HAMMERSMITH AND FULHAM JOINT HEALTH AND WELLBEING STRATEGY DELIVERY PLAN - Appendix 2

KEY: CCG, Public Health, Adult Social Care, Children's Services, Better Care Fund Projects							
Priority	**Goal**	**JHWS ambitions**	**Deliverables**	**Footprint**	**Lead/Governance**	**Supporting plans**	**KPIs**
PA1: Giving children, young people and families the best start in life	Integrated health and care for children, young people and families	1. 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 2. 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 3. Ensure local services work together to minimise duplication and gain the best possible outcomes for families	**Childhood immunisation rates:** o Working group established in 2016 consisting of CCG, NHSE, Local Authority colleagues and Public Health to improve childhood immunisation rates (focus primarily on MMR Second dose, pre-school immunisations and flu immunisations)	LBHF	CCG / LA		Increase population vaccination coverage at (1, 2 and 5 yrs old)
			Child Health Hubs o Development of a child health model based on a population approach to provide multi-disciplinary input to improve outcomes for children and families. o Development of Child Health Leads through the Partnerships in Innovative Education Scheme	LBHF	CCG		
			Paediatric audiology o Joint paediatric audiology service between ChelWest and ICHT	LBHF			
			Integrated Family Support Service (Cabinet paper approved by LBHF and bidder events held by LBHF in Q4 of 16/17. Anticipated start date of Q3 17/18) o Development of a special purpose vehicle to bring together professionals from a broad range of services under a single employer / commissioning arrangement. o Delivery of improved outcomes for children and families through effective and whole family early intervention in the community.	LBHF	CCG / LA		
			Deliver joined up service provision which enhances effectiveness and delivers efficiencies Key deliverables: • Develop a new integrated 0-19 Family Support Service which includes a school health service.	LBHF	Public Health / ChS / CCG		
			Promote good maternal health Key deliverables: • Invest in 3 new borough wide maternity champions projects.	LBHF	Public Health		parents supported through pregnancy, child birth and the transition into parenthood
			Supportive Foundations Portfolio: Collaborative Commissioning Project: • Troubled Families (3B) • Improvement work with provider of health visiting services (3B)	3B	ChS / Rachael Wright-Turner, Melissa Caslake, Dave McNamara		
	Improve health and wellbeing for children and young people with complex needs and disabilities	4. Build on the North-West London 'like Minded' strategy and the Children and Family Act 2014 improvements for young people with Special Educational Needs and Disabilities, both of which recognise the role of wider determinants in the mental and physical health and wellbeing of children and young people 5. Improve access to children and young people's mental health services 6. 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 7. Work with schools to ensure children are taught how to maintain good health and wellbeing 8. Promote better emotional, mental health and early intervention for children and young people inc. access to counselling and psychological therapies and work with partners to tackle cyber-bullying 9. Improve access to psychological therapies and children and young people's mental health services	**Future in Mind** Implementing 'Future in Mind' to improve children's mental health and wellbeing	CCG	DA1: Upgrading prevention and wellbeing	• CAMHS Action Plan • Children's Transformation Plan • Best Start in Life	• Reduction in the need for secondary care activity associated with CYP • Reduction in unplanned care needs for CYP • Reduction in the costs associated in managing CYP per capita
			Integrated care for children and young people (CYP) 16/17 actions • Develop eating disorder support for CYP • CCGs and Local Authorities to jointly commission services for CYP with SEN and disabilities in line with the Children and Families Act (2014) • Public Health Messaging via Schools 17/18 actions • Special Education Needs Review in Schools • Implement crisis and Out of Hours support for CAMHS • Redesign of Speech and Language Therapy Services with the aim of earlier intervention	CCG			2020/21 outcomes • Coordination of support for children and young people across all health and social care services • Improved outcomes for children and young people with one or more LTCs • Reduction in the risk of harm to children and young people
			Enabling Independence and Life Chances Portfolio: SEND Local offer Programme Project: • SEN and Alternative Provision Financial Review • CFA: SEND Transformation • CFA: inspection readiness	3B	ChS / Andrew Tag, Ian Heggs		

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			Enabling Independence and Life Chances Portfolio: Complex Needs Commissioning Project: • SEND Strategy (Part 1 Principles & Part 2 Full Strategy) • SEN Local Offer Contract Review • SEN outreach • SEN systems project (FutureGov) • Speech and language therapy (phase 1 - restructure and operational efficiency) • Speech and language therapy (phase 2 - targeted offer and schools) • Short breaks • Homecare Framework • JSNA • Residential Strategy (Part 1 Design & Part 2 Implementation) • Occupational Therapy (Review and Implementation) • Personal Budgets • Early Years Pathways (Review and Implementation) • Home Tuition & Medical Needs • Nursery Enhanced Offer • Parental Support Contract Recommissioning • TBAP 2017 SLA and SLA Redesign • Special Needs Schools and units SLAs	3B	ChS / Rachael Wright-Turner		
	Support the health and wellbeing of parents and guardians	10. Promote effective support for parents and guardians around sensitive parenting and attachment 11. 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 12. Strengthen the mental health support we provide to parents and guardians 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 13. Support parents and guardians 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 14. Provide support for parents and parents-to-be for their own mental health and for the long-term mental health of their families	**Strengthening Families** Portfolio: Social care service offer Project: • FGM Innovation Fund & Service Sustainability: Children's Services have been leading a comprehensive programme of work to safeguard girls from FGM, and to support those who have been identified as victim • Action for Change: Action for Change works with parents who have had a child(ren) removed permanently from their care and who are resident in Hammersmith & Fulham, Kensington and Chelsea and Westminster boroughs	3B	ChS / Rachael Wright-Turner, Glen Peache, Melissa Caslake		• Decrease in parents of infants with mental health concerns
			Strengthening Families Portfolio: Social care effectiveness Project: • Deregulation opportunities • Neglect – NSPCC • Family assessment • Child protection investigations and case conferences	3B	ChS / Rachael Wright-Turner, Angela Flahive		
			Strengthening Families Portfolio: Partners in Practice Project: • Focus on Practice • Partners in Practice • FutureGov proof of concept Description: 6 councils including the Tri-borough authorities. The government's 'Partners in Practice' have "freedoms to innovate, to improve frontline children's social work and to develop new systems of delivering social care and trialling new ways of working with families"	3B	ChS / Claire Chamberlain, Rachael Wright-Turner		
			Expert Commissioning and Operations Portfolio: Placements Commissioning Project: • Placements Commissioning Review • Improving internal relationships, processes and pathways • Aligning placements costs to level of support provided • More strategic market management of P & V provision • Enhanced in-house fostering • Fostering innovations in recruitment, assesment and housing • EDT and Out of Hours provision • YOT & Remand Commissioning • Presonalised edge of care support • Independence pathways for young people in placements • Widening accommodation options for Care Leavers • Employment for Care Leavers	3B	ChS / Rachael Wright-Turner		
			Perinatal mental health o Pilot in place with redesigned specification. Funding in place for pilot to August 2017.	CCG	CCG		
	Support children, young people, and families to lead healthy lifestyles	12. Support children, young people, and families to lead healthy lifestyles for example by encouraging cycling, traffic-free play spaces, healthy food in schools and better support for families to adopt a healthy diet from an early age	**Children will leave school with a healthy weight** Key deliverables: • Update our obesity strategy and associated action plan.	LBHF	Public Health		• Reduce rates of childhood obesity by increasing the number of children that leave school with a healthy weight and reverse the trend in those who are overweight

			Public Health Initiatives: Childhood Obesity Progress so far: • DA1 obesity business case has been written by CCG and mirrors our local programme of a) Healthy weight behavioural preventative and treatment services underlined by joint pathways and a toolkit b) Whole council approach to childhood obesity under which individual departments identify actions/pledges outlining how they/their partners will contribute to the environmental changes needed to halt and reverse the rise of childhood obesity Actions 2017/18 • There is an extensive programme called Tackling Childhood Obesity Together running across the three boroughs, in recognition of the serious problem.	CCG	Public Health / DA1: Upgrading prevention and wellbeing		• Reduce rates of childhood obesity by increasing the number of children that leave school with a healthy weight and reverse the trend in those who are overweight
			Bring oral health in line with the general population Key deliverables: • Support the implementation of the Oral Health promotion service, procured by NHS England and launched in April 2017, and monitor the impact to ensure it delivers improvements to child oral health, older people and vulnerable groups	LBHF	Public Health		• Reduce the average number of teeth which are actively decayed, filled or extracted amongst children aged five years

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PA2: Good mental health for all	Reduce mental health stigma and deliver parity between physical and mental health services	1. Work with professionals to break down the barriers between physical and mental health and ensure both are treated equally 2. Work with staff in frontline services across the system to build skills and awareness of mental health 3. Work with communities to help change attitudes, tackle stigma, and develop understanding of mental health.	**Development of IAPT and LTC model** o H&F IAPT already undertaking some LTC work/groups/interventions but plan to increase these as their capacity increases pending outcome of NHSE transformation fund bid. Work with service and as a tri borough to support this delivery.	LBHF			
			Objective: Upgrade mental health prevention efforts Key deliverables: • Publish the Director of Public Health's annual report on mental wellbeing in order to initiate review of mental illness prevention locally.	LBHF	Public Health		
	Improve mental health services for older people	4. Encourage awareness and improve the quality of local services and support for people living with memory loss/dementia and their carers 5. Provide early mental health support for older people through effective information and advice and signposting to preventative / universal services	**WLMHT Dementia service (01/08/2017)** o Business case approved at F&P Feb 2017 to increase staffing model to include dementia link workers, increase pre and post diagnostic support	CCG	Public Health		• Increase the number of Dementia Friends in the borough each year
			Social Isolation and Loneliness Steering Group o Co-ordination and shared learning of social prescribing projects across NWL. o Piloting of Age of Loneliness application with the voluntary sector **Commissioning support to services that reduce isolation for Older People** o Desktop research on effective ways (Nationally/Internationally) on reducing isolation o Understand specific services needed to reduce isolation in Older People o Map out what is available presently (DOS) o Evaluate / Commission appropriate service to reduce isolation o Effective communication of services that support isolation – signposting o Refresh service directions and ensure all services provide leaflets to GP's / Care Homes / Hospitals o Involve / communicate with key stakeholders and gain agreement / "buy in" to project o Develop Project Plan, Project Workbook and Communications plan	CCG			reduce social isolation and loneliness among the borough's older people
	Improve care for people with serious and long term mental health conditions	6. Improve health and wellbeing with a focus on people with serious and long-term mental health conditions 7. Encourage 'social prescribing' to improve mental health and wellbeing	**Like minded prevention workstream (HSC Local implementation Group for SLMH Workstream)** o H&F Health & social care work stream considering befriending, crisis café, day centre, peer support, dual diagnosis service and higher supported accommodation.	CCG	CCG / DA4: Improving outcomes for children and adults with mental health needs	• Like Minded Strategy for Mental Health • Five Year Forward View for Mental Health	• Reduce the gap in life expectancy between adults with severe and enduring mental illness and the rest of the population • reduce preventable early deaths among people with serious mental illness. • Reduction in secondary mental health caseloads
			Social Prescribing o Building on the learning of the two social prescribing pilots review the options for a borough wide approach to address the social, emotional and practical needs that impact on health and wellbeing PCMH (CCG MH priority no2) o Investment required to increase PCMH support including 5th PCMH worker plus psychiatry, psychologist and peer support. o Refresh business case, local monthly implementation steering groups, working with Recovery team to discharge suitable patients unto PCMH.	CCG			• More people supported to stay well longer in primary care
			• Early intervention in psychosis service	CCG			
			• Payment mechanism for mental health services moving towards outcome and quality measures	CCG			
			Implement new model of care for people with SMI and ltmhn, to improve physical and mental health and increase life expectancy 16/17 actions • Start implementation of the Community Living Well Service, bringing together clinical and wellbeing services to provide integrated support to people with stable serious ltmhns who are supported in primary care Implement the Community Living Well Service, bringing together clinical and wellbeing services to provide integrated support to people with stable serious ltmhns who are supported in primary care 17/18 actions • Evaluate impact of CLW service and continue to develop service network • Integrate primary and secondary care pathways • Integrate as part of wider Integrated Health and Wellbeing Centres	CCG			2020/21 outcomes • Integrated support for people with stable long term mental health needs which improves mental physical and social resilience • Seamless pathways across secondary and primary care • Greater number of people supported in primary care • Improved physical health for people with sltmh conditions

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			Community Living Well Progress so far: • Good progress on cross-agency OD and recruitment. IT issues may delay opening of VMC - due May 2017 Actions 2017/18 • Develop the Community Living Well strategy to prevent people getting unwell, improve pro-active care and plan for increased capacity for OOH MH & IAPT services	CCG	DA4: Improving outcomes for children and adults with mental health needs		
			Inpatient and Residential Recovery Services Progress so far: • Scoping document being prepared, and initial meeting of CCG and LA partners held. Working group to finalise strategy including both MHTs to be initiated May 2017. Actions 2017/18 • Develop a strategy and action plan covering the Tier 4 Pathway (In-patient, Rehabilitation, Out of Area and supporting Panel Processes) with the aim of ensuring effective pathway flow, reduced DTOCs, increased alternatives to in-patient admission and elimination of unwarranted OOA placements/ECRs in line with NHSE requirements	CCG	DA4: Improving outcomes for children and adults with mental health needs		
			Better Care Fund Schemes Scheme ref: B4 Joint Commissioning Developments Scheme name: Mental Health Outcomes: • Identify the structure for the project • Improve the processes prioir to panel, to ensure Care plans & reviews are presented in a timely/quality manner • Explore options for pooling funding for joint placements • Agree way forward for shared protocol for joint and separate funding for placements • Discuss wider opportunities for joint working Deliverables 2017-19 • Reduction in the numbers in long term MH placements • Options for pooling funding for joint placements	3B			
	Ensure that crisis support is available for people with serious and long-term mental illness	8. Ensure that crisis support is available for people with serious and long-term mental illness	**Suicide prevention** o Awareness training commissioned for staff and volunteers	CCG	DA4: Improving outcomes for children and adults with mental health needs		
			Evaluation of WLMHT SPA o WLMHT SPA has been evaluated and lessons learnt incorporated into future development of service. o To develop warm transfer of calls from 111 to SPA MH SPA Link o Linking the 24/7 mental health crisis support line in north west London to 111, allowing residents undergoing a mental health crisis to access appropriate specialist support via 111 without having to redial. Repatriate out of area patients and improve cross boarder arrangements and funding with CNWL o Review contract specifications. o Clarity and implement processes for repatriation of patients	CCG			
			High Quality Specialist Community Treatment, delivered consistently to time, and increasingly in the community. Progress so far: • SLTMHN Model of Care approved by TB (14/3/17). Local Urgent Pathway being redesigned to address process and delivery issues and will be included in final SLTMHN BC to GB early in July. Actions 2017/18 • Develop Crisis Services to ensure patients are cared for by the rapid response team at home not hospital and reduce unnecessary emergency admissions and facilitate early discharge. Ensure that no preventable MH patients are assessed in Emergency Departments.	CCG			

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PA3: Addressing the rising tide of long-term conditions	Prevent the onset of long term conditions and improve early intervention and diagnosis	1. Intervene early to increase early diagnosis, prevent the onset of LTCs and provide support and information for people to maintain healthy lifestyles 2. Improve and protect the health and wellbeing of our residents and reduce health inequalities across the Borough.	**Objectives: Reduce premature mortality by investment in services which protect and promote mental health, physical health and well-being.** Key deliverables: • Combine individual behaviour change services (including smoking, healthy heart and health trainers) and redesign and recommission a more effective and holistic Healthy Lifestyles Service	LBHF	Public Health		• Increase the proportion of residents who are active and eat healthily • Reduce mortality rates from the top three killers (Cancer, cardiovascular disease, respiratory disease) • Reduction in emergency readmissions after discharge from hospital
			• Cardio-respiritory prevention included in community service	CCG			
	Integrated support for people with one or more long-term conditions	3. Ensure people's long-term conditions are treated by proactive and coordinated health and social care services who share information and provide consistent standards of care 4. Provide increased support to people with diagnosed LTCs for self-care and self-management of conditions 5. Ensure better communication between agencies and better continuity of care for people with LTCs 6. Ensure there is 'no wrong door' and effective signposting to health and social care services	**Diabetes Prevention Programme and roll-out of digital DPP Vitrucare** Roll-out of a self-care platform, integrated with SystmOne, supporting patients to make decisions to improve their lifestyle and overall health. Development of a library of educational content to provide support to patients at different levels of activation to increase self-management	CCG	STP DA2 and 3	• Long Term Conditions Strategy • Dementia Action Plan • Better Care Fund • Whole Systems Integrated Care	• Reduction in unplanned events for people with LTCs • Reduction in the costs associated with supporting people with LTCs • increase in people with an LTC who self-manage elements of their care • Increase in people with an LTC who have an anticipatory care plan Integrated services • More people experience integrated care between services • Increase in the percentage of GP appointments with a named GP
			Patient Activation Measures o Utilisation of Patient Activation Measure licences to allowing educational and clinical interactions to be tailored to patients individual level of knowledge, skill and confidence.	CCG			Self-care • More people feel supported to manage their conditions • Uptake of personal budgets • Increase in the number of days spent at home • Reduction in avoidable (unscheduled) emergency admissions
			Right Care Progress so far: • Emerging priorities identified covering 80% of Right Care opportunities, and collection template submitted Action 17/18 • Establish delivery board and identify RightCare opportunities and develop implementation plans through the 15 stage Wave 2 delivery plan.	CCG/NWL	DA2: Eliminating unwarranted variation and improving long term condition management		
	Improve support for carers	7. Ensure people their carers and families are involved in decisions about their own care 8. Provide support for carers and their families to ensure they can support care receivers effectively					• More people and carers feel empowered and involved in their care planning
	Improve support for older people	9. Support for older people	**Increase the delivery of PHB to improve personalisation support in managing long term conditions for older people and vulnerable adults (including People with Learning Disabilities)** o Develop workbook and programme plan o Increasing the number of people receiving CHC PHB against baseline (Markers of progress) o PHB Steering Group on wider implementation of PHBs	CCG	DA2: Eliminating unwarranted variation and improving long term condition management DA3:	• Whole System Integrated Care Strategy • 3 Borough Better Care Fund • Five Year Forward View • Integrating Care Out of Hospital	• Reduction in overall costs associated with supporting Older People • Reductions in length of stay admissions • Reduction in overall costs associated with supporting older people • Reduction in costs across the system per capita • Better targeted investment • Improved pathway for service users, families and referrers
			Develop a new model for CHC commissioning across Older People, Adults with Physical and Learning Disabilities o Map out the current commissioning model of CHC across different care groups Identify the key risks for each current care / commissioning model o Develop workbook and programme plan – in progress o Make recommendations for a new commissioning model that reduces risks for CCG/Patients o Identify the capacity / skills needed to commission a new model of care including software / packages o Develop a new service specification for a new model of CHC commissioning for 3b o Managing risks of over spending through JCT o Identify opportunities for SRO, Project Management, Project Support and Data Analyst within the JCT team o Identify additional skills from outside of the JCT team to progress projects o To commence from January 2017 to end March 2018 – 5% on outturn	CCG			

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			Develop a Single Market Management plan on long term care placement with ASC to include: o Joint Funding Policy o Dispute Prevention Policy o CHC Operational Policy	CCG			
			Transforming Intermediate Care (IC) bed capacity to ensure productivity and value for money and impact on Delayed Transfers of Care (DToC) o Develop a Steering Group for Intermediate Care (IC) o Set up and lead on workshop with stakeholders to agree care pathways for IC beds	CCG			• Reduction in NEL and in hospital LOS through integrated working between whole systems (WSIC) and CIS
			Better Care Fund Schemes Scheme ref: B1 Joint Commissioning Developments Scheme name: Low level acuity health tasks Outcomes: • Delivery of low-level acuity health tasks by Homecare providers • Improve consistency of care in a customer home • Free up capacity within the District Nursing team • Encourage joint working between Health and Social Care professionals	3B	Ben Gladstone	BCF DA1 DA3	
			ASC Commissioning Strategy Programme - Tactical focus on high cost care packages, providers and system weaknesses. - Better transition planning and management. - Continued focus promoting independence including new annual review appraoch and further focus on Assisted Technology, adaptations and housing. - Establishing Direct Payments as the first choice service option. - Review all remaining in-house services. - Major re-design of care pathways and commissioned service portfolios Workstreams: 1. 'Independence First' Case & Provider Reviews– Heads of Service 2. Forensic needs and payments review – Heads of Finance/Heads of Service 3. Transition Management – Shelia Rodgers 4. Direct Payments as First Choice & Dynamic Purchasing System – Personalisation Lead 5. Care Pathways Re-Design (MH, LD & OP/PD) – Lead Commissioners 6. In house service review - Ben Gladstone 7. Contract review and Major Re-Commissioning Programme – Lead Commissioners	3B	ASC		• More people being supported in the community • Increase in activity managed outside of hospital setting
	Improve care in the last phase of life	10. Improve care in the last phase of life	**Last Phase of Life Programme** Delivery of 6 interventions agreed at the LPOL Steering Group: • Recognition of individuals in their last phase of life • Jointly developing and sharing care plans to support individuals accessing their desired care • Providing easy to access and consistent advice to care homes (generalist and specialist), 24 hours a day. Build upon evidence from elsewhere in the NHS including vanguard sites in Yorkshire (Airedale). • Making sure staff can support last phase of life care through training and education • Ensuring that nursing needs are met in care homes and the community • Ensuring consistent and dedicated GP cover to all Care Homes • Telemedicine Clinical Assessment and Support Function o Provision of a telemedicine support function providing 24/7 clinical support in real-time to care homes. o The function will include direct assessment, diagnosis, consultation, and treatment through the use of interactive audio, video and other electronic media to support on-going care within the patient's usual place of residence.	NWL	STP DA3	• Last Phase of Life Strategy • Better Care Fund	• Increase in people dying in their preferred place of death • Increase in people with anticipatory care plans • Reduction in the costs associated with managing people at End of Life
			Integrating services for people at the end of their life 16/17 actions: • Finalise End of Life Strategy Develop integrated service model including 24/7 SPA and Out of Hours Nursing Support • Develop procurement plans around third sector services 17/18 actions: • Rollout EoL Strategy and new integrated service model • Increase access to Coordinate My Care (CMC) 2020/21 outcomes: • Increasing number of people able to die in their preferred place of death. • Coordination of support to people at End of Life and their families/carers on a 24/7 basis and across all care settings	NWL	STP DA3		

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PA4: Delivering a sustainable health and care system that is fit for the future	Sustainable workforce	1. Work together across organisational boundaries to plan and deliver the workforce needed for the future 2. 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 3. Work with partners including universities, royal colleges, Health Education England (HEE), and other teaching institutions to refocus local health and care worker training programmes towards the workforce needed for the future 4. Work with partners to ensure there are the right reward structures and contract flexibility to incentivise the creation of the workforce we need 5. Prepare staff for multidisciplinary team working rather than the roles of professional groups 6. 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	**Expert Commissioning and Operations** Portfolio: Policy Projects: • Workforce Development Strategy	3B	Rachael Wright-Turner		
			Through the Making Every Contact Count approach, we will up skill staff to divert, refer, prevent and intervene early Key deliverables: • Develop a Making Every Contact Count implementation strategy which includes training social workers, librarians and environmental health officers to take proactive and preventative action where possible.	LBHF	Public Health		
	One public sector estate	11. Develop the primary care estate and council buildings required to support new models of care and a system that is sustainable and fit for the future 12. Increase value from under-used and underutilised estate in the borough	**Children's Hubs (as above)**	CCG	DA1: Radically upgrading prevention and wellbeing / Matt Mead		
			Community Estates Programme	CCG	DA3: Achieving better outcomes and experiences for older people		
	Digital	1. use technology to join up the health and care system and support people to better look after themselves 2. Invest in information technology and data analytics 3. Seek to develop shared digital patient records updated in real-time and shareable across organisational and sector boundaries 4. Improve information collection and management to enable better retrospective and predictive modelling, decision making and improve quality and safety standards for people 5. 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 6. Agree with partners across the borough to share information where it makes sense for patients and they are happy for us to do so 7. 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	**E-Consultations** **Patient Online** o To meet the requirement that at least 20% of patients registered at each practice have signed up to online services in 2017/18 **Babylon**	CCG			
			Expert Commissioning and Operations Portfolio: ICT & Infrastructure Project: • ICT - Converged LAC Forms • ICT - Mobile Working - Paperless Fostering & Adoption panels • ICT - Care Place Information Sharing WLA • ICT - Information Governance • ICT and Finance - Childcare: 2 y/o project and 30 hours • ICT - Fostering and Adoption IT solution • ICT - Schools Data • ICT - CP-IS Child Protection Information Sharing • Mosaic Upgrade	3B	ChS		
			Better Care Fund Schemes Scheme ref: C1 Scheme name: Single system performance dashboard Outcomes: • Delivery of a single BI function Provisional Plans for 2017/18: • Deliver agreed set of metrics 'single version of the truth'	3B	Stephen Potter / Una McCarthy		
	Finance	20. Using finance to enable closer working and commissioning between health and social care and more personalised, integrated and person centred services 21. Increase the use of pooled budgets where it makes sense as a way of enabling closer health and social care collaboration 22. Starting to view our budgets and services in a single joined up way	**Review Public Health Budget Allocations** Key deliverables: Undertake a Prioritisation Programme to inform 2018-19 public health budget allocations and beyond.	LBHF	Public Health		
			Expert Commissioning and Operations Portfolio: Financial Effectiveness Project: • Redesign of Finance Service	3B	Dave McNamara		

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			Better Care Fund Schemes Scheme name: existing s75 best value and alignment assessment Outcomes: • Checking everything spent in the s75 is best value for money & strategically relevant • Check spend against statutory requirements (meets/does not exceed) Provisional Scheme Plans 2017/18: • A set of strategically relevant value for money services in the s75 • Deliver financial savings up to 4% as an ambition • A single accountant to work on this across the 3 boroughs	3B	BCF		
	Communications and Engagement	23. 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 24. Continually monitor our progress with the implementation of this strategy and regularly measure and report our performance to residents and patients.	**Promote good health, self-care and, where appropriate, pathways into support services.** Key deliverables: • Develop and roll out a public health campaign plan aligned with national and local priorities. • Deliver the health information service through libraries, including health information points in multiple libraries	LBHF	Public Health		

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PA5: Radically upgrade prevention and early intervention	Make it easier for people to make positive lifestyle choices	1. provide greater scope for 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', offer 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. 2. work to create healthy high streets working to reduce the impact of fast food outlets on health, using our licensing powers to control the impact of alcohol related crime and gambling and use planning powers to design out crime and increase physical activity.					
			Better Care Fund Schemes Scheme ref: B5 Joint Commissioning Developments Scheme name: Other Opportunities - Prevention Outcomes: • Highlight services that provide good or excellent value for money • Highlight those providing poor vfm or are not sustainable • Reduce movements too other commssioners if spend reduces in prevention • Uncover opportunities for improvement & innovation in the commissioning of secondary prevention services • Establish prioirities for the recommissioning of services • Engage with providers Key deliverables 2017-19: • Align to STP (DA1) adapt not reinvent • Scoping of the total prevention budget and options to pool • Scoping of current spend to understand any alignment or duplication • Support 3rd sector organisations (support resilience) • Community catalysts – how do they fit in here?	3B	Stephen Falvey	DA1: radically upgrading prevention	
			Objectives: Increase accessibility for physical activity in public spaces/ facilities Key deliverables: • Open a outdoor gym in Norland Park	LBHF	Public Health		Increase percentage of adults who are physically active
		3. Increase uptake of immunisations and reduce the risk of new infections					
		4. We will empower people to make positive lifestyle choices that will keep them healthy and well	**Objectives: Reduce the prevalence of substance misuse related offending and disorder through collaborating with criminal justice colleagues to maximise identification and continuity of care.** Key deliverables: • Maximise the uptake and outcomes associated with the provision of holistic drug and alcohol treatment and prevention across all cohorts.	LBHF	Public Health		
			Objectives: Deliver effective and efficient sexual and reproductive health services which promote good sexual health, reduce the prevalence of STI infections and improve access to a range of contraception. Key Deliverables: • Implement a new genitourinary medicine (GUM) service model and online Sexually Transmitted Infection (STI) screening service. • Launch and implement a new community sexual health service model which includes screening, contraception, health promotion and psychosocial support.	LBHF	Public Health		Reduction in STI prevalence
	Tackle social isolation and loneliness	5. We will encourage partnership working between community and voluntary services, the NHS and local authorities to put in place strategies that will reduce social isolation and loneliness in the community.	**See Social Isolation (above)**	CCG	DA1: Radically upgrading prevention		
		6. Support residents at risk of social isolation including older residents who live alone					Reduce social isolation and loneliness across all age cohorts
	Support independence, community resilience and self-care	7. initiate a local movement to build community resilience and relationships and encourage and enable communities to take greater care of themselves and others 8. 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 9. 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.	**See patient self-care, including Vitrucare and video content section (above)**	CCG	DA1: Radically upgrading prevention		
	Make community care, primary care and social services part of an effective front li\ne of local care	10. Ensure the right support is available closer to home in GP surgeries, pharmacies, community hubs and in the home 11 Deliver high quality, consistent and joined up health and care that is accessible and convenient so people can access the right care, in the right place at the right time. 12. treat the time of people using the health and social services as a precious resource and seek to reduce time wasted across the system. This means getting the right care, right first time. We will consider all non-emergency unscheduled hospital	**Primary Care** • Creation of a Primary Care Strategy • Primary Care Homes • Network Configuration	CCG	DA5: Ensuring we have safe, high quality sustainable services	• Five Year Forward View • Strategic Commissioning Framework (SCF) • Sustainability and Transformation Plan (STP)	• Increase in activity managed outside of a hospital setting. • Reduction in costs across the system per capita • Increased access to services • Improved continuity of care • Improved responsiveness with faster on the day access • Broader range of professional s as part of primary care team

HAMMERSMITH AND FULHAM JOINT HEALTH AND WELLBEING STRATEGY DELIVERY PLAN - Appendix 2

		We will consider all non-emergency unscheduled hospital admissions as a failure of the system.	**Reconfiguring acute services** • PfH Contract • Frequent Users • Bicycle Responder • Walk-in centre @ Parson's Green • 111/GP OOH (IUC Review) • I/C Beds • PATCH (Providing Assessment and Treatment for Children at Home) • PACU Redesign	CCG			
			Contract Management for Imperial College Healthcare Trust	CCG	CCG		
			Better Care Fund Schemes Scheme ref: B3 Joint Commissioning Developments Scheme name: Domiciliary care and care homes single commissioner Outcomes:	3B	BCF		
			ASC Front Door and Demand Management Programme - Single commissioning strategy that brings together ASC, Public Health, Corporate and CCG funding. - Refocus towards targeted prevention, short term interventions and priority outcomes. - Simplify front door system for ASC: digital development and self service and transfer to lead provider and/or health front doors. - Extend focus on community and asset model of service delivey - Establish cross sector analytical and demand management function. Workstreams: 1. Commissioning Strategy – Paul Rackham 2. Front Door Development – Stella Bailie & Marc Cohen 3. Analytics and Demand Management – Una McCarthy	3B			
			ASC Whole Systems Integration Programme - Integrate all back office services including commissioning, business analysis, communications and workforce development. - Integration of hospital discharge, CIS and community SW teams with provider trusts supported by systems and practice development. - Development of joint commissioning plans for top cross sector service priorities - as a step toward ACPs. Workstreams: 1. Back Office Integration – Mike Boyle 2. Provider Integration – Stella Baillie 3. Joint Commissioning and ACP – Sarah McBride	3B	ASC		
	Influence the wider determinants of health	2. We will promote the importance of the **wider determinants of health** and wellbeing through work and positive relationships with friends and family 3. 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: 4. Housing 5. Education: continue to work with schools to support the health and wellbeing of children and young people 6. Culture and community cohesion: 7. Air pollution: Work with partners at all levels to reduce air pollution and the effects of air pollution in the borough. 8. Transport: 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. 9. Employment, volunteering and skills: support life-long learning and tailored employment support, targeting those				Housing JSNA	Adults with a learning disability in stable and appropriate housing Adults in contact with secondary mental health services in stable and appropriate housing
						Air Quality Strategy	Reduce fraction of mortality attributable to particulate air pollution
							• Support more people with mental health conditions into employment, training or volunteering • Reduce the number of sick days related to mental illness
							reduce absence rates due to sickness