London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Agenda

Tuesday 24 July 2018 at 6.00 pm
Courtyard Room - Hammersmith Town Hall

MEMBERSHIP

Vanessa Andreae - H&F Clinical Commissioning Group
Janet Cree - H&F Clinical Commissioning Group
Councillor Ben Coleman - Cabinet Member for Health and Adult Social Care (Chair)
Councillor Adam Connell - Cabinet Member for Public Services Reform
Councillor Larry Culhane - Cabinet Member for Children and Education
Steve Miley - Director of Children's Services
Keith Mallinson - Healthwatch Representative
Anita Parkin - Director of Public Health
Lisa Redfern – Director of Social Care (and Acting Director of Public Services Reform)
Glendine Shepherd - Head of Housing Solutions
Dr Tim Spicer - H&F Clinical Commissioning Group (Vice-Chair)
Sue Spillar - Chief Executive Officer, SOBUS (Co-Opted Member)

Nominated Deputy Members
Councillor Lucy Richardson, Chair of the Health, Inclusion and Social Care Policy and Accountability Committee
Councillor Patricia Quigley – Cabinet Assistant to the Cabinet Member for Health and Adult Social Care

CONTACT OFFICER: Bathsheba Mall
Committee Coordinator
Governance and Scrutiny
☎: 020 8753 5758
E-mail: bathsheba.mall@lbhf.gov.uk

Reports on the open agenda are available on the Council's website:
www.lbhf.gov.uk/committees

Members of the public are welcome to attend. A hearing loop is available and the building has disabled access.

Date Issued: 16 July 2018

London Borough of Hammersmith & Fulham

Health & Wellbeing Board
Agenda

Item **Pages**

1. APPOINTMENT OF VICE CHAIR

The Board is asked to appoint a Vice Chair for the 2018-19 Municipal Year.

2. MINUTES AND ACTIONS 4 - 9

(a) To approve as an accurate record and the Chair to sign the minutes of the meeting of the Health & Wellbeing Board held on 21 March 2018; and

(b) To note the outstanding actions.

3. APOLOGIES FOR ABSENCE

4. 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.

5. SOCIAL ISOLATION AND LONELINESS 10 - 15

This report summarises the work undertaken so far by the Health and Wellbeing Board and partners to develop a strategy and action plan to address social isolation and loneliness in Hammersmith and Fulham.

6. DEVELOPING THE 2018/19 WORK PLAN 16 - 19

This report suggests priority areas for the 2018/19 work programme.

7. DATES OF FUTURE MEETINGS

The following dates have been scheduled:

- Wednesday, 12 September 2018
- Wednesday, 21 November 2018
- Wednesday, 30 January 2019
- Wednesday, 20 March 2019

.

London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Draft Minutes

Wednesday 21 March 2018

PRESENT

Committee members:
Vanessa Andreae, H&F CCG
Councillors Ben Coleman (Chair)
Janet Cree, H&F CCG
Keith Mallinson, H&F Healthwatch Representative
Lisa Redfern, Director of Social Care
Dr Tim Spicer, H&F CCG

Nominated Deputies Councillors:
Sharon Holder, Lead Member for Hospitals

Officers: Colin Brodie, Public Health Knowledge Manager; Dr Ashlee Mulimba, Healthy Dialogue; Lisa Redfern, Director of Social Care; Graham Terry, Head of Health Partnerships

134. MINUTES AND ACTIONS

The minutes of the previous meeting held on 20 February 2018 were agreed as an accurate record.

135. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Rory Vaughan and Sue Macmillan; and Janet Cree.

136. DECLARATIONS OF INTEREST

None.

137. BETTER CARE FUND

Graham Terry presented the Better Care Fund (BCF) report which provided a high-level Quarter 3 information, delayed by guidance being issued. This was a precursor to Quarter 4 data available in May/June. The report was being considered by HWB as it was responsible for signing off the BCF plan and review the progress made since submission. The Community Independence Service (CIS) continued to be a priority across all three HWB areas with very good performance on delayed transfers of care. The current contract was due to expire in July 2018, with agreement by seniorhealth and social care leads to roll this forward until end of March 2019, to enable a full quality and financial reivew of the service has been undertaken. As CIS continued to play a strong role in parallel with other services.

Previously low performance on Delayed Transfers of Care (DToC) had been improved, largely due to focus and dedicated leadership from Lisa Redfern and her team to reduce DToC. There was now an upwards trajectory achieving above what was expected and this would meet the cumulative target in July, despite winter figures. The Integrated Care Partnership had been formally signed off with a two-year agreement, operating as committees in common. This provided agreement for a group of partners focused on integrated care to improve care pathways for LBHF residents. A seven-day social work team had been established to provide continuity of care throughout the week. Financial implications meant that both partners faced cost pressures, with a section 75 health funded services shortfall of £9.8 million (covered in report to the September 2017 HWB).

Keith Mallinson expressed concern regarding the introduction of Accountable Care Organisations (ACOs) in the context of Sustainable Transformation Partnerships (STPs) and the fact that LBHF had not agreed to the STP. Graham Terry reported that general concerns about this had been recently discussed at a Kings Fund meeting and no assurances had been offered. Surrey Borders Partnerships NHS Foundation Trust had delivered without an ACO or an integrated partnership. There had been some evidence of frontline working and the benefit to residents and how this had developed, questioning the arguments in support of an ACO, a view which was in line with the LBHF approach.

Councillor Ben Coleman confirmed that there were concerns about ACOs, and unsubstantiated claims about the benefits. Integration was more a term about centralised control. Councillor Coleman said that more robust action might necessary but that they would be happy to continue with local projects such as diabetes if they continued to provide proven health benefits for LBHF residents.

Councillor Coleman commended Lisa Redfern, Graham Terry, and colleagues for their work on DToC, together with CIS. He recognised that failure to deliver the required targets would jeopardise funding. This was a significant achievement given the low numbers from last year and he acknowledged the hard work undertaken to achieve this. Councillor Coleman suggested that residents should know about good work like this going on in

the Borough and congratulated the CIS team. Councillor Coleman and Lisa Redfern had visited the team at Charing Cross and had been impressed with both the service and the Team's ideas for improvement.

ACTION: ASC / COMMUNICATIONS TEAM

Vanessa Andreae also thanked Sue Wisden and her team which had also played a significant role in supporting CIS. She acknowledged that there remained further refinement work to CIS but the CCG and registered partners were still outliers, in terms of going into hospital non-elective care which would need to be addressed. There was a pattern linked to respiratory, urine infections, with the data for LBHF indicating higher occurrences but not necessarily more. There was a clinical backstory as to why residents end up in hospital and a need to consider how to manage things to prevent this. Councillor Coleman enquired how CIS figures for Hammersmith and Fulham compared to WCC and RBKC. This was not an unfavourable comparison and it was agreed that this was a question of mapping data. It was agreed that a report would be prepared for the Board to consider comparative shared data on non-elective admissions.

ACTION: HWB / PH / CCG

138. PHARMACEUTICAL NEEDS ASSESSMENT

Colin Brodie and Dr Ashlee Mulimba presented a report on the Pharmaceutical Needs Assessment (PNA). The draft PNA was in the final stages of completion, following an earlier draft prepared in November 2017, Consultation had been undertaken from December to February 2018. With feedback from CCG, NHS England (NHSE) and pharmacies. The HWB was statutorily responsible for the PNA statement of need for pharmaceutical services, with a requirement to categorise services. LBHF had a good network of pharmacy with no gaps in necessary services.

In response to a query from Vanessa Andreae, Colin Brodie explained that the only key change was the perceived gap in terms of opening hours, particularly in the northern part of the Borough. The only time that a person might need a prescription urgently during out of hours was if they received palliative care. The draft PNA had introduced a recommendation that this was an area that should be looked at. NHSE was reviewing palliative care, out of hours prescriptions and what this might will look like. They had also recommended that NHSE commissioners consider out of hours consultation. There were plans for piloting an out of hours service in LBHF and a trial process would be helpful in terms of identifying long term need.

Lisa Redfern welcomed the report. Referring to page 97 of the pack, care home advice service, she asked how care homes were advised. Colin Brodie explained that currently, advice was largely given by private providers. It was important to understand this aspect and how out of hours service linked to provision for rough sleepers. It was understood that there was also a lack of provision for sexual health screening treatment. Vanessa Andreae explained that this was privately commissioned, and was like the provision of weight management services.

Colin Brodie explained that one of the purposes of the PNA was to identify areas where services could be commissioned in future and potentially identify missed provision. Once the PNA was submitted it would be reviewed by NHSE. NSHE recommendations were looking to expand on the provision of health campaigns. Pharmacy funding conditions included a provision that they participate in up to 6 public health campaigns per year. Colin Brodie was unclear as to how this provision worked in practice and agreed to report back.

ACTION: Public Health

NHSE monitored health campaigns, with some being monitored privately. Colin Brodie explained that there were four categories of service. This included those that were essential and advanced services, which commissioned by NHSE (e.g. smoking cessation). The new Director of Public Health would be responsible for monitoring the take up of services, which would allow them to better understand commissioning needs.

Keith Mallinson referenced paragraph 6.21 and the purchase of medication, expressing concern about the implementation of the policy. The lack of communication had caused confusion and some patients had misunderstood the changes. Vanessa Andreae explained that GP's should ask patients if they were prepared to buy medication that was available without prescription. If not, then it would be provided on prescription. To ensure that the patient was enabled to take responsibility for their own medications, prescriptions would no longer be available on repeat. Approximately 20% of patients were likely to purchase medicines. This would help reduce waste and allow any changes to be identified through a review of patient medication.

Vanessa Andreae acknowledged that some patients were getting the wrong message. GPs should provide a simple message to inform patients more clearly about the changes to the policy and what this would mean for them. It was agreed that the CCG would explore this further and that Healthwatch could work with the CCG to look at how communications could be clearer. Councillor Coleman asked if it was possible to measure how many patients might struggle to gain access to medication, now that it was no longer available on repeat or as an emergency. Vanessa Andreae responded that most practices had contingency policies to provide for patients in need, but individual practices would determine themselves how to implement the practice guidance information disseminated to them. Theoretically, practices would know the number of the repeat prescriptions being issued and that there were systems in place to ensure that high risk patients did not miss out, e.g. those on insulin. Vanessa Andreae confirmed that the CCG would work with Healthwatch to look at the way in which messages were being communicated to patients.

ACTION: CCG and Healthwatch

In considering a possible follow up note to HWB regarding how palliative drugs were dealt with nationally, Lisa Redfern asked what the period was for NHSE to issue recommendations and further guidance. In terms of HWB responsibilities, what was the audit trail and what was the best method to

communicate the Board's views, which she felt was unclear. Dr Mulimba confirmed that the recommendations were for NHSE and that there was a statutory responsibility to produce the PNA. It was clear that further thought was required as to how the recommendations in the report would be taken forward effectively.

With reference to pages 95 and 96, section 7.11, Councillor Sharon Holder identified large gaps across parts of the Brough in the provision of sexual health treatment, with a concentration in Shepherd Bush. Hammersmith Broadway and Sands End had no weight management services. Dr Mulimba explained that the commissioning arrangement was to provide these services outside of pharmacies and were privately commissioned. The Council commissioned weight management services. HWB was invited to sign off on a report with key recommendations but a more comprehensive picture was needed.

Lisa Redfern welcomed the report but observed that the board would like to feedback it's concerns to the NSHE, and would like a response to these. A number of comments and amendments were suggested. The following specific amendments were made on the following recommendations (listed at Agenda page 26):

Recommendation 1
The Board would like to endorse the review on palliative care understands that NSHE is reviewing advanced service including palliative care, as we feel that there may be need for provision of the service in the borough. The Board would support the review and would like to know when it will report.

Recommendation 2 - The Board expressed concern regarding the rates of death caused by respiratory diseases. It was agreed that they would ask the GP Federation to explore this issue and come up with ways to improve adherence, and, find out about best practice.

Recommendation 3 - Some areas in the borough do not have a pharmacy open before 9am or after 7pm. Graham Terry explained that if there were significant changes, there was a statutory requirement to review this (in the context of population projected rises of residents in the Borough. Population rise projection included (Agenda page 25, para 4.23) an increase of 2.39% by 2021. The Board considered that if the increase exceeded the projected figure that the PNA be reviewed. Councillor recommended that the new Public Health team monitor population growth, so JNSA could be reviewed. It was agreed that Recommendation 3 be deleted.

Recommendation 4 - The Board agreed to write to NSHE regarding national health campaigns and requested that the new Director of Public Health review how pharmacies can be brought to work together.

139. WORK PROGRAMME

To be agreed.

140. DATE OF NEXT MEETING

To be confirmed.

Meeting started: 6pm
Meeting ended: 8.05pm

Chair .....

Contact officer: Bathsheba Mall
Committee Co-ordinator
Governance and Scrutiny
☎: 020 8753 5758
E-mail: bathsheba.mall@lbhf.gov.uk

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.

London Borough of Hammersmith & Fulham **HEALTH AND WELLBEING BOARD** **24 July 2018**	
SOCIAL ISOLATION AND LONELINESS	
Report of the Cabinet Member for Health and Adult Social Care – Councillor Ben Coleman	
Open Report	
Classification: For Decision **Key Decision: No**	
Wards Affected: All	
Accountable Director: Lisa Redfern, Director of Social Care	
Report Author: Julien Danero-Iglesias, Policy and Strategy Officer	**Contact Details:** Tel: 020 8753 5093 E-mail: Julien.Danero-Iglesias@lbhf.gov.uk

1. EXECUTIVE SUMMARY

1.1. This report summarises the work undertaken so far by the Health and Wellbeing Board and partners to develop a strategy and action plan to address social isolation and loneliness in Hammersmith and Fulham. The report focuses on a workshop with stakeholders organised in June 2018 and proposes a way forward based on the discussions at the workshop.

2. RECOMMENDATIONS

2.1. The Health and Wellbeing Board is asked to:

- Note the work undertaken so far; and
- Agree on the proposed way forward.

3. REASONS FOR DECISION

3.1. Social isolation and loneliness (SI&L) requires a whole systems response. The report has been produced to support a conversation between the Board and stakeholders to help ensure that a well-rounded collaborative action plan is developed.

4. BACKGROUND

4.1 At its meeting on 21 November 2017, the H&F Health and Wellbeing Board, chaired by Cllr Ben Coleman, discussed SI&L. Members of the public showed the need to map services and activities already available in the borough in order to identify gaps between what already exists in H&F that tackles SI&L and what would be needed to reduce it further.

4.2 This has been taken on board. HWB supporting officers mapped services that currently address SI&L in the borough and carried out a short literature review, desk-based research and interviews with different stakeholders in order to answer three main questions:

1. What is SI&L and how can we fight it?
2. How are H&F residents affected by SI&L?
3. What is already in place in H&F that helps tackle SI&L?

4.3 A provisional answer to these questions was presented at the following Health and Wellbeing Board that took place on 20 February 2018. At this meeting, the board agreed to organise a workshop with all stakeholders to initiate a collaboration and develop eventually a community asset-based approach to tackle SI&L.

5. PROPOSAL

5.1 The workshop took place on 12 June at the Lyric Theatre in Hammersmith town centre. The workshop was facilitated by We Coproduce, a charity based in Hammersmith focusing on co-production at local level. 70 stakeholders from various organisations based or operating in the borough attended the workshop.

5.2 At the workshop, participants worked firstly on a definition of SI&L as a problem. It was agreed that SI&L affect people of all ages across the borough and that building connected communities is key.

5.3 Participants were then divided into labs:

- *Connecting,* where they looked at ways of connecting existing resources and assets in the community;
- *Growing*, where they looked at how to develop new ways of tackling SI&L at local level, using those assets within the community;
- *Mixing things up,* where they looked at how to give incentives to the wider community to get involved.

5.4 The need to work together was recognised by all participants. At the end of the workshop, participants agreed on the next proposed step which was to create a steering group of volunteers. Such a steering group would meet to discuss what to do next, what can be achieved and how to work best with the community.

6. EQUALITY IMPLICATIONS

6.1. *None at this stage*

7. LEGAL IMPLICATIONS

7.1. *None at this stage*

8. FINANCIAL AND RESOURCES IMPLICATIONS

8.1. *None at this stage*

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

None.

LIST OF APPENDICES

Appendix 1 – Feedback from 12 June workshop

H&F's BIG COMMUNITY BRAINSTORM on Loneliness & Isolation 12 June 2018

Thoughts from the day and feedback since

What an amazing turnout – we had more than 70 people in the room. It was a bit crowded but there was so much interest in at the event that it kept growing. We'll bear in that mind for the future.

We had some really helpful comments on the day, including about what we could have done better. You really welcomed the opportunity to be in one room at the same time and hold important conversations together. You enjoyed the brain food and the creative approach to getting us thinking differently. You also felt some of the facilitation could have been better – we agree and will make changes. You loved our inspiring visitors from Yorkshire, Debbie and Phil.

Other feedback on the day was:

"Excellent mix of people and agencies"

"I loved that we were trying to be as radical and innovative as possible"

"I wanted more workshops"

"We needed a more targeted outcome"

"This opportunity to sit together and discuss this issue is extremely valuable"

This event was a first step, an occasion for local *organisations* to think about a collective response to the issue. Like everyone, we're clear that the wider community needs to be fully on board from here on in.

1 Just what is the problem?

We agreed that loneliness and isolation affected people of all ages right across the borough – and that loneliness and isolation were two different things: you can be lonely in a room full of people and isolated by only using social media.

We discussed the different impacts of loneliness and isolation on our borough. People may use GPs as their connection to the world or may suffer if they have long-term conditions which aren't picked up in time. This means that ensuring people stayed connected could save money. But we also felt it was about more than saving money – it was about building resilient communities and growing local assets.

Some of us said austerity had made people more isolated and services which kept people connected had been cut.

We were interested in building connectedness at a grassroots, community level. Funding mattered but we were interested in thinking widely about how to work collectively and move away from the answer being more "services".

2 What did you say in the labs?

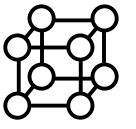
Connecting

We're aware of some of the support that exists but don't know enough about how to connect to it. We need a community system and a framework for connecting.

Is the onus on us, the organisations, to take responsibility to connect more with each other and the wider community?

We need to understand what assets exist in our community – who's offering what.

We need social prescriptions, instead of long-term medication: arts classes, gardening, walking..



Growing new things

There is so much we can do at local level, for example by using schools and churches to reach out or by building micro-communities, such as close neighbours.

We should take responsibility for going out into our community and connecting. We could think about micro-business and things on a very small scale

What we do should not be based on a negative model: we need to reframe this in positive language and look at it with positive eyes.

We need a network, something that pulls us all together and connects organisations. This could be intergenerational and include business and other partners. It would be more than a directory – something active and dynamic which promotes partnerships

Mixing things up

We need to give incentives to the wider community to be involved – such as the power to take their own decisions or work experience.

Let's create a sense of pride.

Too many familiar faces and loud voices can mean others who want to get involved don't have a chance or feel overpowered. We need to mix up who gets heard.

We need to identify the barriers to break down, such as language and culture.

Diversity is important when developing these strategies. How can we make sure we reach everyone?

To get a better understand of the issues, we must speak to those from the community.

We should identify leaders within pockets of the community – create a mapping system. They know people's needs better than 'professionals' guessing (e.g. do older people not attend events or functions because of poor hearing or transport?)

3 Alchemy -what's next?

We need to build more connections with isolated people and find those who need help but aren't part of a network. Everyone is known to someone – we need to work out how to connect.

GPs and organisations could collectively figure out who they know and how to get to those we're not in contact with. Some people are not hard to reach – they're hard for us to hear. They could be reached but might not be understood or heard.

We need to face this in partnership with the community, not just as individual organisations.

We can ask the community to find those who are isolated. We could find leaders or community connectors from within each group. The Somali community, LGBT people and others have regular meetings. We should go to them – and act on the feedback they give us.

We should empower individuals to seek us out rather than us just finding them.

Create social occasions that are interesting and relevant to different groups, e.g. young people and music and sport, lone parents and play dates, etc. Perhaps create a buddy system.

Talking about isolation is okay among ourselves but a leaflet through the door with the words loneliness or isolation will put people off. We need to be smart about our language and present activities to the public in a positive way, e.g. Creative Minds, community gardening, etc.

We should take this forward with events with the community, including local firms. But how best to bring the community together? Who usually attends events? People who most need help? People who know and understand? We need to systemise our actions. There are too many agendas amongst us and not enough connectedness.

Our next step should be to create a steering committee. Who wants to join?

4 Feedback since the meeting

After the meeting, we asked participants to tell us about their three main outcomes of the workshop.
The short survey was sent to all participants and we received 10 responses.

Many respondents welcomed the Health and Wellbeing Board's initiative and the push given for changing the approach to loneliness and isolation, which would be "more positive and less condescending", as one respondent put it.

The event gave participants the opportunity to see that there are many individuals, groups and organisations in the borough who want to make a difference and share a "real desire to do something".

Many liked the opportunity given to network and "connect".

Many also highlighted the need to find new resources and pull together on resources.

A few also gave some tips for the next meetings, such as making sure that all materials and meeting are more inclusive (for example for deaf and hard of hearing people) and ensuring that next time there would be enough time for everyone to say what they want to say.

London Borough of Hammersmith & Fulham **HEALTH AND WELLBEING BOARD** **24 July 2018**	
DEVELOPING THE 2018/19 WORK PLAN	
Open Report	
Classification: For Decision **Key Decision:** No	
Accountable Director: Lisa Redfern, Director of Social Care	
Report Author: Katie Estdale, Service Development, Policy and Governance Manager (ASC)	**Contact Details:** Tel: 07825 423 128

1. INTRODUCTION

1.1 Joint Health & Wellbeing Strategies (JHWSs) are partnership plans developed by the Council, local CCG, Healthwatch and any other member organisations of the Health and Wellbeing Board (HWB). A key role of the HWB, as per the H&F Constitution, is to provide organisational leadership by agreeing the vision and strategic priorities for health and wellbeing in Hammersmith & Fulham. These form the Joint Health & Wellbeing Strategy which the Board drives the development and implementation of.

1.2 The JHWS 2016-2021 was created following a number of workshops from which a vision, four priorities and five underpinning principles emerged. As such, the strategy is relatively high level providing the strategic direction and shared priorities for local health, social care and voluntary sector services.

1.3 This brief paper seeks to summarise the main areas of the Strategy and make suggestions of potential areas for the Board to focus on in 2018/19. Given the strategy covers a broad range of topics and runs for a number of years, it is recommended that the most effective use of the Board's time is to choose a small number of focal priorities (perhaps 2-4) as opposed to covering a high number of topics in less depth.

1.4 A lighter touch approach could then be taken to the broad range of priorities within the scope of the JHWS e.g. limited to an annual review of the strategy and progress on the wider range of shared priorities.

2. JOINT HEALTH AND WELLBEING STRATEGY 2016-2021

2.1 Vision

"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."

2.2 Priorities

1. Good mental health for all
2. Giving children and families the best possible start
3. Addressing the rising tide of long-term conditions
4. Delivering a high quality and sustainable health and social care system

2.3 Principles

1. Upgrading prevention: i.e. supporting people who are 'mostly healthy' with the information and tools they need to stay well and maintain healthy lifestyles.
2. Enabling independence, community resilience and self-care: i.e. promoting and encouraging communities to be more actively involved in their own health and wellbeing and enabling everyone to take a greater role in the management and maintenance of their health and care conditions, and the health and care conditions of others wherever appropriate.
3. Tackling the wider determinants of health: i.e. working to ensure that the environment into which people are born, grow, live work and age supports them to stay well and make healthy choices.
4. Making community, primary care, and social care an effective front line of local care: working to ensure the right support is provided closer to home enabling people to stay well in their homes and communities.
5. Delivering integration and service reform: working to ensure that when people need access to health and care services that those services are personalised and joined up around their needs and the needs of family members and carers.

3. SUGGESTIONS FOR 2018/19

3.1 The Board is invited to make suggestions for topics to include, which will then be used to form the work plan for the year ahead. NB, these are the focal items, other items will come to the Board, but likely as one-offs rather than reoccurring items.

3.2 Initial suggestions from the Chair are as follows:

1. **Loneliness and isolation** – There is a growing understanding that lacking social connections is a comparable risk factor for early death as smoking 15 cigarettes a day, and it worse for us than well-known risk factors such as obesity and physical inactivity. Loneliness and isolation was a topic begun last year by the HWB, and has become a major focus for the Older People's Commission. It is important to maintain momentum on achievements so far in this area, and as a cross-organisational issue, the Health and Wellbeing Board is well placed to do this.

2. **Nutrition (including obesity)** - Diet was a reoccurring theme throughout the JHWS. Within the second priority of giving children and families the best possible start, respondents encouraged the Board to take on diet through school meals, education, cooking lessons and restricting 'unhealthy' food businesses near schools. Childhood obesity is one of the most serious public health challenges of the 21st century. It is estimated that approximately 4,000 children between the ages of 4-15 in LBHF are obese. Obese children are at an increased risk of developing social, psychological and other health problems, with 79% of obese children becoming obese adults, resulting in long term personal ill health, lower life expectancy, social stigmatisation, lower chances of employment, increased social care costs, reduced productivity and increased sickness absence. Nutrition is however about much more than obesity, the Board would take a more holistic view of relationships with food.

   In the third priority of addressing the rising tide of long-term conditions, diet again was a popular topic as part of educating and raising awareness about healthy eating.

3. **Dementia and mental health** – This speaks to the first JHWS priority – 'good mental health for all'. Furthermore, improving mental health services and becoming a dementia-friendly council are both key commitments in the H&F manifesto, and the Integrated Care Partnership's Older Peoples group has recently set up a dementia workstream following a workshop with professionals, the voluntary sector and residents.

4. **Co-operative prevention** – This speaks to the first overriding principle of the JHWS – upgrading prevention. Preventive services are designed to support people below the NHS/social care thresholds, keeping them well and preventing them from needing more serious

interventions later on. Early intervention is vital, but its value can be hard to demonstrate, and with mounting financial pressures, this can be one of the areas most at-risk from cuts. Within the council, prevention services are commissioned by Public Health, Social Care and corporately. The CCG also provides funding for preventative services and now has responsibility for commissioning local primary care services. There is no governance structure currently in place to look at the funding and reach of these services taken together. The HWB could provide key leadership in this area.