Public Document Pack

Committee Agenda

City of Westminster

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

Title:	**Health & Wellbeing Board – Second Despatch**
Meeting Date:	**Thursday 23rd November, 2023**
Time:	**4.00 pm (Tour of the School at 3.45pm)**
Venue:	**St Marylebone Bridge School, Herries St, London W10 4LE**

Members:

Cllr Josh Rendall (Co-Chair)	Lead Member, Adult Social Care and Public Health - RBKC
Councillor Nafsika Butler-Thalassis (Co-Chair)	Cabinet Member for Adult Social Care, Public Health and Voluntary Sector, WCC
Councillor Lorraine Dean	Minority Group, WCC
Bernie Flaherty	Bi-Borough Executive Director of Adult Social Care
Sarah Newman	Bi-Borough Executive Director of Children's Services
Anna Raleigh	Bi-Borough Director of Public Health
Ali Wright	Healthwatch Westminster
Jackie Rosenberg	One Westminster
Angela Spencer	KCSC
Lena Choudary-Salter	Westminster Community Network
Iain Cassidy	Open Age representative
James Benson	NHS London
Bob Klaber	Imperial College Healthcare
Gary Davies	Chelsea and Westminster NHS Foundation Trust
Andrew Steeden	Primary Care Representative
Jan Maniera	Primary Care Representative

Members of the public are welcome to attend the meeting and listen to the discussion Part 1 of the Agenda

If you have a disability and require any special assistance please contact the Committee Officer (details listed below) in advance of the meeting.

An Induction loop operates to enhance sound for anyone wearing a hearing aid or using a transmitter. If you require any further information, please contact the Committee Officer, Maria Burton, Portfolio Advisor.

Email: mburton@westminster.gov.uk
Corporate Website: www.westminster.gov.uk

Note for Members: Members are reminded that Officer contacts are shown at the end of each report and Members are welcome to raise questions in advance of the meeting. With regard to item 2, guidance on declarations of interests is included in the Code of Governance; if Members and Officers have any particular questions they should contact the Director of Law in advance of the meeting please.

AGENDA

PART 1 (IN PUBLIC)

Stuart Love
Chief Executive, Westminster City Council

Maxine Holdsworth
Chief Executive, Royal Borough of Kensington and Chelsea

22 November 2023

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City of Westminster

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

Westminster & Royal Borough of Kensington and Chelsea Health & Wellbeing Board

Date:	**23 November 2023**
Classification:	**General Release**
Title:	Autism Strategy - Update
Report of:	Henry Leak (NWL ICB) Steve Comber (Bi-borough Children's Services) Seth Mills (Bi-borough Adult Social Care)
Wards Involved:	All
Report Author and Contact Details:	Henry Leak (NWL ICB) Steve Comber (Bi-borough Children's Services) Seth Mills (Bi-borough Adult Social Care)

1. EXECUTIVE SUMMARY

1.1. There is a statutory duty under the Autism Act 2009 for local authorities and health bodies to produce and maintain a strategy for supporting autistic adults in their local area.

1.2. Reflecting the close partnership working between Children's Services, Adult Social Care and the local Integrated Care Board in supporting autistic children, young people and adults, we produced an all-age autism strategy for our local area, including how we will meet the needs of children and young people aged 0-25.

1.3. The strategy was published in September 2020, following a programme of co-production with autistic people, their parents/carers, clinicians, professionals, and support providers. A copy of strategy can be accessed via the 'Strategies and Plans' page on our SEND Local Offer websites. The adult social care

Autism strategy which extends from all age strategy was launched November 2022.

- Royal Borough of Kensington and Chelsea SEND Local Offer
- Westminster City Council SEND Local Offer

1.4. A multi-agency Autism Partnership Board is in place to oversee the delivery of the Strategy, the activity for which was broken down into five key workstreams.

- Providing clear and accessible advice and guidance for autistic people and their families.
- Enabling autistic people to succeed in education.
- Identification and Health support – whole system approach to identification and support for all ages.
- Providing specialist support services for autistic adults.
- Enabling autistic people of all ages to live independently and healthily.

1.5. This report provides the Health and Wellbeing Board with an update on the key activities of each workstream so far and the next steps to be taken forward.

2. RECOMMENDATIONS

2.1 The report is for information only and to facilitate the Health and Wellbeing Board's discussion on progress made to date and future priorities.

3. PROGRESS TO DATE AND NEXT STEPS

Governance – Autism Partnership

3.1. The Autism Partnership Group reports in appropriate ways to:

- Health and Wellbeing Board
- Place Based Partnership
- SEND Executive Partnership Board
- NWL MHLDA Steering Groups
- Other Boards as required

3.2. Statutory members will report and follow their own organisations governance structure and ensure that the autism strategy remains a priority.

3.3. The board is co-chaired by:

- Autistic person (Adult Expert by Experience) with co-chair from either the
- Local Authority or the ICB.

Providing clear and accessible advice and guidance for autistic people and their families.

3.4. We have co-produced an accessible leaflet to outline the purpose of the All-Age Autism Strategy and the findings within it. The leaflet also describes the things we will be doing to improve our local area's offer as a result. The leaflet has been published on the Strategies and Plans page our SEND Local Offers and distributed across our local Autism Partnership.

3.5. Following the publication of the Autism Strategy in 2020, we have undertaken a comprehensive review of the 'Autism Zone' within the SEND Local Offer websites. The content has been redesigned to be more accessible and support parents / carers, children / young people and local professionals to find the information that they need more efficiently. This has been achieved by creating a pathway to key information that is based on guiding questions that are tailored to the specific audience.

3.6. An online data gathering form was co-produced by the Autism Partnership, to gather information about the range of services that are available in the local area to support autistic children, young people and adults. A link to this online form was distributed widely across the local area for services and organisations to add details of their offer. The form remains live, to enable us to continually collect new information about the range of support that is available for autistic people across the Bi-borough area.

3.7. The initial information from the form has been collated, categorised and presented on the SEND Local Offer websites to improve the visibility of the range of support that is available locally, improving awareness and access for residents and ensuring those working with autistic children and young people are able to quickly find and refer to services based on their needs.

- Finding Support for Autistic Children and Young People | Royal Borough of Kensington and Chelsea
- Finding Support for Autistic Children and Young People | Westminster

3.8. In terms of next steps, we will:

- Promote the collation of support that is available for people without the need for a diagnosis of autism with our local primary care network.
- Finalise a review of information provided to residents who are on the pathway for autism diagnosis regarding local support.
- Increase our promotion of services, events and local stories involving autistic residents via corporate communications channels.

Enabling autistic people to succeed in education.

3.9. As a result of the Autism Strategies publication in 2020, we established a small representative group of leaders from local educational settings, including headteachers and SENCOs working across early years, primary, secondary and post-16 phases. The group co-produced a list of the key things we would like to achieve to improve the experience and outcomes of autistic children and young people educated in our local area, these are:

- Identifying and implementing a unified approach to providing support for autism in our local schools and settings, which is understood by system leaders.
- Establishing a coordinated approach to identifying schools that require additional support and then providing this.
- Improving the experience of transition to secondary school.
- Providing high quality support for parents relating to education of their children and young people.
- Having high quality early identification and support in our early years settings, that supports timely diagnosis when appropriate

3.10. The Autism Advisory Team within the Bi-borough Inclusion Service and the Educational Psychology Consultation Service have worked together to roll out **information and training about the SCERTS model**.

3.11. The SCERTS model is an evidence-based educational approach and multidisciplinary framework that directly addresses the core challenges faced by autistic children and people and those with related disabilities, and their families. The acronym 'SCERTS' refers to the three key areas that the methodology focusses on:

- "SC" – Social Communication – the development of spontaneous, functional communication, emotional expression, and secure and trusting relationships with children and adults.
- "ER" – Emotional Regulation – the development of the ability to maintain a well-regulated emotional state to cope with everyday stress, and to be most available for learning and interacting.
- "TS" – Transactional Support – the development and implementation of supports to help partners respond to the child's needs and interests, modify and adapt the environment, and provide tools to enhance learning (e.g., picture communication, written schedules, and sensory supports). Specific plans are also developed to provide educational and emotional support to families, and to foster teamwork among professionals.

3.12. We recognised that, for this model to be implemented consistently across our local area, training should be made available not just to education settings, but also to colleagues from across health and social care provision. Training is being delivered by the authors of the SCERTS model. Three days have been delivered, each to approximately 500 attendees from across education, health and social care services in Kensington, Chelsea and Westminster.

3.13. In addition to the training, we are running a more intensive implementation pilot with five identified schools / settings from across the early years, primary, secondary and post 16 phases. The learning from this more intensive programme will be used to inform best practice for implementing SCERTS in the context of our specific local area.

3.14. Alongside this implementation pilot, all schools have been given access to an online learning platform to support them with implementation of SCERTS in their settings. To date 66 schools have signed up to use this. We are keen that schools themselves advocate for the implementation of the model. Senior

leaders from three local schools recently presented their experiences of implementing SCERTS to their colleagues at our Bi-borough SENCO Forum.

3.15. We have spoken with autistic children and young people about their experiences **of transition from primary school to secondary school** and have produced a report outlining the findings from this, identifying what worked well and what could be done better across our system.

3.16. In partnership with our parent carer forums, three secondary schools in our local area took part in the **NHS England 'Autism in Schools' project**. The project was delivered in partnership with the National Autistic Society and provided training to our secondary schools in how to support autistic learners as well as setting up small peer support groups for families of autistic children within their school. It included a 'sensory walk', undertaken by an Occupational Therapist who was able to advise on changes that could be made to the physical environment to support the inclusion of autistic students – this is a model that we have adopted locally, and we now have an Occupational Therapist based within our Autism Advisory Team.

3.17. Following the recommendations in the Autism Strategy, our Educational Psychology Consultation Service and Autism Advisory Team have worked together to develop an **Early Years Pre-Diagnosis pilot**. The aim of the pilot is to ensure that early years practitioners and providers are confident in identifying a child's additional needs that may indicate that they are autistic and are also able to provide a quality first approach to meeting such needs (based on SCERTS), which can be built upon when children transition into our local schools. There will be no need have a formal diagnosis to receive this support – it will be part of our ordinarily available provision.

3.18. The Educational Psychology Consultation Service and Autism Advisory Team worked together to develop a short document that provides examples of strategies that can be implemented and support that can be provided in early years settings. This is supplemented by an observation form that enables the setting to record the needs that have been identified, the support that has been provided and what has and hasn't worked. This will support with a smooth transition to primary school and has also been reviewed by our Child Development Services, so that the information collected can be used if a referral for a diagnosis were ever to be made, thus reducing the time needed for information gathering at the start of the process.

3.19. In terms of next steps, we will:

- complete the intensive implementation pilot of SCERTS and publish outcomes and next steps for continuing to embed the model within our local area, which will include establishing a team of local champions from settings to provide peer support to colleagues in their field.
- provide briefings regarding the importance of the SCERTS model to senior leaders from across education settings in our local area. This will include headteachers and governing bodies.
- act upon what children and young people have told us about their experience of transition – advising our local schools on what processes

will make this work better and building advice into the parent groups that are run by our Autism Advisory Team.

- test the Early Years Pre-diagnosis Pilot with selected settings and then, based on the findings, roll this out more widely. This will be undertaken by a dedicated speech and language therapist, which will help to further embed the SCERTS model across our health providers and maintain a multi-disciplinary approach to delivering the aims of our Autism Strategy.

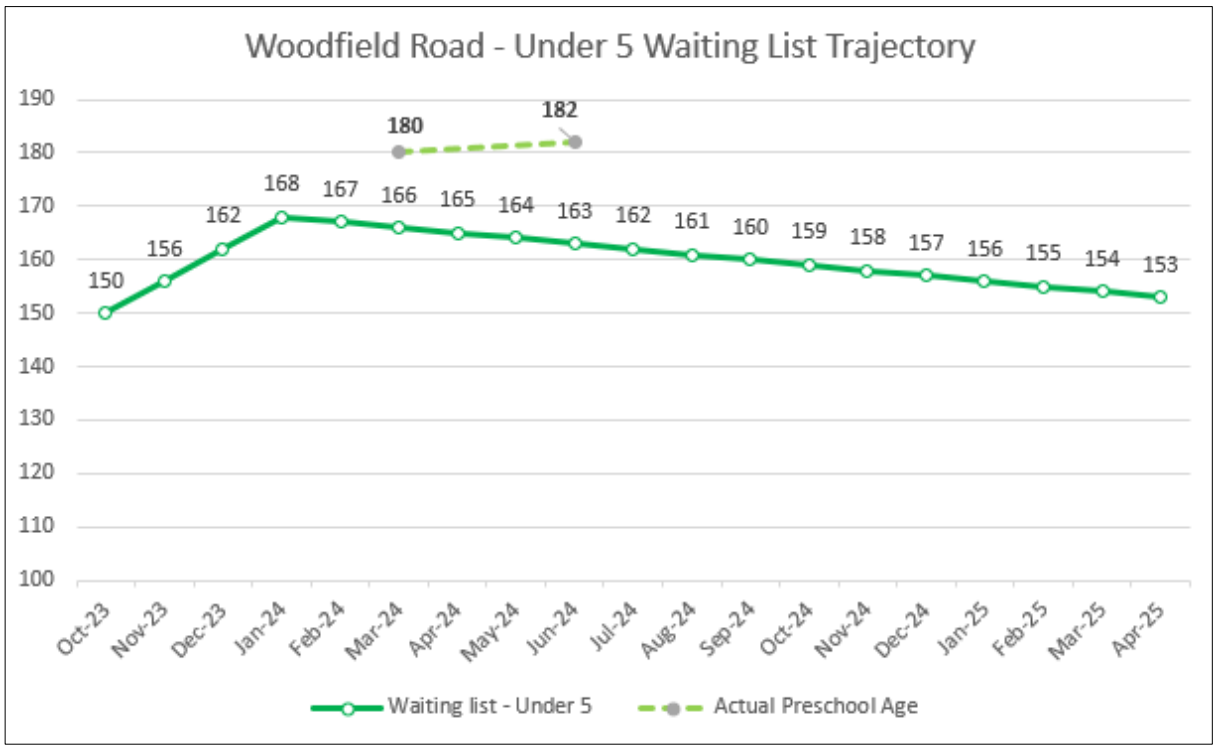
Identification and Health support – whole system approach to identification and support for all ages.

3.20. Following the publication of the Autism Strategy in 2020, the **Adult ASD Assessment Service** in CLCH successfully began a pilot to improve the efficiency of ASD assessments, by offering online input with administrative support. Subsequently, they were successful in the award of a second year of funding to increase and continue the new offer from the NWL MHLDA Programme.

3.21. In Jan 2022 a Business Case was agreed to outsource a number of ASD assessments from the **Cheyne Child Development Service**. Following a comprehensive procurement process and an increase in funding, a provider was sourced to take 400 cases from Feb 2023 to Feb 2024.

3.22. In October 2022 a second Business Case was provisionally agreed by the NWL ICB, later formally confirmed in March 2023, to permanently increase the capacity of the **CDS partnership (Chelsea and Westminster, Imperial and CLCH)**, totalling £1.7 million, with half released in 23/24, and then the full amount from April 2024. The increased funding has increased capacity across the service lines, e.g. ASD assessments and Initial Health Assessments for Looked After Children. Providers have already recruited to a number of posts, with some difficulties still remaining for key Paediatric roles. Both recruitment and impact are being closely monitored and reported on following the trajectory of recovery anticipated with the increased funding. At the same time both CDS (Cheyne and Woodfield Road) are aligning pathways and innovating to maximise capacity across the catchment area.

3.23. The three charts overleaf show the expected impact on the numbers of children and young people on the waiting list for autism diagnosis at Cheyne and Woodfield Road Child Development Centres as a result of this work:


Woodfield Road - Under 5 Waiting List Trajectory
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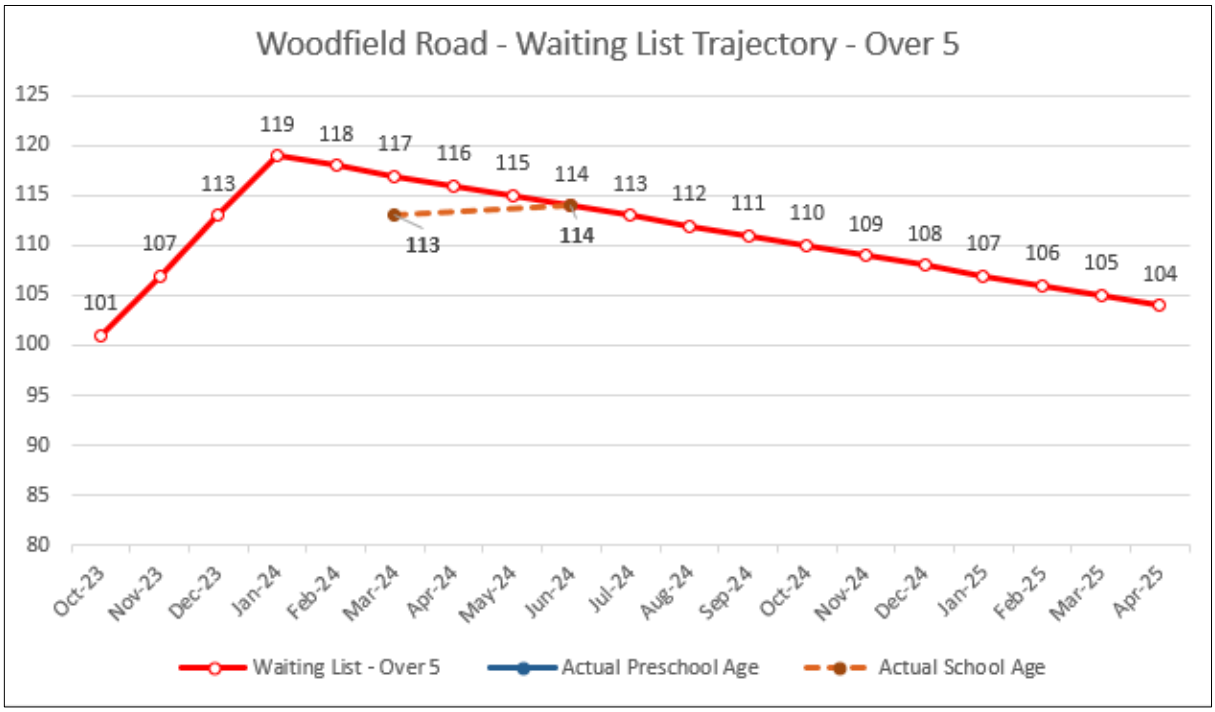
Waiting list - Under 5
Actual Preschool Age


Woodfield Road - Waiting List Trajectory - Over 5
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120
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Apr-25
Waiting List - Over 5
Actual Preschool Age
Actual School Age

3.24. Work has continued to embed the **Dynamic Support Registers (DSR)** for both boroughs, supporting those in crisis, at risk of hospitalisation or of placement breakdown where the individual has either a Learning Disability and/or Autism. The ICB co-ordinate one DSR in each borough separately for CYP and a joint one for Adults. All partners are fully engaged in this multi-agency and multi-disciplinary approach to crisis management, led by the ICB and supported by the two newly appointed NHS ASD Keyworkers who work with the individuals on the register who are at risk.

3.25. **CNWL** has recently employed a **Lead for Autism** across their services. This role will support MH staff to better manage the needs of patients with autism within universal services. It is anticipated that this will also further enhance the close working relationship between mental health and community health services in the two boroughs.

3.26. Following feedback from residents, support for Parent/Carers has been set up via **Full of Life (RBKC) and Make It Happen (WCC)** to provide more intensive therapeutic support.

3.27. The **Centre for ADHD and Autism Support** had originally been commissioned to provide peer support for young people approaching adulthood and for adults over 18, mostly post diagnosis. We have successfully embedded them into our local services, giving peer support to a growing number of residents in local venues. The NWL ICB **Autism Peer Support**

Advice and Inclusion Service (provided by CAAS) has been awarded more funding this year enabling an expanded offer, providing both **pre and post diagnosis support** for those 14 and above, but focussed on those children preparing for adulthood or adults, as well as scoping a potential similar offer for CYP within 23/24 across NWL

3.28. The **Oliver McGowan training** has finally been released by NHSE. NHS providers and the ICB are now mandating the training for all staff in all NHS CQC registered organisations, with Part One being general awareness raising, online, and part two, more specialist training for those working directly with Autistic patients, co-led by people with lived experience.

3.29. We have run a pilot with one **Westminster GP Practice** to enable then to consider the environment and the needs of their autistic patients, following consultations with each patient. This has led to improvements and reasonable adjustments for the individuals concerned. We are now rolling this out to all Westminster GPs and will be following up with Kensington and Chelsea practices early in the new year.

3.30. In Terms of next steps, we will:

- Collaborate with West London Children's Healthcare and CLCH to finalise a new specification and single service contract for the combined CDS services.
- Monitor the implementation of the recovery trajectories for all aspects of the CDS services, including ASD waiting times and IHA performance.
- Support WLCH with their alignment of their services.
- Monitor the impact of continued funding into the Adult Assessment Service.
- Work with CNWL to ensure their services are accessible and suitable for those with Autism in line with new funding
- Work with the new NWL ICB Autism Peer Support Advice and Inclusion Service to embed into services locally and support them to review the CYP peer support offer locally.

<u>Providing specialist support services for autistic adults.</u>

3.31. We want to plan together – **involving autistic adults and their families in service development and delivery**. Workshops have been held with experts by experience, carers, providers and professionals to explore innovations to support Autistic adults.

3.32. Following the publication of the Autism Strategy, recommendations were made to improve the quality of Adult Assessment services for Autistic adults. As a result, ASC employed a Senior Autism social work lead to link with health, social care and housing departments to work on reasonable adjustments and service approach for more Autism friendly assessments and services.

3.33. We are working to **improve understanding and acceptance of autism within society**. Work has started to raise awareness via training for professionals, providers and 3rd sector to promote better understanding of Autism and wider acceptance of neurodiversity.

3.34. Oliver McGowan Mandatory Training (OMMT) is now statutory for certain CQC-regulated providers and activities. Oliver McGowan is basic awareness around autism – for all health and social care staff. Level 1 mandatory for all staff. L2 is mandatory for those who work with ASD.

3.35. We have been improving our joint working and processes to ensure positive transitions for children and young people into adulthood. An **updated protocol has been agreed to strengthen the pathway for Autistic CYP**, and work is underway to implement the protocol. Giving more clarity on pathways for autistic people.

3.36. We have funded specialist music and art activities for autistic young people and adults through the **In-Deep community-based provider**. This service is for people with autism and sensory needs and provides a social space for them to engage with fun music and creative activities. It also brings carers and families together to participate in the activities.

3.37. We are piloting technology to help autistic adults to have more independence. **Brain in Hand** is an app added to a mobile or tablet device that is helping individuals to remember things, make decisions, plan, or manage their anxiety with minimal care and support. The app will monitor and track any patterns and behaviours, to be able to personalise the remote support further.

3.38. In Terms of next steps, we will:

- Work with LA and ICB leads to finalise the new training program for raising awareness of Autism. Funding has already been ring-fenced to launch the training across the Bi-borough.
- Develop Autism champions to help improve awareness and understanding in local organisations such as libraries, businesses, hospitals etc.
- Monitor the impact of Oliver McGowan training through the Bi-Borough Autism partnership board.
- Promote better use of adult Autism services – CAAS and In-Deep who provide resources for CYP to transition into.
- Monitor transition tracking meetings to review impact of new protocol for Autistic CYP.
- Establish closer working relationships with housing colleagues.
- Extend the funding for the senior Autism social worker to continue to support service delivery across agencies.
- Hold further workshops to involve experts by experience.

<u>Enabling autistic people of all ages to live independently and healthily.</u>

3.39. We want autistic people of all ages to have the confidence that services available to them are working to implement autistic friendly environments.

3.40. Research has been undertaken into best practice in **Autism Friendly Communities and Champion programmes** internationally. Buy-in has been secured from some frontline public-facing services for a pilot of Autism

Champions embedded in their workforce. The invitation will be extended to private sector businesses.

3.41. A workplan has been created for **engagement and co-production with residents**, who are invited to discuss their experiences and needs from their local community environment, to undertake **surveys of local venues to assess their autism friendliness**, to share their lived experience of High Streets and co-produce the action plan, and to accompany the Autism Champions programme to inform practice and to co-produce next steps. A number of partners who work with autistic residents have been contacted to promote opportunities for engagement and co-production, including VCSOs and the Council's supported interns programme.

3.42. In Kensington & Chelsea, we've established a £100K small grant programme in partnership with Young K&C to **make youth services more inclusive** by offering organisations training or capacity to enable young people with SEND to attend mainstream provision or to establish dedicated SEND sessions.

3.43. In Westminster, we are working with Young Westminster Foundation to **develop training and proposals for the youth organisations to enable the sector to be more inclusive**.

3.44. The **Holiday Activity & Food Programme**, which was delivered across both boroughs, had a 22% uptake of SEND young people (663 children in WCC and 508 in RBKC).

3.45. As part of the youth review in RBKC and renewing **Service Level Agreements**, a core priority being established is to make youth provision more inclusive.

3.46. Representatives from the Autism Partnership have met with Chairs of staff disability network groups in both Councils and attended session with RBKC Ability to Thrive Network to consult on areas of strength within the Council regarding supporting autistic employees, areas for development and suggestions for action. Results of these conversations were presented to HR with suggestions for action.

3.47. We have been exploring the potential to embed autism friendly practice in future Property audits and strategies, to ensure that needs of autistic residents are considered. A resident friendly environment audit tool has been created from NICE guidelines and a checklist is ready to be used to gather resident feedback on environments in public venues and inform service improvement – residents will be asked to undertake these surveys.

3.48. We have researched existing 'reasonable adjustments' for that should be used in primary care settings and have drafted a combined local 'ask' of GP surgeries and a draft Patient feedback document to be used by surgeries. We have identified a pilot site to take this forward.

4. FINANCIAL CONSIDERATIONS

4.1 None.

5. LEGAL CONSIDERATIONS

5.1 None.

Appendix A – Accompanying PowerPoint presentation

Autism Strategy Update

Bi-borough Health and Wellbeing Board

23 November 2023

Autism Strategy

2020-2025

Priority 1: Planning together
Real improvement through involving autistic people, their families, providers and practitioners in the development of our strategic approach and service delivery.

Priority 2: Establishing autism friendly environments
Supporting staff and the wider community to understand autism and the needs of autistic people and their families, and that our physical locations are accessible.

Priority 3: Providing clear and accessible information, advice and guidance
Supporting autistic people, families and professionals by providing effective resources, advice and signposting.

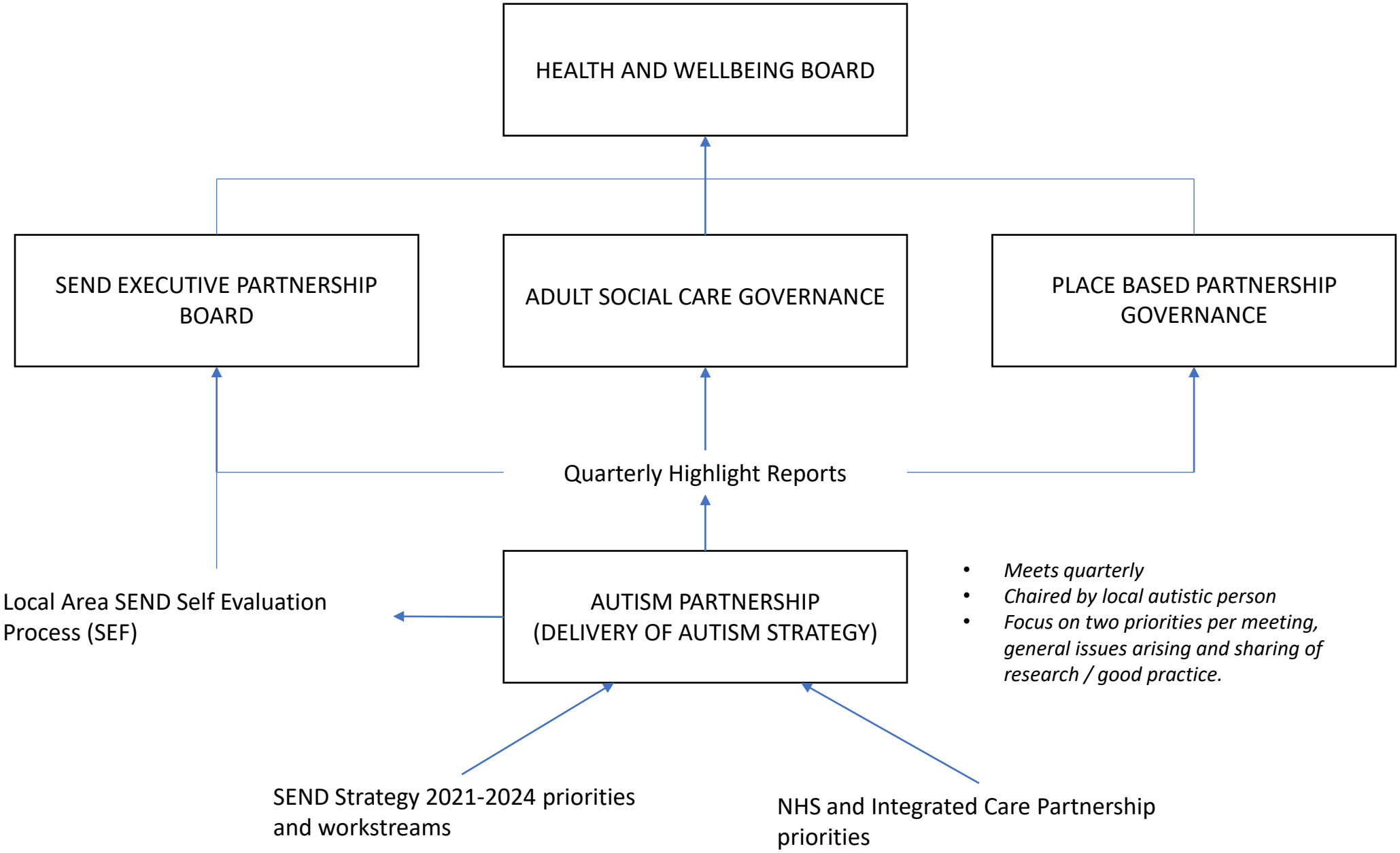
Priority 4: Earlier identification
Identifying autism as early as possible in children, young people and adults.

Priority 5: Improving the diagnostic pathway, reducing waiting times, and providing appropriate support
Providing a high-quality health service which responds quickly to people's needs.

Priority 6: Enabling young autistic people to succeed in education
Providing effective support for autistic people to enable them to fulfill their potential in all educational settings (whether early years, school, college or at home)

Priority 7: Enabling autistic people to live independently and healthily
Working across employment, housing, health, education and social care to support autistic people to live full independent lives.

Priority 8: Providing specialist support services for autistic adults
Increasing and improving the adult support offer in our local area.


HEALTH AND WELLBEING BOARD
SEND EXECUTIVE PARTNERSHIP BOARD
ADULT SOCIAL CARE GOVERNANCE
PLACE BASED PARTNERSHIP GOVERNANCE
Quarterly Highlight Reports
Local Area SEND Self Evaluation Process (SEF)
AUTISM PARTNERSHIP (DELIVERY OF AUTISM STRATEGY)
Meets quarterly
Chaired by local autistic person
Focus on two priorities per meeting, general issues arising and sharing of research / good practice.
SEND Strategy 2021-2024 priorities and workstreams
NHS and Integrated Care Partnership priorities

Our local Autism Partnership

- Board Responsibility: To oversee the delivery of the eight priorities
- Membership : Co-chaired by a local resident who is an Expert by Experience, representation from across the health and care system including Parent Carer Forums, Clinical Leads and Voluntary Sector.
- Frequency – Quarterly online. Core Group meets monthly.
- Next steps – Increasing service user engagement via formalised reference group and reviewing T.O.R.

1. Providing clear and accessible advice and guidance for autistic people and their families

Autism Zone

I am...

- A parent wondering if my child is autistic
- A parent of an autistic child
- An autistic young person
- Interested in Autism Training
- A professional who is supporting autistic children

NEW!

Finding Support: Autistic Children and Young people

- General Support for Everyone
- Support for Specific Needs
- Support with Specific Functional Skills
- Wider Community and Life Skills
- Diagnosis and Specialist Support
- Other Information and Resources

2. Enabling autistic people to succeed in education

SCERTS®

Evidence based, unified approach to meeting needs of autistic students.

Training for all schools and colleges from authors of the model.

Pilot group for more detailed implementation and evaluation.

NHS England

Autism in Schools Project

The Early Years Foundation Stage

3. Identification and Health support – whole system approach to identification and support for all ages

- Increasing capacity within Child Development Services with ongoing investment of £1.7 million – Impact beginning to show, wider support offer improved including links to LA and VCS support.
- 2 year pilot for Adult Diagnostic services has increased numbers being assessed, aligned with improved post diagnosis support.
- Increased capacity from CAAS, pre and post diagnostic peer support for adults, reviewing CYP options across NWL
- Improving Autism awareness and availability of ‘reasonable adjustments’ in health, including mandatory training (Oliver McGowan) and GP Practices surveys.
- Supporting those most at risk of hospital admission or placement breakdown via the Dynamic Support Registers

4. Providing specialist support services for autistic adults

- The Adult Social Care Autism Strategy – extends from the All Age Autism Strategy – November 2022.
- Involving autistic adults and their families in service development and delivery. Workshops held with experts by experience, carers, providers and professionals to explore innovations to support Autistic adults.
- Improving understanding and acceptance of autism within society – training for professionals, providers and third sector organisations.
- Specialist music and art activities for autistic young people and adults through the In-Deep community-based provider
- Piloting technology to help autistic adults to have more independence - **Brain in Hand App**
- Improving pathways for transition from children's services in to adulthood.

5. Enabling autistic people of all ages to live independently and healthily

- Autism Friendly Environments and the value of community champions.
- Surveys of local venues – undertaken by autistic residents – to understand how autism friendly they are and make recommendations for improvements.
- Understanding how autism friendly our Councils are – including for autistic employees.
- Improving the experience of autistic people who are accessing our primary care settings.

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City of Westminster

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

Westminster & Royal Borough of Kensington and Chelsea Health & Wellbeing Board

Date:	**23 November 2023**
Classification:	**General Release**
Title:	Health and Well Being Strategy – Outcomes Framework and Integrated Neighbourhood Teams
Report of:	Joe Nguyen, Borough Director, NHS NW London David Bello, Director of Health Partnerships, BiB
Wards Involved:	All
Report Author and Contact Details:	Grant Aitken, Head of Health Partnerships, Westminster and RBKC, grant.aitken@rbkc.gov.uk Joe McGale, Assistant Director of Primary Care, NHS NW London joe.mcgale@nhs.net Ivan Okyere-Boakye, Head of Integrated Care, NHS NW London, ivan.okyere-boakye@nhs.net

1. Executive Summary

1.1 The aim of the Health and Wellbeing Strategy (HWBS) has been to set out the medium to long-term ambitions for health and wellbeing across Kensington and Chelsea and Westminster and to provide a mechanism for the Health and Wellbeing Board (HWBB) to track progress. Although it will be hard to identify the direct impact on the health of our communities, the strategy provides a context to promote cultural change, mutual accountability, shared understanding and collaborative working[1].

1.2 By reflecting the needs of local populations, the strategy also helps harness local resources, though shared ownership and leader to tackle health

[1] https://www.gov.uk/government/publications/shared-outcomes-toolkit-for-integrated-care-systems

inequalities. The report is therefore intended to be a way for the HWBB to understand how the board can operate over the coming years to inform and influence the wider social determinants.

1.3 Not everything will be within the direct control of the HWBB members, therefore the metrics (Appendix A) provide a basis by which the HWBB can understand impact and to understand areas where their shared leadership can be used to improve these outcomes across the 10 Ambitions. This will be supported by the development of an annual implementation plan that needs to be developed with HWBB members and the community. Appendix B outlines the approach to developing and agreeing the plan.

1.4 The development of Integrated Neighbourhood Teams (INTs) is a key platform that seeks to change the way partners work across organisations and with communities to improve population health. This work follows the ambitions of the HWB Strategy and takes forward national recommendations outlined in the Fuller Stocktake Report (2022).

2. Recommendations

2.1 The HWBB to comment on the draft outcomes, implementation plan development process and note the update on Integrated Neighbourhood Teams.

3. Background

"Shared outcomes have proved to be a powerful means of bringing organisations together across the health and social care system to deliver on a common purpose. Where outcomes are agreed at place, they can enable organisations to address the needs of their local populations with a focus on health improvement – while also reinforcing shared efforts to meet national outcomes and requirements"[2]

3.1 Following the adoption of the HWBS a "basket" of key metrics (Appendix A) are proposed as the basis for the joint HWBB to monitor progress and to support identification of areas where the HWBB wants to focus its effort. The metrics are based on what are already publicity available, and in a number of areas report to different boards. However, they are seen as key indicators that allows the HWBB to understand how, working across all ambition areas, it can assess the impact it is making on health inequalities. The indicators will change over time as local priorities depending on progress.

3.3 The aim of the implementation plan (see appendix B) is to identify local actions, against each of the 10 ambitions and are seen as key in starting to have an impact on health inequalities. It will cover a 2-year period and has picked up from the issues raised through the consultation and also links key existing work priorities across HWBB partners. Where the HWBB is responsible for the delivery of the action, this will be delegated to a led organisation, for example Place Based Partnership, local authority, or VCS etc.

[2] https://www.gov.uk/government/publications/shared-outcomes-toolkit-for-integrated-care-systems

3.5 The implementation plan is not a fixed document. As delivery proceeds it will be reviewed on a quarterly basis and if areas need strengthening or new actions required, then these will be captured.

4. Integrated Neighbourhood Teams

4.1 Integrated Neighbourhood Teams (INT) are the delivery vehicle (see appendix C) through which the ambitions within the HWBS will be implemented over the coming years. This programme of work will bring together local partners and services across health, social care and community groups to support better health and wellbeing in our neighbourhoods and reduce health inequalities for our residents.

4.2 Through the INTs, partners will strengthen prevention and early intervention care by working together better in neighbourhoods and actively using population health information insights to drive their work. This will enable care professionals to improve how we support our increasingly complex residents through more effective integrated working across our health, care and local communities. This is important as we know that partners can only effectively address the social determinants of health that have a causal effect on our resident's health and wellbeing, if we improve our close working with our active local communities.

4.3 The development to date has focused on engaging and co-producing with partners across the Bi-Borough a draft INT framework to inform our joint understanding of what INTs should be and what they should support. The co-design also included interviews and surveys with residents as well as those delivering services. Personas that provided examples of real-life challenges that people can face were developed and also used in workshop discussions to inform the development of this framework. In addition, development of the framework involved identifying areas of best practice both within and across the Bi-Borough to support discussions. This ensures that we continue to build on the many successful existing models of integration (e.g. Family Hubs) as an opportunity to learn and share good working practices.

4.4 Across WCC and RBKC, there will be a total of 3 INTs each of which will be led by an INT Leadership teams made up of health, care and community sector representation. These INTs are:

- North Kensington & Chelsea and Queen's Park & Paddington – with initial focus on supporting people 65yrs and over, including Mental Health needs
- South Kensington & Chelsea – supporting children and young people, including through family hubs, and development of community connectors programme
- Westminster – supporting people 65yrs and over, and Octopus community connectors programme

4.5 Each INT will use a data-led population health management approach in order to identify as key INT representatives what the local population challenges are and to collectively design and deliver a localised support offer that improves the outcomes for people facing those challenges. hyper-local delivery which is

reflective of population need. We have started with the priorities above, which in time will move to other locally agreed areas of focus.

4.6 A Bi-Borough INT Steering Group of senior executive leads from all of the partner organisations involved has also been established, and will oversee the development and delivery by the INTs. This group in turn reports into the Bi-Borough Collaboration Delivery Group for strategy and steer which is overseen by the HWBB.

4.7 An overview of Bi-Borough INT development can be found within Appendix C.

5. Financial Considerations

5.1 None.

6. Legal Considerations

6.1 The Health and Wellbeing Board has a statutory duty to prepare a joint health and wellbeing strategy under s116A of The Local Government and Public Involvement in Health Act 2007.

END

Appendix A

Draft shared outcomes frameworks

Appendix B

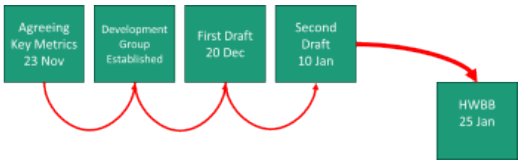
Draft Implementation Planning Process

Implementation Plan Development

1. Establishing a HWBB led development group
2. Working with community led organisations to develop the key priorities and focus
3. Recommending to the HWBB the focus of the implementation plan, for example

    - INT roll out (Ambition 7)
    - CYP - (Ambition 1)
    - VCS commissioning– (Ambition 5)
    - Early detection– immunisation, screening, smoking etc (Ambition 2)

4. Mapping the existing strategic and operational partnerships to identify existing actions and to identify areas of responsibility and reporting
5. Continue to work with the HWBB on its role and approach to deliver and be accountable for the HWB strategy



Appendix C

Bi-Borough Integrated Neighbourhood Team Development Overview

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Metric	RBKC Present Performance			WCC Present Performance			Latest time period	Source	Source link	Definition RAG	Borough Story	Frequency	London	England
	Latest data	Comparison to London / target	Trend	Latest data	Comparison to London / target	Trend								
Number of families who are struggling financially (LIFT data)											Not included, but has: chi			
16-17 year olds not in education, employment or training	3.6%	Similar	No change	3.3%	Similar	No change	2022/23	PHOF B05	Public Health Outcon	As reported by OHID:	What we do well' section	Annual	3.4%	5.2%
The mean average number of teeth decayed, missing or filled (DMFT) per 5 year old	19.3%	Similar	Not available	39.5%	Higher	Not available	2021/22	Percentage of 5 ye	Public Health Outcon	As reported by OHID:	Start well section	Every two-three	25.8%	23.7%
Parents of disabled children receive the support they need with caring														
Uptake of MMR - 95% target for five-year-olds receiving two doses of the measles, mumps and rubella (MMR) vaccine	67.2%	Lower	No change	74.0%	Similar but <90%	Increasing	2022/23	PHOF indicator D0	https://fingertips.ph	As reported by OHID:	Start well section	Annual, and preli	74.0%	84.5%
waiting time standards for 95% of children and young people with a suspected eating disorder to start NICE concordant treatment within 1 week if urgent and within 4 weeks if non urgent (Not sure – need to check with service)											Not included			
Percentage of adults who are overweight or obese	45.5%	Lower	Not available	49.7%	Lower	Not available	2021/22	Percentage of adu	https://fingertips.ph	As reported by OHID:	Live well section	Annual	55.9%	63.8%
Percentage of resident with long term health conditions	30%	Not available	Not available	30%	Not available	Not available	Jun-22	WSIC	Local analysis	Not available - local d	Live well section	Annual	Not available	Not available
Uptake of NHS health checks	56.5%	Higher	Not available	47.5%	Higher	Not available	2018/19 - 22/23	PHOF indicator C2	Public Health Outcon	As reported by OHID:	Live well section	Annual	34.1%	27.4%
Number of residents who drink more than is recommended	41.3%	Higher	Not available	26.9%	Similar	Not available	2015-2018	Fingertips ID92778	https://fingertips.ph	As reported by OHID:	Live well section	Every four years	20.1%	22.8%
Proportion of physically inactive adults (aged 19+)	23.4%	Similar	Not available	20.9%	Similar	Not available	2021/22	Percentage of phy	Public Health Outcon	As reported by OHID:	Live well section	Annual	22.9%	22.3%
Reduced life expectancy gap	Men: 17 years Women: 18 yea	Higher	Not available	Men: 18 years Women: 9 years	Higher	Not available	2018-20	OHID local health:	Local Health - Small /	As reported by OHID	Live well section	Annual	Men: 7.5; W	Men: 9.7; Women: 7.9
Ensure 75% of LD patients receive Annual Health Checks and personalised Health Action Plans											Not included			
Gap in poor health years (number of years in poor health)	Men: 17 years; Women: 18 ye	Not available	Not available	Men: 18 years; Women: 22 yea	Not available	Not available	2018-20	Difference between	PHOF healthy life ex	Not available	Age well section	Annual	Men: 17 yea	Men: 16 #years; Women:
% of residents who reported feeling anxious yesterday	25.3%	Similar	Not available	28.2%	Similar	Not available	2021/22	PHOF indicator C2	Public Health Outcon	As reported by OHID:	Live well section	Annual	23.8%	22.6%
60% of people with severe mental illnesses receive annual physical health checks in primary care											Not included			
IAPT access rate of 25% expected prevalence and 50% recovery rate											Not included			
No. of vulnerable residents supported to continue living in their home											Not included			
No. of cases of homelessness prevented for familites with children											Not included			
No. of people supported in homelessness accommodation	429			Borough Story includes rough sleeping: 2,000 people were seen rough sleeping in Westminster			Apr-23	Local service data provided by Hideo Ikehara			Included for RBKC only; W	Annual		
% of women who feel safe walking in their area after dark											Not included			
% of residents who think their local area is a place where people from different backgrounds get on well together											Not included			
Average concentration of particulate matter 2.5 (PM2.5) in Westminster	Based on modelled projections, two thirds of the		Air pollution has reduced by half over the last 15 years.	All our air quality monitoring sites do not meet World		Air pollution has reduced.		Confirmed by Adam Webber (WCC) and Louise Grimes (RBKC)			Place section			
% of residents who regularly or often cycle around/ walk around Westminster											Not included			
Residents with worsening asthma (something to show the effect of air quality)											Not included			
Number of parks and open spaces awarded with green flag status	The council manages over 30 parks and open spaces including 10 with green flag status. How			Over 200 identified parks and open spaces				Westminster Oper	WCC: https://www.westminster.gov.uk/sit		Place section			
% of carers (caring for an adult) who have received an assessment or review of their needs											Not included			
% of residents who give support to family members, friends, neighbours or others because of long-term physical or mental ill-health or disability, or problems related to old age	Approximately 2,300 residents	Lower		Approximately 3,500 residents	Lower		2021	Census 2021	https://officeshareds	Comparison to London (age-standardised), neu		Every 10 years	7.8%	9.1%
Satisfaction - Primary Care											Not included			
Satisfaction - Secondary Care											Not included			
Proportion of people adged 65+ who were still at home 91 days after discharge from hospital into reablement/rehabilitation											Not included			
Gap in poor health years	*As included in Ambition 2*			*As included in Ambition 2*										
Life expectancy gap between those living in the wealthiest and poorest wards in Westminster (male/female)	*As included in Ambition 2*			*As included in Ambition 2*										
Ensure continuity of maternity care is provided for at least 75% of women from Black, Asian and minority ethnic communities and from the most deprived groups											Not included			
Employment rate for working age population (residents aged 16-64)	63.2%	Lower	No change	71.7%	Similar	No change	2022/23	PHOF B08d Percer	Public Health Outcon	As reported by OHID:	Includes modelled unemp	Annual	75.8%	75.7%
Proportion of children in relative low income families (under 16) Suggest replacing with children living in poverty	21.4%: 1 in 5	Lower	Not available	24.8%: 1 in 4	Lower	Not available	2020/21	End Child Poverty	https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fendchildpoverty.				35%	27%

% of 16-17 year olds not in Education, Employment or Training (NEETs)	*As included in Ambition 1*			*As included in Ambition 1*									
Percentage of adults who feel lonely									Not included: residents 65				
% of residents who have a confident internet user (including themselves) in their household									Not included				
Ensure 75% of LD patients receive Annual Health Checks and personalised Health Action Plans	*As included in Ambition 2*			*As included in Ambition 2*									
Adult with learning disabilities in paid employment	10.5%	Higher	No change	10.3%	Higher	No change	2021/22	PHOF B08b The pe	Public Health Outcomes Framework - Data	Not included	Annual	5.2%	4.8%

Health and Well Being Strategy

"Turning the Strategy into a plan for delivery


HEALTH & WELLBEING FOR OUR COMMUNITY MEANS
FRIENDSHIPS
GREEN SPACES
COMMUNITY CELEBRATIONS
A SAFE HOME
A GP YOU RECOGNISE
GOOD FOOD
GOOD COMMUNICATION
GOOD AIR
PEOPLE & COMMUNITIES WORKING TOGETHER CAN REALLY MAKE A DIFFERENCE
SERVICES HAVE TO BE DESIGNED & DELIVERED TOGETHER TO HAVE A REAL IMPACT
NEIGHBOUR HOODS
LEISURE
FAMILY HUB
HEALTH CENTRE
TOWN HALL
LIBRARY
HOSPITAL
SERVICES
LOCAL BUSINESSES
COMMUNITY HUB
VOLUNTEER HUB
SCHOOL
VIRTUAL SPACES
LINKING UP
OUR HEALTH IS DETERMINED BY MANY DIFFERENT FACTORS INTERACTING
WIDER SOCIAL DETERMINANTS
AIR
WATER
SOIL
ENVIRONMENT
HOUSING
EDUCATION
WORK
LIFESTYLE
SOCIAL NETWORKS
CLIMATE CHANGE
REDUCING HEALTH INEQUALITIES INVOLVES EVERYONE
TRUST
BELONGING
CONNECTION
OUR SYSTEM FITS AROUND THE PERSON
NOT THE OTHER WAY AROUND!
MEDICAL
SOCIAL SERVICES
MENTAL HEALTH SUPPORT
COMMUNI-CATION
@SOMANG LEE STUDIO

Background

- Joint Health and Well being Board (HWBB) has agreed a 10 year strategy to address inequalities in our boroughs. It does this by bringing together the councils, NHS, voluntary and community sector and other local partners to promote integrated health and social care to improve residents' health and wellbeing.
- There is now a need to develop and agree annual deliverables and to identify the key metrics the HWBB needs to focus on.
- The HWBB can't deliver the whole strategy, but it can provide leadership and influence other sectors to address the wider social determinants.

Indicators

- Local indicators across all Ambition areas have been identified for year 1 based on the following:
  - Information is publicly available
  - Data reflects the wider social determinant
- Annual report on progress, compared to London and sub region performance will be presented to the HWBB alongside the Public Health Annual report

Implementation Plan Development

1. Establishing a HWBB led development group
2. Working with community led organisations to develop the key priorities and focus
3. Recommending to the HWBB the focus of the implementation plan, for example

   - INT roll out (Ambition 7)
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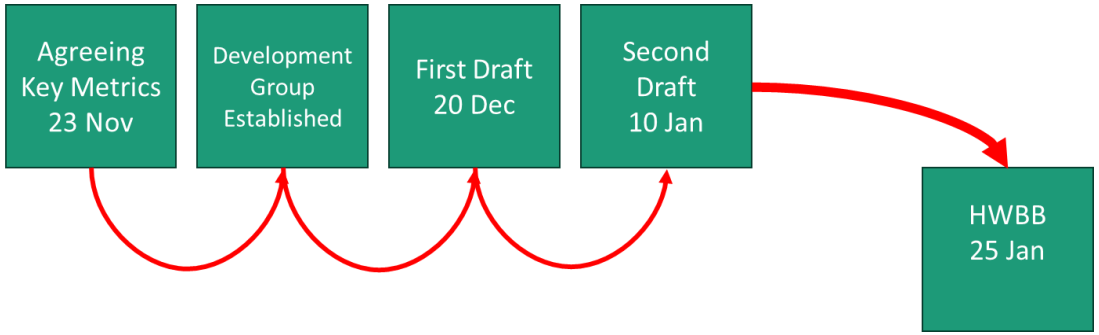


Questions


REDUCING HEALTH INEQUALITIES INVOLVES EVERYONE
WIDER SOCIAL DETERMINANTS

Bi-Borough Integrated Neighbourhood Team Development Overview

Westminster & Royal Borough of Kensington and Chelsea Health & Wellbeing Board

23rd November 2023

INTs are the deliverable vehicle for …

What's the purpose, ambition & scope?

DRAFT

Why Integrated Neighbourhood Teams?

- Multi-sector professionals of local providers working with community
- Integrated service teams working on priority groups / cases / issues; sharing care plans, approaches and processes
- Reducing health inequalities - achieving improvement in population health outcomes and deliver a more holistic support system that addresses wider social determinants
- Reducing health inequalities
- Improving collaboration, reducing barriers, silos and handoffs
- Defining population health strategy and priorities in given neighbourhood

Why is this important?

- Opportunity to **work with residents and partners differently** - tailoring to our communities - addressing equity (e.g. rough sleeper, lonely resident, patient with complex needs, etc.)
- Direction of **policy travel**, regulators are asking provider partners to work in an integrated way
- Bringing together **what we already have** and making it '**business as usual**'
- Creating **economies of scale** (e.g. CYP, Specialist Support, etc.)
- This is not new, it's about ***building on existing integrated delivery models*** and programmes of work:

The Change We Want to See

Stories we want to create with our residents

DRAFT

Joy and her family are supported to keep her healthy at home and out of hospital.

The Past

"Without my children I don't know what I'd do. They used to spend so much time repeating information and trying to book appointments, and helping to make sense of the system. I was stuck in hospital for two extra weeks because I needed a special bed and alarm fitting in my home to be discharged. When I returned home, I felt I was keeping up with the system rather than focusing on getting better."

The Future

"Now we have health visitors who sorted out my flat and check in on me to make sure I'm doing my exercises and managing my medication. They set up my phone and showed me how to make appointments with my GP. They even found a local church that does day trips and picks me up every week. My children have more of their lives back and don't worry so much."

Alina, Krish and their children are supported in more suitable housing, and managing their youngest child's health conditions.

The Past

"Where we used to live and our whole family's health were intertwined. The flat had damp and mould, and the kids would get chest infections in winter. We couldn't afford to open the windows each day and heat the house again. The school used to call to ask why they had been absent so much. We tried everything to get better housing, but were on waiting lists for waiting lists."

The Future

"When our youngest who has epilepsy and autism started to deteriorate, we were brought into conversations between a nurse, housing support and a social worker. By joining the dots together, we could create a plan to make sure where we live now is going to a place where we see them all thrive."

Graham is supported in managing his mental health and training to get back into work.

The Past

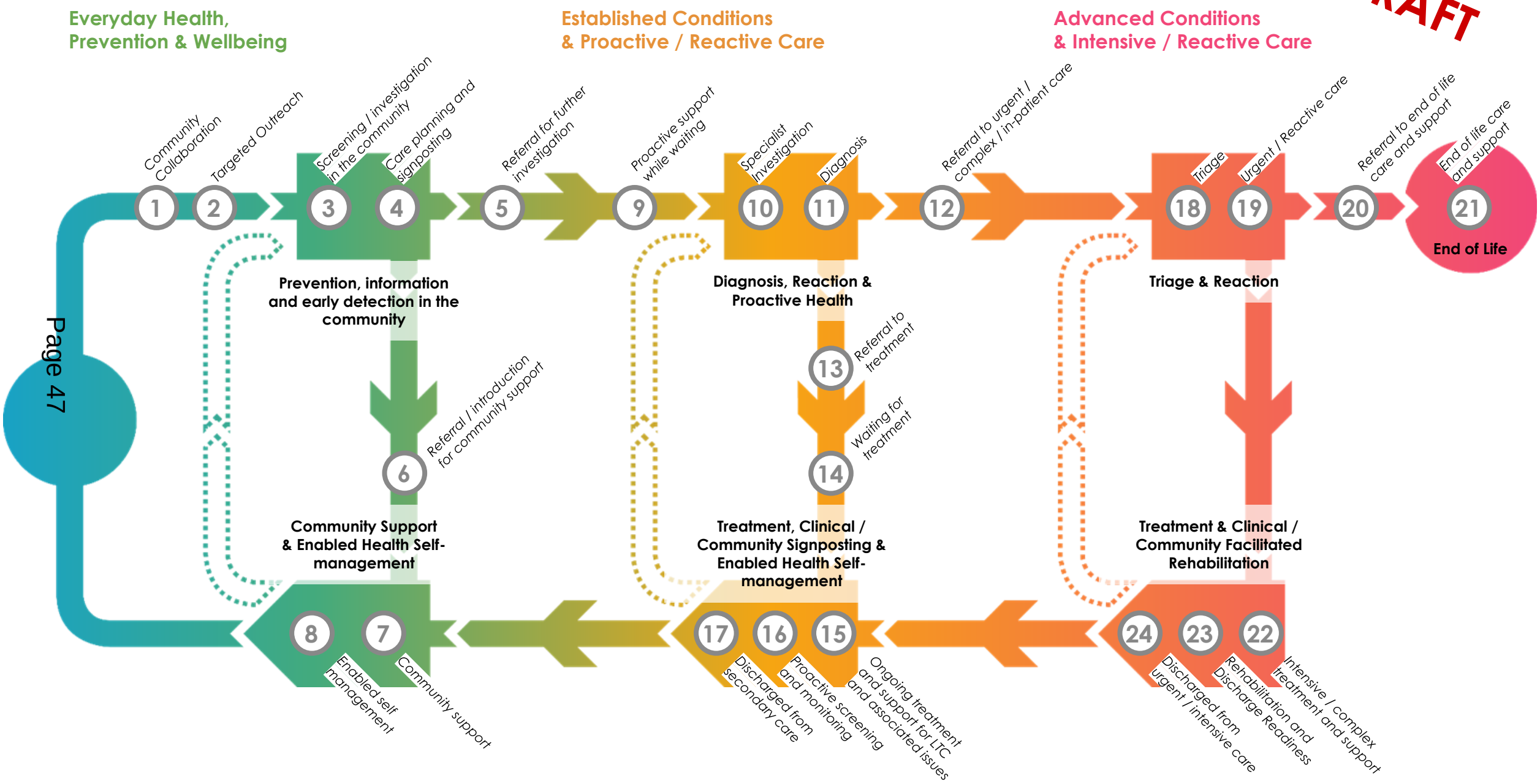
"After losing my job, I felt isolated. My confidence and mental health were really low. Medicine and treatments are one side of things. The other is being connected to other people going through similar situations, and doing things that make me feel independent. I missed that so much when I lost my job, and couldn't bounce back financially or mentally."

The Future

"My GP introduced me to a Social Prescriber. They sat down with me and listened to what I thought might help. Now I'm a regular at a mindfulness class in the local library, get exercise and volunteer at my local parkrun and am on a training course to ease me back into work. If you try to live positively, and get support to help you stay at work it has a great impact on all parts of your health."

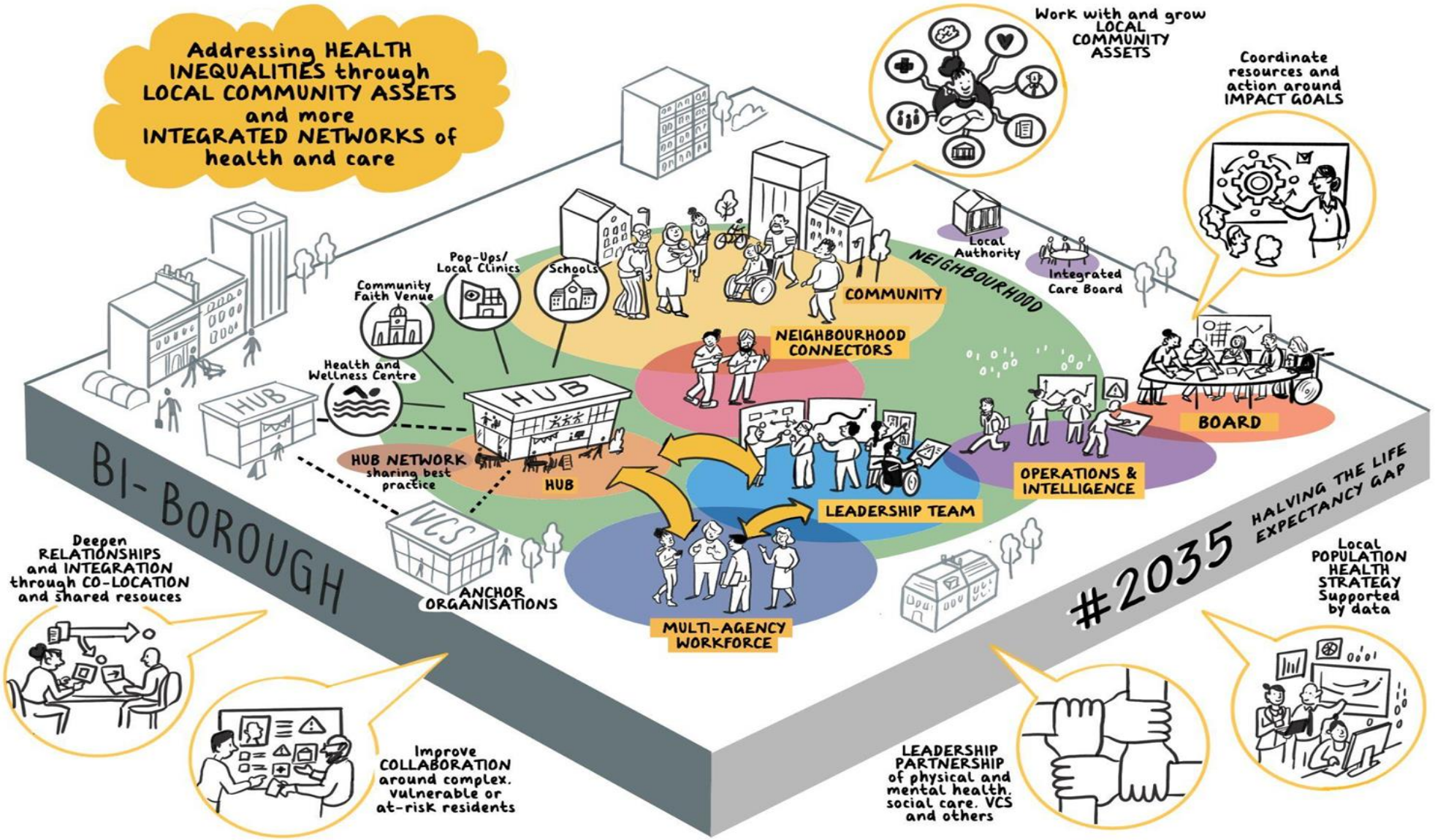
Our over-arching operating model

DRAFT



Our co-designed operating model

DRAFT



Our Fundamentals

DRAFT

For residents and communities

Growing and Connecting Local Community Assets

Residents are connected to, and supported by rich and thriving local health and wellbeing offers. Residents and community groups are involved in co-delivering support.

Smart Collaboration Around At-Risk Residents

Residents in complex or deprived circumstances experience joined-up care from a broad range of professionals. Care plans are personalised; tasks and data are shared where appropriate

Co-Location and Collaboration

We foster closer relationships between professionals, agencies and community organisations. This includes multi-agency working at local hubs, as well as simplifying ways to collaborate virtually.

For staff

Informing and Adapting Services to Local Needs, Evidence and Data

We are data-led and gather research with community members to influence how services are delivered to meet local needs and reduce health inequalities.

Multi-agency Partnership Leadership

A core group leaders work together to set the course of action and monitor its collective impact on local residents. These include physical and mental health, social and community services.

Coordinating Action Towards Shared Goals

We galvanise action around shared missions with agreed priorities and measurable targets. These are acted upon by a local network of staff and community, including connector roles, Hubs, PCNs and other partners.

We're already doing it

INTs are not new: It's about ***building on existing integrated programmes of work:***

Vibrant & Healthy Communities
Our delivery vehicle to address health equity across Bi-Borough
including vax/imms/screening, Connector Roles, Core 20+5 (pathways), #2035, Homelessness / Changing Futures

My Care My Way:
An integrated health and social care system for older adults

North Kensington Grenfell Recovery
A wide range of community-based support to bereaved and survivors

Violet Melchett
Wide-Ranging health & care for our residents

Connector (Octopus) Network
Connecting the ecosystem of health and care in our communities

Access
Primary Care & PCN

0-5 Early Start - Family Hubs

People with Long Term Conditions