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City of Westminster

Committee Agenda

Title:	**Health & Wellbeing Board**
Meeting Date:	**Thursday 21st May, 2015**
Time:	**3.00PM**
Venue:	**Rooms 3 & 4 - 17th Floor, City Hall**

Members:

Councillor Rachael Robathan	Cabinet Member for Adults & Health
Dr Ruth O'Hare	Central London Clinical Commissioning Group
Councillor Danny Chalkley	Cabinet Member for Children's Services
Councillor Barrie Taylor	Minority Group
Meradin Peachey	Tri-Borough Public Health
Liz Bruce	Tri-borough Adult Social Care
Andrew Christie	Tri-borough Children's Services
Dr Naomi Katz	West London Clinical Commissioning Group
Janice Horsman	Healthwatch Westminster
Jackie Rosenberg	Westminster Community Network
Dr David Finch	NHS England

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

Admission to the public gallery is by ticket, issued from the ground floor reception at City Hall from 2.30pm. 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, Andrew Palmer; Senior Committee and Governance Officer.

Tel: 020 7641 2802; Email: apalmer@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 Head of Legal & Democratic Services in advance of the meeting please.

AGENDA

PART 1 (IN PUBLIC)

1. MEMBERSHIP

To report any changes to the Membership of the meeting.

2. DECLARATIONS OF INTEREST

To receive declarations of interest by Board Members and Officers of any personal or prejudicial interests.

3. MINUTES AND ACTIONS ARISING **(Pages 1 - 10)**

I) To agree the Minutes of the meeting held on 19 March 2015.

II) To note progress in actions arising.

4. NORTH WEST LONDON MENTAL HEALTH & WELLBEING STRATEGIC PLAN **(Pages 11 - 16)**

To consider the Programme Initiation Document for the development of the North West London Mental Health & Wellbeing Strategic Plan.

5. CHILDREN & YOUNG PEOPLE'S MENTAL HEALTH **(Pages 17 - 36)**

To review the Action Plan from the Tri-borough Children's Trust Board on implementing the recommendations of the Children & Young People's Mental Health Task and Finish Group, and to discuss "Shaping a new bold for Children & Young People's Mental Health Services".

A supporting presentation will follow separately.

6. THE ROLE OF PHARMACIES IN COMMUNITIES AND PREVENTION **(Pages 37 - 46)**

To consider how the Westminster Health & Wellbeing Board can be supported in scoping a review of the current role that pharmacies play in communities, and how this could be

increased to support prevention and improved outcomes.

7. WHOLE SYSTEMS INTEGRATION **(Pages 47 - 56)**

To consider the developing models of care and patient pathways under Whole Systems integration.

8. JOINT STRATEGIC NEEDS ASSESSMENT **(Pages 57 - 62)**

To receive an update on delivery of Westminster's Joint Strategic Needs Assessment.

9. BETTER CARE FUND **(Pages 63 - 74)**

To receive an update on delivery of the Better Care Fund programme.

10. CARE ACT IMPLEMENTATION

To receive a verbal update on progress in implementation of the Care Act 2014.

11. CO-COMMISSIONING **(Pages 75 - 80)**

To receive an update on progress in Primary Care Co-Commissioning.

12. WORK PROGRAMME **(Pages 81 - 84)**

To consider the Work Programme for the forthcoming 2015-16 Municipal Year.

13. ANY OTHER BUSINESS

Peter Large
Head of Legal & Democratic Services
May 2015

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MINUTES

CITY OF WESTMINSTER

WESTMINSTER HEALTH & WELLBEING BOARD
19 MARCH 2015
MINUTES OF PROCEEDINGS

Minutes of a meeting of the **Westminster Health & Wellbeing Board** held on Thursday 19 March 2015 at 4.00pm at Westminster City Hall, 64 Victoria Street, London SW1E 6QP

Members Present:
Chairman: Councillor Rachael Robathan, Cabinet Member for Adult Services & Health
Clinical Representative from the Central London Clinical Commissioning Group: Dr Ruth O'Hare
Minority Group Representative: Councillor Barrie Taylor
Tri-Borough Executive Director of Children's Services: Andrew Christie
Tri-Borough Executive Director of Adult Social Care – and representative for Public Health: Liz Bruce
Clinical Representative from the West London Clinical Commissioning Group: Dr Philip Mackney (acting as Deputy)
Representative from Healthwatch Westminster: Janice Horsman
Chair of the Westminster Community Network: Jackie Rosenberg
Representative for NHS England: Dr Belinda Coker (acting as Deputy)

Also in attendance: Councillor Christabel Flight (Deputy Cabinet Member for Adults & Public Health)

1. MEMBERSHIP

1.1 Apologies for absence were received from Councillor Danny Chalkley (Cabinet Member for Children & Young People), and from Eva Hrobonova (acting as Deputy for the Director of Public Health).

1.2 Apologies for absence were also received from Dr Naomi Katz (West London CCG) and Dr David Finch (NHS England). Dr Philip Mackney and Dr Belinda Coker attended as their respective Deputies.

2. DECLARATIONS OF INTEREST

2.1 Councillor Barrie Taylor declared a personal, non-prejudicial interest in that he had a long-term medical condition that required him to use health services provided by pharmacies. No other declarations were received.

3. MINUTES AND ACTION TRACKER

3.1 **Resolved:** That

(1) The Minutes of the meeting held on 22 January 2015 be approved for signature by the Chairman; and

(2) Progress in implementing actions and recommendations agreed by the Westminster Health & Wellbeing Board be noted.

4. PHARMACEUTICAL NEEDS ASSESSMENT

4.1 Liz Bruce (Tri-Borough Executive Director of Adult Social Care) presented the final version of the Westminster Pharmaceutical Needs Assessment (PNA) for approval, prior to its being published by 1 April 2015 in line with statutory requirements.

4.2 The PNA identified the key health needs of the local population, together with how they were being fulfilled by pharmaceutical services in different parts of the Borough and whether there were any gaps. The PNA also informed local plans for the commissioning of pharmaceutical services, and supported the 'market entry' decision making process (undertaken by NHS England) in relation to applications for new pharmacies or changes in pharmacy premises.

4.3 Holly Manktelow (Principal Policy Officer) informed Board Members that work had begun on a separate wider review of the role of pharmacies in health provision, and within integrated whole systems working and the wider health landscape in Westminster. Once initial scoping for the review had been completed, the proposed Terms of Reference would be referred to the Board for discussion and approval.

4.4 Board Members acknowledged the role of pharmacies in providing medication to manage substance abuse, and suggested that consideration be given to pharmacies also offering advice on sexual health issues for young people. Members commented that specific guidance was needed on the disposal of needles used for Diabetes, and the Board noted that this issue had been discussed with Westminster's Clinical Commissioning Groups.

4.5 Research carried out by Healthwatch had indicated that 40% of people used pharmacies as an alternative to GPs and urgent care, and the Board agreed that pharmacies should be developed and used in a much more creative way. Members acknowledged that any additional services that were provided would need to be commissioned and funded.

4.6 The Board commented that some of the detail and key suggestions that had been received through consultation would need to be clarified prior to wider publication,

and Liz Bruce confirmed that the three year assessment could be changed and updated as frequently as required.

4.7 The Health & Wellbeing Board commended the work that had been undertaken, and approved the Assessment as amended. The Board also agreed that the PNA should be reviewed at least annually.

5. PRIMARY CARE CO-COMMISSIONING IN NORTH WEST LONDON

5.1 The Board received a report from Matthew Bazeley (Central London Clinical Commissioning Group) and Simon Hope (West London Clinical Commissioning Group), which provided an update on the involvement of Health & Wellbeing Boards and Healthwatch in co-commissioning. The report also set out recent changes to governance proposals, and provided an update on engagement and member voting.

5.2 Following the release of further national guidance in November 2014, the North West London Clinical Commissioning Groups (CCGs) had considered that local needs would best be met by "delegated" co-commissioning arrangements, which had been reflected in their application made to NHS England in January 2015. Following feedback on the application, the CCGs had subsequently determined that the necessary actions could not be undertaken within the timelines required with the full engagement of member practices. The CCGs were accordingly recommending to their members that it would be preferable to initially pursue "joint" co-commissioning arrangements with NHS England, with a potential move to future delegation being explored at a later date. The Board noted that the proposals for co-commissioning would be put to members of the Central London and West London Clinical CCGs for approval within the next week.

5.3 NHS England were positive about working collectively and closer with Westminster's CCGs, and the Board acknowledged the need for the joint working to have local accountability and be sensitive to local needs. Members commented on the potential for pooling funds and achieving economies of scale, and acknowledged that the duty and responsibility of the Westminster Health & Wellbeing Board lay with Westminster. Board Members emphasised the importance of engaging with patients and user groups like Healthwatch before making decisions for commissioning, and highlighted the need for the specification to take into account Tri-borough operational issues. Members also commented on the lack of availability of property for GP services, and highlighted the importance of Health & Wellbeing Board and local authority being involved in integrated estate development.

5.4 In view of the high level decisions that would be taken, Members emphasised the need for the eight Health & Wellbeing Boards situated within North West London to be adequately represented on the Co-Commissioning Committee. Members also highlighted the importance of the Health & Wellbeing Board needing to be involved in decisions which affected Westminster, and Matthew Bazeley confirmed that representation was still to be determined.

5.5 Matthew Bazeley welcomed the comments that had been made on progress in implementing co-commissioning, and confirmed that a further update would be given to the Health & Wellbeing Board at its next meeting in April.

6. CARE ACT IMPLEMENTATION

6.1 Liz Bruce (Tri-Borough Strategic Director for Adult Social Care) provided an update on progress in the implementation of the 2014 Care Act in Westminster. The Board noted that governance arrangements to implement the reforms had been in place since April 2014, and that the majority of provisions would come into force on 1 April 2015; with the second phase being introduced following the forthcoming General Election.

6.2 The report also considered the 'go live' implications of the key deliverables contained in the two phase approach, which included a new national minimum threshold for eligibility; the implementation of new safeguarding duties; and an updated and formalised appeals process for complaints.

6.3 Appropriate training had been taking place in preparation for the changes, with the approach to implementation being reviewed and refined as the training had progressed. The Board acknowledged that more active promotion of the forthcoming changes was needed.

6.4 The Board discussed the single set of criteria for carers, which formed part of the first phase of implementation, and noted that Westminster was committed to supporting carers as part of the wider prevention strategy.

6.5 The Board highlighted the work of the third sector, which were important partners, and noted that the Care Act provided for greater delegation of powers to local authorities, which in turn could devolve functions to Community Groups. Members also commented on the importance of advocacy, and highlighted the value of the People First website in promoting health and wellbeing.

7. BETTER CARE FUND

7.1 Liz Bruce (Tri-Borough Executive Director of Adult Social Care) updated the Board on further progress in the Better Care Fund (BCF) Plan, and on preparations for implementation.

7.2 Work on the new models for commissioning and delivery had continued to progress, with the most significant project being the new, standardised Tri-borough Community Independence Service (CIS), which would provide consistent rapid response for people at risk of emergency admission to hospital; together with in-reach for people getting ready to leave hospital, and support for rehabilitation and reablement. The Board noted that future reports would include further updates on patient engagement.

8. WORK PROGRAMME

8.1 The Board noted its work programme for the remainder of the current year, together with proposals for 2015-16. Board Members were invited to suggest possible issues for future meetings.

9. TERMINATION OF MEETING

9.1 The meeting ended at 5.10pm.

CHAIRMAN _____ DATE _____

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WESTMINSTER HEALTH & WELLBEING BOARD
Actions Arising

Meeting on Thursday 19th March 2015

Action	Lead Member(s) And Officer(s)	Comments
Pharmaceutical Needs Assessment		
Terms of reference for a separate wider review of the role of pharmacies in health provision, and within integrated whole systems working and the wider health landscape in Westminster, to be referred to the Board for discussion and approval.	Adult Social Care	Coming to the Health and Wellbeing Board for discussion 21st May 2015

Meeting on Thursday 22nd January 2015

Action	Lead Member(s) And Officer(s)	Comments
Better Care Fund Plan		
Further updates on implementation of the Care Act to be a standing item on future agendas.	Adult Social Care	Completed.
Child Poverty		
Work to be commissioned to establish whether and how all Council and partner services contributed to alleviating child poverty and income deprivation locally, through their existing plans and strategies – to identify how children and families living in poverty were targeted for services in key plans and commissioning decisions, and to also enable effective identification of gaps in provision.	Children's Services	In progress.
To identify an appropriate service sponsor for allocation to each of the six priority areas, in order to consolidate existing and future actions that would contribute to achieving objectives.	Children's Services	In progress.
Local Safeguarding Children Board Protocol		
Protocol to be revised to avoid duplication and to be clear on the different and separate roles of the Health & Wellbeing Board and the Scrutiny function.	Local Safeguarding Children Board	In progress.
Primary Care Commissioning		
A further update on progress in Primary Care Co-Commissioning to be given at the meeting in March 2015.	Clinical Commissioning Groups. NHS England	Completed.

Meeting on Thursday 20th November 2014

Action	Lead Member(s) And Officer(s)	Comments
Primary Care Commissioning		
The possible scope and effectiveness of establishing a Task & Finish Group on the commissioning of Primary Care to be discussed with Westminster's CCGs and NHS England, with the outcome be reported to the Health & Wellbeing Board.	Clinical Commissioning Groups NHS England	Completed
Work Programme		
A mapping session to be arranged to look at strategic planning and identify future agenda issues.	Health & Wellbeing Board	Completed.

Meeting on Thursday 18th September 2014

Action	Lead Member(s) And Officer(s)	Comments
Better Care Fund Plan 2014-16 Revised Submission		
That the final version of the revised submission be circulated to members of the Westminster Health & Wellbeing Board, with sign-off being delegated to the Chairman and Vice-Chairman, subject to any comments that may be received.	Director of Public Health.	Completed.
Primary Care Commissioning		
The Commissioning proposals be taken forward at the next meeting of the Westminster Health & Wellbeing Board in November	NHS England	Completed.
Details be provided of the number of GPs in relation to the population across Westminster, together with the number of people registered with those GPs; those who are from out of borough; GP premises which are known to be under pressure; and where out of hours capacity is situated.	NHS England	Completed.
Measles, Mumps and Rubella (MMR) Vaccination In Westminster		
That a further report setting out a strategy for how uptake for all immunisations could be improved, and which provides Ward Level data together with details of the number of patients who have had measles, be brought to a future meeting of the Westminster Health & Wellbeing Board in January 2015.	NHS England Public Health.	To considered at the forthcoming meeting in May 2015. This has been pushed back to later in 2015

Meeting on Thursday 19th June 2014

Action	Lead Member(s) And Officer(s)	Comments
Whole Systems		
Business cases for the Whole Systems proposals to be submitted to the Health & Wellbeing Board in the autumn.	Clinical Commissioning Groups.	Complete.
Childhood Obesity		
A further report to be submitted to a future meeting of the Westminster Health & Wellbeing Board by the local authority and health partners, providing an update on progress in the processes and engagement for preventing childhood obesity.	Director of Public Health.	To be considered at a forthcoming meeting
The Health & Wellbeing Strategy		
A further update on progress to be submitted to the Westminster Health & Wellbeing Board in six months.	Priority Leads.	To considered at a forthcoming meeting.
NHS Health Checks Update and Improvement Plan		
Westminster's Clinical Commissioning Groups to work with GPs to identify ways of improving the effectiveness of Health Checks, with a further report on progress being submitted to a future meeting.	Clinical Commissioning Groups	In progress.
Joint Strategic Needs Assessment Work Programme		
The implications of language creating a barrier to successful health outcomes to be considered as a further JSNA application. *Note: Recommendations to be put forward in next year's programme.*	Public Health Services Senior Policy & Strategy Officer.	In progress

Meeting on Thursday 26th April 2014

Action	Lead Member(s) And Officer(s)	Comments
Westminster Housing Strategy		
The consultation draft Westminster Housing Strategy to be submitted to the Health & Wellbeing Board for consideration.	Strategic Director of Housing	Coming back to the Health and Wellbeing Board in July 2015
Child Poverty Joint Strategic Needs Assessment Deep Dive		
A revised and expanded draft recommendation report to be brought back to the Health & Wellbeing Board in September.	Strategic Director of Housing Director of Public Health.	Completed.

Tri-borough Joint Health and Social Care Dementia Strategy		
Comments made by Board Members on the review and initial proposals to be taken into account when drawing up the new Dementia Strategy.	Matthew Bazeley Janice Horsman Paula Arnell	Completed
Whole Systems		
A further update on progress to be brought to the Health & Wellbeing Board in June.	Clinical Commissioning Groups	Completed.

City of Westminster

Westminster Health & Wellbeing Board

Date:	21 May 2015.
Classification:	General Release
Title:	**Briefing paper for Like Minded - a programme to develop a Mental Health & Wellbeing Strategy across North West London**
Report of:	Thirza Sawtell, Director of Strategy & Transformation Team, NHS NWL
Wards Involved:	All
Policy Context:	Mental health and wellbeing
Financial Summary:	As the strategy is still being developed, there are not yet any financial implications identified.
Report Author and Contact Details:	Eleanor Wyllie & Jane Wheeler, Programme Leads, NW London Whole System Mental Health & Wellbeing Strategic Plan

1. Executive Summary

1.1 The Collaboration Board of NWL CCGs and the NWL Mental Health Programme Board have approved the commencement of a programme to develop a NWL-wide Whole System Mental Health & Wellbeing Strategic Plan. It will build on the previous NWL Mental Health Strategy (Shaping Healthier Lives) and the Whole Systems approach to involving health and social partners as well as service users and the voluntary sector. A launch event for the programme '*Like Minded: Working together for mental health and wellbeing in NW London*' was held on 6 February 2015.

1.2 The programme plan is to:

- develop a case for change and agree priority strategic areas (c.4 months)
- develop care models for those areas (c. 7 months)
- hold a joint health & social care public consultation (if required) (c. 3 months)
- revise the care models further to consultation feedback (c.4-5 months).

1.3 CCGs, Local authorities and the broader constituent members of Health and Wellbeing Boards will play an essential role in commissioning and provision

of mental health and wellbeing services, and therefore their commitment will be crucial to the success of this programme.

1.4 The Like Minded Programme has embedded co-production as a touchstone or how we work – and we know to make this real we need the commitment and involvement of Service Users, practitioners and the broader community in the Like Minded programme.

1.5 Governance arrangements ensure that quality and safety are reflected – by including senior clinical and professional representation from across all partner organisations.

2. Key Matters for the Board

2.1 Recognising that Mental Health is a key priority area for the Board the Like Minded team want to secure the support of the Board, and also feedback now and as the programme progresses to ensure that the approach meets local Westminster requirements.

2.2 We would like members to share details of any concurrent work that Like Minded should link to and also any key local representatives we should involve in our work. We are aware of the Westminster review of public mental health services and will ensure we continue to link Like Minded to the emerging outputs of that programme to ensure clarity and reduce duplication.

3. Background

3.1 The NWL Mental Health and Wellbeing Transformation Board is developing a refreshed vision for mental health services which further defines the overall aim:

'**Excellent, integrated** mental health services to **improve mental and physical health**, secured through collaboration and determination to **do the best** for the population of North West London.

3.2 The people and the organisations of North West London have a commitment to, and a passion for, ensuring that mental health has an equal priority with physical health and that everyone who needs mental health care should get the right support at the right time.

3.3 Wellbeing covers both physical and mental wellbeing, and is impacted by many factors, including those within the influence of local authorities, such as public health services, housing and education. Poor wellbeing leads to low educational attainment and employment levels, anti-social and criminal behaviour. It also leads to worse mental and physical health, often resulting in increased mortality.

3.4 Mental health problems are common and expensive:

- At least one in four of us will experience a mental health condition at some point in our lives and one in six adults has a mental health condition at any given time.
- One in ten children (aged 5-15) has a mental health condition and half of all people with lifelong mental health conditions have developed them by the age of 14. Therefore schools have a key role.
- Sickness absence due to mental health problems costs the UK economy £8.4bn a year and also results in £15.1bn in reduced productivity.
- The cost of mental health in England is estimated to be £105bn and the cost of health services to treat mental illness could double over the next 20yrs.
- Mental illness accounts for 23% of the total burden of disease in the UK; more than cardiovascular disease or cancer.
- One in three people over 65 will develop dementia; two-thirds of whom will be women.

3.5 Changing demographics, including an ageing population, mean the demand for services is increasing, creating pressure on service quality and outcomes, as well as on the sustainability of the current system over time.

<table>
<tr><th>Age</th><th>'Mostly' healthy (rest of the population)</th><th>One or more physical or mental long-term conditions</th><th>Cancer</th><th>Severe and enduring mental illness</th><th>Learning disability</th><th>Severe physical disability</th><th>Advanced dementia, Alzheimer's etc.</th><th>Socially excluded groups</th></tr>
<tr><td>0-12</td><td>'Mostly' healthy children 1</td><td colspan="2" rowspan="2">Children and young people with one or more long-term condition or cancer 5</td><td colspan="3">Children with intensive continuing care needs 9</td><td rowspan="2">N/A</td><td rowspan="4">Homeless individuals and/or families (including children, young people, adults and older people), often with alcohol and drug dependencies</td></tr>
<tr><td>13-17</td><td>'Mostly' healthy young people 2</td><td colspan="3">Young people with intensive continuing care needs 10</td></tr>
<tr><td>18-64</td><td>'Mostly' healthy adults 3</td><td>Adults with one or more long-term condition 6</td><td rowspan="2">Adults and older people with cancer 8</td><td>Adults and older people with severe and enduring mental illness 11</td><td>Adults and older people with learning disabilities 12</td><td>Adults and older people with physical disabilities 13</td><td>Adults and older people with advanced dementia and Alzheimer's 14</td></tr>
<tr><td>65+</td><td>'Mostly' healthy older people 4</td><td>Older people with one or more long-term condition 7</td><td></td><td></td><td></td><td></td><td></td></tr>
</table>

3.6 Within Like Minded we are using the NWL population segmentation approach (remaining mindful that there in real life people do not necessarily fit within particular population segments). What this does ensure is that we consider the needs of those groups who are often under-served and where evidence shows there is increased risk of mental health needs, or barriers to accessing current services. This work stream aims to ensure those needs are considered separately, but also factored into the work on other population groups.

3.7 To date we have held workshops covering;

- Children and Young People (with good representation from Westminster across sectors). We are working closely with Steve Buckerfield and Jacqui Wilson to ensure Like Minded and the required response to the new national strategy *Future in Mind* are mutually supportive.
- Under-served populations (with again great input from some of the local voluntary sector organisations working with specific groups such as the homeless)
- Prevention and Wellbeing (primarily public health focused to scope this work stream. It should be noted that this is the workstreams which has generated most excitement and where there is an understanding that 'upstream' interventions have the potential to have the widest individual and system-wide impact)
- Mental Ill-health (covering both common and serious mental health needs).

3.8 The outputs of these workshops are shared with participants and inform the Case for Change alongside data, mapping current services and evidence of effective Models of Care and interventions across the whole population.

3.9 Without pre-judging the outputs of the Case for Change (which is currently in early stages of development and will be brought back to the Board) we know there are areas of particular interest in Westminster which will be reflected

- Current provision of services (and current needs) across a wide range of sectors – health, social care, public health, leisure, education, voluntary sector, employment etc.
- Linked to this the wider pathway for those with a diagnosed mental health need – including early intervention, primary care, acute services and the broader range of social support that is evidenced to provide most effective support to recovery.
- A Children and Young People's approach which focuses on the national recommendations set out in Future in Mind and assessing what the first priorities for NWL are, as well as how these may differ across boroughs.

4. Options / Considerations

4.1 The programme is taking a 'Whole System' approach (i.e. looking across health and social care services) to transforming the way that mental health and wellbeing services are delivered in NWL.

4.2 Within our proposed governance structure we have included representation from local authorities (Directors of Adult Services, Directors of Children's Services and Public Health). We will need Local Authority representation in order to have an informed debate about the services they commission that impact on mental health and wellbeing.

4.3 We recognize that each Local Authority will have a formal role in signing-off any proposals to make changes to mental health and wellbeing services they commission, and in order to do so they will need to input into the governance of this programme developing those proposals.

4.4 We are seeking to work collaboratively with members of the wider community – Service Users, their families and carers, Voluntary sector organisations (including via the VCS), Education teams, housing, leisure services and other statutory and local services. This includes in the formal governance structures of the programme – and within working groups on particular areas and populations.

5. Legal Implications

5.1 As the programme is in mobilisation phase, and there are not yet any proposals that impact on services, there has not been the need to seek legal advice.

6. Financial Implications

6.1 One of the stated objectives of the programme is to develop improved outcomes – and ensure a financially sustainable system for at least the next 5 years. In working up detailed models with partners both the qualitative and financial impact will be key considerations. At this stage in the programme these cannot be quantified.

6.2 The NHS NWL Collaboration Board recommended that significant additional resource would be required to develop the Whole Systems Mental Health & Wellbeing Strategy, which has been taken into account in developing the 2015/16 budgets across NHS NWL.

6.3 Within the proposed programme governance arrangements there is a Financial and Technical Reference Group, whose role will be to scrutinise financial and activity models, and provide assurance on them to the programme Transformation Board. Representation from Local Authority Finance Departments will be required to enable sign-off of plans that might have a financial or activity impact on services they commission.

If you have any queries about this Report or wish to inspect any of the Background Papers please contact:
Jane Wheeler and Eleanor Wyllie (Job share)
Programme Leads for Like Minded
jane.wheeler2@nhs.net eleanor.wyllie@nhs.net,
07875 429320 (Jane) 07919 383540 (Eleanor)

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City of Westminster

Westminster Health & Wellbeing Board

Date:	21 May 2015
Classification:	General Release
Title:	**Improving Young Peoples' Mental Health Service – 'Future in Mind' report and local progress.**
Report of:	The Children's Joint Commissioning Team
Wards Involved:	*N/A*
Policy Context:	The national CAMHS Taskforce published its report, 'Future in Mind' in March 2015. The report makes 49 recommendations to improve services and support for young people.
Financial Summary:	Prior to the publication of the Taskforce Report, Deputy Prime Minister Nick Clegg MP announced an additional investment of £250 million for the next five years.
Report Author and Contact Details:	Steve Buckerfield & Jacqui Wilson – Children's Joint Commissioning Team

1. Executive Summary

1.1 The Children's Joint Commissioning Team will lead a discussion with the Board on "Shaping a bold future for Children and Young Peoples' Mental Health Services", taking into account the recent publication of '***Future In Mind***[1]' and progress made on the Westminster Task & Finish Group CAMHS Action Plan .

2. Key Matters for the Board

2.1 The presentation and discussion will:

- Summarise the recommendations or *Future in Mind* and the additional resources announced for young people's mental health

[1] Report of the national CAMHS Taskforce published in March 2015

- Provide an update on local progress following the 2014 CAMHS Task & Finish group's work

- Provide an opportunity to shape local work on *Future in Mind*, in line with Health & Wellbeing Board responsibilities described in the report. This includes the submission of a 'Transformation Plan' for young peoples' mental health service to NHS England.

3. Background

3.1 In 2014 the Westminster Health & Wellbeing Board commissioned a Task & Finish Group to consider:

a) **A new vision** – to think boldly about whether the current services delivered what young people needed.

b) **Immediate key changes** - how the Health & Wellbeing Boards could use their levers to ensure that services were arranged and commissioned now and in the future to achieve improved outcomes for Children and Young People in relation to mental health and wellbeing.

3.2 Subsequently, the London Borough of Hammersmith & Fulham Health & Wellbeing Board and the Royal Borough of Kensington & Chelsea Health & Wellbeing Board asked for this work to be undertaken on a three council basis.

3.3 The Task and Finish Group agreed to focus on three particular areas where it was agreed that more could be done to improve the outcomes for children and young people. These areas were:

i) Ensuring early intervention and prevention in relation to children and young peoples' mental health and wellbeing.
ii) Reducing the impact of parental mental health disorders on children and young people.
iii) The transition from Children's to Adult mental health services

3.4 The final report including 12 recommendations has been presented to all three Health & Wellbeing Boards. It was agreed that the three council's Children's Trust Board would co-ordinate and overseen implementation and lead development of the 'vision' for young people's mental health services.

3.5 The Children's Trust Board held a well-attended workshop with stakeholders and agreed that local ambitions need to be co-ordinated with the recommendations and outcomes of the national CAMHS Task Force report. "Future in Mind" has now been published and makes 49 recommendations.

4. Options / Considerations

4.1 The Health & Wellbeing Board is asked to:

a) Note the local progress on implementing the recommendations of the CAMHS Task & Finish Group report.

b) Contribute to developing the 'future', 'vision' and 'priorities' which will underpin the development of a *Future in Mind* Transformation Plan.

5. Legal Implications

5.1 There are no immediate legal implications in relation to this paper.

6. Financial Implications

6.1 The CCGs and Westminster City Council are waiting to receive Government guidance on the process for distributing the additional resources announced for young people's mental health.

If you have any queries about this Report or wish to inspect any of the Background Papers please contact:

Steve Buckerfield & Jacqui Wilson – Children's Joint Commissioning Team

Email: steve.buckerfield@nw.loncon.nhs.uk Jacqui.wilson@nw.london.nhs.uk

Telephone: 0203 350 4331 and 0203 350 4324

APPENDICES:

The Westminster Health & Wellbeing Task & Finish Group - Recommendations and Action Plan.

Future in Mind report

BACKGROUND PAPERS:
Future in Mind

https://www.gov.uk/government/publications/improving-mental-health-services-for-young-people

Recommendations and Implementation Plan for the Tri-borough Children and Young People Mental Health Task and Finish Group

Version 6.1

Ensuring Early Intervention and Prevention in Relation to Children & Young Peoples' Mental Health and Wellbeing

	Recommendation	Action required	Lead agency	Key leads	Current position and Implementation target date
1.	An Out of Hours CAMHS Consultation, Advice and Referral (CAR) telephone line should be established across Tri-borough to ensure that young people are referred to the right service at the right time. *Future in Mind:* Ensuring the support and interventions for young people being planned in the Mental Health Crisis Care concordat are being implemented.	1. The service needs to be funded by CCGS. 2. Service specification needs to be agreed with providers. 3. Contract needs to be in place. 4. Service implementation plan needs to be agreed.	Health CCGS	CAMHS commissioners. Clinical commissioners Contract leads. Providers – CNWL and WLMHT.	This is part of the new CAMHS OOHs service, funding has been agreed by the CCGS. Jan 2015. CNWL and WLMHT have been sent the service specification; CNWL have agreed the specification, WLMHT are in the process of agreeing this. The Children's Joint commissioning team have met with CNWL to start planning the implementation of the service.

	Recommendation	Action required	Lead agency	Key leads	Current position and Implementation target date
2.	A programme of training accessible for front line professionals and 'co-produced' with young people should be developed for 2015-16 to improve mental health and emotional well-being awareness. *Future in Mind:* Developing a joint training programme to support lead contacts in specialist children and young people's mental health services and schools.	1. The programme devised locally needs to be rolled out and road tested further. 2. Clinical support needs to be arranged as the clinician involved is no longer working locally. 3. Clear costings need to be established including paying young people and their support.	Joint Children's and PH Commissioners. Providers. Rethink Champions.	Joint Children's Commissioning team. Public health children's team. Director of CAMHS services CNWL and WLMHT.	Re-think programme: There has been one session run and this needs to be followed up and run again. A planning meeting has been held in April 15. There is now a clinical lead from WLMHT to support Re-Think in running the programme six times in the next nine months. There will be an evaluation of the programme at the end of this time period.
3.	The Health and Wellbeing Board should support the Local Safeguarding Children Board's (LSCB) call for a 2015-16 programme of 'guidance, support and prevention' activities in schools to address: the stigma of mental health; managing self-harm; suicide prevention; and cyber bullying. *Future in Mind:*	1. There needs to be discussion at the Children's Trust board to identify the best way to achieve this and a lead.			

	Recommendation	Action required	Lead agency	Key leads	Current position and Implementation target date
4.	Local commissioners and senior clinicians should continue to be engaged and contribute to NHS England's work on improving the care and treatment pathways for young people with eating disorders.	1. Local commissioners to liaise with NHSE. 2. New government money has been announced for this area of CAMHS, local commissioners to ensure that they identify bid opportunities for new services and engage providers.	Children's Joint Commissioning Team.	Head of the Children's Joint commissioning Team & Children's Joint CAMHS commissioner.	The leads have met with the local NHSE Area Team Manager and have agreed a series of meetings to understand how co-commissioning might provide an improved care pathway.

Reducing the Impact of Parental Mental Health Disorders on Children and Young People

	Recommendation	Action required	Lead agency	Key leads	Current position and Implementation target date
5.	All services providing mental health care to adults should be contractually required to demonstrate that the patient has been asked about their parental responsibilities and assessed the potential impact of their mental health problems may have had on the children they are responsible for.	1. There are CQUINs in place via CCG contracts and these are being improved for 2015/16. 2. Need to continue to monitor progress on CQUIN targets	Health CCGS. Providers. LAs. AMH joint commissioning team.	AMH Commissioners will need to monitor this going forward.	The contract monitoring process has shown that this new contractual requirement is being met by CNWL and WLMHT. This will continue to be monitored in the next contract year. There have been new CQUINs put in place for 2015/2016 to further ensure that parents and children accessing mental health services have clear joined up care planning.
6.	Health and Wellbeing Boards should make improving local data and information sharing a priority for improvement. An inter-agency Data and Information Sharing Protocol or Policy should be developed to cover all services for families in the Tri-borough area.	1. There are some current CQUINS in place for the provider and local authorities to work on this together at a local level.	Providers. LAs. AMH Joint commissioning team.	WLMHT and CNWL. Lambert Allman. Adult Mental Health commissioners.	There has been some progress and providers and LAs have managed to produce draft policies.

	Recommendation	Action required	Lead agency	Key leads	Current position and Implementation target date
7.	A Think Family or 'Whole Family' approach should be adopted and championed in adult mental health services, with a view to: improving 'holistic' assessment processes, improving multi-agency planning and interventions and encouraging 'joint work' with families with multiple problems. Think Family champions should be established, with the support of Health and Wellbeing Boards, CCGs and Public Health to develop a programme of engagement with ante and post-natal services.	1. For the contract for 15/16. There is a CQUIN in place to ensure identification of families with service users in both CAMHS and AMHS. That such families are offered joint care planning and where appropriate joint treatment sessions. 2. Monitoring to ensure that the CQUIN is actioned and new practice is in place.	CCGS. Providers. AMH and Children's Joint Commissioners.	Head of AMH. Joint Commissioners. Lead CCG.	The CQUIN has been agreed via thee contract process.
8.	Health and Wellbeing Boards should encourage local Health, Social Care and Voluntary providers to collaborate in publishing a 'local offer' explaining what services are available to support mental health and emotional well-being.	1. The tri borough children's trust board are looking at identifying a new vision for CAMHS; members of the HWBB are engaged in the trust board. 2. The children trust board will identify how local offer can be identified and published.	TBC	TBC	

	Recommendation	Action required	Lead agency	Key leads	Current position and Implementation target date
9.	Health and Wellbeing Boards should support the development of a Young Carers Strategy across Health, Adult and Children's Social Care and the Voluntary Sector to improve inter agency working maximise outcomes for young people.	1. To develop in a co-productive manner a draft strategy.	Peter Beard. Bernadette Jennings. Health CCGs. Lambert Allman.	TBC	TBC

The Transition from Children's to Adult Mental Health Services

	Recommendation	Action required	Lead agency	Key leads	Current position and Implementation target date
10.	Further discussion should be facilitated with both Central North West London NHS Foundation Trust (CNWL) and West London Mental Health Trust (WLMHT) to clarify the position on numbers of young people in transition in order to establish: • A comprehensive understanding of local discharge and transition activity, in preparation for the national changes expected next year; • Whether a 16-25 year old service has advantages for young people with mental health; and • Whether young people are leaving CAMHS support prematurely.	1. Local commissioners have been involved with NHSE who have transition as part of their wok plan. 2. As a result of conversation with NHSE there is a CQUIN proposal for 2015/2016. 3. The CQUIN has the following elements: Improved data collection by providers in AMH and CAMHS. The need for policies and procedures that reflect the children and families act of 2014 (in terms of services for up to 25s) The need for advance planning and follow up once transfer has occurred to ensure young people have not disengaged. Identify cases where the need for CAMHS extended beyond 18 years.	Health CCGs. Providers. Joint commissioners from CAMHS and AMHS.	Joint CAMHS Commissioner. Head of AMH. Joint Commissioning. Lead CCG Providers.	The CQUIN has been drawn up to include the information and has been negotiated with the providers for inclusion in the 2015/2016 contract.

	Recommendation	Action required	Lead agency	Key leads	Current position and Implementation target date
11.	With a successful outcome in mind, both WLMHT and CNWL should identify Transition Champions – one in CAMHS and one in Adult Mental Health Services, who together are challenged to deliver the improved transition planning envisaged by the Care Quality Commission and the forthcoming National Institute for Health and Care Excellence (NICE) guidance.	1. The CQUIN mentioned above identifies the need for services to identify leads for transition. 2. Champions will be identified as part of the service improvement plan.		AMH Joint commissioner • Janice Woodruff • CAMHS Commissioner Jacqui Wilson	The CQUIN has been accepted and will be acted upon in 2015/2016.

1. Executive summary and key proposals

1.1 The Children and Young People's Mental Health and Wellbeing Taskforce[1] was established in September 2014 to consider ways to make it easier for children, young people, parents and carers to access help and support when needed and to improve how children and young people's mental health services are organised, commissioned and provided.

1.2 Key themes emerged which now provide the structure of this report. Within these themes, we have brought together core principles and requirements which we consider to be fundamental to creating a system that properly supports the emotional wellbeing and mental health of children and young people.

1.3 **In summary, the themes are:**

- **Promoting resilience, prevention and early intervention**
- **Improving access to effective support – a system without tiers**
- **Care for the most vulnerable**
- **Accountability and transparency**
- **Developing the workforce**

The case for change

1.4 Mental health problems cause distress to individuals and all those who care for them. One in ten children needs support or treatment for mental health problems. These range from short spells of depression or anxiety through to severe and persistent conditions that can isolate, disrupt and frighten those who experience them. Mental health problems in young people can result in lower educational attainment (for example, children with conduct disorder are twice as likely as other children to leave school with no qualifications) and are strongly associated with behaviours that pose a risk to their health, such as smoking, drug and alcohol abuse and risky sexual behaviour.

1.5 The economic case for investment is strong. 75% of mental health problems in adult life (excluding dementia) start by the age of 18. Failure to support children and young people with mental health needs costs lives and money. Early intervention avoids young people falling into crisis and avoids expensive and longer term interventions in adulthood. There is a compelling moral, social and economic case for change. We set this out in full in **Chapter 3.**

1.6 Evidence presented to the Taskforce also underlined the complexity and severity of the current set of challenges facing child and adolescent mental health services. These include:

i. **Significant gaps in data and information and delays in the development of payment and other incentive systems.** These are all critical to driving change in a co-ordinated way.

[1] *Children and Young People's Mental Health and Wellbeing Taskforce: Terms of Reference.* Available at: www.gov.uk/government/groups/children-and-young-peoples-mental-health-and-well-being-taskforce

ii. **The treatment gap.** The last UK epidemiological study[2] suggested that, at that time, less than 25% – 35% of those with a diagnosable mental health condition accessed support. There is emerging evidence of a rising need in key groups such as the increasing rates of young women with emotional problems and young people presenting with self-harm.

iii. **Difficulties in access.** Data from the NHS benchmarking network and recent audits reveal increases in referrals and waiting times, with providers reporting increased complexity and severity of presenting problems.

iv. **Complexity of current commissioning arrangements.** A lack of clear leadership and accountability arrangements for children's mental health across agencies including CCGs and local authorities, with the potential for children and young people to fall though the net has been highlighted in numerous reports.[3]

v. **Access to crisis, out of hours and liaison psychiatry services are variable** and in some parts of the country, there is no designated health place of safety recorded by the CQC for under-18s.

vi. **Specific issues facing highly vulnerable groups of** children and young people and their families who may find it particularly difficult to access appropriate services.

1.7 These issues are addressed in considering the key themes that form the basis of this report and the proposals it makes.

Making it happen

1.8 The Taskforce firmly believes that the best mental health care and support must involve children, young people and those who care for them in making choices about what they regard as key priorities, so that evidence-based treatments are provided that meet their goals and address their priorities. These need to be offered in ways they find acceptable, accessible and useful.

1.9 Providers must monitor, and commissioners must consider, the extent to which the interventions available fit with the stated preferences of young people and parents/carers so that provision can be shaped increasingly around what matters to them. Services need to be outcomes-focused, simple and easy to access, based on best evidence, and built around the needs of children, young people and their families rather than defined in terms of organisational boundaries.

1.10 Delivering this means making some real changes across the whole system. It means the NHS, public health, local authorities, social care, schools and youth justice sectors working together to:

- **Place the emphasis on building resilience, promoting good mental health, prevention and early intervention** (Chapter 4)

2 Green H, McGinnity A, Meltzer H, Ford T, Goodman R (2005). *Mental health of children and young people in Great Britain, 2004*. A survey carried out by the Office for National Statistics on behalf of the Department of Health and the Scottish Executive. Basingstoke: Palgrave Macmillan.

3 National CAMHS Review (2008). *Children and young people in mind: the final report of the National CAMHS Review*. National CAMHS Review; HM Government (2011). *No Health Without Mental Health: A cross-government mental health outcomes strategy for people of all ages*. London: Department of Health; Department of Health (2012). *Annual Report of the Chief Medical Officer 2012*. London: Department of Health; CAMHS Tier 4 Report Steering Group (2014). *CAMHS Tier 4 Report*. London: NHS England.

- **Simplify structures and improve access**: by dismantling artificial barriers between services by making sure that those bodies that plan and pay for services work together, and ensuring that children and young people have easy access to the right support from the right service (Chapter 5).
- **Deliver a clear joined up approach**: linking services so care pathways are easier to navigate for all children and young people, including those who are most vulnerable (Chapter 6), so people do not fall between gaps.
- **Harness the power of information**: to drive improvements in the delivery of care, and standards of performance, and ensure we have a much better understanding of how to get the best outcomes for children, young people and families/carers and value from our investment (Chapter 7).
- **Sustain a culture of continuous evidence-based service improvement** delivered by a workforce with the right mix of skills, competencies and experience (Chapter 8).
- **Make the right investments**: to be clear about how resources are being used in each area, what is being spent, and to equip all those who plan and pay for services for their local population with the evidence they need to make good investment decisions in partnerships with children and young people, their families and professionals. Such an approach will also enable better judgements to be made about the overall adequacy of investment (Chapter 9).

1.11 In some parts of the country, effective partnerships are already meeting many of the expectations set out in this report. However, this is by no means universal, consistent or equitable.

A National ambition

1.12 This report sets out a clear national ambition in the form of key proposals to transform the design and delivery of a local offer of services for children and young people with mental health needs. **Many of these are cost-neutral, requiring a different way of doing business rather than further significant investment.**

1.13 **There are a number of proposals in this report which require critical decisions, for example, on investment and on local service redesign, which will need explicit support from the next government, in the context of what we know will be a very tight Spending Review.** We are realistic in this respect. At both national and local level, decisions will need to be taken on whether to deliver early intervention through an 'invest to save' approach and/or targeted reprioritisation, recognising that it will take time to secure an economic return for the nation.

The Government's aspirations are that by 2020 we would wish to see: *(The numbers in brackets refer to the proposals in and at the end of each chapter)*

1. **Improved public awareness and understanding, where people think and feel differently about mental health issues for children and young people where there is less fear and where stigma and discrimination are tackled.** This would be delivered by:
   - a hard hitting anti-stigma campaign which raises awareness and promotes improved attitudes to children and young people affected by mental health difficulties. This would build on the success of the existing Time to Change campaign; (3)
   - with additional funding, we could also empower young people to self-care through increased availability of new quality assured apps and digital tools. (5)
2. **In every part of the country, children and young people having timely access to clinically effective mental health support when they need it.** With additional funding, this would be delivered by:
   - a five year programme to develop a comprehensive set of access and waiting times standards that bring the same rigour to mental health as is seen in physical health. (17)
3. **A step change in how care is delivered moving away from a system defined in terms of the services organisations provide (the 'tiered' model) towards one built around the needs of children, young people and their families.** This will ensure children and young people have easy access to the right support from the right service at the right time. This could be delivered by:
   - joining up services locally through collaborative commissioning approaches between CCGs, local authorities and other partners, enabling all areas to accelerate service transformation; (48)
   - having lead commissioning arrangements in every area for children and young people's mental health and wellbeing services, responsible for developing a single integrated plan. We envisage that in most cases the CCG would establish lead commissioning arrangements working in close collaboration with local authorities. We also recognise the need for flexibility to allow different models to develop to suit local circumstances and would not want to cut across alternative arrangements; (30)

- transitions from children's services based on the needs of the young person, rather than a particular age. (15)

4. **Increased use of evidence-based treatments with services rigorously focused on outcomes.** With additional funding, this would be delivered by:
   - building on the success of the CYP IAPT transformation programme and rolling it out to the rest of the country. (44)
5. **Making mental health support more visible and easily accessible for children and young people.** With additional funding, this would be delivered by:
   - every area having 'one-stop-shop' services, which provide mental health support and advice to children and young people in the community, in an accessible and welcoming environment. This would build on and harness the vital contribution of the voluntary sector; (16)
   - improving communications, referrals and access to support through every area having named points of contact in specialist mental health services and schools. This would include integrating mental health specialists directly into schools and GP practices. (16)
6. **Improved care for children and young people in crisis so they are treated in the right place at the right time and as close to home as possible.** This would be delivered by:
   - ensuring the support and intervention for young people being planned in the Mental Health Crisis Care Concordat are implemented; (12)
   - no young person under the age of 18 being detained in a police cell as a place of safety; (19)
   - implementing clear evidence-based pathways for community-based care, including intensive home treatment where appropriate, to avoid unnecessary admissions to inpatient care. (13)
7. **Improving access for parents to evidence-based programmes of intervention and support to strengthen attachment between parent and child, avoid early trauma, build resilience and improve behaviour.** With additional funding, this would be delivered by:
   - enhancing existing maternal, perinatal and early years health services and parenting programmes. (4)
8. **A better offer for the most vulnerable children and young people, making it easier for them to access the support that they need when, and where they need it.** This would include:
   - ensuring those who have been sexually abused and/or exploited receive a comprehensive assessment and referral to the services that they need, including specialist mental health services. (24)
9. **Improved transparency and accountability across the whole system, to drive further improvements in outcomes.** This would be delivered by:
   - development of a robust set of metrics covering access, waiting times and outcomes to allow benchmarking of local services at national level; (36)
   - clearer information about the levels of investment made by those who

commission children and young people's mental health services; (38)

- subject to decisions taken by future governments, a commitment to a prevalence survey for children and young people's mental health and wellbeing, which is repeated every five years. (39)

10. **Professionals who work with children and young people are trained in child development and mental health, and understand what can be done to provide help and support for those who need it.**

Local Transformation Plans

1.14 Delivering the national ambition will require local leadership and ownership. We therefore propose the development and agreement of **Transformation Plans for Children and Young People's Mental Health and Wellbeing** which will clearly articulate the local offer. These Plans should cover the whole spectrum of services for children and young people's mental health and wellbeing from health promotion and prevention work, to support and interventions for children and young people who have existing or emerging mental health problems, as well as transitions between services.

1.15 In terms of local leadership, we anticipate that the lead commissioner, in most cases the Clinical Commissioning Group, would draw up the Plans, working closely with Health and Wellbeing Board partners including local authorities. All these partners have an important role to play in ensuring that services are jointly commissioned in a way that promotes effective joint working and establishes clear pathways. Lead commissioners should ensure that schools are given the opportunity to contribute to the development of Transformation Plans.

1.16 To support this, NHS England will make a specific contribution by prioritising the further investment in children and young people's mental health announced in the Autumn Statement 2014 in those areas that can demonstrate robust action planning through the publication of local Transformation Plans.

1.17 What is included in the Plan should reflect the national ambition and principles set out in this report and be decided at a local level in collaboration with children, young people and their families as well as providers and commissioners. Key elements will include commitments to:

Transparency

- A requirement for local commissioning agencies to give an annual declaration of their current investment and the needs of the local population with regards to the full range of provision for children and young people's mental health and wellbeing.
- A requirement for providers to declare what services they already provide, including staff numbers, skills and roles, waiting times and access to information.

Service transformation

- A requirement for all partners, commissioners or providers, to sign up to a series of agreed principles covering: the range and choice of treatments and interventions available; collaborative practice with children, young people and families and involving schools; the use of evidence-based interventions; and regular feedback of outcome monitoring to children, young people and families and in supervision.

Monitoring improvement

- Development of a shared action plan and a commitment to review, monitor

and track improvements towards the Government's aspirations set out in this Report, including children and young people having timely access to effective support when they need it.

Next steps in 2015/16

1.18 **At a national level, we will play our part to deliver the ambition by:**

- delivering waiting times standards for Early Intervention in Psychosis by April 2016;
- continuing development of new access and waiting times standards for Eating Disorder;
- commissioning a new national prevalence survey of child and adolescent mental health;
- implementing the Child and Adolescent Mental Health Services Minimum Dataset, which will include the new CYP IAPT dataset;
- continuing to focus on case management for inpatient services for children and young people, building on the response to NHS England's Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report;[4]
- testing clear access routes between schools and specialist services for mental health by extending the recently established co-commissioning pilots to more areas;
- improving children's access to timely support from the right service through developing a joint training programme to support lead contacts in mental health services and schools. This will be commissioned by NHS England and the Department for Education and tested in 15 areas in 2015/16. DfE will also support work to develop approaches in children's services to improve mental health support for vulnerable children;
- improving public awareness and understanding of children's mental health issues, through continuing the existing anti-stigma campaign led by Time to Change and approaches piloted in 2014/15 to promote a broader national conversation;
- encouraging schools to continue to develop whole school approaches to promoting mental health and wellbeing through a new counselling strategy for schools, alongside the Department for Education's other work on character and resilience and PSHE.

1.19 **In the medium to longer term, the Taskforce would like a future government to consider formalising at least some parts of this national ambition to ensure consistency of practice across the country.** This would also give a more precise meaning to what is meant by the existing statutory duties in respect of parity of esteem between physical and mental health, as they apply to children and young people.

4 CAMHS Tier 4 Report Steering Group (2014). *CAMHS Tier 4 Report*. London: NHS England.

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City of Westminster

Role of Pharmacies in the Community

Westminster Health and Wellbeing Board

21 May 2015

Stuart Lines, Deputy Director of Public Health

Westminster Health and Wellbeing Board

Food for thought

Professor John Newton, Chief Knowledge Officer at PHE:

"Community Pharmacy has great potential as a setting for people to stop and think about their health, and to get advice and support from someone they trust. Many pharmacy teams are already playing a significant role in promoting and improving people's health in their local communities. ***We need to understand how delivery of public health services in local pharmacies could contribute to improving health outcomes and reducing health inequalities in those communities****."*

What do pharmacies offer?

- Easy accessibility for those who cannot or do not wish to access other conventional NHS services
- Long opening hours and convenience
- A health resource on the high streets and supermarkets
- Anonymity, where appropriate
- Flexible setting within an informal environment
- Local businesses well connected to their local communities
- Staff tend to reflect the social and ethnic backgrounds of the populations they serve

Case Study: The 'Healthy Living Pharmacies' Pilot

A '**Healthy Living Pharmacy**' (HLP) builds on existing pharmacy services with provision of locally commissioned enhanced services. The principle categories of service delivery are based around **promotion**, **prevention** and **protection**.

DH launched the first six HLP in Portsmouth in June 2010. There are now over 800 HLPs in the United Kingdom with 3,000 Health Champions working within these HLPs.

The pilot

What was it?

An approach which **uses community pharmacies as a hub model for health services**, including:

- Advice on healthy lifestyle issues supported by health champions
- Medicine usage.
- Six public health campaigns per year.
- Locally commissioned services - stop smoking, alcohol, sexual health, NHS Health Check

Why pharmacies?

1.8 million people visit a pharmacy each day.

Range of provider models: in communities, on the high street, in supermarkets, in shopping centres, in health centres and online.

Accessibility in terms of **location and long opening hours**. No need to build or identify new space. **Captive client base** and community identity

High level of training, including **clinical training**.

Healthy Living Pharmacies

Views of people

21% of people wouldn't have done anything if they hadn't accessed a service or support in the Healthy Living Pharmacy

Almost **100% of people were comfortable** being supported in the pharmacy and thought they were treated well

98% would recommend the service to others

What did it achieve?

29% increase in chlamydia screening (Stoke on Trent)

12% increase in 4 week smoking quit rate (Blackburn)

242% increase in alcohol advice given between a normal pharmacy and a Healthy Living Pharmacy

Outcomes improved in 26 of 33 evaluations

PHE Evidence[1] on the pharmacy contribution to public health

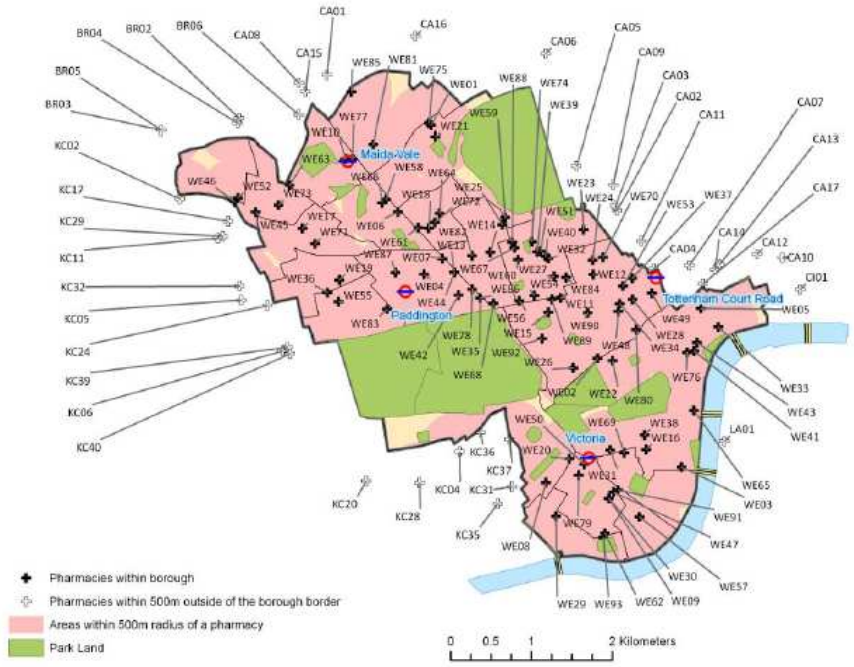
Service	Evidence of success
Stop Smoking Services	**Very positive** *55% quit rate (49% UK average and 42% GP av.)*
Emergency hormonal contraception (EHC)	**Positive** Evidence to suggest highly rated services
Healthy eating	**Promise, but positive** Insufficient evidence
Drug and alcohol misuse	**Promise, but positive** Insufficient evidence
Infection control and prevention	**Promise, but positive** Insufficient evidence
Chronic disease management & prevention	**Very positive** Good empirical evidence to suggest improved prevention in patients.

[1] *Public Health England (2013) Consolidating and developing the evidence base and research for community pharmacy's contribution to public health: a progress report from Task Group 3 of the Pharmacy and Public Health Forum*

The Westminster Context

68 out of 93 community pharmacies in Westminster (73%) are interested in becoming an accredited Healthy Living Pharmacy

At least 52 pharmacies in Westminster provide Medicine Usage Reviews and at least 46 pharmacies provide a New Medicines Services



Pharmacies within Westminster and surrounding Boroughs
Westminster Pharmaceutical Needs Assessment 2015-2018 - www.jsna.info for full report
Ordnance Survey data © Crown copyright and database right

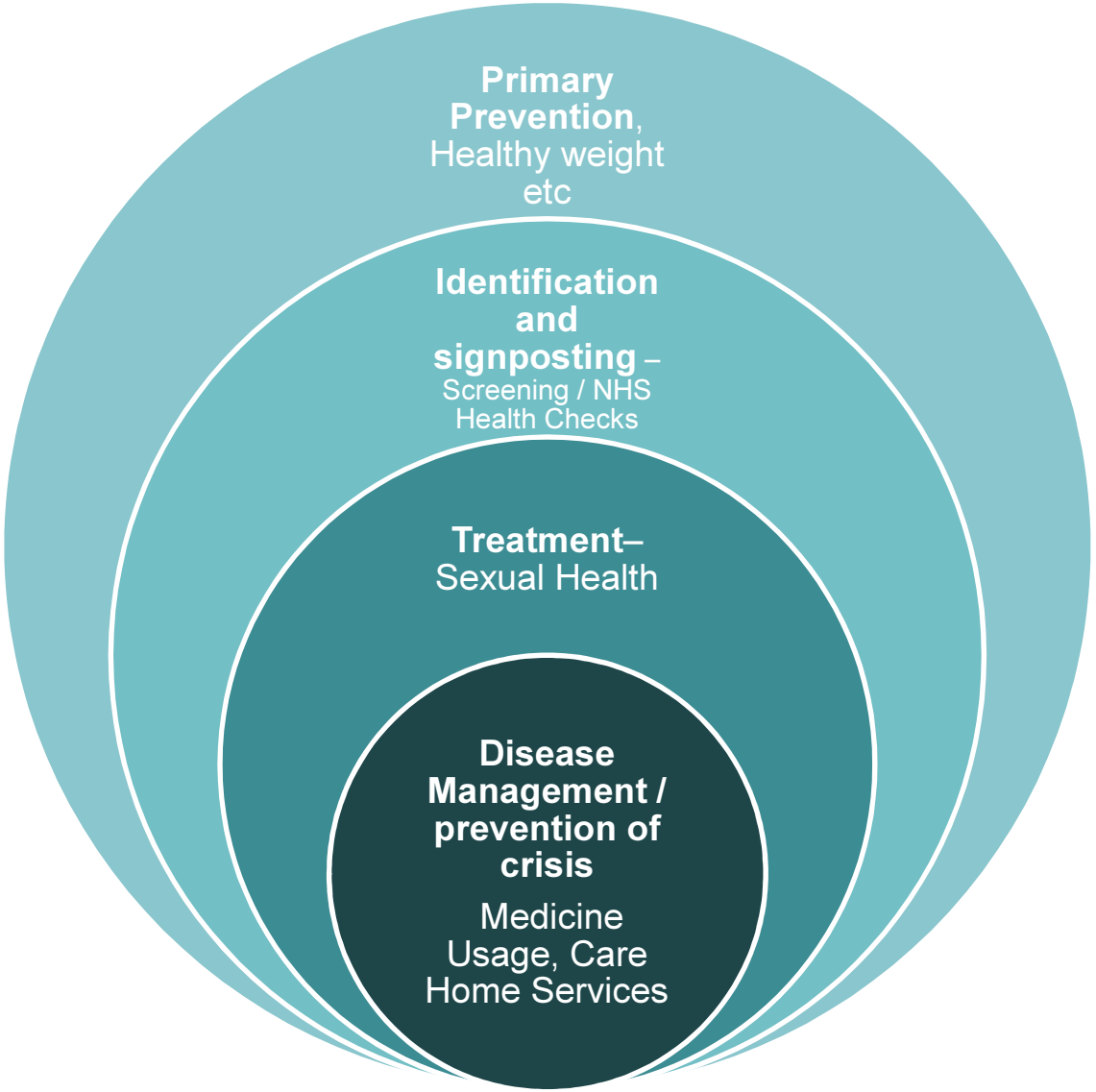
Areas where pharmacies may be currently underused as identified in the PNA:

- Care Home Service
- Medicines Assessment and Compliance Support Services
- Only one pharmacy reported having a health champion
- Only 4 pharmacies reported having a health trainer
- Screening and Immunisation services
- Public Health behaviour change services (stop smoking, healthy weight etc.)
- Sexual Health services

Locally Commissioned Services

Service	Type	Commissioner	No. Pharmacies
Flu Vaccinations	Locally Enhanced Service	NHS England	44
Minor Ailment Scheme	Locally Enhanced Service	NHS England	9
NHS Health Checks (Screening Service)	Other Locally Commissioned Service	Public Health	8
Supervised Administration Service (Methadone etc)	Other Locally Commissioned Service	Public Health	30
Needle and Syringe Exchange Service	Other Locally Commissioned Service	Public Health	12
Stop Smoking Service	Other Locally Commissioned Service	Public Health	67

What role do we want pharmacies to play in our health economy?



Are we maximising our community pharmacy resource in Westminster?

Do we consider the role that community pharmacy could play when designing and commissioning services?

Are we engaging effectively with community pharmacies in relation to our integration and whole systems work or our public health strategy?

Could an increased role for community pharmacies potentially reduce demand for:

- GPs
- Acute Services
- Adult Social Care
- Public Health services
- Children Services

Should we be considering the role that communities pharmacies could play in the wider determinants of health , i.e. housing, employment, managing debt, social isolation etc.

Developing a system-wide approach to community pharmacy

Does the Health and Wellbeing Board want to develop a system-wide approach to community pharmacy. If so:

- What questions should this work aim to answer?
- What should be out of scope for this work?

- Which Health and Wellbeing Board member should be the accountable lead for the work?
- When would it be best to deliver this work to inform future commissioning

- Should the PNA reference group we re-shaped to support the development of the approach?
- What other organisations need to be involved – Local Pharmaceutical Committee; GPs; Providers etc.?

Westminster policy and scrutiny committee may be keen to work with the Health and Wellbeing Board on this work by building an evidence base of how community pharmacies can go beyond Healthy Living Pharmacies to increase their role in tackling the wider determinants of health

Whole Systems Integrated Care

North West London
Whole Systems Integrated Care

NHS
Central London
Clinical Commissioning Group

Across NWL we are continuing to work together to be a Pioneer site for integrated care

Living ***longer***
and living ***well***

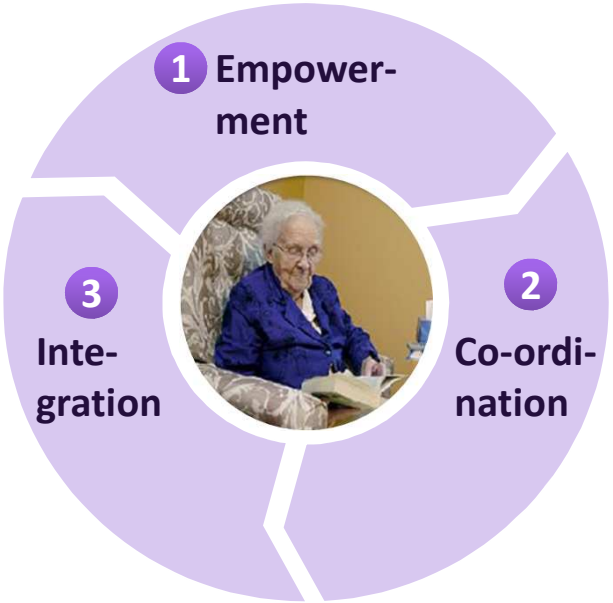
We have a 3 – 5 year vision for integration

Our shared vision of the WSIC programme …

> We want to improve the quality of care for individuals, carers and families, empowering and supporting people to maintain independence and to lead full lives as active participants in their community

… supported by 3 principles

1. People will be empowered to direct their care and support and to receive the care they need in their homes or local community
2. GPs will be at the centre of organising and coordinating people's care
3. Our systems will enable and not hinder the provision of integrated care



Together we have described how care will be different

Organising care

- Care is **organised around groups** of people with similar needs
- People are involved with their **own care plan,** with their own goals.
- They **agree, with their care team**, what happens when they become unwell and when they can return home
- Care plans include **self care**, **community services** and the **voluntary sector**
- People **choose the services they want** and have a say in how **money is spent** on them
- Health and social care staff work as **one team**, with the **GP at the centre** of people's health and wellbeing, finding people the right care in the right setting
- The team **communicate frequently** and keep each other **up to date** on patients' progress

Providing care

- Health and social care professionals come together to form an **Accountable Care Partnership (**ACP), where they work in a **coordinated** and **collaborative** way
- The ACP **listen to everyone's** views and **share objectives**
- **Decisions are made together** within the ACP covering how best to deliver care, where to allocate budget and how to resource care
- When more specialised services are needed, the ACP can **invite other providers** to help deliver care
- The ACP is its **own entity** which works **efficiently** as one, supported by a joined up back office with shared managerial and administrative support
- When **money is over or underspent**, the ACP agrees together what to do

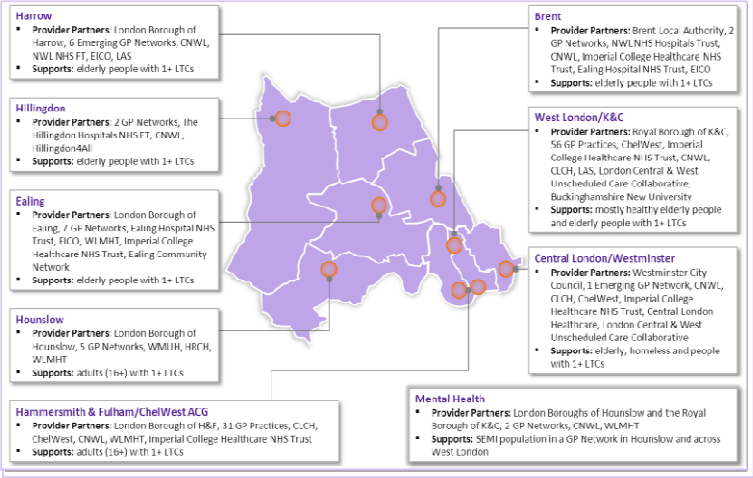
Paying for care

- **Governance** around co-commissioning **agreed by LA, CCG and NHSE**
- **Budgets** across social, mental health, acute, community and primary care are pooled for groups of people with similar needs who receive integrated care
- **Contracts are in place** to provide clarity over these arrangements which also define how **risk is shared**, for commissioners and ACPs
- These contracts set out **targets that ACPs** need to deliver against, including clinical, financial and outcomes

During 2014/15 we have worked hard to plan how we will implement Whole Systems Integrated Care

The WSIC toolkit

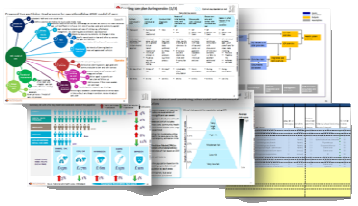
9 Early Adopters



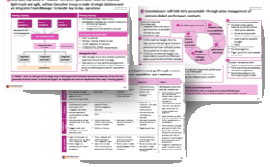
Co-designed implementation plans

The WSIC toolbox

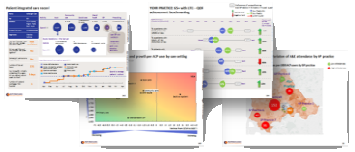
1 Model of care operational handbooks and costing tool



2 Governance models



3 Dashboards



4 Organisational development plan

Summary description of model care

Central London CCG proposed model of care for residents, aged over 75 or with LTCs

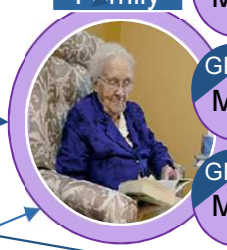
- Everyone accesses care plan
- Care coordinator arranges diagnostics/home visit/team input to prepare for first plan

Care plan
- Lists personal goals and how to achieve them
- Planned care interventions
- Contingency plan for emergency

Multi-disciplinary team

Every Village :
- Care coordinator
- Community Matron
- Community Nursing
- Social care and Home Care
- Social prescriptions provider
- Volunteers (expert and non)
- Carers
- PCLN Mental Health Nursing

Every Hub:
- Physiotherapist
- Environmental health officer (housing)
- OT
- Specialist Community Services
- Specialist i.e. Geriatrician
- Podiatrist
- Mental health expert
- Clinical Pharmacist
- Equipment
- Team manager
- Interpreters
- Discharge Co-ordinator
- EOL Specialist



One or more named GP(s)

GP MDT

NORTH HUB

CENTRAL HUB

SOUTH HUB

Whole Systems Integrated Care

Shared services and support that can serve patients, service users and the MDT Includes:
- Single IT System
- Home care
- Rapid response
- Specialists (e.g., diabetologist, cardiologist or geriatrician)
- Diagnostics
- Driver able to transport people to hubs
- Back office / operations team
- Third sector services coordinator (organises social interventions on behalf of MDT)
- Long term care coordinator (e.g., liaison with home care provided beyond initial reablement or by agency outside MDT)
- Hospital discharge coordination team (led by Geriatrician and able to negotiate timely community discharge via support at home)
- Out-of-hours Skype enabled switch board, staffed by a GP

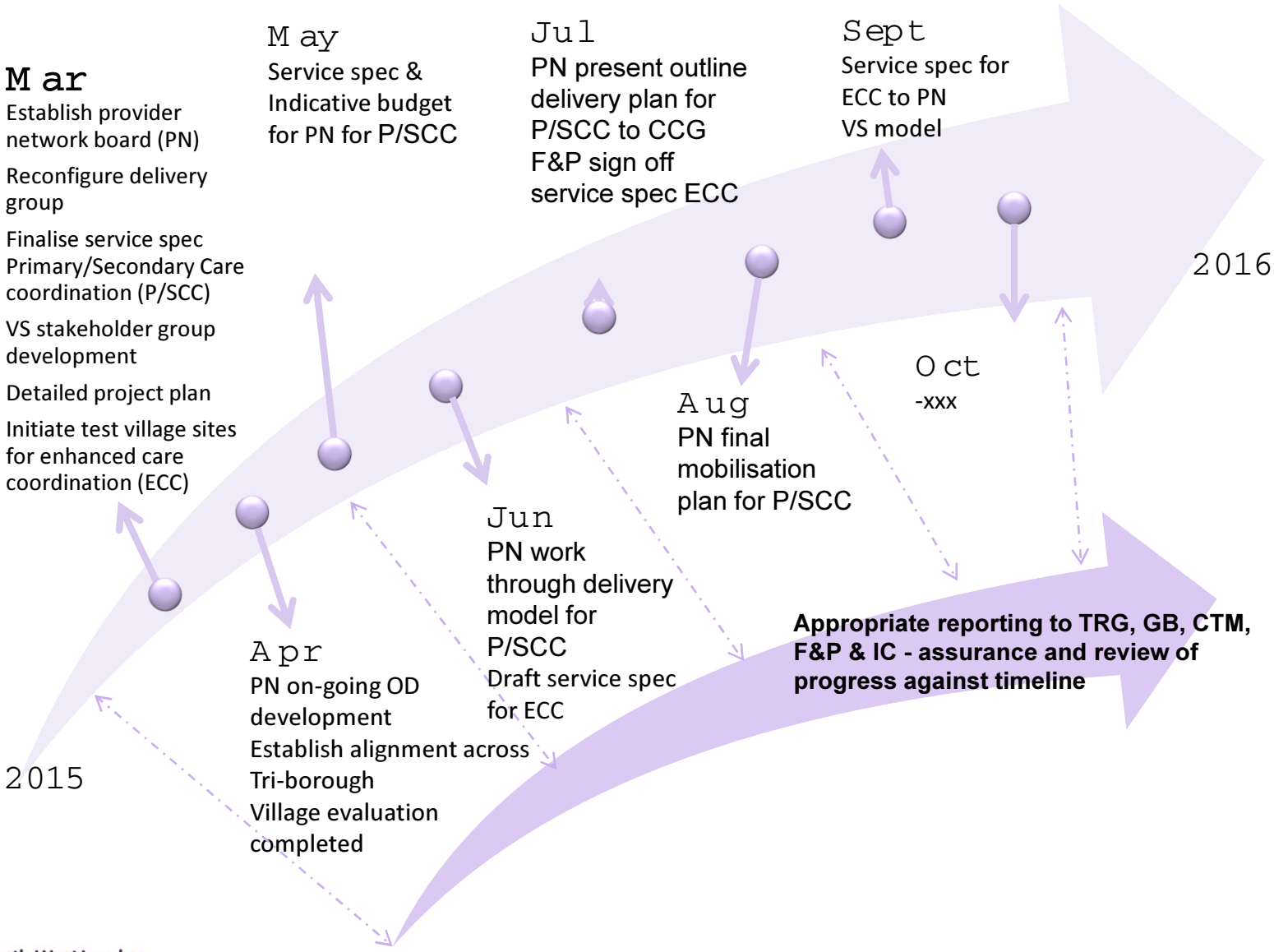
Capabilities include:
- Home care visits
- Rapid response (shift working to extend OOH cover within team)
- Reablement
- Clinics in hubs

GP has more time and can:
- Make home visits, including to care plan
- Offer longer, more regular appointments
- Direct MDT to provide care for people in line with care plan
- Case conference with MDT

- Operating base for each MDT
- Central venue for:
  - Care appointments/diagnostics so patients only travel to one place
  - Services like patient education
- Whole Systems services are hosted across hubs

North West London
Whole Systems Integrated Care

Whole Systems Integrated Care key milestones



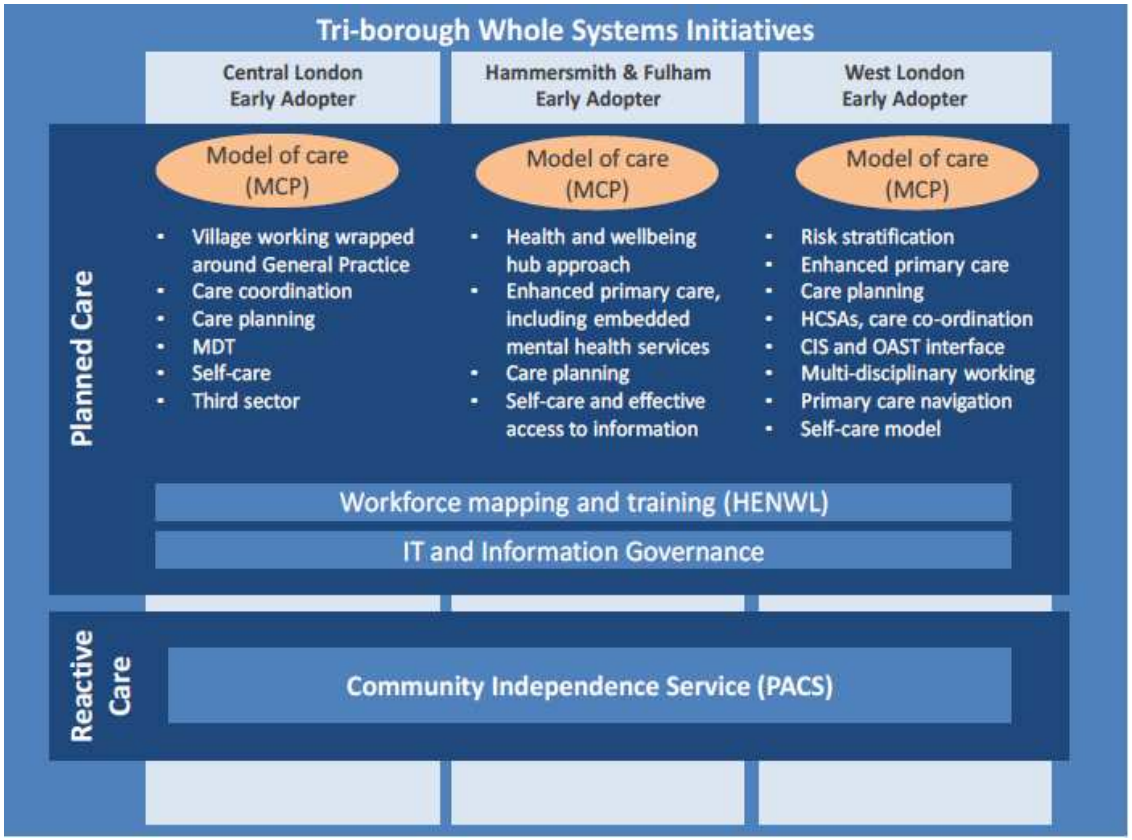
Planned and reactive models of care to support Whole Systems

As part of the North West London Whole Systems Pioneer Programme, Tri-borough partners are developing both planned and reactive models of care in support of the Whole Systems shared vision and principles:

1. People will be empowered to direct their care and support and to receive the care they need in their homes or local community;

2. GPs will be at the centre of organising and coordinating care so that it is accessible and provided in the most appropriate setting; and

3. Our systems will enable and not hinder the provision of integrated care and ensure that funding flows to where it is needed most.



This will be supported by on-going enabling work across North West London

Model of Care (MoC) and Outcomes	§ Develop a common set of outcomes across NWL including embedding the outcomes in the way that Early Adopters performance manage and evaluate § Provide support and shared learning to developing Models of Care for existing and new population segments
Governance & Contracting	§ Support to develop the new capabilities and capacity required to move into a WSIC model § Support to make the necessary contracting changes that will support shifting from shadow to 'real' ways of working § Development of a consistent approach to assurance of new commissioning and provider models
Analytics and Informatics	§ Roll-out across NWL of the data warehouse and dashboards § Training and support to users as the dashboards get taken up across NWL § Consistent management of IG processes, stakeholder engagement and vendor management
Finance and capitation	§ Move Early Adopters towards capitated budgets and pooled budgets from a technical and contractual perspective (development of a pricing methodology and principles) § Support Early Adopters with the changes that are required and provide, where appropriate, technical guidance in the implementation
New ways of working (Change Academy)	§ Roll-out the Change Academy to embed new ways of working for teams and their leaders § Run the Change Academy day-to-day including supporting participants, organising sessions, coordinating programmes

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City of Westminster

Westminster Health & Wellbeing Board

Date:	21st May 2015
Classification:	**General Release**
Title:	JSNA Work Programme Update
Report of:	Acting Director of Public Health
Wards Involved:	all
Policy Context:	Health and Wellbeing Board
Financial Summary:	None
Report Author and Contact Details:	Jessica Nyman, JSNA Manager Colin Brodie, Public Health Knowledge Manager Email: jnyman@westminster.gov.uk Tel: 0207 641 8461

1. Executive Summary

1.1 This paper provides a short update on the current stage of delivery of the Joint Strategic Needs Assessment (JSNA) products agreed by the Health and Wellbeing Board for the 2014/15 work programme. It also reports on two subsequent requests received from partners for JSNA support that are either pending or have not yet been agreed

2. Key Matters for the Board

2.1 The Health and Wellbeing Board are invited to consider progress on the 4 deep dive JSNAs in the current work programme (Dementia JSNA, Childhood Obesity JSNA, End of Life Care JSNA and Housing JSNA).

2.2 The Health and Wellbeing Board are invited to consider how they may wish to get involved in the development of specific JSNAs in the current work programme

2.3 The Health and Wellbeing Board are asked to consider how they may wish to inform the scope and development of the Evidence Hub.

3. Background

3.1 There are currently 4 JSNA projects underway which are at different stages of delivery. These were approved by the Health and Wellbeing Board in 2014 for the JSNA work programme.

3.2 Two new proposals for JSNA products are also currently being considered for the 2015/16 work programme. These proposals are at different stages of development and are currently being scoped in further detail.

4. Current JSNA Work Programme

Dementia JSNA

4.1 The purpose of this JSNA is to provide a comprehensive evidence base and information about the local population to inform the development of a dementia strategy that takes account of national and local policy, strategy, and guidance.

4.2 Information has been collected from a variety of sources including audit, relevant policy and research as well as local data provided by stakeholders, providers and service users. This evidence has been analysed to identify gaps and solutions and forms the basis of the recommendations.

4.3 The first draft is now complete. Feedback is being collated from stakeholders, and the Task and Finish Group will shortly work through this feedback to update the document where appropriate.

4.4 The JSNA report will come to the next Health and Wellbeing Board meeting in July 2015 for consideration and final sign-off.

Childhood Obesity JSNA

4.5 This JSNA will look at the prevalence of childhood obesity in Westminster, Hammersmith and Fulham, and Kensington and Chelsea. The report will examine the factors which are known to influence levels of obesity in our population, analysing the available data for the local area.

4.6 Some of the wider implications of obesity for local services and society more generally will be described, relating these to the available data.

4.7 This analysis of data and other sources of information is underway, and the first draft will be sent to stakeholders at the start of June 2015 for comment and

feedback. A final draft is expected to be ready for consideration by the Health and Wellbeing Board in September 2015.

4.8 The Childhood Obesity JSNA will inform and support the next phase of the Childhood Obesity Programme.

End of Life Care JSNA

4.9 This JSNA will assist in identifying the future capacity requirements to meet the increasing End of Life Care needs of residents in Westminster, Hammersmith and Fulham, and Kensington and Chelsea.

4.10 This work draws together information from key partners to provide a local evidence base for future integrated commissioning. It is an opportunity to understand the whole landscape for people approaching end of life, and their carers' and to highlight areas of improvement to be addressed in joint strategic planning.

4.11 Data analysis and evidence review is currently underway by Public Health. In early June 2015 a first draft will be sent around to wider stakeholders to assist with gaps in data and for comment. A final draft will be completed end of September.

Housing JSNA

4.12 The Housing JSNA is being developed along with stakeholders to support their key business needs, and in particular in relation to the new duties for local authorities around health and wellbeing contained within the Care Act. The JSNA will support the duties of the Care Act to prevent, delay or reduce an individual's need for care and to support and cooperate across departments and with relevant partners.

4.13 A briefing paper will be presented to the Shared Services Board in June 2015 outlining the project deliverables and outputs required to complete the JSNA.

4.14 The JSNA will focus on the disability and health related housing needs of our local population. It will investigate and map the supply of existing housing stock (e.g. extra care housing, sheltered and supported housing, warden supported housing, temporary accommodation etc.) and any projected changes in future supply. It will explore the links between housing and health and social care needs and provide a picture of local need with a focus on vulnerable groups (e.g. people with learning disabilities, physical disabilities, long term conditions or mental illness).

5. Proposals for 2015/16 JSNA work programme

Two new proposals for 2015/16 have been submitted

Evidence Hub

5.1 An initial proposal to develop a JSNA data observatory, or Evidence Hub, was agreed in principle by the JSNA Steering Group in January 2015. The aim of this observatory will be to present information drawn from a range of national and local data and evidence sources, and provide a toolkit for users to interrogate in a more interactive and flexible way e.g. prevalence data for particular conditions, links to evidence briefings, maps to identify the location of services. This will be an online tool which will enable users to find specific data.

5.2 The scope of the Evidence Hub content is currently being developed. Consultation has taken place within Public Health. Consultation with other stakeholders (including the NHS, Adult Social Care, Children's Services, Housing, Planning, Community Safety) has begun and will take place until the end of June.

5.3 The scope of the Evidence Hub will be developed by mid-July based on the consultation and taken back to the JSNA Steering Group for agreement. The Health and Wellbeing Board will then be presented with a proposal on how the Evidence Hub will work in practice for their agreement.

5.4 One function of the Evidence Hub will be to inform a refresh of the JSNA highlights reports.

Fuel Poverty JSNA

5.5 A draft proposal for a JSNA on Fuel Poverty has been submitted. This is currently being scoped in more detail before it is considered by the JSNA Steering Group.

6. Financial Implications

6.1 The two new projects set out above could be progressed within existing resources. Although, the Health and Wellbeing Board may wish to consider these projects more fully at their next meeting alongside other potential draws on the Joint Strategic Needs Assessment resource.

7. Legal Implications

7.1 The Joint Strategic Needs Assessment (JSNA) was introduced in the Local Government and Public Involvement in Health Act 2007

7.2 The Health and Social Care Act 2012 placed the duty to prepare a JSNA equally and explicitly on local authorities (LAs), Clinical Commissioning Groups (CCGs) and the Health and Wellbeing Boards (HWB)

If you have any queries about this Report or wish to inspect any of the Background Papers please contact:

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APPENDICES:
N/A

BACKGROUND PAPERS:
N/A

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City of Westminster

Westminster Health & Wellbeing Board

Date:	**21st May 2015**
Classification:	**General Release**
Title:	**Better Care Fund Update**
Report of:	**WCC and Central and West London CCGs**
Wards Involved:	**All**
Policy Context:	**Health and Social Care Integration**
Report Author and Contact Details:	**Stella Baillie, Director of Integrated Care for Adult Social Care and Health** **Matthew Bazeley, MD of Central London Clinical Commissioning Group**

1. Executive Summary

1.1 This paper is the regular update requested by the Health & Wellbeing Board on progress with development of the Better Care Fund (BCF).

1.2 After a reminder of the national context for the BCF, a brief progress update on BCF schemes in the Triborough is provided. The progress update starts with the most significant scheme, the new integrated Community Independence Service (CIS). There is also a specific update on the pilot that has now commenced to test a new approach to hospital discharge. Following these, there is a broader update on the other schemes that form the Triborough BCF plan.

2. Key Matters for the Board

2.1 The Health and Wellbeing Board is asked to note the progress made with the BCF schemes.

3. Background

3.1 The BCF is a single pooled budget for health and social care services to work closer in local areas, based on a plan agreed between the NHS and local authorities. A national fund of at least £3.8bn was announced in the summer of 2013.

3.2 The BCF is a national initiative to improve health and social care outcomes and cost-effectiveness, with an emphasis on more care at and near home. Every Health and Wellbeing Board has been tasked with developing a plan, and the Westminster BCF plan has been approved by NHS England. The BCF did not come into full effect until 2015/16, but a significant amount of planning and preparatory work was required in 2014/15. Regular updates on the progress to date have been provided to the Health and Wellbeing Board.

4. Progress Update

Community Independence Service

4.1 The new, integrated CIS will provide consistent rapid response, hospital in-reach, and rehabilitation and reablement services. This is the most significant scheme in terms of anticipated benefits.

4.2 Each borough currently has a CIS, but the services in each of the three boroughs work in different ways and are provided by a range of different organisations. In autumn 2014, Triborough CCGs and local authority Cabinets agreed a business case for investment in a single, integrated CIS, serving all three boroughs. It is not possible in 2015/16 to create one organisation to provide the whole of CIS. Instead, the BCF plan aims to invest in improvements in front-line services through two lead provider roles, one for health services and the other for social services. This goes a considerable way to simplifying existing arrangements.

4.3 Following selection of Imperial College Healthcare Trust (ICHT) and partners as lead health provider, joint working has been established with Triborough Adult Social Care to develop and implement the service changes needed. Joint mobilisation, investment and communication plans have been developed, and at the end of March, health and social care commissioners reviewed and approved the plans against a set of pre-agreed requirements.

4.4 The new service led by ICHT and Triborough Adult Social Care therefore commenced as planned at the beginning of April 2015. Contractual arrangements, including performance indicators and measures, have been developed and agreed to monitor and manage the new service. A joint governance structure across health and social care has also been developed, which includes a clinical reference group to review and approve detailed service design. Patients and residents will be involved in design and scrutiny through this governance structure.

4.5 Lead providers are working together to plan and deliver communications to increase awareness, firstly amongst health and social care professionals and then the wider public. This includes briefings for GPs to build their confidence in the CIS changes and additional capacity, encouraging more referrals from them into the service. In-depth patient communications are scheduled for July.

Piloting Enhancements to Hospital Discharge Processes

4.6 Plans were developed in 2014/15 for hospital social work teams to pilot improvements in the support for people leaving hospital. The pilot started in March and will evaluate process changes against a range of criteria, including patient and carer experience, reductions in length of stay in hospital, and the interface with CIS.

4.7 In the pilot, assigned social workers are responsible for all Triborough residents on selected wards across Imperial and Chelsea and Westminster hospitals. For example, on the Manvers and Witherow wards at St Mary's Hospital, social workers involved in the pilot are working closely with medical and nursing teams to provide social care input into multi-disciplinary decision making; and are seeing residents and their carers earlier to provide support. Feedback to date from St. Mary's has been very positive. Links between the discharge process and WCC housing colleagues are being strengthened to help support smooth transition back home from hospital.

4.8 The pilot is scheduled to run until mid-June, with subsequent evaluation to provide recommendations and options for wider roll-out. A briefing paper on the pilot is provided at Appendix 1.

Other BCF Schemes

4.9 Work is also continuing to improve other operational services as part of the BCF plan. These include commissioning of the new homecare service to help more people remain independent in their own homes. Providers for the new service are being procured, and more ways to support joint working between health and social care are being established. Work is also progressing on the business case to increase capacity for neuro rehabilitation in the Triborough, helping to reduce Delayed Transfers of Care in acute hospitals.

4.10 In the BCF schemes focusing on patient and customer experience, a model of care for self-management has been developed through public engagement workshops in each borough and a review of national best practice. An approach to testing the model is now being developed with Whole Systems leads. A review of personal budgets for patients with Continuing Healthcare needs has informed development of a business case, now approved, to increase CCG investment in support provided by Triborough Adult Social Care.

4.11 In the schemes focusing on integrated commissioning and contracting, finance and commissioning leads across health and adult social care are meeting regularly to review opportunities for greater effectiveness and efficiency in services included in existing pooled budgets; and a business case has been developed to assess the benefits of establishing a joint health and social care placements and review team for nursing and residential care.

4.12 In the schemes supporting programme delivery, work is continuing to enable consistent use of the NHS number as the primary identifier of individuals across health and social care. Complementary work on information governance has led to accreditation against the Department of Health's self-assessment toolkit, which measures compliance with legal requirements and central government guidance on information governance. BCF investment is also continuing to support a range of tasks to support Care Act implementation.

5. BCF Ownership

5.1 The BCF plan is owned by the Health and Wellbeing Board and overseen by the BCF Board. Delivery is led by the executive teams for health and social care, which regularly meet jointly and are supported in between meetings by a steering group of the officers responsible for BCF schemes.

If you have any queries about this Report please contact:

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Appendix 1: Update on Hospital Discharge Pilot

1. Purpose of Paper

1.1 This paper provides an update on the hospital discharge scheme that is part of BCF Group A.

2. Background

What is the objective of the pilot?

2.1 The pilot is about testing a new approach to hospital discharge. The Better Care Fund Programme and Customer Journey Programme are supporting the three ASC borough hospital teams to prepare a pilot that will test a new approach to Adult Social Care hospital discharge, and alignment to hospital discharge and in-reach functions. The new approach will enhance the timeliness and quality of hospital discharge, and prepare the ground for reform of the wider hospital discharge process (including the CIS and discharge services of the acute trusts).

2.2 The pilot will test (and evaluate) the following areas:

- **Improving multi-disciplinary teams and integrated working** – are staff members more satisfied working together and sharing information/knowledge – and more effective?
- **Patient and carer experience** – is this really improving outcomes for people? Or impacting on patient safety and quality?
- **Improving discharge process** – are we finding a reduction in length of stay and more effective transfer into CIS?
- **Improving quality of post-discharge** – are their less re-admissions due to holistic care planning? Is there less usage of long-term care arrangements, and specifically placements directly from hospitals?
- **What care needs are not being met currently** – how are we addressing these needs differently?
- **Staffing and skills** – what is the best way to deliver an integrated discharge?
- **Wider recommendations** – what staff resources are needed? What is the business case (quality, finance) based on the activity/outcomes of the pilot wards?
- **Reciprocal arrangements between authorities** – what are the operational requirements on the ground?

What is in scope?

2.3 The pilot will run for three months (16 March to 15 June 2015) across the three borough footprint across Imperial and Chelsea & Westminster hospitals.

2.4 The pilot will only affect the three borough residents that are being discharged from the following 8 wards:

- Imperial – St Mary's Hospital: Witherow and Manvers
- Chelsea & Westminster: Edgar Horne and David Erskine
- Imperial – Hammersmith Hospital: Fraser Gamble and Christopher Booth
- Imperial – Charing Cross Hospital: 8 West and 8 South.

2.5 The primary aim of the pilot is to test redesign of social care and in-reach discharge related functions and workforce – and will directly affect:

- RKBC, H&F and WCC ASC hospital teams
- CLCH in-reach assessment functions across the patch.

2.6 The secondary aim of the pilot is to engage and align to the following services – to ensure improved integration between health and social care:

- Imperial and Chelsea & Westminster medical, nursing, therapy and discharge teams
- The pilot will measure the effect of these changes on demand for other services and make recommendations to optimise the service pathway. Specifically it will look at the referral volumes and demand for the following services:
    - Current CIS and other service provision teams delivering short term care
    - ASC long term assessment teams and provision across the three boroughs
    - Information and advice – potentially access teams and voluntary sector.

What are the desired outcomes?

2.7 The pilot seeks to demonstrate a new approach that will enhance the timeliness and quality of hospital discharge, and provide increased alignment between CIS and the discharge services of the acute trusts; and contribute to the MTFP savings in the Customer Journey programme.

2.8 It will produce evidence-based recommendations and options for wider roll-out across the three boroughs (and potentially with neighbouring authorities across NW London) and inform a business case for integrated 7 day working across the health and social care discharge model for residents of the three boroughs.

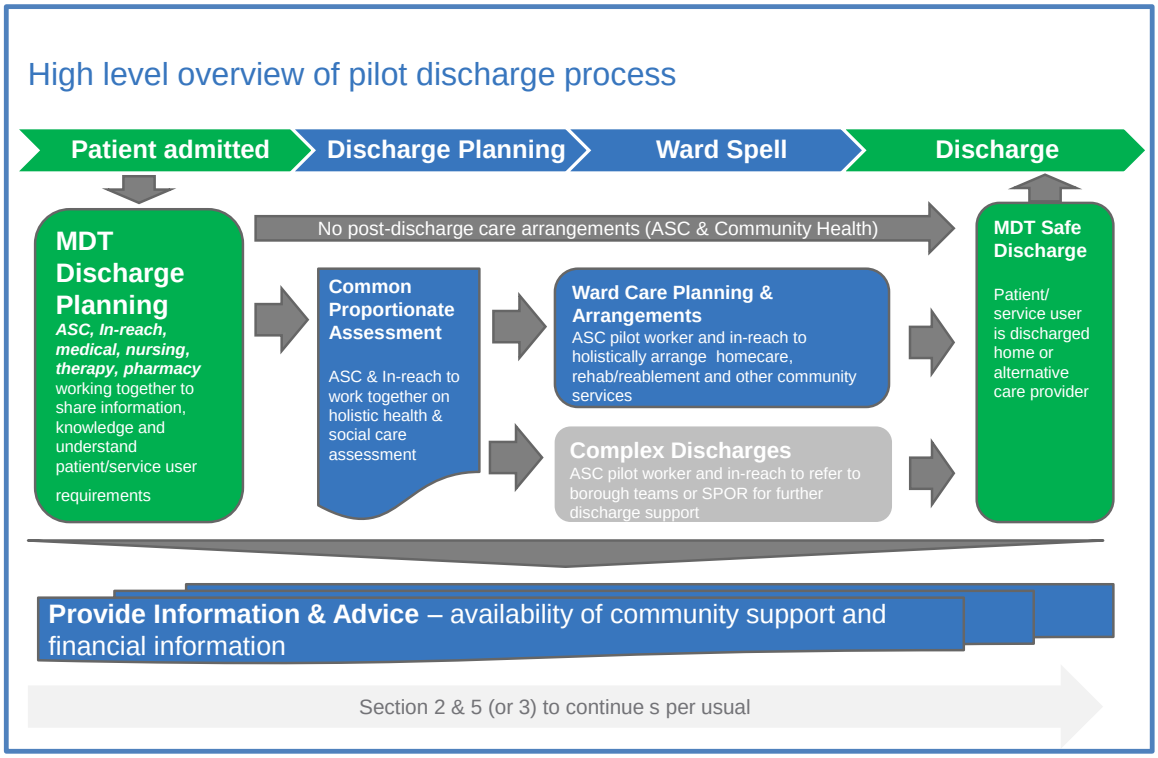
How does it work?

2.9 Starting on Monday 16th March an assigned ward social worker is responsible for all patients/residents from LBHF, RBKC and WCC on selected wards (8 altogether) across Imperial and Chelsea & Westminster hospitals. They are working as one team with the CIS in-reach assessors.

2.10 They will be attending the multi-disciplinary meetings and board rounds, and be available to provide information and advice for and about patients, carers, hospital discharge, nursing, medical and therapy staff. They are also trialling a common proportionate assessment between social care and in-reach, which will help reduce any duplication and delays in discharge planning.

2.11 Figure 1 depicts the overall process of the pilot.

Figure 1: Overview of hospital discharge pilot process for all patients from the three boroughs:



What are the key features of the discharge process?

2.12 Immediate benefits of the pilot include:

- Information and advice for patients and carers in the ward, to improve transition of care to community services
- Named social care and in-reach staff working with one MDT on the wards
- One access point to social care and in-reach for H and F, K and C and Westminster, with common assessment across both teams for all three boroughs
- Access to information from social care records (Frameworki) as part of MDT meetings and board rounds
- More integrated working between Hospital Discharge and Hospital Adult Social Care

- Easy access to knowledgeable professionals and resources around social care and community health provision including CIS (Rapid Response, Reablement, Rehabilitation), voluntary sector and long-term care options
- Streamlined referral processes for CIS and community services
- Reduced duplication and delays between current ward teams and adult social care
- Managed as part of BCF Group A to ensure consistency with development of the new CIS.

Method: co-production

2.13 Taking a pilot approach has been highly beneficial as we can develop and test a different model. The staff who deliver the service, and who know what does and doesn't work on the ground. We have been able to engage with staff, managers and wider stakeholders to shape the approach and gain real buy-in from staff in ASC, in the acute and community NHS trusts.

2.14 A co-production and "test and implement" approach has been taken to designing, developing and implementing this pilot. The co-production consists of:

- Running a weekly working group involving front-line managers and staff across ASC, in-reach and hospitals, to inform design and day-to-day management
- Monthly pilot staff development workshops to listen to and engage with staff
- Direct input and support from:
  - The wider ASC hospital team, including support functions
  - ASC teams including extended hours, long-term care, Frameworki and performance teams
  - Acute medical, nursing, therapy, performance and IT teams
  - CIS project implementation team
- Survey and other feedback from a wide range of customers, patients and ward hospital staff to inform the design of the pilot, and for planning evaluation.

2.15 This approach has been very well received. Operational staff and managers are feeling engaged and working in a safe environment to provide both feedback and develop their own solutions – and they know what works best.

How is this being funded?

2.16 This pilot is being funded by the BCF programme. The staffing costs have been funded through current staffing budgets in addition to Winter Resilience funding which will continue to give us operational capacity to continue with this pilot and keep the service running during such a busy period for the acute system.

3. Progress to Date

What are the key achievements to date?

Pre Go-Live

3.1 Managers and front-line staff from ASC hospital and in-reach teams have developed and agreed a joint assessment and support planning process that is streamlined across the 3 boroughs.

3.2 A joint health and social care assessment has been developed, and is to be tested by both ASC and in-reach staff during the pilot. The pilot design and process has been very well received by the Imperial medical team: “It’s great that we are removing silos and bringing the right staff together to manage discharges”.

3.3 There has been excellent buy-in and contribution from acute teams, including a successful push for Wifi access on pilot wards for ASC and in-reach staff members. This is allowing MDT teams to access Frameworki information live on the ward for the first time. Overall, there is good enthusiasm and momentum from both managers and staff. Induction and training have been completed and well received.

Post Go-Live

3.4 The pilot went live on 16th March, with all pilot workers (including ASC and In-Reach), management and support teams. Since then, there has been a robust issue-resolution process in-place. It has been possible to resolve 90% of issues, with emphasis on front-line support by operational managers across ASC, CLCH, Imperial and Chelsea & Westminster hospitals and the project team.

3.5 Work is continuing to embed new processes, and refine based on staff, support and managerial feedback. This is contributing to continual improvement of the hospital discharge process across the three boroughs, taking good practice from each borough.

3.6 An evaluation approach and plan has been developed by the working group, and there will be further exploration of how the approach could be scaled across hospitals in the three boroughs. This includes “front-door” acute units and out-of-borough hospitals (e.g. UCLH/St. Thomas etc).

What is the early feedback so far?

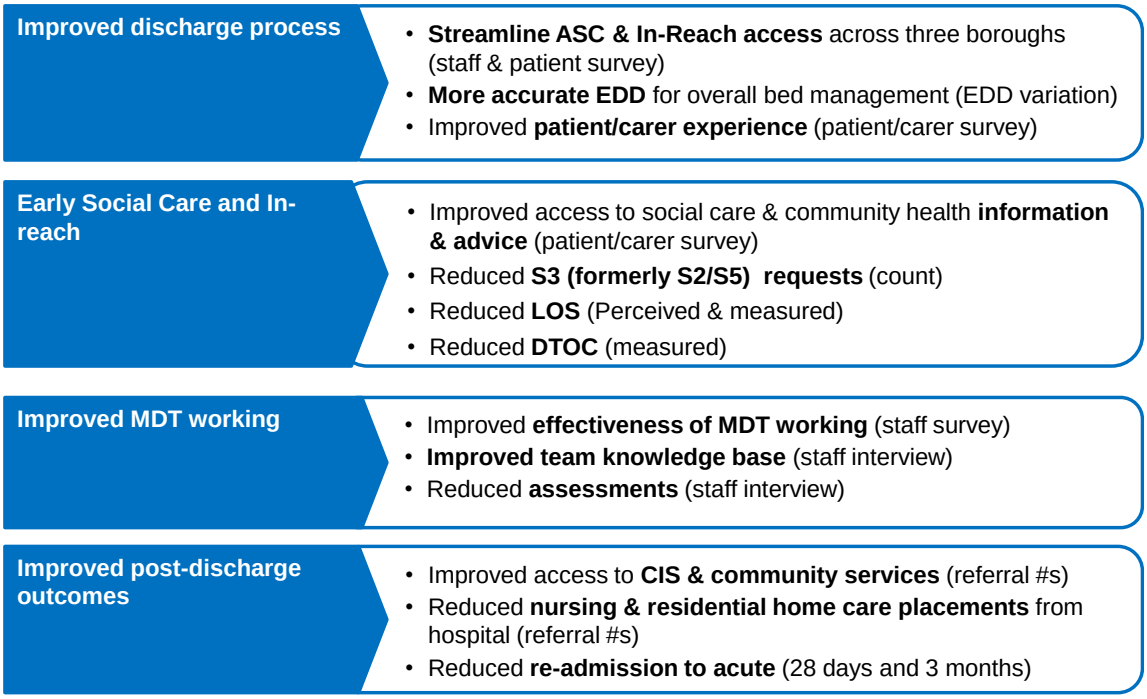
3.7 Over the first 3 weeks of the pilot, early feedback has been obtained from carers, ASC, CIS In-Reach and hospital staff on how the pilot is shaping:

*Early **successes** to date…* • Ability to assess **holistic needs** of patients and in particular for carers – early wins of identifying alternative and cost-effective options • Staff involved have highlighted is **reduced duplication** between different professionals – e.g. assessments, administration, referrals • **'One-stop' access** for patients, carers and professionals on community assessment, service planning and information and advice • Building relationship and **breaking down traditional cultural barriers** between health and social care and acute and community care • **Locally tailored** pilot discharge design to different ward and patient-population type • Ward Consultants feedback **"Why have you not done this before?"**	*Key **issues/challenges** to date…* • **Information governance** between multiple organisations (LA, CLCH, Imperial, Chelsea & Westminster) – having to develop "workarounds" (e.g. joint assessments – storage issue of information) • Effective discharge may potentially **increase demand on 'downstream' services** – long-term ASC, CIS, home care – this is being measured as part of the evaluation to better understand impact for wider recommendations and to ensure appropriate resourcing. Demand for CIS is high and increasing, so resourcing is needed to meet this demand. Clinical support will be crucial in order to satisfactorily change the practices of supporting people at home. • Running a **hybrid environment** of pilot vs. non-pilot wards – we have developed operational processes to enable this and reviewed on a weekly basis
***Opportunities** to further explore…* • Further develop **whole team' approach** - Front-line management and staff have recognised that different teams (i.e. hospital discharge, therapist, CIS, in-reach, ASC hospital teams) using this pilot as an opportunity to test an integrated discharge model • Pilot should expand to **7 day MDT approach** on emergency and acute wards (e.g. AAU and medical units) – where pilot approach and 'turn-around' outcomes • Enhance current **care coordination/arrangement** processes – e.g. enhanced carer support in tandem with CHC packages • **Reduce duplication and handover** between hospital and community teams for both social care and health – e.g. looking at in-reach assessment as a function of CIS rather than a separate team. A discharge role, encompassing both aspects could reduce duplication and provide economies of scale.	***Risks and barriers** to mitigate/ overcome…* • Further explore **clinical responsibility** – who is accountable for what decisions – and what functions can be shared between professionals (e.g. joint assessments to inform **workforce recommendations)** • Continue to develop and implement **CIS** service to enable smooth discharge and transition into community

4. Next Steps

Focus on evaluation and data collection

4.1 An evaluation framework has been developed (with an associated data collection process) based on the original pilot objectives and areas we want to test:



4.2 Next steps and considerations will include how to:

- Further 'operationalise' and embed pilot processes across pilot, hospital and wider ASC borough hospital and in-reach teams
- Develop recommendations and an options paper for wider implementation, informed by evaluation and stakeholder input/feedback
- Implement automated data collection across adult social care in the three boroughs, and in Imperial and Chelsea & Westminster performance teams.

4.3 After the completion of the pilot, an evaluation report will be produced, including feedback from staff, patients and carers.

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City of Westminster

Westminster Health & Wellbeing Board

Date:	Thursday 21 May 2015
Classification:	**General Release**
Title:	**UPDATE ON PRIMARY CARE CO-COMMISSIONING**
Report of:	Central London CCG & West London CCG
Wards Involved:	All
Policy Context:	Primary care co-commissioning allows CCGs to become more involved in commissioning local GPs services and, through this, to align the development of primary care with the wider transformation of local health and care services.
Financial Summary:	Not applicable
Report Author and Contact Details:	Christopher Cotton NWL primary care transformation programme chris.cotton@nw.london.nhs.uk

1. Executive Summary

1.1 This report updates board members on progress made on primary care co-commissioning since their last discussion on this subject in March 2015.

1.2 Central London and West London CCGs began joint co-commissioning primary care medical services with NHS England on 1 April 2015. This followed a membership ballot in which all voting practices supported the constitutional amendment required to enable it. The CCGs' governing bodies have approved the necessary governance structures.

1.3 Co-commissioning is the key means by which the CCGs can work with NHS England and other stakeholders, including the Health and Wellbeing Board, to improve the provision of primary care services for the people of Westminster.

1.4 The first meeting of the Central London and West London joint co-commissioning committee is on 21 May 2015. The CCGs are currently engaging the Westminster Health and Wellbeing Board and Westminster City Council on how they can be more closely involved in the CCGs' new remit over primary care.

2. Key Matters for the Board

2.1 Board members are asked to continue their discussion about how they can best participate in primary care co-commissioning in Westminster, to ensure that it benefits from the full range of local expertise and aligns with strategies being implemented across the borough's health and care economy.

3. Background

The context for primary care co-commissioning

3.1 In June 2014 NHS England invited CCGs to submit an expression of interest in an increased role in the commissioning of primary care services. The intention was to enable CCGs to improve primary care services for the benefit of local patients.

3.2 At that point NHS England commissioned all primary care services, including primary care medical services, ophthalmology, dentistry and pharmacy, specialised services, offender healthcare, and healthcare for people in the military.

3.3 Primary care co-commissioning currently refers only to primary medical care services, i.e. GP services.

3.4 The NW London CCGs submitted a joint expression of interest in primary care co-commissioning to NHS England in June 2014 and a further submission of draft proposals in January 2015.

3.5 Central London and West London CCGs, along with the other North West London CCGs, have opted for joint co-commissioning, in which decision-making is shared with NHS England. This was one of three models set out by NHS England guidelines in November 2014. (See *Next steps towards primary care co-commissioning*, NHS England and NHS Clinical Commissioners, 10 November 2014. Publications Gateway Reference 02501.)

3.6 This position was arrived at following extensive engagement with the NHS England local area team, all of the North West London CCG governing bodies, CCG practices, London-wide LMC, and local borough LMC chairs. (LMC is the Local Medical Committee, which represents GPs.)

The vision for primary care in North West London

3.7 The North West London CCGs have a vision to improve the quality of care for individuals, carers and families, empowering and supporting people to maintain independence and to lead full lives as active participants in their community.

3.8 Primary care co-commissioning is a governance enabler by which the CCGs can work together to deliver this vision. The ultimate aim is to achieve the right benefits for patients:

- Improved access to primary care and wider out-of-hospitals services, with more services available closer to home;
- High quality out-of-hospitals care;
- Improved health outcomes, equity of access, reduced inequalities;
- Services that are joined up, coordinated and easy for users to navigate around;
- A better patient experience through these more joined up services; and
- A greater focus on prevention, staying healthy, and patient empowerment.

3.9 The vision is supported by three principles, all of which focus on integrated systems that are co-ordinated around the needs of the patient:

- People will be empowered to direct their care and support and to receive the care they need in their homes or local community;
- GPs will be at the centre of organising and coordinating people's care; and
- The NW London systems will enable and not hinder the provision of integrated care.

3.10 General practice will be the cornerstone for this new way of delivering services, with the majority of patient care being delivered in the primary care setting and with general practice delivering more accessible, co-ordinated services with a focus on prevention.

3.11 Therefore in NW London there is an ambition of achieving sustainable general practice that is supported to deliver the services and high-quality care that local people need. This is designed to respond to a number of challenges being faced by primary care:

- A growing and aging population with increasingly complex health and care needs;
- Variable levels of accessibility and quality of primary care services;
- Workforce challenges with an increasing proportion of general practitioners nearing retirement age and with limited number of clinicians coming into the system; and
- A significant fall in investment in general practice as a percentage of total health spending, with minimal investment into developing and maintaining primary care estates and facilities.

3.12 Given these challenges, in NW London there is an ambition to shift investment into primary care, to achieve sustainable general practice.

3.13 Primary care co-commissioning will be an enabler to helping NW London achieve this vision, by giving local commissioners and stakeholders the ability to:

- Influence decision-making in primary care to align with wider local strategies for integrated and coordinated care;
- Commission for a new contractual offer for general practice to deliver the necessary enhanced services in a sustainable way and to limit current variations in quality and access; and
- Influence the necessary investment in primary care estates and workforce to deliver the enhanced role of general practice.

4. Considerations

Governance and next steps

4.1 The CCGs have established a primary care co-commissioning joint committee with NHS England, comprising the following voting members:

Central/West London CCGs		NHS England	
Chair	Ruth O'Hare-Central Fiona Butler-West	**Director of Primary Care Commissioning (London)**	David Sturgeon
Chief Officer	Clare Parker	**Director of Commissioning and Operations (NW London)**	Jo Ohlson
Deputy CFO	Helen Troalen	**Deputy Medical Director (London)**	Mark Spencer
Secondary care doctor	Alan Hakim	**Medical Director (NW London):**	David Finch
Nurse	Jonathan Webster		
Lay audit chair	Philip Young		
Lay member	TBC		

4.2 The following extract from the joint committee's current terms of reference shows the remit of its functions and responsibilities:

Functions and duties	The role of the Joint Committee includes the following activities: • Designing new extended scope services (locally commissioned services), including an additional wrap-around contractual GP offer, to support the delivery of the new model of care for General Practice (in alignment with other NWL out-of-hospital strategies); • GMS, PMS and APMS contracts (including the design of PMS and APMS contracts and, jointly with the NHS England area team, contractual GP practice performance management); • Designing a local incentive schemes as an alternative to the Quality

	Outcomes Framework; • Making recommendations on whether to establish new GP practices in an area; • Making recommendations on practice mergers, plus retirements, dispersals, and contract terminations; and • Making recommendations on discretionary payments (e.g. returner/retainer schemes).
Key responsibilities	The key responsibilities of the Joint Committee will be in strategic planning and coordinating a consistent approach to primary care commissioning in the CCG through: • Carrying out local needs assessments and reviews in primary care, as required; • Identifying local needs in primary care based on reports and recommendations from the CCG, local HWBB, NHS England, and Londonwide and local LMCs; • Developing new models of care for general practice and primary care to align with wider local strategic direction; • Developing quality improvement strategies based on reports and recommendations from the CCG, local HWBB, NHS England, and Londonwide and local LMC; • Recommending appropriate mechanisms to support providers in optimum delivery, including: o Supporting the development of GP networks and federations; o Succession and resilience plans; and o Strategies for providing additional financial support in primary care. • Co-developing investment criteria and procurement plans across CCG boundaries based on the agreed model of care for general practice and wider local strategic priorities; and • Updating and upholding processes for addressing conflicts of interest related to primary medical services commissioning across NW London, in alignment with statutory national guidance and the member CCGs' constitutions and conflict of interest policies.

4.3 Central and West London's committee will meet in public at the same time as the joint committees of the other six CCGs in North West London. The overlap in committee membership means that there will be 32 voting members in total. Each CCG's committee remains a separate entity and any voting will be undertaken CCG by CCG. This governance structure was designed to strike the right balance between CCG sovereignty and co-ordination across North West London.

4.4 There will, in addition, be non-voting advisors from the LMC and Healthwatch as well as the Health and Wellbeing Boards:

- LMC – There will be two LMC non-voting advisors across the eight committees.

- Healthwatch – The current intention is for the eight Healthwatch committees to provide two representatives to attend the combined joint committee meetings, one from inner NWL and one from outer NWL. The eight Healthwatch committees will discuss primary care issues together either through a separate co-commissioning sub-group (as provided for in the current terms of reference) or through their existing collaborative structures.
- Health and Wellbeing Boards – CCG chairs have written to their Health and Wellbeing Board counterparts to take forward the discussion on how the existing joint work of the CCG and Health & Wellbeing Board, along with other local stakeholders, can be extended more fully into primary care. Additionally, each Health & Wellbeing Board has been invited to nominate a representative to act as a non-voting advisor at the combined joint committee meetings, if this is felt to be the appropriate forum.

4.5 Meeting details and papers will be published on the CCGs' websites.

5. Legal Implications

5.1 The co-commissioning structure and processes are being established with NHS England and in line with national guidance.

6. Financial Implications

6.1 There are no direct financial implications (although the co-commissioning joint committee – see above – is able to take decisions with financial implications, such as the commissioning of new primary care services).

If you have any queries about this Report or wish to inspect any of the Background Papers please contact:

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APPENDICES:

None.

BACKGROUND PAPERS:

- *Next steps towards primary care co-commissioning*, NHS England and NHS Clinical Commissioners, 10 November 2014. Publications Gateway Reference 02501
- Paper 11 for the Central London CCG governing body agenda for 11 March 2015: http://www.centrallondonccg.nhs.uk/news-publications/publications.aspx?n=2135

Westminster Health & Wellbeing Board
Work Programme
2015 / 2016

KEY
FOR DECISION
FOR DISCUSSION
FOR INFORMATION
PLANNING

Agenda Item	Summary	Lead	Item
Meeting Date 21st May 2015: SYSTEM IMPROVEMENT			
PHARMACIES ROLE IN COMMUNITIES	Discussion to scope a review of the wider role that pharmacies play in prevention, integration and community life.	Public Health	
MENTAL HEALTH TRANSFORMATION	Presentation on development of the NWL Mental Health and Wellbeing Strategic Plan. Update from 3B Children's Trust on developing and delivering the CAMHS improvement plan	NWL CCGs Exec Director of FCS	For discussion
WHOLE SYSTEM INTEGRATION	Discussion on the developing models of care and patient pathways under Whole Systems	CLCCG WLCCG	For discussion
JOINT STRATEGIC NEEDS ASSESSMENT UPDATE	Update on the 2015/16 Joint Strategic Needs Assessment Programme	Deputy Director of Public Health	For information
PRIMARY CARE	Update on NWLCCG Primary Care Co-Commissioning Discussion on Westminster Primary Care Task and Finish Group	CLCCG / WLCCG Chair of HWB	For information
BETTER CARE FUND AND CARE ACT	Update on implementation Better Care Fund and of the Care Act	Exec Director of ASC	For information

Meeting Date 9th July 2015: JHWS, JSNA AND WIDER DETERMINANTS			
HEALTH AND WELLBEING STRATEGY DEVELOPMENT	Discussion on refreshing the Westminster Joint Health and Wellbeing Strategy	Chairman of the HWB	For discussion
CHILD POVERTY	Provide steer on the developing approach to reducing child poverty in Westminster	Exec Director of FCS	For discussion
JSNA PROGRAMME (including Dementia JSNA)	Discussion of the current JSNA programme and the use of remaining resource. Discussion on the findings of the dementia JSNA and how these will be taken forward through commissioning	Deputy Director of Public Health	For discussion
WESTMINSTER HOUSING STRATEGY	Discussion on the consultation draft of the Westminster Housing Strategy	Exec Director of GPH	For discussion
PUBLIC HEALTH STRATEGY	Discussion on the three borough Public Health Strategy and how the Health and Wellbeing Board can use its levers to support implementation	Deputy Director of Public Health	For discussion
BETTER CARE FUND AND CARE ACT	Update on implementation Better Care Fund and of the Care Act	Exec Director of ASC	For information
EARLY YEARS (TBC)	*Consider the preparations underway for the transfer of health visiting from NHS England to the local authority*	*Public Health*	*For information*

Agenda Item	Summary	Lead	Item
Meeting Date 17th September 2015: 2016/17 COMMISSIONING			
LOCAL HEALTH AND CARE COMMISSIONING	Key commissioning themes from CCG and local authority	Exec Director of ASC	To steer 2016/17 commissioning across health and wellbeing system
	"Health of the health system" dashboard		
	Key messages from Adult and Children Safeguarding Boards, Children's Trust and other partnership groups		
	Key messages from Patients and Service Users		
	Primary Care Co-Commissioning		
PREVENTATIVE HEALTHCARE	Follow on from MMR discussion: Partnership strategy for improvement of preventative healthcare	Public Health, FCS NHSE	For discussion
CHILDREN AND FAMILIES ACT 2014	Presentation on the new requirements on the local health and care economy following the Children and Families Act 2014 and the progress being made to implement the necessary changes	Executive Director of FCS	For discussion
HEALTH HUBS	Presentation on the need and opportunities analysis underpinning the development of health and wellbeing hubs in Westminster. Discussion on the role of the Health and Wellbeing Board in support implementation	Chairman of the Health and Wellbeing Baord	For Discussion
BETTER CARE FUND AND CARE ACT	Update on implementation Better Care Fund and of the Care Act	Exec Director of ASC	For information

Agenda Item	Summary	Lead	Item
Meeting Date 19th November 2015: SYSTEM IMPROVEMENT			
EARLY YEARS	Consider progress made in improving partnership and integration relating to child health and wellbeing	Exec Director of FCS	For discussion
DEMENTIA	Discussion on improving dementia identification and care in Westminster	Exec Director of ASC	For discussion
MENTAL HEALTH	Follow up discussion on developing NWL Mental Health and Wellbeing Strategic Plan	NWL CCGs	For discussion
PRIMARY CARE PROJECT	Update on the Westminster HWB Primary Care Modelling Project	TBC	For information
INTEGRATION	Update on Better Care Fund and Whole Systems Integration	Exec Director of ASC	For information
AVAILABLE SLOT			
Meeting Date: 21st January 2016: MISCELLANEOUS			
HEALTH AND WELLBEING STRATEGY	Discussion on the refreshed Westminster Joint Health and Wellbeing Strategy following engagement with CCG/LA and others	Chairman of the HWB	For discussion
CHILD POVERTY	Discussion on progress being made to reduce child poverty in Westminster	Exec Director of FCS Housing	For discussion
AVAILABLE SLOT			
AVAILABLE SLOT			
AVAILABLE SLOT			
Meeting Date: 17th March 2016: END OF YEAR STRATEGIC PLANNING MEETING			
STRATEGIC PLANNING	Review delivery and plan for the year ahead	Exec Director of ASC	Planning
PRIMARY CARE PROJECT	Presentation on the findings of the Westminster Health and Wellbeing Board Primary Care Project	TBC	For discussion
BETTER CARE FUND	Update on delivery of the Better Care Fund outcomes	Exec Director of ASC	For information
AVAILABLE SLOT			
AVAILABLE SLOT			
AVAILABLE SLOT			