London Borough of Hammersmith & Fulham **HEALTH AND WELLBEING BOARD** **21 MARCH 2016**	
STRATEGIC PLANNING: REVIEWING PROGRESS AND LOOKING FORWARD TO THE REFRESH OF THE JOINT HEALTH AND WELLBEING STRATEGY	
Report of the Executive Director, Adult Social Care	
Open Report	
Classification - For Decision, Review & Comment **Key Decision: No**	
Wards Affected: ALL	
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1. EXECUTIVE SUMMARY

1.1. This paper, which is in three parts, considers research into the effectiveness of health and wellbeing boards across the country, outlines the changing needs of the Hammersmith & Fulham population and sets out a framework for the refresh of the Joint Health and Wellbeing Strategy in 2016.

2. RECOMMENDATIONS

2.1. It is recommended that the board:

a) consider the position of Health and Wellbeing Boards across the country and reflect back on progress made to date.

b) Consider population health need in the borough, how needs and demography have changed and how they are expected to change in the future

c) Consider recent policy announcements and how the board will need to adapt to offer systems leadership in the future

d) Discuss early thinking about what the new Health and Wellbeing Strategies could cover;

e) Discuss a high level timeline for the development of the plans at this stage;

3. REASONS FOR DECISION

3.1. The board are invited to consider research into the effectiveness of health and wellbeing boards across the country, where it stands in comparison and where there is potentially room for further improvement and development.

3.2. Changing population health needs will inform the board's thinking in relation to the refresh of the Health and Wellbeing Strategy and potential priority groups and health conditions.

3.3. Recent policy announcements point to a potentially very different future health and care landscape with implications for the future role of health and wellbeing boards.

3.4. A high level outline of a health and wellbeing strategy is presented for the Board's consideration. The Board are asked to comment on the headings and agree an outline structure to enable Officers to begin the process of drafting the document

3.5. A high level timeline for development is also presented. The board are asked to comment on and agree this.

4. INTRODUCTION AND BACKGROUND

4.1. The meeting at which this paper is presently tabled offers the Board a time for reflection and consideration ahead of the refresh of the Joint Health and Wellbeing Strategy in 2016.

4.2. Health and Wellbeing Boards were established by the Health and Social Care Act 2012 as a forum where local leaders from across local health and social care systems could come together with the voluntary sector and other stakeholders to improve the health and wellbeing of the populations they serve and promote integrated services.

4.3. Many Boards met in shadow form in 2012 prior to being placed on a full statutory footing in April 2013. Research conducted by the King's Fund (October 2013) found that most Boards had used this shadow year well. Against a backdrop of complex organisational change and financial instability, most Boards made good progress building the relationships at the heart of a successfully functioning Board and fulfilling core statutory duties such as the development of Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies.

4.4. However, until very recently, research into Health and Wellbeing Boards has tended toward the consensus that whilst many Boards have made good progress and many had ambitions to assume a full systems leadership role, they are still on a journey and are very much a work in progress (London Councils, March 2015)

4.5. This has changed recently as a result of developments in Greater Manchester, Leeds and more recently London. *The Greater Manchester Health and Social Care Devolution: Memorandum of Understanding* (GMCA 2015) signals the delegation and ultimate devolution of health and social care responsibilities and funding worth £6 billion to accountable, statutory organisations in Greater Manchester.

4.6. The London Health and Care Collaboration Agreement (December 2015) signals the possibility of substantial devolved powers and funding for health and social care to London. (London Partners, December 2015). The five London Devolution pilots announced in December 2015 pave the way for further devolution of healthcare in London to local leaders.

4.7. Developments in Manchester, Leeds, London and elsewhere now offer local Health and Wellbeing Boards a model to aspire to. One where substantial funds, powers and responsibilities for health and social care are devolved to accountable

organisations and local leaders who are collectively responsible for improving the health and wellbeing of the populations they serve.

4.8. Part I of this paper invites the board to consider the findings of research into the ambitions and effectiveness of Health and Wellbeing Boards across the country and to reflect back on progress made in Hammersmith and Fulham to date. Having established where the Board stands, part II invites the Board to consider features of the borough's population including current health needs, how needs and demography have changed and how they are expected to change in the future. Part III recaps on recent significant policy announcements and invites the Board to consider how it will need to adapt to offer leadership in a potentially very different health and care landscape in the future. The paper concludes by inviting the Board to consider a potential answer to this question by setting out some key elements of a future Joint Health and Wellbeing Strategy for 2017 – 2020/21 and an approach and timetable for developing it.

5. PART I – THE POSITION OF HEALTH AND WELLBEING BOARDS NATIONALLY

5.1. There has been a not insignificant amount of research into and review of the ambitions and effectiveness of Health and Wellbeing Boards both in their shadow year and since they were set on a statutory footing in April 2013.

5.2. In 2012, shortly after Boards were established, the King's Fund published *Health and Wellbeing Board's: System Leaders or Talking Shops* which concluded that the single biggest test for health and wellbeing boards would be whether they could offer strong, credible and shared leadership across local organisational boundaries. (Humphries et al 2012).

5.3. In 2013, the King's Fund published *Health and Wellbeing Boards: One Year On (*King's Fund, Oct 2013*)* in which it followed up its first report by looking at what had changed, how Boards had used their shadow year, what they had achieved and whether they could provide effective leadership across local systems of care.

5.4. That research found that whilst there has been definite progress against a back drop of considerable organisational change and financial instability, particularly in areas such as relationship building and the delivery of core duties, Boards are still very much a work in progress.

5.5. Research has found that generally, reported relationships between CCGs and local authorities are good and improving and nearly all Boards have produced joint strategic needs assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWS). (October 2013).

5.6. Interestingly, public health and health inequalities tended to be the highest priorities in health and wellbeing strategies indicating that public health was exerting real influence and impact on local authorities. However, there was little sign in 2013 that boards had begun to grapple with the immediate and urgent strategic challenges facing their local health and care systems and the King's Fund report found that unless Boards did so, there was a real danger they will become a side show rather than a source of system leadership. (King's Fund, October 2013).

5.7. Despite important early progress, in-depth research conducted in 2015 by London Councils and Shared Intelligence found that the vast majority of London HWBs described their board as being on a journey, with very few claiming it was yet fulfilling its full potential. And although most Boards reported aspirations to do so, researchers found little evidence of London HWBs yet providing genuine systems leadership across the piece (*Conquering the Twin Peaks* London Councils, 2015).

5.8. This finding was replicated again in the Local Government Association's review of the second year of the national health and wellbeing board improvement programme which found that Boards nationally could all be located somewhere on a spectrum of maturity and ambition, with progress best represented by a bell-curve rather than a linear graph. (*Stick with it: A review of the second year of the health and wellbeing improvement programme* Local Government Association, February 2015*)*

6. WHAT ARE THE CHARACTERISTICS OF AN EFFECTIVE BOARD IN A CHANGING WORLD?

6.1. There is a high level of consensus amongst research findings and best practice guidance about the traits displayed by the more advanced and effective boards.

6.2. Firstly, HWB chairs were found to have the single biggest influence over a Board's focus and tone and the relationship between the council and CCG and between the chair (in most cases a senior councillor) and vice chair (often from the CCG) were also key markers of effectiveness.

6.3. The London Council's study suggested that effective boards: create the conditions in which there is genuine collaboration between key players in the local health and wellbeing system; ensure the existence of effective systems leadership; and ensure effective engagement with the public and other stakeholders. As a result, effective boards tend to display focussed, prioritised action which impacts on the wider determinants of health; a shared vision for the future of health and care in place, which has traction with the strategies and business planning processes of the key local organisations; and a work programme to deliver and monitor this (London Councils, 2015).

6.4. Factors enabling boards to operate effectively also included: a shared purpose and tight focus; a small number of priorities (typically between 3 and 5) with the discipline to stick with them; an explicit role in creating groups and forums for other related conversations and activities; effective sub-structures and time to meet in informal settings; an ability to influence all the key players; and a shared strategy which secures action by relevant organisations (London Councils, 2015).

6.5. The LGA (2015) found that the small number of boards who were ahead of the curve in their view had looked beyond tackling immediate 'problems' in the system and kept a disciplined focus on the bigger picture. Some of the key steps these Boards have taken included:

- Having difficult conversations about shifting money around
- Keeping a tight focus on long-term health issues and not getting distracted by other local and national 'noise'
- Having clarity on quick wins (first 100 days plans) and short to medium term gains in the first two or three years and longer term
- Maintaining focus on health and wellbeing, prevention and acute care
- Ensuring all board members and their organisations are brought into and acting upon board strategy

6.6 Features found to potentially impede board's progress include pressures to address issues that are not a priority; a tendency to focus on the board as a meeting rather than as an institution with a wider reach; failure to engage with, or seem meaningful to, providers; and being by-passed, with key discussions taking place in other forums outside the board's ambit (London Councils, 2015).

6.7 Table 1 captures a list of traits found by the Local Government Association to be markers of an effective Health and Wellbeing Board. Although not an

exhaustive list it offers a valuable tool for thinking about the Board's progress so far.

Table 1 – What are the characteristics of an effective health and wellbeing board?

best practice criteria	commentary	areas for discussion
Vision, ambition and role of the health and wellbeing board	• Is there demonstrable passion, ambition and enthusiasm displayed not only by the Chair but all Board members about what can be achieved locally and about the potential of the partnership to offer leadership and effect fundamental change? • Does the Board's Better Care Fund plan and Joint Health and Wellbeing Strategy display a clear focus on prevention, health inequalities, the wider determinants of health, and a recognition of the importance of 'big ticket' items such as health and care integration? • Does the Board have effective support and sub-structures?	• Does the Board's strategy have clear ties with the strategic objectives of providers and other stakeholders outside the partnership? • Has the Board articulated a clear and compelling narrative and road map for change setting out how the system can move from where it is now to where it needs to be?
System leadership and partnership working	• Are there strong and productive relationships between board members and do Board members feel comfortable offering critical challenge, holding each other to account and influence each other's organisations? • Do Board members have a good understanding of the major constraints and opportunities facing organisations in the local care system? • Are members clear about the role of the Board and the roles of scrutiny and Healthwatch. • Does the Board have productive relationships with external bodies (e.g. Council scrutiny, Safeguarding Boards)	• To what extent do board members have the right amount of authority to challenge and influence wider organisations not represented on the Board to secure action? • Is there an alignment between relevant partners' strategies and plans so they are focused on delivering shared priorities?
Delivery and impact	• Does the board ensure that the JSNA is updated regularly and informs partners' priorities and commissioning? • Does the board's strategy articulate clear milestones, performance indicators and outcomes and receive regular updates on progress?	• Does the Board have fit for purpose performance measures focused on the delivery of health and wellbeing outcomes? • Does the HWB effectively use a range of quantitative data such as financial,

	• Do board members and their respective organisations invest time outside of formal meetings developing relationships, trust and collaboration, purpose, roles and focus? • Is there parity between members with all afforded the opportunity to contribute at meetings and to the work of the board?	system performance and patient satisfaction, as well as qualitative evidence such as personal stories?
Communication and engagement	• Does the Board use mechanisms to ensure that community views are considered and represented in the deliberations and action taken by the Board, including the voices of seldom heard and hard to reach groups?	• Does the board have the appropriate mechanisms in place to engage with provider trusts (e.g. through representation on the board, attendance at relevant meetings, or through the development of appropriate sub-structures).
Integration and system redesign	• Is the Board enabling a shift of resources to make prevention and early intervention a priority? • Is the board thinking broadly about service integration across the public sector to maximise money? • Does the HWB focus on maximising community assets e.g. GP surgeries, children's centres and schools?	• Do board members display a willingness to learn from other boards, best practice and national developments?

7. PART II – THINKING ABOUT HOW HAMMERSMITH & FULHAM IS CHANGING

7.1. Hammersmith and Fulham is a small, densely populated borough. GLA 2015 projections estimate the population to be 189,850. It is common to other inner city areas in that it has a very large young working age population (73.9%) and smaller proportions of children (16.8%) and older people (9.3%). Compared with nationally, the proportion of people aged over 65 is almost half that of England. The borough has the 5th lowest proportion of children, 4th highest of young working age residents and 9th lowest of retirement age

7.2. The population is socio-economically and culturally diverse. 42% were born abroad and one third (32%) were from BAME groups in 2011, up from 22% in 2001. A range of European languages are spoken in the borough. A quarter of the borough's residents state their main language is not English and of these, 1 in 10 state they cannot speak English well (approx 3%). French, Arabic, Spanish and Polish are the most common languages other than English. The population is very mobile which can create significant challenges in providing health services and accurately recording population size.

7.3. Three quarters (75%) of the borough's housing stock is flats, compared to half in London. Many have limited outdoor space and nearly half have no ground floor entrance and some have no lifts potentially making it difficult for some people with mobility issues. A third of people (34%) live in private rented housing – the 5th highest in London – and a similar proportion (35%) are owner occupiers – 8th lowest in London. Just under a third (30%) live is social housing.

7.4. 38% of households are one person households and almost one in ten (8.8%) is a lone pensioner household. Almost half (43%) of older people live alone carrying a risk of social isolation.

7.5. Pressure on social housing stock and property prices in London has resulted in overcrowding particularly among families. Across all tenures, approx 13% of households are considered to be overcrowded, similar to the rate across London.

7.6. Despite house prices, Hammersmith and Fulham was classified as the 55th most deprived borough in the country in 2010 according to the index of multiple deprivation. Pockets of deprivation are spread throughout the borough but are particularly focussed in the north of the borough and usually correspond to areas of social housing and poorer than average health. Those living in areas of high density social housing are around twice as likely to report bad/very bad health compared to those in areas with low density, across all ages. This can make targeting of support easier, if areas of social housing in the borough are well defined

7.7. A third of children under 16 (29%) live in poverty according to official definitions, which is higher than London and England. The Job Seekers Allowance rate in November 2013 was 3.1%, similar to London (3.1%) and Great Britain (2.9%), but rates are almost double this in areas such as College Park & Old Oak and Wormholt & White City.

7.8. Men living in Hammersmith and Fulham have a lower life expectancy than London and England (79.1 years), and for women it is worse than London (83.3 years). Whilst many residents are affluent, there are significant areas of poorer health in the more deprived parts of the borough and therefore large health inequalities between rich and poor. The difference in male life expectancy between affluent and deprived areas in the borough – 9.2 years. The difference in female life expectancy is 3.9 years.

7.9. Most people (86%) in Hammersmith and Fulham consider their health to be good reflecting the younger age profile in the borough. The minority of people who

consider their health to be bad or very bad are more likely to have long term conditions that limit their ability to lead normal lives and are much more likely to be older. They also tend to be clustered around areas of deprivation and social housing.

7.10. The principle cause of premature (<75) and avoidable death in Hammersmith and Fulham is cancer, followed by cardiovascular disease (which includes heart disease and stroke). A significant number of people also die from COPD. Accidents and injuries are most common among younger residents. This is pattern is broadly similar to the rest of the country.

7.11. Tackling chronic diseases using a range of interventions, including support for lifestyle change and improved support for those already with chronic disease. Compared to a decade ago, around 135 fewer people die before the age of 75 each year, with differing levels of success across disease types.

7.12. The growing burden of disability also requires a co-ordinated response, with mental disorders, substance use, musculoskeletal disorders and falls all having a significant impact on the ability to lead a fulfilling life and contribute to society through stable employment up to retirement. Locally, mental health is the most common reason for long term sickness absence, and several of the wards in the deprived parts of the borough fall into the 20% highest in London for incapacity benefit/ ESA claimant rates for mental health reasons.

7.13. Although some of the causes of poor health and long-term conditions are easily identified – tobacco use, high blood pressure, being overweight, poor diet, and physical inactivity in particular – the public health challenge remains facilitating behaviour change amongst populations who may not be ready to change. Understanding and tackling the factors which prevent healthy choices includes tackling underlying issues around housing, the urban landscape, employment, and education.

7.14. The public health team have supplied further detailed supporting information at Appendix 1.

8. PART III – GETTING READY FOR THE FUTURE

8.1. Recent significant policy announcements and developments provide an indication of how health and social care systems might change in 2016/17 and beyond:

- The publication in December 2015 of *Delivering the Forward View: NHS Shared Planning Guidance 2016/17 – 2020/21* signals a radical shift in policy for the NHS over the next few years. The guidance requires NHS commissioners and providers to come together with local organisations, including local government, to develop five year *place-based* plans. The shift to a place-based approach to planning signals an acknowledgement that widespread deficits cannot be remedied by providers alone but instead require collective action and cooperation between commissioners, providers and local authorities managing common resources to secure a financially sustainable system (McKenna and Dunn. Feb 2016) The strongest place based plans will also unlock transformation funding from 2017/18 onwards, a recognition that funding is required to support transformation.

- Accompanying and consistent with the place-based approach to planning, has been the introduction of multi-year CCG funding allocations providing greater certainty to long-term planning and a shift toward looking at the

sum totality of allocations and aggregate financial balance across local systems (rather than individual organisational financial positions).

- the Government announcement in the 2015 Spending Review that it expects health and social care be fully integrated by 2020 with local plan for integration in place by 2017 is a recognition that health and care integration are central to the future sustainability of both systems and a desire to move at pace to achieve this.
- the ambition by more than 30 partners across North West London to become an Accountable Care Partnership by 2018 will require groups of providers to come together and assume clinical and financial accountability for delivering pre-agreed outcomes for particular segments of the population.
- The announcement of the five London devolution pilots which will road test new ways of working across London's health economy signal the prospect of a longer term aim for further devolution of London's healthcare to local leaders
- The *Greater Manchester Health and Social Care Devolution: Memorandum of Understanding* (GMCA 2015) signals the delegation and ultimate devolution of health and social care responsibilities and funding worth £6 billion to accountable, statutory organisations in Greater Manchester.
- The London Health and Care Collaboration Agreement (December 2015) signals the possibility of substantial devolved powers and funding for health and social care to London. (London Partners, December 2015). The five London Devolution pilots announced in December 2015 pave the way for further devolution of healthcare in London to local leaders.

8.2. The refresh of the Board's Joint Health and Wellbeing Strategy in 2016 will be a key vehicle for moving forward in this context and a key mechanism for grasping the opportunities presented by recent and ongoing developments.

9. REFRESHING THE JOINT HEALTH AND WELLBEING STRATEGY

9.1. The Health and Wellbeing Strategy is an opportunity to agree what is important for local people and how the whole system can take collective action to deliver those priorities. It also offers an opportunity to fulfil a systems leadership role across Hammersmith & Fulham with responsibility for all funding and decisions relating to the health and care of the population. To do this, the strategy would need to articulate the outcomes expected, say how commissioning and resources need to shift and how they would be managed over the short to longer term. This means:

- Delivering the framework within which accountable care partnerships could operate
- Providing the framework for commissioning across health and care
- Developing a vision and agreeing the outcomes which should be reflected in future commissioning arrangements
- Moving from an approach where the Board focuses on particular conditions and services, to one where it focuses on the needs of particular population

segments, enable a shift towards integration, prevention and early intervention
- Developing a governance structure involving the organisations involved in delivering health and care to take decisions in pursuit of agreed objectives
- Identifying the system enablers required to be able to manage the above such as developing the appropriate workforce, governance and IT.

9.2 The Health and Wellbeing Strategy could therefore set out:

- A high-level 5 year vision
- What has been achieved over the lifespan of the previous Health and Wellbeing Strategy
- The local context (e.g. demographic, economic, social, cultural), local assets and the key health and wellbeing challenges in Hammersmith & Fulham
- The strategic priorities for integrating health and care and taking a broader approach to supporting people in the community – including:
    - A plan for fully integrated health and social care services by 2020
    - Realising the benefits of outcomes based commissioning and accountable care from 2018
    - Taking advantage of new freedoms and flexibilities through devolution and the BCF
    - Working as a whole system to tackle the wider determinants of health
- Population group priorities (this is key to enable the move to capitated budgets which are a key aspect of the accountable care partnership model) – e.g.:
    - children and young people
    - looked after children
    - children with mental health needs
    - working age adults with episodic health needs
    - working age adults with enduring conditions (including mental health needs and learning disabilities)
    - older people
- Outcomes KPIs or key performance indicators to be measured in each population group.
- Key enablers to ensure delivery such as:
    - Integrated information and technology
    - Integrated workforce planning and organisational development
    - Governance and accountability arrangements
    - System leadership and delivery plans

9.3 A joint working group has been established to guide the development of the Joint Health and Wellbeing Strategy in parallel with the North West London Sustainability and Transformation Plan. A high level plan has been developed which proposes 3 phases of work:

Phase 1 (between now and end of March) – mobilisation, base case and local analysis

This includes:

- What has worked well/needs further development in the role of system leadership locally
- What the local evidence base suggests in terms of health and wellbeing in each of the areas
- The plan approach and plan structure

Phase 2 (between March and May) – setting population level priorities and engagement (including with residents)

This will include engagement with the Health and wellbeing Board on:

1. Defining the outcomes framework
2. Agreeing the priority population groups
3. Developing strategic priorities (overall and in population groups)
4. Engaging with subject matter experts in the creation of the plans (e.g. housing)
5. Developing the operational plans to underpin the STP and health and wellbeing plans
6. Creating the plans for system wide enablers

Phase 3 (May and July) – plan completion, further engagement and sign off

This will include:

1. Finalising the planning with Health and Wellbeing Boards
2. Engaging with residents and partners on the final draft plans
3. Mapping the plan outputs to operational plans
4. Agreeing the forward plan for delivery
5. Aligning resourcing plans

10. CONSULTATION

10.1. Under Local Government and Public Involvement in Health Act 2007 the Health and Wellbeing Board must involve the local community continuously throughout the JSNA and JHWS process. The duty to involve the local community covers people who live or work in the area, and includes children and adults. Extensive public, patient and professional engagement will be undertaken as part of the refresh and will be ongoing throughout the lifespan of the strategy. A detailed stakeholder engagement plan will be developed as part of the refresh programme and will be shared with Board members. The refreshed strategy will also draw on the JSNA and other strategic documents which themselves were formed on the basis of extensive public engagement**.**

11. EQUALITY IMPLICATIONS

11.1. *N/A*

12. LEGAL IMPLICATIONS

12.1. This report concerns the duty imposed by the Health and Social Care Act 2012 on the Local Authority and the CCGs to prepare a joint health and wellbeing strategy (JHWS) which is a strategy for meeting the needs included in the Joint Strategic Needs Assessment (JSNA).

13. FINANCIAL AND RESOURCES IMPLICATIONS

13.1. *None identified at this stage.*

11. IMPLICATIONS FOR BUSINESS

11.1 None identified at this stage.

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

Background papers:

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McKenna, H. and Dunn, Phoebe (February 2016) *What the planning guidance means for the NHS: 2016/17 and beyond* The King's Fund (available at: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Planning-guidance-briefing-Kings-Fund-February-2016.pdf)