hammersmith & fulham

London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Supplementary Agenda

Wednesday 13 September 2017
6pm
Courtyard Room - Hammersmith Town Hall

MEMBERSHIP

Vanessa Andreae - H&F Clinical Commissioning Group
Councillor Ben Coleman, Cabinet Member for Health and Adult Social Care (Chair)
Janet Cree - H&F Clinical Commissioning Group
Ian Lawry – SOBUS (Co-Opted Member)
Councillor Sue Macmillan - Cabinet Member for Children and Education
Keith Mallinson - Healthwatch Representative
Steve Miley – Director for Children's Services
Lisa Redfern - Director of Adult Social Care
Mike Robinson - Shared Services Director of Public Health
Dr Tim Spicer - H&F Clinical Commissioning Group (Vice-Chair)

Nominated Deputy Members

Councillor Rory Vaughan
Councillor Sharon Holder

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Date Issued: 11 September 2017

London Borough of Hammersmith & Fulham

Health & Wellbeing Board
Supplementary Agenda

13 September 2017

Item **Pages**

1. **MINUTES AND ACTIONS** 1 - 7

(a) To approve as an accurate record and the Chair to sign the minutes of the meeting of the Health & Wellbeing Board held on Tuesday, 20th June 2017

(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. **DRAFT BETTER CARE FUND** 8 - 40

This report provides the Health and Wellbeing Board with details of the Integration and Better Care Fund Plan for 2017-19 submitted on the 11th September to NHS England.

5. PRIMARY CARE STRATEGY 41 - 49

This paper provides an update to the Health and Wellbeing Board on the key aspects of the Primary Care Strategy, ahead of its publication in mid-September 2017.

6. LIKE MINDED STRATEGY UPDATE 50 - 61

This is report provides an update to the Health and Wellbeing Board on the current position with the Like Minded strategy. The report provides both a general overview of the key elements of the strategy together with specific details of the actions that have been/are being taken within Hammersmith and Fulham.

7. WORK PROGRAMME 62 - 63

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

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

8. DATES OF NEXT MEETINGS

The Board is asked to note that the dates of the meetings scheduled for the municipal year 2017/2018 are as follows:

Tuesday, 21st November 2017
Wednesday, 31st January 2018
Wednesday, 21st March 2018

London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Minutes

Tuesday 20 June 2017

PRESENT

Board Members: Councillor Ben Coleman (Chair)
Janet Cree, H&F CCG and Mike Robinson, Director of Public Health

Nominated Deputy Councillors:
Sharon Holder, Lead Member for Hospitals

Officers: Colin Brodie, Public Health, Craig Williams, Head of Health Partnerships, Harley Collins, Health and Wellbeing Manager, Robin Barton, Head of Commissioning, Children's Services, and Ian Riley, NWL CCG, Director of Business Intelligence

102. MINUTES AND ACTIONS

The minutes of the meeting held on 20th March 2017 were agreed as a correct record, subject to an amendment that the last four words of Minute 98 be deleted.

103. APOLOGIES FOR ABSENCE

Apologies for absence were received from Clare Chamberlain, Executive Director of Children's Services, Sue Redmond, Executive Director of Adult Social Care, Dr Tim Spicer, H&F CCG (Vice-chair) and Vanessa Andreae, H&F CCG.

104. DECLARATIONS OF INTEREST

There were no declarations of interest.

105. SERVICE RESPONSE TO GRENFELL TOWER FIRE - BRIEFING

This was included in the agenda as a late report, in order to provide the Board with the most up to date picture of the current situation as possible, following the Grenfell Tower fire on Wednesday, 14th June. Craig Williams commended the professionalism and dedication of emergency services staff, throughout their handling of fire and its aftermath. He expressed his sympathies and condolences for residents of the Tower who had been injured or lost loved ones. Providing an overview, he explained that over 100 families had been allocated a social worker and 220 people had been placed in temporary accommodation. Support from a number of London boroughs was

Minutes are subject to confirmation at the next meeting as a correct record of the proceedings and any amendments arising will be recorded in the minutes of that subsequent meeting.

being provided, with different Councils taking the lead according to their areas of expertise and knowledge; to illustrate, Westminster were leading on communications, Ealing were leading on support for rest centres and an officer from Haringey was providing advice on setting up a Humanitarian Assistance Centre. Barbara Brownlee, Director of Housing, Westminster City Council, was leading and co-ordinating work on the allocation of accommodation. It was understood that most individuals and families had been allocated temporary housing, the next step was to find suitable, longer term accommodation, with a view to finding permanent housing for the future.

In response to a question from Councillor Holder, Mike Robinson gave an explanation of the strategic command structure used by the emergency services and how this was designed to respond to emergency situations. Bronze command indicated operational control of resources at the site of an incident, silver indicated tactical control and gold undertook strategic oversight and control of the whole incident. The structure was replicated across all agencies including the police, NHS and local authorities.

Support on site at the Westway rest centre was continuing, with health professionals co-ordinating care, signposting clinical care pathways and collaboratively working to ensure that efforts were focused on the needs of both individual and family groups.

There was on-going work to address the impact on residents in the locality, indirectly affected by the fire, particularly those with long term conditions. There had been anecdotal reporting of increased mental health issues that would require monitoring. It was noted that CNWL, the mental health provider for RBKC, would lead on this area.

Janet Cree reported that LBHF GPs had formed part of the local volunteer workforce. The approach being taken was that those patients located in the area would continue to be seen by their existing practitioner, in order to maintain continuity of care. It was noted that there was one patient registered with an LBHF GP, who was not in the tower but evacuated from the vicinity.

Janet Cree explained that emotional support was being provided through the allocated key worker. This will increasingly progress to being outreach work. Key workers would advise on a case by case basis, referring according to need. The Mental Health Single Point of Access service was operating as normal and a crises drop in centre would be operational, by Thursday at the latest.

In response to a question from Councillor Holder, Craig Williams explained that the standard discharge process operated. Once discharged from hospital, they would be first allocated temporary accommodation, then semi-permanent accommodation. It was noted that the first of these allocations had begun, with offers being made with considerable sensitivity, given that there were still many missing people who had not been accounted for. Discharges were most difficult with those who were not physically affected but traumatised. An estimate of up to a 1000 people were evacuated from the vicinity of the tower, from surrounding homes. Mike Robinson confirmed that

officers would provide more information about the level of support available on discharge.

ACTION: Mike Robinson / Janet Cree

In terms of officer support, Children's Services had taken the lead, with support from ASC. A rota had been agreed and weekly team meetings arranged, with 8 voluntary social workers available per day. A "business as usual" plan had been agreed that would release resources but would also ensure continuity of existing provision.

Officers were working closely with colleagues in housing. Craig Williams confirmed that all affected residents that were known to ASC had now been contacted and will be prioritised. It was explained that on-going work with partners, voluntary sector agencies and mental health teams would continue to evolve with the aim of ensuring that residents would have access to the support they needed. It was understood that this might have an impact on discharge teams. It was also noted that RBKC staff had set up a single point of contact telephone number to ensure continuity and provider information.

Mike Robinson explained that lists were being compiled, identifying groups of people and the type of help required. There was also a data and governance issue to consider. Public Health teams would take a lead on helping to rebuild communities, with the overall aim of being alert to early warning indicators that might indicate that an individual is struggling. There was a small window of opportunity, where symptoms of PTSD (post-traumatic stress disorder) would manifest themselves at a period of between 4 to 12 weeks. Most will find that their symptoms will settle but there will be a need for counselling to within this window to prevent any mental health issues from becoming chronic.

During the course of the discussion, concern was expressed about ensuring that confidentiality regarding medical conditions was maintained, for those residents currently being supported in the rest centres. This made it difficult to ensure that information could be accurately combined in a database, which they had just begun to do. Further clarification was also required to ensure that people could access support payments through nominated organisations and that there would be continued co-ordination across the agencies to ensure that assistance is provided to those in need.

Councillor Coleman expressed his thanks to all staff who had volunteered across the boroughs, who had worked professionally and unstintingly, responding to the needs of those affected by the fire.

106. NORTH WEST LONDON WHOLE SYSTEMS INTEGRATED CARE DASHBOARD

Ian Riley presented the report which set out details of the Whole Systems Integrated Care (WSIC) Dashboards Programme, implementation across North West London (NWL) and information of future plans and developments. The report invited the Board to note the benefits of the WSIC Dashboards to support system wide integration and proactive case finding and management

of patients. The London Borough of Hillingdon was the only authority of the eight local authorities yet to have signed up to the information governance protocols, which was an information sharing agreement.

Briefly, Ian Riley explained that the dashboard would collectively draw together patient information that could be accessible by clinicians across departments, ensuring integrated care per patient records. Health and social care systems were currently siloed, using clinical systems at a basic, individual level. Going forward, data sharing would not include confidential information and general information protocols would be in place to maintain this. Mike Robinson commented that the information was an extract from the departmental submissions, detailing for example, the number of GP visits made by a patient in a given period. The Patient Activation Measure (PAM) assessed an individual's knowledge, skill and confidence for managing their own health and healthcare. Selected parameters could manage the data to provide evidence, for example, of which patients had an agreed healthcare plan in a given period.

The overall intention was to facilitate a move from reactive to proactive health management, improving quality of care and patient outcomes. Janet Cree observed that one of the challenges was managing work on refining GP referrals, for which the LBHF CCG was developing a local scheme. She added that an observable pattern of healthcare use and the build-up of attendances would allow them to refine and more precisely target resources more effectively.

Councillor Coleman sought assurance that a method of measuring progress would be factored into the operation of the dashboard, from its commencement. It was noted that the My Care, My Way scheme introduced by West London CCG was a new, integrated care service for those aged over 65, in Kensington & Chelsea designed by both patients and GPs. It was agreed that a briefing note will be provided to demonstrate how this would be measured. Following further discussion, Mike Robinson observed that the WSIC dashboard could be used to inform the Health and Wellbeing Strategy, and asked, how this could be facilitated. It was agreed that he would arrange to meet with Ian Riley to help develop the briefing note.

ACTION: Ian Riley, NWL CCG, Mike Robinson, Public Health

In response to a query from Councillor Coleman, Ian Riley explained that security protocols were in place to protect the data and had been tested. It was noted that the data held was high level, without personal details. The information sharing agreement ensured that the data was anonymised. Security access also required a designated security card. It was also reported that 28 GP practices had signed up to the information sharing agreement. This could potentially offer greater integration of community arrangements, a priority which aligned closely with the Health and Wellbeing Strategy.

RESOLVED

That the report be noted.

107. PROPOSAL TO ESTABLISH JOINT BCF HEALTH AND SOCIAL CARE TRANSFORMATION PROGRAMME

Craig Williams presented a report which set out a proposed way forward, using the Better Care Fund Plan (BCF), the Joint Executive Team (JET) and a Joint Investment Fund as key levers for delivering change. The Board would be required to sign off on the proposals, although there remained issues and decisions to be fully resolved around the governance structure. The report was confirmed as being tri-borough and had been considered at a JET meeting on 13th June.

Mike Robinson explained it was understood that each borough maintained its sovereign status and that the BCF would be tailored accordingly. Janet Cree acknowledged that the disaggregation process that the three boroughs were pursuing would require carefully consideration in this context. It was noted for example, that the joint commissioning for older people team was hosted by LBHF and that the BCF had been set up on a tri-borough basis. The final structure was yet to be agreed in all three boroughs, the level of resourcing and the cost of staffing would also need to be understood.

Craig Williams explained that a Programme Board will be established, with a duty to ensure that safe standards were maintained, the cost of which were unknown. The report set out an agenda that would map out the next two years and also included discussions about tri-borough within this dialogue.

Councillor Coleman enquired about the areas of the BCF that officers aimed to concentrate on and the impact of the BCF on the local market, for example, residential care homes. Referring to page 30 of the report, Craig Williams responded that work in conjunction with the 8 boroughs in the area would render a separate LBHF approach on this unhelpful.

Janet Cree observed that this was what was reflected in the proposals for the North West London Sustainability and Transformation Plan (STP). While the BCF will remain tri-borough, she acknowledged that they “had not got the terminology right” and would continue to work closely with the West London collaboration of CCGs to address this. She reported that the issue was understood clearly by their Accountable Officer, Clare Parker.

Referring to the Community Independence Service (CIS), which was funded by the BCF, Janet Cree explained that this was configured according to the needs of each borough. She also explained that they were currently exploring how to make the CIS more effective, on a borough by borough basis. As part of this, they hope to encourage GPs to identify residents who might benefit from the CIS.

Craig Williams reported that the guidance for the BCF had not yet been issued and it was noted that there may be either a Chair's delegated authority to agree the proposals, once finalised, or an additional meeting of Board.

108. ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH 2016-17

Mike Robinson informed the Board about the approach being considered for the preparation and production of the Annual Report of the Director of Public Health 2016-17. It would focus on mental health and wellbeing. Work on the report was anticipated to commence by the third week in August and also inform 2018/19 priorities.

Janet Cree commented that mental health was covered under Development Area 4, under the STP. Mike Robinson responded that the community aspiration would be to address mental health treatment from within the community but that it was also important to think about prevention methods. He invited the Board and officers to provide case histories that might be used as helpful illustrations. Colin Brodie outlined their intention to write to each of the Board members in order to solicit case histories, focusing particularly on how people maintained their mental health.

ACTION: Colin Brodie, Public Health

In response to a query from Councillor Coleman, Janet Cree explained the Annual Report would inform parts of the evidence collected, to assist with the allocation of resources. During the brief discussion which followed, it was agreed that it would be helpful for Public Health to meet separately with health colleagues, to further explore themes for the report, what "good" mental health might look like and how people maintained this.

ACTION: Public Health, CCG

109. JOINT HEALTH AND WELLBEING STRATEGY 2016-21: DEVELOPING OUR IMPLEMENTATION PLANS

Harley Collins provided brief details as to the background and work undertaken in producing the Joint Health and Wellbeing Strategy (JHWS). The main objective was to now agree a programme of work for the Board which could be informed by the strategy and the four agreed priority areas identified for 2016-21. Members of the Board and support officers had attended two, facilitated development half-day workshops, to review national best practice, to consider how the Board could operate more effectively and to consider the programmes of work that should be prioritised via the delivery plan.

Councillor Coleman welcomed the JHWS. He was keen to see focus on the strategic areas which were cross-cutting and for outcomes to be set and measured.

In response to Council Coleman's query, Janet Cree commended the work undertaken in developing the JHWS, which she felt was intrinsically more focused, located more in ASC rather than Children's Services.

Councillor Coleman enquired about the location of transition services within the framework. It was noted that a joint team had been established to provide greater support for transitioning young people. It was agreed to explore making the Carers Strategy a sponsor item.

Action: HWB

It was noted that the JHWS was not going to be a static tool and was subject to review as a part of an evolving process. It set out the agenda for the work to be carried out within the next 12 months, to be further refined up to 2021. Craig Williams suggested that improved utilisation of communal spaces and voids be further explored and how this tied in with the estates strategy.

Action: CCG

RESOLVED

That the report be noted.

110. WORK PROGRAMME

The Board noted the work programme, planned for 2017/18.

RESOLVED

That the report be noted.

111. DATE OF NEXT MEETING

The date of the next meeting was noted as Wednesday, 13th September 2017.

Meeting started: 6pm
Meeting ended: 9.05pm

Chair ....

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Minutes are subject to confirmation at the next meeting as a correct record of the proceedings and any amendments arising will be recorded in the minutes of that subsequent meeting.

Agenda Item 4

Integration and Better Care Fund

Better Care Fund Plan for 2017/19

Updated Narrative Plan 17/19

Local Authorities	City of Westminster (WCC) London Borough of Hammersmith & Fulham (LBHF) Royal Borough of Kensington & Chelsea (RBKC)
Clinical Commissioning Groups	Central London Clinical Commissioning Group (CLCCG) Hammersmith & Fulham Clinical Commissioning Group HFCCG) West London Clinical Commissioning Group (WLCCG)
Date agreed at Health and Wellbeing Boards:	Original plan agreed 24.03.2014, 2nd revised plan agreed 19.09.2016 Integration & BCF Plan 2017-19 agreed 11th September 2017

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1. Introduction / Foreword

This Integration and Better Care Fund (BCF) narrative document for the 17-19 plan provides an updated summary to the previously agreed BCF Plans for the three boroughs of Westminster City Council, the Royal Borough of Kensington & Chelsea, Hammersmith & Fulham Council, and the Central London, West London and Hammersmith & Fulham Clinical Commissioning Groups in 15/16 and 16/17. The plan summarises our collaboration and proposed actions to take forward our shared ambitions over the next two years, in 2017-2019.

The aims and principles of the original BCF Plan and the shared ambition remain broadly similar: to deliver the best possible outcomes for residents, and to work as a system towards integrated health and social care by 2020. However the plan has been updated to reflect the changes that have taken place since the last plan was developed and also to highlight the successes and challenges of delivery of our BCF over the past two years in 15/16 and 16/17.

Together, each borough, health commissioners and providers and other local stakeholders continue to work towards realising our ambition and moving towards full integration of our services. Success will enable better, more personalised care to be provided for all of our residents and for scarce resources to be used in the most effective way possible.

This BCF Plan has been requested by the Department of Communities and Local Government and NHS England for assurance purposes. **It has been developed jointly across health and social care taking into account the current strategic priorities and the financial challenges of the six organisations.**

Since the inception of the Better Care Fund pressures on both health and social care have continued to increase and this presents a greater challenge in delivering the required integration and transformation.

The evidence base to support the Case for Change and to support the identification of our agreed BCF schemes was outlined in the agreed 15/16 BCF plan. This evidence and thinking is summarised and updated in this plan.

2. What is the local vision and approach for health and social care integration?

Across the three boroughs our vision for health and social care integration is people centred and focuses on enabling people to be well, keep well and stay well.

- In Westminster, our vision is that “all people in Westminster are enabled to be well, stay well and live well supported by a collaborative and cohesive health and care system”.
- In Hammersmith and Fulham, 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”.
- In Kensington and Chelsea, our vision is “to enable everyone to be as healthy as they can be; to start well, stay well and age well”.

Integration across the health and social care system is a key priority in each borough’s Joint Health and Wellbeing Strategy (JHWS) and this plan has been developed in the light of the new JHSWs which have been developed and agreed in each borough for the period 2017-22.

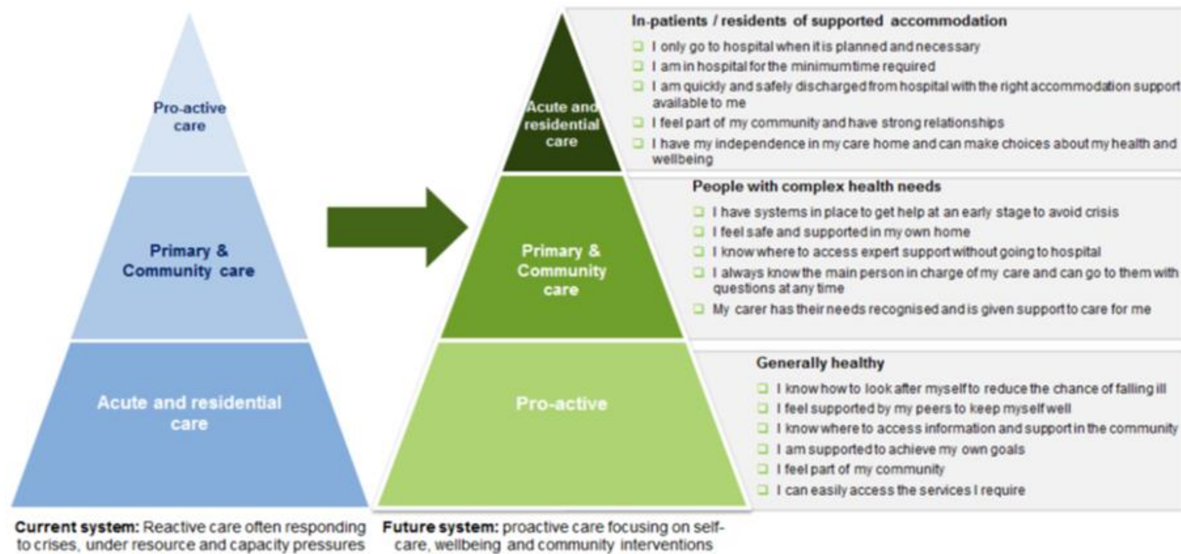
Overall there is commonality across health and social care in terms of our local strategic priorities and we are all committed to ensuring transformational change that benefits our residents. We have synthesised our boroughs’ vision for health and social care into a single shared vision and this is set out in the NWL Sustainability and Transformation Plan (NWL STP).

Hammersmith Council does not support the NWL STP due to proposals to reconfigure acute services in the borough. It remains committed to continuing collaboration on the joint programmes of work as envisaged in STP delivery areas 1 to 4.

We are working toward an integrated health and care system that enables people to live well and be well by: addressing the wider determinants of health, such as employment, housing and social isolation; enabling people to make healthy choices; proactively identifying people at risk of becoming unwell and treating them in the most appropriate, least acute setting possible; and helping people to regain independence whenever possible. Out of hospital commissioned services such as our Community Independence Service help to deliver this ambition. When people do need more specialist care then our aim is to make this available when needed and to ensure that is is consistently high quality with access to senior doctors seven days a week.

The diagram below sets out the systems change we are collectively trying to achieve, from a reactive system where resources are under pressure and concentrated in acute services to a more proactive system based on appropriate self-care, wellbeing and community interventions.

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



Key elements of our vision are:

- A focus on prevention and providing better mental health services;
- Personalised and empowering care, tailored around individual needs;
- Integrated, community based health and social care, provided through multi-disciplinary teams, operating within natural communities;
- A focus on supporting people to live safely and happily at home and able to access health services in the community;
- Good enablers: a skilled workforce; high quality and shared estates; effective use of technology; and appropriate data sharing where it makes sense.

2.1 Our approach

Our approach to delivering the vision across the three boroughs is to work collaboratively at all levels to deliver better outcomes for residents and to utilise where possible existing organisational and governance arrangements, legislative requirements and local collaborations.

We are committed to our health and wellbeing priorities, agreed by each boroughs Health and Wellbeing Board and set out in the recently updated Joint Health and Wellbeing Strategies.

Personalised Care: Our STP Vision

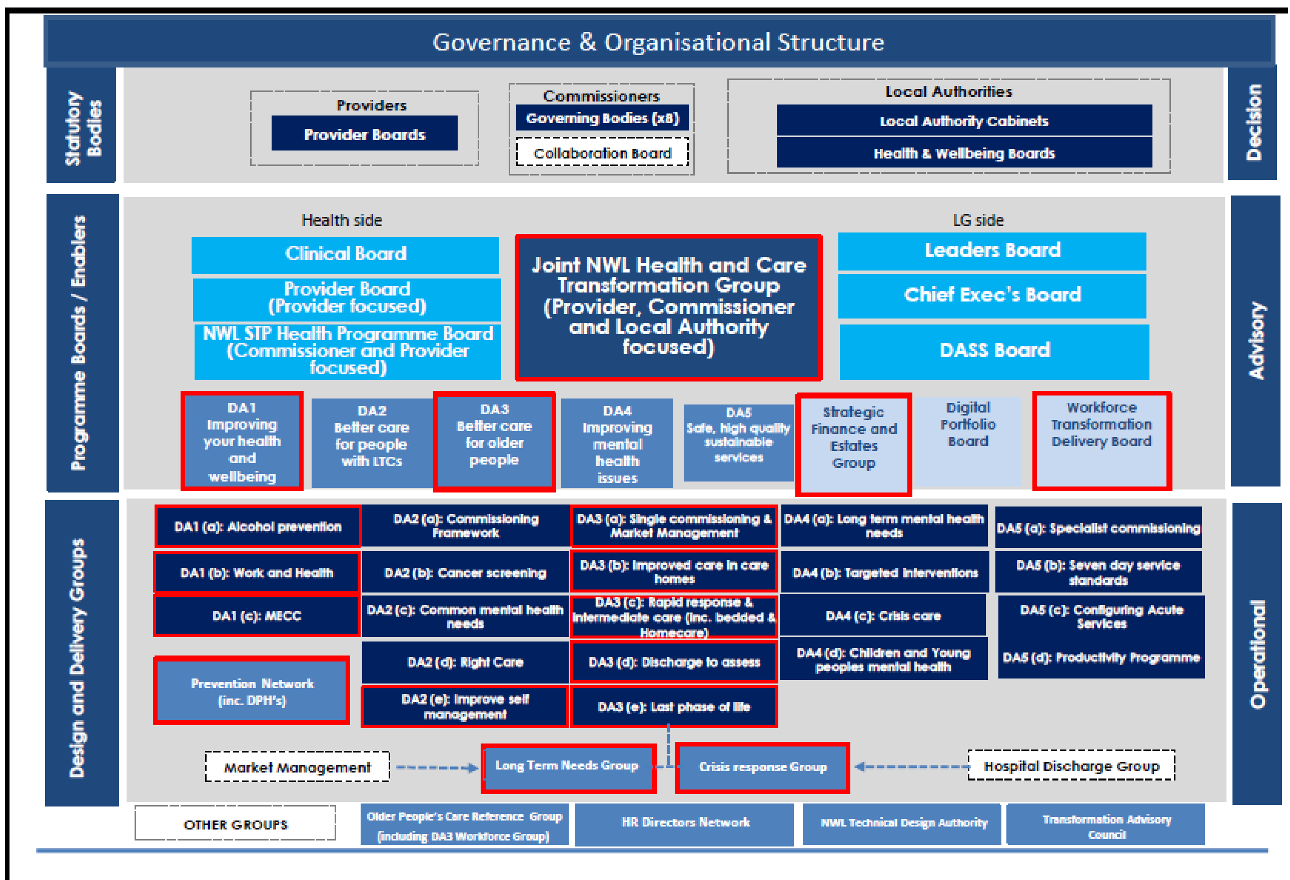
1. **People have a better experience of care**
   - Fewer changes in care provider when a person's eligibility for social care or continuing healthcare changes
   - Patients will be supported closer to home as commissioners develop joint market management strategies
2. **People are cared for in a safe environment and are protected from avoidable harm**
   - Robust joint health and social care monitoring of care providers
   - Safeguarding concerns recognised early through joint health and social care intelligence
3. **People know what choices are available to them locally and what they are entitled to**
   - Focus on personalisation will ensure both health and social care ensure people are in control of what, how and when support is delivered to match their needs

The table below shows how the health and wellbeing priorities align with the aim of improving health and wellbeing, improving care and quality and improving productivity against the STP delivery areas.

The diagram following the table provides an overview of the governance arrangements established to deliver the shared integrated health and social care vision.

As noted, Hammersmith Council does not support the NWL STP due to proposals to reconfigure acute services in the borough. It remains committed to continuing collaboration on the joint programmes of work as envisaged in STP delivery areas 1 to 4.

The triple aim	STP delivery areas	JHWS priority areas	STP Plans
	DA1 Radically upgrading prevention	PA 5 Radically upgrade prevention and early intervention	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
Improving health and wellbeing	DA2 Eliminating unwarranted variation and improving LTC management	PA 1 Improving outcomes for children and young people	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'
Improving care and quality	DA3 Achieving better outcomes and experiences for older people	PA 2 Reducing the risk factors for and improving the management of long term conditions such as dementia	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
Improving productivity & closing the financial gap	DA4 Improving outcomes for children and adults with mental health needs	PA 3 Improving mental health outcomes through prevention and self-management	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	PA 4 Creating and leading a sustainable and effective local health and care system	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
	Enablers		a) Estates b) Digital c) Workforce



Our Better Care Fund Plan constitute only part of this wider change programme and more detail about specific schemes within the scope of the BCF are presented in section 6.

Section 10 of this document sets out specific governance arrangements for BCF Projects.

3. Background and context to the plan

This BCF Plan is a jointly agreed plan launched in 15/16. It sets out our ambition to deliver key transformation and integration plans across three boroughs that include six organisations: Central London, West London, Hammersmith and Fulham CCGs and Westminster City Council, Royal Borough Kensington & Chelsea and Hammersmith & Fulham Council.

Community and voluntary sector (CVS) and other partners

As well as being a key priority for commissioning organisations, this plan is also a priority for providers and community sector organisations, who between them play an important part in:

- Delivering services;
- Working with residents to support and promote independence; and
- Providing insight and participating in the co-design of new services.

The CVS has a firm presence across the three boroughs and in the development of the Integration and BCF Plan. CVS representatives also sit on each of the respective Health and Wellbeing Boards.

CVS organisations have played a particularly key role in enabling local populations to have a voice in the planning and monitoring of services locally. This has been achieved through the following initiatives:

- Clear governance structure: a PPE Committee reports directly into each governing body, PPE lay member on the governing body and Patient Reference Group which is made up of local CVS organisations.
- PPE grants have been set up and established over the last three years which enable short funding to the VCS to enable the health and wellbeing of local people.
- CVS are part of co-production models: for example they are part of the design and implementation and delivery phase of key integrated care programmes My Care My Way and Community Living Well.
- Umbrella CVS also host social prescribing schemes across the three boroughs which support the STP agenda in delivery areas 1 to 4 and the five-year forward view.

In particular, Healthwatch have played a key role in supporting and delivering the integrated health and care vision. Since the last BCF submission Healthwatch have undertaken specific reviews of Care Coordination in Westminster and Socially Isolated Older People in Kensington and Chelsea.

Health and social care environment

This updated BCF Plan has been developed within the following context:

- **History of collaboration and joint working**. The BCF Plan 2017-19 has been updated using our experience, maturity and learning developed over the past few years. The BCF plan builds upon the successes and challenges of previous years. We have critically evaluated the BCF schemes that underpin our BCF and moved forward with schemes that will continue our ambition of further integration between Health and Social Care. In the past two years some schemes have delivered the required integration and whilst the services or initiatives continue and are funded accordingly, they are no longer required as part of the BCF programme;

- **Updated Health and Wellbeing Strategies**. Each borough has undertaken an extensive programme of joint working and engagement to refresh and update their Health and Wellbeing strategies (see appendix 1, three documents);

- **North West London Sustainability and Transformation Plan**. Since the last BCF submission, partners have worked collaboratively to develop the North West London STP and are now working together to implement the plan. Hammersmith Council does not support the NWL STP due to proposals to reconfigure acute services in the borough. It remains committed to continuing collaboration on the joint programmes of work as envisaged in STP delivery areas 1 to 4. The BCF is closely aligned to the STP and how we take forward both transformation and integration (see appendix 2);

  - **Increasing demographic pressures and complexity of care required.** More information about the specific health and social care needs is presented in section 5. A detailed analysis at borough level is presented in each Joint Strategic Needs Assessment but pressure on the health and social care system continues to grow and without the changes proposed we will be unable to continue to deliver the same outcomes with the resources available (https://www.jsna.info/online.);

- **Challenging financial environment**. Across the North West London STP footprint, combined QIPP and CIPP savings of £347.5m have been agreed and an additional savings programme of £70m devised for the financial year 2017/18. In Westminster, since 2011 net spending on social care has reduced by £31.436m; in Kensington and Chelsea, since 2012/13 net spending on social care has reduced by 5%; and in Hammersmith and Fulham, net spending on social care has reduced by 16% since 2011/12;

- **Reconfiguration of three borough partnership**. This process is underway and it is anticipated it will be completed by December 2017, resulting in a new bi-borough partnership between Westminster City Council and the Royal Borough of Kensington & Chelsea and a sovereign arrangement for Hammersmith & Fulham Council.

  In 2017-18, Hammersmith & Fulham Council has been moving on from the three borough arrangement to focus more keenly on outcomes for its own residents and enhance residents' satisfaction with the services they receive. It will be maintaining successful collaborations such as the North West London hospital discharge service and the Community Independence Service and will continue to explore options for a single commissioning collaborative. It will also be seeking fresh opportunities for collaboration and partnership to improve outcomes.

- **Grenfell Tower Fire**. Everybody within the three boroughs has been affected by the Grenfell Tower fire on 14 June 2017. The impact of this tragedy has resulted in health and local authority staff across West London CCG and the Royal Borough of Kensington & Chelsea focusing on efforts to ensure that survivors and members of the community affected by the events have been supported. On a positive note it has also resulted in an increased focus and determination across all stakeholders to work together better at a local level to improve outcomes for residents.

4. Integration and BCF progress to date

This Integration and BCF plan is now in its third year. Over the past three years we have continued to learn and develop together as organisations to try and deliver a shared vision.

In 2016/17, good progress was made in translating the shared BCF vision into a strategy and a plan that can be delivered. In particular we have delivered against the following three areas

Strategic

- In each borough we have undertaken an extensive process of collaboration and engagement in order to update and produce Health and Wellbeing Strategies for the period 2017-22. All Strategies have now been considered and adopted by their respective Health and Wellbeing Boards;
- The three boroughs have worked collaboratively with CCGs and local authorities across North West London to devise and agree a Sustainability and Transformation Plan. Hammersmith & Fulham Council does not support the NWL STP due to proposals to reconfigure acute services in the borough. It remains committed to continuing collaboration on the joint programmes of work as envisaged in STP delivery areas 1 to 4. Work is now underway to shift from design to delivery.;
- Within the three CCGs, and across NW London work has begun to consider the benefits of commissioning at scale, and in particular across the whole NW London STP Footprint. This work is at an early stage and will develop further through the remainder of 2017/18.

Better Care Fund Schemes

- Across the three boroughs we have progressed our Customer Journey Adult Social Care Transformation Programme; embedding the changes required because of the Care Act and establishing a more positive, proactive asset based approach to social care which focuses on helping individuals with unmet needs to take control and manage their own independence and wellbeing;
- We have continued to commission and collaborate at a system level where appropriate. In particular, through the BCF process we have established and continue to administer a £100m pooled commissioning budget through a Section 75 Agreement. This incorporates joint mental health, learning disabilities, older people and prevention priorities. We have also established a number of joint commissioning teams;
- We have advanced and developed our whole systems thinking and re-comissioned our Community Independence Service to provide an integrated approach to intermediate care services across the three boroughs. The service is currently working well and user satisfaction is high. We continue to support our ambition to increase Rapid Response Service referrals to reduce non elective admissions;
- There has been delivery and improvement of seven day services for CIS liaison, rapid response, rehabilitation and reablement.
- Operational staff have made good progress towards integration using practical approaches like stronger working networks with colleagues, made

possible from co-location, sharing IT/ clinical information and through work to streamline processes.

- Through the year we have increased our focus on improving the citizen's experience of hospital discharge, establishing clear plans for implementing each element of the high impact change model for improving hospital discharge.
- The three borough Neuro-rehabilitation service across the three boroughs was re-procured and has now moved to business as usual, having delivered the required transformation and is now contract managed by the CCG joint commissioning team.
- Our scheme looking at increasing Personal Health Budgets (PHB) has resulted in health and social care redefining how PHBs are managed and delivered to our residents and is now firmly in place within the CCG Joint Commissioning Team. This scheme has now moved to business as usual.
- IT Integration – over the past few years together we have implemented the NHS number as a single identifier. In addition as part of the CIS we have one Integrated Patient Record (IPR). This has enabled health and social care staff to use one patient record to enable appropriate record sharing and improved patient pathway resulting in improved efficiency across our integrated workforce. This scheme has now moved to business as usual
- Patient Public Engagement – We have worked hard to ensure that the voice of local residents is embedded within the commissioning of services by both local authority and CCG. In particular, the scheme has resulted in:

  The establishment of a central repository where both individual and collective feedback and experience can be brought together efficiently;

  Better utilisation of patient experience/feedback insight resource to support commissioners in service redesign/transformation;

  The establishment of a consistent pathway for CCG and local authority staff to ensure Patient Experience & Patient and Public Engagement are embedded in their work. This scheme has now moved to business as usual

Whole Systems Integrated Care

- In Kensington and Chelsea and North Westminster, over 60 People are now employed in the innovative My Care, My Way programme, involving local GPs, CLCH, voluntary organisations and the local authority, providing case management and preventative support to residents aged 65 and over.
- In Westminster, the CL CCG has recently presented for consultation its draft Primary Care Strategy and a full business case to establish a collaborative care partnership by December 2017;

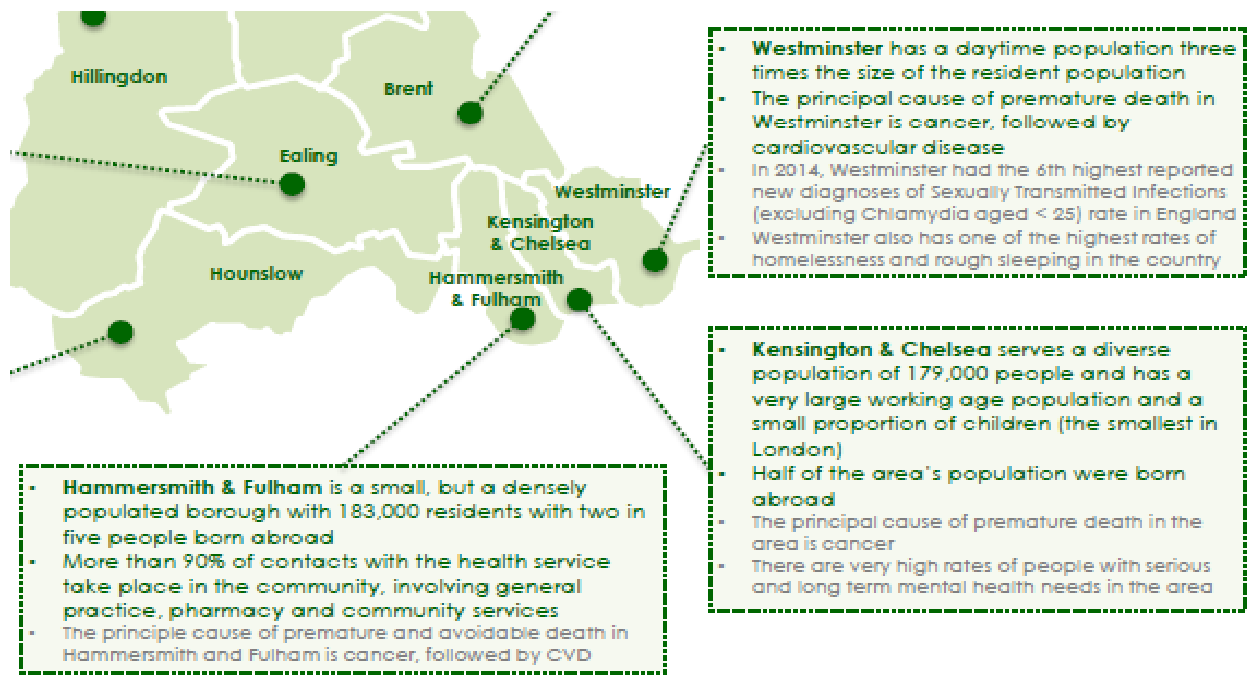
- In Hammersmith and Fulham, the innovative Virtual Ward project continues and a steering group has been operational for over 12 months to develop a wider Integrated Care Partnership; a draft Primary Care Strategy has also been developed and this will be considered by the H&F CCG GB and at the Health and Wellbeing Board meetings in September

5. Evidence base and local priorities to support plan for integration

The previously agreed BCF Plan clearly outlined our evidence base for integrated services and transformational change. Previously submitted and agreed BCF plans in 15/16 and 16/17 clearly outline the evidence base as part of our new plan we have not replicated this but have built upon the agreed approach in the 17-19 BCF Plan. As a result the vision across the three boroughs is founded on a population needs assessment and patient, service user and carer feedback, which has developed over the long-term through a broad spectrum of engagement and consultation.

The development of our evidence base has continued across the three boroughs since our BCF plan was agreed. As part of our ongoing commitment to service redesign and out of hospital services we have continued to engage with our citizens. Our services are founded on co production and ensuring that where possible we deliver services to our populations at the right time in the right setting.

The diagram below provides an overview of key health and social care characteristics across the three boroughs.



In addition to the specific health and social care challenges set out above the key challenge for the health and social care system across the three boroughs is an ageing population. Key challenges for the three boroughs are;

- There is a forecast rise of 13% in the number of people over 65 in NW London from 2015 to 2020. Between 2020 and 2030, this number is forecast to rise again by 32%;
- People aged 65 or over in NW London constitute 13% of the population, but 35% of the cost across the health and care system;
- 24% of people over 65 in NW London live in poverty, and this is expected to increase by 40% by 2030, which contributes to poor health;
- Nearly half of our 65+ population are living alone, increasing the potential for social isolation;
- 42% of non-elective admissions were of people 65 and over;
- 11,688 over 65s have dementia in NW London, a number which is only going to increase; and
- There are very few care homes in the central London boroughs, and the care home sector is struggling to deal with financial and quality challenges, leaving a real risk that the sector will collapse, increasing the pressure on health and social care services

More details about our health and social care needs and the evidence underpinning our approach is contained within our Joint Strategic Needs Assessments (https://www.jsna.info/online).

6. Outline of Better Care Fund Plan 17-19

Subsequent to the submission and agreement of the Better Care Fund Plan 16/17, CCGs and local authorities have developed and updated their Joint Health and Wellbeing Strategies and devised with other North West London boroughs a Sustainability and Transformation Plan (STP). Local delivery plans have also been agreed for each Health and Wellbeing Strategy and a Programme Delivery Framework established (see section 2).

Hammersmith Council does not support the STP due to proposals to reconfigure acute services in the borough. It remains committed to continuing collaboration on the joint programmes of work as envisaged in STP delivery areas 1 to 4.

Within this wider change environment, our BCF Delivery Plan consists of a number of specific projects within a wider transformation programme. BCF projects have been identified on the basis of three criteria:

- They follow, or are a continuation of, projects developed as part of previous BCF submissions (Community Independence Service, Community Neuro-rehabilitation Beds)
- They relate directly to specific requirements within the BCF Policy Framework (Improving Hospital Discharge, Seven Day Services, Disability Facilities Grant review)
- They relate directly to the pooled budget that has been established as part of the BCF Initiative (Review of jointly commissioned services)

The table below provides an overview of the schemes specifically within the scope of the BCF Delivery Plan. It is not a definitive outline of all of the projects and programmes underway to deliver the vision of integrated health and social care by 2020. More details about each, including the agreed investment is outlined in the accompanying BCF Planning Templates.

No	BCF Scheme	Overview
A1	Community Independence Service	This scheme will focus on embedding the existing Community Independence Service contract and in particular shifting the focus of the service away from supporting hospital discharge to preventing hospital admission. In parallel, work will take place to develop and deliver a re-commissioning strategy in preparation for the end of the existing contract in July 2018.

A2	Community Neuro-rehab Beds – Business As Usual Scheme	Following the re-commissioning of this service focus will now shift to improving health outcomes and delivering better value for money
A4.1	Improving Hospital Discharge (High Impact Change Model)	This scheme will be a key focus for the BCF Programme in 2017/2019 and in particular implementing the High Impact Change Model and achieving the targets set for each borough for reducing delayed transfers or care. As well as focussing on reducing Acute DTOC, work will also be concentrated on reducing Non Acute DTOC rates associated with West London Mental Healthcare Trust.
A4.2	Seven Day Services	A key element of our Improving Hospital Discharge Plan is providing 7 Day Services. We have established a dedicated social care team to support this. A key priority for 2017/18 will be to review and refine this service model.
C2	Review of Jointly Commissioned Services	Managing more effectively, delivering better outcomes and increased value for money from the £100m pooled Section 75 Budget will be a key priority for the BCF Plan 2017/19. In particular there is a requirement to deliver CCG QIPP Savings and local authority efficiency savings from this budget in 2017/18 and 2018/19 and this work is currently underway.
D4	BCF Implementatio n & Monitoring	This scheme is to support delivery of the agreed aims and objectives of the Integration and BCF Plan. This includes programme development and delivery.
N/A	Disability Facilities Grant and Community Equipment Review	Aids and adaptations for people with disabilities are key for maintaining independence and wellbeing, supporting prevention and delaying higher care need costs associated with hospital admissions and residential care home costs. Housing departments in all three boroughs administer the DFGs. The plans are developed together by Housing and Adult Social Care and the agreed funding is allocated to the Housing

		depts. However, as Social Care capital and DFG capital funding has been combined from 2016/17, the DFG will be influenced by the Housing plan, spending patterns and commitment and ASC need for capital. A new priority for the BCF Programme in 2017/18 will be a fundamental review of arrangements for administering and allocating Disability Facilities Grant and the Community Equipment Budget

As indicated in section 4 of this integration and BCF Plan 17-19, some of the previous BCF schemes have now moved to business as usual and although they are still commissioned will no longer form part of the ongoing monitoring of this plan.

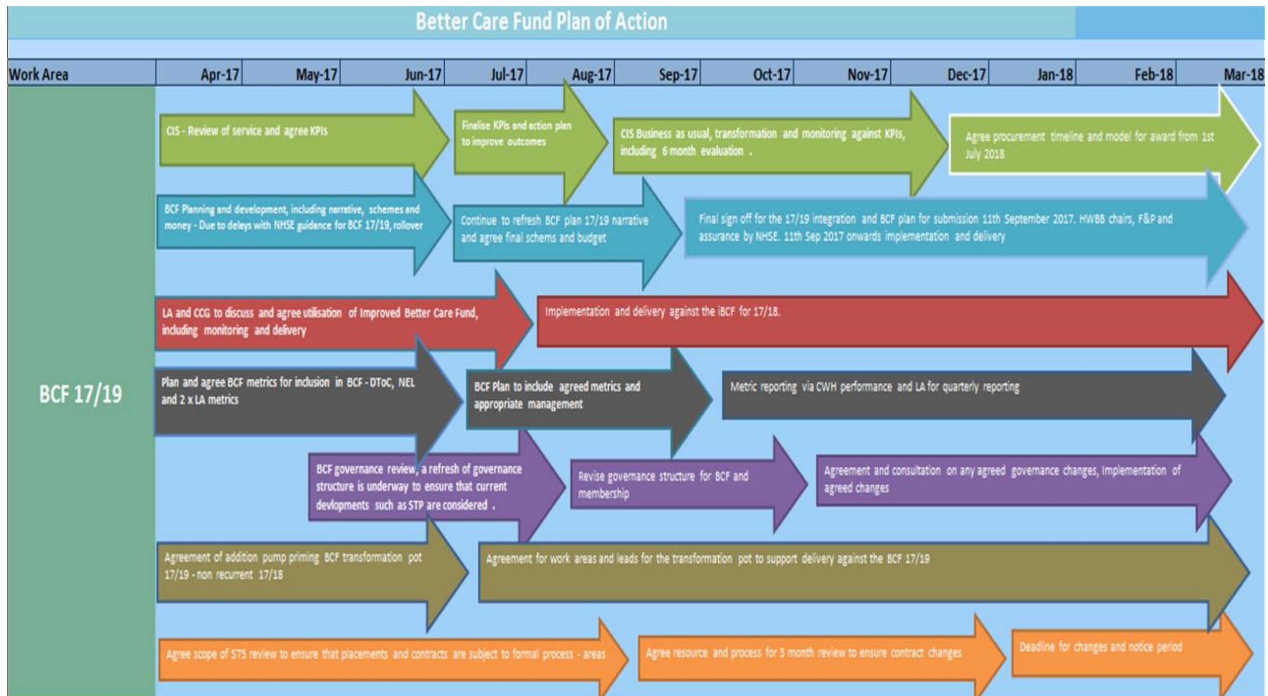
Other key projects that are underway which will play a key role in delivering our vision of Integrated Health and Social Care by 2020 but are not within the direct scope of the BCF Delivery Plan are set out in the table below.

No	Programme	Overview
1	Reconfiguration of Tri Borough Operational Arrangements	IThis process is underway and it is anticipated it will be completed in April 2018 resulting in a new Bi-Borough Partnership between Westminster City Council and the Royal Borough of Kensington & Chelsea and a sovereign arrangement for Hammersmith & Fulham Council. We will be maintaining successful collaborations such as the North West London hospital discharge service and the Community Independence Service and continue to explore options for a single commissioning collaborative.
2	Health commissioning at scale	Work has begun to consider the benefits of CCGs that form the NWL STP footprint collaborating at scale. Agreement has been reached across the eight CCG Governing Bodies to develop a detailed case for change, and Carnall Farrar have been appointed to develop the Case for Change and a Business Case. This will be considered by CCG Governing Bodies and Health and Wellbeing Boards late in 2017 with a view to implementing any agreed proposals in 2018.
3	Kensington and Chelsea My Care, My Way Integrated Care	Excellent progress has been made in establishing the My Care, My Way partnership. Based in GP Surgeries and with a North and a South Hub for complex patients, integrated care is now being provided to over 4,500 older people with

	Pilot	one or more long term conditions through GP multi-disciplinary teams. Work is now underway to evaluate the impact of the service and to consider next steps. These are likely to include further integration with social care and the development of a long term, integrated commissioning strategy.
4	Westminster Primary Care Strategy & Accountable Care Partnership (ACP) Development	A Primary and Community Care Strategy has been developed and considered and approved by the Westminster Health and Wellbeing Board; work is now underway to develop a Commissioning Strategy for an ACP which is on track for delivery in November. It is anticipated that a shadow ACP organisation which will combine health and social care services will come into operation in April 2019 following a market engagement and procurement exercise in 2018.
5	Hammersmith and Fulham Virtual Ward Project and ACP Development	In Hammersmith and Fulham, the Community Independence Service also incorporates a 'Virtual Ward' function. This helps to provide a single point of contact for patients and carers and for the patient's registered GP throughout the interaction with the service, and supports the transition into longer term services where required by initiating appropriate referrals. Specifically, the Virtual Ward: • Works alongside GP practices to increase appropriate referrals and proactively target support to those patients in greatest need. • Provides more intensive support to patients who people who are particularly unwell as part of a multidisciplinary team • Helps to coordinates this support by liaising with families, carers, GPs, community and hospital provider partners etc. In 17/18, the Virtual Ward is being reviewed by the lead provider for the CIS, CNWL, to ensure that it is working effectively alongside primary care and community teams to manage complex patients in their own homes and the development of new pathways of care as part of the H&F Accountable Care Partnership.

6.2 Integration and BCF 17-19 - High level action plan milestones.

The 17/18 BCF plan key milestones is illustrated below. Each agreed scheme has a Senior Responsible Officer (SRO) and a BCF Implementation Lead. We are currently refreshing reporting arrangements to ensure that the required work is delivered and governed appropriately.



7. Risks relating to the Integration and BCF Plan 2017-19

Our Sustainability and Transformation Plan provides a comprehensive overview of the system risks (see appendix 3) associated with delivering our people centred health and social care vision. Hammersmith Council does not support the NWL STP due to proposals to reconfigure acute services in the borough. It remains committed to continuing collaboration on the joint programmes of work as envisaged in STP delivery areas 1 to 4.

7.1 What are the key risks related to your plan?

Risks relating to individual schemes are recorded and monitored monthly through the BCF Implementation Group (see appendix 5 for BCF Risk Register) and escalated as necessary. Each scheme has a Senior Responsible Officer (SRO) and a lead manager.

The same core principles of risk sharing as previously agreed in the 16/17 BCF plan will be maintained for 2017-19:

- Organisations take responsibility for the services they sign up to deliver (against agreed specification of service quality, type and volume)
- Organisations take responsibility for the benefits that are expected to be realised intheir organisation
- There will be effective monitoring arrangements to identify where there are variances against planned spend and to reconcile back to the original budget (similar to the Section .75 arrangement)
- There is a commitment to a shared approach to resolving variances and amending the service model and share of costs if required.

7.2 Further 2017/18 partnership developments

A key step forward for 2017/18 is the establishment of a Joint Transformation Pot utilising I BCF funding which will be used to support the implementation of the High Impact Change Model for Improving Hospital Discharge and the wider Health and Social Care Integration Programme.

The Transformation Pot is founded on the need to deliver the aims and ambitions of the BCF and to deliver the transformational change needed to achieve challenging financial targets.

7.3 Pooled budget, Section 75 Agreement and managing financial risks

A key element of our Better Care Fund Plan are pooled budgets which are administered by each local authority and managed through Section 75 Agreements.

While the budget is pooled, specific commissioners are accountable for specific areas of expenditure and on this basis each organisation is accountable for expenditure within that area. In 2017/18 and 2018/19 all organisations are required to deliver efficiency savings from within the Section 75 element of the Better Care Fund.

Within the Section 75 Agreements there is an explicit agreement that each organisation will be responsible for the effective delivery of their commissioned services. The final expenditure will be met by the organisation responsible for the customer/patient as per the agreed risk protocol outlined in the BCF Plan. Where efficiency savings are not delivered then this financial liability will rest with the relevant organisation responsible for the customer/patient.

In addition within the Section 75 Agreements there are good practice principles setting out how service changes will take place. In particular where:

- contracts are to be reduced or terminated, unless extraordinary circumstances apply, six months' notice will be given to the existing provider; or

- a commissioning partner intends to reduce or terminate an existing contract this will only be undertaken following consultation with all partners within the scope of the BCF and following consideration of an equality and service impact assessment.

8. National conditions

As part of our 17-19 BCF plan we will continue to monitor, develop and meet the requirements of the National Conditions as outlined in the 17-19 Policy Framework. Details of the metrics that underpin these are provided within the accompanying 17-19 BCF templates.

National condition 1: Jointly agreed plan

Across the three boroughs we have jointly developed and agreed the 2017-19 Integration and Better Care Fund.

Since the commencement of the BCF in 15/16 our vision has remained consistent, however, we have updated our work programme, schemes and narrative to appropriately reflect changes as the BCF reaches maturity.

The draft Better Care Plan has been circulated for review and comment to all Health and Wellbeing Board Members. It will be considered and reviewed by each Health and Wellbeing Board in the week beginning 10 September 2017. Prior to submission this BCF Plan has been reviewed and approved for submission by each Health and Wellbeing Board Chair and each CCG Chair.

National condition 2: Social care maintenance

In 17/18 there is a requirement for health to increase the CCG minimum by 1.79% and in 18/19 by 1.90%. As part of our agreed Integration and BCF plan, CCGs have increased their contribution to protect Social Care by 1.79%.

The increases in line with the required national condition can be summarised as follows:

Borough	16/17 CCG minimum	17/18 1.79% uplift	17/18 CCG minimum with uplift
Westminster City Council	£7,944,000	£142,195	£8,086,075
The Royal Borough of Kensington & Chelsea	£5,279,060	£94,495	£5,373,555
London Borough of Hammersmith & Fulham	£5,680,129	£101,674	£5,781,803

National condition 3: NHS commissioned out-of-hospital services

Across North West London and in each borough we have continued to develop and invest in our out of hospital services above the minimum required levels. This represents a key part of our strategy to support delivery of care to our patients closer to home and in the right setting.

A full breakdown of the continued BCF investment in our out of hospital services is detailed in the BCF Planning Template 17-19. This expenditure excludes spend on core community nursing contracts and so in total CCGs continue to commission out of hospital services well in excess of the prescribed BCF minimum.

Ambitious plans for the future delivery of out of hospital services are being developed for each borough and an overview is provided in Section 6.

National Condition 4: Managing Transfers of Care

All partners are committed to implementing the High Impact Change Model and have defined the areas that need input and also the timeline of implementation by October 2017.

The High Impact Change Model remains challenging to implement across the three boroughs with inherent differences across the multiple work areas.

In particular, there are specific challenges in North West London in reducing non acute delayed transfers of care associated with the West London Mental Health Trust. Plans are being developed within Hammersmith and Fulham to address this and improvement is anticipated.

In addition, each borough has allocated significant of iBCF funding in 2016/17 to invest in schemes to improve hospital discharge and delivered better integrated care.

A separate Managing Transfers of Care (DTOC reduction delivery plan)2017-19 to implement the High Impact Change Model is being developed (see appendix 4).

This has been informed by the High Impact Change Stocktake which was undertaken and submitted to NHS England in June 2017 (appendix 5). This builds on the initial thinking undertaken and presented in the Q1 iBCF Submissions submitted at the end of July 17.

9. Overview of funding contributions

A full breakdown of our Integration and BCF funding contribution is provided within the BCF planning template 17-19. The template confirms that we have met the required contributions for each organisation, including the National Conditions and also an agreement for the Improved Better Care Fund (iBCF).

An overview of the allocation of BCF Funds is attached as appendix 6.

Carers' breaks

CCGs continue to fund Carers' breaks above the minimum level required and this is incorporated within the funding allocated within the Section 75 Agreements. In addition through the Section 75 Agreement significant investment continues to be made in support and assistance for carers. Work is also underway to update and refresh the Carers' Strategy.

Improved Better Care Fund allocations

The table below provides an overview of how Year One Improved Better Care Fund resources will be utilised.

Borough	Westminster (£m)	Kensington and Chelsea (£m)	Hammersmith and Fulham (£m)	Total
Market Stabilisation	2.128	1.35	1.457	4.935
Demographic Pressures/Additional Capacity	4.62	1.15	2.852	8.622
Transformation and implementation of High Impact Change Model	2.172	1.448	0.919	4.539
Total	**8.92**	**3.948**	**5.228**	**18.096**

As can be seen resources have been utilised to deliver the three priorities of:

- Stabilising the care market;
- Meeting demographic pressures and greater levels of need;
- Working to reduce delayed hospital discharges through implementation of the High Impact Change Model for managing Hospital Discharges.

Utilisation of the Transformation Fund (Joint Transformation Pot) in 2017/18 will be considered in the light of the Hospital Discharge Plan which will be completed in

October. Consideration will also be given to utilising the fund to deliver other projects related to delivering the integrated health and social care vision.

The utilisation of iBCF Funds in 2018/19 and beyond will be considered in the second part of 2017/18 in the light of progress implementing the High Impact Change Model for Managing Hospital Discharge, demographic pressures and market stability.

10. BCF Programme Governance

The governance arrangements for the BCF agreed for 16/17 will continue for 17/19.

Across the three boroughs, we have worked hard to develop robust governance arrangements to support Better Care Fund implementation. The diagram below provides an overview.

Each Health and Wellbeing Board will continue to have sovereignty over each borough's element of the Better Care Fund. Each local authority and CCG continue to be represented on each H&WB Board. A regular BCF Update is provided to each H&WB Board.

Strategic oversight and coordination will continue to be provided through the Joint Executive Team, which is made up of CCG Managing Directors and the Adult Social Care Leadership Team. This will also provide a forum for us to continue to review pooled budget requirements for the new financial year 17/18.

Risks to funding and performance will continue to be identified through the monthly Joint Finance Oversight Group (JFoG). This is a joint meeting made up of finance representatives from each CCG and local authority.

Each CCG also reports quarterly progress to its Finance and Performance Committee.

Issues requiring escalation will be escalated first of all to the Joint Executive Team and then to Health and Wellbeing Boards if required.

The BCF Implementation Group will be led by the overall BCF Senior Responsible Officer and will consist of those officers responsible for delivering specific BCF Projects. It will consider delivery risks and also review and oversee implementation of BCF projects. It provides monthly updates to the Joint Executive Team.

The pooled budget will continue to be managed through Section 75 Health and Wellbeing Partnership Agreements in place between each borough and CCG The pooled budget will continue to be administered by local government partners.

11. BCF National Metrics

11.1 Non Elective Admissions (NEL)

Targets for Non Elective Admissions (NEL) in 17/18 have been set and have been included in the BCF Planning Template. NEL performance continues to be monitored as part of the Operating Plan.

Outcomes against the NEL target in 16/17, per CCG were

- NHS Central London CCG (Westminster, excluding QPP); 16/17 achieved a reduction of -1.50%
- NHS Hammersmith & Fulham CCG 16/17 achieved a reduction of -5.17%
- NHS West London CCG 16/17 RBKC and QPP (Westminster) achieved a reduction of -6.24%

Set out below are the agreed trajectory for each HWBB for 2017/19.

The following trajectories show the monthly targets set as part of the agreed operating plan with NHSE and will be monitored accordingly. As part of the BCF the main scheme that is linked to reducing NEL is the Three Borough Community Independence Service (CIS). This is based on ensuring that where appropriate our residents receive timely health and social care input in their own home or place of residence. Across the three CCGs there are other schemes that may have an impact on reducing NEL but these have been identified to ensure that there is no duplication in respect of benefits.

We have not agreed a further reduction in Non Elective Admissions, additional to those in the each CCG Operating Plan in 17/18.

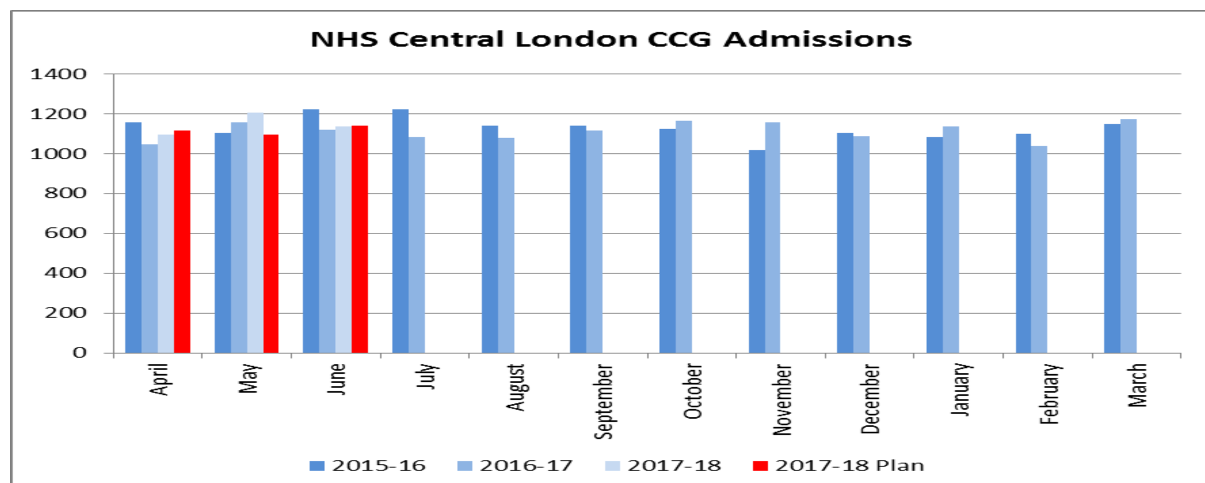
Further information supporting the NEL trajectory is attached in appendix 7.

Westminster (Central London CCG)

Westminster HWB

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Total
Westminster HWB Non-Elective Admission Trajectory for FY 2017/18	1260	1259	1291	1302	1265	1241	1294	1209	1271	1243	1192	1260	15088

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Total
Westminster HWB Non-Elective Admission Trajectory for FY 2018/19	1240	1241	1275	1277	1240	1216	1231	1143	1208	1172	1120	1195	14557



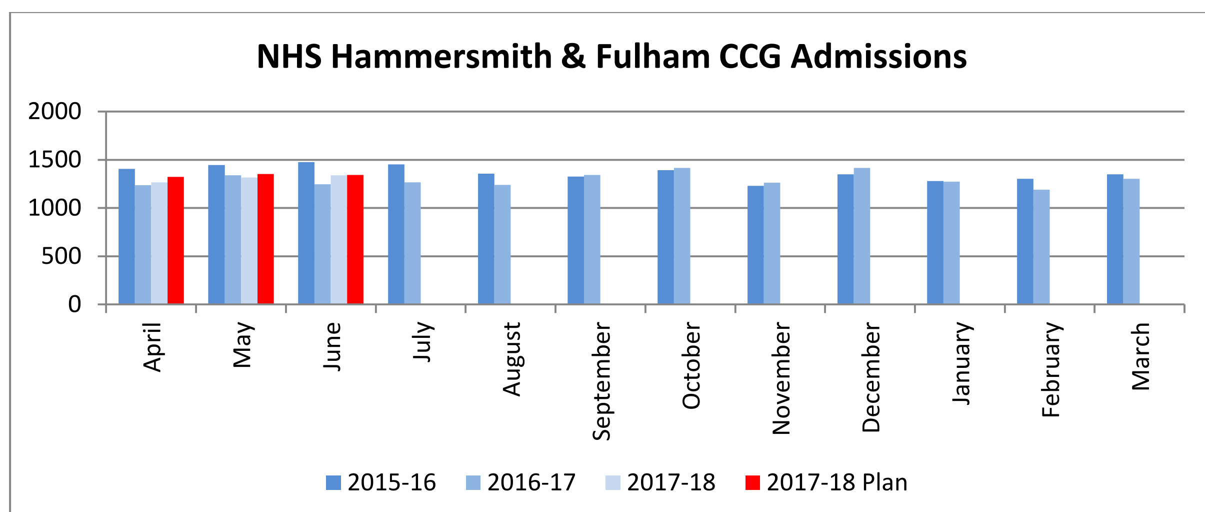
- CLCCG Q1 indicates we are slightly below target for NEL reduction

London Borough Hammersmith & Fulham (Hammersmith & Fulham CCG)

Hammersmith & Fulham HWB

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Total
Hammersmith & Fulham HWB Non-Elective Admission Trajectory for FY 2017/18	1354	1386	1376	1385	1330	1282	1381	1277	1342	1297	1241	1315	15967

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Total
Hammersmith & Fulham HWB Non-Elective Admission Trajectory for FY 2018/19	1326	1358	1349	1359	1304	1255	1301	1197	1264	1218	1162	1238	15331



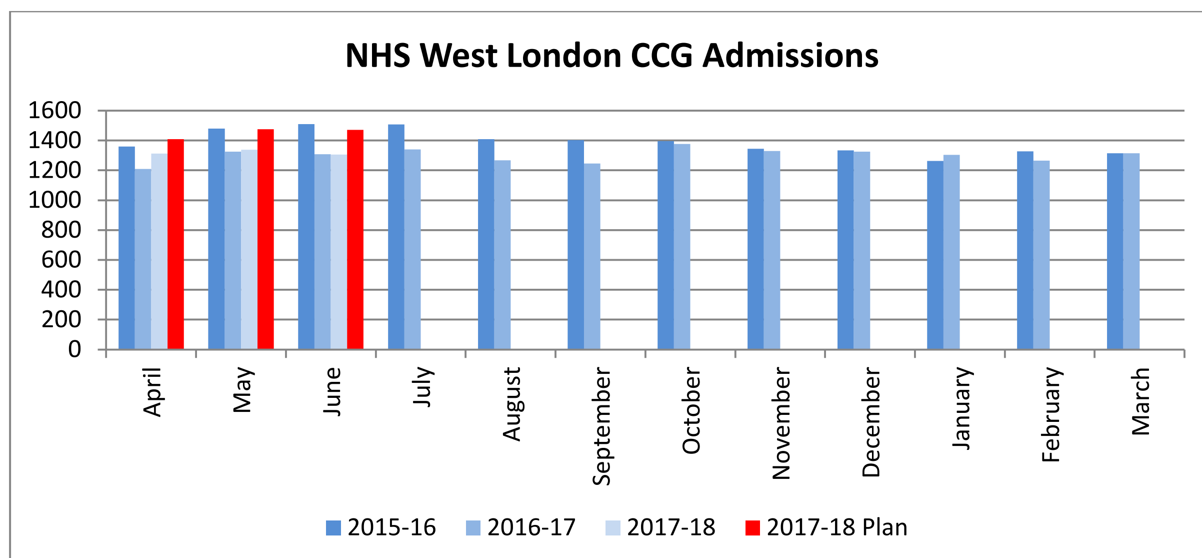
- H&FCCG Q1 indicates we are slightly below target for NEL reduction

Royal Borough Kensington & Chelsea (West London CCG)

Kensington & Chelsea HWB

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Total
Kensington & Chelsea HWB Non-Elective Admission Trajectory for FY 2017/18	955	998	997	1008	965	937	947	900	913	883	851	879	11234

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Total
Kensington & Chelsea HWB Non-Elective Admission Trajectory for FY 2018/19	920	966	967	980	938	912	921	873	889	860	830	860	10916



- WLCCG Q1 indicates we are above target for NEL reduction

11.2 Delayed transfers of care

We recognise that a key part of our BCF is the interdependency of our schemes and commissioned services that reduce Delayed Transfers of Care (DToC) and support the principle that quality care is delivered in the right place.

We are committed to implementing the High Impact Change Model and have defined the areas that need input and the timeline of implementation by October 2017. A summary stocktake of our current position against each of the 8 High Impact Changes is attached as appendix 5.

The High Impact Change Model remains challenging to implement and the three boroughs have therefore agreed to utilise approximately a third of the iBCF monies to support improvement and change across the DToC pathway.

Progress on managing transfers of care and achieving the DTOC targets will be managed on a day to day basis by the two A&E/Urgent Care Delivery Boards. Progress

will be overseen by the three borough Hospital Discharge Steering Group, which is chaired by a Director of Adult Social Care. Key decisions and current performance levels will be overseen by the Joint Executive Team and by each Health and Wellbeing Board.

There is a strong base to build on from the 2016-17 which has enabled improvements both in the processes within hospitals and the capacity available to support people at home and in the community. They include:

- Developed integrated hospital discharge teams and pathways within several hospital wards to provide a common discharge approach across the three boroughs and working on extending this to include three additional boroughs to better manage hospital discharge
- Development of Home First (Discharge Home to Assess) model with enhanced care package, as well as access to Step Up Interim care beds should care breakdown at home
- Increased the provision of interim beds to enable step down from hospital and to allow for full assessments of people's needs to be undertaken in the community. This includes interim bed options to carry out Continuing HealthCare Assessments (CHC) outside hospital as well as support people with care needs who have temporary accommodation needs.
- Development of two Trusted Assessor Nurse posts for Care Homes to speed up assessment and discharge to care homes
- Utilised BCF resources to establish a 7-day hospital social work and therapy services which are due for review in 17-18 to evalaute their impact.
- Modelling and re-commissioning the established Community Independence service to enhance its focus on integrated working with GP's and, also preventing hospital admissions.
- Alignment of organisational Choice policies supported by information for patients, families, and carers on the local options available for community or home based care upon discharge

The draft Managing Transfers of Care Action Plan seeks to extend single Hospital Discharge function across health and social care and scale it up to support achievement of the DTOC targets which have been set for each borough.

Our agreed trajectories for DToC 2017/19 are as follows:

*Please note these trajectories may be subject to change.

CCG Code	CCG Name	Type	Days (September)	NHS/Social Care Ratio	Baseline Total	Baseline Split	September Position	September Split	March Position	March Split	Phase 1 Step	Phase 2 Step
08C	NHS HAMMERSMITH AND FULHAM CCG	NHS	6.94	55.79%	16.6	9.26	12.45	6.95	8.3	4.63	0.39	0.39
08C	NHS HAMMERSMITH AND FULHAM CCG	Social Care	5.5	44.21%	16.6	7.34	12.45	5.50	8.3	3.67	0.31	0.31
09A	NHS CENTRAL LONDON (WESTMINSTER) CCG	NHS	5.49	70.29%	9.76	6.86	7.81	5.49	5.86	4.12	0.23	0.23
09A	NHS CENTRAL LONDON (WESTMINSTER) CCG	Social Care	2.32	29.71%	9.76	2.90	7.81	2.32	5.86	1.74	0.10	0.10
08Y	NHS WEST LONDON CCG	NHS	6.72	67.20%	12.5	8.40	10	6.72	7.5	5.04	0.28	0.28
08Y	NHS WEST LONDON CCG	Social Care	3.28	32.80%	12.5	4.10	10	3.28	7.5	2.46	0.14	0.14

11.3 National Metric 3: Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population

The table below sets out progress in reducing the number of local authority funded residential care admissions per 100,000 population and proposed targets for 17/18 and 18/19 for each borough.

	15/16	16/17	17/18	18/19
Hammersmith and Fulham	584.9	545.9	453.6	445.1
Westminster City Council	472.1	352.0	331.3	322.6
Kensington and Chelsea	335.9	183.5	283.3	277.3

As can be seen there are significant variations in activity levels but with each borough achieving significant year on year reductions between 2015/16 and 2016/17.

While the variations in performance are partly a result of different demographic characteristics, variations in personal income and levels of clinical need it is likely that some of the variation is also a result of different operational practices in each boroughs and different criteria for awarding home care support.

In each borough there has been an increased focus on providing home based support packages where possible and promoting greater independence and choice and it is anticipated that this will continue to result in an overall reduction in the number of older people placed in residential and nursing care. However in all boroughs there has been a shift in the proportion of placements in nursing care homes compared to residential care homes (the proportion placed in nursing care homes is increasing). It is anticipated that this trend will continue so that by 2019/20 there will be a smaller proportion of older people in long term residential care but with more complex needs.

11.4 National Metric 4: Effectiveness of reablement service

The table below sets out the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services and the proposed targets for 2017/18 and 2018/19.

	15/16	**16/17**	**17/18**	**18/19**
Kensington & Chelsea	89.2%	89.7%	90%	90%
Westminster City Council	88.6%	89%	90%	90%
Hammersmith and Fulham	86.4%	89.7%	90%	90%

As can be seen performance levels in all boroughs were good in 15/16 and these improved further in 16/17 with the roll out of the new Community Independence Service contract and the more coordinated working that has resulted between re-ablement, rehabilitation and rapid response staff and with GPs.

In 2017/18, it is anticipated that this trajectory will continue so that all boroughs achieve a success rate of 90% in 2017/18 and that this performance is maintained through the reconfiguration and re-commissioning of out of hospital services to establish accountable care partnership arrangements in 2019/20.

12. Approval and sign off for the 17-19 Integration and BCF Plan

This Integration and Better Care Fund 17-19 has been agreed by all six sovereign organisations. The delegated signatories are listed below. This revised narrative upholds the previously agreed plans in 15/16 and 16/17. At the time of submission the full plan has not been ratified due to the timetable of Health and Wellbeing Boards and CCG Finance and Performance Committees, however, the plan has been agreed outside of this governance process to meet the NHSE submission deadline.

Central London Clinical Commissioning Group

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City of Westminster

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Hammersmith & Fulham Clinical Commissioning Group

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Hammersmith & Fulham Council

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West London Clinical Commissioning Group

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Royal Borough Kensington & Chelsea

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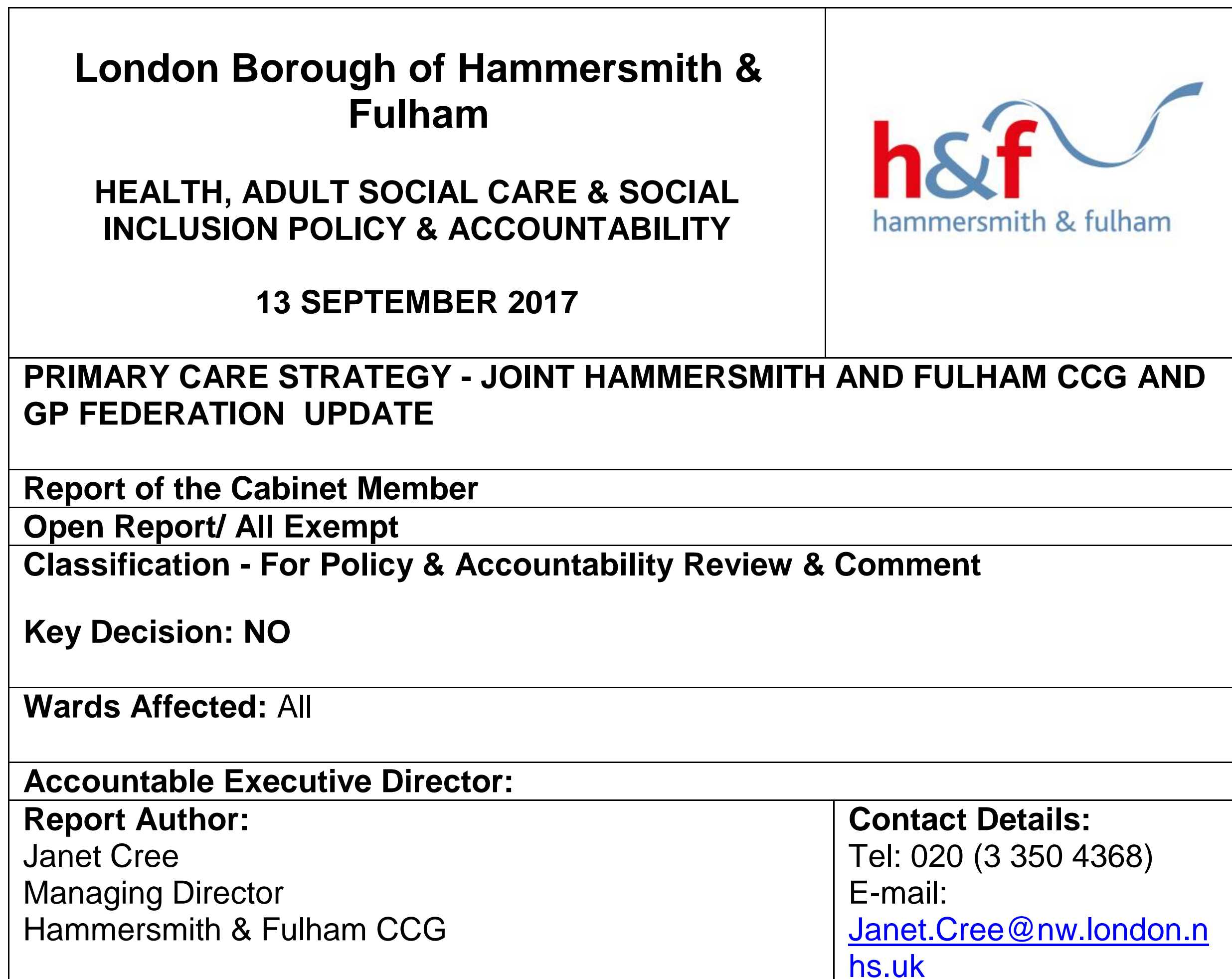
Appendices

No	Document
1	Joint Health and Wellbeing Strategies (3 documents)
2	NW London Sustainability and Transformation Plan
3	Better Care Fund Plan Risk Register
4	Managing Transfers of Care (DToC Reduction Delivery Plan) 2017-19
5	High Impact Change Model Stocktake (June 2017)
6	Overview of BCF Funding Allocations
7	NE London Non Elective Admissions Trajectory

Agenda Item 5



London Borough of Hammersmith & Fulham HEALTH, ADULT SOCIAL CARE & SOCIAL INCLUSION POLICY & ACCOUNTABILITY 13 SEPTEMBER 2017	h&f hammersmith & fulham
PRIMARY CARE STRATEGY - JOINT HAMMERSMITH AND FULHAM CCG AND GP FEDERATION UPDATE	
Report of the Cabinet Member	
Open Report/ All Exempt	
Classification - For Policy & Accountability Review & Comment **Key Decision: NO**	
Wards Affected: All	
Accountable Executive Director:	
Report Author: Janet Cree Managing Director Hammersmith & Fulham CCG	**Contact Details:** Tel: 020 (3 350 4368) E-mail: Janet.Cree@nw.london.nhs.uk

1. EXECUTIVE SUMMARY

1.1. Hammersmith and Fulham CCG and the GP Federation have developed a joint strategy which sets out our shared vision for an integrated health and social care system, with primary care as the foundation for better population health across the borough. The Primary Care Strategy, which is currently undergoing internal governance, is due to be published in mid-September 2017.

1.2. This paper provides an update to the Health and Wellbeing Board on the following key aspects of the strategy, ahead of its publication:

1. Our vision for an integrated care system for residents in Hammersmith and Fulham and the key stages in achieving this
2. Strategy implementation work programme
3. Governance and next steps

2. RECOMMENDATIONS

2.1. The Health and Wellbeing Board are being to provide comment on the vision set out in this paper and to endorse the CCG working closely with Public Health, Children's and Adult Social Care teams to progress the implementation of its strategy.

3. INTRODUCTION AND BACKGROUND

3.1. Primary care in Hammersmith and Fulham is improving with greater access to more services, including enhanced support for mental health, warfarin monitoring and more diabetic care and support. However, the experience of care is still fragmented and inefficient for many of our local residents, particularly for people with complex needs whose care is provided by a number of different health and care professionals spanning primary care, community and acute organisations.

3.2. Over the past five months, the CCG and GP Federation have worked closely together and in consultation with local residents, GP members and other stakeholders to develop a strategy for delivering improvements in patients' experience of care and population health outcomes.

3.3. A series of public engagement events were undertaken (including two patient focus groups) which have helped to define local residents' wants and expectations of care from General Practice and the wider health and care system. *Appendix 1* provides a summary of our local engagement. The outputs from our engagement have been incorporated into the final iteration of the strategy.

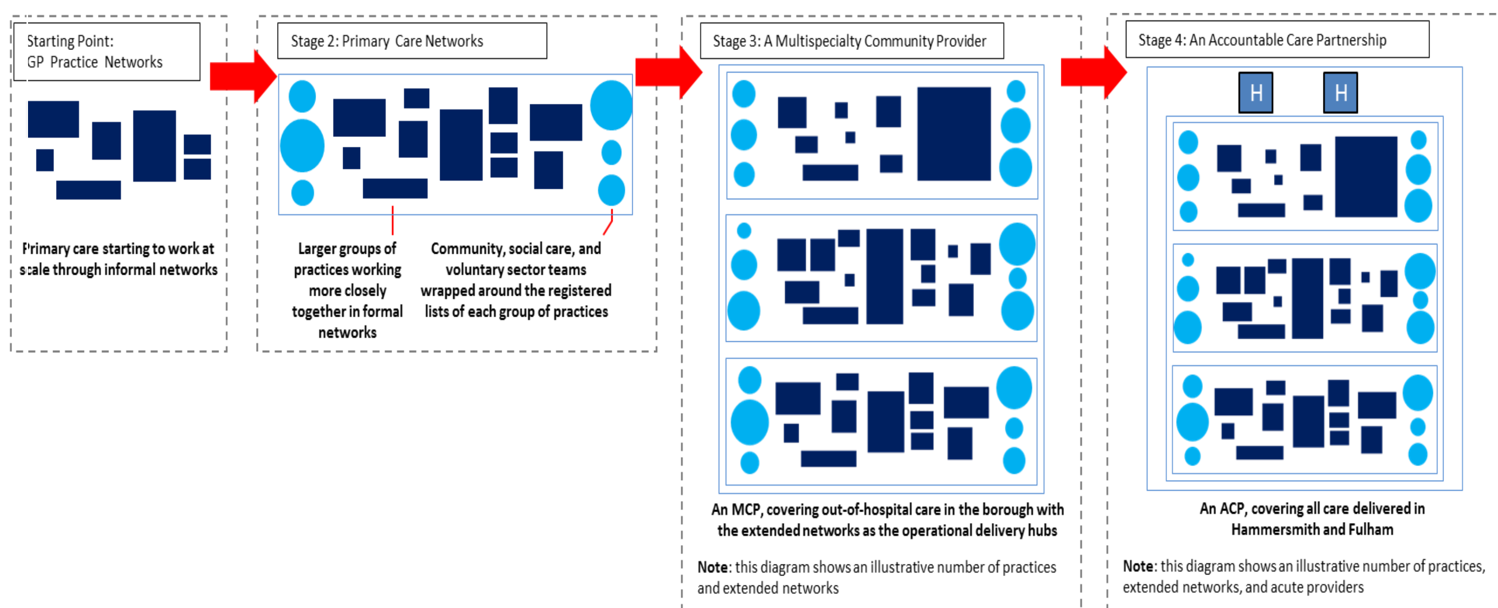
4. KEY CONSIDERATIONS

The stages of local transformation

4.1. The strategy, which builds on the Whole System Integration Care programme, sets out our ambition for achieving a more unified and co-ordinated care system for local residents. This will be achieved by:

1. Reinvigorating existing General Practice networks to become 'primary care networks' which will deliver services at scale for the benefit of local residents
2. Bringing primary care networks together into a unified approach to community based care – this will be through the platform of a Multispecialty Community Provider (MCP); a place based model of integrated care which serves the whole population
3. Adding hospital-based services to the MCP for a co-ordinated, outcome-based borough-wide approach to all care which we describe as 'accountable care'

Figure 1 illustrates the stages in our journey towards achieving our end-point ambition for accountable care



4.2. The characteristics of each stage of our transformation journey and the benefits that local residents can expect to see as a result of the strategy are summarised below:

4.3. *Stage 1: Reinvigorating existing General Practice networks to become 'primary care networks' which will deliver services at scale for patients*

- Practices will work in larger established networks to provide services at scale for the local population. Patients will be able to access a wider range of services provided by practices within the networks through inter-practice referrals.
- Primary care networks will work towards reducing variation and unnecessary admissions /referrals through an agreed common set of outcomes and quality standards
- A shared workforce will be established across primary care networks: this will enable practices to address their workforce issues more comprehensively than when working alone, including recruiting for a wider range of roles across multiple practices

4.4. *Stage 2: Bringing primary care networks together into a unified approach to community based care – this will be through the platform of a Multispecialty Community Provider (MCP)*

- Principles of joint working will be well established through integrated community care teams
- The integration of services around the needs of local residents will be extended across health and social care under a 'one person, one service, one team, one budget' approach
- Broader multi-disciplinary teams will be established bringing together all expertise to deliver better population health outcomes

- Links with the voluntary sector will be established to increase the services available locally

4.5. *Stage 3: Adds acute services to the MCP for a co-ordinated, outcome-based borough-wide approach to all care – this is accountable care*

- Improved patient access to community and specialist care closer to the patient's home
- Community-facing consultants delivering services linked to the management of long term conditions
- Greater focus on driving better health outcomes for local residents with payment systems linked to this

Appendix 2 provides two examples of how patients with long term conditions and mental illness will benefit from the strategy.

Strategy Implementation Work Programme

4.6. The following work streams have been defined to support the implementation of the strategy:

PROVIDER DEVELOPMENT	COMMISSIONING AND CONTRACTING
High level deliverables: ▪ Reconfiguration of existing GP networks into 'primary care networks' and development of new ways of working at scale ▪ Assessment of the maturity and readiness of primary care at scale organisations to take on the delivery and leadership of community-based care under an MCP. (The North West London Collaboration of CCGs have developed a tool to facilitate this exercise) ▪ Development of system leadership - supporting providers to establish an MCP/Accountable Care Partnerships ▪ Implementation of system enablers (i.e. workforce, estates and digital technology) in line with the General Practice Forward View	***High level deliverables:*** ▪ Development and implementation of commissioning and contracting plans for the new primary care 'wrap-around' offer ▪ Development of MCP and ACP commissioning strategy and plans setting out how the CCG will procure an MCP and ACP contract for award and mobilisation ▪ Implementation of MCP contract

Governance and next steps

4.7. Hammersmith and Fulham GP Federation Board to review and agree Primary Care Strategy on the 4 September 2017

4.8. Hammersmith and Fulham CCG to publish Primary Care Strategy following Governing Body sign off (12 September 2017) – pending the outcome of this

meeting the CCG will provide hard copies of the strategy for the Health and Wellbeing Board (13 September 2017)

4.9. A joint CCG and GP Federation Programme Management Office (PMO) to be established to oversee the operational delivery of the work streams aligned to the strategy

4.10. The progress of primary care network configuration to be reviewed with GP members and next steps to be agreed for the development of new ways of working - 21 September 2017

4.11. CCG and GP Federation to continue developing partnerships, ensuring links with the Local Authority Adult Social Care, Children's and Public Health teams

5. CONSULTATION

5.1 As previously stated, a series of public engagement events were undertaken (including two patient focus groups) which have helped to define local residents' wants and expectations of care from General Practice and the wider health and care system. *Appendix 1* provides a summary of our local engagement. The outputs from our engagement have been incorporated into the final iteration of the strategy.

6. EQUALITY IMPLICATIONS

6.1 A series of public engagement events were and patient feedback. For example, a request to see greater emphasis on mental health needs alongside physical health needs has been incorporated into the strategy.

7. LEGAL IMPLICATIONS

7.1 There will be contracting implications in the eventual formation of accountable care and the CCG will ensure that it adheres to all appropriate contractual guidance.

7.2 It is worth noting that NHS England has recently published guidance on Accountable Care Partnerships. The CCG will work with NHS England to incorporate this guidance into the development of its contracting approach for accountable care, to ensure that local integration agreements reflect the national view in terms of the level of integration required between primary care and the wider system to deliver effective integrated care.

8. FINANCIAL AND RESOURCES IMPLICATIONS

8.1 There are no direct financial implications. An increasingly integrated way of working is anticipated to enable more effective use of resource through improved care co-ordination and the diminishing of organisational boundaries.

9. IMPLICATIONS FOR BUSINESS

9.1 *Not applicable*

10. RISK MANAGEMENT

10.1 The CCG has engaged with stakeholders and residents in order that their views can inform development of the strategy to facilitate understanding of primary care within the borough.

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.			

*[**Note:** Please list only those that are not already in the public domain, i.e. you do not need to include Government publications, previous public reports etc.] Do not list exempt documents. Background Papers must be retained for public inspection for four years after the date of the meeting.*

LIST OF APPENDICES:

- *Appendix 1 – Local Engagement for Strategy Development*
- *Appendix 2 – Patient example highlighting the benefits of accountable care for a patient with mental illness*
- *Appendix 3 – Patient example highlighting the benefits of accountable care for a patient with multiple long term conditions*

APPENDIX 1:
Hammersmith & Fulham – Local Engagement for Strategy Development

Stakeholders / Forum	Dates
Hammersmith and Fulham GP Members Meeting	27th April 2017
Hammersmith and Fulham GP Members Meeting	7th June 2017
Patient Reference Group (which included representation from Healthwatch as well as LBHF and community and Voluntary sector organisations)	15th June 2017
Practice Managers Forum	5th July 2017
Primary Care Strategy Patient Focus Group	10th July 2017
Primary Care Strategy Patient Focus Group	27th July 2017

APPENDIX 2:

Patient Example 1

To highlight benefits of Accountable Care for a patient with mental illness

ROD SMITH: Age 53. Diagnosed with Schizophrenia aged 24. Lives with sister, but often sleeps rough especially when drinking. Prescribed small dose of regular tranquiliser.

Currently:	Anticipated benefits of Accountable Care:
• Has been discharged from follow up by psychiatrist • Under care of Community Psychiatric Nurse (CPN) but frequently fails to attend • Rod feels he is a nuisance to his sister who works from home. He tries to get out from under her feet and spends a lot of time wandering the area, smoking, and sometimes sleeps rough for days or weeks at a time. • Rod sometimes forgets to take his medication. Over the years there have been a couple of crises that have required urgent visits by a psychiatrist. • Rod doesn't like his current medication. His GP would like specialist advice on an alternative but Rod is reluctant to visit the psychiatrist • Rod seems to develop chronic bronchitis rather suddenly. The GP recommends an urgent hospital investigation but knows that Rod is unlikely to attend for all the necessary appointments	• CPN is available to see patients locally in one of the GP practices that forms part of a small, local health and social care network, and can visit patients at home when necessary. • The Primary Care Collaboration includes various local community organisations. The CPN has referred Rod to a health and social care coordinator. After a discussion Rod has joined a local allotment group and finds he enjoys gardening. He has also joined an art group and smokes and drinks much less. • The Primary Care Collaboration employs pharmacists who routinely monitor repeat prescribing systems including Rod's usage of medication. They can use the shared computer system to leave messages for GP colleagues, the CPN and to ensure that someone contacts Rod to check on his wellbeing • The GP and consultant can both access Rod's medical record and hold a 'virtual clinic' where they discuss the case by video link while both viewing the record at the same time. They agree on a plan of action including a trial of a modern medicine with fewer side-effects. • There is a multidisciplinary diagnostic service in the local hospital where the staff includes GPs from Rod's local GP network. A care navigator keeps him informed as the day progresses with various investigations. • The chest specialist and GP compare notes and can exclude cancer. They make a record in Rods clinical notes and agree with Rod that he will attend for follow up with his GP rather than the hospital

APPENDIX 3:

Patient Example 2

To highlight benefits of Accountable Care for a patient with multiple long term conditions

DANUTA SALEEM: Age 79. Widow. Lives alone. Suffers from diabetes, chronic kidney disease, high blood pressure and mild heart failure. She has been admitted to hospital recently following some falls. She tries to help her struggling daughter with cash, leaving her with little money of her own to feed herself properly.

Currently:	Anticipated benefits of Accountable Care:
• A heart failure nurse visits Danuta at home, but sometimes Danuta needs to attend the hospital for tests. She tries to combine visits to her GP for diabetes or blood pressure review with days when her daughter is available. She can also usually co-ordinate her hospital visits to the kidney specialist every three months to suit her daughter. She sometimes misses her appointments • Danuta frequently needs hospital admissions, for heart failure or worsening of her kidney condition. • Currently, communication between health care professionals and social care is typically in the form of letters. • There are frequent mix-ups over medication, when for example one of the specialists recommends a change, but the letter arrives late at the GP surgery • Danuta's daughter is re-housed to another borough with the birth of her child, and Danuta becomes increasingly isolated. A neighbour suggests she discuss the issue with social services. She is offered a weekly visit to a day care centre but feels that would not suit her • Danuta's daughter is increasingly pre-occupied and it becomes more difficult for Danuta to access help or get equipment. • Danuta sees a GP she has not seen before who is a little concerned to hear about Danuta's financial support for the daughter. The GP doesn't want to cause a fuss and lets the matter slide	• Local GPs and social services are combined in an integrated care service. The team is based in one of the GP practices. The combined team ensures that the same, suitably trained nurse can provide home visiting for all the various specialist needs in a single, regular visit. The nurse can discuss Danuta's case regularly with each of the specialists in virtual clinics where both have access to the same, shared record system. Hospital visits become less frequent • An integrated team as well as shared records allows for better planning and anticipation of crises, especially by making use of pharmacists who keep track of medication usage. When crises do occur, they can usually be managed by a community support team that visits Danuta several times daily including the use of mobile diagnostic equipment. • With health and social care combined in a single, local organisation, communication is much easier using a shared record and regular meetings. • All the specialists involved have access to the GP record, and changes to medication are more immediate. Also each integrated local care network will include pharmacists who can regularly review prescribing and raise issues with the doctors or nurses involved. • Integrated health and social care makes it easier for the nurse and social care to share information. With more emphasis on prevention and with better communication, this situation is anticipated much earlier, and a local housing solution is found which allows Danuta's daughter to continue providing some support. • Whenever help is required, it is accessed by a single phone call to the same number each time. Danuta knows her care navigator very well, and since payments for equipment come directly from a single, unified budget personalised help and equipment can be accessed much quicker. • The care navigator is able to connect Danuta to a local visiting service. One of their volunteers is Polish and subsequently visits Danuta regularly to chat in her native language. • The GP is very familiar with their social care colleagues who now work in the same team. They are able to have an informal discussion and the nurse who visits feels able to raise

Agenda Item 6

London Borough of Hammersmith & Fulham HEALTH AND WELLBEING BOARD 13 September 2017	h&f hammersmith & fulham
LIKE MINDED STRATEGY UPDATE	
Report of Janet Cree, Managing Director Hammersmith and Fulham Clinical Commissioning Group	
Open Report	
Classification: For review and comment **Key Decision: No**	
Consultation: **Not applicable**	
Wards Affected: All	
Accountable Director: **Janet Cree, Managing Director Hammersmith and Fulham Clinical Commissioning Group**	
Report Author: **Jane Wheeler, Deputy Director (Mental Health) Collaboration of CCGS North West London** **Carol Lambe, Head of Planned Care & Mental Health Hammersmith and Fulham CCG**	**Contact Details:** Tel: 0203 350 4535) Jane.wheeler@nw.london.nhs.uk Tel: 0203 350 4831 Carol.lambe@nw.london.nhs.uk

1. EXECUTIVE SUMMARY

1.1 This is report provides an update to the Health and Wellbeing Board on the current position with the Like Minded strategy. The report provides both a general overview of the key elements of the strategy together with specific details of the actions that have been/are being taken within Hammersmith and Fulham.

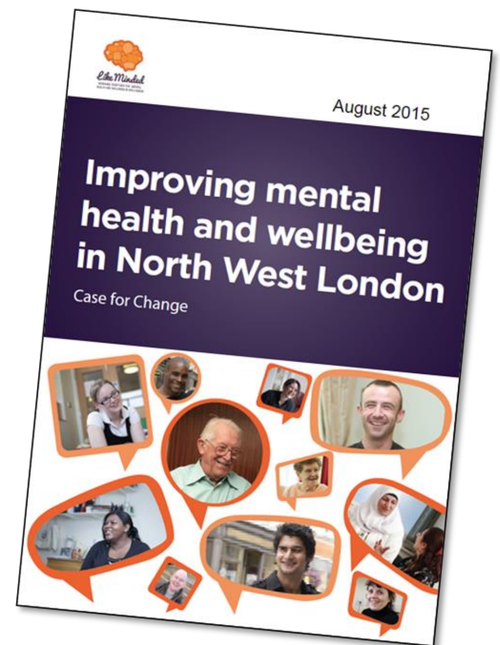
2. RECOMMENDATIONS

2.1 The Health and Wellbeing Board is asked to reflect on how the Local Implementation Group can further support local implementation of the Like Minded strategy in Hammersmith and Fulham.

3. INTRODUCTION

3.1 Like Minded is a strategy for establishing joined up care that leads to excellent mental health and wellbeing outcomes across North West London.

3.2 Its development is led by the North West London Collaboration of CCGs and is co-produced with service users, carers, health and care professionals, third sector and user-led organisations and other experts.



3.3 Both Mental Health Trusts in North West London are actively involved in developing the strategy- as are teams from each Local Authority, service users, carers and a wider range of other partners such as the police.

3.4 In August 2015 we published a Case for Change – describing a shared picture of the issues and our shared ambitions – this was endorsed by each Health and Wellbeing Board.

4. SUSTAINABILITY AND TRANSFORMATION PLAN (STP)

4.1 The STP has 5 delivery areas, with delivery area 4 focusing on mental health. However mental health is referenced throughout the STP and threaded throughout our delivery areas – within prevention and within work on long term conditions.

4.2 One of the aims for **Delivery Area 1**, Improving Healthcare and Wellbeing, is to support people to stay healthy through targeted work with the population who need mental health support.

4.3 Common mental health needs falls under **Delivery Area 2**, eliminating unwarranted variation and improving long term condition (LTC) Management.

4.4 **Delivery Area 4**, improving mental health services, is the focus of the mental health strategy in the STP:

- Implement the new model of care for people with serious and long term mental health needs, to improve physical, mental health and increase life expectancy
- Focused interventions for target populations
- Perinatal treatment
- Transforming Care Plan for people with learning disabilities, autism and challenging behaviours
- Crisis support services delivering the 'Crisis Care Concordat'
- Implementing 'Future in Mind' to improve children's mental health and wellbeing

5. OBJECTIVES AND VISION OF LIKE MINDED

5,1 Our vision is for North West London to be a place where people say:

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

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

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

1. **Core Principles**

Core principles

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

5.2 Whilst the strategy is focused on sharing learning and raising standards across North West London, delivery is happening locally with a commitment in every borough to improving the outcomes of people with mental health needs.

Work to date

6. PREVENTION AND WELLBEING

6.1 An approach to Making Every Contact Count (MECC) for North West London is being developed within all boroughs. Training is taking place in Westminster, Kensington & Chelsea and Hammersmith & Fulham.

6.2 Training is being targeted at a broad range of frontline staff groups including non-clinical NHS staff; housing, employment and probation officers; adult social care teams; library staff, and frontline staff of voluntary sector organisations. So far, there has been good uptake of training from GP receptionists and the voluntary sector. Work will continue to recruit a range of staff groups into the training.

7. IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES FOR LONG TERM CONDITIONS (IAPT-LTC)

7.1 The IAPT-LTC Wave 2 programme is part of the North West London STP delivery area focusing on "eliminating unwarranted variation and improving long term condition management". The overall objective of the programme is to improve outcomes for people with long term conditions and prevent the escalation of poor mental health through better management of their condition.

7.2 The service delivery model includes the placement of 21 Psychological Wellbeing Practitioners (PWPs) and 26 High Intensity therapists(HITs) to provide

backfill, enabling the NWL IAPT services to accommodate additional long term condition patient contacts. All trainees were planned to be in placement by Health Education England (HEE) in October 2017, however, due to unforeseen circumstance, HEE has confirmed a phased release of trainees. The new trainee placement schedule has had a significant impact on IAPT-LTC 17/18 trajectory. Since receiving information about the delayed trainee placement, providers and commissioners have worked together to revise the programme trajectory, and this has been submitted to NHS England for approval.

7.3 Long term condition IAPT training funded by HEENWL is being delivered to low intensity IAPT therapists and practice based counsellors; 53 staff were trained in the period July – August 2017.

7.4 **Next Steps:**

- An online training module is in development and will be available in the autumn, to ensure training remains accessible to staff particularly with the high turnover of low intensity workers.
- Top-up long term condition training for IAPT therapists will commence this autumn, delivered by Royal Holloway University and University College London.
- Continue building strong working relationships with the 2x IAPT providers (CNWL & WLMHT) and share learning from IAPT wave 1 work in Hillingdon. The providers have a positive history of collaborative work to improve outcomes and implement change.

Local delivery in Hammersmith & Fulham

7.5 In Hammersmith and Fulham over 4,500 patients with anxiety and depression accessed psychological therapies in 2016/17, with 52% of people who completed treatment moving to recovery. Hammersmith and Fulham IAPT performance is above target at M4 2017 with access at 5.52% compared to a threshold of 5.00%. Recovery performance is at 53.5% compared to a threshold of 50%.

7.6 There is a local delivery group in place developing a new IAPT service model focusing on delivery of improved outcomes for patients with long term conditions. Initial work is focused on supporting patients with diabetes and COPD.

7.7 In addition suicide awareness training is being rolled out to 700 frontline workers across the three boroughs, with a particular focus on staff in non-mental health services. The e-learning training will enable staff to identify, approach and support a person who may be suicidal, particularly giving staff the skills and confidence to start a conversation with that person, to listen, and to know what support is available.

8. PERINATAL SERVICES

8.1 Community Perinatal Mental Health commenced in WLMHT (Ealing, Hounslow and Hammersmith & Fulham) in April 2016 and was launched in CNWL in June 2017 (Brent, Harrow, Hillingdon, Kensington & Chelsea and Westminster). The model of care is community based for women and their families with mild-to-severe mental illness and covers pre-conception, through pregnancy and up to 12 months' post-

natal support. There is a clear focus on prevention, early detection and diagnosis and prompt treatment. In addition, the service offers patent infant mental health support.

8.2 The service accepts referrals from any professional including mental health professionals, midwives, obstetricians & GPs, and offers telephone advice to professionals if they have concerns about a woman's mental health.

Local delivery in Hammersmith & Fulham

8.3 WLMHT perinatal service received excellent evaluation from the Royal College of Psychiatrists and is used as an example of good practice. The service aims to reduce unscheduled psychiatric admissions for women during the perinatal period by ensuring that all women at risk of severe mental illness during the perinatal period are identified early in pregnancy; referred to a specialist perinatal mental health service and have a clear and co-ordinated care plan. In 2016/17 over 500 women across Hammersmith and Fulham, Ealing and Hounslow were seen by the service. The service has also developed a screening tool and e-learning module to further support midwives and health visitors improve understanding and early identification of perinatal mental health issues.

9. SERIOUS AND LONG TERM MENTAL HEALTH NEEDS

9.1 The Serious and Long Term Mental Health Needs Clinical Model of Care has been endorsed by all 8 CCGs.

9.2 The Like Minded team has looked into alternative phasing options for funding and implementing the serious and long term mental health needs new model of care. Discussions are taking place with senior stakeholders regarding the viability of implementing specific elements of the model per borough and local implementation plans are starting to be explored. The intention is to support providers and CCGs with targeted pieces of work to resolve blockages in local implementation.

9.3 The revised financial model has been produced in greater detail to demonstrate savings of using a phased implementation approach and highlighting the challenges of the "invest to save" premise and the investment required to ensure a safe and sustainable system.

9.4 **Next Steps**

- Create local "roadmaps" for each borough to identify how to implement the model locally.
- Review resources needed to implement the elements of model of care in the boroughs
- The new model of care agreed by all CCGs is aligned to the Mental Health Five Year Forward View and modelling which reflects this will be shared with Trusts and CCGs in the coming months.

Local Delivery in Hammersmith & Fulham

9.5 Hammersmith and Fulham CCG has successfully implemented a Single Point of Access (SPA) and crisis response teams in the community. Further work is under way with partner organisations across the borough, including police and ambulance services on an integrated approach to using the SPA for clinical advice, face to face support and assessment where needed. Clearly defined pathways will speed up response and ensure that those in crisis are conveyed to the most appropriate place for their mental and physical needs. Community services which respond quickly and appropriately to crises provide better alternatives to A&E; releasing capacity for an improved service for those who do need to attend A&E.

9.6 There is strong joint working across partner organisations to review acute community and in-patient pathways to ensure they are consistently performing to the correct standards, and that they work well for referrals from across the whole system including the police, London Ambulance Service, acute Trusts, Local Authority, housing providers and the third sector, as well as for GPs, service users and their carers.

9.7 A number of work streams are being delivered via the WLMHT transformation programme including implementing the “shifting settings of care” model to assist people with on-going but stable mental illness to be supported in the community by GPs and primary care mental health workers; developing care pathways for people with psychosis, complex depression and complex trauma via the planned and primary care work stream. The primary care mental health service is reviewing delivery of social inclusion and therapy and a new service model for employment services will be developed in 17/18.

Enhancing the GP ‘offer’ for those with Serious & Long-Term Mental Health Needs

9.8 Hammersmith and Fulham together with Central and West London CCGs have designed and implemented a new enhanced GP service to enable GPs to provide the extra, proactive care required by those with on-going mental health needs but not under the care of a mental health Trust. All patients registered with practices across the CCGs’ geographic areas can benefit from extended GP appointments throughout the year, and a bio-psycho-social (holistic) ‘Recovery & Staying Well Plan’ created with the service user. Outcomes are being measured using a nationally validated health & well-being scale.

Older people’s mental health

9.9 The development of older people’s mental health services for both ‘functional’ mental illnesses such as schizophrenia and bipolar and ‘organic’ illnesses like dementia is a key priority for commissioners and West London Mental Health Trust. Work is underway to bring together key representatives from Older Peoples Community Mental Health Teams, Memory Assessment Service staff, alongside primary and community care staff, to explore:

- Current pathways and interfaces
- Opportunities for service and pathway development, including as a priority, access to Memory Assessment Services
- Current position on integration with community based services

- Identification of additional opportunities for further integration

10. TRANSFORMING CARE PARTNERSHIP (TCP)

10.1 Transforming Care Partnerships (TCP) in North West London is about making out of hospital care for people with learning disabilities (PLD) better and safe so that fewer people will need to be in specialist learning disabilities hospitals.

10.2 To deliver this the CCGs across North West London have been developing a service plan that provides an Enhanced/Intensive Community Support for PLD-particularly for those people who may have behaviours that can challenge others.

10.3 To date progress against the TCP's key outcomes continues to be strong and remains on track to deliver our discharge trajectories over the next two years.

10.4 **Next Steps**

- Dynamic Risk Registers: TCP to develop and appraise a North West London governance pathway that can be utilised across Children Young People (CYP)/Adult services, to ensure consistency in approach to understanding and supporting those most at risk
- Service Mapping: To systematically map the existing specialist crisis and prevention offering (incorporating local variations) across North West London CYP/Adult services. This will include; Community Learning Disability Teams, 'mainstream' mental health services, social care provision (private and voluntary sector), access to secondary care (A&E, Urgent Care Centres), services for LD/non LD autism, inpatient services and community forensic support. Utilising this information we will identify areas of under/over provision for specialist and universal services and employ existing best practice and training

Local delivery in Hammersmith & Fulham

10.5 Locally:

- Hammersmith and Fulham there is an established Community Learning Disabilities Team led by a Consultant Psychiatrist providing expert support in the community for people who display behaviour that is challenging and who may have forensic support needs. It gives them the right support to stay in the community.
- Within the last year there have been 3 discharges from long stay specialist care into community settings. Another discharge is due in October 2017
- All 10 people in hospital (9 adults and 1 child) have discharge plans and have had Care and Treatment Reviews (CTR)

10.6 Transformation funding is being utilised to:

- identify future housing and support needs (which is critical to ensure that local services are developed in response to identified needs)
- increase capacity to undertake complex case reviews
- workforce development to increase clinical capacity and expertise within the TCP.

10.7 Work continues to ensure transformation projects remain on track to develop and deliver comprehensive reviews and anticipated learning outcomes.

10.8 Stakeholder engagement is on-going with events taking place in January, March and a further event planned for September 2017. There is also a TCP workforce and learning needs workshop in November 2017. All of these initiatives will contribute towards the development of new service models and approaches to support the delivery of our service plan.

10.9 The TCP maintains effective financial oversight and leadership of the delivery of the transforming care programme, so that the best possible outcomes are achieved within the available resources.

11. CRISIS CARE CONCORDAT

11.1 Across North West London 25 partner organisations in health, policing, social care, housing, local government and the third sector came together and signed the Crisis Care Concordat, covering a population of 2 million people of which 32,000 are living with serious mental illness.

11.2 The Single Point of Access has been rolled out across North West London as a first point of contact for people needing crisis advice or referral. The Rapid Response Home Treatment Team aims to provide 24/7-365 emergency mental health care with the same urgency that people expect from the NHS in a physical health emergency. The evaluation is currently being finalised.

11.3 The quarterly Crisis Care Concordat meeting took place 13 July to oversee the programme of work for delivering priorities across North West London. A crisis care co production plan has been developed by the Making a Difference (MAD) Alliance service user and carer group to support improving crisis care across North West London.

11.4 **Next Steps**

- A refreshed action plan is due to be circulated which will shape national priorities in 2018/19.
- A proposal is being developed to look at how services within the scope of the crisis pathway can be better integrated to provide efficiently resourced high quality 24/7 provision (this will include current developments across London for the section 136 pathway, health based places of safety and liaison psychiatry services).
- To develop a plan for a pan-London section 136 pathway and an all age Health Based Place of Safety (HBPoS) specification.

Local delivery in Hammersmith & Fulham

11.5 Hammersmith and Fulham are optimising crisis care through on-going collaboration in the delivery of liaison psychiatry services delivered by WLMHT and CNWL across a number of acute hospital sites accessed by Hammersmith and Fulham residents including St Mary’s, Charing Cross and Chelsea and Westminster Hospitals.

11.6 Transformation investment is being used to develop delivery of a 24/7; 4 hour assessment response. However, there is acknowledgement of the challenges and pressures across the system which is being addressed through clear cross-organisation senior team escalation processes.

12. CHILDREN AND YOUNG PEOPLE

12.1 West London Mental Health Trust implemented a specialist community eating disorder service for under 18's in February 2016, in line with national standards. The service accepts referrals via self, GPs, schools/colleges and other professionals across Hammersmith and Fulham, Hounslow and Ealing. Commissioners are currently reviewing the service with input from Rethink Young Champions.

12.2 An out of hours crisis service has been implemented across North West London. Additional funding has been allocated to deliver a fully integrated 24/7 crisis service for children and young people. Pathways are in development and the services are delivered by Central and North West London and West London Mental Health Trusts.

12.3 Commissioners have drafted a new 24/7 crisis care service specification that is currently out to consultation. This will integrate the in-hours, out of hours and new crisis care work currently being planned for 2018-19, making sure that the quality of provision is compliant with the new, Healthy London Partnership Crisis Care guidelines for Child and Adolescent Mental Health Services (CAMHS).

12.4 Our North West London Children and Young People's Mental Health and Wellbeing Strategy and Transformation Plan is currently being refreshed. It is due to be completed for submission on 31st of October. An agreed draft will be complete by the end of September and presented to HWBB Chair in October for sign off.

12.5 **Next Stepswest**

- Development of a new multi-agency service delivery model (working with West London Mental Health Trust, Central North West London Trust, the new Family Support Service, the voluntary sector and schools) which will enable children and young people to access the right intervention at the right time
- Development of a comprehensive work plan for children and young people with Learning Disability and Autistic Spectrum Disorder.

Local Delivery in Westminster; Kensington and Chelsea; and Hammersmith and Fulham.

12.6 A great deal of work is underway across the three boroughs to progress the implementation of the CAMHS Transformation Plan in 2017-2020, which is reported via the separate Health and Well-being Boards of Westminster, Kensington and Chelsea, and Hammersmith and Fulham.

12.7 Service redesign work continues with the focus of enhancing prevention and early intervention CAMHS in order to manage increasing demand on CAMHS. Enhanced training and delivery in schools is key to this aim, and the voluntary sector

provision will be expanded to include new providers, for example Mencap, Xenzone and the Octavia Foundation joining current CAMHS local providers, MIND, Rethink and West London Action for Children.

12.8 A new model of care for young people with serious mental health problems is under development with West London Mental Health and Central and North West London Trusts. This NHS England CAMHS pilot has several aims:

- to reduce the number of young people sent outside London for an inpatient bed
- to reduce the amount of time a young person is admitted
- to develop more assertive outreach community care to prevent young people needing to access an inpatient bed.

12.9 The three CCGs are investing funds in 2017-20 to assist with this project.

12.10 The sustainable training programme plans to include parents in 'train the trainers' programmes, particularly around managing adolescent and challenging behaviour from those young people with learning disabilities and autism.

12.11 The learning disabilities and autism pathways work is a focus for this year with the aim to publish agreed multi-agency pathways for learning disabilities, ADHD and Autism.

12.13 Co-production work with young champions continues to strengthen across the three boroughs. Further work this year will be to make links between Young Champions and schools, the Youth Council and other service user groups. Planning of the second Young People's mental health conference is underway and will take place in November 2017.

12.14 Digital solutions on engagement and delivery with young people are being developed nationally, regionally and locally across the three boroughs. The challenge is to avoid duplication and to map what works and is young people friendly. Young Champions and partners are working with 'Coders and Founders' to try out a range of available apps, and may take part in developing a bespoke app for local young people.

12.15 A new 12 month pilot for on-line counselling, 'Kooth' commissioned from Xenzone, will go live in local schools in September 2017. This will enable young people to book a telephone appointment or text a counsellor, take part in moderated focus groups, and access good quality information and support from their mobile phone.

Local Delivery in Hammersmith & Fulham

12.16 In addition to the reporting of CAMHS to the Hammersmith and Fulham Health and Wellbeing Board, commissioners also report to the Children and Education Policy and Accountability Committee, and the Adult Social Care and Social Inclusion Committee.

12.17 Implementing Mental Health Leads in schools is a priority for commissioners across North West London. In Hammersmith and Fulham this work is already underway with Health Education Partnership supporting schools to identify a mental health lead whom is then offered training to take up this role.

12.18 The Council is also developing an integration of their Early Help services with children's physical health and children centres staff. The CCG and the Council plan to co-locate the Primary Mental Health Community CAMHS team provided by WLMHT with the new Family Support Service (FSS) model later in the year.

13. ENABLERS AND INFRASTRUCTURE

13.1 NW London CCGs are delivering a free one day mental health training course 'Let's Talk about Mental Health' for frontline staff and carers. The first two courses have been delivered to over 50 multi-agency staff with overwhelmingly positive feedback on the quality and delivery of the training. Feedback received will help to enhance and improve future training.

13.2 Mental Health Leadership Diploma supports a cadre of GPs to broaden their mental health knowledge and take leadership roles in mental health transformation. 37 GPs across NWL have now completed the diploma; 4 from Hammersmith and Fulham.

13.3 **Next steps**

- Act as champions for transformation in CCGS, NW London and London work.
- Act as points of local cascade to practices and for escalation of issues
- Offer peer support across localities.

Local delivery in Hammersmith & Fulham

13.4 A number of Hammersmith and Fulham GPs have completed the North West London GP Leadership Programme; a bespoke programme, tailored to the local context of North West London and the Like-Minded Strategy delivered by University of Stafford. Many of the GPs involved are actively involved in providing clinical leadership for local mental health initiatives in Hammersmith and Fulham including working in a targeted way with individual GP practices to increase awareness and improve assessment skills. Hammersmith and Fulham CCG continue to deliver a series of GP training days under its GP education programme.

14. AREAS FOR HELATH AND WELLBEING BOARD DISCUSSION

14.1 Hammersmith and Fulham Health and Wellbeing Board is asked to reflect on how the Local Implementation Group can further support local implementation of the Like Minded strategy in Hammersmith and Fulham.

15. CONSULTATION

15.1 This is an update report and has not required any specific consultation in its preparation.

16. EQUALITY IMPLICATIONS

16.1 There are no equality implications highlighted in the report.

17. LEGAL IMPLICATIONS

17.1 Under the Health and Social Care Act 2012 the Health and Wellbeing Board has a duty to make it easier for health and social care services to work together. Section 3 of the Care Act places the Local Authority under a duty to carry out its care and support functions in a way that promotes integrating services with those of the NHS or other health-related service. Progress on the Like Minded strategy included in this report discharges this responsibility.

18. FINANCIAL IMPLICATIONS

18.1 There are no financial implications in this report.

19. IMPLICATIONS FOR BUSINESS

19.1 There are no specific local business implications arising from this report.

20. COMMERCIAL IMPLICATIONS

20.1 There are no commercial implications arising from this report

21. BACKGROUND PAPERS USED IN PREPARING THIS REPORT

21. 1 None.

Agenda Item 7

London Borough of Hammersmith & Fulham **Health and Wellbeing Board** **13 SEPTEMBER 2017**	h&f hammersmith & fulham
WORK PROGRAMME 2017-18	
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 2017/18.

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 2017-18

Hammersmith and Fulham: Health and Wellbeing Strategy Implementation and Work Plan 2017/18

	May –June 17	July-August 17	Sept-Oct 17	Nov-Dec 17	Jan – Feb 18	March – April 18
Meeting Date	**June**	**20 June**	**13 Sep**	**21 Nov**	**31 Jan**	**21 March**
Key Plans (Sponsor)						
H&WB Strategy Implementation Plan	• Workshop to develop Plan	• Delivery Plan for agreement (LBHF)			• Workshop to develop 18/19 Plan	• Plan for agreement
Better Care Fund Plan	• Update	• Update (LBHF)	• Draft plan for agreement (LBHF, CCG)		• Update	
Sustainability & Transformation Plan				• Update		• Update
H&WB Priorities						
HWB Priority 1: Improving health and care for children, young people and families				• **Integrated services for children and young people (HF CCG, ChS, GP Fed)**		• Enabling independence and life chances (ChS) • Transitions (ChS) • Children and Young People's emotional health and wellbeing (inc implementing future in mind) (ChS)
HWB Priority 2: Improving the management of long term conditions			• **Primary Care Strategy (CCG)**	• **Whole Systems Commissioning Intentions (CCG)**	• Care Homes Commissioning Strategy and Improvement Programme (LBHF) • Carers Strategy (LBHF)	
HWB Priority 3: Improving Mental Health Outcomes		• Public Health consultation on Mental Wellbeing to inform Annual report (LBHF)	• **Mental Health Transformation Update & Overview (CCG)**		• **Mental Health Transformation Update & Overview (CCG)**	
HWB Priority 4: Delivering a sustainable health and social care system		• Whole Systems Dashboard and measuring health outcomes demonstration (CCG)		• **One public sector estate (CCG)**		• Whole Systems Dashboard and measuring health outcomes demonstration
HWB: Priority 5: Radically upgrade prevention and early intervention			~~• Consideration of Annual Public Health Report (LBHF)~~(withdrawn)	• Healthy lifestyle service (LBHF) • Social Isolation and Loneliness	• **Making Every Contact Count presentation and action planning (CCG)**	