

Health & Wellbeing Board Agenda

Wednesday 11 December 2024 at 6.30 pm

Copper Suite (Ground Floor), Clockwork Building,
45 Beavor Lane, London, W6 9AR

Watch live on YouTube: youtube.com/hammersmithandfulham

MEMBERSHIP

Councillor Bora Kwon (Chair) - Cabinet Member for Adult Social Care and Health
Councillor Alex Sanderson – Deputy Leader (with responsibility for Children and Education)
Dr James Cavanagh – H&F GP
Carleen Duffy – Healthwatch H&F
Caroline Farrar - HCP Managing Director
Dr Nicola Lang – Director of Public Health
Katharine Willmette – Interim Director of Adult Social Care
Jacqui McShannon – Executive Director of People’s Services
Sarah Bright - Director of People’s Commissioning, Transformation and Partnerships
Susan Roostan – H&F ICB Borough Director
Sue Spiller – Chief Executive Officer, SOBUS
Detective Chief Inspector Mark Staples – Metropolitan Police

Nominated Deputy Members

Councillor Natalia Perez – Chair of Health and Adult Social Care Policy and Accountability Committee
Councillor Helen Rowbottom – Chair of Children and Education Policy and Accountability Committee
Nadia Taylor – Healthwatch, H&F

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Members of the public and press are welcome, but spaces are limited so please contact David.Abbott@lbhf.gov.uk if you’d like to attend. The building has disabled access.

Health & Wellbeing Board Agenda

<u>Item</u>		<u>Pages</u>
1.	APOLOGIES FOR ABSENCE	
2.	DECLARATIONS OF INTEREST <p>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.</p> <p>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.</p> <p>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.</p> <p>Members are not obliged to withdraw from the meeting where a dispensation to that effect has been obtained from the Standards Committee.</p>	
3.	MINUTES AND ACTIONS <p>To approve the minutes of the previous meeting as an accurate record and note any outstanding actions.</p>	4 - 10
4.	BETTER CARE FUND QUARTER 2 REPORT 2024-2025 <p>This Better Care Fund paper sets out the London Borough of Hammersmith & Fulham and the H&F Integrated Care Board quarter 2 report.</p>	11 - 30
5.	OVERARCHING PARTNERSHIP PLAN 2025-26 <p>This item from the Hammersmith & Fulham Health and Care Partnership presents their overarching partnership plan for 2025-26.</p>	31 - 46

6. WORK PROGRAMME

To discuss the Board's work programme and suggest items for future meetings.

7. DATES OF FUTURE MEETINGS

To note the following dates of future meetings:

- 19 March 2025

Agenda Item 3

London Borough of Hammersmith & Fulham
Health & Wellbeing Board
Minutes



Wednesday 11 September 2024

PRESENT

Members

Councillor Alex Sanderson (Deputy Leader with responsibility for Children and Education)

Dr Nicola Lang (Director of Public Health)

Katharine Willmette (Director of Adult Social Care)

Jacqui McShannon (Executive Director of People's Services)

Sarah Bright (Director of People's Commissioning, Transformation and Partnerships)

Susan Roostan (H&F ICB Borough Director)

Sue Spiller (Chief Executive Officer, SOBUS)

Nominated Deputy Members

Councillor Natalia Perez (Chair of Health and Adult Social Care Policy and Accountability Committee)

Councillor Helen Rowbottom (Chair of Children and Education Policy and Accountability Committee)

Nadia Taylor (Healthwatch, H&F)

Guests, officers and other attendees

Chloe Howcroft (Healthwatch)

Ruchi Wadhwa (Healthwatch)

Julius Olu (Assistant Director, Commissioning and Partnerships)

Prakash Daryanani (Head of Finance, Social Care & Public Health)

David Abbott (Head of Governance)

NOTE: Councillor Alex Sanderson took the Chair for this meeting as she was covering the role of Cabinet Member for Adult Social Care and Health while Councillor Bora Kwon was on medical leave.

1. MEMBERSHIP CHANGES 2024/25

RESOLVED

1. That the Health & Wellbeing Board noted the following membership changes for the 2024/25 municipal year:
 - Replace Councillor Ben Coleman with Councillor Bora Kwon

- Replace Philippa Johnson with Caroline Farrar (HCP Managing Director)
- Replace Linda Jackson with Katharine Willmette (Director of Adult Social Care)

2. That the Health & Wellbeing Board agreed the following addition to its membership:

- Sarah Bright, Director of People’s Commissioning, Transformation and Partnerships as a non-voting member

2. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Bora Kwon, Caroline Farrar, and Detective Chief Inspector Mark Staples.

Apologies for lateness were received from Councillor Rowbottom (who entered the meeting at 6.58pm).

3. DECLARATIONS OF INTEREST

There were no declarations of interest.

4. MINUTES AND ACTIONS

RESOLVED

That the minutes of the meeting held on 12 March 2024 were agreed as an accurate record.

5. HEALTH AND WELLBEING STRATEGY 2024-2029

Dr Nicola Lang (Director of Public Health) presented the Health and Wellbeing Strategy 2024-2029 for approval. Dr Lang explained that producing a Health and Wellbeing Strategy was a key function of the Director of Public Health and a statutory duty for the local authority. She talked about the work undertaken to ensure the strategy was informed by the latest data and residents – including oversampling groups that didn’t normally have a voice like new immigrant communities.

Dr Lang highlighted the Strategy’s four priorities:

- Address key health issues innovatively and proactively so that people stay as healthy as possible for as long as possible
- Amplify community strengths and capabilities to tackle health inequities
- Cultivate the conditions necessary for people to flourish and build their resilience
- Eliminate the barriers to information and mitigate misinformation

Councillor Alex Sanderson thanked Dr Lang and commended the strategy.

Councillor Natalia Perez thanked officers for the report. She then asked if officers were satisfied by the level of community engagement achieved, or if there were areas to improve on. Dr Lang said the work done for the Strategy was the start of a continuous process of engagement and listening to communities across the borough. She gave the example of two recent awards of NHS inequalities funding of £30,000 for conversations with Muslim groups to lead their own work around awareness of immunisations and cancer screening and £10,000 for gym memberships for care experienced children.

Councillor Perez asked if children's mental health was a priority, particularly the negative impact of social media. Dr Lang said it was a key issue and Public Health worked closely with colleagues in Education on this issue. Jacqui McShannon noted that this was one of the advantages of a unified People's department that combined Children's Services, Adult Social Care, and Public Health. Councillor Sanderson noted that Fulham Boys School had recently banned smart phones for younger pupils and was interested to see the impact.

Sue Spiller praised the Strategy and asked if thought had been given to how to publicise the strategy and reach the people that needed it. Dr Lang said that the department had learned a lot about engaging different communities during the Covid-19 pandemic. For example, some groups preferred to receive messages via WhatsApp rather than Facebook or other platforms. The team were also trying new things such as producing a video on the MMR (measles, mumps and rubella) vaccine in various community languages that was directly shared with mothers. They listened to groups and tried to do what they said was most effective.

Councillor Sanderson asked what the next steps were for the Strategy. Dr Lang explained that once it had been agreed, it would be published, then work would continue on the priority areas.

Councillor Perez asked about the timeline for reviewing priorities and if emerging needs could be incorporated. Dr Lang said the team would come back to report on progress against the action plan annually. She ensured the Board that emerging issues could be incorporated in-year.

RESOLVED

1. That the Health & Wellbeing Board approved the Health and Wellbeing Strategy 2024-2029.

6. SOCIAL CARE POSITION STATEMENT AND CQC UPDATE (VERBAL UPDATE)

Katharine Willmette (Director of Adult Social Care) provided a verbal update on the Social Care Position Statement and Care Quality Commission (CQC) inspection.

Katherine Willmette gave a summary of changes in Adult Social Care over the past few months and noted that following a corporate reorganisation, Adult Social Care and Public Health had joined with Children's Services to form the new People department led by Jacqui McShannon. This new department had a unified leadership team with shared governance arrangements and enabled closer working around key areas such as special educational needs and disabilities (SEND).

The department's top priority in the short term was the upcoming CQC inspection of Adult Social Care. She explained that it was a new inspection process that had only been running since December 2023. The inspection covered all Adult Social Care teams. The inspection was in two parts - the first was a self-assessment and information gathering which started in May, then a site visit which had been scheduled for 21 October. The inspectors would meet with frontline staff, residents, carers, and partners including the NHS and the voluntary sector. It was a comprehensive process that would result in an Ofsted-style grade of outstanding, good, requires improvement etc. She added that the CQC process was new and evolving, and so each local authority had a slightly different experience – so it was harder to prepare for. There was a lot of work involved but staff were reasonably confident.

Nadia Taylor asked if the Council had a say in which partners the inspectors spoke to. Katherine Wilmette said the inspectors decided who to speak to.

Nadia Taylor asked how confident officers were going into the inspection. Katherine Wilmette said staff were confident, but it was new for many of them. Jacqui McShannon noted that inspections always provided useful insights and direction.

Sue Spiller asked if the self-assessment had highlighted any areas that required further work. Katherine Wilmette said their focus was ensuring that learning from partners and internally was embedded in all areas of their work. She gave the example of the co-production strategy and the importance of ensuring that it feed through to frontline staff. She also noted the importance of working with partners to build on existing positive relationships.

Sue Spiller noted that the Council used to have an internal quality assurance team and worried that with the turnover of staff in recent years she worried that some of that learning would be lost. She also said it was important to keep external partners updated with changes to systems and processes. Katherine Wilmette agreed that staff turnover meant the department had to work harder to retain learning. She

added that there was still a quality assurance team, and they were a key part of ensuring teams responded to feedback and learning.

Councillor Alex Sanderson said she had been reading several CQC reports in preparation for the inspection and noted there was volatility in the grades given, despite similar write-ups. She said there was a lot of brilliant work happening in the borough and hoped that was recognised in the inspection but was conscious that it was a new regime still finding its feet.

7. BETTER CARE FUND PLAN 2024 - 2025 AND QUARTER 1 REPORT 2024 - 2025

Julius Olu (Assistant Director for Independent Living, Commissioning & Partnerships) presented the paper which set out the Council and the H&F Integrated Care Board's proposed plan for 2024 – 2025 and the BCF quarter 1 report which were submitted to NHS England on 5 July 2024 and 29 August 2024 respectively. He explained that the Better Care Fund supported community health and social care resources to reduce the number of people who needed to be admitted to hospital. Residents that did require admission to hospital were supported to get home as soon as they are well. He added that the plan had been signed off by Chair's action in June and had come to the Board to be ratified.

Councillor Rowbottom noted that at the Board meeting on 20 September 2023, there had been a discussion¹ about the discrepancy between delayed transfers of care statistics from the Council and the NHS and asked if this had been resolved. Sue Roostan said they had regular escalation meetings with Imperial College Healthcare NHS Trust but noted that there could be discrepancies due to differences in data collection. She said she could share information on this with Board members.

ACTION: Sue Roostan

Councillor Natalia Perez asked if there were any areas of concern at this stage of the reporting. Julius Olu said there were no areas of concern at present.

Councillor Rowbottom asked if there had been any negative impacts from the reduced capacity of the Police to issue section 136 orders. Katherine Willmette said it was her understanding that the impact had been mostly felt by the NHS. She clarified that the issue was that the Police were not attending sectioning and welfare visits unless there was an immediate risk to a person. She said more work was needed to understand the impact. Councillor Perez asked to look at this issue in more detail at the Health and Adult Social Care Policy and Accountability Committee meeting in November.

¹ Health and Wellbeing Board minutes from 20 September 2023, Better Care Fund 2023/25, paragraph 10 onwards: <https://democracy.lbhf.gov.uk/mgAi.aspx?ID=69283>

ACTION: Katherine Wilmette

Sue Spiller asked if it was possible to flex money to support additional capacity in high pressure areas. Sue Roostan said funding was usually allocated for specific purposes and was difficult to move in-year.

RESOLVED

1. That the Health & Wellbeing Board, ratified the planned total expenditure and the proposed schemes in the plan for 2024-2025 (Appendix 1).
2. That the Health and Wellbeing Board ratified the BCF quarter 1 report for 2024- 2025 (Appendix 2).
3. That the Health and Wellbeing Board receive an end of year report outlining the outcomes of each scheme and the difference it has made for residents of H&F.

8. ICB UPDATE (VERBAL)

Susan Roostan (H&F ICB Borough Director) provided a verbal update on the work of the Integrated Care Board (ICB). She noted that the ICB covered eight London boroughs: Brent, Ealing, Hammersmith & Fulham, Hillingdon, Harrow, Kensington & Chelsea, and Westminster. NHS North West London had a budget of £6 billion serving 2.1 million residents. Their goal was to help local people live healthier lives, improve the quality of healthcare, tackle inequalities and make sure the NHS makes best use of resources.

Susan Roostan discussed the ICBs new organisation structure, ways of working, and values of inclusivity, respect, innovation, and empowerment. She also highlighted the Joint Forward Plan and its nine priorities for the next five years:

- Reduce inequalities and improve health outcomes through population health management
- Improve children and young people's mental health and community care
- Establish Integrated Neighbourhood Teams (INTs) with general practice at their heart
- Improve mental health services in the community and for people in crisis
- Embed access to a consistent, high quality set of community services by maximising productivity
- Optimise ease of movement for patients across the system throughout their care – right care, right place
- Transform maternity care
- Increase cancer detection rates and deliver faster access to treatment

- Transform the way planned care works

Jacqui McShannon thanked Susan Roostan for the update and added that the Council had also undertaken a restructure, with a new People department that comprised Children’s Services, Adult Social Care, and Public Health. A new post had been created – Director of People’s Commissioning, Transformation and Partnerships – to give more capacity to work with health partners in a responsive and flexible way. Jacqui McShannon then reiterated the Council’s commitment to work in partnership with the ICB for the benefit of the borough’s residents.

9. WORK PROGRAMME

Members made the following suggestions for the work programme:

- Update on vaccines
- Review of suicide prevention (following commissioning in 2025)
- A regular Healthwatch update at future meetings
- Community mental health services – including capacity, what support is available, engagement and access for different communities

10. DATES OF FUTURE MEETINGS

The following dates of future meetings were noted:

- 11 December 2024
- 19 March 2025

Meeting started: 6.30 pm
Meeting ended: 7.47 pm

Chair

Contact officer: David Abbott
Governance and Scrutiny
Tel: 07776 672877
Email: David.Abbott@lbhf.gov.uk

Report to: Health and Wellbeing Board

Date: 11 December 2024

Subject: Better Care Fund (BCF) Quarter 2 report 2024-2025

Report author: Julius Olu, Assistant, Director for Independent Living, Commissioning & Partnerships, Peoples Services, H&F

Responsible Director: Katharine Willmette, Director Adult Social Care (DASS) & Sue Roostan, Borough Director, H&F ICB

SUMMARY

This Better Care Fund (BCF) paper sets out the London Borough of Hammersmith & Fulham (H&F) and the H&F Integrated Care Board (ICB)'s quarter 2 report. The report was submitted to NHS England on 31 October 2024, which was the deadline for submission.

NHS England requires the BCF plan and quarterly reports to be approved by the Health and Wellbeing Board (HWB) or the board's Chair on behalf of the HWB where submission deadlines do not align with the sitting of the board. Where NHS England submissions precede the sitting of the board, HWB Chair's approvals will need to be ratified at the next HWB.

RECOMMENDATIONS

1. That the Health and Wellbeing Board ratifies the BCF quarter 2 report for 2024 - 2025 (Appendix 1).
 2. That the Cabinet Member for Adult Social Care and Health receive an end of year report outlining the outcomes of each scheme and the difference it has made for residents of H&F.
-

Wards Affected: All

Our Values	Summary of how this report aligns to the H&F Values
Creating a compassionate council	The Better Care Fund supports community health and social care resources to reduce the number of people who need to be admitted to hospital and supporting people to get home as soon as they are well.

Background Papers Used in Preparing This Report

None.

EXECUTIVE SUMMARY

1. In accordance with the statutory duties and powers given to the Health and Wellbeing Board (HWB) by the Health and Social Care Act 2012, the Board's Terms of Reference in Hammersmith & Fulham Council's constitution include overseeing the development and use of the Better Care Fund (BCF) by the Council and the H&F Integrated Care System (ICS).
2. For clarity, the Better Care Fund supports community health and social care resources to reduce the number of people who need to be admitted to hospital. Residents that do require admission to hospital are supported to get home as soon as they are well.
3. The H&F BCF quarter 2 report details the following:
 - Planned and actual expenditure to date
 - Planned and actual outputs delivered to date
4. Where activity levels are low for the time of year when compared against the planned target the responsible officer provides justification within the report. At the moment three of the four BCF metrics are not on track to meet target as follows:
 - *Avoidable admissions* (Unplanned hospitalisation for chronic ambulatory care sensitive conditions) - NHS metric – Data is currently unavailable to assess progress due to suspected issues with the National BCF Data, which appears abnormally low for this measure. The ICB Business Intelligence team is collaborating with the National Team to investigate the issue and develop a solution for setting future plans and monitoring progress.
 - *Discharge to normal place of residence* (Percentage of people who are discharged from acute hospital to their normal place of residence) - NHS metric – On track to meet target.
 - *Falls* (Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000) - NHS metric – Data is currently unavailable to assess progress due to suspected issues with the National BCF Data, which appears abnormally low for this measure. The ICB Business Intelligence team is collaborating with the National Team to investigate the issue and develop a solution for setting future plans and monitoring progress.
 - *Residential admissions* (Rate of permanent admissions to residential care per 100,000 population (65+)) – Local authority metric – Not on track to meet target.

Our rise in numbers of residential placement is due largely to increase in level of resident need as they are being discharged from hospital. The BCF through discharge funding is helping to manage this as it is enabling a focus on strengthening our bridging services as we work on its utilisation, model standardisation, and further embedding of the model to help reduce delays for pathway 1 patients. Our extra care stepdown facility "Minterne Lifestyle beds" is operating at full capacity and we are working at better understanding how to improve the residents move on through the discharge pathway so we maximise its use. We are also meeting with extra care, learning disabilities and mental health supported living providers to discuss innovative ways to ensure we increase admission into extra care settings from their specialist supported living services.

5. The BCF quarter 2 report submission deadline date set by NHS England was 31 October 2024. The Chair of the H&F HWB Board approved the final version of the BCF quarter 2 report before officers submitted it to NHS England on 28 October 2024.
6. The HWB is asked to ratify the BCF quarter 2 submission 2024 - 2025 which is enclosed with this paper.

HWB BCF requirements

7. The HWB is required to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2024-25 continue to be met through the delivery of joint BCF plan¹
8. The four national conditions are as follows:
 - National condition 1: Plans to be jointly agreed – This continues to be met.
 - National condition 2: Implementing BCF Policy Objective 1: *Enabling people to stay well, safe and independent at home for longer* – This continues to be met as the H&F BCF planning template 2024 - 2025 comprises a list of relevant BCF funded services that were jointly agreed by all partners and signed off through the HWB Chair's action on the H&F HWB on 5 July 2024. The enclosed quarter 1 submission template also detail planned versus delivered outputs to date for the BCF funded services.
 - National condition 3: Implementing BCF Policy Objective 2: *Providing the right care in the right place at the right time* – This continues to be met as the H&F BCF planning template 2024 - 2025 comprises a list of relevant BCF funded services that were jointly agreed by all partners and signed off through the HWB Chair's action on the H&F HWB on 5 July 2024. The enclosed quarter 1 submission template also detail planned versus delivered outputs to date for the BCF funded services.

¹ [Better Care Fund planning](#)

- National condition 4: *Maintaining NHS contribution to adult social care and investment in NHS commissioned out of hospital services.* – This continues to be met as the H&F BCF planning template 2024 - 2025 comprises a list of relevant BCF funded services that were jointly agreed by all partners and signed off through the HWB Chair's action on the H&F HWB on 5 July 2024. The enclosed quarter 1 submission template also detail planned versus delivered outputs to date for the BCF funded services showing the NHS contribution to adult social care and NHS commissioned out of hospital services.

9. The key purposes of BCF reporting are as follows:

- To confirm the status of continued compliance against the requirements of the fund (BCF)
- In Quarter 2 to refresh capacity and demand plans, and in Quarter 3 to confirm activity to date, where BCF funded schemes include output estimates, and at the End of Year actual income and expenditure in BCF plans
- To provide information from local areas on challenges, achievements and support needs in progressing the delivery of BCF plans, including performance metrics
- To enable the use of this information for national partners to inform future direction and for local areas to inform improvements

List of Appendices

Appendix 1 - Quarter 2 submission 2024 – 2025

Better Care Fund 2024-25 Q2 Reporting Template

1. Guidance

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2023-25, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Ministry for Housing, Communities and Local Government (MHCLG), NHS England (NHSE). Please also refer to the Addendum to the 2023 to 2025 Better Care Fund policy framework and planning requirements which was published in April 2024. Links to all policy and planning documents can be found on the bottom of this guidance page.

As outlined within the BCF Addendum, quarterly BCF reporting will continue in 2024 to 2025, with areas required to set out progress on delivering their plans. This will include the collection of spend and activity data, including for the Discharge Fund, which will be reviewed alongside other local performance data. The primary purpose of BCF reporting is to ensure a clear and accurate account of continued compliance with the key requirements and conditions of the fund, including the Discharge Fund. The secondary purpose is to inform policy making, the national support offer and local practice sharing by providing a fuller insight from narrative feedback on local progress, challenges and highlights on the implementation of BCF plans and progress on wider integration.

BCF reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including ICB's, local authorities and service providers) for the purposes noted above.

In addition to reporting, BCMs and the wider BCF team will monitor continued compliance against the national conditions and metric ambitions through their wider interactions with local areas.

BCF reports submitted by local areas are required to be signed off by HWBs, or through a formal delegation to officials, as the accountable governance body for the BCF locally. Aggregated reporting information will be published on the NHS England website.

Note on entering information into this template

Please do not copy and paste into the template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.

The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

Please DO NOT directly copy/cut & paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy & paste', please use the 'Paste Special' operation and paste Values only.

The details of each sheet within the template are outlined below.

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'
3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric ambitions and capacity and demand from your BCF plans for 2023-24 will prepopulate in the relevant worksheets.
2. HWB sign off will be subject to your own governance arrangements which may include a delegated authority.
3. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to:
england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)
4. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2023-25 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.

This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met for the year and how this is being addressed. Please note that where a National Condition is not being met, an outline of the challenge and mitigating actions to support recovery should be outlined. It is recommended that the HWB also discussed this with their Regional Better Care Manager.

In summary, the four national conditions are as below:

National condition 1: Plans to be jointly agreed

National condition 2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer

National condition 3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time

National condition 4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services

4. Metrics

The BCF plan includes the following metrics:

- Unplanned hospitalisations for chronic ambulatory care sensitive conditions,
- Proportion of hospital discharges to a person's usual place of residence,
- Admissions to long term residential or nursing care for people over 65,
- Emergency hospital admissions for people over 65 following a fall.

Plans for these metrics were agreed as part of the BCF planning process outlined within 24/25 planning submissions.

This section captures a confidence assessment on achieving the locally set ambitions for each of the BCF metrics.

A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and successes in the first six months of the financial year.

Data from the Secondary Uses Service (SUS) dataset on outcomes for the discharge to usual place of residence, falls, and avoidable admissions for the first quarter of 2024-25 has been pre populated, along with ambitions for quarters 1-4, to assist systems in understanding performance at local authority level.

The metrics worksheet seeks a best estimate of confidence on progress against the achievement of BCF metric ambitions. The options are:

- on track to meet the ambition
- Not on track to meet the ambition
- data not available to assess progress

You should also include narratives for each metric on challenges and support needs, as well as achievements. Please note columns M and N only apply where 'not on track' is selected.

- In making the confidence assessment on progress, please utilise the available metric data along with any available proxy data.

Please note that the metrics themselves will be referenced (and reported as required) as per the standard national published datasets.

5. Capacity & Demand Actual Activity

Please note this section asks for C&D and actual activity for total intermediate care and not just capacity funded by the BCF.

Activity

'For reporting across 24/25 we are asking HWB's to complete their actual activity for the previous quarter. Actual activity is defined as capacity delivered.

For hospital discharge and community, this is found on sheet "5.2 C&D H1 Actual Activity".

5.1 C&D Guidance & Assumptions

Contains guidance notes as well as 4 questions seeking to address the assumptions used in the calculations, changes in the first 6 months of the year, and any support needs particularly for winter and ongoing data issues.

5.2 C&D H1 Actual Activity

Please provide actual activity figures for April - September 24, these include reporting on your spot purchased activity and also actuals on time to treat for each service/pathway within Hospital Discharge. Actual activity for community referrals are required in the table below.

Actual activity is defined as delivered capacity or demand that is met by available capacity. Please note that this applies to all commissioned services not just those funded by the BCF.

Expenditure

Please use this section to complete a summary of expenditure which includes all previous entered schemes from the plan.

The reporting template has been updated to allow for tracking spend over time, providing a summary of expenditure to date alongside percentage spend of total allocation.

Overspend - Where there is an indicated overspend please ensure that you have reviewed expenditure and ensured that a) spend is in line with grant conditions b) where funding source is grant funding that spend cannot go beyond spending 100% of the total allocation.

Underspend - Where grant funding is a source and scheme spend continues you will need to create a new line and allocate this to the appropriate funding line within your wider BCF allocation.

Please also note that Discharge Fund grant funding conditions do not allow for underspend and this will need to be fully accounted for within 24/25 financial year.

For guidance on completing the expenditure section on 23-25 revised scheme type please refer to the expenditure guidance on 6a.

Planning requirements

<https://www.england.nhs.uk/wp-content/uploads/2023/04/PRN00315-better-care-fund-planning-requirements-2023-25.pdf>

Policy Framework

<https://www.gov.uk/government/publications/better-care-fund-policy-framework-2023-to-2025/2023-to-2025-better-care-fund-policy-framework>

Addendum

<https://www.gov.uk/government/publications/better-care-fund-policy-framework-2023-to-2025/addendum-to-the-2023-to-2025-better-care-fund-policy-framework-and-planning-requirements>

Better Care Exchange

<https://future.nhs.uk/system/login?nextURL=%2Fconnect%2Eti%2Fbettercareexchange%2FgroupHome>

Data pack

<https://future.nhs.uk/bettercareexchange/view?objectId=116035109>

Metrics dashboard

<https://future.nhs.uk/bettercareexchange/view?objectId=51608880>



HM Government



Better Care Fund 2024-25 Q2 Reporting Template

2. Cover

Version 3.0

Please Note:

- The BCF quarterly reports are categorised as 'Management Information' and data from them will be published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

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Health and Wellbeing Board:	Hammersmith and Fulham	
Completed by:	Julius Olu, Rashesh Mehta, Chakshu Sharma	
E-mail:	Julius.Olu@lbhf.gov.uk ; rasheshmehta@nhs.net ; Chakshu.sharma@nhs.net	
Contact number:	07887 524 892, 07507637721	
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No	
If no, please indicate when the report is expected to be signed off:	Mon 28/10/2024	<< Please enter using the format, DD/MM/YYYY

Checklist

Complete:

Yes
Yes
Yes
Yes
Yes
Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. This does not apply to the ASC

Please see the Checklist on each sheet for further details on incomplete fields

	Complete:	
2. Cover	Yes	For further guidance on requirements please refer back to guidance sheet - tab 1.
3. National Conditions	Yes	
4. Metrics	No	
5.1 C&D Guidance & Assumptions	Yes	
5.2 C&D H1 Actual Activity	Yes	
6. Expenditure	Yes	

[<< Link to the Guidance sheet](#)

^^ Link back to top

Better Care Fund 2024-25 Q2 Reporting Template

3. National Conditions

Selected Health and Wellbeing Board:

Hammersmith and Fulham

Has the section 75 agreement for your BCF plan been finalised and signed off?	Yes	
If it has not been signed off, please provide the date section 75 agreement expected to be signed off		
If a section 75 agreement has not been agreed please outline outstanding actions in agreeing this.		
Confirmation of Nation Conditions		
National Condition	Confirmation	met in the quarter and mitigating actions underway to support compliance with the condition:
1) Jointly agreed plan	Yes	
2) Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	Yes	
3) Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	Yes	
4) Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	Yes	

Checklist

Complete:

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Better Care Fund 2024-25 Q2 Reporting Template

4. Metrics

Selected Health and Wellbeing Board:

Hammersmith and Fulham

National data may be unavailable at the time of reporting. As such, please utilise data that may only be available system-wide and other local intelligence.

Metric	Definition	For information - Your planned performance as reported in 2024-25 planning				For information - actual performance for Q1	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs <i>Please:</i> - describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans - ensure that if you have selected data not available to assess progress that this is addressed in this section of your plan	Achievements - including where BCF funding is supporting improvements. <i>Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics</i>	Variance from plan <i>Please ensure that this section is completed where you have indicated that this metric is not on track to meet target outlining the reason for variance from plan</i>	Mitigation for recovery <i>Please ensure that this section is completed where:</i> a) Data is not available to assess progress b) Not on track to meet target with actions to recovery position against plan	
		Q1	Q2	Q3	Q4							
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3)	60.3	43.3	58.2	51.1	49.2	Data not available to assess progress	In the Avoidable Admission Indicator data published by the National BCF team the indicator value drops dramatically during 23/24 with these extremely low figures continuing into 24/25. So there appears to be significant data quality issues and therefore this data cannot be currently used to compare to the 24/25 plan to monitor performance.	x	x	In H&F locally there are a range of schemes/initiatives in place ensuring patients are not admitted to acute settings unnecessarily including: - HCP Diabetes workstream across primary, community and secondary care for timely monitoring, management and prevention of complications. - Flu vaccination promotion programmes to increase uptake and thereby reduce complications in people with chronic cardio-respiratory conditions. - HCP frailty workstream with focus on frailty pathway to better support frail adults with chronic conditions in the community.	
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	96.7%	96.7%	95.7%	97.0%	94.98%	On track to meet target	We are on track to meet this target by year-end. However, we are facing some challenges, including an increase in patient acuity, which is causing delays. This requires additional assessments to determine if patients are suitable for discharge to their usual place of residence	A programme of work is in place to improve discharge and the flow out of acute hospitals. This includes discharge funding to support a bridging service and better joint working between health and social care. The implementation of the bridging (bridging to home service) has significantly reduced delays in Pathway 1 and facilitated more patients to return home within 12 hours of being discharge ready. This improvement boosted performance in discharging patients to their usual place of residence, particularly for Pathway 1 cases. This also effectively mitigated the necessity for long-term care in residential/nursing settings. In essence, it has ensured that patients are discharged to usual place of residence, averting the escalation of their care needs. We are also continuing a focus as a sector on improving our discharge levels and are implementing measures to improve flow by local and sector partnership working and internal improvements within trusts and our integrated care hubs. The local schemes/initiatives supporting this metric are: - Early discharge planning - Home first - Enhanced support and training for care homes - Multi-agency focus on discharge home from hospital - Multi agency input for reablement and managing people at home	x	x	
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				2,294.0	38.5	Data not available to assess progress	Falls Actual Performance YTD data for 24/25 published by the National BCF team appears to not be comparable to the Public Health Outcomes Framework - Data used to set the 24/25 plan. The data published by the National BCF team for 24/25 is so much lower than the data used to set the 24/25 plan that it is felt it cannot be used even to reliably look at the trend of the falls data to make an estimation on the Q2 performance.	Falls prevention service in place along with a VCSE service providing a 52 week falls prevention programme.	x	x	In H&F this service provides assessment, advice, exercise and strength and balance groups for older people who are at risk of falling. The service aims to prevent falls and unnecessary admission to hospital by seeing a patient before an injurious fall occurs or after a fall to rebuild strength, balance and confidence. This assessment will identify falls risk factors and rehabilitation needs. Individuals are then invited to join an 8-week physical activity programme to improve strength and balance and increase awareness of falls risk factors.
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)				308	not applicable	Not on track to meet target	Target 309.5 (62 people) Q1 actual = 139.8 (28 people) Q2 actual = 209.6 (42 people)	Our rise in numbers of residential placement is due largely to increase in level of resident need as they are being discharged from hospital. BCF through discharge funding is helping as it is enabling us to focus on strengthening our bridging services as we work on its utilisation, model standardisation, and further embedding of the model to help reduce delays for pathway 1 patients. In addition this will ensure more patients get access to timely care at home which reduces the risk of deterioration due to unnecessary hospital stays and that more patients have the opportunity to recover at home as the most appropriate support for their on-going care will be identified through an assessment at home. Where possible most people should continue to live in their own home with the clinical wraparound they need and the social care support. Only when this is not possible, should nursing and residential care be offered. Our stepdown extracare facility "Mintene Lifestyle beds" is operating at full capacity and we are working at better understanding how to improve the residents move on and ensuring that appropriate multi-disciplinary wraparound support is effectively supporting discharge from hospital. We are also meeting with extra care, learning disabilities and mental health supported living providers to discuss innovative ways to ensure we increase admission into extra care settings from the specialist supported living services.	x	x	

Complete:

Yes

Yes

Yes

Yes

Better Care Fund 2024-25 Q2 Reporting Template

5. Capacity & Demand

Selected Health and Wellbeing Board:

Hammersmith and Fulham

Actual activity - Hospital Discharge		Prepopulated demand from 2024-25 plan						Actual activity (not including spot purchased capacity)						Actual activity through <u>only</u> spot purchasing (doesn't apply to time to service)					
Service Area	Metric	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Reablement & Rehabilitation at home (pathway 1)	Monthly activity. Number of new clients	51	57	54	57	57	56	35	42	34	41	32	45	0	0	0	0	0	0
Reablement & Rehabilitation at home (pathway 1)	Actual average time from referral to commencement of service (days). All packages (planned and spot purchased)	2	2	2	2	2	2	2	2	2	2	2	2						
Short term domiciliary care (pathway 1)	Monthly activity. Number of new clients	32	37	36	37	37	36	32	37	36	37	37	36	11	13	12	13	13	12
Short term domiciliary care (pathway 1)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	1	1	1	1	1	1	1	1	1	1	1	1						
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly activity. Number of new clients	26	30	29	30	30	29	25	17	18	12	18	8	0	0	0	0	0	0
Reablement & Rehabilitation in a bedded setting (pathway 2)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	2	2	2	2	2	2	3.6	3.2	2.9	2.7	3.1	3.1						
Other short term bedded care (pathway 2)	Monthly activity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other short term bedded care (pathway 2)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	0	0	0	0	0	0	0	0	0	0	0	0						
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly activity. Number of new clients	27	32	31	32	32	31	19	8	10	6	12	7	0	0	0	0	0	0
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	10	10	10	10	10	10	10	10	10	10	10	10						

Actual activity - Community		Prepopulated demand from 2024-25 plan						Actual activity:					
Service Area	Metric	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Social support (including VCS)	Monthly activity. Number of new clients.	66	72	60	41	46	79	16	23	15	22	24	34
Urgent Community Response	Monthly activity. Number of new clients.	89	89	90	91	92	89	98	89	94	107	98	97
Reablement & Rehabilitation at home	Monthly activity. Number of new clients.	40	31	13	44	36	41	4	11	10	8	8	6
Reablement & Rehabilitation in a bedded setting	Monthly activity. Number of new clients.	0	0	0	0	0	0	10	8	14	4	7	8
Other short-term social care	Monthly activity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0

Checklist

Complete:

- Yes
- Yes
- Yes
- Yes
- Yes
- Yes
- Yes
- Yes
- Yes
- Yes

Further guidance for completing Expenditure sheet

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:

- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:

- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	<ol style="list-style-type: none"> 1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other 	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	<ol style="list-style-type: none"> 1. Independent Mental Health Advocacy 2. Safeguarding 3. Other 	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	<ol style="list-style-type: none"> 1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other 	<p>Supporting people to sustain their role as carers and reduce the likelihood of crisis.</p> <p>This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.</p>
4	Community Based Schemes	<ol style="list-style-type: none"> 1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other 	<p>Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams)</p> <p>Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'</p>
5	DFG Related Schemes	<ol style="list-style-type: none"> 1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other 	<p>The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes.</p> <p>The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate</p>

6	Enablers for Integration	<ol style="list-style-type: none"> 1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other 	<p>Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes.</p> <p>Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.</p>
7	High Impact Change Model for Managing Transfer of Care	<ol style="list-style-type: none"> 1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other 	<p>The ten changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.</p>
8	Home Care or Domiciliary Care	<ol style="list-style-type: none"> 1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other 	<p>A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.</p>
9	Housing Related Schemes		<p>This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.</p>

10	Integrated Care Planning and Navigation	<ol style="list-style-type: none"> 1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other 	<p>Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals.</p> <p>Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams.</p> <p>Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.</p>
11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	<ol style="list-style-type: none"> 1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other 	<p>Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.</p>
12	Home-based intermediate care services	<ol style="list-style-type: none"> 1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other 	<p>Provides support in your own home to improve your confidence and ability to live as independently as possible</p>
13	Urgent Community Response		<p>Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.</p>
14	Personalised Budgeting and Commissioning		<p>Various person centred approaches to commissioning and budgeting, including direct payments.</p>

15	Personalised Care at Home	<ol style="list-style-type: none"> 1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other 	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
16	Prevention / Early Intervention	<ol style="list-style-type: none"> 1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other 	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
17	Residential Placements	<ol style="list-style-type: none"> 1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other 	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Workforce recruitment and retention	<ol style="list-style-type: none"> 1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other 	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme descriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care or Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed based intermediate Care Services	Number of placements
Home-based intermediate care services	Packages
Residential Placements	Number of beds
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

See next sheet for Scheme Type (and Sub Type) descriptions

Better Care Fund 2024-25 Q2 Reporting Template

To Add New Schemes

6. Expenditure

Selected Health and Wellbeing Board:

		2024-25			
Running Balances		Income	Expenditure to date	Percentage spent	Balance
DFG		£1,631,323	£372,000	22.80%	£1,259,323
Minimum NHS Contribution		£18,135,401	£9,067,700	50.00%	£9,067,701
iBCF		£10,027,236	£5,013,618	50.00%	£5,013,618
Additional LA Contribution		£7,518,282	£3,628,479	48.26%	£3,889,803
Additional NHS Contribution		£4,421,746	£2,210,873	50.00%	£2,210,873
Local Authority Discharge Funding		£2,343,005	£1,184,072	50.54%	£1,158,933
ICB Discharge Funding		£1,584,046	£523,262	33.03%	£1,060,784
Total		£45,661,039	£22,000,004	48.18%	£23,661,035

<< Link to summary sheet

Comments if income changed

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

		2024-25		
	Minimum Required Spend	Expenditure to date	Balance	
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£5,153,567	£5,134,072		£19,495
Adult Social Care services spend from the minimum ICB allocations	£7,867,257	£3,933,629		£3,933,628

Checklist	Column complete:	Yes	Yes

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Planned Outputs for 2024-25	Outputs delivered to date (Number or NA if no plan)	Units	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Previously entered Expenditure for 2024-25 (£)	Expenditure to date (£)	Comments
001	NHS Community Service - Anticipatory Care	Anticipatory care planning and delivery	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care		0	N/A		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£416,796	£208,398	Note activity (Outputs) not in plan
002	Community Independence Service - Health Element (ICB)	Community Independence Service - Health Element	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care		0	N/A		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£3,694,066	£1,847,033	Note activity (Outputs) not in plan
003	Community Neuro	Community Neuro	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care		0	N/A		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£923,373	£461,687	Note activity (Outputs) not in plan
004	Falls Prevention	Community based Falls Prevention service	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care		0	N/A		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£220,650	£110,325	Note activity (Outputs) not in plan
005	Original 256 (Stroke Pathway & Open Age)	Original 256 (Stroke Pathway & Open Age)	Integrated Care Planning and Navigation	Care navigation and planning		0	N/A		Community Health		NHS			Private Sector	Minimum NHS Contribution	£47,956	£23,978	Note activity (Outputs) not in plan
006	NHS Community Service - Ageing Well Rapid	Ageing Well Rapid Response	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care		0	N/A		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£361,709	£180,855	Note activity (Outputs) not in plan
007	Red Cross	Red Cross	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning		0	N/A		Community Health		NHS			Private Sector	Minimum NHS Contribution	£68,329	£34,165	Note activity (Outputs) not in plan
008	Safeguarding	Safeguarding	Care Act Implementation Related Duties	Safeguarding			N/A		Community Health		NHS			Local Authority	Minimum NHS Contribution	£47,070	£23,535	Note activity (Outputs) not in plan
009	Community Equipment	Community Equipment	Assistive Technologies and Equipment	Community based equipment		13568	2516	Number of beneficiaries	Community Health		NHS			Local Authority	Minimum NHS Contribution	£1,213,082	£606,541	To plan
010	Night Nursing	Community night nursing service	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care		0	N/A		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£70,679	£35,340	Note activity (Outputs) not in plan
011	Community Matrons	Community matrons	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care		0	N/A		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£441,335	£220,668	Note activity (Outputs) not in plan
012	Intermediate care Beds (Alexandra Ward) - CLCH	Bed based intermediate care	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		43	21	Number of placements	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£529,798	£264,899	To plan
013	Intermediate care Beds (Athlone Ward) - CLCH	Bed based intermediate care	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		76	38	Number of placements	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£784,156	£392,078	To plan
014	Tissue Viability	Community tissue viability service	Community Based Schemes	Integrated neighbourhood services		0	N/A		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£181,125	£90,563	Note activity (Outputs) not in plan
015	District Nursing	District nursing care in community	Community Based Schemes	Integrated neighbourhood services		0	N/A		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£1,268,019	£634,009	Note activity (Outputs) not in plan

016	Community Independence Service - Joint	Community Independence Service - Joint Element	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs			NA		Social Care		LA		Local Authority	Minimum NHS Contribution	£1,176,168	£588,084	Note activity (Outputs) not in plan
017	S256 Transfer to Social Care	Reablement & Packages of Care	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge			NA		Social Care		LA		Local Authority	Minimum NHS Contribution	£6,014,663	£3,007,332	Note activity (Outputs) not in plan
018	Care Act	Care Act Implementation Services	Care Act Implementation Related Duties	Other	Care Act		NA		Social Care		LA		Local Authority	Minimum NHS Contribution	£676,427	£338,213	Note activity (Outputs) not in plan
019	Farm Lane PFI	Contract Beds - Care UK	Residential Placements	Nursing home		32	32	Number of beds	Community Health		NHS		Local Authority	Additional NHS Contribution	£1,556,415	£778,208	To plan
020	St Vincent PFI	Contract Beds - Care UK	Residential Placements	Nursing home		30	30	Number of beds	Continuing Care		NHS		Local Authority	Additional NHS Contribution	£1,785,931	£892,966	To plan
021	PFI Contract Monitoring	Contract Monitoring	Enablers for Integration	Programme management			NA		Community Health		NHS		Local Authority	Additional NHS Contribution	£26,349	£13,175	Note activity (Outputs) not in plan
022	Direct Payment	Direct Payment/ (Personal Budget)	Personalised Care at Home	Physical health/wellbeing		0	N/A		Community Health		NHS		Local Authority	Additional NHS Contribution	£44,655	£22,328	Note activity (Outputs) not in plan
023	Joint Equipment Contract Monitoring	Contract Monitoring	Enablers for Integration	Programme management			NA		Community Health		NHS		Local Authority	Additional NHS Contribution	£16,194	£8,097	Note activity (Outputs) not in plan
024	LD Placement Reviewing Officer Dual Diagnosis	LD Placement Reviewing Officer	Workforce recruitment and retention				1	WTE's gained	Mental Health		NHS		Local Authority	Additional NHS Contribution	£53,164	£26,582	To plan
025	Carer's Advice, Info & Support	Carer's Advice, info and support service	Workforce recruitment and retention	Carer advice and support related to Care Act duties			1	WTE's gained	Community Health		NHS		Local Authority	Additional NHS Contribution	£44,989	£22,495	To plan
026	Look Ahead North East Cluster	Look Ahead North East Cluster	Housing Related Schemes			0	N/A		Mental Health		NHS		Local Authority	Additional NHS Contribution	£71,344	£35,672	Note activity (Outputs) not in plan
027	London Cyrenians North West Cluster	London Cyrenians North West Cluster	Housing Related Schemes			0	N/A		Mental Health		NHS		Local Authority	Additional NHS Contribution	£24,572	£12,286	Note activity (Outputs) not in plan
028	Housing Support (PATHS)	Housing Support (PATHS)/ Hospital Liaison Scheme	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning			NA		Mental Health		NHS		Local Authority	Additional NHS Contribution	£23,659	£11,829	Note activity (Outputs) not in plan
029	Dual Diagnosis Worker	Dual Diagnosis Worker	Personalised Care at Home	Mental health /wellbeing			NA		Mental Health		NHS		Local Authority	Additional NHS Contribution	£28,408	£14,204	Note activity (Outputs) not in plan
030	Groundswell Peer Support	Groundswell Peer Support	Personalised Care at Home	Mental health /wellbeing		0	N/A		Community Health		NHS		Local Authority	Additional NHS Contribution	£16,806	£8,403	Note activity (Outputs) not in plan
031	Contract Monitoring for Support Housing	Contract Monitoring for Supporting Housing Projects	Enablers for Integration	Programme management			NA		Mental Health		NHS		Local Authority	Additional NHS Contribution	£14,696	£7,348	Note activity (Outputs) not in plan
032	S256 Recurrent Reablement	Enhanced Bolstering	Home-based intermediate care services	Reablement at home (to support discharge)		347	173	Packages	Community Health		NHS		Local Authority	Additional NHS Contribution	£267,755	£133,878	To plan
33	7 Day Social Work Service (Formerly System Resilience)	7 Day Social Work Hospital Discharge Service	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge			NA		Community Health		NHS		Local Authority	Additional NHS Contribution	£446,807	£223,403	Note activity (Outputs) not in plan
34	ICB Discharge Funding - Bridging care	Bridging service to support patients on P1 pathway to be discharged home sooner	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs		0	0				NHS		Local Authority	ICB Discharge Funding	£654,100	£327,050	To plan
36	ICB Discharge Funding	Reviewing Officers x 2	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs			2				NHS		Local Authority	ICB Discharge Funding	£110,000	£55,000	To plan
37	LA Discharge Funding	Hospital Discharge Programme	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs		0	N/A				LA		Local Authority	Local Authority Discharge	£2,343,005	£1,184,072	Note activity (Outputs) not in plan
38	Contract Beds Older People (Farm Lane)	Contract Beds	Residential Placements	Nursing home		28	28	Number of beds	Social Care		LA		Private Sector	Additional LA Contribution	£1,564,309	£784,233	
39	Contract Beds Older People (St Vincent)	Contract Beds	Residential Placements	Nursing home		40	40	Number of beds	Social Care		LA		Private Sector	Additional LA Contribution	£2,534,986	£1,184,072	
40	Direct Payment	Direct Payment/ (Personal Budget)	Personalised Budgeting and Commissioning			0	0		Continuing Care		LA		Private Sector	Additional LA Contribution	£129,859	£64,930	
41	Joint Equipment Budget	Community Equipment	Assistive Technologies and Equipment	Assistive technologies including telecare		1927	1749	Number of beneficiaries	Social Care		LA		Local Authority	Additional LA Contribution	£877,300	£443,482	
42	Look Ahead North East Cluster	Look Ahead North East Cluster	Housing Related Schemes				NA		Social Care		LA		Charity / Voluntary Sector	Additional LA Contribution	£469,586	£189,993	
43	London Cyrenians North West Cluster	London Cyrenians North West Cluster	Housing Related Schemes				NA		Social Care		LA		Charity / Voluntary Sector	Additional LA Contribution	£583,956	£296,190	
44	Housing Support/ PATHS	Supporting Discharges related to Homelessness	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning		0	0		Mental Health		LA		Charity / Voluntary Sector	Additional LA Contribution	£25,248	£12,624	

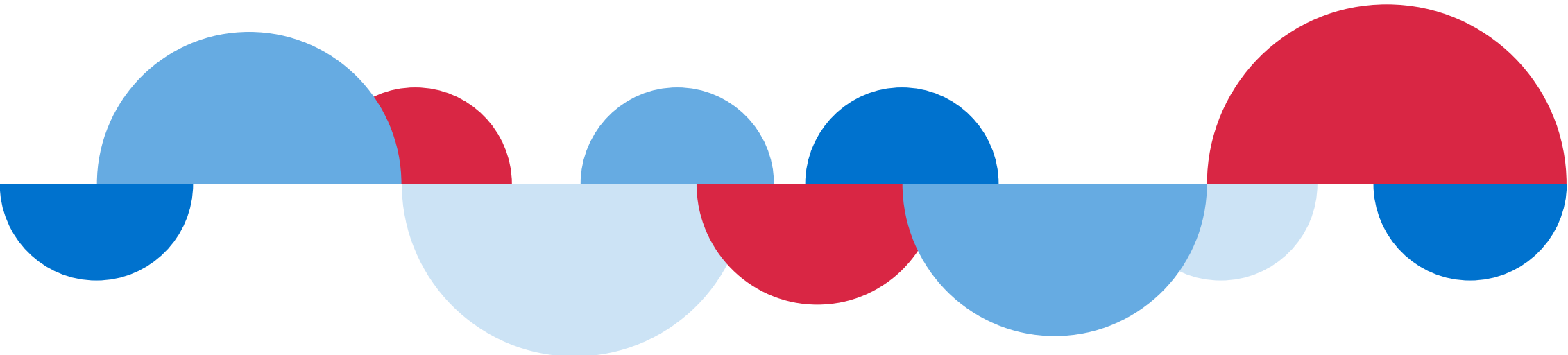
Adding New Schemes:

[Back to top](#)

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Planned Outputs for 2024-25	Outputs delivered to date (Number)	Units (auto-populated)	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner) (auto-populate)	Provider	Source of Funding	Planned Expenditure (£)	Expenditure to date (£)
			<Please Select>														

Overarching Partnership Plan

December 2024



Key facts about the borough



183,158 residents



28 GP Practices / 5 Primary Care Networks



42 Pharmacies



Acute Trust – Imperial College Healthcare Trust,
Chelsea & Westminster Foundation Trust



9 Care Homes



Hammersmith & Fulham Local Authority



Mental Health & Community Trust – West London
NHS Trust



Community Services – Central London Community
Health Trust

- According to the latest census, there were 183,158 residents in H&F in 2021.
- The largest proportion of residents were working aged adults between 25-49 years (45.1%).
- Children and young people (CYP) made up the second largest age group in H&F, with 28.5% aged 0-24 years.
- 10.5% of the population were aged 65 years and above.
- 63.2% of residents were from a 'White' ethnic group. This is larger than the London average of 56%.
- The largest ethnic minority group in the borough is 'Mixed/Other' (14%).
- The smallest ethnic minority group in the borough is 'Asian' (10%).

Insights from the Shared Needs Assessment

The Shared Needs Assessment was published in September 2024 and aims to enable teams across North West London to gain an understanding of the health needs of the population and to identify which needs have the biggest prevalence, inequality, unmet need and overall impact.

Key issues for Hammersmith and Fulham highlighted within the report include the following:

- Hammersmith and Fulham had the **lowest 3-year life expectancy at birth** for 2020-22 in NWL, and the second lowest when looking at the one-year trend. In common with other areas this has worsened over the last three years, with life expectancy for males falling at a faster rate than for females. This is inconsistent with the average deprivation profile, (as the borough is only the fifth most deprived by average IMD score in NWL) and requires further investigation.
- **18% of the population is in the Core 20 most deprived areas**, compared with 12.7% in NWL. This is the third highest level in NWL. Children within the Core 20 are more likely to live with adults who are smokers and involved in substance or alcohol abuse, with children living in the more deprived communities being three times more likely to live with someone who is engaged in substance abuse than the least deprived group.
- There are **pockets of deprivation across the borough**. The largest area of deprivation is White City and Wormholt in the north, which contains areas of high food and fuel poverty, overcrowding, high crime, high male unemployment, and a higher rate of children living with substance abuse.
- Across the whole borough, older adults have a higher risk than the NWL average of physical inactivity, smoking and substance abuse. There are higher rates of anxiety and depression, cancer, COPD, falls and stroke.
- Among adults there are higher rates of anxiety and depression.

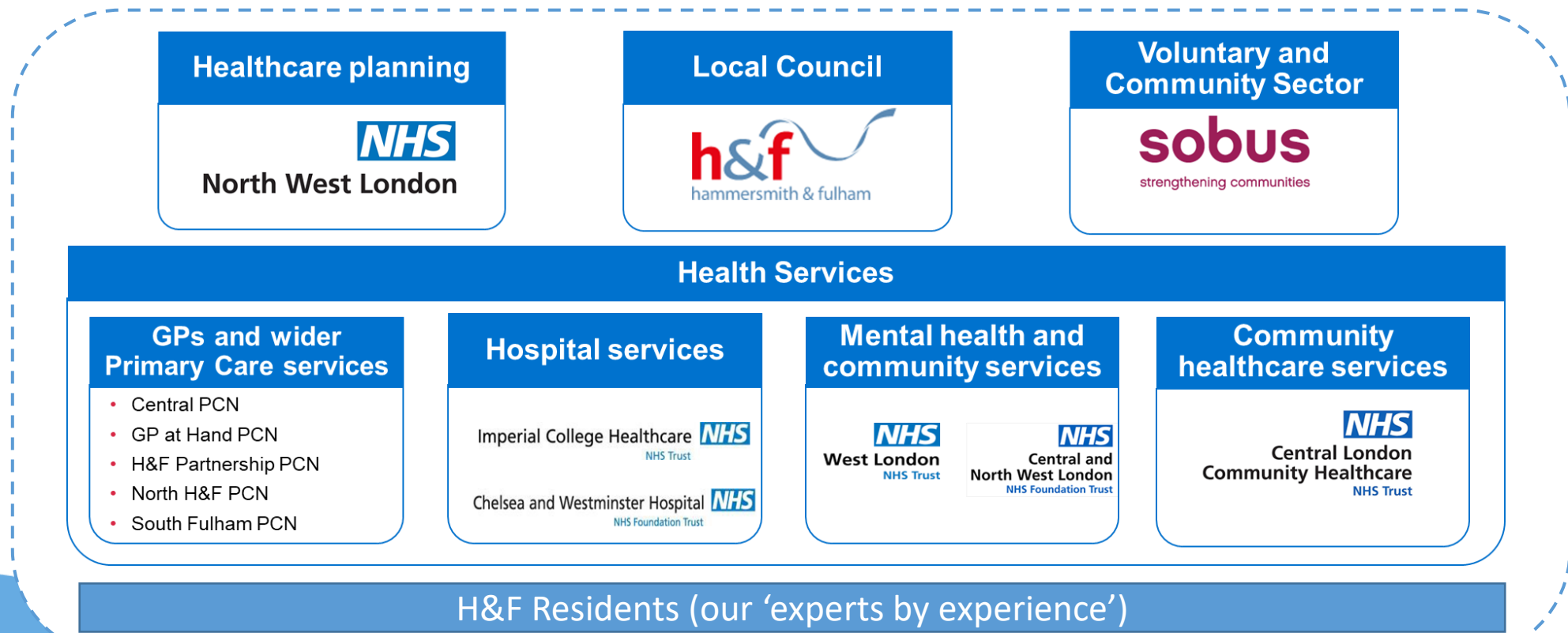
Our Partnership



The Hammersmith & Fulham Health and Care Partnership, our borough based partnership, was first established in 2016 to work with and for local residents to improve health, care and wellbeing outcomes.

The partnership includes health and care organisations working together with residents of Hammersmith & Fulham to improve health and care services for local people. It is a key part of the changes in the NHS which has seen commissioning responsibility move to North West London level, but with the borough based partnerships responsible for planning and delivering care.

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Healthcare planning



North West London

Local Council



Voluntary and
Community Sector



Health Services

GPs and wider
Primary Care services

- Central PCN
- GP at Hand PCN
- H&F Partnership PCN
- North H&F PCN
- South Fulham PCN

Hospital services



Mental health and
community services



Community
healthcare services



H&F Residents (our 'experts by experience')

What do people say about our services?

People rate most individual services very highly, and we have high quality providers

There are significant inequalities in experience of accessing healthcare with a lack of trust in large organisations such as the NHS, particularly within some of our black communities

Care is often perceived as fragmented and disjointed between providers, including between health and social care

Specific areas of feedback include patient transport and disabled access

Experience of general practice is variable and this has been a recent focus locally

People experience a lack of continuity in some services, with multiple professionals involved in their care

These are issues being experienced in most areas across the country, and the partnership is focusing on working together where this will help us improve

Refreshing the Partnership

- The Place Partnership Managing Director role has been created as a dedicated partnership post for the first time in Hammersmith and Fulham
- As part of beginning the role, a review has been conducted of how the partnership is operating, including its workstreams and governance
- Partners fed back that there was more work to do on developing the collective sense of purpose and ambition within the partnership, and greater clarity was needed on what we are trying to achieve through working together
- There was also clear feedback that the workstreams and governance were not as effective as they could be and needed to be refreshed
- All the strategic partners have signed up to a refreshed purpose statement and new governance structure
- Conversations are continuing to agree priorities and workstreams, taking into account feedback from frontline staff and residents in this process

Purpose of the partnership

We will work together as partners in Hammersmith and Fulham to improve health and wellbeing and reduce inequalities.

We will develop more integrated, connected services that deliver tangible improvements that are better for our population and more sustainable for our organisations.

We will focus on tackling the wider factors that influence health and wellbeing.

We will work with local people to develop trusting relationships, empower communities and co-produce service changes.



Creating Health

By this, we mean we will:

- Focus on the wider determinants of health and wellbeing
- Work on reducing health inequity
- Empower communities to create health
- Leverage our social capital
- Support self-care and independence
- Ensure a focus on children

We will be guided by the more detailed priorities listed in the **Hammersmith & Fulham Health and Wellbeing Strategy**

Integrating Services

By this, we mean we will:

- Join up our services for people with more complex needs
- Understand and share care and risk collectively, rather than perpetuating a referral culture
- Develop more accessible services and support
- Improve quality of care
- Reduce repetition and duplication
- Address functional overlaps and gaps

Understanding “neighbourhood health”

- Many years ago, GP practices were surrounded by a wider primary care health offer for people with additional needs, with linked team members including professionals such as midwives, health visitors, district nurses, therapists and mental health practitioners
- Services were accessed through the surgery and associated clinics, and were trusted and understood in a very local neighbourhood context – with the family doctor at the heart of this
- GPs also had strong relationships with their local hospital colleagues – often they had trained at their local hospital, and people knew each other by name and had each other’s phone numbers
- Over time, as demands on the NHS grew and services were increasingly delivered by multiple different providers, professionals retreated from GP practices and into organisational teams. As the population has grown and aged, it is no longer possible for GPs to know most hospital doctors
- Over a long period, working practices have become more transactional (based on referral forms, criteria and operational protocols) than relationship-based, and some services have reduced in size relative to the size of the population

Why does this matter?

- As the population has aged and general health has declined, many more people have medium (more than one long term condition) or highly complex needs
- Our population continues to change, in particular our older population, which is small but growing. It has increased by 16% since 2011 and is predicted to further increase by 36% by 2033. Dementia prevalence is predicted to rise by 34% by 2030
- This will increase demand for health and social care services
- For people who have limited need for contact with the NHS, who are generally well and have no ongoing needs, the current way of working can work well – but the pressure services are under from people with greater needs affects them too, and general practice is a good example
- For people with more complex needs, the requirement for coordinated, joined up services has increased, but it has proved difficult to deliver this in practice

Why “neighbourhood health” could help

- Neighbourhood health involves reconnecting professionals from different organisations together, working around general practice, in a more relationship-based way
- It is important to be connected through general practice as the only truly local “neighbourhood” service that is continuously serving and in touch with our whole population
- However, it is no longer possible to align services around single practices, with very variable sizes (in H&F our smallest practice has about 2,300 patients and our largest has 19,000)
- Our health “neighbourhoods” will serve local populations of around 70,000 to 100,000 residents – this is a size that we believe means a greater range of services can be more connected
- Much of this work will be behind the scenes, in the day-to-day contact between professionals and the way they work – it will also involve working more closely in co-production with people, particularly those with additional needs
- Services will continue to be delivered more locally than at “neighbourhood” level – at GP surgeries, in people’s own homes, and at other locations in the borough – this is not about all services being delivered in one location, and most services are unlikely to move

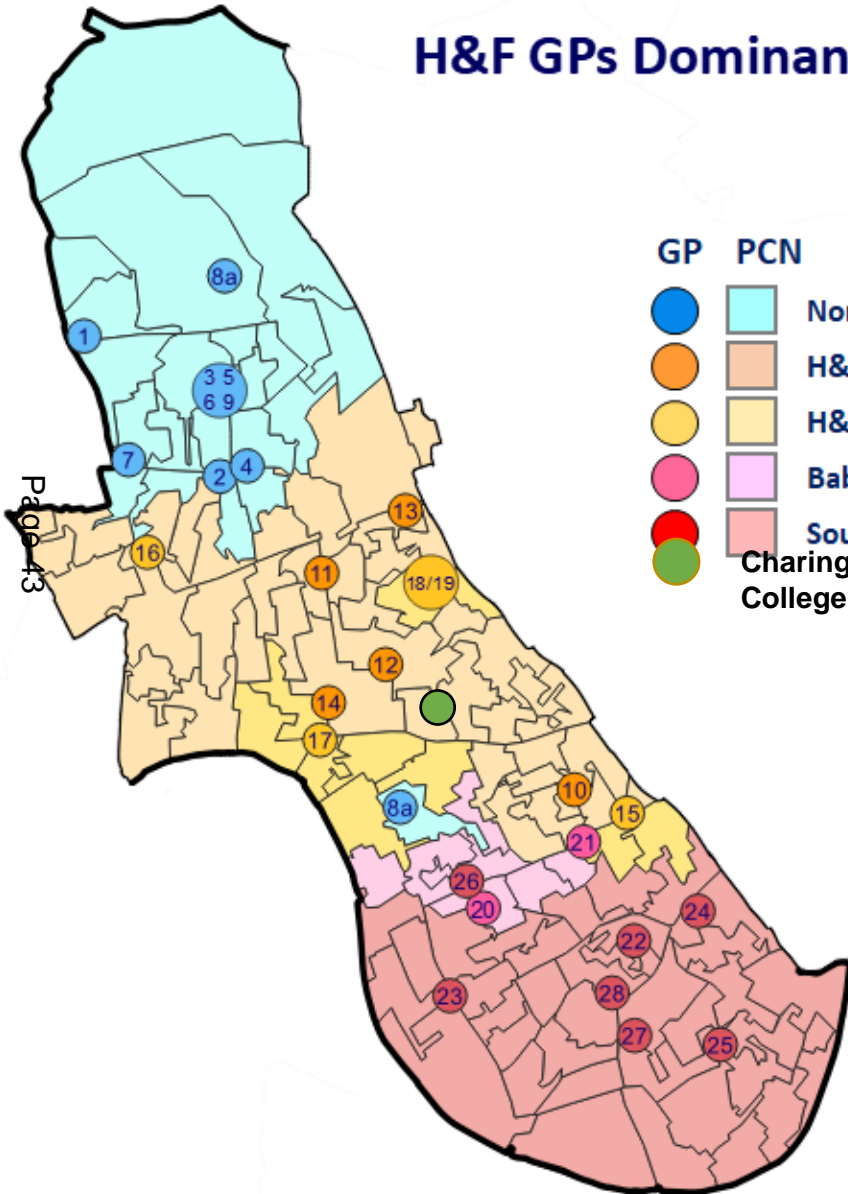
What will be different?

- NHS organisations serving the Hammersmith and Fulham population are working together to develop what Integrated Neighbourhood Teams mean locally – this will take some time
- We are also working with council colleagues to work out how best to connect their services
- We believe we need three Integrated Neighbourhood Teams in Hammersmith and Fulham, formed around groups of GP practices who are already working together – North, Central, and South
- We hope this will mean that people experience:
 - Better access to services
 - More joined up services
 - More personalised care, meeting people’s holistic needs
 - Better continuity of care
 - Better health outcomes



Integrated Neighbourhood Teams

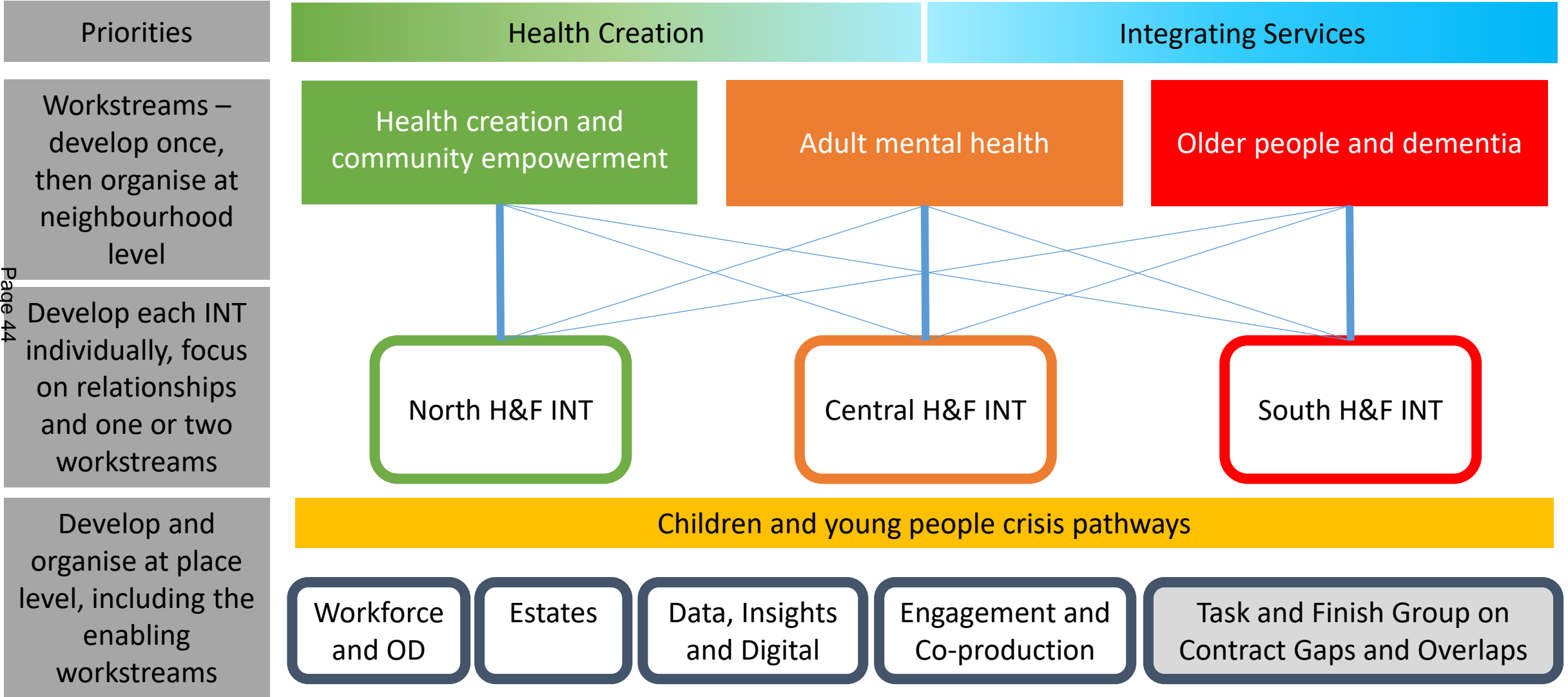
H&F GPs Dominant PCN by LSOA - Dec 23



GP	PCN	Geography
Blue circle	North H&C	North
Orange circle	H&F Partnership	Centre
Yellow circle	H&F Central	Centre
Pink circle	Babylon GP@Hand	South
Red circle	South Fulham	South
Green circle	Charing Cross Hospital (Imperial College Healthcare NHS Trust)	

GP	Primary Care Networks	Geography	Number
Westway Surgery	North H&F PCN	North	1
The New Surgery	North H&F PCN	North	2
Parkview Practice	North H&F PCN	North	3
Shepherd's Bush Medical Centre	North H&F PCN	North	4
Dr Uppal & Partners, Parkview	North H&F PCN	North	5
Dr Kukar, Parkview	North H&F PCN	North	6
Dr Kukar, The Medical Centre	North H&F PCN	North	7
H&F Centres for Health (Hammersmith)	North H&F PCN	North	8a
H&F Centres for Health (Charing Cross)	North H&F PCN	North	8b
Canberra old oak Surgery	North H&F PCN	North	9
North End Medical Centre	H&F Partnership PCN	Centre	10
Richford Gate Medical Practice	H&F Partnership PCN	Centre	11
Brook Green Medical Centre	H&F Partnership PCN	Centre	12
The Bush Doctors	H&F Partnership PCN	Centre	13
Park Medical Centre	H&F Partnership PCN	Centre	14
North Fulham Surgery	H&F Central PCN	Centre	15
Ashchurch Surgery	H&F Central PCN	Centre	16
Hammersmith Bridge Surgery	H&F Central PCN	Centre	17
West Kensington GP Surgery	H&F Central PCN	Centre	18
Sterndale Surgery	H&F Central PCN	Centre	19
Dr Jefferies & Partners	Babylon GP at Hand PCN	South	20
Babylon GP at Hand	Babylon GP at Hand PCN	South	21
Cassidy Road Medical Centre	South Fulham PCN	South	22
Palace Surgery	South Fulham PCN	South	23
Fulham Medical Centre	South Fulham PCN	South	24
Sands End Health Clinic	South Fulham PCN	South	25
Fulham Cross Medical Centre	South Fulham PCN	South	26
Lillyville @ Parsons Green	South Fulham PCN	South	27
Ashville Surgery	South Fulham PCN	South	28

Our whole partnership programme and workstreams



New Partnership Structure



Key Next Steps

Our focus in the immediate term will include:

- Continuing to build the relationships at strategic and operational levels that will support delivery of our priorities
- Implementing our revised partnership governance
- Developing our priorities, workstreams and enablers, in a way that ensures partners are signed up to delivery of realistic and achievable programmes
- Organising to deliver, with aligned resources and the development of work plans
- Clarifying our arrangements and planning improvements for engagement and co-production with local people

