Hammersmith & Fulham Joint Health and Wellbeing Strategy 2016-2021

1. Chair's Foreword

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

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

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

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

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

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

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

This plan sets out our ambitions for overcoming these challenges. To deliver the change we need we will work across the public sector to influence the wider determinants of health such as employment, housing and education; We will embed prevention in all that we do, intervening early to help people to stay well; We will support people to stay well in their communities by making community, primary care and social services part of an effective front line of local care; We will support people who want to take greater responsibility for their own health and wellbeing; and we will undertake an ambitious programme of service integration and reform to ensure health and social care services are joined up, in line with the needs of people, families and carers.

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

1. **enabling good mental health for all**
2. **supporting children, young people, and families to have the best possible start in life**

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

3. **addressing the rising tide of long-term conditions; and**
4. **delivering a high quality and sustainable health and social care system.**

Our Joint Health & Wellbeing Strategy for 2016 – 2021 is an ambitious, forward thinking plan for improving the health and wellbeing of people in the borough. Through this strategy and the hard work which will follow, we will achieve even closer working between health, social care, the voluntary sector and other partners to enable people to stay healthy, independent and well and aim to ensure the financial sustainability of our health and social care services for the future. This strategy signals the start of a journey by the council, local NHS and voluntary sector working together towards a common set of objectives and goals. To provide more clarity on our priorities and ambitions, we will develop a detailed Delivery Plan to sit alongside this strategy which will set out the programmes of work that will be delivered through this strategy.

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

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

1.1 Our population at a glance

Table 1: The borough at a glance… (Hammersmith & Fulham JSNA Highlights report 2013-14)			
80,600	Households	**8**	Live births each day
£464,000	Median house price	**2-3**	Deaths each day
189,850	Residents	**11,900**	Local businesses
32%	From BAME groups	**£33,000**	Annual pay
43%	Born abroad (2011 Census)	**3.1%**	Unemployment rate (JSA) *(London 3.1%)*
23%	Main language not English	**22%**	Local jobs in Public Sector
46%	State school pupils whose main language not English	**Ranked 55th**	Most deprived borough in England *(out of 326)* (13th in London)
17k/19k	Annual flows in and out of the borough	**29%**	Children <16 in poverty, 2011 *(HMRC)*
198,900	Registered with local GPs	**Ranked 6th**	Highest carbon emissions in London *(not including City of London)*
260,000	Daytime population in an average weekday	**9.6 years**	Gap in life expectancy between most and least affluent residents (2015)
7.1%	Fraction of deaths attributable to human made air pollution (8th worst in London)	**33%**	children of school age either overweight or obese

1.2 Our vision

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

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

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

We are already on our way to achieving this vision. We have a strong record of collaboration. The Better Care Fund is an ambitious plan by health and social care partners across Hammersmith & Fulham, Kensington & Chelsea, and Westminster to bring together health and care funding where it

makes sense with the goal of driving closer integration of health and care, reducing incidences of crisis, and delivering care in out of hospital settings. And in health, North West London is a whole systems integrated care pioneer site. NHS commissioners across North West London have agreed an integrated care system by April 2018.

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

1.3 The case for change

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

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

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

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

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

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

1.4 Achieving the change we need

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

(1) Radically upgrading prevention and early intervention

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

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

We will mainstream prevention into everything that we do and introduce measures to prevent ill health across the life course including increasing uptake of immunisations, working with our partners in housing, employment, education, and planning to promote health and wellbeing, initiate a local movement to build community resilience, and deliver intelligent, outcomes based commissioning that keeps people well. And we will empower people to make lifestyle choices that will keep them healthy and well and able to lead a full life as active members of their communities and the local economy.

(2) Supporting independence, community resilience and self-care

Population growth, breakthroughs in treatment and management of conditions and changing needs mean that the health and care system is under increasing pressure. In Hammersmith & Fulham we have a diverse and mobile population.

The potential benefits of people engaged in the management of their own care are significant. Small shifts in self-care have the potential to significantly impact the demand for professional care. In Hammersmith & Fulham, we must be ambitious in our attempts to change cultures so that people are better supported by the system and by technology where appropriate to take more responsibility for their own care. We know that self-care is a virtuous circle. When a person has the skills, knowledge and confidence to manage their own health and care it is a strong predictor of better health outcomes, healthcare costs and satisfaction with services.

To support people to take greater responsibility we will need to make sure the right services, facilities and support are provided to help people help themselves. We will harness the potential of digital technologies to facilitate control and choice and enable patients to manage their health in the way that best suits them. And we will fully engage people in service design and work with communities to co-produce health and care-related services.

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

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

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

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

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

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

(4) Taking a population-level health management approach

Approximately four-fifths of our population are healthy. Being in good health isn't just about the treatment of illness. It encompasses the food we eat, the air we breathe, the relationships we maintain, the environments in which we live and work and the opportunities we have in our lives to flourish. Supporting people to remain healthy, independent, and well is a crucial part of our plan as is identifying those most as risk so that services can intervene early. This plan will not succeed without working across organisational and sector boundaries.

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

- ✓ Housing: Poor quality and inappropriate housing and overcrowding can have an adverse impact on the physical and mental health and wellbeing of individuals, families and communities. We are committed to working with partners to improve the quality and supply of housing and reduce homelessness in recognition that a safe and secure home is a fundamental determinant of good health, both physical and mental. Hammersmith & Fulham is set to be a major contributor to London's economic growth over the next decade with three major regeneration projects that individually are on the same scale as Kings Cross and Stratford. Three of London's 'Opportunity Areas' are in our borough at White City, Old Oak and Earls Court which, combined, could include up to 20,000 new homes and 60,000 jobs.
- ✓ Education: Schools are central to the lives of children and families and it is important that we continue to work both with schools and other educational establishments to give children, young people and families the support they need to achieve and maintain good health and wellbeing.
- ✓ Culture and community cohesion: Libraries have an important role to play as a source of information and advice as well as venues providing social support and access to the internet.

Along with libraries, cultural organisations are an important asset in bringing communities together, building resilience, reducing loneliness and isolation and offering a range of convenient services in a community setting.

- ✓ Environment: We are fortunate to have many beautiful parks and green spaces that provide opportunities for exercise and relaxation. We will also work to create healthy high streets, reducing the impact of fast food outlets on health, using our licensing powers to control the impact of alcohol related harm and gambling and use planning powers to design out crime and increase physical activity.
- ✓ Transport: We will continue to encourage people to incorporate active travel into everyday journeys, create safer routes and raise participation in cycling. We will work to encourage the creation of school travel plans and cycle initiatives to contribute to reducing road traffic accidents. And we will work with partners to review and make recommendations to improve quality and choice in transport arrangements within health and care services.
- ✓ Air Quality: Our borough's poor air quality also affects all of us – bringing forward everyone's death by nearly 16 months on average. This compares with the least polluted area, rural Cumbria, where the reduction in life is an average of 4 months. Air pollution affects vulnerable groups more acutely, particularly young children and people living with chronic heart and respiratory diseases.
- ✓ Employment and skills: Evidence shows that being employed can help improve health and wellbeing and reduce health inequalities, while unemployment is linked to higher levels of sickness and psychological morbidity.[2] At the same time, we know that long-term unemployment is a serious barrier to good health. We will continue to support tailored employment support, targeting those who will benefit the most.

(5) Delivering integration and service reform

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

1.5 Improving population health outcomes

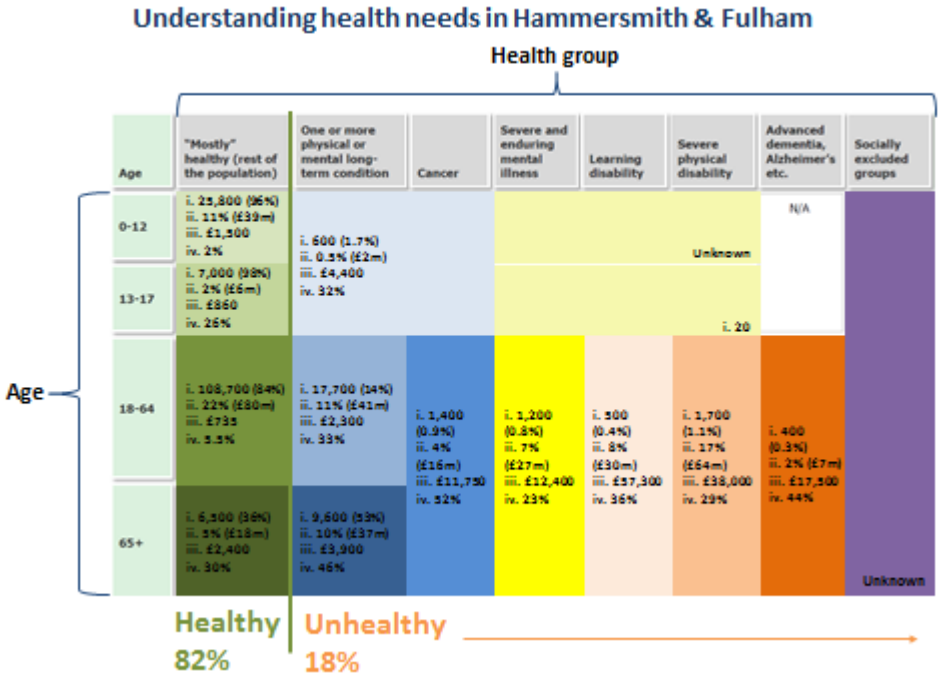
In Hammersmith & Fulham we have taken a population segmentation approach to understanding local need for health and care. Hammersmith & Fulham has:

- 182,500 residents and an average weekday daytime population of 260,000. The borough also has significant population 'churn' with annual flows in and out of the borough of approximately 19,000
- Significant variation in wealth
- A large young working age population
- Diverse ethnicity with one in four of the borough's population born abroad
- Almost a third of children under the age of 16 living in poverty
- Almost a third of state primary school age children who are overweight or obese
- Low vaccination and immunisation coverage
- 7th highest population with severe and enduring mental illness known to GPs in the country in 2014/15
- Poor air quality and the 6th highest carbon emissions in London

[2] (2015) Workplace health, National Institute for Health and Care Excellence (NICE) local government briefings

- A large proportion (38%) of one person households, including lone pensioner households and significant numbers living in overcrowded housing conditions
- High rates of smoking, alcohol use, poor diet and sexually transmitted infections and low levels of physical activity

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



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

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

1.6 Our health and wellbeing priorities

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

(1) Good mental health for all

Where are we now?

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

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

The borough had the 7th highest population with severe and enduring mental illness known to GPs in the country in 2014-15. People with serious and long-term mental illness have the same life expectancy as the general population had in the 1950s; one of the greatest health inequalities in England. People with mental health problems also face significant physical health problems and live significantly shorter lives as a result.

What will we do?

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

- Work to reduce waiting and referral times to talking therapies so that conditions do not deteriorate
- Work to ensure that mental health services are more flexible in terms of access criteria, the length of time services are offered for and the time and physical location services are made available
- Promote good workplace mental health and wellbeing and work with employers to educate them about employee mental health
- Work with staff in frontline services across the system to build skills and awareness of mental health
- Promote better emotional and mental health and early intervention in schools,

How will we know we're making a difference?

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

encouraging greater discussion of mental health in the school curriculum including access to counselling and mental health support services in schools • Provide support and self-help strategies for parents and parents-to-be for their own mental health and for the long-term mental health of their children • Encourage awareness and improve the quality of local services and support for people living with dementia and their carers including programmes to identify dementia early on • Work to reduce the high suicide rate among men • Promote access to activities that promote wellbeing, volunteering and stronger social contact to improve outcomes for adults at risk of serious mental health conditions and reduce social isolation • Provide early support for older people through effective information and advice and signposting to preventative/universal services • Work with communities to help change attitudes to mental health and develop better understanding of mental health. • Work with professionals to break down the barriers between physical and mental health and ensure both are treated and resourced equally • Improve the physical health and lifestyles of people with mental health conditions with a particular focus on people with serious mental health conditions and provide advice and support for all people with mental health conditions to have healthy lifestyles and good mental wellbeing • Improve access to children and young people's mental health services.	<u>Targeted support for vulnerable groups</u> We will target the support provided for vulnerable groups and those most in need including: • Those living in deprived or disadvantaged circumstances, or experiencing discrimination who are more likely to have a mental health problem than those in the most affluent areas. • Children in families vulnerable to mental health conditions who are more likely to develop mental health conditions as adults. • People in older age who have experienced events that affect emotional well-being, such as bereavement or disability • Men who are less likely to recognise or act on the early signs of mental health conditions and less likely to seek support from friends, family, and community or from their GP or another health professional. This worsens outcomes and contributes to suicide risk • Ethnic groups who have longstanding inequalities in mental health. Caribbean, African, and Irish communities are significantly over-represented in secondary care mental health services. Community links, and understanding of different cultural contexts for mental health are important to help improve access and outcomes • People with serious mental illness who are up to 15 times less likely to be employed than the general population and almost three times more likely to die early • Carers who play a pivotal role in the health system and who often have little time to care for their own health and wellbeing

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

<table>
<tr><td colspan="2">Where are we now?

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

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

• Develop an integrated health promotion offer for children and families focussed on breastfeeding and good nutrition, oral health, play and physical activity, immunisation, and tobacco free homes
• Develop shared multi-agency services that intervene early and impact on parental behaviour in the areas of substance misuse, domestic violence, mental health and neglect.
• Bring together services currently provided by Early Help, Children's Centres, and Youth Services into a single integrated family support offer that sustains and enhances universal provision, whilst providing further support to those families who need additional help through more targeted services
• Build on the Children and Family Act 2014 improvements for young people with Special Educational Needs and Disabilities, both of which recognise the role of wider</td><td>How will we know we're making a difference?

• Increase the proportion of mothers breastfeeding at six to eight weeks after birth
• Decrease the number of pregnant women smoking and of families exposing infants to second hand smoke
• Decrease in parents of infants with mental health concerns
• A reduction in the average number of teeth which are actively decayed, filled or extracted amongst children aged five years
• Reduce rates of childhood obesity: increasing the number of children that leave school with a healthy weight and reverse the trend in those who are overweight
• Increase in number of children who reach a good level of development in communications and language at the end of reception
• Increase in number of children who reach good level of development in personal, social, and emotional development at the end of reception
• Increase uptake of childhood vaccinations

Targeted support for vulnerable groups

We will target the support provided for vulnerable groups and those most in need including:
• Children and young people from low income households where poverty is associated with poor health and developmental outcomes
• Children from vulnerable families (e.g. teen pregnancy, homelessness, substance misuse and domestic violence) known to services
• Children and families from socially excluded</td></tr>
</table>

determinants in the mental and physical health and wellbeing of children and young people. • Empower children and young people experiencing poor or worsening mental, physical health or disabilities to access appropriate and reliable information, advice and expert care in ways that are convenient and tailored to them • Promote effective support for parents around sensitive parenting and attachment • Support the development of strong communications and language skills in infancy. • Provide evidence-based support for mothers, fathers, and other carers to help prepare them for parenthood and improve their resilience when they have a new baby • Strengthen the mental health support we provide to parents early on, including training key frontline staff to assess, support or refer families into relevant support services and ensure those needing specialist services receive them • Support parents of children who are frequent users of primary and unscheduled care services to understand and manage minor illness and ailments at home, and when and how to access wider support. • Ensure local services work together to minimise duplication and gain the best possible outcomes for families • Work with schools to promote health and wellbeing messages and harness the energy of young people to improve the health of their families. • Work with schools and families to improve children's diets and levels of physical activity	groups • Parents and parents to be with poor mental health which can often have a significant impact on early child development.

(3) Addressing the rising tide of long-term conditions

<table>
<tr><td colspan="2">Where are we now?

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

We are committed to improving care for people with LTCs to enable them to have an independent and fulfilling life and to receive the support they require to manage their health. We will work with all partners to prevent, identify, and manage LTCs. We will:
• Intervene early to prevent the onset of LTCs and provide support and information for people to maintain healthy lifestyles
• Provide increased support to people with diagnosed LTCs for self-care and self-management of conditions
• Ensure the continuity of care for people with LTCs
• Ensure people’s conditions are treated by coordinated health and social care services who can share information
• Ensure there is ‘no wrong door’ and effective signposting to health and social care services
• Ensure people their carers and families are involved in decisions about their own care
• Provide support for carers and their families to ensure they can support care receivers effectively
• Proactively identify those at high risk of developing Type 2 Diabetes and refer them on to behaviour change programmes</td><td>How will we know we’re making a difference?

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

Targeted support for vulnerable groups

We will target the support provided for vulnerable groups and those most in need including:
• The homeless population
• BME groups who are disproportionately likely to develop some long-term conditions</td></tr>
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(4) Delivering a high quality and sustainable health and social care system.

Where are we now?

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

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

What will we do?

We will:

- Work together across organisational boundaries to plan and deliver the workforce needed for the future;
- Work with our partners to look at the current and future needs of our population and map projected demand for health and care services to understand gaps in our workforce.
- Work with partners including universities, royal colleges, Health Education England, and other teaching institutions to refocus local health and care worker training programmes towards the workforce needed for the future.
- Work with partners to ensure there are the right reward structures and contract flexibility to incentivise the creation of the workforce we need
- Prepare staff for multidisciplinary team working rather than the roles of professional groups
- Support and better harness the power of the informal workforce by creating a 'social movement' to support those in need, including a more strategic approach to the support and development of volunteers.
- encourage and enable communities to take greater care of themselves and others;
- Identify and capitalise on people's strengths and residents' commitment to managing their own care and work with them to find ways to influence others so that they can do the same.
- Capitalise on our capacity to enable and promote healthy lifestyles
- Empower people to make lifestyle choices that will keep them healthy and well and able to lead a full life as active members of their communities and the local economy, working with our partners across the public sector to embed health improvement in all policies
- Developing the primary care estate and council buildings required to support new models of care nd a system that is sustainable and fit for the future.
- Increase value from under-used and under-utilised estate in the borough
- use technology to join up the health and care system and support people to better look after themselves;
- Invest in information technology and data analytics
- Seek to develop shared digital patient records updated in real-time and shareable across organisational and sector boundaries
- Improve information collection and management to enable better retrospective and predictive modelling, decision making and improve quality and safety standards for people.
- Exploit the smart phone revolution and use people's phones and other digital devices as a

new “front door” to self-care, health promotion information and services, building on the “One You” app recently launched by Public Health England and providing a seamless link to self-care and prevention work for adult social care

- Agree with partners across the borough to share information where it makes sense for patients and they are happy for us to do so
  Investigate the role of technology in enabling people to manage their own care investigate the viability of these approaches locally and scale up what works.
- Using finance to enable closer working and commissioning between health and social care and more personalised, integrated and person centred services.
- increase the use of pooled budgets where it makes sense as a way of enabling closer health and social care collaboration.
- Starting to view our budgets and services in a single joined up way
- Improve the way we communicate, engage, and co-produce with our residents ensuring information about health and care services is clearly signposted and tailored to audiences, and ensure people can have a say in local service changes and the development of new services
- Continually monitor our progress with the implementation of this strategy and regularly measure and report our performance to residents and patients

2. Implementing the plan

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

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

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

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

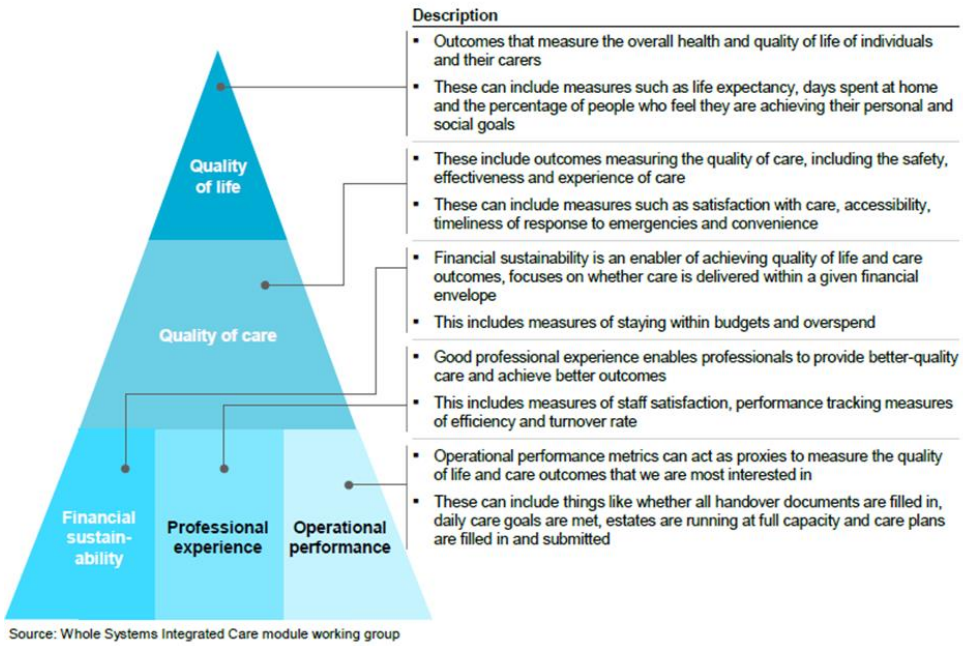
APPENDIX

Appendix A - Outcomes-based commissioning

- Traditional ways of buying health and social care services ("commissioning") have tended to focus on processes, individual organisations and single inputs of care. That is, the people who buy services ("commissioners") have tended to pay the people and organisations that provide health and social care services ("providers") according to the number of instances of treatment provided. This focuses the health and care system on completing specific tasks and away from treating people in a holistic way and on a person's overall wellbeing.
- As funding is attached to treatment, there are perverse incentives for providers of health and care services try to provide as much treatment to individuals as possible. This can be costly for the system as a whole and militates against the prevention of ill health. This approach has inadvertently helped fragment the way care is delivered and has acted as a barrier to the development of more integrated services and models of care.
- "Outcomes" are the end results we aspire to achieve for people, their families and their carers. Outcomes-based commissioning allows us to focus on the important aspects of care - the result from a patient's perspective. Under outcomes-based commissioning providers are paid for meeting specified outcomes, including things like the patient's experience of care and the extent to which they are kept well. Outcomes based commissioning therefore can be used to incentivise shifting of resources into out-of-hospital settings, focus health and care providers on keeping people healthy and in their own homes and co-ordinated care across settings and regions. It also encourages a focus on the experience of people using the services, and achieving the outcomes that matter to them.
- This is the approach needed in Hammersmith & Fulham. The Health & Wellbeing Board partners commit, through this strategy, to outcomes-based approaches to commissioning.

Our Outcomes Framework

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



Source: Whole Systems Integrated Care module working group

- The Hammersmith & Fulham Health and Wellbeing Strategy uses the North West London outcomes framework to ensure that there is a consistent approach to understanding people's needs and buying services in support of them across the sub-region. Being consistent across larger geographies including North West London is important, particularly in London, because so many providers of health and care operate across borough boundaries and because Hammersmith & Fulham residents access services outside of Hammersmith & Fulham.
- Basing our future commissioning on a shared framework in this way allows us to deliver scale to the range of services we have on offer for Hammersmith & Fulham residents and it means that we can make a shift, across the whole system, in the way that health and care is organised, bought, delivered and measured.
- In this outcomes framework and hierarchy, the most important perspective is the well-being of the person who is receiving services and as such, the first two domains – 'quality of life' and 'quality of care' (what we have termed quality of experience of care) - are the most important. The other three outcomes domains – financial sustainability; professional experience; and operational performance – are all crucial enablers for delivering quality care and quality of life for Hammersmith & Fulham residents and are addressed holistically in the systems section.
- Outcomes-based commissioning provides a way of paying for health and care services based on rewarding the outcomes that are important to the people using them. This typically involves the use of a fixed budget for the care of a particular population group ("capitated budget"), with incentives for health and care providers to work together to deliver services which meet specified outcomes. This approach aims to achieve better outcomes through more integrated, person centred services and ultimately provide better value for every pound spent on health and care.
- The approach can help rather than hinder provider coordination and collaboration; incentivise a focus on prevention; allow providers the freedom and flexibility to innovate and personalise care according to what is best for patients' outcomes rather than sticking rigidly to service specifications; and incentivise provides to manage overall system costs because providers are accountable for the end-to-end costs of care for a group there is no advantage in passing on costs to another organisation in the system.

Appendix B - Our population health priorities

	What do health and care services look like today?	Outcomes	Priorities	Measures
pre-birth and early years (0-12 years)	Babies generally receive a good start in life in the borough: there is good breastfeeding uptake, low numbers of underweight babies born, low numbers of women who are smokers at the time of birth. However, there is still room for improvement. Giving every child the best start in life is crucial to reducing health inequalities. Children who live in poverty are at greater risk of health and social problems later in life – from obesity, heart disease and poor mental health, to educational achievement and employment status. The number of 10 and 11 year old children who are obese in our schools is almost 40%. This matters, as they have a much higher risk of growing up to be overweight or obese as adults and of getting diabetes, heart disease, stroke and some cancers as they grow older.	• Children's physical, social and emotional development is improved • Young children, parents and carers are supported to start well and stay healthy and independent	• Planned pregnancy (Sex and Relationships Education in school) • Additional support for vulnerable families (e.g. teen pregnancy, homelessness, domestic violence) known to services and supported through pregnancy/early years • Access maternity services early. • Integrated maternity, midwifery and local authority early years and health visiting services to ensure there are valuable connections and information sharing • Supporting a healthy pregnancy (e.g. smoking, alcohol, weight gain, folic acid) • Prepared for birth: antenatal education/maternity care • Parents supported through the healthy child programme (e.g. health visiting, breastfed to 6 months, immunised, support for post-natal depression) • Early help support for families to ensure readiness for school (e.g. development reviews, speech/ language, physical, and emotional health) • All children supported to achieve good educational attainment and qualifications, including vulnerable groups (e.g. healthcare plans for children with additional needs) • Reduce detrimental effects of poverty on educational outcomes • Good oral health: healthy diet, brushing teeth, & visiting dentist	• School readiness • Reducing number of low birth weight babies • Reduce excess weight in 4-5 and 10-11 year old children • Improve population vaccination coverage at 1, 2 and 5 years • Increase parental employment • Reduce child poverty

	What do health and care services look like today?	Outcomes	Priorities	Measures
			• Discouraged from starting habits detrimental to health (e.g. smoking, drug use) • Maintaining healthy weight (e.g. school environment, being physically active) • Supported in building mental health resilience (e.g. education, school nursing, anti-bullying) • Intensive support for families facing multiple difficulties where this is resulting in poor outcomes, high costs, or safety issues • Immunisations and vaccinations including uptake of HPV vaccine for girls • Better integration and joint commissioning of social care support services (Early Help) and community health services: health visiting, school nurses, and mental health support in schools. • Improving air quality	
young people (13-17 years)	Young people in the borough face particular challenges. There are a significant number of children living in poverty and many young people are not in education, employment or training. Child obesity rates are high, there is poor child vaccination coverage and high levels of tooth decay in children.	• Young people are supported to start well and stay healthy and independent	• Received screening and advice around STIs and conception • Where appropriate, received additional training or support to get into paid work • Help giving up smoking through a stop smoking service • Integrated health and care services for young people to ensure good care coordination • Received support for low-level mental illness via IAPT programme, if needed • CAMHS support for young people with serious mental health disorders • Support managing any hazardous alcohol or drug use through statutory services • Registered with GP and women attending cervical screening	• Increase parental employment • Reduce child poverty • Reduce child obesity • Improve vaccination and immunisation rates

	What do health and care services look like today?	Outcomes	Priorities	Measures
			• Ensuring multi-agency planning and services for young people in challenging circumstances (e.g. young offenders, gang members, looked after children, homeless young people and young people who have been exploited or abused) • Investment in young people's mental health services • Implementation of the Children and Families Act 2014 (e.g. children with Special Educational Needs) • Ensuring good transitions between child and adult services (e.g. early care planning, key workers and coordinators)	
working age adults (18-64 years)	Working age adults make a significant contribution to society and to the health and wellbeing of others including as workers, as parents and as carers for parents, relatives or friends. These responsibilities mean it is important adults know how to keep themselves healthy and build this into their everyday lives. There are significant health challenges in this population however: suicide rates are high, there is a large homeless population, high levels of drug misuse and smoking, low uptake of breast and cervical cancer screening, and a high prevalence of mental ill-health. There are a larger proportion of people	• Working age adults are supported to stay healthy, independent and well • The gap in life expectancy between adults with serious mental health needs and the rest of the population is reduced	• Support for healthy lifestyles (e.g. smoking cessation, physical activity, diet, alcohol consumption) • Retain an active lifestyle to prevent overweight and the risk of long-term conditions • Undiagnosed long term conditions such as high blood pressure and diabetes is picked up via health checks, to be offered in a range of settings • Effective self-management of these conditions, through information, training, and a change in habits • Good access to sexual health services to detect, diagnose and treat STIs • Women attending cervical and breast screening • Support for those on long-term sickness to return to work • Received support for low-level mental illness via IAPT programme, if needed • Support for people with severe and enduring	• Increasing the number of parents in good work • Increase the number of people with learning disabilities in employment • Increase the number of people with mental health needs in employment • Reduce health inequalities between most and least affluent residents in the borough • Improving premature mortality from Cancer, CVD, respiratory disease • Reduce statutory

	What do health and care services look like today?	Outcomes	Priorities	Measures
	infected with HIV and high proportion of sexually transmitted disease. Unhealthy lifestyle choices tend to cluster together. So people who smoke are more likely to drink too much alcohol or to use other drugs and are also more likely to have poor diets and live inactive lives. We need to consider how we can help people address multiple rather than individual unhealthy behaviours.		mental illness • Support for people with learning disabilities • Support for people affected by suicide • Support for homeless communities and those sleeping rough • Early detection and diagnosis of HIV • Mitigating the impact of poor air quality for people living with cardiovascular disease or respiratory disease	homelessness • Reduce social isolation of carers and social care users • Reduce smoking prevalence
Older people (65+ years)	Older people make a valuable contribution to society. The majority of volunteers are aged 50 or over, and older people also represent a significant proportion of carers. Older people also have a wealth of skills, knowledge and experience. It is vital therefore that we support older people to age well. Our population is ageing and this means we will need to support growing numbers of people living with multiple conditions including dementia, cardiovascular disease, respiratory disease and frailty.	• Social isolation is reduced • Older people are supported to age well and stay healthy and independent	• Undiagnosed conditions picked up and self-managed or managed through GP/ community services, rather than through emergency care • Avoiding social isolation through the active engagement in activities and pastimes. In particular, partaking in gentle physical activity (e.g. walking, gardening) to lower risk of cancer, heart disease, mental ill-health and weak bone strength • Screening for early signs of dementia • Uptake of schemes which improve self-management of care • Receiving high quality health and social care designed around the person, not the condition, in convenient settings and at convenient times • Preventing sight loss • On reaching the last phase of life, support for dying in preferred place of death	• Reducing the number of people over 65 admitted to hospital due to falls • Reduce emergency readmissions within 30 days of discharge from hospital

	What do health and care services look like today?	Outcomes	Priorities	Measures
	These conditions are often linked with factors like social isolation and poor housing which can make care more complicated. Preventing chronic disease requires a range of interventions such as screening and vaccinations. Overall there is good uptake of NHS Health Checks and diabetic screening, good flu vaccination uptake, low number of hip fractures and low excess winter deaths.		• Mitigating the impact of poor air quality for people living with cardiovascular disease or respiratory disease	