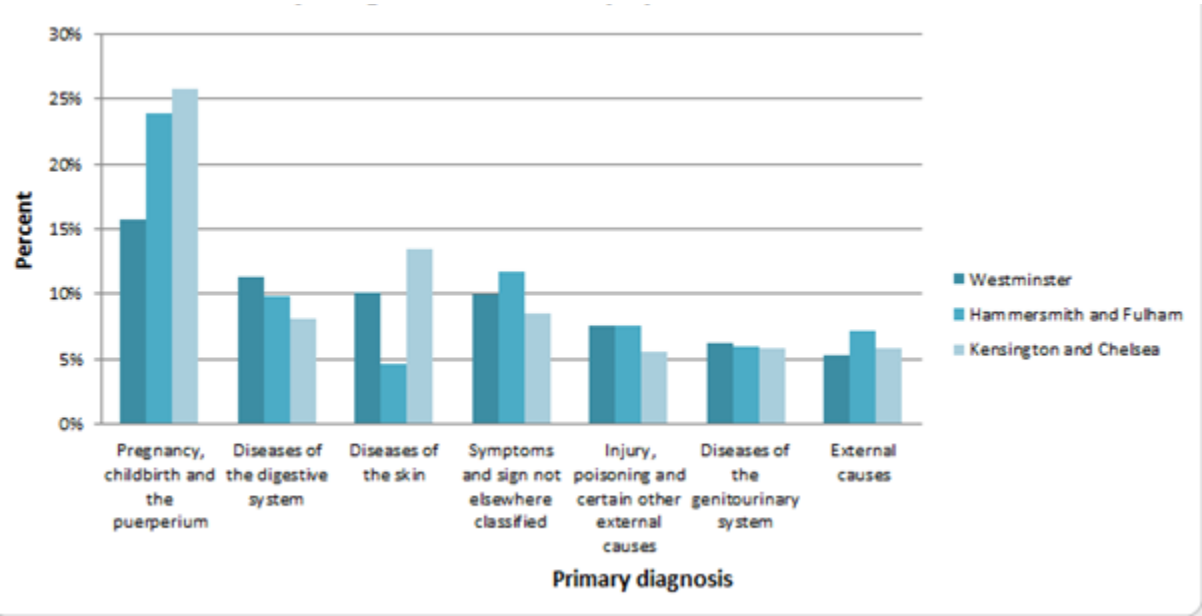
Figure 7: A&E attendances as a proportion of resident population by ethnic group, 2015/16



4.4 Inpatient admissions

Figure 8 below shows the most common primary diagnoses in young adult inpatients in each local authority. The top five diagnoses make up 60% of young adult inpatient admissions in Hammersmith and Fulham. "Pregnancy, childbirth and the puerperium" is the number one reason for admission in the young adult population in all three boroughs. There are higher hospital admissions in BME groups, due to their lower average age of pregnancy.

Figure 8: Young adult hospital admissions by main primary diagnosis and local authority, 2015/16



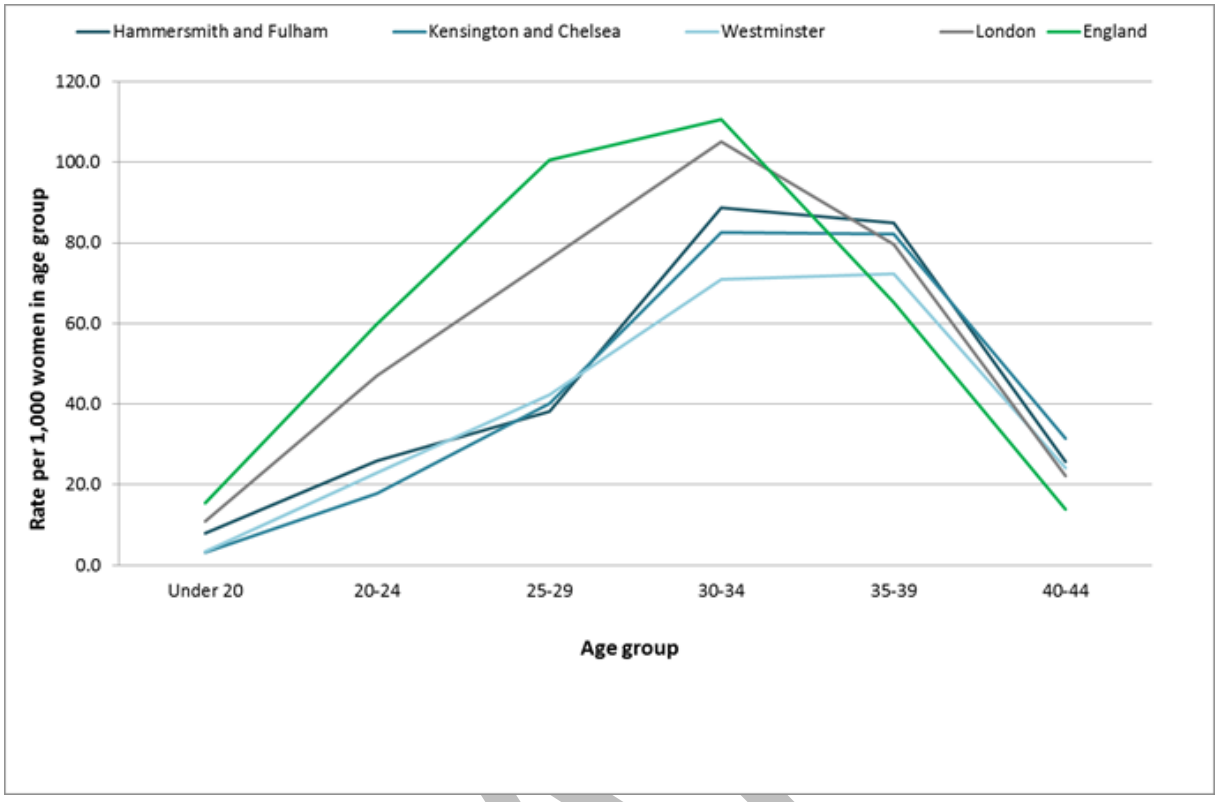
The most common inpatient diagnoses highlight some key themes that will be investigated further in this report, such as diseases of the genitourinary system (see sexual health chapter 8), injury, poisoning and certain other external causes (see substance misuse chapter 7) and diseases of the digestive system (likely to be alcohol related – see substance misuse chapter 7).

4.4.1 Births

The rates of births to mothers age 18-25 are lower in all three boroughs compared to London and England averages. Hammersmith and Fulham has higher numbers, particularly in mothers under the age of 20.

In 2014, there were 232 mothers age 20-24 in Hammersmith and Fulham. Figure 9 below compares the distribution of birth rates by age of mother between local boroughs, London and England. **Compared to the London and England average, Hammersmith and Fulham has a lower birth rate among mothers aged less than 30 years.**

Figure 9: Live birth rates per 1,000 females by age of mother, 2014



Source: ONS Live Births by Area of Usual Residence

5 Eating disorders

5.1 What is the issue?

Eating disorders are illnesses which disproportionately affect adolescents and young adults, and so constitute a key area of investigation in this report.

Eating disorders are mental health disorders that are characterised by an attitude towards food that causes people to change their eating habits and behaviour. Someone with an eating disorder may have a preoccupation with their weight and/or body shape which may lead to harmful eating habits, impacting negatively on their physical health and sometimes proving fatal.

The long-term negative effects of eating disorders can be seen across education, employment opportunities (lost employment is estimated to account for 69% of the total cost to society of eating disorders (McCrone, Dhanasiri, Patel, Knapp, & Lawton-Smith, 2008)), fertility, relationships and parenting. It puts a huge burden on family and carers (PricewaterhouseCoopers, 2015). Comorbidities commonly associated with eating disorders include depression and obsessive-compulsive disorder.

Table 4: Types of eating disorders

Eating disorder	Symptoms
Anorexia nervosa	Seeking to maintain a low body weight as a result of a preoccupation with weight: either a fear of fatness or a pursuit of thinness.
Bulimia nervosa	Recurrent episodes of binge eating and then trying to prevent weight gain through any one or a combination of behaviours, such as vomiting, fasting, or excessive exercise.
Binge eating disorder	Recurrent episodes of binge eating without compensatory behaviour (e.g. vomiting, fasting, or excessive exercise).
Atypical eating disorders	May closely resemble anorexia nervosa, bulimia nervosa, and/or binge eating, but do not meet the precise diagnostic criteria.

5.2 What do we know nationally?

5.2.1 Prevalence and incidence

Although eating disorders are not considered common, **over 1.6 million people in the UK are estimated to be affected**, and are most common in teenagers and young women. **For every male with anorexia or bulimia, there are 10 females** (Joint Commissioning Panel for Mental Health, 2013; NICE, 2014a).

Atypical eating disorders are the most common, followed by binge eating disorders and bulimia nervosa. **Anorexia is least common, but has the highest mortality amongst all psychiatric**

disorders. Research has shown that incidence of eating disorders (in particular atypical eating disorders) has been increasing (Micali, Hagberg, Petersen, & Treasure, 2013).

5.2.2 Link to substance misuse

Eating disorders show high levels of comorbidity with substance abuse disorders, depression, and anxiety disorders (World Health Organization, 2004). Individuals with eating disorders were up to 5 times as likely as those without eating disorders to abuse alcohol or illicit drugs, and those who abused alcohol or illicit drugs were up to 11 times as likely as those who did not to have had eating disorders. Up to 50% of individuals with eating disorders abused alcohol or illicit drugs, compared to 9% of the general population. Up to 35% of individuals who abused or were dependent on alcohol or other drugs have had eating disorders, compared to 3% of the general population (National Center on Addiction and Substance Abuse at Columbia University, 2003).

5.2.3 Causes of eating disorders

The evidence base on what causes an eating disorder is weak as is the evidence for successful prevention, but positive body image and healthy eating messages are thought to help. However, professionals should understand common risk factors to help identify an eating disorder:

- Family history of eating disorders, depression or substance misuse
- Gender – women and girls are more likely to develop eating disorders
- Age – eating disorders tend to present in adolescence and young adulthood
- Adverse life events, particularly involving relationships with close family or friends
- Socio-cultural factors such as the pressure to be thin
- Premorbid characteristics – perfectionism, low self-esteem [7]

5.2.4 Effective treatment

Treatment of eating disorders requires co-ordinated and multidisciplinary care across primary, secondary and tertiary care. Psychological interventions seek to address the core attitudes and improve longer-term outcomes for patients.

Existing good practice

Vincent Square uses guided self-help with a book for patients with low level needs. This is an evidence-based approach which is cost effective as each book is approximately £12, compared to £100 per person cost for web based self-help with lower engagement.

NICE set guidelines of evidence-based effective treatment in 2004 for all tiers[8]; an update is expected in 2017. In addition the Joint Commissioning Panel for Mental Health has produced guidelines for commissioning mental health services for people with eating disorders (2013).

Evidence- based treatment for eating disorders such as Cognitive Behavioral Therapy (CBT) should be available in a primary care setting. NICE guidance states that for people presenting in primary

[7] NICE Clinical Knowledge Summaries. *Eating disorders (online).* https://cks.nice.org.uk/eating-disorders (accessed 19.12.16)

[8] NICE Pathways. *Eating Disorders (online)* https://pathways.nice.org.uk/pathways/eating-disorders (accessed 14.12.16)

care, GPS should take responsibility for the initial assessment and coordination of care, and determine the need for emergency medical or psychiatric assessment.

Early detection and treatment may improve outcomes and so a key theme for effective treatment across eating disorders and levels of severity is waiting times. NICE advise that people with eating disorders should be assessed and receive treatment at the earliest opportunity. The more entrenched the illness, the less likely it is to be treatable. The FREED study demonstrated higher uptake of treatment when waiting times were greatly reduced and illness was in its first 3 years (Glennon, South London and Maudsley NHS Foundation Trust, & King's College London, 2015).

There is a clear pattern of delay in seeking help for eating disorders, which in turn delays diagnosis and treatment, creating more severe and long term impacts. A recent survey of eating disorder patients indicates that the speed at which help is initially sought has a material impact upon likelihood of relapse (PricewaterhouseCoopers, 2015). Effective treatment needs to take into account other health impacts such as dental issues and substance misuse for people with bulimia nervosa (NICE, 2004).

Good practice case study: Bristol

Bristol's Student Health Service initiated a discussion with Bristol Primary Care Trust (PCT) to set up an additional eating disorder service outside of secondary care, for people with less severe eating disorders who may not have been seen by the existing service, for example if they did not meet BMI criteria. The service had its pilot year in 2009 and has now been rolled out to the whole of Bristol due to its success. This service is a satellite of the main service and managed by the same provider, delivered in a timely way and crucially in partnership with GPs.

The GP can refer any suspected eating disorder patient to a specialist rapid assessment and triage service with the appropriate skills level (more specialist than a normal IAPT practitioner), which will either continue to see the patient in a primary care setting, or refer them onto the specialist secondary care service if appropriate. It is important that high need patients are not treated in this service without the expertise and wrap-around support of the secondary care service.

The service provides evidence that a primary care-based service can offer an appropriate and highly cost effective assessment process. Further, where interventions can be appropriately provided in primary care (i.e. for less complex cases) this too is more cost effective alternative than a referral to secondary or tertiary services. This allows the secondary care service to focus on offering a specialist, multi-disciplinary approach to those who need it most. It is estimated that the service is about 1/3 of the price per patient than the secondary care service. Additionally, it prevents cases from worsening to the point where secondary care is inevitable.

The service has received positive feedback from service users and local GPs, and effectively

5.3 What do we know locally?

5.3.1 Local service provision

Specialist: The specialist eating disorder service for Hammersmith and Fulham, Vincent Square Clinic, is provided by Central North West London Mental Health Foundation Trust (CNWL). Vincent Square Clinic provides inpatient and specialist outpatient care for children and adults in one service.

Other services: there are other services that identify patients with an eating disorder, but are not eating disorder specialists and may be unable to treat such patients. These include:

- Primary care - NICE recommends that GPs should take the responsibility for the initial assessment and coordination of care, as well as determining the need for emergency medical or psychiatric assessment. There must be a clear agreement between primary and secondary or tertiary care about who takes responsibility for monitoring people with an eating disorder.
- Dietetics – who will refer back to the GP to get a referral for eating disorder services.
- Talking Therapies (IAPT) – when an eating disorder is detected, they will refer back to the GP if this is the key presenting issue.

5.3.2 Gaps in local service provision

The only specialist eating disorder service for adults is in one secondary care clinic for all three boroughs. National and local strategies require the development of out of hospital services and early intervention to protect mental and physical health and wellbeing, so eating disorder patients should be able to receive treatment in the community closer to home – in particular patients who are not yet severely unwell or do not meet diagnostic criteria. Treatment in primary care is highly cost efficient and preferable for lower level patients. (see Bristol Case Study above).

Such a service would offer NICE recommended rapid triage and assessment by a skilled practitioner in partnership with GPs, without the need for referral to Vincent Square clinic, and, as clinically indicated, up to 26 weeks of CBT and GP-based support for those with emerging but not life-threatening Eating Disorders, or onward referral to Vincent Square for those who require it.

5.3.3 Numbers in eating disorder services

Table 7 below shows that the majority of patients are treated for anorexia nervosa and bulimia nervosa and 'unspecified' (which often resembles anorexia and bulimia but does not meet all of the diagnostic criteria such as BMI). Although anorexia nervosa is the least common eating disorder, it is the most common to receive treatment for locally and nationally due to the seriousness of the illness. The numbers receiving a service (Tables 7 and 8) is not a good measurement of local need, as demand is high and waiting times are long.

Table 5: Number of 18-25 year olds attending CNWL Eating Disorder clinics from 2013/14 to 2015/16 from the three local CCGs by type of diagnosis

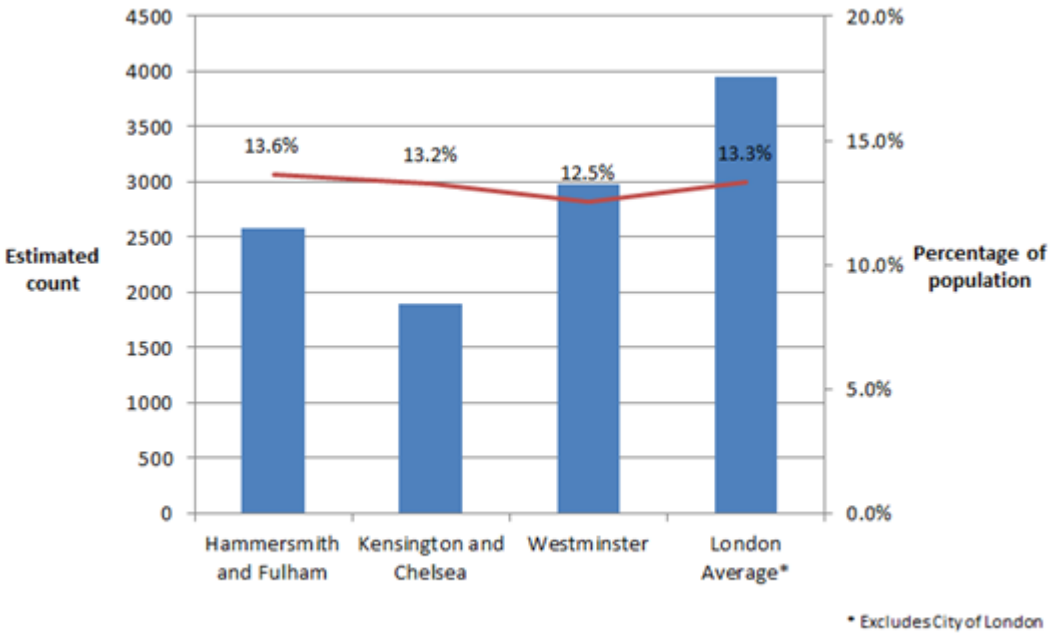
Anorexia nervosa	Bulimia nervosa	Eating disorder, unspecified
80	90	62

5.3.4 Estimated prevalence

Scoring two or more on the SCOFF scale is the clinical threshold that should prompt a more detailed investigation to be undertaken to diagnose eating disorder, although not everyone scoring two or more on this scale would be eligible for a service. If more GPs were trained to use the SCOFF scale more actively, there would be an even greater pressure on the current service for assessments, but would importantly enable eating disorders to be picked up proactively before the condition

deteriorates. Figure 10 below shows the estimated numbers of local people age 16-24 who score two or more on the SCOFF scale.

Figure 10: Estimated prevalence of potential eating disorders among young people



Using the estimates in Figure 10, table 8 shows clearly that the current service is only able to see a small fraction of the estimated number of people with an eating disorder.

Table 6: Number of 18-25 year olds attending CNWL Eating Disorder clinics from 2013/14 to 2015/16 by CCG

CCG	CNWL Patients	Estimated prevalence (borough)
Hammersmith and Fulham CCG/ borough	87	2580
Central London CCG / Westminster	126	2975
West London CCG / Kensington and Chelsea	79	1899

5.3.5 Referrals

The GP practices with the highest numbers of referrals to Vincent Square are the practices with the highest numbers of registered young adults in each CCG. However as a percentage of young adult population, **the highest patient referral rates came from Richford Gate (1.41%), Marylebone Health Centre (1.05%) and King's Road Medical Centre (1.06%).**

5.3.6 Access to services

Using a model that estimates ED prevalence based on ethnicity (Solmi, Hotopf, Hatch, Treasure, & Micali, 2016), it appears that **locally 'white' patients have a significantly better access to services than 'Black' or 'Asian' as well as 'Other'.**

Table 7: Ethnicity of Vincent Square patients from the three boroughs compared to estimated prevalence

Ethnicity	Number of patients	Estimated number of people with eating disorders	Estimated % accessing a service
White	207	2265	**9.1%**
Black	7	725	**1%**
Asian	18	1638	**1.1%**
Other	40	954	**4.2%**

5.3.7 Challenges identified by local practitioners

- **Waiting times for services**: Whilst the children's eating disorder service sees new referrals very quickly, particularly since the launch of the new rapid access service, the adult service has a waiting time of up to a year and frequently over 8 months. Whilst the secondary care service is very good, less severe patients would benefit from an early intervention community service based in primary care. As mentioned above, the less entrenched the illness, the higher the chance of recovery and patients seen within a short time of referral are significantly more likely to enter treatment.
- **Transfers of care:** Transitioning from the children's to adults' service works well locally as the provider is the same, but it is more challenging when a young adult moves to a different borough, which is common at this age (see figure 3 above - migration).
- **Liaison between services:** Good relationships and links between services are hindered by capacity. There is a lack of a network of professionals who come into contact with eating disorder patients. Other services may be unaware of appropriate referral pathways.

> ***Existing good practice***
>
> LBHF have a Child Health Network WhatsApp group through which professionals communicate about problems and advise each other.

- **Training:** Training was identified as a red flag for improvement in several areas. Clear guidance is needed on identifying and monitoring eating disorders.
  - Professionals outside of ED services are inconsistently knowledgeable of how to work with people with eating disorders, particularly if it is not the primary issue they are presenting with, and do not know the correct pathways. Clear guidance is needed on how to manage ED patients in primary care, e.g. how to monitor blood and weight, particularly as BMI isn't always the best indicator. **Free resources for health care professionals can be found here**.
  - Training for frontline staff in a motivational interviewing approach was identified by local experts as a positive opportunity to effectively upskill the workforce
- **Awareness:**
  - Many young people are not aware of the health risks of being underweight
  - Many people, including young adults, professionals and families, are not aware of the signs of eating disorders
  - There are opportunities to raise awareness amongst young people with eating disorders such as in bathrooms in colleges and university buildings.

- **Gender:** Young men are underrepresented in their estimated numbers in services. Local practitioners identified that boys and young men are not aware of having an eating disorder, but have similar characteristics related to an obsession with body image such as excessive exercising and not eating a healthy and balanced diet. However, they are less likely to engage with services. This perception is supported in recent research (Räisänen & Hunt, 2014; Strother, Lemberg, Stanford, & Turberville, 2012; Sweeting et al., 2015) which also highlights the potential impact that delayed help-seeking behaviour may have on treatment outcomes (Räisänen & Hunt, 2014).
- **System / Commissioning issues**: As NHS England commission the local specialist mental health service for eating disorders, the CCGs are less involved and do not receive monitoring information. Currently, there is only an eating disorder service in a secondary care setting.

5.3.8 Opportunities

The North West London CCG Collaborative mental health transformation programme Like Minded, of which *Serious and Long Term Mental Health Need* is a key population group has resources for transitional support until funding can be transferred from secondary care when demand is reduced.

5.4 Recommendations

Gap / challenge	Potential solution / recommendation
A small fraction of the estimated numbers of young adults with eating disorders are being seen in services. Additionally, evidence shows better outcomes when ED is treated promptly in the first 3 years of the illness, but waiting times locally are long. National and local strategies require the development of out of hospital services and an early intervention approach to protect mental and physical health and wellbeing. There is currently only a service in secondary care. The exemplar primary care eating disorder service in Bristol provides cost-effective and well received help before the patient's condition deteriorates and requires treatment in secondary care.	1. Review the eating disorder pathway as part of Like Minded *Serious and Long Term Mental Health Need* population group Business Cases. Consider ways to provide an early intervention eating disorder service in primary care offering NICE recommended rapid triage and assessment by a skilled practitioner in partnership with GPs for those with emerging but not life-threatening Eating Disorders. a. Such a service would then be capable of providing the leadership and momentum for the following recommendations.
Current NICE guidelines are from 2004, and new guidelines are expected in 2017.	2. Review existing services against new NICE guidelines when available in 2017.
Professionals outside of specialist ED services do not consistently understand what to do when an eating disorder is identified, and how to manage an eating	3. Map pathways and create a tool for professionals to use to enable appropriate and timely referrals.

disorder patient.	4. Offer guidance to GPs and other health professionals to identify and then work constructively and appropriately with people with an eating disorder. a. Identify GPs with high numbers of young adults and low referral rates to eating disorder services as a target group for training.

6 Care Leavers

Care leavers are a group of young people who are disproportionately affected by some of the issues discussed in this JSNA. Although their physical health has not been found to be substantially different to the general population, their mental health needs are higher and some lifestyle choices affect their health needs (such as higher usage of substances). Additionally, former unaccompanied asylum seeking children (UASC) have particular physical and mental health needs.

Care leavers are a highly transient population, and some will experience the breakdown of placements, which can cause interruption to health services they are receiving. These issues may shape their help-seeking behaviours.

Whilst many care leavers go on to have good health and wellbeing as adults, a number are more vulnerable and require consideration as a specific cohort. New research underway by The Care Leavers Association suggests that there may be more long-term impacts on the physical and mental health, later in life, of people who have been in care.

6.1 Who are Care Leavers?

The term 'care leavers' refers to a person aged 25 or under, who has been looked after by a local authority for at least 13 weeks since the age of 14. At age 18, a looked after child is no longer in care, but the local authority still has a responsibility to them as a care leaver until age 21, or up to age 25 if they are in full time education. Looked after children can stay in stable foster placements up to the age of 21, but those in residential care must leave at age 18 and are likely to be more vulnerable.

The definition also includes current and former Unaccompanied Asylum Seeking Children (UASCs), who are care leavers who have more particular health needs. UASC are defined as people under the age of 18, who are applying for asylum in their own right, and are separated from both parents and are not being cared for by an adult who in law or by custom has responsibility to do so. The number of UASC has almost tripled in the last two years. The Home Office statistics show that 61.3% of UASC are aged between 16 and 17 when they arrive, and so would go almost straight into leaving care services.

Young adults that the local authority has a responsibility towards because they have been remanded in Local Authority care or in a Young Offender institute for 13 weeks or more also become care leavers. Both groups have specific needs.

Care leaver statutory requirements are set out in the Children Act 1989 (Department of Education, 2014) and in the Children Leaving Care Act 2000[9].

New legislation is expected to come in 2017 following the *Keep on Caring* government strategy (HM Government, 2016) which will extend the duty on local authorities to provide a personal advisor and other services, such as training costs for apprenticeships, for all care leavers up to the age of 25

[9] HM Government. *Children Leaving Care Act 2000 (online)* http://www.legislation.gov.uk/ukpga/2000/35/contents (accessed 14.12.16)

(instead of 21). This will mean that the local authority will have a duty to a far greater number of young people, and will be unlikely to have more resources.

6.2 What do we know nationally?

Care leavers face complex psychological challenges. While most young people make a gradual transition to independence, supported by their family, care leavers often experience multiple, overlapping and simultaneous changes in their living circumstances.

National evidence shows that care leavers consistently experience some of the worst health, social, educational and employment outcomes in our society (Driscoll, 2011; Dunlop, 2013; Philip Mendes, 2009; P. Mendes & Moslehuddin, 2006). For example, **care leavers are more likely to have poor mental health, have poor dental health, experience homelessness, not succeed academically, live in poverty, and be more commonly represented in the criminal justice system**. **Additionally, nearly half of female care leavers are mothers by the age of 24** (Fallon, Broadhurst, & Ross, 2015). This is often a consequence of living a fragmented life, moving from one placement to another, and severing important relationships with family and support networks. The disadvantages that care leavers experience before entering care can then be compounded by their experiences in care (P. Mendes & Moslehuddin, 2006).

6.3 What do we know locally?

The numbers of current care leavers and LAC about to become care leavers can be seen in table 10 below. Table 11 shows that **33-45% of young people in the three boroughs come into the care system at age 16 and over**, which is when preparation for adulthood and leaving care takes place. This is compared to 20% nationally and 30% across London coming into care age 16+.

Table 8: Current numbers of LAC and Care Leavers in services (2015/16)

	Looked After Children age 15-17	Care Leavers age 18+
LBHF	94	165
RBKC	52	134
WCC	64	178

Table 9: Age at which children and young people enter care, by borough

Age (years)	Hammersmith & Fulham		Kensington & Chelsea		Westminster	
	2014-15 entries	as of 31/01/2016	2014-15 entries	as of 31/01/2016	2014-15 entries	as of 31/01/2016
0 to 15	66%	71%	57%	62%	62%	65%
16 and over	**33%**	**30%**	**43%**	**38%**	**39%**	**35%**

6.3.1 *Current and former Unaccompanied Asylum Seeking Children (UASC)*

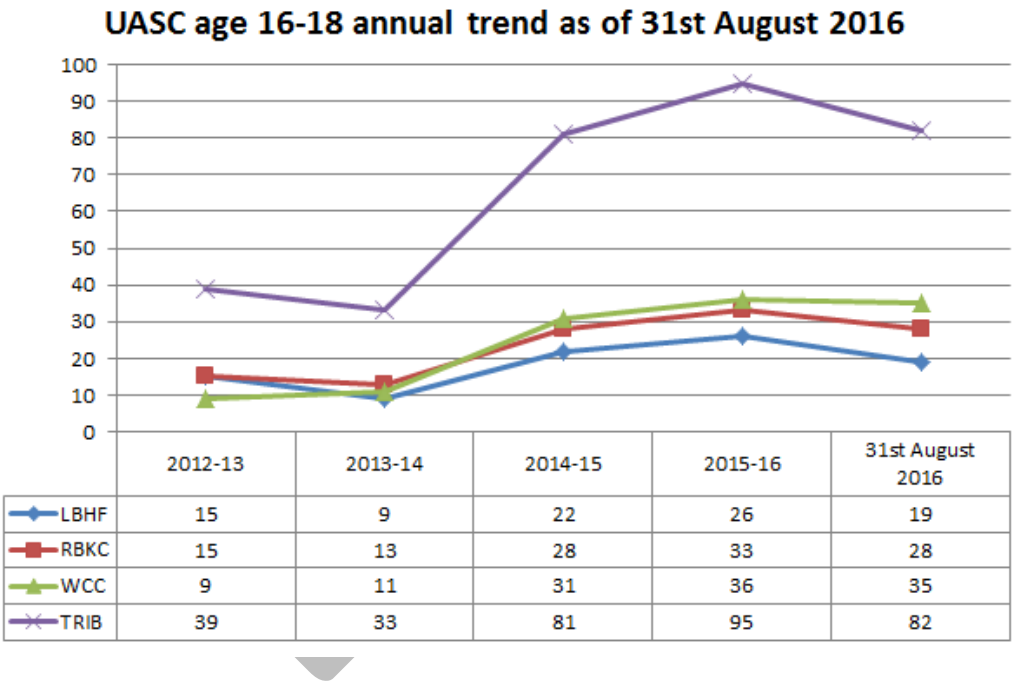
The number of care leavers who are either under the age of 18 and so still UASC, or 'former UASC' if over the age of 18 but with similar health needs, has also increased locally (see Figure 11 for UASC age 16-18).

Local Authorities are expected to take a number of UASC that equates to 0.07% of their child population. However numbers are not expected to increase as sharply as they have over recent years as numbers above the 0.07% will be distributed to other local authorities.

Table 10: Number of former UASC care leavers by borough

Local Authority	Count as of 31st March 2016	% of all care leavers
Hammersmith and Fulham	52	31.5
Kensington and Chelsea	53	39.7
Westminster	29	16.3

Figure 11: Numbers of UASC looked after children age 16-18 in the three boroughs, 2010-31st March 2016 (Source: Frameworki)



The UASC that the three local authorities have responsibility for are placed all over London, so are not concentrated in one particular area. NICE quality standards state that looked-after children and young people who move across local authority or health boundaries must continue to receive the services they need.[10] However, an audit of UASC in England found that the receiving local authorities are rarely informed of these transfers and keep no record of unaccompanied children placed from other local authorities (Humphris & Sigona, 2016). Although the three local boroughs have a clear

[10] NICE (2013). *Looked-after children and young people (online)* https://www.nice.org.uk/guidance/QS31 (accessed 28.10.16)

system for their UASCs placed out of borough, it could be inconsistent for care leavers from other boroughs placed within the three boroughs.

6.4 Care leaver health needs

An audit of the health records of care leavers in the three boroughs suggests that their physical health needs are not different from a normal child or young adult. However, they find it harder to engage with health services, so conditions deteriorate. Not having a parent-type figure telling them to go to a doctor can mean they are less likely to do so.

The health needs of care leavers are described below using: national evidence; evidence from a workshop for local professionals who work with care leavers; evidence from groups of care leavers consulted in the process of developing this JSNA; and evidence from the formal consultation held on health for each of the Corporate Parent Boards.

6.4.1 Mental Health needs

Children in care have higher rates of mental health problems than the general population; nearly half have a mental health disorder (HM Government, 2011, 2013). For many, this persists past the age of 18. The risks of not addressing mental health needs (including 'low level' mental health needs) are known to impact on physical health, education, employment, and relationships. **National and local evidence overwhelmingly supports the option to extend CAMHS for care leavers up to age 25 based on need:**

- The government report *Future in Mind* (Department of Health & NHS England, 2015) acknowledges that care leavers are more vulnerable to mental health problems and find it harder to access help, and that mental health services must get it right with this cohort. The report recommends promoting resilience, prevention, and early intervention for good mental health for all. The report adds that for many, adult services are either not available or not appropriate, and recommends flexibility around age boundaries and transition based on individual circumstances rather than age.
- In a 2015 report (Bazalgette et al., 2015) the NSPCC have described the withdrawal of CAMHS at 18 as a "cliff edge" and recommended that local authorities and health services should work together to provide mental health support for care leavers up to the age of 25. Extending mental health support for care leavers until the age of 25 was also included in the Alliance for Children in Care and Care Leavers' seven key recommendations to the House of Commons Education Committee report (House of Commons Education Committee, 2016).
- Locally, the Anna Freud Centre needs assessment of CAMHS recommends a 'tapered transition' to Adult Mental Health Services (AMHS) between the ages of 16-25, which would allow people already receiving CAMHS could continue even though they wouldn't meet the eligibility criteria for adults. It would also allow a young person to choose whether to be seen in Children or Adult services if they are aged 16 or over when they first become known to mental health services.
- **Local practitioners identified that the biggest area of unmet need is in mental health needs that do not meet AMHS threshold or diagnosis criteria.** It is recognised nationally and by local practitioners that adults' services are very different to those offered to children, as CAMHS has a far lower eligibility threshold than AMHS. The tapered transition from CAMHS

up to age 25 would make a significant difference, however, **professionals have identified that many young care leavers are only just ready to start engaging with CAMHS at the age of 18 or over.** This 'tapered' model would not allow them to start engaging with the service at that age – they could only continue an existing relationship. Additionally, LAC CAMHS provides a more specialist service with more therapeutic interventions and specialism in trauma, which is particularly needed with such high numbers of former UASCs.

Furthermore, CAMHS must be able to work flexibly with this cohort as some lead more chaotic lives and are more likely to miss appointments and prefer visits outside of clinical settings.

The consultations with care leavers discussed emotional wellbeing and mental health. A number of issues were reported:

- It can be difficult for an individual to recognise when they (or someone else) has a mental health condition
- Some lack of awareness of mental health, of services available, and of coping strategies such as mindfulness
- Mixed experience of therapies. One consultation reported that talking therapies were popular for emotional issues as young people said that they needed someone who would listen and be reliable. In the other group, all of those who spoke of counselling reported negative experiences and that it made matters worse.
- Young people didn't want to be told it is 'only mental health' in response to their emotional problems.

6.4.2 Alternatives to CAMHS / AMHS

In some cases, IAPT may be a suitable option and should be promoted to care leavers. A practitioner noted that IAPT is not popular with care leavers as it is not well understood as a service by professionals, who then do not advise care leavers to try it. However, IAPT is best suited to people with a structured definition of depression or anxiety, whereas **many care leavers' problems are emotional, behavioural and relational, but do not fit a diagnosis category.** Local clinicians reported that sometimes a diagnosis such as personality disorder is given to get the young person a service, but this may be unhelpful and carry a stigma.

Local good practice

Local professionals noted that having a clinical psychologist in the Leaving Care team has made a noticeable difference just working 2/3 days a week in RBKC.

For some care leavers, **their need could be met outside a clinical setting**. A study of mentoring for young people leaving care concluded that mentoring offers them a different style of supportive relationship but one which complements formal professional support. In the study, 93% had some 'positive outcomes' from their mentoring relationship (Clayden, Stein, & University of York, 2005).

6.4.3 Emotional needs

Many care leavers are not mentally ill, but are emotionally vulnerable. There are a wide range of 'emotional ages' and the needs of care leavers will vary considerably.

The **quality of individual relationships** is very important to care leavers, and often requires great flexibility on behalf of the professional. Care leavers have a variety of people they may form a

particularly close and trusting relationship with; this can be their social worker, personal advisor, a nurse, CAMHS worker, guardian or foster parent, or key worker from a provided service.

Continuity is felt to be incredibly important for people going through the transition of leaving care. For example, the Virtual Schools are felt to be effective, but the teachers want to continue to work with the young person after they turn 18.

Care leavers have less support infrastructure with more pressure than other people their age. Young care leavers often live alone at a far younger age than their peers, causing social isolation which is well evidenced to cause deterioration in health and wellbeing (Durcan, Bell, & UCL Institute of Health Equity, 2015).

The issue of confidentiality around physical and emotional health was important to care leavers, as this was not always possible when they were looked after children. The young people interviewed also had some flexibility in their views on confidentiality, stating that if it was "life or death" or "puts someone else at risk" then there may be exceptions to their confidentiality.

6.4.4 Substance misuse and chaotic lives

A small number of care leavers lead 'chaotic lives', bringing them into contact with a range of services and professionals. Substance misuse is often a symptom or cause of a chaotic lifestyle; it is estimated that 11% of care leavers have problematic alcohol use and 21% have problematic drug use. Care leavers are twice as likely to have used illegal drugs as the general population.

6.4.5 Dental health

Looked After Children have regular dental checks, however care leavers are more likely to experience poor dental health than their peer groups. During consultation with a group of local care leavers, none had been to the dentist in the last 12 months because of the cost.

6.4.6 Sexual health

The care leavers at the Corporate Parent Board consultation reported that the most talked about health topic was sexual health.

Professionals have identified that **'inappropriate' sexual relationships** which are not illegal present a challenge to professionals where they believe a young person is vulnerable, but has mental capacity. This links to the findings when discussing sexual health with young people around peer pressure (see chapter 8 – sexual health, where this topic is discussed in more detail), but may be more extreme in care leavers who have not seen a model of a positive relationship.

6.4.7 Pregnancies

A quarter of young women leaving care are pregnant or already mothers. **Almost half of female care-leavers become mothers between the ages of 18 and 24,** compared to 29% of women aged 24 or under in the general population.[11] Young people with a background in care are more likely to continue a pregnancy, planned or unplanned. This group is also more likely to experience poor

[11] According to Community Care research article, citing earlier research briefing by SCIE. Available at http://www.communitycare.co.uk/2008/01/23/teenage-pregnancies-among-children-in-care-research/ (accessed 19.12.2016)

outcomes including having a low birth weight baby, single parenthood, and symptoms of depression, and are more likely to smoke during pregnancy (Fallon et al., 2015).

Research also suggests that teenage motherhood (defined as conception under the age of 20) has a detrimental effect on later life outcomes. Teenage mothers, by age 30, experience lower rates of employment, lower wages, lower levels of educational attainment and higher benefits needs. This effect is more pronounced for young women who conceived between the ages of 18 and 20 (Walker, Goodman, & Kaplan, 2004).

6.4.8 UASC-specific physical health needs

UASC have very different physical and mental health problems to the indigenous population. Examination of the LAC nurse's records and relevant social work notes reveals a range of physical and emotional effects as a result of the journey, and sometimes of conditions and experiences in the young people's home countries beforehand.

Typically, the medical history of a UASC is unknown, including vaccinations. Common physical complaints, which seem to be the result of deprivation on the journey, are abdominal conditions and various musculo-skeletal issues. There also seems to be a high incidence of dental need, but it is not entirely clear whether these are the result of pre-existing conditions or as a result of the journey to the UK. Common low-level health problems are ringworm and scabies when UASC first arrive.

6.4.9 UASC-specific mental health needs

NICE states that UASCs have an increased likelihood of mental health problems, suicide attempts and mental illness, due to post-traumatic stress disorder and ongoing stress arising from language barriers, immigration systems and being separated from loved ones and community (Simmonds, Merredew, & British Association for Adoption and Fostering, 2010).

Separation, bereavement and uncertainty about the fate of loved ones often has a negative emotional impact. Additionally, emotional distress can sometimes be observed due to a lack of understanding of the situation after arrival due to language barriers.

Anxiety over the immigration process and the implications of getting a negative decision, such as the threat of an involuntary return to their home countries, are also influential factors on UASC's wellbeing. It has also been suggested by some practitioners that anxiety caused by the effort of maintaining a (potentially false) story to be conveyed to the Home Office may have a negative effect on wellbeing.

Several young people were supported to cope with the effects of these issues through LAC CAMHS specializing in trauma up to the age of 18, but are not necessarily eligible for adult mental health services.

6.4.10 Care leavers in custody

The recent Ofsted inspection of Hammersmith and Fulham's Children's Services noted that greater focus needs to be given to young care leavers in custody. Nationally, care leavers are over-represented in the criminal justice system. Research by the Ministry of Justice (Williams, Papadopoulou, & Booth, 2012) found that **24% of the adult prison population had been in care at**

some point as a child, and reported that this was comparable with the 1991 National Prison Survey showing that 26% of adult prisoner were in care as a child (only 2% of the general population spend time in prison)**.** As discussed under 'mental health' above, there is also an over-representation of mental health needs in this cohort, and so early identification and better outreach should be done proactively with care leavers in custody.

6.5 Local service provision and use

Consultation with practitioners during the JSNA process has highlighted **tension between wanting to teach care leavers to be independent adults, and offering additional support**. Care leavers are the most vulnerable group of young adults; if services cannot be flexible to them, they will continue to fall between the cracks.

6.5.1 Services up to age 18

Up to age 18, the following services are used by Looked After Children and younger care leavers:

Service	Description
LAC CAMHS	Many care leavers would have accessed CAMHS up to age 18.
LAC Nurses	This service is only available to looked after children and care leavers up to the age of 18. The LAC nurses give annual health checks to young people and oversee regular dental checks. In practice, LAC nurses often give ongoing support and advice and communicate with their patients' personal advisors
Healthcare summaries	At the request of young people, care leavers are offered a health summary when they leave care.
Focus on Practice clinicians/ family therapist	Work with young people to provide an effective therapy service.

6.5.2 Care Leaver services

The following services are for care leavers over the age of 18:

Service	Description
Leaving care teams / Independence Support Team	Leaving care teams facilitate the transition for a young person from being 'looked after' to being a 'care leaver'.
Care Leavers Child Psychologist (RBKC only)	One psychologist placed within the Leaving Care team
Personal Advisors / keyworkers / foster carers	Provide health and wellbeing support such as healthy eating classes

The Children's Services and Leaving Care services have been recently rated as 'Outstanding' and 'Good' by Ofsted.[12] Local professionals have noted that the quality of social work has improved, particularly since the Focus on Practice training.

A challenge that has been identified locally is that care leaver services are provided during the week during working hours, however care leavers often need support 'out of hours' too.

6.5.3 Access to universal services

The key issue highlighted throughout the development of the JSNA was the transition from children's services to adults (over 18s) and the different inherent philosophies – under-18 services focus on the family unit, while adult services focus on the individual self-managing. Young adults' personal motivation and confidence to seek help and support may be in its infancy, and therefore they may not take up services that are geared towards self-determination and self-help. As a result, there can be issues with care leavers (and young adults generally) engaging with services. This is particularly prevalent when attempting to access mental health assessments.

Local good practice

Outreach work by LAC nurses has a positive impact, especially where the nurse is able to discharge to a GP with an understanding of young adults, and is able to discuss the transition with the care leaver at an early stage so they know how to independently access adult general health services.

A number of barriers to accessing services were reported by the small group of care leavers including:

- cost of certain services, particularly dentistry/oral health
- not always able to make an appointment with GP
- not always able to see the same GP or other health professional – continuity was important for care leavers
- transition from children's services to adult services was highlighted as an important issue (for example from CAMHS to adult mental health services).

When asked about developing health services for young people, awareness about drugs and smoking was suggested (for more information on substance misuse, see chapter 7).

At the consultation for the Corporate Parent Boards the majority of young people rated health as important. However barriers to prioritizing health included:

- the cost of gyms
- being busy with other things such as work or college
- living on a very tight budget.

6.5.4 Help-seeking behaviour

Most of the care leavers consulted reported waiting until a problem is severe before seeking help, and would often go directly to A&E rather than their GP. This was partly due to previous negative experiences with GPs.

[12] Inspection reports can be viewed on the Ofsted website https://www.gov.uk/government/organisations/ofsted (viewed 28 October 2016)

When seeking advice on health issues, care leavers mentioned non-health professionals such as social workers, personal advisors, key workers and carers. **The importance of a strong and trusting relationship with a professional or guardian/foster parent to help care leavers through different challenges in life was a recurring theme.**

A recommendation from one of the consultations was use of a health app for young people with tailored information. NHS Go provides this platform, and promoting it and ensuring local services have up to date information on NHS Choices (the information source for NHS Go) would be more cost effective than creating a new app.

6.5.5 Communication and Co-location of services

Communication between children's services and adults' services was highlighted as an area for improvement. Although good practice exists, it is not always consistent between all relevant services.

Co-location was consistently discussed as an effective way to improve communication and encourage young adults to access a range of appropriate services. Young adults are more likely to miss appointments and less likely to visit GPs to obtain referrals, which has been improved in other areas through co-location. (See case study in chapter 6, primary care).

Co-location local good practice

Care leaver group drop-in sessions in Westminster which take place one evening a week have been used by staff to have 'health days': care leavers visit stations relating to different health issues such as oral health and sexual health. The group sessions have other positive impacts; participants are encouraged to discuss their feelings and build a peer support network.

6.6 Recommendations

Gap / challenge	Potential solution / recommendation
Looked after children have higher rates of mental illness than the general population; nearly half have a mental disorder. During consultation with care leavers, there was a lack of awareness of mental health and coping strategies. However, some may not want help in a clinical setting. National evidence suggests good outcomes for mentoring, which may be more appropriate where psychological therapies are not wanted.	1. Actively promote resilience, prevention and early intervention for good mental health for all in generic services for care leavers. a. Review current and past mentoring and peer mentoring schemes in the three boroughs for care leavers and / or young adults.
The greatest area of unmet health and wellbeing needs of care leavers is mental health and emotional wellbeing that would not meet the threshold for Adult Mental Health Services.	2. Extend existing CAMHS or LAC CAMHS services to a tapered service for 16-25 year old care leavers to give continuity to those with a relationship with the

The Anna Freud Centre needs assessment for CAMHS recommended a tapered transition from age 16-25. LAC CAMHS see children over long time periods and specialise in trauma, which is most appropriate to this cohort. Some care leavers have existing relationships with LAC CAMHS staff which they would benefit from continuing; other are not ready to engage with counselling services until they are age 18 or above.	service, and extend the offer to include care leavers age 18-25 not already open to LAC CAMHS who are not eligible or suitable for Adult Mental Health services. a. The offer to care leavers should include flexibility if appointments are missed or service users don't want to be seen in a clinical setting.
A significant proportion of local care leavers are former UASCs, and have specific health and care needs.	3. Professionals including Leaving Care teams to be fully trained on NICE guidance for unaccompanied asylum seeking and trafficked care leavers
Consultation with care leavers identified that many sought advice from non-health professionals who they had a trusting relationship with e.g. their social worker. Although almost all are registered with a GP, most prefer to use walk in centres, A&E and urgent care. The needs and preferences of care leavers vary significantly from person to person, meaning a specific service may not be appropriate.	4. Non-health professionals working with care leavers e.g. personal advisors and key workers should routinely take an active role in the health of care leavers, such as taking them to the GP, and encourage seeking help in the appropriate setting. a. Pilot a personal budget for care leavers, where an assessed physical or mental health need is established, to allow them to choose a relationship with the professional that best meets their needs.
A small number of care leavers have significant multiple complicated physical, mental and social care needs, and a large number of professionals become involved in their case.	5. Pilot a transitions panel similar to the disabled children's panel for cases of care leavers with multiple or complicated needs.

7 Substance misuse

7.1 What is the issue?

Substance and alcohol misuse is a key issue for adolescents and young adults. The level of any drug use in the last year was highest among 16 to 19 year olds (18.8%) and 20 to 24 year olds (19.8%). In contrast, the level of drug use was much lower in older age groups (2.4% of 55 to 59 year olds). **5.1% of young adults aged 16-24 were classed as frequent drug users. Drug related deaths reached record levels in 2015;** 3,674 drug poisoning deaths involving both legal and illegal drugs were registered in England and Wales in 2015, the highest since comparable records began in 1993 (Lader & Home Office, 2015).

Cannabis, ecstasy and powder cocaine are most commonly used by 16-24 year olds, with **16.3% using in the last year,** compared with 6.7% for the general population (Lader & Home Office, 2015).

Drug and alcohol interventions can help young adults get or stay in education, employment and training; prevent homelessness; and improve family relationships key to recovery, bringing a total lifetime benefit of up to £159m. **Every £1 spent on young adults' drug and alcohol interventions brings a benefit of £5-£8** (Public Health England, 2014)**.**

Figure 12: National age-specific trends in drug use

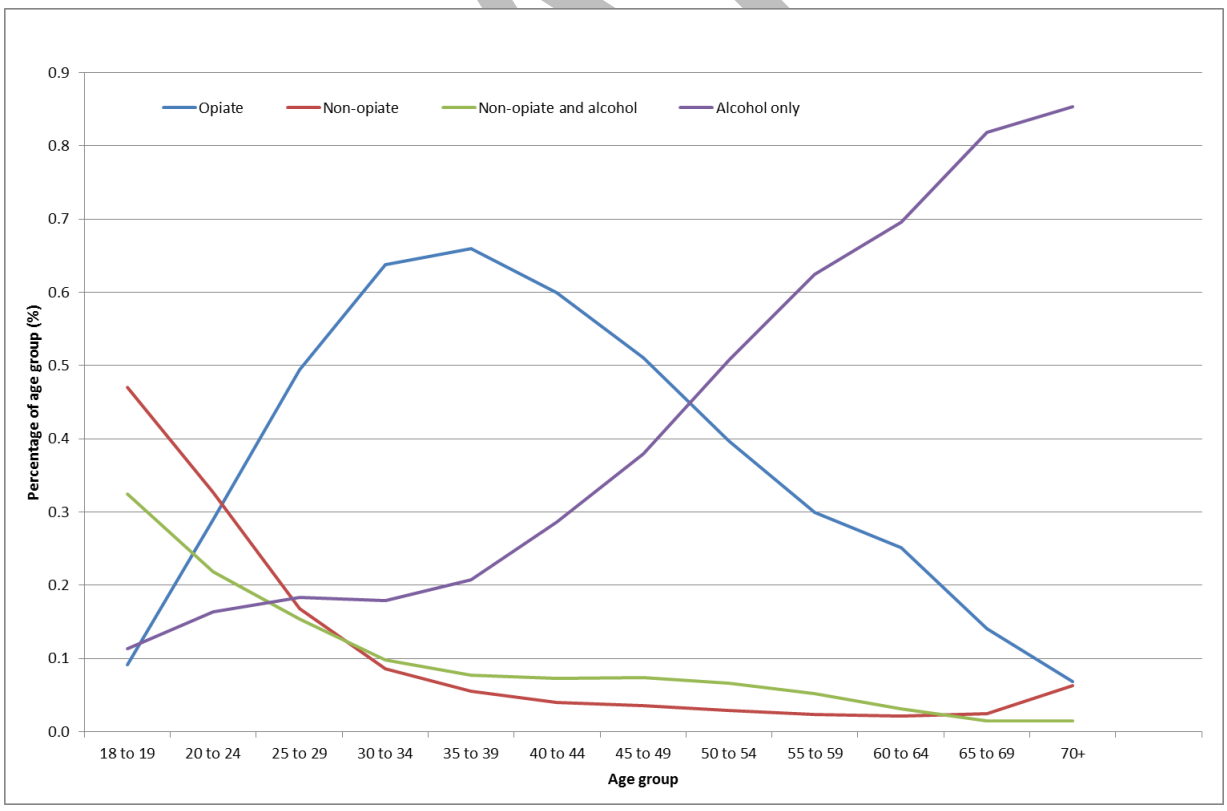


Figure 12 above shows that the key drug that adults present for treatment is opiates, however this is only the case after the age of 24. **For 18-24 year olds, non-opiates and combined non-opiates and alcohol are the primary drugs. This information is based on treatment population, so although it**

may not necessarily be indicative of need in the wider population, it does highlight the disparity around the substances which bring people into services.

Links to other chapters

As discussed in chapter 5 on Eating Disorders, those who abused alcohol or illicit drugs were up to 11 times as likely as those who did not to have eating disorders - up to **35% of individuals who abused or were dependent on alcohol or other drugs have had eating disorders, compared to 3% of the general population** (National Center on Addiction and Substance Abuse at Columbia University, 2003).

As discussed in chapter 8 on sexual health, there is a strong link between alcohol abuse and poor sexual health outcomes, including unplanned teenage pregnancy and sexually transmitted infections (P. Cook et al., 2010).

7.2 National strategy and guidance

7.2.1 Drug Strategy 2010

The Government's 2010 Strategy (Home Office, 2010) stated that specialist interventions should prevent young people's drug and alcohol use from escalating, reduce the harm young people can cause to themselves or others, and prevent them from becoming drug or alcohol-dependent adults.

7.2.2 *NICE Guidance: Substance misuse interventions for vulnerable under 25s*

Chapter 6 highlighted that care leavers have higher rates of substance misuse, which is true of other vulnerable groups. NICE has produced evidence-based public health guidance (NICE, 2007) which focuses on reducing substance misuse among vulnerable under-25s with a number of recommendations. This includes pathways for both alcohol use disorders[13] and drug misuse[14].

The guidance recommend that local authorities should **develop a local strategy** that will help them to reduce substance misuse in vulnerable young people in their area. Services and professionals should **identify young people who are at risk of using drugs**, and refer them to services that can support them. These services should include **family based support** and **parental skills training**. Psychosocial interventions ('talking therapies') such as CBT and motivational interviewing, which explore the underlying causes of the substance misuse and seek to change the young person's attitude and behaviour towards drugs and alcohol, are considered to be most effective.

7.3 What do we know nationally?

7.3.1 Alcohol

Nationally, in the short term **1/4 of all deaths among 16-24 year old men** are attributable to alcohol. Alcohol use in adolescents and young adults causes long term health problems including **risks to**

[13] NICE Pathways. *Alcohol use disorders (online)* http://pathways.nice.org.uk/pathways/alcohol-use-disorders (accessed 16.12.16)

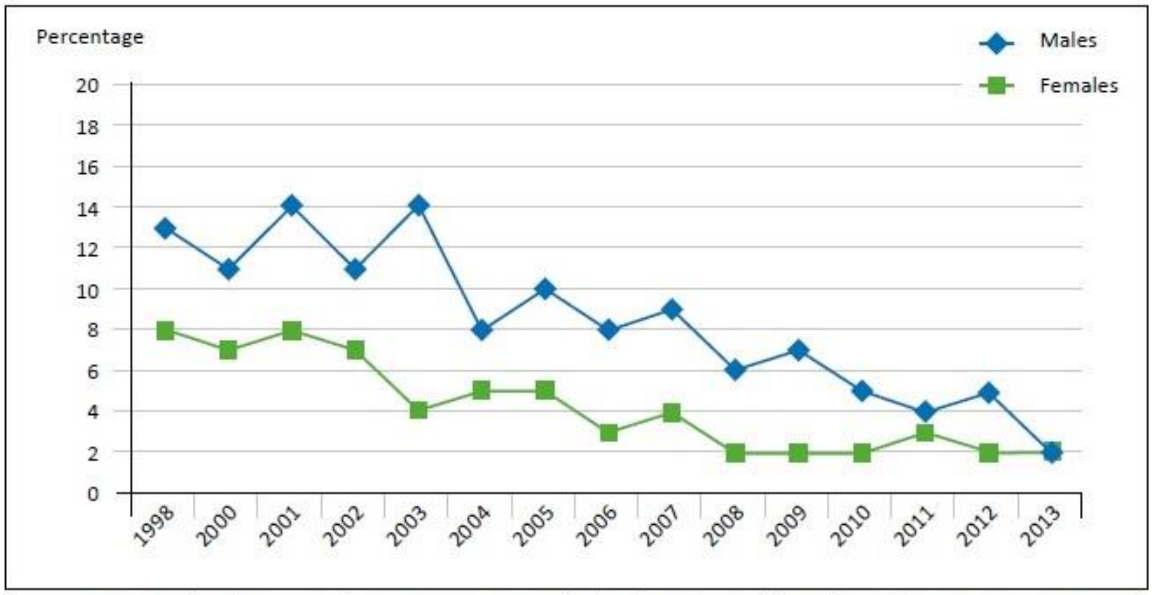
[14] NICE Pathways. *Drug misuse (online)* https://pathways.nice.org.uk/pathways/drug-misuse (accessed 16.12.16)

brain development and long term memory, **mental health disorders and social problems**, and **increased risks of teenage pregnancy and contracting sexually transmitted infections (STIs)**.

The highest levels of alcohol dependence in women is amongst those aged 16 to 24 (9.8%), however they are under-represented within services. In men the highest levels of dependence were in those aged between 25 and 34 (16.8%) (National Centre for Social Research & University of Leicester, 2009).

There has been a fall over time in regular drinking (5 or more days per week) in 16-24s. However, young drinkers were more likely than any other age group to consume more than the weekly recommended limit in one day. **Among 16 to 24 year old drinkers, 17% consumed more than 14 units compared with 2% of those aged 65 and over** (Office for National Statistics, 2016).

Figure 13: Young people aged 16-24 years drinking on 5 days per week or more, Great Britain, 1998-2013



Source: Office for National Statistics, Opinions and Lifestyle Survey, Adult Drinking Habits in Great Britain, 2013

7.3.2 Cannabis and synthetic cannabinoids

Cannabis is particularly harmful in under-18s in terms of physical impact on health, as well as social impacts from misuse. A study in New Zealand found that adolescents who used cannabis regularly were at **risk of cognitive impairment including reduced intelligence, memory loss, and reduced attention span** (Meier et al., 2012)**.**

Most young adults in England smoke 'skunk', a higher grade and more chemically based version of cannabis produced in the UK, which has a severe impact on frequent users including mood swings and loss of motivation. Although cannabis is not considered addictive, frequent users feel dependent.

Synthetic cannabinoids such as 'Spice' and 'Black Mamba' are significantly more potent than cannabis, have a drastic impact on behaviour and are highly addictive. They have been legal until

recently, and different versions may emerge which are not yet illegal. Synthetic cannabinoids are more likely to lead to emergency medical treatment than any other drug.[15]

7.3.3 New psychoactive substances (NPS)

Estimating the prevalence of NPS usage is often a challenge, especially through general population surveys. One insight is provided by the 2014 Flash Eurobarometer, a survey of just over 13,000 young adults aged 15–24 in the EU Member States, which asked about the use of NPS. It found that 8% of respondents had used an NPS at least once, with 3% using them in the last year (European Monitoring Centre for Drugs and Drug Addiction, 2015).

The majority of deaths from NPS (a total of 114 in England and Wales in 2015) reference mephedrone (a stimulant) and GHB (a sedative). According to the Global Drug Survey, in the UK patients are 3 times more likely to end up seeking emergency medical treatment with NPS than traditional drugs.

7.3.4 Inequalities

- Vulnerabilities increase likelihood of young people using drugs and alcohol. Care leavers and victims of domestic abuse, sexual assault and/or sexual exploitation are disproportionately likely to be seen in services, as are people with lower socio-economic status.
- Issues may differ by gender. There is a far higher rate of substance misuse amongst young men compared to young women.
- Gay or bisexual adults were more likely to have taken any illicit drug in the last year than heterosexual adults. In particular, gay or bisexual men were the group most likely to have taken any illicit drug in the last year (33%), with higher levels of illicit drug use than gay or bisexual women (23%) and heterosexual men (11%) (Health and Social Care Information Centre, 2014).

7.3.5 Risk factors

Risk factors include neglect, truancy, offending, early sexual activity, antisocial behaviour and being exposed to parental substance misuse (Donaldson, 2009). Mental health is a key factor in problematic substance misuse as both cause and effect.

The strongest single predictor of the severity of young people's substance misuse problems is the age at which they start using substances (Public Health England, 2016).

7.3.6 Protective factors

Physical and mental wellbeing, and good social relationships and support are all key protective factors of problematic substance misuse. Important predictors of wellbeing include positive family relationships, a sense of belonging at school and in local communities, good relationships with adults outside the home, and positive activities and hobbies.

[15] Global Drugs Survey. *Global Drugs Survey 2016 (online)* https://www.globaldrugsurvey.com/past-findings/the-global-drug-survey-2016-findings/ (accessed 16.12.16)

7.3.7 Barriers to accessing substance misuse services

The authors of a review of the characteristics, needs and perceptions of 18-25 year old drug users in Liverpool identified the following potential barriers to accessing services:

- **Age restrictions or cut-offs for services:** users stated that services needed to listen to them more. Passing them on when they reached a certain age was a barrier to staying in treatment.
- Differences in the **definition of a 'young person**' among young people and service providers alike could lead to confusion as to which service they should attend and how **transition** should be managed.
- Adolescents and young adults are more likely to seek advice **from family or friends** than from professionals**.**
- Poor attitudes of some service providers act as a barrier, as young adults find it important to have someone that they can rely on and trust.
- Services focusing on single needs (e.g. drug use) – services should address a **range of needs.**
- Lack of 'joined-up' services and multiple points of entry – it would be preferable to have a single source organisation instead of having to move from one service to another. (Wareing, Sumnall, & McVeigh, 2007)

7.4 What do we know locally?

Each borough provides a substance misuse service for young people under the age of 18 and a range of adults' services for over 18s.

7.4.1 Specialist services: Young People Services

Hammersmith and Fulham Children's Services provides a service for children and adolescents up to age 18. Public Health contributes the funding of Hammersmith and Fulham Children's Services for young people's sexual health and drug/alcohol misuse provision for residents.

The Hammersmith and Fulham service works across statutory and voluntary services including Youth Offending Teams, Family Support and Child Protection, CAS, Early Help services in the north and south of the borough, and Family Assist. They also provide support to looked after children, attend parenting groups to provide substance misuse education, and deliver training to professionals within the borough around substance misuse.

7.4.2 Specialist services: Adult Services

The three boroughs have jointly commissioned adult drug and alcohol services for people over the age of 18. The treatment system was reconfigured in April 2016, with the new model focusing on transforming services to ensure they are responsive to local need, embed a culture innovative service user involvement, and embody an ethos of ambition for individual success.

> **Drug & Alcohol Wellbeing Service (DAWS):** Turning Point and Blenheim jointly run the DAWS service in Hammersmith and Fulham, Kensington and Chelsea and Westminster, providing support for those using drugs and/or alcohol.

Change Grow Live (CGL): There is a separate alcohol-specific service which also operates in Hammersmith and Fulham

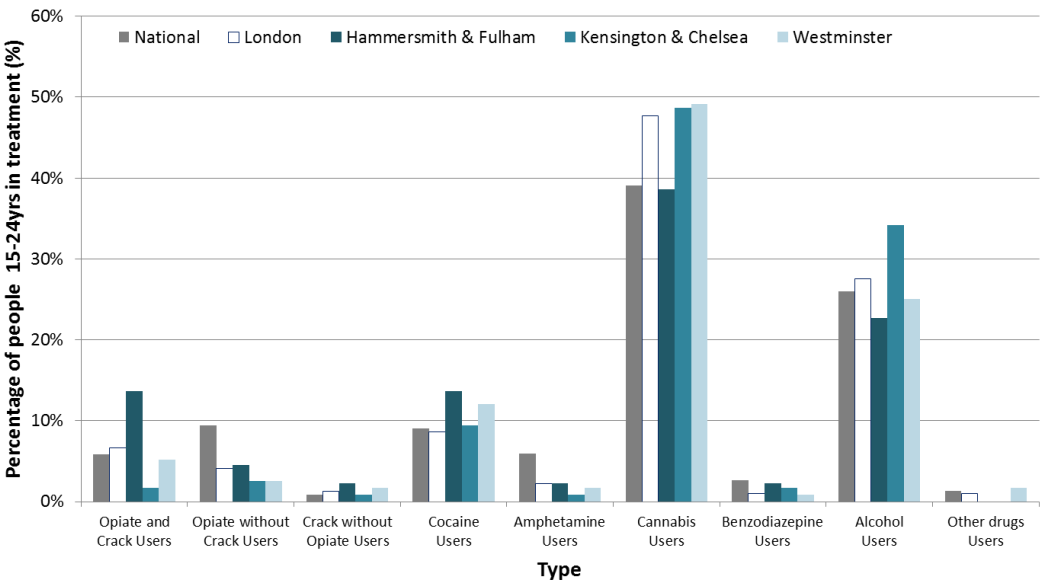
Club Drug Clinic: Provided by CNWL, this service covers the three boroughs and focuses on 'club drugs' such as MDMA, cocaine and ketamine as well as NPS use. It also offers a bespoke service for those from LGBT communities, especially men who have sex with men.

Primary Care Support Service: The Blenheim service works in partnership with GPs and primary care staff across Hammersmith & Fulham, Kensington and Chelsea, and Westminster. It offers a free, friendly and confidential service which is open to people aged 18 or above who have alcohol or drug problems.

7.4.3 Specialist Service use

The majority of 15-24 year olds receiving a service in Hammersmith and Fulham do so for cannabis, followed by alcohol, as is the case nationally. The numbers receiving a service for crack and opiates are small. Figure 14 shows Bulls Eye data on what young people are being treated for, obtained from services through the National Drug Treatment Monitoring System (NDTMS).

Figure 14: Bulls Eye data, 15-24 year olds receiving treatment, NDTMS



7.4.4 Club Drug Clinic use by young adults

The Club Drug Clinic (CDC) is an innovative service for adults in the three boroughs who have developed problems with club drugs and new psychoactive substances (NPS). Established in 2010, the clinic has seen over 700 clients, of which a relatively small percentage has been aged 18-24. Research tells us that NPS use seems to be concentrated among young adults between the ages of 16 to 24 years, which is more than 3 times higher than adults in general. It is also particularly so among young men. It can be assumed that most young people who use NPS will do so without any significant acute harm or long-term effects. However, some will suffer from adverse effects, which can be severe. It is in no doubt that more research is needed on the specific needs of young adults.

The CDC is actively involved in research and hosts Project NEPTUNE, the comprehensive clinical guidance on NPS. It is therefore well placed to identify new and emerging drug trends. The main drugs used by the 18-24 year old cohort of clients to date are MDMA, ketamine, LSD and mephedrone.

The experience of the CDC service also suggests that some young people may have problems associated with hallucinogenic drugs. 15% of clients presented with symptoms of hallucinogen persisting perception disorder (HPPD). This is a condition characterized by a continual presence of sensory disturbances, often visual, that can be experienced for up to two years after using hallucinogenic substances.

7.4.5 Prevalence of opiate, cocaine and crack use

Service use does not necessarily reflect needs. Although we don't often see residents aged 18-25 years olds accessing services for support with opiates, cocaine and crack, there is a local need. In 2011/12 when prevalence estimates were last updated, prevalence of **opiate and crack cocaine use in 15-24 year olds was estimated (per 1,000 population) as H&F – 69, RBKC – 54, WCC – 130**.[16]

It is known that many people do not seek help from a service until reaching a crisis point, but start using substances a long time before – see figures in section 7.1 above showing that drug use is highly prevalent in this age group. Adult treatment data collects information on the age that the first problematic substance was used. Table 10 shows that **the majority of people receiving a service for opiates, cocaine and crack started using in their early twenties.**

Table 11 Age that first problematic substance was used, 2012-13 NDTMS

		H&F	RBKC	WCC
Opiates	% who began use aged 25 or under	64%	70%	76%
	Mean age	24 years	24 years	22 years
Powder Cocaine	% who began use aged 25 or under	85%	81%	87%
	Mean age	22 years	21 years	20 years
Crack Cocaine	% who began use aged 25 or under	76%	52%	65%
	Mean age	20 years	27 years	24 years

While cannabis and alcohol tend to be the substances that young people present to services with, there is a wider need. The service offer for residents aged 15-24 therefore needs to be flexible and able to respond to a range of needs. Proactive preventative outreach work and harm reduction, such as needle exchanges, therefore need to be available for people not yet in touch with services.

7.4.6 Referral sources to specialist services

Substance misuse services work closely with a number of other services. Figure 15 below shows that common referral sources are from Youth Justice and Education services, as well as Children and Family Services. Referrals also come from GPs, Leaving Care teams, homeless hostels, schools, mental health services, as well as referrals from family, friends and self-referrals.

[16] NTA. *Facts and figures: prevalence data (online)* http://www.nta.nhs.uk/facts-prevalence.aspx (accessed 19.12.16)

Differences in the numbers accessing services or referral pathways are often indicative of changes to process or service design. The reduction in referrals in RBKC and WCC, and the historically low level of referrals in H&F, reflects the increased emphasis on training other professionals to identify misuse and provide tailored harm reduction and brief interventions. Referral sources are heavily impacted by resources and location. For example, Westminster's benefit from the secondment of a CAMHS worker means referrals from mental health services look comparatively high. Changes to young people's housing provision can grow or shrink a referral route.

Figure 15: Numbers of young people up to age 18 referred for treatment 2012/13 to 2014/15

7.4.7 Primary care

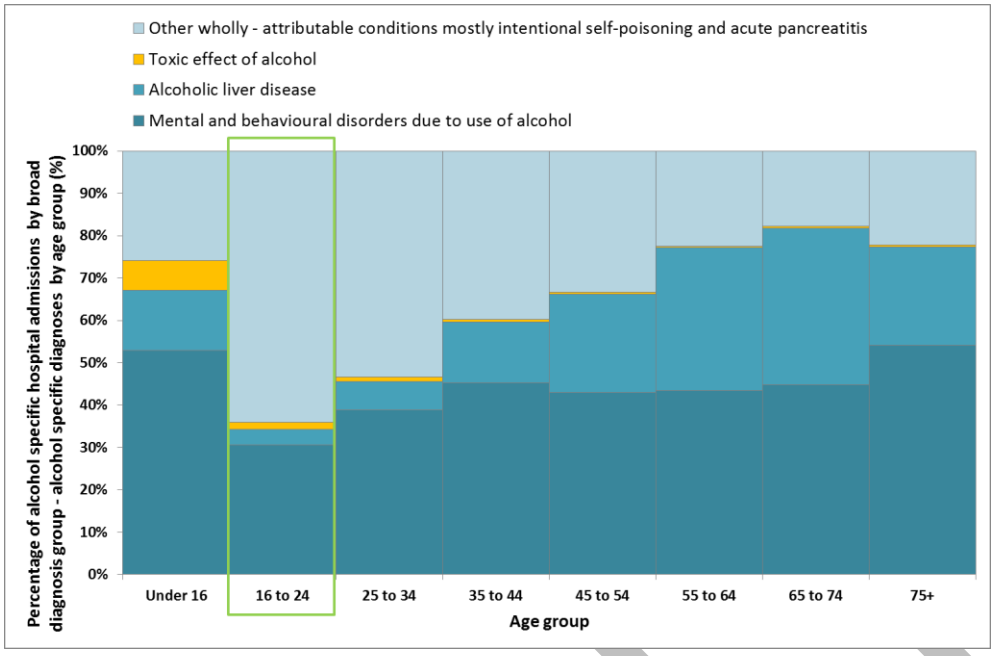
Currently, there is a relatively low number of referrals into services through GPs. As substance misuse is relatively common in young adults, although not necessarily identified as problematic, it is important that GPs are comfortable proactively discussing substance and alcohol misuse with young people. Many young adults are not aware that they have an issue until they reach a crisis. GPs must be aware of new trends in substance misuse, such as the emergence of new psychoactive substances.

However, GPs should be aware that young adults may be concerned about visiting their GP because of confidentiality/privacy fears at practices that relatives also visit. (See chapter 4 – Primary Care).

7.4.8 Alcohol misuse treatment in secondary care

Anecdotally, it is known that many young adults are misusing alcohol but do not proactively engage with services; however, a number of people will attend hospital services due to alcohol-specific causes or alcohol-related conditions. Figure 15 below shows how this affects 16-24 year olds differently from other age groups nationally. This shows that alcoholic liver disease is low in young adults, and so successful early intervention at this age will prevent alcoholic liver disease later in life.

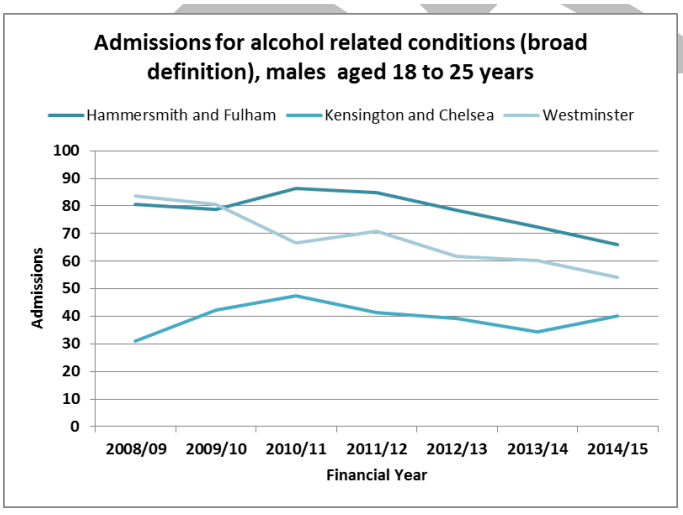
Figure 16 Distribution of alcohol specific diagnoses by broad type: National

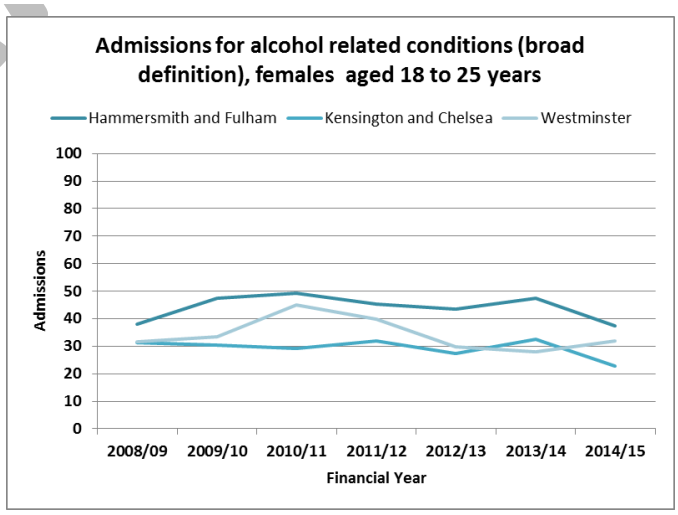


SOURCE: LAPE

Figure 17 shows the number of alcohol related hospital admissions by borough for males and females respectively. The data relates to the 'broad' definition of alcohol related hospital admissions. For both sexes, numbers are higher in Hammersmith and Fulham. Levels of admissions are generally higher for males but have fallen more rapidly than for females over the 7-year period. Rise in male admissions in Kensington and Chelsea and females in Westminster are noted in the most recent period.

Figure 17: Alcohol related admissions: males and females, aged 18-25 (Source: LAPE, 2015)





Alternatives to secondary care: Soho Alcohol Recovery Centre (SARC) Pilot

The SARC pilot project ran in 2010 around Christmas time to relieve pressure on A&E and the London Ambulance Service (LAS). It comprised of a single site in the centre of Soho staffed by LAS. **58% of the patients were in the 18-25 age group**, with an equal gender split. Based in the West End, the service was created to address the medical needs of intoxicated patients which can be effectively dealt with outside a hospital environment and without an ambulance. The project used Alternative Response Vehicles known as the 'Booze Bus', instead of ambulances, which can take up to 5 people at a time.

The Centre successfully treated 88% of those who required sobering up, with no further medical intervention required. At particularly busy periods such as New Year's Eve, **treating patients in the Centre was more than half the estimated cost of treating them in A&E.** On less busy nights, the costs were similar to A&E but analysis shows wider benefits beyond savings to A&E such as identifying high risk drinkers. The **evaluation highlighted the need to develop initiatives to reduce the likelihood of re-presentations amongst under- 25s.**

7.5 Challenges and barriers identified by local commissioners and practitioners

Practitioners from substance misuse services, social work teams, the community and voluntary sector, and other related services discussed the services in a workshop in July 2016. A number of challenges were identified for young adults specifically.

7.5.1 Challenges with specialist services

Local good practice

The new adult substance misuse services have a single triage form to ensure that a service user doesn't have to complete multiple assessments if they enter the service at the wrong point.

Appropriate settings for treatment: As discussed above, the majority of young adults in services are receiving treatment for cannabis or alcohol, which is the focus of the young people's services (as opposed to the adult service which focusses on crack and opiates). Services should be needs led, and allow flexibility for whether a young person would be best treated in an adult service or a young person's service. Flexibility should also be offered in the setting for care; if a young person is uncomfortable in a certain building because of other service users, services should be available in the community. Practitioners also identified that the 'emotional age' and needs of young adults differ widely, and many young adults prefer the more creative style of the young people's services.

Challenge of reciprocal arrangements with other borough and integrated services: substance misuse services are provided by the council for residents only, however health professionals including GPs have a large registered population who do not live within the boroughs, particularly in central London with registered students (see chapter 3 – Population Profile). Effective recovery from substance misuse may require the cooperation of professionals across organisations, and the disconnect between health and council-provided services could hinder recovery if not well coordinated. Young adults registered with GPs in the borough but living in another borough must receive treatment for substance misuse in their borough of residence. Services not being integrated also presents as a barrier and may mean some young adults fall between the cracks, and so it is important that professionals foster strong reciprocal relationships, in particular GPs with substance misuse services in other boroughs.

'Postcode Wars': For a few very vulnerable young adults, it may be unsafe to travel to particular areas due to gang tensions. If a young person is moved outside of the borough (e.g. 'Tom' from the case study below) further complications arise with their treatment.

Identifying with diagnosis: Some people, particularly those who are still considered highly functioning, find it difficult to identify and accept that they have an unhealthy relationship with substances. They are therefore more challenging to work with and engage. Substance problems may remain unapparent in university students due to a culture of widespread alcohol misuse and the unstructured nature of university life. They are more likely to enter treatment services after a hospital visit.

Cross agency working: The case study below highlights how many different professionals may be involved with a young person with substance misuse. However, there are safeguarding issues regarding whether sensitive patient information can be shared between services.

1.1.1 Case study

'Tom' was referred to the LBHF substance misuse worker from the Early Help team as his cannabis use was impacting on his engagement with education or employment; he had begun using and dealing cannabis, where he became indebted to the people he was dealing for. He disengaged with the service when he was confronted directly about his dealing.

Tom was arrested and the substance misuse worker worked with the Youth Offending Team (YOT), and successfully reengaged with Tom's parents, who soon informed the worker that Tom was a risk to the family home and could not remain there. Tom stayed briefly with other family members, but the relationships soon broke down, and he was placed in a young person's hostel. He continued to use cannabis, and hostel staff suspected he had restarted dealing. At this point, Tom was being supported by the substance misuse worker, his allocated YOT social worker, a specialised worker in violent offences and young people (as Tom had been arrested and had also admitted to dealing), his hostel worker, and an allocated social worker from Children's Services.

Tom was stabbed following direct orders from people he had known and associated with, who believed that he still owed a debt.

He was then moved out of borough due to concerns about his life, however there were disputes across borough around providing the funding for Tom to reside in his new safe hostel. He was granted LAC status and was able to remain in his chosen hostel where he is engaging well with services but socially isolated, which escalated his cannabis use.

Tom has now turned 18 and the substance misuse worker is obliged to close the case. Drug services in Tom's new area are limited, and focussed on people using crack and heroin.

Funding for Preventative Work: Service specifications and contracts must incentivise or support prevention and early intervention so services do not only cater to people with high support needs.

7.5.2 Challenges with key related services

- **Training**: Professionals working with or close to young adults (e.g. health professionals including GPs, social workers, family, carers) need to be well educated in substance misuse in order to identify it and react appropriately.
- **Housing:** The key area of the environment where change is needed for a young person to change their lifestyle, but equally is very difficult to change.
- **A&E:** Young adults are more inclined to visit A&E or urgent care in a crisis or with substance-related issues than engage proactively with substance misuse services, so good referral routes from secondary care into specialist services need to be in place such as through alcohol liaison nurses.
- **Dealing:** Responsibility for addressing drug dealing lies with youth offending or substance misuse teams. Funded tailored interventions for those who are dealing would be more effective. There are more complex issues around dealing such as the 'grooming' of young men, who are then very vulnerable once they start dealing but are criminalised rather than supported to escape that lifestyle.
- **Prevention work in schools:** From January 2017, school nurses will be required to deliver substance misuse teaching as part of the school health offer. This may have a positive impact on preventing harmful substance misuse in young adults if tackled effectively whilst the young person is still in school.
- **Prison:** Some staff report working with individuals who go into prison and come out heavy drinkers or substance users, particularly of Spice (synthetic cannabinoids). There is a feeling that more support is required to work with this group perhaps before they go into prison.

1.1.2 Local good practice

Outreach work works well with young people such as treatment services within the local community. For example, the MetroSexual Centre and St Georges encourage clinicians to ensure that thorough questions about the bigger aspects of person's health are asked about rather than just the presenting issue.

7.5.3 Youth Council feedback

Members of the Westminster Youth Council confirmed many of the points made above, including that cannabis use had become normalised, with many young people believing it was not really illegal and daily expenditure on cannabis of over £20 was common, funded through dealing. The young people consulted as part of this project were not aware of substance misuse services but supported the principle of young adults being treated in appropriate settings.

It was noted that advice in the case of substance-related sickness or overdose is not easily or quickly accessible to find good quality information and advice. First-aid training specific to these types of incidents was recommended.

7.5.4 Recommendations

Gap / challenge	Potential solution / recommendation
The majority of young adults in treatment for substance misuse are addressing cannabis and alcohol issues, however adult services cater predominately to crack and opiate users.	1. Review adult and young people's service offer to ensure a flexible, responsive and coordinated service is available to meet the needs of young people who use a range of substances. Allow flexibility in the young people's substance misuse services to provide for young adults up to the age of 25, based on a professional appraisal of where their need can best be met.
Vulnerable groups are more susceptible to harmful substance misuse.	2. Develop a local strategy to reduce substance misuse among vulnerable and disadvantaged under-25s as recommended by NICE (2007).
Although numbers in services are relatively small, substance misuse is widespread amongst young adults. There is significant variation between the boroughs in their referral rates into substance misuse services from key partners.	3. Continue to develop awareness and training for a broad range of professionals in contact with young adults to enable conversations to be started earlier, rather than when a problem has taken hold. Training should include building resilience in young people to resist pressures in their social groups, schools and universities. a. Work with young people's services, GPs and hospitals to embed effective pathways and interventions which target those most at risk of substance misuse.

8 Sexual Health

National statistics show that young people aged 15-24 experience the highest rates of new sexually transmitted infections (STIs) than other age groups. As with substance misuse, this is characteristic of more risk taking behaviour in young adults. The consequences of poor sexual health can be serious as many sexual infections have long-term health impacts, such as infertility and cervical cancer. Furthermore, there are inequalities in sexual health – there is a clear link between social deprivation and poor sexual health. Women, gay men, young people and people from Black and Minority Ethnic (BME) groups are disproportionately affected by poor sexual health.

8.1 Link to substance misuse

Sexual health issues are linked to alcohol and substance misuse. Earlier alcohol use is associated with early onset of sexual activity and is a marker of later sexual risk-taking, including lack of condom use and multiple sexual partners. Sexual assault is strongly correlated with alcohol use by both victim and perpetrator (Royal College of Physicians, 2011).

Although a causal link cannot be proven, 16-24-year-olds are among the highest consumers of alcohol in the UK as well as having the highest rate of sexually transmitted infections. Young people are also more likely to become re-infected with STIs. In a review of 11 studies on the subject, 8 were found to show a significant relationship between alcohol consumption and at least 1 STI. This did not appear to vary according to gender or pattern of alcohol consumption (R. L. Cook & Clark, 2005).

Alcohol is also often given in interviews as a factor contributing to teenage pregnancy. 85% of the increase in alcohol-related hospital admissions that occurred between 2005/2006 and 2006/2007 in 15–17-year-olds was in the local authorities with the highest teenage pregnancy rates (RCP 2011). In young adults, alcohol is a key causal factor in unplanned pregnancies.

8.2 Best practice guidelines

In 2011 the government published *You're Welcome - Quality criteria for young people friendly health services* (Department of Health, 2011). These standards are largely in line with the NICE guidance on contraceptive services for the under-25s (NICE, 2014b). The Department of Health *Framework for Sexual Health Improvement for England* (Department of Health, 2013) sets out ambitions for improving sexual health outcomes for 16-24 year olds.

These criteria include assurances of confidentiality for young people (as far as safeguarding allows) and the routinely offered opportunity for patients to be seen without a parent or carer present. It is advised that staff receive training on young people's health needs, and in supporting young people to make their own, informed choices about their health and care. Vulnerable groups (including care leavers and UASC) may also need specialist services made available to them according to their particular needs.

STI testing and treatment (or 'seamless' referral to a more relevant service) and opportunistic chlamydia screening should be offered to young people. Free contraception, condoms, pregnancy testing and emergency hormonal contraception should be made available, including to young people who are not ordinarily patients of that service. Referrals for abortions and antenatal care should be offered when appropriate; in the case of unplanned pregnancy it should be possible for young

women to immediately be seen by an impartial practitioner (e.g. with no ethical opposition to abortion).

The Framework promotes resilience by enabling young people to make informed decisions and prioritise prevention through information as well as access to appropriate sexual and reproductive health services.

Other criteria refer to staff training in speaking to young people about sexual health issues, contraceptive options, and STI and pregnancy prevention. This should be sensitive to the person's age, gender, sexual orientation and ethnicity.

8.3 What do we know locally?

The percentage of new STI diagnoses made in GUM clinics of patients aged 15-24 were 31% for Hammersmith and Fulham, compared to an average of 46% in England.

Reinfection rates among our resident in this age group, within a 5 year period, varies from **20% to 18.4% for women and 17.5% and 16.5% for men.**[17]

The *Framework for Sexual Health Improvement in England* (Department of Health, 2013) outlines several ambitions specific to the improvement of sexual health outcomes for 16-24-year-olds. These include rapid access to appropriate sexual and reproductive health services and the prioritisation of prevention. Reduction of unwanted pregnancies (in women of all fertile ages) is also cited, and is linked to the ambition to ensure young people are aware of the risks of unprotected sex.

Measures such as chlamydia detection rates, rates of repeat abortions in under-25s, and conceptions in 15-17-year-olds are indicative of how well these ambitions are being achieved. Data presented below is taken from Public Health England's *Sexual and Reproductive Health Profiles*[18].

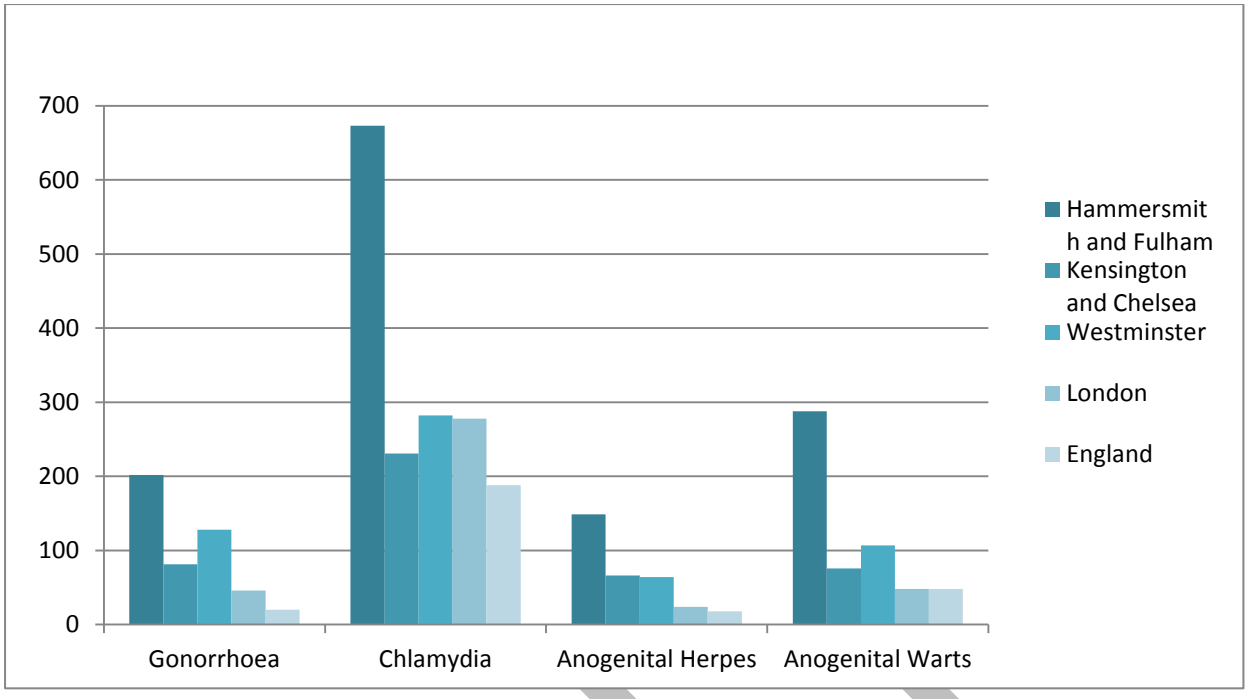
8.3.1 STI Diagnosis rate

As shown in figure 18, sexual health outcomes for the three boroughs vary according to the metric of measurement but broadly perform well against London averages, with the exception of Westminster's chlamydia detection rate.

Figure 18: Rates of STI diagnosis per 10,000 16-24-year-olds (2014/15) (GUMCad)

[17] Public Health England (2015). Local Authority HIV, sexual and reproductive health epidemiology report (LASER): 2014.

[18] Public Health England. *Sexual and Reproductive Health Profiles* http://fingertips.phe.org.uk/profile/sexualhealth/ (accessed 16.12.16)



As chlamydia is most often asymptomatic, a high detection rate reflects success at screening coverage which will aid identification of infections that, if left untreated, may lead to serious reproductive health consequences. **The detection rate is not a measure of prevalence**. PHE recommends that local areas achieve a rate of at least 2,300 per 100,000 resident 15-24 year olds, a level which is expected to produce a decrease in chlamydia prevalence. Areas already achieving this rate should aim to maintain or increase it; other areas should work towards it. Figure 18 shows that Hammersmith and Fulham are performing well at detection rather than having significantly higher prevalence.

8.3.2 Unplanned pregnancies

There is a public health need to ensure that rates of abortion and repeat abortion in women of all ages, but particularly young women, are managed. Although Hammersmith and Fulham is doing better than the average for London, figure 20 shows that they are behind nationally.

Figure 19: Percentage of repeat abortions* in under-25s (2015 data, PHE)

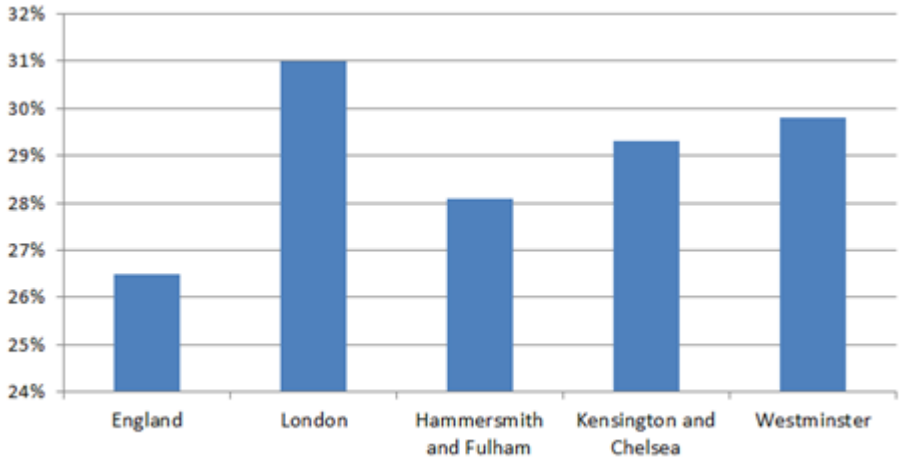


Figure 20 Under 25s repeat abortions, 2015. Source: PHE Sexual and Reproductive Health Profiles

*The percentage of women having an abortion who have had at least one abortion in any previous year

8.3.3 Contraception

Long Acting Reversible Contraceptives (LARCs) offer young women an effective choice and in so doing, reduce rates of unplanned pregnancy. LARCs are also known to be highly cost effective. However, the rates of LARC prescription in Hammersmith and Fulham are below average. Improving the rate of LARC prescription will contribute to ensuring that rate of under-18s conceptions and repeat abortions is maintained and further reduced.

Table 12 rate per 1,000 of Long Acting Reversible Contraception 2014 (PHE Sexual and Reproductive Health Profiles)

Borough	LARCs rate /1,000
Hammersmith and Fulham	29.9
Kensington and Chelsea	18
Westminster	20
London	35.3
England	50.2

8.4 Youth Council feedback

8.4.1 Services

Discussion with the Westminster Youth Council revealed a sense of there being a lack of reliable access to good sexual health information, advice and support. It was felt that by the time sexual health among teenagers and young people ceased to be a taboo, sexual activity had already become normalised. Difficulty in accessing contraceptives was raised and the Come Correct scheme[19], offering free condoms to young people aged 13-24, was mentioned; however, the three boroughs

[19] Come Correct http://www.comecorrect.org.uk/ (accessed 16.12.16)

are not participating at present. Freedoms provides our local condom distribution service. This service is available, although not targeted at young people.

8.4.2 Psychosocial issues

Confidence, peer pressure and technology were discussed at length. It was mentioned that girls often concede to pressure to have unprotected sex or be filmed or photographed in sexual situations, which can then be used for blackmail or circulated on social media. One participant recommended that instilling confidence, and in particular empowering girls to say 'no', should be prioritised over 'online safety' education. Teaching a better understanding of the consequences of sharing material online was also suggested.

This consultation informed that there is a common issue of distribution of sexual images of under 18s around schools in the borough (usually female, and without the consent of the person pictured), which raises legal and safeguarding concerns.

8.5 Recommendations

Gap / challenge	Potential solution / recommendation
Sexual health is a key health issue for the vast majority of young adults.	1. Ensure all commissioned sexual health services adhere to the You're Welcome standards.
There is a strong link between substance misuse and risky sexual behaviour.	2. Consider integration of substance misuse and sexual health services for young people.
There are clear inequalities in sexual health, particularly in socio-economic status. Care leavers have significantly higher rates of unplanned pregnancy than the general young adult population.	3. Work with young people's services to embed effective pathways and interventions which target high risk groups including care leavers.
Young people consulted reported that adults and professionals over medicalise what to them is a social issue.	4. Develop sexual health services to proactively address the psychosocial aspects of sexual health.
The *Framework for Sexual Health Improvement in England* recommends the prioritisation of prevention and that all young people are informed to make responsible decisions, and are aware of the risks of unsafe sex.	5. Collaborate with other London boroughs to prioritise prevention and provide consistent health messages to enable young people to make informed and responsible decisions**.**
	6. Improve local prescription of Long Acting Reversible Contraception (LARCs).

9 Wider determinants of heath

Housing, employment and crime and safety are key health and wellbeing issues for young adults. Each of the three boroughs is tackling these issues through local authority departments in slightly different ways.

9.1 Crime and safety

There is a well evidenced link between crime and safety, and health and wellbeing (P. S. M. Marmot, 2010). This applies to young adults both as being a victim of crime, as well as perpetrators, and particularly the issue of gang life and the risk of violence for this age group. Drug and alcohol misuse (chapter 7) has a significant impact on violent crime.

Gang crime

Gang crime is an important issue in Hammersmith and Fulham. As well as the severe impact and consequences for the victims of gang crime, there is evidence that those involved in gang crime have poor health outcomes. 2015 research from John Moores University on males aged 18 to 34 years found that those who were gang members had significantly higher levels of mental illness than both men in the general population and non-gang affiliated violent men. Using standardised screening tools, 86% of gang members were identified as having antisocial personality disorder, 67% alcohol dependence, 59% anxiety disorder, 58% drug dependence, 34% suicide attempt, 25% psychosis and 20% depression (Centre for Public Health, 2015).

A 2013 report undertaken by the Public Health (Madden, 2013) team highlighted that young people in gangs had higher rates than the general population or offender population of antisocial personality disorder; anxiety disorders; psychosis; and suicide attempts. In addition, young people involved in gangs have higher rates of drug and alcohol misuse.

This is a cohort who do not engage conventionally with universal mainstream services, especially where any stigma on mental health exists. Consideration needs to be given on how to help this cohort access support.

Student crime

Crimes involving the student population are hard to identify. The *Complete University Guide*[20] has produced heat maps based on crime statistics described as the most relevant to students – robbery, burglary, and violence and sexual crimes - for the previous 12 months, based on student term-time addresses. However, the figures are for all victims, not specifically students.

Most support services linked to the juvenile justice system only cater for young people up to the age of 18. In contrast, there are relatively few programmes specifically targeted at the rehabilitation of young adults aged 18-20 who are in transition from Young Offenders' Institutions to adult prisons, where conditions and treatment can be remarkably different (Garvey et al., 2009).

[20] Complete University Guide. *Crime in student cities and towns (online)* http://www.thecompleteuniversityguide.co.uk/crime-in-university-towns-and-cities/ (accessed 16.12.16)

9.2 Housing

The evidence relating good quality, appropriate housing and health is well evidenced (Building Research Establishment, 2008; Leng, 2011; M. Marmot et al., 2010). Any young adult age 18-25 is likely to be living independently for the first time and so the associated challenges of managing finance, bills and regular payments may be difficult due to lack of experience. Whilst there is a lot of good advice on these matters, signposting to it is important for any health and wellbeing service that regularly comes into contact with young adults.

The boroughs cover one of the most densely populated areas in the country and demand for accommodation is very high, as reflected in house and rent prices. There is limited housing which is affordable on low incomes, benefits or student loans, and demand for social and affordable housing outstrips supply, leading to long waiting times. In addition, a large proportion of properties in the private rented sector are in poor condition.[21]

By 2020, it is estimated that there will be a significant decrease in young adults owning their own properties and having their own social rented tenancies. Private renting is estimated to increase, as are young adults living with parents in all accommodation types (Clapham, Mackie, Orford, Buckley, & Thomas, 2012). Housing benefit payments are restricted to the rate of a single room for people under 35, which many young adults find undesirable.

Some groups of young adults are particularly vulnerable to housing problems and homelessness, including NEETs, care leavers, former unaccompanied asylum seekers, ex-offenders, young parents and people with disabilities. Leaving care is a time that young adults are more vulnerable to homelessness. Whilst some care leavers go into specialist supported accommodation, many move into social housing, and increasingly commonly in the three boroughs into shared houses due to high costs. Chaotic housing pathways and homelessness are predicted to increase (National Youth Agency).

Research led by the National Housing Federation shows that those aged 16 to 24 and living in social housing often face specific difficulties in managing their finances (National Youth Agency).

Homeless young people may experience vulnerabilities that are less common amongst the general population of young people. For example, to try and support themselves, homeless young people may be tempted towards the opportunistic sale of drugs or sex. This clearly adds to the vulnerabilities experienced by young people who are homeless including of sexual exploitation. It is known that some sub-populations of young people such those who are LGBT are at particular risk of homelessness or hostile housing environments. Additional factors such as sexuality and gender may further exacerbate the vulnerability of those young people to exploitation.

Young adults are also vulnerable to fuel poverty. Although this is commonly associated with older people, it is also common amongst students. Though the health impacts are less severe in young adults, it impacts negatively on health and wellbeing.

[21] Housing and Care JSNA www.jsna.info/housingandcare (accessed 16.12.16)

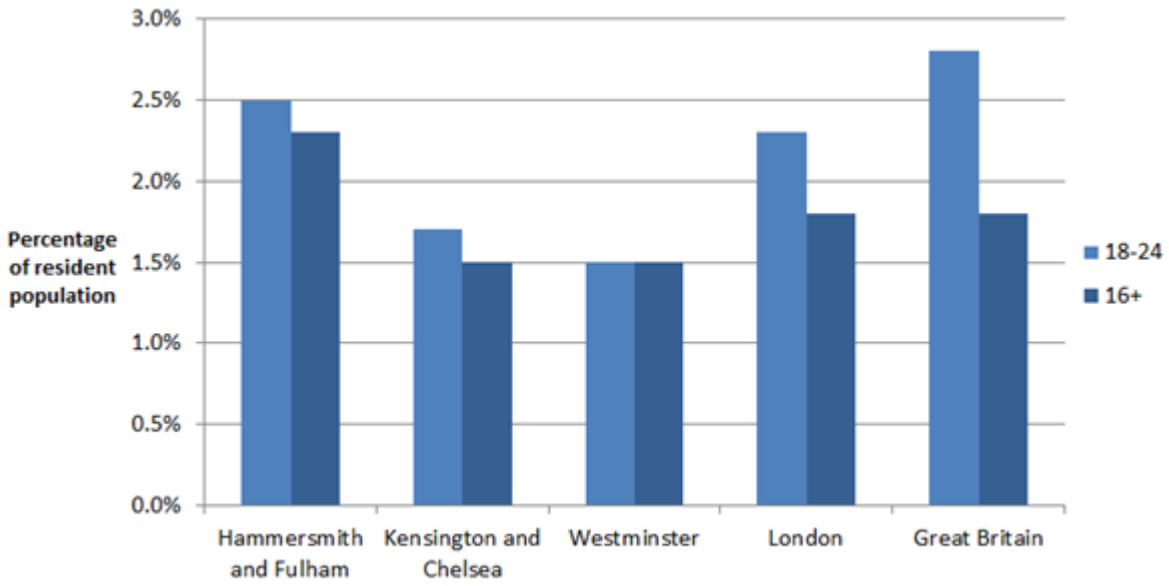
9.3 Employment

The relationship between employment and good health outcomes is well understood, and this link is particularly pronounced among young adults. According to a 2014 evidence review (Allen & UCL Institute of Health Equity, 2014), unemployment is linked to premature death, deteriorating mental health and increased suicide risk. Young men not in employment, education or training (NEET) were three times more likely to be depressed than those who were not. Unemployment is also linked to increased unhealthy behaviours (such as substance misuse) and to having a criminal record, although the causal relationship is hard to establish. Those who have been supervised by a Youth Offending Team and/or have disclosed substance abuse are over twice as likely to be NEET for six months or more.

Young adult unemployment is a risk factor for long-term unemployment. Those who are NEET at the age of 18-19 are 28% more likely than others to be unemployed five years later, and 20% more likely to be unemployed ten years on.

The effects are extremely persistent, with evidence showing that unemployment under the age of 23 can still lower health status and life satisfaction over twenty years later. It is also the case that young people with a history of unemployment tend to then move into low-paid jobs, which are themselves associated with poorer health outcomes.

Figure 21: Claimant count by age across the three boroughs, September 2016



Source: Nomis local authority profiles

As shown in figure 20, the claimant count is higher (as a proportion of population) among 18-24-year-olds. However, this contrast is less marked than that between the target group and general population in both the London and Great Britain averages.

10 Summary of Recommendations and Conclusion

10.1 Recommendations

The recommendations emerging from throughout this report are summarised here by chapter.

Topic	Gap or challenge	Potential solution/recommendation	Supporting Evidence in JSNA	Implementation lead
Primary Care	The current model of primary care is not well suited to young adults, who are overall less satisfied with their GP than older adults. YA would benefit from GP services configured to their health needs, such as at The Well Centre in Lambeth. Co-location has come up across chapters as an effective way of increasing young adults' uptake of appropriate services, particular in hard to engage cohorts such as care leavers. Small changes that all GP practices can facilitate would make a positive difference.	1. Pilot an integrated primary care model at one or more GP practice in each CCG with a high number of young adult patients. Consider services which could have a presence, such as sexual health services, eating disorder services and talking therapies. Offer training for GPs in young adults' health. a. Consider opportunities for this approach in other contexts with target populations, such as co-location of health services at care leaver peer support groups.	Section 4.1 – YA less satisfied with GPs, number of issues e.g. Confidentiality Section 4.3 indicates high usage of urgent care and A&E among this age group	Toby Hyde, Head of Strategy, Hammersmith and Fulham CCG
		2. Train local GPs and GP practice staff in the GP Champions for Youth Health Project's *Toolkit for General Practice*. CCGs should make use of the GP Champions for Youth Health Project's *Commissioning Effective Primary Care Services for Young People*	Section 4.1 – the GP Champions for Youth Health Project	

Eating disorders	A small fraction of the estimated numbers of young adults with eating disorders are receiving a service. Additionally, evidence shows better outcomes when ED is treated promptly in the first 3 years of the illness, but waiting times locally are long. National and local strategies require the development of out of hospital services and an early intervention approach to protect mental and physical health and wellbeing. There is currently only a service in secondary care. The exemplar primary care eating disorder service in Bristol provides cost-effective and well received help before the patient's condition deteriorates and requires treatment in secondary care.	3. Review the eating disorder pathway as part of Like Minded *Serious and Long Term Mental Health Need* population group Business Cases. Consider ways to provide an early intervention eating disorder service in primary care offering NICE recommended rapid triage and assessment by a skilled practitioner in partnership with GPs for those with emerging but not life-threatening Eating Disorders. a. Such a service would then be capable of providing the leadership and momentum for the following recommendations.	Section 5.3 – in particular 5.3.2 indicating estimated prevalence and 5.3.3 for numbers being treated in Vincent Square clinic Section 5.2.4 for importance of early treatment (national evidence and guidance) Section 5.2.4 Effective Treatment – Bristol case story	Julie Scrivens, Head of Planned Care and Mental Health, Hammersmith and Fulham CCG
	The current NICE guidelines are from 2004, over a decade old, and are currently being updated with publication expected in 2017.	4. Review existing services against new NICE guidelines when available in 2017.	Section 5.2.4 (national guidance)	

Eating disorders	Professionals outside of specialist ED services do not consistently understand what to do when an eating disorder is identified, and how to manage an eating disorder patient.	5. Map pathways and create a tool for professionals to use to enable appropriate and timely referrals. 6. Offer guidance to GPs and other health professionals to identify and then work constructively and appropriately with people with an eating disorder. a. Identify GPs with high numbers of young adults and low referral rates to eating disorder services as a target group for training.	Section 5.3.6 and 5.3.7. Qualitative evidence Identified through consultation with local stakeholders	
Care Leavers	Looked after children have higher rates of mental illness than the general population; nearly half have a mental disorder. In consultation with care leavers, there was a lack of awareness and coping strategies. However, some may not want help in a clinical setting. National evidence suggests good outcomes for mentoring, which may be more appropriate where psychological therapies are not wanted.	7. Actively promote resilience, prevention and early intervention for good mental health for all in generic services for care leavers. a. Review current and past mentoring and peer mentoring schemes in the three boroughs for care leavers and / or young adults.	Section 6.3.1. National evidence and supported by local qualitative evidence through consultation. Mentoring supported by evidence in section 6.4.2	3B Leaving Care teams, Helen Farrell - Assistant Director for LAC and Care Leavers

Care Leavers	The greatest area of unmet health and wellbeing needs of care leavers is mental health and emotional wellbeing that would not meet the threshold for Adult Mental Health Services. Nationally, 'Future in Mind' and locally, The Anna Freud Centre needs assessment for CAMHS recommend a tapered transition from age 16-25. LAC CAMHS see children over long time periods and specialise in trauma, which is most appropriate to this cohort. Some care leavers have existing relationships with LAC CAMHS staff which they would benefit from continuing; other are not ready to engage with counselling services until they are age 18 or above.	8. Extend existing CAMHS or LAC CAMHS services to a tapered service for 16-25 year old care leavers to give continuity to those with a relationship with the service, and extend the offer to include care leavers age 18-25 not already open to LAC CAMHS who are not eligible or suitable for Adult Mental Health services. a. The offer to care leavers should include flexibility if appointments are missed or service users don't want to be seen in a clinical setting.	Section 6.3.1 and 6.3.2. As above - national evidence and supported by local qualitative evidence through consultation	Steve Buckerfield – Head of Children's Joint Commissioning Angela Caulder - CAMHS commissioner
	A significant proportion of local care leavers are former UASCs, and have specific health and care needs.	9. Professionals including Leaving Care teams to be fully trained on national guidance for unaccompanied asylum seeking and trafficked care leavers	Section 6.4. Combination of national evidence and local evidence from practitioners (LAC nurse records and social work notes)	3B Leaving Care teams, Helen Farrell - Assistant Director for LAC and Care Leavers

Care Leavers	Consultation with care leavers identified that many sought advice from non-health professionals who they had a trusting relationship with e.g. their social worker. Although almost all are registered with a GP, most prefer to use walk in centres, A&E and urgent care. The needs and preferences of care leavers vary significantly from person to person, meaning a specific service may not be appropriate.	10. Non-health professionals working with care leavers e.g. personal advisors and key workers should routinely take an active role in the health of care leavers, such as taking them to the GP and encourage seeking help in the appropriate setting. a. Pilot a personal budget for care leavers, where an assessed physical or mental health need is established, to allow them to choose a relationship with the professional that best meets their needs	Section 6.3, 6.5.3 and 6.5.4. Evidence largely drawn from consultation with professionals and care leavers but also supported by national evidence	3B Leaving Care teams, Helen Farrell - Assistant Director for LAC and Care Leavers Steve Buckerfield – Head of Children's Joint Commissioning
	A small number of care leavers have significant multiple complicated physical, mental and social care needs, and a large number of professionals become involved in their case.	11. Pilot a transitions panel similar to the disabled children's panel for cases of care leavers with multiple or complicated needs.	Section 6.2 – national evidence of care leavers chaotic lives Section 6.4 wide range of care leaver mental and physical health needs	3B Leaving Care teams, Helen Farrell - Assistant Director for LAC and Care Leavers

Substance misuse	The majority of young adults in treatment for substance misuse are addressing cannabis and alcohol issues, however adult services cater predominately to crack and opiate users.	12. Review adult and young people's service offer to ensure a flexible, responsive and coordinated service is available to meet the needs of young people who use a range of substances. Allow flexibility in the young people's substance misuse services to provide for young adults up to the age of 25, based on a professional appraisal of where their need can best be met.	Section 7.1 drawn from national data and reflected in 7.4.3 from local service data	Gaynor Driscoll, Head of Commissioning for Substance Misuse and Sexual Health
	Vulnerable groups are more susceptible to harmful substance misuse.	13. Develop a local strategy to reduce substance misuse among vulnerable and disadvantaged under 25s as recommended by NICE (2007).	Section 7.3.3 drawn from national data from HSCIC on inequalities	
	Although numbers in services are relatively small, substance misuse is widespread amongst young adults. There is significant variation between the boroughs in their referral rates into substance misuse services from key partners.	14. Continue to develop awareness and training for a broad range of professionals in contact with young adults to enable conversations to be started earlier, rather than when a problem has taken hold. Training should include building resilience in young people to resist pressures in their social groups, schools and universities. a. Work with young people's services, GPs and hospitals to embed effective pathways and interventions which target those most at risk of substance misuse.	Section 7.1 widespread substance misuse amongst young adults. Section 7.4 numbers in local services Section 7.5.2 flags training as an issue – drawn from local stakeholders Section 7.4.5 Local data showing referrals from key partners locally	

Sexual Health	Sexual health is a key health issue for the vast majority of young adults.	15. Ensure all commissioned sexual health services adhere to the You're Welcome standards.	Section 8. National evidence show that 15-24s experience highest rate of STIs.	Gaynor Driscoll, Head of Commissioning for Substance Misuse and Sexual Health
	There is a strong link between substance misuse and risky sexual behavior.	16. Consider integration of substance misuse and sexual health services for young people.	Section 8.1 National evidence of link between substance misuse and risky sexual behavior.	
	There are clear inequalities in sexual health, particularly in socio-economic status. Care leavers have significantly higher rates of pregnancy than the general young adult population.	17. Work with young people's services to embed effective pathways and interventions which target high risk groups including care leavers.	Sexual health and pregnancies for care leavers drawn from national and local research and highlighted in section 6.3.5 and 6.3.6. Sexual health and inequalities described in Section 8.	
	Young people consulted reported that adults and professionals over-medicalise what to them is a social issue.	18. Develop sexual health services to proactively address the psychosocial aspects of sexual health.	8.4 Youth council feedback	
	The *Framework for Sexual Health Improvement in England* recommends the prioritisation of prevention and that all young people	19. Collaborate with other London boroughs to prioritise prevention and provide consistent health messages to enable young people to make informed and responsible decisions**.**	Section 8.2, 8.3 give more information on the Framework	

	are informed to make responsible decisions, and are aware of the risks of unsafe sex.	20. Improve local prescription of Long Acting Reversible Contraception (LARCs).	Section 8.3.3 low rates of local LARC prescription.	
General	There is existing good practice guidance for services working with young adults on transitions and service design.	21. Health and care services should self-assess against the NICE guidance on transition from children's to adults' services for young people using health or social care services, and services that young people access should adopt the Government's '*You're Welcome*' quality criteria to be more suited to young adults.		ALL Service Leads
	Young adults are particularly difficult to involve in participation and engagement exercises in the typical ways that services engage patients and users.	22. Coproduce the redesign of services with young people.		ALL Service Leads

10.2 Conclusion

In conclusion, many of the recommendations include flexibility in the age restriction on services to incorporate young adults into young people services, early intervention, adaptation of current service models to better meet the needs of young adults, and upskilling health and care professionals with knowledge and skills to recognise and address young adults' needs. The chapters all had strong crossovers with each other, and so co-location, collaboration and joint working is key.

These approaches are not always easy to implement, especially where they have not been done before. For example, young people's services that accept adults may need to consider adequate child protection and safeguarding. However, it is clear that better person-centred care and health outcomes can be achieved when services focus on the needs of the individual, not strict age criteria.

11 Resources for professionals

11.1 Resources for professionals

11.1.1 Eating disorders

- Free resource for health care professionals, patients and carers on support for Eating Disorders **http://www.network-ed.org.uk/**
- Joint Commissioning Panel for Mental Health. (2013). Guidance for commissioners of eating disorders services. 2013: Joint Commissioning Panel for Mental Health.

11.1.2 Substance misuse

- Public Health England. (2016). Young people – substance misuse JSNA support pack 2017-18: commissioning prompts. Good practice prompts for planning comprehensive interventions. London: Public Health England.

11.1.3 Primary care

- The GP Champions for Youth Health Project's Toolkit for General Practice
- GP Champions for Youth Health Project's Commissioning Effective Primary Care Services for Young People
- NHS guidelines on funding care for transient populations

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13.1.1 Professionals workshop: Care Leavers

A workshop was held with professionals from the three boroughs who work with care leavers.

13.1.2 Professionals workshop: Substance Misuse

A workshop was held with professionals from the three boroughs who work with substance misusers.

13.1.3 Professionals workshop: Eating Disorders

A workshop was held with professionals from the three boroughs who work with people with eating disorders.

13.1.4 Westminster Youth Council

A workshop was held at Westminster Youth Council with 17 year olds.

13.1.5 Hammersmith and Fulham Youth Council

A workshop was held at Hammersmith and Fulham Youth Council with 14-17 year olds.

13.1.6 Westminster Care Leavers group

A workshop was held with a group of care leavers in Westminster at a peer support group.

13.1.7 Central London CCG Transformation Redesign Group (TRG)

The TRG was consulted and feedback was incorporated into the final draft.

13.1.8 Hammersmith and Fulham CCG Governing Body Development Session

The Governing Body was consulted and feedback was incorporated into the final draft.

13.1.9 West London CCG Transformation Board

The Transformation Board was consulted and feedback was incorporated into the final draft.

London Borough of Hammersmith & Fulham **HEALTH AND WELLBEING BOARD** **08 FEBRUARY 2017**	
PHARMACEUTICAL NEEDS ASSESSMENT	
Report of the Director of Public Health	
Open Report	
Classification - For Information/Decision **Key Decision: No**	
Consultation	
Wards Affected: All	
Accountable Director: Mike Robinson, Director of Public Health	
Report Author: Colin Brodie, Public Health Knowledge Manager	**Contact Details:** Tel: 020 76414632 E-mail: cbrode@westminster.gov.uk

1. EXECUTIVE SUMMARY

1.1 This report outlines the responsibility of the Health and Wellbeing Board to publish a Pharmaceutical Needs Assessment (PNA) for Hammersmith and Fulham, describes the purpose and requirements for the PNA and outlines the local arrangements to produce the PNA.

2. RECOMMENDATIONS

1.2 That the Health and Wellbeing Board review and note the current PNA, and Department of Health guidance on PNAs.

1.3 The Health and Wellbeing Board are invited to consider and approve the local arrangements to producing the PNA for Hammersmith and Fulham

1.4 The Health and Wellbeing Board are invited to consider and discuss the role of community pharmacies to deliver local strategies and priorities, particularly the Joint Health and Wellbeing Strategy and STP.

1.5 The Health and Wellbeing Board member organisations are requested to agree to provide any data necessary to complete the PNA, where they are the source organisation

3. REASONS FOR DECISION

3.1. The Health and Wellbeing Board are legally required to publish and maintain a PNA for their local area by virtue of Section 128a of the National Health Service Act 2006 (Pharmaceutical Needs Assessments) and the Health and Social Care Act 2012.

4. BACKGROUND TO THE PNA

4.1. Pharmacies provide a range of services to their local community. As well as dispensing medicines and appliances, they promote healthy lifestyles and public health campaigns, signpost to local sources of care and support, and provide advice to support self-care of minor ailments and common conditions. Some pharmacies are also commissioned to provide services such as medication use reviews, support with new medicines for people with long term conditions, NHS Health Checks, stop smoking services, flu vaccinations, and needle & syringe exchange programmes.

4.2. Pharmaceutical Needs Assessments (PNAs) are a statement of the needs for pharmaceutical services of the population in a defined geographical area, and are an important tool in market entry decisions.

4.3. Under the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations ("the 2013 Regulations"), anyone who wishes to provide NHS pharmaceutical services must apply to NHS England to be included on a pharmaceutical list, and prove that they are able to meet a pharmaceutical need as set out in the relevant local PNA. These applications can be keenly contested by applicants and existing contractors and so can be open to legal challenge. As such, it is important that the local PNA is robust.

4.4. The responsibility for producing and managing the content and update of PNAs transferred from NHS Primary Care Trusts (PCTs) to Health and Wellbeing Boards on 1st April 2013.

4.5. The current PNA, and the first to be published by the Health and Wellbeing Board, was published in March 2015 in accordance with the "2013 Regulations". A new PNA must be developed by the Health and Wellbeing Boards every 3 years, and so a new PNA is due to be published by the end of March 2018.

4.6. In 2013 the Department of Health produced an Information Pack on PNAs for Health and Wellbeing Boards

4.7. It is recommended that the Board review and familiarise themselves with the current PNA and the Information Pack

5. PURPOSE AND REQUIREMENTS OF THE PNA

5.1. The objectives of the PNA are:

- to provide a clear picture of the current services provided by community pharmacies and identify gaps in service provision in relation to NHS pharmaceutical services;
- to be able to plan for future services to be delivered by community pharmacies and ensure any important gaps in services are addressed;
- to provide robust and relevant information on which to base decisions about applications for market entry in accordance with The National Health Service (Pharmaceutical Services) Regulations 2012

5.2. The detailed requirements for the PNA are set out in Regulations 3-9 and Schedule 1 of the "2013 Regulations"

5.3. The PNA project deliverable are:

- A PNA report for Hammersmith and Fulham, in accordance with the "2013 Regulations"
- A map of local pharmacy service provision for Hammersmith and Fulham

5.4. Health and Wellbeing Boards are required by law to consult a specified list of bodies at least once for a minimum of 60 days during the process of developing the PNA.

6. LOCAL ARRANGEMENTS FOR DELIVERING THE PNA

6.1. While overall responsibility and accountability for the PNA rests with individual Health and Wellbeing Boards, on 24 March 2014 the Health and Wellbeing Board agreed that the PNA would be incorporated into the JSNA work programme. Individual PNAs for each of Hammersmith and Fulham,

Kensington and Chelsea, and Westminster are produced using a jointly-agreed and combined approach.

6.2. To provide assurance to the three Health and Wellbeing Boards:

- As part of the JSNA work programme, the Public Health Knowledge Manager and JSNA Manager are responsible for the day to day management of the production of the PNA
- The JSNA Steering Group retains overall accountability to the three Health and Wellbeing Boards for the production of the PNAs and should provide assurance to the Boards on progress and quality.
- A smaller PNA Task and Finish Group will be established to steer the work. This group will be responsible for ensuring that all the legislative and regulatory requirements are fully met by the revised PNAs

6.3. Key milestones for producing the PNA are outlined below:

Milestone	**Date completed**
Establish PNA Task and Finish Group	Mar 2017
Complete analysis of health needs and priorities	May 2017
Complete analysis of current pharmaceutical services provision	August 2017
Prepare draft PNA for consultation and sign-off at HWB	Sept 2017
Consultation	Dec 2017
Prepare final report for HWB sign-off	Jan 2018
Final sign-off by HWB and publication	Mar 2018

6.4. The PNA Task and Finish Group is currently drafting the project plan and scoping an options appraisal on whether the PNA will be delivered in-house or through contracting PNA specialist support.

7. ISSUES FOR CONSIDERATION BY THE HEALTH AND WELLBEING BOARD

Pharmacies supporting local strategy and priorities

7.1. The Health and Wellbeing Board will wish to consider the role of community pharmacies in delivering on local priorities and strategies, such as the Joint Health and Wellbeing Strategy (JHWS) and Sustainability and Transformation Plan (STP). Although the PNA is largely a technical document and its primary use is for market entry decision making, the PNA also provides an opportunity to add to the local evidence base to inform strategic and commissioning decision-making.

7.2. Community pharmacies offer accessibility for those who cannot or do not wish to access conventional services, long opening hours and convenience, a health resource on the high street and in supermarkets, anonymity, a flexible and informal environment, a local business well connected to their local community, and staff who tend to reflect the social and ethnic backgrounds of the population they serve.

7.3. Delivering services through pharmacies has the potential to relieve pressure on GPs and Accident and Emergency Departments, ensure optimal use of medicines, provide better value and better patient outcomes, and contribute to delivering 7 day health and care services.

7.4. A 2013 review by PHE found the following evidence on the pharmacy contribution to public health:

PHE Evidence[1] on the pharmacy contribution to public health

Service	Evidence of success
Stop Smoking Services	**Very positive** *55% quit rate (49% UK average and 42% GP av.)*
Emergency hormonal contraception (EHC)	**Positive** Evidence to suggest highly rated services
Healthy eating	**Promise, but positive** Insufficient evidence
Drug and alcohol misuse	**Promise, but positive** Insufficient evidence
Infection control and prevention	**Promise, but positive** Insufficient evidence
Chronic disease management & prevention	**Very positive** Good empirical evidence to suggest improved prevention in patients.

[1] *Public Health England (2013) Consolidating and developing the evidence base and research for community pharmacy's contribution to public health: a progress report from Task Group 3 of the Pharmacy and Public Health Forum*

7.5. The Health and Wellbeing Board are invited to consider the role of community pharmacies to deliver local strategies and priorities, particularly the Joint Health and Wellbeing Strategy and STP

Funding for community pharmacies

7.6. This PNA will be undertaken at a time when community pharmacies are facing financial challenges. The majority of NHS income for community pharmacies comes from NHS England through the NHS pharmaceutical services contract. As part of wider efficiency savings across the NHS, the Government announced in October 2016 that funding for NHS contractors providing services under the contract would be reduced in 2016/17 and 2017/18

(equivalent to a 4% reduction in 2016/17 and a further 3.4% reduction in 2017/18). These changes came into effect from 1 December 2016

7.7. There has been criticism and opposition to these funding cuts with industry groups asserting that the cuts will lead to the closure of community pharmacies. At the current time the impact of these funding cuts locally is uncertain.

Access to data

7.8. Another challenge for the PNA is ensuring timely access to data. The data required to produce the PNA is held by a number of organisations, including Public Health, other local authority departments, Clinical Commissioning Groups, NHS England, and local pharmacies.

7.9. **The Health and Wellbeing Board member organisations are asked to agree to provide any data where they are the source organisation.**

8. CONSULTATION

8.1. Health and Wellbeing Boards are required by law to consult a specified list of bodies at least once for a minimum of 60 days during the process of developing the PNA. These bodies include the Local Pharmaceutical Committee; Local Medical Committee; any persons on pharmaceutical lists and any dispensing doctors; any local Healthwatch or any other patient, consumer and community group which (in the opinion of the Health and Wellbeing Board) has an interest; NHS England; and neighbouring Health and Wellbeing Boards.

9. EQUALITY IMPLICATIONS

9.1. Schedule 1 of the “2013 Regulations” includes a requirement of the PNA to assess the different needs of people in its area who share a protected characteristic.

10. LEGAL IMPLICATIONS

10.1. Health and Wellbeing Boards are legally required to publish and maintain a PNA for their local area by virtue of Section 128a of the National Health Service Act 2006 (Pharmaceutical Needs Assessments) and the Health and Social Care Act 2012.

10.2. All Health and Wellbeing Boards were required to publish a PNA by 1 April 2015. After it has published its first PNA, each HWB must publish a statement of its revised assessment within 3 years of its previous publication of a PNA.

10.3. PNAs must be developed in line with the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013

10.4. Implications verified by Kevin Beale, Senior Corporate Lawyer, Shared Legal Services

11. FINANCIAL IMPLICATIONS

11.1. Costs required to produce the PNA will be identified from the 2017/18 Public Health budget and have been estimated at £30K for Hammersmith and Fulham. Governance for the budget will be addressed through the Cabinet Member.

11.2. Implications verified by: Richard Simpson, Public Health Finance Manager.

12. IMPLICATIONS FOR BUSINESS

12.1. Under the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations ("the 2013 Regulations"), anyone who wishes to provide NHS pharmaceutical services must apply to NHS England to be included on a pharmaceutical list, and prove that they are able to meet a pharmaceutical need as set out in the relevant local PNA.

13. COMMERCIAL IMPLICATIONS

13.1. The PNA is a technical document which informs market entry decisions for NHS pharmaceutical services as described in 12.1 above. It also adds to the local evidence base to inform strategic and commissioning decision-making, which may inform the services commissioned by community pharmacies.

14. BACKGROUND PAPERS USED IN PREPARING THIS REPORT

14.1 None.

London Borough of Hammersmith & Fulham **HEALTH AND WELLBEING BOARD** **8 FEBRUARY 2017**	
HAMMERSMITH AND FULHAM JOINT HEALTH AND WELLBEING STRATEGY: DELIVERY AND IMPLEMENTATION PLANNING	
Report of the Director of Partnerships (Adult Social Care)	
Open Report	
Classification - For Decision **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: Liz Bruce, Executive Director Adult Social Services	
Report Author: Harley Collins, Health and Wellbeing Manager, London Borough of Hammersmith and Fulham Toby Hyde, Head of Strategy, Hammersmith & Fulham CCG	**Contact Details:** Tel: 0208 753 5072 Harley.collins@lbhf.gov.uk

1. EXECUTIVE SUMMARY

1.1. This report updates on progress in relation to the development of a Delivery Plan for the Hammersmith and Fulham Joint Health and Wellbeing Strategy 2016-21. The Board is asked to endorse the proposed approach in taking this work forward.

2. RECOMMENDATIONS

2.1. The Health and Wellbeing Board is requested to:

i. Note progress with the development of a Delivery Plan
ii. Comment on the proposed approach to the work
iii. Approve a programme of engagement with stakeholders to develop the Delivery Plan to take place over the next 6-8 weeks

3. REASONS FOR DECISION

3.1 The Health and Wellbeing Board must prepare a strategy that meets the needs identified in the Joint Strategic Needs Assessment.

4. INTRODUCTION AND BACKGROUND

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

4.2. The Board's first Joint Health and Wellbeing Strategy expired in 2016. Throughout the last year, the HWB has engaged widely with stakeholders and the public to develop a vision for health and wellbeing in the borough and identify a small number of priority areas of focus for the next five years:

P1. Ensuring children and families get the best possible start in life
P2. Addressing the rising tide of long-term conditions
P3. Ensuring good mental health for all
P4. Delivering a sustainable health and care system fit for the future

4.3. Adopted by the Council in December 2016, the JHWS 2016-21 offers the Health and Wellbeing Board the opportunity to assume a systems leadership role in addressing and health challenges and system sustainability in the borough.

4.4. Following adoption of the strategy by the HWB a joint press release and comms launch is intended by council and CCG communications and engagement leads on 30th January. The final public-facing version of the strategy is included at Appendix 1. The strategy has been uploaded to the council and CCG websites. A small number of hard copies of the strategy have been printed and will be circulated to key stakeholders.

4.5. Communications and engagement leads will disseminate news items via a range of channels including newsletters, bulletins, patient and public networks and social media. And information about the strategy launch has been circulated to all borough councillors and respondents to the public consultation.

4.6. Hammersmith and Fulham CCG, NHS partners and Local Authorities across north west London (NWL), have come together to develop a North West London Sustainability and Transformation Plan (STP), the first draft of which was submitted to NHS England in June 2016. It should be noted that London Boroughs of Hammersmith and Fulham and Ealing were not signatories of the June submission due to concerns regarding proposed changes to acute services at Ealing and Charing Cross hospital sites.

4.7. The STP contains 5 delivery areas as follows:

DA-1. Radically upgrading prevention
DA-2. Eliminating unwarranted variation and improving LTC management
DA-3. Achieving better outcomes and experiences for older people
DA-4. Improving outcomes for children and adults with mental health needs
DA-5. Ensuring we have a safe, high quality sustainable acute services

4.8. As described within Appendix B, delivery areas DA1 to 4 match the priorities outlined within the Health and Wellbeing strategy and should therefore feed into the agreed, shared delivery plan. Delivery area 5 is outside the remit of the joint working partnership but the CCG will continue to inform and engage with the Health and Wellbeing Board as the work progresses.

5. DELIVERY PLANNING

5.1. The JHWS signals the start of a journey by the local health economy in working together towards a common set of objectives. Whilst the strategy identifies the outcomes the HWB has agreed to work to deliver over the next five years, it does not specify the projects and initiatives that will, taken together, deliver these outcomes. To provide more clarity therefore, the Health and Wellbeing Board has agreed to develop a Delivery and Implementation Plan to sit alongside the strategy.

5.2. The Delivery and Implementation Plan will set out the programmes of work that support the delivery of each of the four priority areas with the JHWS. It will also set out key milestones, deliverables and KPIs and describe programme governance and accountability.

5.3. A half-day development session has been arranged for HWB members taking place on 14th February at Linden House. The purpose of the session will be to discuss an approach to joint working and develop a first draft joint delivery plan.

6. PROPOSAL AND ISSUES

6.1. A Partnership Working Group, established in late 2016, is developing a draft Delivery and Implementation Plan. The group has developed a draft Delivery Plan which will be used as a discussion document at the HWB development session on 14th February (see Appendix 2).

6.2. The Partnership Group is proposing to organise a series of workshops with commissioners, analysts, subject matter experts and others over the next 8 weeks with a view to presenting a JHWS Delivery and Implementation Plan to the HWB in Spring 2017.

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

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

LIST OF APPENDICES:

Appendix 1: Joint Health and Wellbeing Strategy 2016-21
Appendix 2: Delivery Plan discussion document

Appendix 2

The triple aim	JHWS priority areas	STP delivery areas	STP Plans
Improving health and wellbeing Improving care and quality Improving productivity & closing the financial gap	**PA 1** Ensuring children, young people and families get the best possible start	**DA1** Radically upgrading prevention	a) Enabling and supporting healthier living for the whole population b) Keeping people mentally well and avoiding social isolation c) Helping children get the best start in life
	PA 2 Addressing the rising tide of long-term conditions	**DA2** Eliminating unwarranted variation and improving LTC management	a) Delivering the Strategic Commissioning Framework and FYFV for Primary Care b) Improve cancer screening to increase early diagnosis c) Better outcomes and support for people d) Reducing variation by focusing on Right Care e) Improve self-management and 'patient activation'
		DA3 Achieving better outcomes and experiences for older people	a) Improve market management and take a whole systems approach to commissioning b) Implement accountable care partnerships c) Upgrade rapid response and intermediate care services d) Create an integrated and consistent transfer of care approach e) Improve care in the last phase of life
	PA 3 Ensuring good mental health for all	**DA4** Improving outcomes for children and adults with mental health needs	a) Implement new models of care for people with serious and long-term mental health needs to improve physical and mental health and increase life expectancy b) Focused interventions for target populations c) Crisis support services d) Implementing Future in Mind
		DA5 Ensuring we have a safe, high quality sustainable acute services	a) Specialised commissioning to improve pathways from primary care and support consolidation of specialised services b) Deliver 7 day service standards c) Reconfigure acute services d) NW London Productivity Programme
	PA 4 Delivering a sustainable health and care system that is fit for the future	**Enablers**	a) Estates b) Digital c) Workforce

10

NHS
Hammersmith and Fulham
Clinical Commissioning Group

h&f
hammersmith & fulham

Hammersmith & Fulham Joint Health and Wellbeing Strategy 2016-2021

www.lbhf.gov.uk

1. Chair's Foreword

The Hammersmith & Fulham Health and Wellbeing Board Partners[1] are committed to improving the health and wellbeing of the people we serve and putting them at the heart of a high quality and sustainable health and social care system.

Many of us who sit on the Health and Wellbeing Board live and work in Hammersmith & Fulham and have a strong connection to our local communities as GPs, local representatives and public servants. We are motivated to ensure that everyone has access to the same high quality health and care services that we expect for our families and friends.

We have a bold and ambitious vision in Hammersmith & Fulham for a people-centred health and social care system that supports communities to stay well, consistently providing the high quality care and support people need when they need it and enabling communities to stay healthy and independent with choice and control over their lives.

We know we will not achieve this as individual organisations working alone. Whilst there are areas where we have different perspectives about how local health and care needs to change, there is much that we do agree upon.

To drive standards of health and care up locally we need a collective approach where all local organisations work together as one system, thinking and working beyond organisational boundaries for the good of people in Hammersmith & Fulham.

The many staff we have working in health and social care services in the borough will need to work together in partnership with our voluntary sector partners, public bodies, and the wider community. And we will want to support families and communities to take greater responsibility for their own health, be more resilient and self-reliant, where appropriate.

We face many challenges including entrenched health inequalities within our communities, higher than average levels of child poverty and child obesity and some of the highest levels of severe and enduring mental illness in the country. We also have growing numbers of people living with long-term conditions who require person-centred, coordinated care and we are face significant financial challenges at a time when demand for health and social care services is growing.

This plan sets out our ambitions for overcoming these challenges.

To deliver the change we need we will work across the public sector to influence the wider determinants of health such as employment, housing and education; We will embed prevention in all that we do, intervening early to help people to stay well; We will support people to stay well in their communities

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

by making community, primary care and social services part of an effective front line of local care; We will support people who want to take greater responsibility for their own health and wellbeing; and we will undertake an ambitious programme of service integration and reform to ensure health and social care services are joined up, in line with the needs of people, families and carers.

Our plan acknowledges that we must target resources where need is greatest and where the evidence tells us action will make the greatest improvements to people's health and wellbeing. We have therefore agreed four priorities over the lifespan of this strategy:

1	Enabling good mental health for all
2	Supporting children, young people and families to have the best possible start in life
3	Addressing the rising tide of long-term conditions
4	Delivering a high quality and sustainable health and social care system

Our Joint Health & Wellbeing Strategy for 2016 – 2021 is an ambitious, forward thinking plan for improving the health and wellbeing of people in the borough. Through this strategy and the hard work which will follow, we will achieve even closer working between health, social care, the voluntary sector and other partners to enable people to stay healthy, independent and well and ensure the financial sustainability of local health and social care services for the future.

This strategy signals the start of a journey by the council, local NHS and voluntary sector working together towards a common set of objectives and goals. To provide more clarity on our priorities and ambitions, we will develop a detailed Delivery Plan to sit alongside this strategy which will set out the programmes of work that will be delivered through this strategy

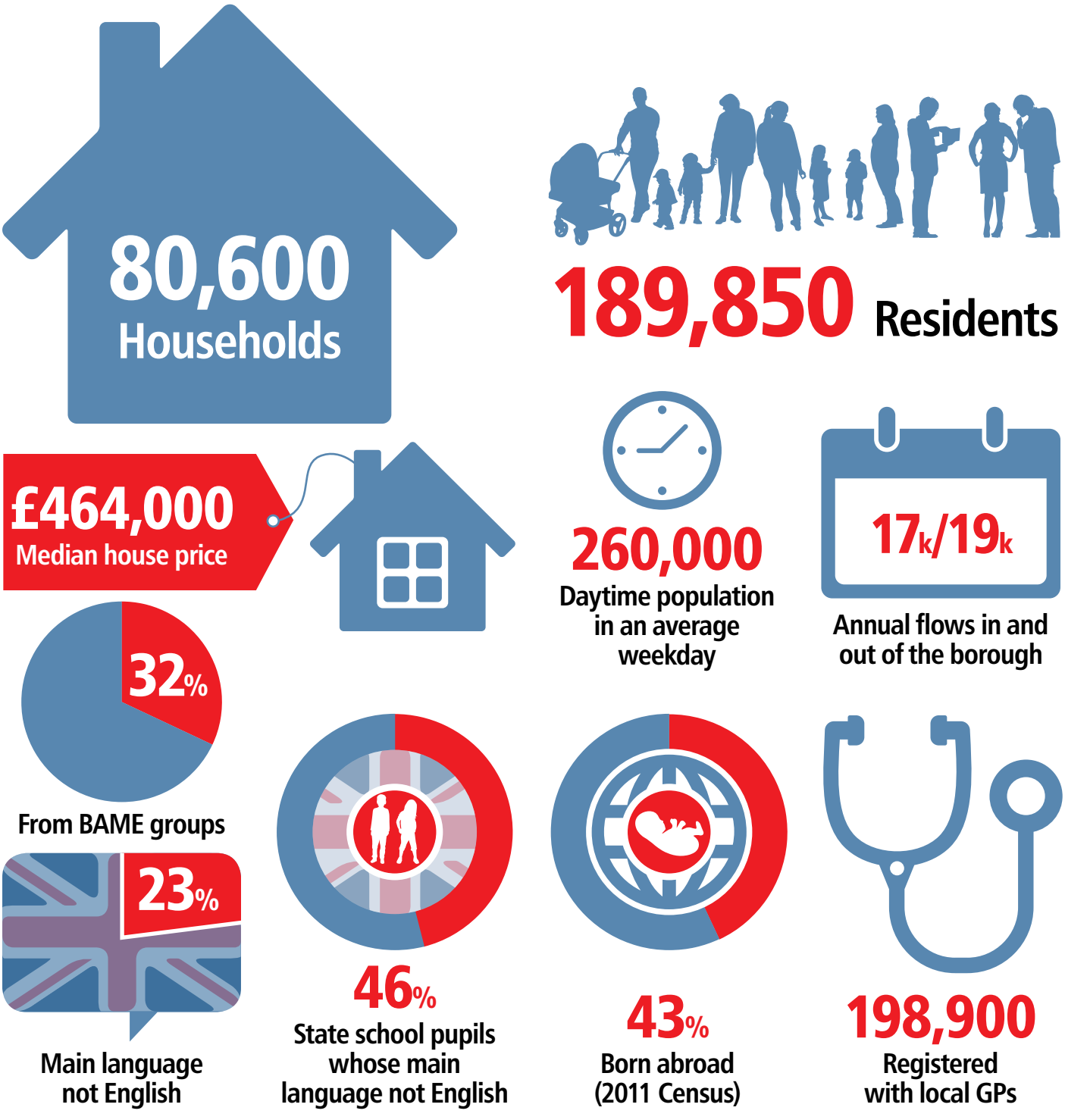
I would like to thank the many people who have contributed to the development of this plan. We have had many conversations along the way which have led us to this point. We now embark on the hard work of realising the vision set out here over the next five years.

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

1.1 Our population at a glance

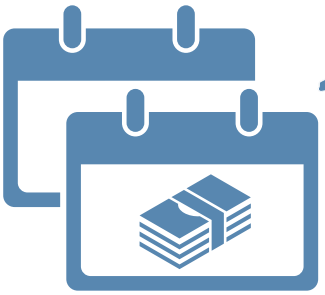
The borough at a glance…

(Hammersmith & Fulham JSNA Highlights report 2013-14)



8
Live births each day

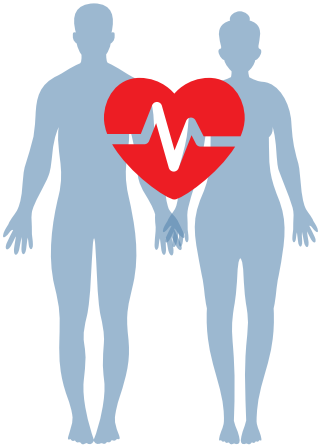
11,900 Local businesses



£33,000
Annual pay

Ranked 55th
Most deprived borough in England (out of 326) (13th in London)

22%
Local jobs in Public Sector

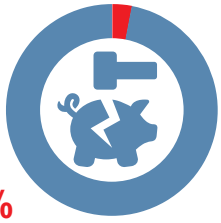


9.6 years
Gap in life expectancy between most and least affluent residents

2-3
Deaths each day

7.1%
Fraction of deaths attributable to human made air pollution (8th worst in London)

Ranked 6th
Highest carbon emissions in London (not including City of London)



3.1%
Unemployment rate (JSA) (London 3.1%)

29%
Children <16 in poverty, 2011 (HMRC)

33%
children of school age either overweight or obese

1.2 Our vision

Our vision is for a people-centred health and social care system that supports communities to stay well, consistently providing the high quality care and support people need when they need it and enabling communities to stay healthy and independent with choice and control over their lives.

We are ambitious for the whole of the public and private sectors, not just the health and care system, to recognise the contribution it makes to health and wellbeing, through jobs, housing and human relationships. And we want everyone in our community to have a valued role through work, volunteering or family, have a safe and secure living space and rewarding relationships with their loved ones.

We will work with our colleagues within the council, the NHS and other partners to improve and protect health and wellbeing and reduce health inequalities within Hammersmith & Fulham, with an aim to close the life expectancy gap across the borough within the next 10 years.

We are already on our way to achieving this vision. We have a strong record of collaboration. The Better Care Fund is an ambitious plan by health and social care partners across Hammersmith & Fulham, Kensington & Chelsea and Westminster to bring together health and care funding where it makes sense with the goal of driving closer integration of health and care, reducing incidences of crisis and delivering care in out of hospital settings.

In health, North West London is a whole systems integrated care pioneer site. NHS commissioners across North West London have agreed that Accountable Care Partnerships are the preferred model for delivering an integrated care system by April 2018.

Achieving our vision is paramount for improving health outcomes in the borough and securing a sustainable system for the future.

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

1.3 The case for change

Hammersmith & Fulham is a vibrant and exciting place to live. Most people in our borough consider their health to be good, many residents are affluent and rates of life expectancy for men have been increasing more quickly than nationally over the past decade.

But we also face significant challenges. A third of children under 16 live in poverty and more than a third of children of school age are either overweight or obese. We must address the 9.6 year difference in life expectancy between affluent and deprived areas which has been resistant to reduction despite longstanding efforts. The main causes of avoidable death in the borough are cancer, followed by cardiovascular disease and respiratory illnesses which are linked to lifestyle choices that are within our power to control and change such as smoking, drinking alcohol, diet and physical inactivity.

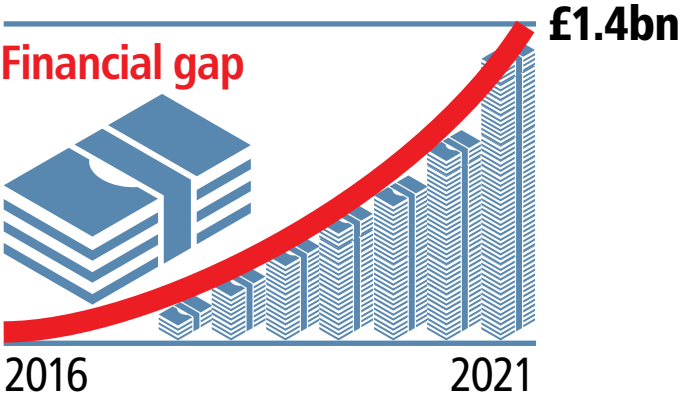
We know that the current system of health and care can be confusing for patients, families and carers. And as our population gets older and more people develop long-term conditions our system is becoming less able to cope with the changing needs and expectations of the people we serve. This is already leading to higher demand for social care, carers and community health services in out of hospital settings and these pressures will only increase.

Under the Care Act, local authorities have clear legal duties in the event of provider failure to temporarily ensure people's needs continue to be met. Nevertheless, the care provider market is fragile and is presenting quality and safety issues nationally and in London. Health and care partners need to invest in the care market and upskill providers to enable them to support the increasingly complex and acute needs of the population.

Our current health and care system is under pressure. The way we pay for health and care services can encourage high end care in expensive settings and reinforce isolated working practices. We spend too much on services which respond at the point of crisis and not enough on early intervention and preventative support that keeps people well.

Across North West London, if we continue as we are currently doing, there will be a £1.4 billion financial gap in our health and care system by 2021.

This plan is about grasping the opportunity to reform the way services are bought, delivered and accessed in Hammersmith and Fulham.



1.4 Achieving the change we need

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

1 Radically upgrading prevention and early intervention

Evidence suggests that 60% of what we can do to prevent poor health and improve wellbeing relates to the social determinants of health i.e. the conditions in which people are born, grow, live, work and age.

We are well placed to provide greater scope for local people to choose positive lifestyles; by ensuring the local environment enables and promotes active travel rather than car use, that high streets offer fresh fruit and vegetables rather than 'fast food', offer reputable banking facilities, not betting shops and pay day loan shops and ensuring that in providing parks and leisure facilities we secure greatest gain for health and wellbeing.

60%
PREVENTION OF POOR HEALTH RELATES TO THE CONDITIONS PEOPLE ARE BORN, GROW, AGE, WORK AND LIVE IN.

We will mainstream prevention into everything that we do and introduce measures to prevent ill health across the life course including increasing uptake of immunisations, working with our partners in housing, employment, education, and planning to promote health and wellbeing, initiate a local movement to build community resilience, and deliver intelligent, outcomes based commissioning that keeps people well

We will empower people to make lifestyle choices that will keep them healthy and well and able to lead a full life as active members of their communities and the local economy.

2 Supporting independence, community resilience and self-care

Population growth, breakthroughs in treatment and management of conditions and changing needs mean that the health and care system is under increasing pressure.

The potential benefits of people engaged in the management of their own care are significant. Small shifts in self-care have the potential to significantly impact the demand for professional care.

In Hammersmith & Fulham, we must be ambitious in our attempts to change cultures so that people are better supported by the system and by technology where appropriate to take more responsibility for their own care.

We know that self-care is a virtuous circle. When a person has the skills, knowledge and confidence to manage their own health and care it is a strong predictor of better health outcomes, healthcare costs and satisfaction with services.

To support people to take greater responsibility we will need to make sure the right services, facilities and support are provided to help people help themselves. We will harness the potential of digital technologies to facilitate control and choice and enable patients to manage their health in the way that best suits them.

We will also fully engage people in service design and work with communities to co-produce health and care-related services.

In 2014, the then newly elected administration of Hammersmith and Fulham Council set out its overarching objective to tackle social exclusion in all of its forms and stated that it was committed to delivering social inclusion in "everything we do". The Council has established a Social Inclusion Unit which will look at the work taking place to expand digital inclusion and agree a way forward on the development of a digital inclusion strategy. Communities that most commonly experience digital exclusion are often the most socially excluded. Harnessing the potential of digital technologies could alleviate feeling of loneliness and isolation and empower communities in managing their own health and care.

Hammersmith and Fulham's Poverty and Worklessness Commission, established in late 2015, is considering amongst other issues how best to support residents to self-reliance. It will report in early 2017 and is expected to contain recommendations on increasing and strengthening volunteering in the borough as a means of building confidence, community resilience and better health.

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

We know that many patients in hospital settings do not need or want to be there. Children in Hammersmith and Fulham attend A&E and other urgent care much more frequently than is typical for London or England. In 2010/11, there were over 8,000 attendances in the borough among under 5s, in many cases for conditions that could be managed in primary care.

Our ambition is to support people to stay well in their communities. This means ensuring the right support is available closer to home in GP surgeries, pharmacies and community hubs. It also means ensuring community facilities like parks, community centres, schools and libraries are well maintained accessible and there to keep people well.

To deliver our ambition of care closer to home, we will encourage and help people make healthier choices by working with local organisations to support health improvement through the contacts they have with individuals. We must deliver high quality and consistent primary, community and social care which is easily accessible and convenient to ensure people access the right care at the right time and are supported to stay well in their homes and communities.

4 Taking a population-level health management approach

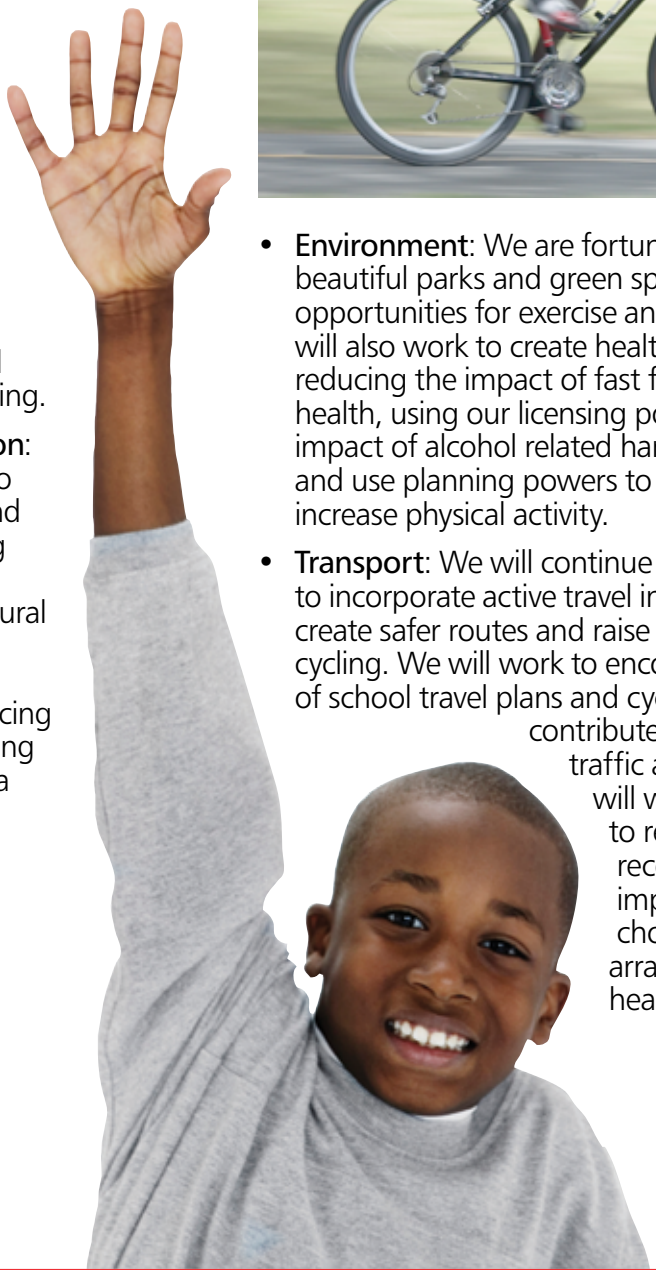
Approximately four-fifths of our population are healthy. Being in good health isn't just about the treatment of illness. It encompasses the food we eat, the air we breathe, the relationships we maintain, the environments we live and work in and the opportunities we have in our lives to flourish.

Supporting people to remain healthy, independent and well is a crucial part of our plan as is identifying those most as risk so that services can intervene early. This plan will not succeed without working across organisational and sector boundaries.

For instance, we know that the "wider determinants of health" - employment, education, housing, environment, and transport – all have a significant impact on health and wellbeing. So we will work with our partners across the public sector to embed health improvement in all policies. This includes local institutions such as schools, hospitals, parks, roads, housing developments, and cultural institutions which can have huge positive or negative impacts on mental health, how we live our lives and whether we realise our potential for a full and healthy life:

- Housing: Poor quality and inappropriate housing and overcrowding can have an adverse impact on the physical and mental health and wellbeing of individuals, families and communities. We are committed to working with partners to improve the quality and supply of homes and reduce homelessness in recognition that a safe and secure home is a fundamental determinant of good health, both physical and mental. Hammersmith & Fulham is set to be a major contributor to London's economic growth over the next decade with three major regeneration projects that individually are on the same scale as Kings Cross and Stratford. Three of London's 'Opportunity Areas' are in our borough at White City, Old Oak and Earls Court which, combined, could include up to 20,000 new homes and 60,000 jobs.

- **Education**: Schools are central to the lives of children and families and it is important that we continue to work both with schools and other educational establishments to give children, young people and families the support they need to achieve and maintain good health and wellbeing.
- **Culture and community cohesion**: Libraries have an important role to play as a source of information and advice as well as venues providing social support and access to the internet. Along with libraries, cultural organisations are an important asset in bringing communities together, building resilience, reducing loneliness and isolation and offering a range of convenient services in a community setting.



- **Environment**: We are fortunate to have many beautiful parks and green spaces that provide opportunities for exercise and relaxation. We will also work to create healthy high streets, reducing the impact of fast food outlets on health, using our licensing powers to control the impact of alcohol related harm and gambling and use planning powers to design out crime and increase physical activity.
- **Transport**: We will continue to encourage people to incorporate active travel into everyday journeys, create safer routes and raise participation in cycling. We will work to encourage the creation of school travel plans and cycle initiatives to contribute to reducing road traffic accidents. And we will work with partners to review and make recommendations to improve quality and choice in transport arrangements within health and care services

- **Air Quality:** Our borough's poor air quality also affects all of us – bringing forward everyone's death by nearly 16 months on average. This compares with the least polluted area, rural Cumbria, where the reduction in life is an average of 4 months. Air pollution affects vulnerable groups more acutely, particularly young children and people living with chronic heart and respiratory diseases.
- **Employment and skills:** Evidence shows that being employed can help improve health and wellbeing and reduce health inequalities, while unemployment is linked to higher levels of sickness and psychological morbidity[3]. At the same time, we know that long-term unemployment is a serious barrier to good health. We will continue to support tailored employment support, targeting those who will benefit the most.

5 Delivering integration and service reform

We will work together, taking a collective, place-based approach that moves beyond organisational boundaries to provide facilities, care and support that is joined up around the needs of people, families and carers. Staff working in health and social care services in the borough will need to work together in multidisciplinary teams, breaking down artificial barriers between primary and secondary care, physical and mental health and between health and social care. And we will work with families and our communities to support them to take greater responsibility for their own health.

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

1.5 Improving population health outcomes

In Hammersmith & Fulham we have taken a population segmentation approach to understanding local need for health and care. Hammersmith & Fulham has:

- 182,500 residents and an average weekday daytime population of 260,000. The borough also has significant population 'churn' with annual flows in and out of the borough of approximately 19,000
- Significant variation in wealth

- A large young working age population
- Diverse ethnicity with one in four of the borough's population born abroad
- Almost a third of children under the age of 16 living in poverty
- Almost a third of state primary school age children who are overweight or obese
- Low vaccination and immunisation coverage
- 7th highest population with severe and enduring mental illness known to GPs in the country in 2014/15
- Poor air quality and the 6th highest carbon emissions in London
- A large proportion (38%) of one person households, including lone pensioner households and significant numbers living in overcrowded housing conditions
- High rates of smoking, alcohol use, poor diet and sexually transmitted infections and low levels of physical activity.

Dividing the population into groups of people with similar needs is an important step to achieving our goal of better outcomes through integrated care. Grouping the population will ensure that models of care address the needs of individuals holistically, rather than being structured around different services and organisations.

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

The table at Appendix B sets out our priorities for addressing the health needs of our population.

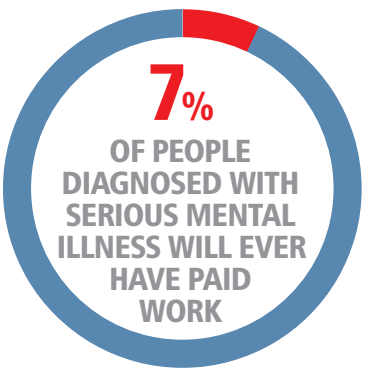
UNDERSTANDING HEALTH NEEDS IN HAMMERSMITH & FULHAM

Age	HEALTH GROUP							
	'Mostly' healthy (rest of the population)	One or more physical or mental long-term condition	Cancer	Severe and enduring metal illness	Learning disability	Severe physical disability	Advanced dementia, Alzheimer's etc.	Socially excluded groups
0-12	i 25,800 (96%) ii 11% (£39m) iii £1,500 iv 2%	i 600 (1.7%) ii 0.5% (£2m) iii £4,400 iv 32%		Unknown			N/a	
13-17	i 7,000 (98%) ii 2% (6m) iii £860 iv 26%			i 20				
18-64	i 25,000 (84%) ii 22% (£80m) iii £753 iv 5.5%	i 17,700 (14%) ii 11% (£41m) iii £2,300 iv 33%	i 1,400 (0.9%) ii 4% (£16m) iii £11,750 iv 52%	i 1,200 (0.8%) ii 7% (£27m) iii £12,400 iv 23%	i 500 (0.4%) ii 8% (£30m) iii £57,300 iv 36%	i 1,700 (1.1%) ii 17% (£64m) iii £38,000 iv 29%	i 400 (0.3%) ii 2% (£7m) iii £17,500 iv 44%	
65+	i 6,500 (36%) ii 5% (£18m) iii £2,400 iv 30%	i 9,600 (53%) ii 10% (£37m) iii £3,900 iv 46%						Unknown
	Healthy 82%	Unhealthy 18%	→					

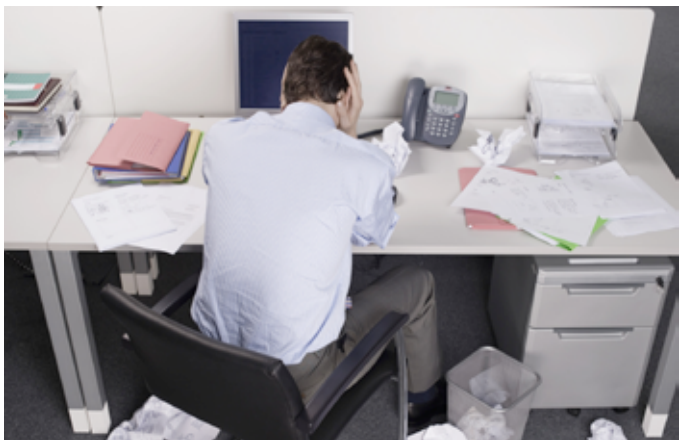
Table: KEY: i = number (%) in age group; ii = % total annual spend on group; iii = average cost per person per year; iv = population increase by 2030

1.6 Our health and wellbeing priorities

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



1 Good mental health for all



Where are we now?

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

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

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

What will we do?

We are committed to improving mental and physical wellbeing by designing and delivering services that have the capacity to have the biggest impact on prevention, early intervention and positive health promotion. We will prevent, identify and treat mental health in all settings and across all age groups. We will:

- Work to reduce waiting and referral times to talking therapies so that conditions do not deteriorate
- Work to ensure that mental health services are more flexible in terms of access criteria, the length of time services are offered for and the time and physical location services are made available
- Promote good workplace mental health and wellbeing and work with employers to educate them about employee mental health
- Work with staff in frontline services across the system to build skills and awareness of mental health
- Promote better emotional and mental health and early intervention in schools, encouraging greater discussion of mental health in the school curriculum including access to counselling and mental health support services in schools
- Provide support and self-help strategies for parents and parents-to-be for their own mental health and for the long-term mental health of their children
- Encourage awareness and improve the quality of local services and support for people living with dementia and their carers including programmes to identify dementia early on
- Work to reduce the high suicide rate among men
- Promote access to activities that promote wellbeing, volunteering and stronger social contact to improve outcomes for adults at risk of serious mental health conditions and reduce social isolation

- Provide early support for older people through effective information and advice and signposting to preventative/universal services
- Work with communities to help change attitudes to mental health and develop better understanding of mental health
- Work with professionals to break down the barriers between physical and mental health and ensure both are treated and resourced equally
- Improve the physical health and lifestyles of people with mental health conditions with a particular focus on people with serious mental health conditions and provide advice and support for all people with mental health conditions to have healthy lifestyles and good mental wellbeing
- Improve access to children and young people's mental health services.

How will we know we're making a difference?

- We will increase the proportion of children and young people referred to child and adolescent mental health services seen within 8 weeks of referral
- Reduce the gap in life expectancy between adults with sever and enduring mental illness and the rest of the population
- Increase the proportion of people treated for anxiety and depression
- We will help more people with mental health conditions into employment, training or volunteering
- Reduce the number of sick days related to mental illness
- We will increase the number of Dementia Friends in the borough each year
- We will increase the number of women, experiencing, or with a previous history of mental health conditions, accessing perinatal mental health services.
- We will reduce preventable early deaths among people with serious mental illness.

Targeted support for vulnerable groups

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

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

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

Where are we now?

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

What will we do?

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

- Develop an integrated health promotion offer for children and families focussed on breastfeeding and good nutrition, oral health, play and physical activity, immunisation, and tobacco free homes
- Develop shared multi-agency services that intervene early and impact on parental behaviour in the areas of substance misuse, domestic violence, mental health and neglect
- Bring together services currently provided by Early Help, Children's Centres, and Youth Services into a single integrated family support offer that sustains and enhances universal provision, whilst providing further support to those families who need additional help through more targeted services
- Build on the Children and Family Act 2014 improvements for young people with Special Educational Needs and Disabilities, both of which recognise the role of wider determinants in the mental and physical health and wellbeing of children and young people
- Empower children and young people experiencing poor or worsening mental, physical health or disabilities to access appropriate and reliable information, advice and expert care in ways that are convenient and tailored to them
- Promote effective support for parents around sensitive parenting and attachment
- Support the development of strong communications and language skills in infancy

- Provide evidence-based support for mothers, fathers, and other carers to help prepare them for parenthood and improve their resilience when they have a new baby
- Strengthen the mental health support we provide to parents early on, including training key frontline staff to assess, support or refer families into relevant support services and ensure those needing specialist services receive them
- Support parents of children who are frequent users of primary and unscheduled care services to understand and manage minor illness and ailments at home, and when and how to access wider support
- Ensure local services work together to minimise duplication and gain the best possible outcomes for families
- Work with schools to promote health and wellbeing messages and harness the energy of young people to improve the health of their families
- Work with schools and families to improve children's diets and levels of physical activity.

How will we know we're making a difference?

- Increase the proportion of mothers breastfeeding at six to eight weeks after birth
- Decrease the number of pregnant women smoking and of families exposing infants to second hand smoke
- Decrease in parents of infants with mental health concerns
- A reduction in the average number of teeth which are actively decayed, filled or extracted amongst children aged five years
- Reduce rates of childhood obesity by increasing the number of children that leave school with a healthy weight and reverse the trend in those who are overweight

- Increase in number of children who reach good level of development in communications and language at the end of reception
- Increase in number of children who reach good level of development in personal, social and emotional development at the end of reception
- Increase uptake of childhood vaccinations.

Targeted support for vulnerable groups

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

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

3 Addressing the rising tide of long-term conditions

Where are we now?

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

£7 OUT OF EVERY £10

SPENT ON HEALTH AND SOCIAL CARE IN ENGLAND IS ASSOCIATED WITH THE TREATMENT OF PEOPLE WITH ONE OR MORE LONG-TERM CONDITIONS

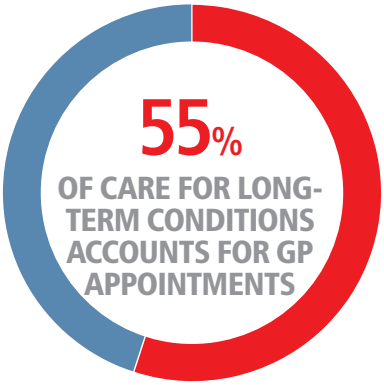
What will we do?

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

- Intervene early to prevent the onset of LTCs and provide support and information for people to maintain healthy lifestyles
- Provide increased support to people with diagnosed LTCs for self-care and self-management of conditions
- Ensure the continuity of care for people with LTCs
- Ensure people's conditions are treated by coordinated health and social care services who can share information
- Ensure there is 'no wrong door' and effective signposting to health and social care services
- Ensure people their carers and families are involved in decisions about their own care
- Provide support for carers and their families to ensure they can support care receivers effectively
- Proactively identify those at high risk of developing Type 2 Diabetes and refer them on to behaviour change programmes

How will we know we're making a difference?

- Increase the proportion of residents who are active and eat healthily
- Reduce death rates from the top three killers (Cancer, cardiovascular disease, respiratory disease)
- More people feel supported to manage their conditions
- More people and carers feel empowered and involved in their care planning
- More people experience integrated care between services
- Reduction in avoidable (unscheduled) emergency admissions
- Reduction in emergency readmissions after discharge from hospital
- Increase in the percentage of GP appointments with a named GP
- Increase in the number of days spent at home
- Reduction in falls
- Uptake of personal budgets
- Increase in the percentage of people still at home 91 days after discharge from hospital into reablement.



Targeted support for vulnerable groups

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

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

4 Delivering a high quality and sustainable health and social care system

Where are we now?

We know that the current system of health and care can be confusing for patients, families, and carers. And as our population gets older and more people develop long-term conditions our system is becoming less able to cope with the changing needs and expectations of the people we serve. This is already leading to higher demand for social care, carers, and community health services in out of hospital settings and these pressures will only increase.

Our current health and care system is under pressure. The way we pay for health and care services can encourage high end care in expensive settings and reinforce isolated working practices. We spend too much on services which respond at the point of crisis and not enough on early intervention and preventative support that keeps people well. Across North West London, if we continue as we are currently doing, there will be a £1.3 billion financial gap in our health and care system by 2021.

What will we do?

We will:

- Work together across organisational boundaries to plan and deliver the workforce needed for the future
- Work with our partners to look at the current and future needs of our population and map projected demand for health and care services to understand gaps in our workforce
- Work with partners including universities, royal colleges, Health Education England, and other teaching institutions to refocus local health and care worker training programmes towards the workforce needed for the future
- Work with partners to ensure there are the right reward structures and contract flexibility to incentivise the creation of the workforce we need
- Prepare staff for multidisciplinary team working rather than the roles of professional groups

- Support and better harness the power of the informal workforce by creating a 'social movement' to support those in need, including a more strategic approach to the support and development of volunteers
- encourage and enable communities to take greater care of themselves and others
- Identify and capitalise on people's strengths and residents' commitment to managing their own care and work with them to find ways to influence others so that they can do the same
- Capitalise on our capacity to enable and promote healthy lifestyles
- Empower people to make lifestyle choices that will keep them healthy and well and able to lead a full life as active members of their communities and the local economy, working with our partners across the public sector to embed health improvement in all policies
- Developing the primary care estate and council buildings required to support new models of care and a system that is sustainable and fit for the future
- Increase value from under-used and under-utilised estate in the borough
- use technology to join up the health and care system and support people to better look after themselves
- Invest in information technology and data analytics
- Seek to develop shared digital patient records updated in real-time and shareable across organisational and sector boundaries
- Improve information collection and management to enable better retrospective and predictive modelling, decision making and improve quality and safety standards for people
- Exploit the smart phone revolution and use people's phones and other digital devices as a new "front door" to self-care, health promotion information and services, building on the "One You" app recently launched by Public Health England and providing a seamless link to self-care and prevention work for adult social care
- Agree with partners across the borough to share information where it makes sense for patients and they are happy for us to do so
- Investigate the role of technology in enabling people to manage their own care investigate the viability of these approaches locally and scale up what works
- Using finance to enable closer working and commissioning between health and social care and more personalised, integrated and person centred services
- Increase the use of pooled budgets where it makes sense as a way of enabling closer health and social care collaboration
- Starting to view our budgets and services in a single joined up way
- Improve the way we communicate, engage, and co-produce with our residents ensuring information about health and care services is clearly signposted and tailored to audiences, and ensure people can have a say in local service changes and the development of new services
- Continually monitor our progress with the implementation of this strategy and regularly measure and report our performance to residents and patients.

2. Implementing the plan

This plan signals a radical shift in our local planning approach for health and social care. Building on our last Joint Health and Wellbeing Strategy, we have an opportunity to bring together local NHS commissioners and providers, local government and other local public services to develop a renewed vision for improved health in Hammersmith and Fulham. This place-based approach is an acknowledgement by us that collective action, cooperation and management of common resources is necessary to secure better and more sustainable care.

We have already had many conversations with local people and our partners over recent years about improving health and social care and preventing ill health including workshops, consultations, patient and public groups. This plan represents the fruits of these conversations and we will build on these over the next five years using ways of engaging directly with residents, including building on the success of our recent Neighbourhood Health Forums.

We have many staff in Hammersmith & Fulham working in health and social care services who will be central to the success of this plan. Partner organisations will lead engagement with their own staff to enable them to deliver this vision.

Following agreement of this plan, the Health and Wellbeing Board partners will set out a timetable for talking with staff and local people about our plans. In early 2017, the Health and Wellbeing Board partners will work to develop a detailed Delivery and Implementation Plan setting out the detailed programmes of work to be delivered under each priority area, the outcomes and performance indicators we will use to measure progress and the governance and accountability mechanisms needed to deliver the work. We will also run events with Healthwatch and with local people about the support they require to take control of their own health and wellbeing.

APPENDIX

Appendix A - Outcomes-based commissioning

Traditional ways of buying health and social care services ("commissioning") have tended to focus on processes, individual organisations and single inputs of care. That is, the people who buy services ("commissioners") have tended to pay the people and organisations that provide health and social care services ("providers") according to the number of instances of treatment provided. This focuses the health and care system on completing specific tasks and away from treating people in a holistic way and on a person's overall wellbeing.

As funding is attached to treatment, there are perverse incentives for providers of health and care services try to provide as much treatment to individuals as possible. This can be costly for the system as a whole and militates against the prevention of ill health. This approach has inadvertently helped fragment the way care is delivered and has acted as a barrier to the development of more integrated services and models of care.

"Outcomes" are the end results we aspire to achieve for people, their families and their carers. Outcomes-based commissioning allows us to focus on the important aspects of care - the result from a patient's perspective. Under outcomes-based commissioning providers are paid for meeting specified outcomes, including things like the patient's experience of care and the extent to which they are kept well. Outcomes based commissioning therefore can be used to incentivise shifting of resources into out-of-hospital settings, focus health and care providers on keeping people healthy and in their own homes and co-ordinated care across settings and regions. It also encourages a focus on the experience of people using the services, and achieving the outcomes that matter to them.

This is the approach needed in Hammersmith & Fulham. The Health & Wellbeing Board partners commit, through this strategy, to outcomes-based approaches to commissioning.

Our Outcomes Framework

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

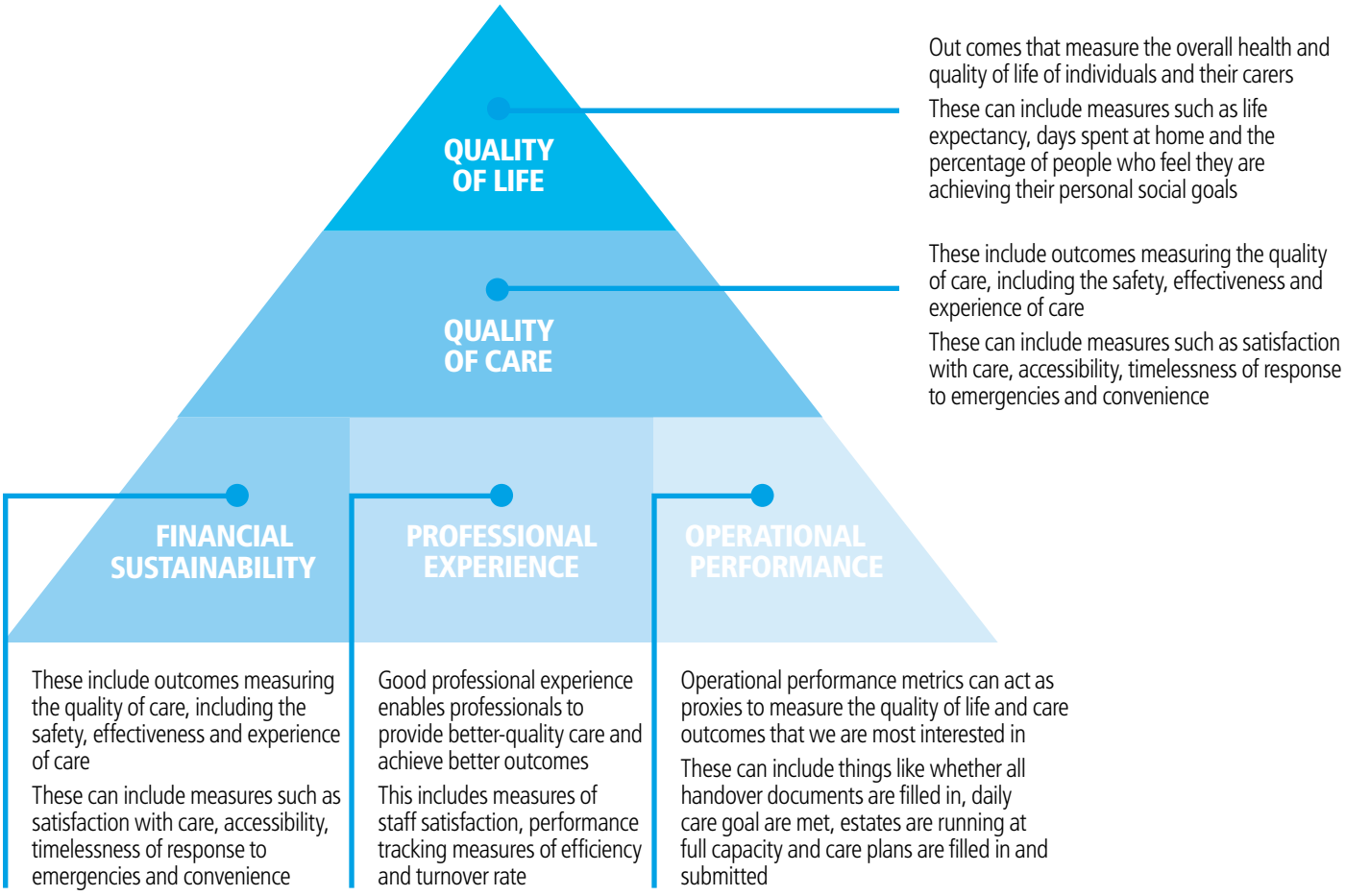
The Hammersmith & Fulham Health and Wellbeing Strategy uses the North West London outcomes framework to ensure that there is a consistent approach to understanding people's needs and buying services in support of them across the sub-region. Being consistent across larger geographies including North West London is important, particularly in London, because so many providers of health and care operate across borough boundaries and because Hammersmith & Fulham residents access services outside of Hammersmith & Fulham.

Basing our future commissioning on a shared framework in this way allows us to deliver scale to the range of services we have on offer for Hammersmith & Fulham residents and it means that we can make a shift, across the whole system, in the way that health and care is organised, bought, delivered and measured.

In this outcomes framework and hierarchy, the most important perspective is the well-being of the person who is receiving services and as such, the first two domains – 'quality of life' and 'quality of care' (what we have termed quality of experience of care) - are the most important. The other three outcomes domains – financial sustainability; professional experience; and operational performance – are all crucial enablers for delivering quality care and quality of life for Hammersmith & Fulham residents and are addressed holistically in the systems section.

Outcomes-based commissioning provides a way of paying for health and care services based on rewarding the outcomes that are important to the people using them. This typically involves the use of a fixed budget for the care of a particular population group ("capitated budget"), with incentives for health and care providers to work together to deliver services which meet specified outcomes. This approach aims to achieve better outcomes through more integrated, person centred services and ultimately provide better value for every pound spent on health and care.

The approach can help rather than hinder provider coordination and collaboration; incentivise a focus on prevention; allow providers the freedom and flexibility to innovate and personalise care according to what is best for patients' outcomes rather than sticking rigidly to service specifications; and incentivise provides to manage overall system costs because providers are accountable for the end-to-end costs of care for a group there is no advantage in passing on costs to another organisation in the system.



Source: Whole Systems Integrated Care module working group

Appendix B - Our population health priorities

Pre-birth and early years (0-12 years)

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

Young people (13-17 years)

What do health and care services look like today?	Outcomes	Priorities	Measures
Young people in the borough face particular challenges. There are a significant number of children living in poverty and many young people are not in education, employment or training. Child obesity rates are high, there is poor child vaccination coverage and high levels of tooth decay in children.	• Young people are supported to start well and stay healthy and independent	• Received screening and advice around STIs and conception • Where appropriate, received additional training or support to get into paid work • Help giving up smoking through a stop smoking service • Integrated health and care services for young people to ensure good care coordination • Received support for low-level mental illness via IAPT programme, if needed • CAMHS support for young people with serious mental health disorders • Support managing any hazardous alcohol or drug use through statutory services • Registered with GP and women attending cervical screening • Ensuring multi-agency planning and services for young people in challenging circumstances (e.g. young offenders, gang members, looked after children, homeless young people and young people who have been exploited or abused) • Investment in young people's mental health services • Implementation of the Children and Families Act 2014 (e.g. children with Special Educational Needs) • Ensuring good transitions between child and adult services (e.g. early care planning, key workers and coordinators)	• Increase parental employment • Reduce child poverty • Reduce child obesity • Improve vaccination and immunisation rates

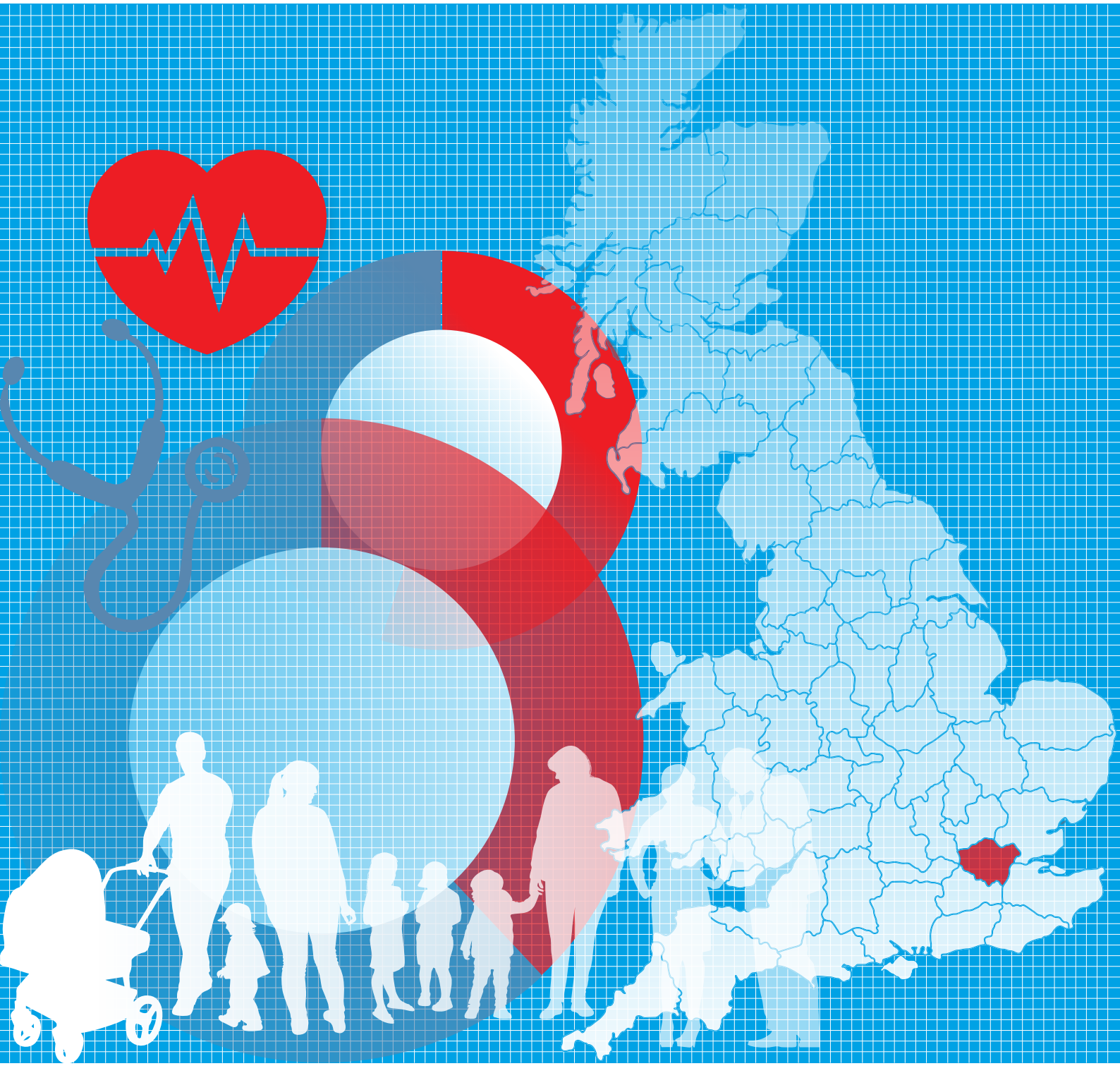
Appendix B - Our population health priorities

Working age adults (18-64 years)

What do health and care services look like today?	Outcomes	Priorities	Measures
Working age adults make a significant contribution to society and to the health and wellbeing of others including as workers, as parents and as carers for parents, relatives or friends. These responsibilities mean it is important adults know how to keep themselves healthy and build this into their everyday lives. There are significant health challenges in this population however: suicide rates are high, there is a large homeless population, high levels of drug misuse and smoking, low uptake of breast and cervical cancer screening, and a high prevalence of mental ill-health. There are a larger proportion of people infected with HIV and high proportion of sexually transmitted disease. Unhealthy lifestyle choices tend to cluster together. So people who smoke are more likely to drink too much alcohol or to use other drugs and are also more likely to have poor diets and live inactive lives. We need to consider how we can help people address multiple rather than individual unhealthy behaviours	• Working age adults are supported to stay healthy, independent and well • The gap in life expectancy between adults with serious mental health needs and the rest of the population is reduced	• Support for healthy lifestyles (e.g. smoking cessation, physical activity, diet, alcohol consumption) • Retain an active lifestyle to prevent overweight and the risk of long-term conditions • Undiagnosed long term conditions such as high blood pressure and diabetes is picked up via health checks, to be offered in a range of settings • Effective self-management of these conditions, through information, training, and a change in habits • Good access to sexual health services to detect, diagnose and treat STIs • Women attending cervical and breast screening • Support for those on long-term sickness to return to work • Received support for low-level mental illness via IAPT programme, if needed • Support for people with severe and enduring mental illness • Support for people with learning disabilities • Support for people affected by suicide • Support for homeless communities and those sleeping rough • Early detection and diagnosis of HIV • Mitigating the impact of poor air quality for people living with cardiovascular disease or respiratory disease	• Increasing the number of parents in good work • Increase the number of people with learning disabilities in employment • Increase the number of people with mental health needs in employment • Reduce health inequalities between most and least affluent residents in the borough • Improving premature mortality from Cancer, CVD, respiratory disease • Reduce statutory homelessness • Reduce social isolation of carers and social care users • Reduce smoking prevalence

Older people (65+ years)

What do health and care services look like today?	Outcomes	Priorities	Measures
Older people make a valuable contribution to society. The majority of volunteers are aged 50 or over, and older people also represent a significant proportion of carers. Older people also have a wealth of skills, knowledge and experience. It is vital therefore that we support older people to age well. Our population is ageing and this means we will need to support growing numbers of people living with multiple conditions including dementia, cardiovascular disease, respiratory disease and frailty. These conditions are often linked with factors like social isolation and poor housing which can make care more complicated. Preventing chronic disease requires a range of interventions such as screening and vaccinations. Overall there is good uptake of NHS Health Checks and diabetic screening, good flu vaccination uptake, low number of hip fractures and low excess winter deaths.	• Social isolation is reduced • Older people are supported to age well and stay healthy and independent	• Undiagnosed conditions picked up and self-managed or managed through GP/ community services, rather than through emergency care • Avoiding social isolation through the active engagement in activities and pastimes. In particular, partaking in gentle physical activity (e.g. walking, gardening) to lower risk of cancer, heart disease, mental ill-health and weak bone strength • Screening for early signs of dementia • Uptake of schemes which improve self-management of care • Receiving high quality health and social care designed around the person, not the condition, in convenient settings and at convenient times • Preventing sight loss • On reaching the last phase of life, support for dying in preferred place of death • Mitigating the impact of poor air quality for people living with cardiovascular disease or respiratory disease	• Reducing the number of people over 65 admitted to hospital due to falls • Reduce emergency readmissions within 30 days of discharge from hospital



The triple aim	JHWS priority areas	STP delivery areas	STP Plans
Improving health and wellbeing Improving care and quality Improving productivity & closing the financial gap	**PA 1** Ensuring children, young people and families get the best possible start	**DA1** Radically upgrading prevention	a) Enabling and supporting healthier living for the whole population b) Keeping people mentally well and avoiding social isolation c) Helping children get the best start in life
	PA 2 Addressing the rising tide of long-term conditions	**DA2** Eliminating unwarranted variation and improving LTC management	a) Delivering the Strategic Commissioning Framework and FYFV for Primary Care b) Improve cancer screening to increase early diagnosis c) Better outcomes and support for people d) Reducing variation by focusing on Right Care e) Improve self-management and 'patient activation'
		DA3 Achieving better outcomes and experiences for older people	a) Improve market management and take a whole systems approach to commissioning b) Implement accountable care partnerships c) Upgrade rapid response and intermediate care services d) Create an integrated and consistent transfer of care approach e) Improve care in the last phase of life
	PA 3 Ensuring good mental health for all	**DA4** Improving outcomes for children and adults with mental health needs	a) Implement new models of care for people with serious and long-term mental health needs to improve physical and mental health and increase life expectancy b) Focused interventions for target populations c) Crisis support services d) Implementing Future in Mind
		DA5 Ensuring we have a safe, high quality sustainable acute services	a) Specialised commissioning to improve pathways from primary care and support consolidation of specialised services b) Deliver 7 day service standards c) Reconfigure acute services d) NW London Productivity Programme
	PA 4 Delivering a sustainable health and care system that is fit for the future	**Enablers**	a) Estates b) Digital c) Workforce

London Borough of Hammersmith & Fulham **HEALTH AND WELLBEING BOARD** **08 February 2017**	
BETTER CARE FUND 2017/18	
Report of the Executive Director for Adult Social Care and Health and NHS Hammersmith & Fulham CCG	
Open Report	
Classification - For information and decision **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: Liz Bruce, Executive Director of Adult Social Care and Health	
Report Author: Sarah McBride, Interim Director of Partnerships for LBHF, RBKC and WCC. Janet Cree, Managing Director of Hammersmith & Fulham CCG	**Contact Details:** Tel: 020 8753 6966 E-mail: Sarah.Mcbride@lbhf.gov.uk janet.cree@nw.london.nhs.uk

1. EXECUTIVE SUMMARY

1.1 This report provides an update to the Health and Wellbeing Board on progress towards developing the Better Care Fund arrangements for 2017/18.

1.2 This report also asks that the Board note that it may be necessary to convene an extraordinary meeting in March to agree the final BCF plan if national timescales mean that it is not possible to return to a planned Board meeting.

2. RECOMMENDATIONS

2.1 That the Health and Wellbeing Board note progress towards the development of arrangements for the Better Care Fund 2017/18 and that the national policy framework and planning guidance have not yet been released.

2.2 That the Health and Wellbeing Board note that it may be necessary to convene an extraordinary meeting in March to agree the final BCF plan if

national timescales mean that it is not possible to return to a planned Board meeting.

3. REASONS FOR DECISION

3.1. Health and Wellbeing Boards are required to sign off the Better Care Fund Plan for their area.

4. INTRODUCTION AND BACKGROUND

4.1. At the time of writing this report, the national policy framework and planning guidance have not yet been released which were expected in November 2016. It is understood that the policy framework will be broadly similar to previous years and that the deadline for the completion of local plans will be March 2017. This delay will mean tight timeframes for developing, approving, and submitting plans and therefore officers from the Council and the CCG have decided to progress with preparation and planning.

4.2. The Better Care Fund in 2016/17 supported the development of key projects including the implementation of the refreshed CIS service.

4.3. The overarching approach proposed is to build on previous years of the BCF, noting the development of the Hammersmith & Fulham Joint Health and Wellbeing (HWB) Strategy as an important point of reference. There is strong alignment between the ongoing approach to the BCF and the HWB strategy.

4.4. In December 2016, officers from the Council and the CCGs asked the Better Care Board to consider a set of draft principles to guide planning discussions about the 2017/18 BCF. The draft principles were discussed and amended, resulting in the principles set out below:

i. The Health and Wellbeing (HWB) Strategy and Delivery Areas 1,2 and 3 of the NWL STP sets out plans for integrated working. The BCF will support these plans
ii. We will meet any national BCF conditions within the context of HWB Strategy ambitions
iii. We spend the fund on protecting and developing services which are integral to achieving the aims and service developments of the HWB Strategy and STP Delivery Areas 1, 2 and 3
iv. This 2 year agreement will be set within the context of our overall ambitions of increasing joint working and exploring developments such as accountable care meaning that flexibility during the 2 years will be required
v. We will seek to simplify, align, improve and embed rather than creating new schemes or projects for the BCF
vi. We use indicator performance trajectories and targets that mirror those being used across the system to ensure a consistent picture of system performance
vii. High trust, transparent approach and mature system outlook
viii. Consistency between three boroughs with local flavour
ix. We agree payment and performance reporting schedules in advance
x. Set within a context of our ambitions to pool more resources and increase joint commissioning

5. PROPOSAL AND ISSUES

5.1 During preparations, analysis of 2016/17 projects has taken place to determine which projects require further development and which are now embedded as business as usual. Using this analysis and the principles above, the following draft framework for our 2017/18 projects has been created to support planning:

A	Embedding the Community Independence Service (CIS)	
B	Joint commissioning developments	i. Low level health tasks and domiciliary care
		ii. Existing S75 best value and alignment assessment
		iii. Domiciliary care & care homes single commissioner
		iv. Mental health
		v. Other opportunities identified
C	Single system performance dashboard and oversight	

5.2 To support the delivery of key projects and ensure clear financial arrangements, the following draft financial framework has been developed to support planning discussions:

a. Protection and development of social care services
b. Protection and development of NHS community services
c. Services interfacing with acute services (including CIS, reablement and 7 day working)
d. Capacity to support key projects e.g. Joint commissioning developments
e. 2016/17 legacy services

5.3 Projects briefs will be drafted for each of the projects. Once national guidance is received including national requirements, conditions and final financial allocations, further planning can take place.

6. CONSULTATION

6.1. No consultation has taken place, however the approach proposed to the BCF is aligned with the Health and Wellbeing Strategy which has recently been developed following a period of extensive consultation.

7. EQUALITY IMPLICATIONS

7.1. Each project will require an Equality Impact Assessment during development.

8. LEGAL IMPLICATIONS

8.1. There are no particular legal implications arising from this report.

8.2. Implications completed by: Rhian Davies, Chief Solicitor 02076412729

9. FINANCIAL AND RESOURCES IMPLICATIONS

9.1. Although there are no financial implications set out in the report, it should be noted that the Better Care Fund forms an important part of a sustainable social care budget in Hammersmith and Fulham Council and a sustainable budget in the CCG.

9.2. Implications verified/completed by: P. Daryanani, Interim Director of ASC Finance, Tel: 0208-753-2523.

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

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

London Borough of Hammersmith & Fulham **HEALTH AND WELLBEING BOARD** **08 February 2017**	
DELEGATED PRIMARY CARE COMMISSIONING	
Report of the Managing Director, Hammersmith and Fulham CCG	
Open Report	
Classification - For information **Key Decision: No**	
Wards Affected: All	
Accountable Director:	
Report Author: Janet Cree, Managing Director, Hammersmith and Fulham CCG	**Contact Details:** Tel: 020 8753 6966 E-mail: Sarah.Mcbride@lbhf.gov.uk

1. EXECUTIVE SUMMARY

1.1 This report provides an update to the Health and Wellbeing Board on primary care delegation. Members of the Health and Wellbeing Board are asked to note the paper.

2. RECOMMENDATIONS

2.1. That the Health and Wellbeing Board note, a further report will be presented on the outcome of the membership vote at the next meeting of the Board; and

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

3. REASONS FOR DECISION

3.1. Primary care co-commissioning is one of a series of changes set out in the NHS Five Year Forward View. It gives Clinical Commissioning Groups (CCGs) an opportunity to take on greater responsibility for general practice

commissioning. It was introduced to support the development of integrated out-of-hospital services, based around the needs of local people.

4. CONTEXT

4.1. In April 2015 Hammersmith and Fulham Clinical Commissioning Group (CCG) entered into a primary care co-commissioning arrangement with NHS England following approval by the CCG membership. This level 2 commissioning arrangement meant that, although NHS England retained all responsibility for their existing primary care commissioning, they would discharge them in conjunction with the CCG. A dedicated co-commissioning committee was established as a formal committee of the CCG Governing Body. At the time of establishment membership included a local authority representative.

4.2. The overall direction of travel nationally for primary care commissioning has been for NHS England to delegate the majority of their current primary care responsibilities to Clinical Commissioning Groups. Across the country a number of CCGs have taken on delegation with numbers anticipated to increase further from April 2017.

5. HAMMERSMITH AND FULHAM POSITION

5.1. In November 2016 the CCG Governing Body discussed the planning that had been taking place to consider whether the CCGs would make an application to NHS England for primary care delegation from April 2017. The original timetable for the CCGs had been to apply for delegation as from April 2018. The Governing Body was advised that the eight NW London CCGs were actively exploring a move to full delegation of Primary Care medical services commissioning from 1 April 2017. This would mean each CCG assuming full responsibility for commissioning Primary Care medical services in response to the needs and circumstance of our registered populations.

5.2. On 5 December 2016 the NWL CCGs submitted applications to NHS England to take on primary care delegation from 1 April 2017. The applications contained a number of caveats based on feedback from CCG memberships, including the right to withdraw the applications should CCG memberships vote against the proposal in February 2017.

5.3. Within Hammersmith and Fulham a number of engagement activities have taken place with the CCG membership. This was initially to seek their views on whether an application should be made to NHS England and more recently to discuss the issues associated with taking on delegation from NHS England in order that they have all relevant information to enable them to take an informed decision when the proposal is put to a membership vote in February. Engagement has taken place through membership meetings, network meetings and, where requested, one to one meetings with practices. Two stakeholder events have been run in order to discuss primary care delegation with GPs, patients and other interested.

5.4. Within Hammersmith and Fulham the membership will be asked to vote on the proposal for the CCG to assume responsibility for commissioning primary care medical services from 1 April 2017, under fully delegated (level 3) arrangements from NHS England. Voting will take place between 1-14 February.

5.5. If CCG members vote in favour of delegation, Hammersmith and Fulham, in line with the other NW London CCGs will adopt a common borough based (and where appropriate, shared) model of decision making and operational delivery, that will allow for greater responsiveness to local commissioning needs.

5.6. Additionally, it is proposed that a common approach will be adopted across NW London footprint where it:

- Supports delivery of the NW London Sustainability and Transformation Plan (STP), and in particular the Local Services strategy developed for our sector of London;
- Allows the CCGs to drive efficiency, best value, and consistency in our locally-driven commissioning approach and processes, and in the outcomes derived across NW London; and
- Secures the most efficient and effective governance processes for Primary Care commissioning.

6. BACKGROUND PAPERS USED IN PREPARING THIS REPORT

6.1 None.

London Borough of Hammersmith & Fulham **HEALTH & WELLBEING BOARD** **08 February 2017**	
QUALITY PREMIUM: 2016/17 UPDATE AND 2017/18 PLANNING	
Report of the Hammersmith & Fulham CCG	
Open Report	
Classification - For information **Key Decision: No**	
Consultation: CCG Operational Group	
Wards Affected: All	
Accountable Director: Janet Cree, CCG Managing Director, Hammersmith & Fulham CCG	
Report Author: Helen Poole	**Contact Details:** Tel: 020 3350 4032 E-mail: Helen.Poole@nw.london.nhs.uk

1. EXECUTIVE SUMMARY

1.1. The Quality premium is intended to reward CCGs to:
- Improve the quality of services they commission
- Improve health outcomes and
- Reduce inequalities in access and in health outcomes

1.2. The premium is paid to CCGs each year based on performance against measures that incorporate a combination of national and local priorities

1.3. The submission date for the 2017/18 Quality Premium is to be confirmed but expected to be within February/March

2. RECOMMENDATIONS

2.1. That the Health and Wellbeing Board note of the performance against the 2016/17 Quality Premium indicators and requirements for the 2017/18 submission.

3. REASONS FOR DECISION

3.1. Each CCG is required to submit its choice of Quality premium indicators to NHSE - date to be confirmed

4. PROPOSAL AND ISSUES

4.1. The performance against current year indicators and requirement for 2017/18 including targets and allocation is outlined in Appendix 1 (attached)

4.2 The CCG will have its Quality premium payment reduced if the providers from whom it commissions services do not meet the NHS Constitution requirements against cancer treatment times, referral to treatment times for planned care, the 4-hour A & E target and ambulance response times

5. OPTIONS AND ANALYSIS OF OPTIONS

5.1. In agreeing the quality premium measures and targets, review of baseline information and service plans will be considered. All proposals will be discussed and robustly challenged at relevant CCGs Committees before a final decision is reached

6. ENGAGEMENT

6.1. We will discuss the requirements and assess baseline information, target, and delivery plans at CCG Operational Group meetings and other relevant Committees. The HWB will be engaged during this progress.

7. EQUALITY IMPLICATIONS

7.1. Equality impact assessment is not required.

8. LEGAL IMPLICATIONS

8.1. No legal implications are perceived.

9. FINANCIAL IMPLICATIONS

9.1. It is assumed that the maximum Quality premium payment for 2017/18 will be approximately £1.05m, paid in 2018/19 subject to performance.

10. IMPLICATIONS FOR BUSINESS

10.1. To deliver the target performance for some indicators, CCG may need to consider additional investment, which will be approved as per current Governance arrangement in place.

11. COMMERCIAL IMPLICATIONS

11.1 No commercial implications are envisaged.

12. OTHER IMPLICATIONS PARAGRAPHS

12.1. None.

13. BACKGROUND PAPERS USED IN PREPARING THIS REPORT

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1	Technical Guidance Annex B Information on Quality Premium	NHS England	NHS England
2	CWHHE Quality Premium Dashboard	CCG	CCG, MBR

LIST OF APPENDICES:

Appendix 1: 2017-19 Quality Premium Guidance

Appendix 1: 2017-19 Quality Premium Guidance

Background

The 2017-19 Quality Premium (QP) guidance was published by NHS England (NHSE) in early January 2017 and CCGs are expected to make a submission for 2017/18 QP in early 2017 (submission date to be confirmed).

Quality premium payments should be used by the CCGs to secure improvement in:

- The quality of health services; or
- The outcomes achieved from the provision of health services; or
- Reducing inequalities between patients in terms of their ability to access health services or the outcomes achieved

The CCG may utilise the QP payment with other organisations to deliver the improvements above.

Each CCG is also required to publish an explanation of how it has spent a QP payment.

The Quality Premium award is based on measures that cover a combination of national and local priorities, and on delivery of gateway tests. As in previous years, a CCG may have its quality premium award reduced according to delivery of NHS Constitution targets e.g. Referral to Treatment times. However, as in 2017/18, some providers will continue to have agreed bespoke trajectories in relation to constitutional standards, for example where remedial action plans are in place. .

The local indicators remain a strong tool by which CCGs are able to engage and drive improvements in areas agreed with their local partners. This year the local element of the scheme is focused on the Right Care suite of indicators as set out in the Commissioning for Value packs. The NHS RightCare programme is about improving population-based healthcare, through focusing on value and reducing unwarranted variation. It includes Commissioning for Value packs, which are designed to identify priority programmes which offer the best opportunities to improve healthcare - improving the value that patients receive from their healthcare and that populations receive from investment in their local health system.

2016-17 Update

The maximum QP payment for the CCG is expressed as £5 per head of population, calculated using the same methodology as for CCG running costs. Based on estimated registered population of 210,546, the maximum QP funding available for H & F in 16/17 is £1.05m. However, as described above, payment made to the CCG on its QP indicators is directly linked to its performance against constitutional measures.

The latest performance of our 2016-17 Quality Premium measures is summarised below, based on reporting in January 2017.

Priority	Measure	QP allocation	Target	Current performance	RAG
Cancer diagnosis at early stage	Demonstrate a 4 percentage point improvement in the proportion of diagnosed at stages 1 and 2 in the 2016 calendar year compared to the 2015 calendar year OR Achieve greater than 60% of all cancers diagnosed at stages 1 and 2 in the 2016 calendar year	20%	42%	Latest performance available is for 2014 - 41.9% Proxy measure is number of emergency presentations of cancers resulting in IP spell. Average for the first 10 months is 16 against the target of 21	
Increase in the proportion of GP referrals made by e-referrals	Meet a level of 80% by March 2017 (March 2017 performance only) and demonstrate a year on year increase in the percentage of referrals made by e-referrals (or achieve 100% e-referrals) OR March 2017 performance to exceed March 2016 performance by 20 percentage points	20%	32.4%	12.6% (to October 2016).	
Overall experience of making GP appointment	Achieve a level of 85% of respondents who said they had a good experience of making an appointment OR A 3 percentage point increase from July 2016 publication on the percentage of respondents	20%	73%	Latest achievement as per July 2016 survey - 71% Next survey released in July 2017 against which July 2016 performance will	

	who said they had a good experience of making an appointment			be measured	
Antimicrobial resistance (AMR) Improving antibiotic prescribing in primary care	Part A: reduction in the number of antibiotics prescribed in primary care The required performance in 2016/17 must either be: 1) 4% (or greater) reduction on 2013/14 performance OR 2) Equal to (or below) the England 2013/14 mean performance of 1.161 items per STAR-PU	5%	1.161	0.850 (to October 2016)	
	Part B: reduction in the proportion of broad spectrum antibiotics prescribed in primary care. Number of co-amoxiclav, cephalosporins and quinolones as a proportion of the total number of selected antibiotics prescribed in primary care either: 1) to be equal to or lower than 10%, or 2) to reduce by 20% from each CCG's 2014/15 value	5%	10.2%	11.0% (to end of October 2016)	
3 Local priorities	Reported prevalence of COPD on GP registers as % of estimated prevalence	10%	41.80%	46.30% (to end of December 2016)	
	% of the eligible population, aged 40-74 who have received an NHS Health Check since 1st April 2013	10%	16.00%	25.1% (to end of September 2016)	
	% of IAPT referrals with treatment outcome measured	10%	96.00%	99.0% (as at April 2016) Data has now been received and is being processed	

Where performance is below target, we are taking the following mitigating actions:

GP referrals made by e-referrals

- Practice performance is being discussed at the H&F SystmOne 9GP clinical system) user group meeting on 26th Jan
- Performance is also discussed at network meetings as part of network plan review. Some networks have received training at their network meeting
- The Primary Care IT team have done training at practices
- Utilisation data has been shared with practices on a monthly basis. Reports can be broken down to individual clinician and then to each individual referral so Practices can analyse their own data
- CCG representatives are also attending the working group at Imperial to drive up update and mitigate any barriers

Reduction in the proportion of broad spectrum antibiotics prescribed in primary care

The CCG lead pharmacist is working closely with the 4 practices that have missed the target to discuss any issues and agree action plan for improvement.

To the end of November 2016, the CCG was not delivering the target performance for the 4 constitutional measures, so risks being rewarded with £0 payment for QP achievements.

2017-18 Planning

The five national quality premium measures are worth 85% of the total quality premium, with 15% associated with the local element as outlined below.

Quality measure	**New measure in 17/18**	**Threshold**	**Allocation of QP**
Cancer diagnosis at early stage	No	Demonstrate a 4 percentage point improvement in the proportion of cancers diagnosed at stages 1 and 2 in the 2017 calendar year compared to the 2016 calendar year OR Achieve greater than 60% of all cancers	17%

		diagnosed at stages 1 and 2 in the 2017 calendar year.	
Overall experience of making a GP appointment	No	Achieve a level of 85% of respondents who said they had a good experience of making an appointment OR A 3% point increase from July 2017 publication on the % of respondents who said they had a good experience of making an appointment	17%
NHS Continuing Healthcare (CHC)	Yes	CCGs must ensure that in more than 80% of cases with a positive NHS CHC Checklist, the NHS CHC eligibility decision is made by the CCG within 28 days from receipt of the Checklist (or other notification of potential eligibility) - **50%** AND CCGs must ensure that less than 15% of all full NHS CHC assessments take place in an acute hospital setting - **50%**	17%
Mental Health	Yes	Choose one based on the inequality most pertinent to the CCG **Part A: Out of area placements (OATs)** A reduction in the number of inappropriate adult OAPs for non-specialist adult acute care Total number of bed days relating to out of area placements to have reduced by 33% of the baseline number as at 1 April 2017 **Part B: Equity of access and outcomes in to IAPT services** Recovery rate of people accessing IAPT services identified as BAME; improvement of at least 5 percentage points or to same level as white British, whichever is smaller AND	17%

		Proportion of people accessing IAPT services aged 65+; to increase to at least 50% of the proportion of adults aged 65+ in the local population or by at least 33%, **Part C: Improve inequalities rates of access and Children & Young People's MH Services** Required performance in 17/18 is whichever is the greater of: At least a 14% increase in the number of individual children and young people aged 0-18 with a diagnosable Mental Health condition starting treatment in NHS funded community services when they need it in 2017/18 based on 2016/17 baseline The increase in activity necessary to enable 32% of children and young people aged 0-18 with a diagnosable Mental Health condition starting treatment in NHS funded community services when they need it in 2017/18	
Reducing Gram Negative Bloodstream Infections (GNBSIs) and inappropriate antibiotic prescribing in at risk groups	Yes	Measure consists of 3 parts: Part A: Reduction in the number of gram negative blood stream infections across the whole health economy **(worth 45%)** Part B: Reduction of inappropriate antibiotic prescribing for UTI in primary care **(worth 45%)** Part C: Sustained reduction of inappropriate prescribing in primary care **(worth 10%)**	17%
Local priority	Yes	The indicator should be selected from the RightCare suite of indicators – as set out in the Commissioning for Value packs, focusing on an area of unwarranted variation locally which offers the potential for CCGs to drive improvement. **Note: H & F CCG is leading the diabetes Rightcare Programme on behalf of NWL and we therefore anticipate selecting an indicator relating to improvement in**	15%

		diabetes indicators	

The level of improvement needed to trigger the reward will be locally agreed between the CCG and NHSE regional team, ensuring that it is robust and sufficiently stretching.

Next steps

- The CCG Operational Group will discuss the issues and action plan to maximise the delivery of 16/17 indicators
- Baseline data is to be established for each of the 17/18 indicators to assist with the choice (where applicable) and set the ambition for the year
- The CCG Operational Group will review the data to formulate a long/ short list of potential measures for consideration with stakeholders for the local priority.
- The CCG MD will discuss the local priority options with the Chair of Health & Wellbeing Board

London Borough of Hammersmith & Fulham **Health and Wellbeing Board** **08 February 2017**	
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: Harley Collins**,** Health and Wellbeing Manager, London Borough of Hammersmith and Fulham	**Contact Details:** Tel: 0208 753 5072 Harley.collins@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.

3. LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

3.1 None.

LIST OF APPENDICES:

Appendix 1 – Work Programme 2016

Appendix 1

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

KEY

FOR DECISION
FOR DISCUSSION
FOR INFORMATION
PLANNING

Agenda Item	Summary	Lead	Item
Meeting Date: 8 February 2017			
STRATEGIC ITEMS			
UPDATE: JOINT HEALTH AND WELLBEING STRATEGY	To update the Board: on progress since the submission of the STP in October; on the development of a delivery plan for the JHWS and STP	CCG/ASC	**For information and decision**
BETTER CARE FUND PLANNING UPDATE AND ALLOCATIONS 2017/18	To update on the policy framework and planning guidance for 2017-19	ASC/CCG	**For information and decision**
PRIMARY CARE DELEGATION	The CCG will apply for full delegated commissioning of GP services in early Dec subject to a ballot of CCG members in early Feb. This report is to ensure the HWB is sighted on the process and next steps	CCG	**For information**
QUALITY PREMIUMS UPDATE		CCG	**For information**

PHARMACEUTICAL NEEDS ASSESSMENT		PH	**For information**
JSNA UPDATE	To update on the online JSNA and approve for publication the young adults JSNA	PH	**For decision**
Meeting Date: 20 March 2017			
STRATEGIC ITEMS			
SUSTAINABILITY AND TRANSFORMATION PLAN UPDATE		WLA	**For decision**
INTEGRATED FAMILY SUPPORT SERVICE	To update the board on progress developing an integrated family support service	CS	**For discussion**
PRIMARY CARE DELEGATED COMMISSIONING	The CCG will apply for full delegated commissioning of GP services in early Dec subject to a ballot of CCG members in early Feb. This report will update on the outcome of the Feb ballot	CCG	
ACCOUNTABLE CARE PARTNERSHIPS		CCGs	**For discussion**
JOINT HEALTH AND ADULT SOCIAL CARE DEMENTIA PROGRAMME:	Progress update implementing JSNA recommendations	CCG/ASC Frank Hamilton	**For information**
THE ROLE OF PHARMACY IN OUR HEALTH AND CARE SYSTEM		PH	**For discussion**
BUSINESS ITEMS			

JOINT HEALTH AND WELLBEING STRATEGY: DELIVERY PLANNING	discussion focusing on a particular aspect of the strategy tba	ASC	**For discussion**

Other possible items

- Update on tackling mental health in the borough and Mind briefing on the role of local community services in supporting people with mental health problems
- Primary care transformation plans
- REVIEW TERMS OF REFERENCE APRIL 2017

KEY

STRATEGIC ITEMS – items concerning system level issues (e.g. health and care integration, devolution, primary care transformation)

DISCUSSION ITEMS – items of interest focusing on a specific part of the system such as a specific health condition, service or population group (e.g. JSNA deep dives)

BUSINESS ITEMS – items for the board's approval or information but which do not require a discussion (e.g. items that have been agreed offline but require formal approval by the Board)

INFORMATION ITEMS – items for information only and not requiring discussion