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City of Westminster

# Committee Agenda

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| Title: | **Health & Wellbeing Board** |
| Meeting Date: | **Thursday 9th July, 2015** |
| Time: | **4.00 pm** |
| Venue: | **Rooms 3 & 4 - 17th Floor, City Hall** |

Members:

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| Councillor Rachael Robathan (Chairman) | 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 |
| Eva Hrobonova | 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 6.00pm. 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, Toby Howes, Senior Committee and Governance Officer.**

**Tel: 020 7641 8470; Email: thowes@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 - 14)**

I) To agree the Minutes of the meeting held on 21 May 2015.

II) To note progress in actions arising.

**4. FIVE YEAR FORWARD VIEW AND THE ROLE OF NHS ENGLAND IN THE LOCAL HEALTH AND CARE SYSTEM** **(Pages 15 - 34)**

To consider the role of NHS England in the local health and care system.

**5. JOINT STRATEGIC NEEDS ASSESSMENT UPDATE** **(Pages 35 - 56)**

To receive an update on the current Joint Strategic Needs Assessment (JSNA) work programme and evidence hub and details of the impact review of deep dive JSNAs.

**6. WESTMINSTER DRAFT HOUSING STRATEGY** **(Pages 57 - 64)**

To consider the Westminster Draft Housing Strategy's impact and links with the health and wider care system.

**7. UPDATE ON PREPARATIONS FOR THE TRANSFER OF PUBLIC HEALTH RESPONSIBILITIES FOR 0 - 5 YEARS** **(Pages 65 - 70)**

To receive an update on preparations.

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| **8.** | **BETTER CARE FUND**<br>To receive an update on delivery of the Better Care Fund programme. | **(Pages 71 - 78)** |
| **9.** | **PRIMARY CARE CO-COMMISSIONING**<br>To receive an update on progress in Primary Care Co-Commissioning. | **(Pages 79 - 82)** |
| **10.** | **WORK PROGRAMME**<br>To consider the Work Programme for the forthcoming year. | **(Pages 83 - 86)** |
| **11.** | **ANY OTHER BUSINESS** | |

**Tasnim Shawkat**
**Tri-borough Director of Law**
30 June 2015

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# MINUTES

**CITY OF WESTMINSTER**

**WESTMINSTER HEALTH & WELLBEING BOARD**
**21 MAY 2015**
**MINUTES OF PROCEEDINGS**

Minutes of a meeting of the **Westminster Health & Wellbeing Board** held on Thursday 21 May 2015 at 3.00pm 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 Neville Purssell (acting as Deputy)
Cabinet Member for Children and Young People: Councillor Danny Chalkley
Minority Group Representative: Councillor Barrie Taylor
Director of Public Health: Stuart Lines (acting as Deputy)
Tri-Borough Executive Director of Children's Services: Rachael Wright-Turner (acting as Deputy)
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 Naomi Katz
Representative from Healthwatch Westminster: Janice Horsman
Chair of the Westminster Community Network: Jackie Rosenberg

Also in attendance: Councillor Barbara Arzymanow, Matthew Bazeley (Managing Director, NHS Central London Clinical Commissioning Group) and Simon Hope (Deputy Managing Director, NHS West London Clinical Commissioning Group).

## 1. MEMBERSHIP

1.1 Apologies for absence were received from Dr David Finch (NHS England) and Dr Belinda Coker (NHS England).

1.2 Apologies for absence were also received from Dr Ruth O'Hare (Central London Clinical Commissioning Group), Eva Hrobonova (acting as Deputy for the Director of Public Health) and Andrew Christie (Tri-Borough Executive Director of Children's Services). Dr Neville Pursell, Stuart Lines and Rachael Wright-Turner attended as their respective Deputies.

## 2. DECLARATIONS OF INTEREST

2.1 No declarations were received.

## 3. MINUTES AND ACTION TRACKER

3.1 **Resolved:** That

(1) The Minutes of the meeting held on 19 March 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. NORTH WEST LONDON MENTAL HEALTH AND WELLBEING STRATEGIC PLAN

4.1 Jane Wheeler (Programme Lead, North West London Whole System Mental Health & Wellbeing Strategic Plan) presented the report and advised the Board that there had been a launch event on 6 February 2015 for the programme 'Like Minded: Working together for mental health and wellbeing in North West London'. The programme intended to cover the health and wellbeing needs of the whole population of North West London and considered matters such as the approach to healthcare and governance arrangements. Changing demographics amongst the population, including an ageing population, placed increased demand on services and created pressure on service quality and outcomes as well as sustainability of the current system over time.

4.2 The Board heard that the Like Minded programme was using a North West London segmentation approach that helped ensure that the needs were addressed of those groups that were often underserved and where evidence showed increased risk of mental health needs. Jane Wheeler then referred to the workshops that had been covered to date, which had identified the importance of access to universal services, including those groups that did not routinely access such services, the commissioning of mental health services and earliest intervention. The workshops helped inform the Case for Change alongside other data. Jane Wheeler advised that the Case for Change would draw out the priority areas identified which would then be reported back to the Board for further consideration.

4.3 During discussion, Board members emphasised the need for local authority input at the workshops and in contributing to the Case for Change. Liz Bruce (Tri-Borough Executive Director of Adult Social Care) commented that there was a need for an Adult Social Care representative on the Transformation Board. Members concurred that there was a need for a more joined up approach to mental health with other services. It was noted that children's mental health needs would also be fed into the process.

4.4 The Board noted that the Clinical Commissioning Groups (CCGs) had met with the local authority recently to discuss new models of care around Primary Care Plus and to identify both areas of mental health services and pathways that were working well and those that were not so successful. Members commented that patient and service user engagement was an issue for the Transformation Board to consider, as well as the capacity of the third sector to address mental health issues in their communities. It was remarked that children's mental health services should be of the same standard as adult mental health services. The Board also recognised the need for a more strategic approach between the shifting of care from secondary care to primary care.

4.5 It was recognised that there was a need for community support in respect of children's mental health, as local authorities needed to consider what services would be provided in future in view of the financial challenges they faced. Members also needed to be satisfied that the medical drivers were not overwhelming the social needs and it was agreed that information be circulated as to what measures were in place to consider the social needs.

4.6 Members commented on the need for greater collaboration with registered social landlords in helping address the needs of those with mental health issues and in identifying how they were being cared for. Members also commented that schools provided opportunity for a direct avenue in which mental health services could be accessed for children, however it was acknowledged that there was presently only one local authority school in Westminster.

4.7 The Board acknowledged that there was a need to address governance issues and of the importance of ensuring that all the relevant groups' voices were heard. The Board agreed that a briefing paper be produced outlining how different parts of mental health services would work and how the various partners could feed into this process.

## 5. CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH

5.1 Steve Buckerfield (Head of Children's Joint Commissioning) gave a presentation on the report that summarised the recommendations of the national CAMHS Taskforce report, 'Future In Mind'. The report also provided an update on local progress in respect of the recommendations of the Westminter Children and Young People's Mental Health Task & Finish Group and asked the Board to consider its vision for mental health and wellbeing in Westminster and the ways in which it could shape local work on Future In Mind, including the submission of a 'Transformation Plan' for young peoples' mental health services to NHS England.

5.2 Steve Buckerfield advised that considerable determination would be needed to reshape children and young people's mental health. As there were limited resources, there needed to be consideration in what services should be prioritised and on how mental health services could work better with existing services, such

as the Gangs Unit in Westminster. The Board heard that £1.25 billion Government funding would be available nationally for young people's mental health over the next five years and guidance was expected soon on how to complete the Transformation Plan to access the funding, whilst the sign-off process was yet to be determined. Members were then asked to consider the principles which underpin its vision for the future of mental health and wellbeing services in Westminster.

5.3 The Board commented that increasing hours of access to mental health services was important, as well as providing appropriate and flexible settings for children to feel comfortable in. The Board noted that work was underway within the council to develop health and wellbeing hubs with a wide range of co-located services. These will be co-designed with young people and mental health would need to be considered as part of this work. It was also stated that there was a need for more support on mental health issues in schools.

5.4 The Board heard that children provided a wide range of views when asked about what settings they preferred to access mental services. Members commented that universal settings had a destigmitising effect and helped give children confidence to access services. Providing a helpline was also useful as it gave immediate access, whilst a 'handbook' or similar signposting support may also be beneficial. The importance of providing a setting where children felt safe and ensuring that there was a clear pathway between and through services was emphasised, and a preventative model was also deemed desirable.

5.5 Members commented on the effectiveness of the Connecting Care for Children in North West London which had taken a multidisciplinary, flexible approach involving CAHMS, GPs, paedatricians and school nurses working together to look at each child individually and model care accordinng to their individual needs appropriately. The need to build flexibilty into treatment as well as assessment was also acknowledged. Members added that community navigation, peer coaching, investment in training and increaing capacity were all important in ensuring the success of multidisciplinary working.

5.6 Members suggested that culture, the arts and music all contributed in giving youth confidence and improve their mental health and an integrated approach with mental health services should be considered. In addition, engaging with local businesses in providing appropriate training and a route into employment would be desirable. The timing of providing support was also important, such as events in life that could cause stress, including moving from primary to secondary school and during exams.

5.7 The Board commented on the apparent drop-off of services upon reaching 18 years of age. Jacqui Wilson (Children's Joint Commissiong Team) advised that the Transition Group had identified that the number of 18 year olds being referred to future services did not correspond with the number accessing services when they were 17. Work was underway to compile figures for all those of 17 years or older to see how many were being referred and how many were not. Steve

Buckerfield advised that under the Children and Families Act 2014, CCGs and local authorities were obliged to publicise the mental health services on offer. He added that more needed to be done to publicise mental health services for young people and that the local offer needed to be developed and this could include discussions with voluntary sector organisations on what they could offer. The Board noted that negotiating continuity of care in terms of providers of medical teams during transition was being considered.

5.8 It was stated that the reshaping of Children's mental health services would involve making hard decisions, including consideration of disinvesting in some services in order to invest in other services. Members commented that views had been expressed by young people at Corporate Parenting Committee meetings that they viewed reaching 18 years as a very difficult time in their lives due to coming out of care, having to find housing and starting work and so not having access to services happened at the worst possible time. It was suggested that there was a need to model transitional arrangements.

5.9 The Board agreed that more work needed to be undertaken in considering mental health services during the transition phase from child to adult (16 to 25 years) and that more frontline training be provided to staff in whatever settings mental health services were provided. The Board also agreed that pathways of access to services needed to be clearer, including more ways of accessing services and providing extended hours. There also needed to be considerable flexibility in providing both the appropriate setting and the type of mental health care that the child felt most comfortable with, as well as taking a multidisciplinary approach. The Board agreed that a vision aligned to the principles above be brought back for further consideration at a future meeting.

## 6. THE ROLE OF PHARMACIES IN COMMUNITIES AND PREVENTION

6.1 Stuart Lines (Deputy Director of Public Health) gave a presentation on this item which set out the services pharmacies currently offered. It also included details of the 'Healthy Living Pharmacies' pilot scheme which had been well received and had been effective with outcomes improved in 26 of 33 valuations. The Board heard that 68 out of 93 community pharmacies in Westminster had expressed an interest in becoming an accredited Healthy Living Pharmacy. Members heard that there also needed to be more thought as to who the key stakeholders were.

6.2 Holly Manktelow (Principal Policy Officer) added that consideration needed to be given as to what role the Board wished pharmacies to play in the health economy and could an increased role for community pharmacies potentially reduce demand for GPs, Acute Services, Adult Social Care, Public Health Services and Children Services.

6.3 Members stated that it was important that staff as well as the pharmacists had the motivation to be accredited and to feel that they played an important role as a community pharmacy. It was suggested that linking work with pharmacies in

providing checking services at events and festivals be undertaken. Janice Horsman (Healthwatch Westminster) advised that Healthwatch Westminster was undertaking a needs analysis of customers who accessed pharmacy services and a report was due in September 2015. She also informed Members that whilst at a recent Urgent Care Conference, she had heard about a Mental Health Information Exchange scheme in Sheffield that helped to ensure that patients complied correctly with their medication which was vital, for instance, in preventing relapse and she felt a similar scheme could benefit Westminster.

6.4 Members emphasised the importance of identifying any areas lacking pharmacies signed up to the scheme, particularly if such areas had any specific health issues and if so attention should be focused on ensuring these areas had the appropriate pharmaceutical provisions. Consideration also needed to be given with regard to staff training and the costs involved. The Board noted that the larger pharmacies in London were able to train their staff appropriately, however engaging staff in smaller pharmacies was more difficult. Members acknowledged the importance of ensuring that pharmacies joined up their customer information records with GPs' patient records to prevent inappropriate or unnecessary treatment being provided.

6.5 The Board agreed that the Public Health Team liaise with Healthwatch Westminster in order to exchange information on their respective studies and also to liaise with the Local Pharmaceutical Committee and the Royal Pharmaceutical Society on increasing the role of pharmacies in health promotion.

## 7. WHOLE SYSTEMS INTEGRATION

7.1 Matthew Bazeley (Managing Director of Central London CCG) provided an update on Whole Systems Integrated Care (WSIC) and advised that the Community Independence Service had gone live on 1 April 2015 and the partnership working had gone well. Dedicated pieces of work were being undertaken in respect of care navigation and care planning which included patient input, whilst a provider network for Central London was also being developed. A draft specification for the future model of care had been produced and this would be brought to a future meeting of the Board. Matthew Bazeley confirmed that a fully integrated IT system was now in place, whilst Members also heard that a Village based model of care was being developed, involving multidisciplinary teams providing services within each village.

7.2 Dr Naomi Katz (West London Clinical Commissioning Group) advised that the West London model continued apace and that it was centred around patients' needs. GPs were signed up from 1 June 2015 for the First Wave of the programme and patients would be tiered according to their needs. Particular focus would be given on providing additional services for older patients that were in greater need.

7.3 Members acknowledged the progress in delivering WSIC and expressed an interest in receiving information in evaluating its progress and achievements. The

Board agreed that the first update on the WSIC's effectives be presented in around six months' time and that progress be monitored regularly.

## 8. JOINT STRATEGIC NEEDS ASSESSMENT

8.1 Colin Brodie (Public Health Knowledge England) presented the report that provided an update on the progress of the Joint Strategic Needs Assessment (JSNA) agreed by the Board for the 2014/2015 work programme. He advised that the Pharmaceutical Needs Assessment had now been published and referred to the JSNAs in the current JSA work programme, including the Dementia JSNA, Childhood Obesity JSNA, End of Life Care JSNA and Housing JSNA.

8.2 The Board were informed of two new JSNA proposals for the 2015/2016 work programme. The first, Evidence Hub, was presently being scoped and developed, whilst the second, the Fuel Poverty JSNA, was currently in being scoped in more detail before being considered by the JSNA Steering Group on 4 June 2015.

8.3 The Board welcomed the proposed Evidence Base JSNA and emphasised the need to ensure that it was user friendly. Members queried the inclusion of a Fuel Poverty JSNA as they felt it was not especially relevant to what the JSNA should be focusing on. The Board therefore felt it was more appropriate that fuel poverty be included as part of the Housing JSNA.

8.4 Members requested that the JSNAs be brought more in line with what the Board was focusing on and the issues the local authority and the CCGs were addressing. This included issues involving carers, the impact the Care Act had on carers and personalisation. More thought was also needed on how CCG Governing Bodies could make more use of the JSNA. The Board also requested that they be informed more frequently of any JSNA requests that are put forward for consideration.

## 9. BETTER CARE FUND

9.1 Liz Bruce provided an update on progress for the Better Care Fund Plan and on preparations for implementation. She advised that the Community Independence Service's discharge from hospital to home was now being carried out using the new method and an evaluation of its effectiveness would take place in June 2015, with a view to building further on this scheme. An update on the scheme would be provided at a future Board meeting.

9.2 The Board requested that a more detailed update, including information on performance and spending, be provided in around six months' time.

## 10. CARE ACT IMPLEMENTATION

10.1 The Board noted that there were no specific updates on the Care Act Implementation.

## 11. PRIMARY CARE CO-COMMISSIONING

11.1 Members remarked that the Board continued to focus on the need for appropriate representation during the process of primary care co-commissioning. There was also a need for further discussion about a liaison representing the local authority and whether each of the tri-boroughs should have their own liaison.

## 12. WORK PROGRAMME

12.1 The Board noted its proposed Work Programme for 2015/2016. Holly Manktelow updated Members on progress with the Primary Care Project that sought to provide an understanding of how local need will change over the medium and long term due to changes in resident and visitor population. This modelling would support primary care and inform wider services design. Some questions remained in respect of governance, a report on these questions had been produced and would be circulated to the Board for comments. The Board was invited to nominate a sponsor to oversee progress on the project in between Board meetings.

## 13. ANY OTHER BUSINESS

13.1 Members noted that the NHS England representative would be asked to describe how they saw their role on the Board and to respond to the Board's questions and views on the role at the next Board meeting on 10 July.

## 14. TERMINATION OF MEETING

14.1 The meeting ended at 4.55pm.

CHAIRMAN _____ DATE _____

# WESTMINSTER HEALTH & WELLBEING BOARD
## Actions Arising

**Meeting on Thursday 21st May 2015**

| Action | Lead Member(s) And Officer(s) | Comments |
|---|---|---|
| **North West London Mental Health and Wellbeing Strategic Plan** | | |
| That a briefing paper be prepared outlining how the different parts of the mental health services will work and how various partners can feed into the process. | NHS North West London | To be considered at a forthcoming meeting. |
| Adult Social Care representative to be appointed onto the Transformation Board. | NHS North West London<br>Adult Social Care | To be confirmed. |
| **Children and Young People's Mental Health** | | |
| A vision statement be produced and brought to a future Board meeting setting out the work to be done in considering mental health services for 16 to 25 year olds, the pathways in accessing services and the flexibility in both the setting and the type of mental health care provided, whilst embracing a multidisciplinary approach. | Children's Services | To be considered at a forthcoming meeting. |
| **The role of pharmacies in Communities and Prevention** | | |
| Public Health Team and Healthwatch Westminster to liaise and exchange information in their respective studies on pharmacies, including liaising with the Local Pharmaceutical Committee and the Royal Pharmaceutical Society. | Public Health<br><br>Healthwatch Westminster | Completed |
| **Whole Systems Integrated Care** | | |
| That the Board be provided with updates on progress for Whole Systems Integrated Care, with the first update being provided in six months' time. | NHS North West London | First update to be considered at the 19th November 2015 Health and Wellbeing Board meeting. |
| **Joint Strategic Needs Assessment** | | |
| Consideration be given to ensure JSNAs are more line with the Board's priorities. | Public Health | Report being considered 9th July 2015 |
| The Board to be informed more frequently on any new JSNA requests put forward for consideration. | Public Health | On-going. |
| **Better Care Fund** | | |
| An update including details of performance and spending be provided in six months' time. | | Update to be considered at the 19th November 2015 Health and |

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| | | Wellbeing Board meeting. |
| **Primary Care Co-Commissioning** | | |
| Further consideration of representation, including a local authority liaison, to be undertaken in respect of primary care co-commissioning. | Health and Wellbeing Board | In progress |
| **Work Programme** | | |
| Report to be circulated on progress on the Primary Care Project for comments. | Holly Manktelow<br><br>Health and Wellbeing Board | Circulated. |
| The Board to nominate a sponsor to oversee progress on the Primary Care Project in between Board meetings. | Health and Wellbeing Board | To be confirmed. |
| NHS England to prepare a paper describing how they see their role on the Board and to respond to Members' questions at the next Board meeting. | NHS England | To be considered at the 9th July 2015 Health and Wellbeing Board meeting. |

**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 | Completed |

**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. | Children's Services | In progress. |

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| decisions, and to also enable effective identification of gaps in provision. | | |
| 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 | Completed. |
| **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.<br><br>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<br><br>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 |
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| **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** | | |

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| 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.<br><br>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. | Completed |
| **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 | Completed |
| **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. | Public Health Services<br><br>Senior Policy & | Completed |

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| *Note: Recommendations to be put forward in next year's programme.* | Strategy Officer. | |

**Meeting on Thursday 26th April 2014**

| Action | Lead Member(s) And Officer(s) | Comments |
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| **Westminster Housing Strategy** | | |
| The consultation draft Westminster Housing Strategy to be submitted to the Health & Wellbeing Board for consideration. | Strategic Director of Housing | Being considered at the 9th July 2015 Health and Wellbeing Board |
| **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. |

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City of Westminster

# Westminster Health & Wellbeing Board

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| **Date:** | **9th July 2015** |
| **Classification:** | **Public** |
| **Title:** | **Five Year Forward View and the role of NHSE in the local health and care system** |
| **Report of:** | **NHS England (London region)** |
| **Wards Involved:** | **All** |
| **Policy Context:** | **Health and Care** |
| **Financial Summary:** | **N/A** |
| **Report Author and Contact Details:** | Belinda Coker<br>belinda.coker@nhs.net |

## 1. Executive Summary

1.1 This report aims to provide the Health and Wellbeing Board with an overview of the NHS Five Year Forward View and set out the role of NHS England in the local health and care system

## 2. Key Matters for the Board's Consideration

2.1 The Health and Wellbeing Board are asked to consider the role that NHS England should play within the local health and care system, and how this could be undertaken within the context of the Westminster Health and Wellbeing Board

## 3. Background

3.1 The NHS Commissioning Board was established on 1st October 2012 as an executive non-departmental public body. Since 1st April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

3.2 The vision and purpose of the NHS England is set out in the diagram below

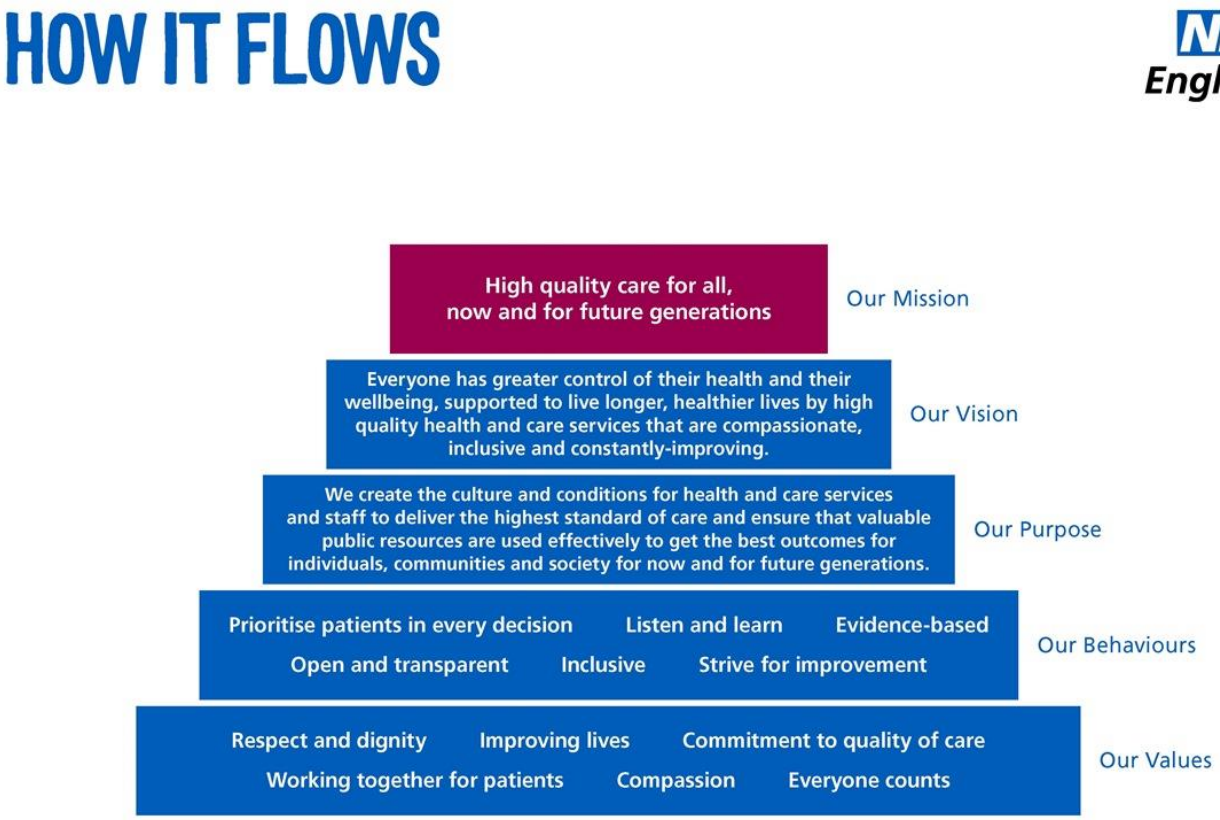


Fig 1: NHS Vision and Purpose[1]

3.3 NHS England is one organisation; however it operates in part through four regional teams: London, Midlands and East, North and South which all maintain a local presence.

3.4 The regional teams cover healthcare commissioning and delivery across their geographies and provide professional leadership on finance, nursing, medical, specialised commissioning, patients and information, human resources, organisational development, assurance delivery.

3.5 The regional teams work closely with local organisations such as clinical commissioning groups, local authorities, health and wellbeing boards as well as individual GP practices.

[1] http://www.england.nhs.uk/about/our-vision-and-purpose/

3.6 NHS England (London region) has oversight and leadership of the NHS in London and commissions more than £15 billion of services for the 8.17 million people living in the capital. These include primary care general practitioners (which are now being co-commissioned with CCGs) and over 140 specialised services, such as:

- Mental Health
- HIV treatment
- Treatment for children with congenital heart conditions
- Cystic fibrosis treatment
- Complex spinal surgery; and
- Healthcare for those in the criminal justice system.

3.7 NHS England (London Region) have provided the presentation attached as Appendix A to this covering note which provides an overview of the NHS Five Year Forward View and sets out the role of NHS England (London Region) in the local health and care system.

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

**Toby Howes, thowes@westminster.gov.uk**

**APPENDICES:**

A: Presentation from NHS England (London Region) on the NHS Five Year Forward View and the role of the NHSE (London Region) in the local health and care system

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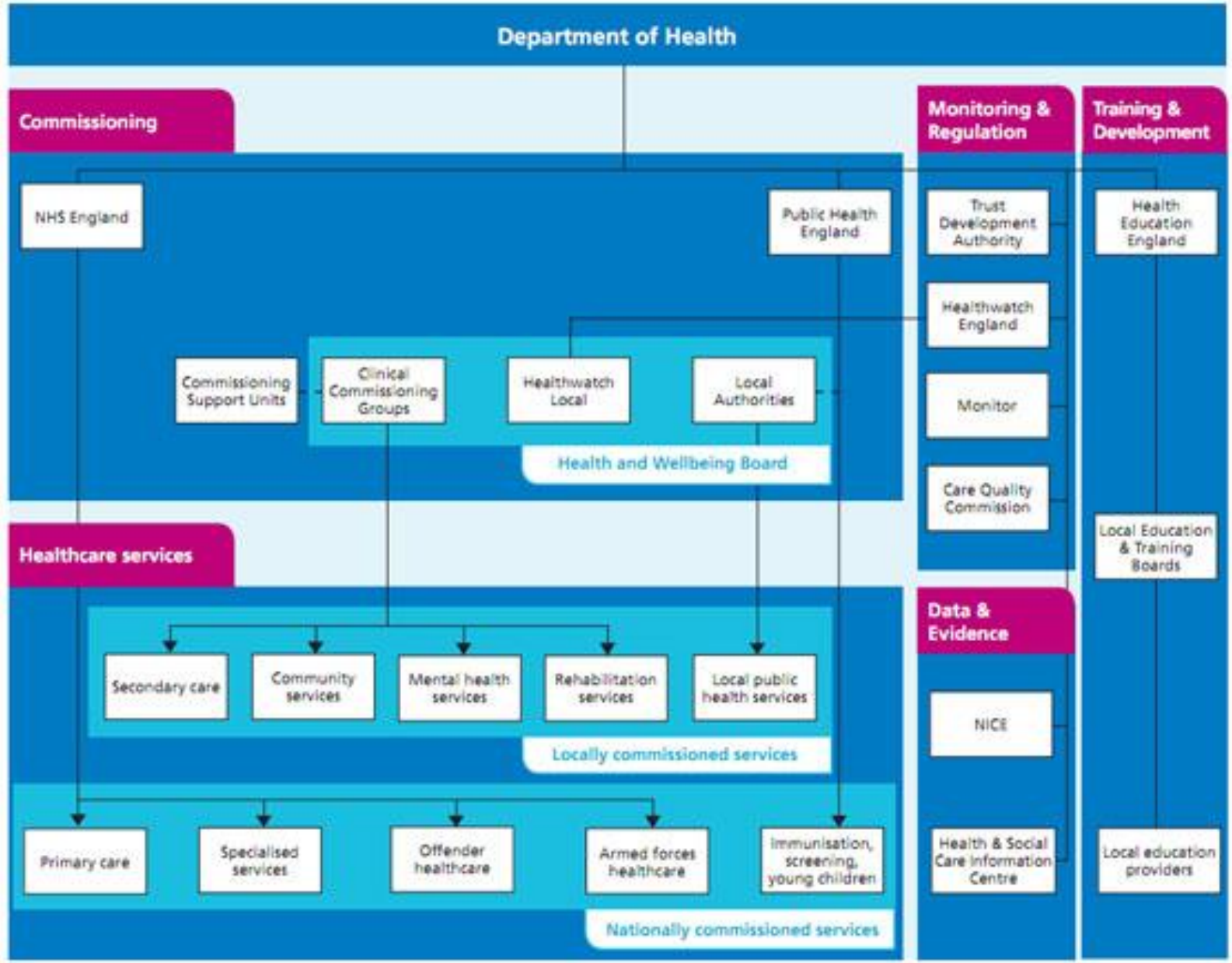
# Five year forward view and the role of NHS England in the local health and care system

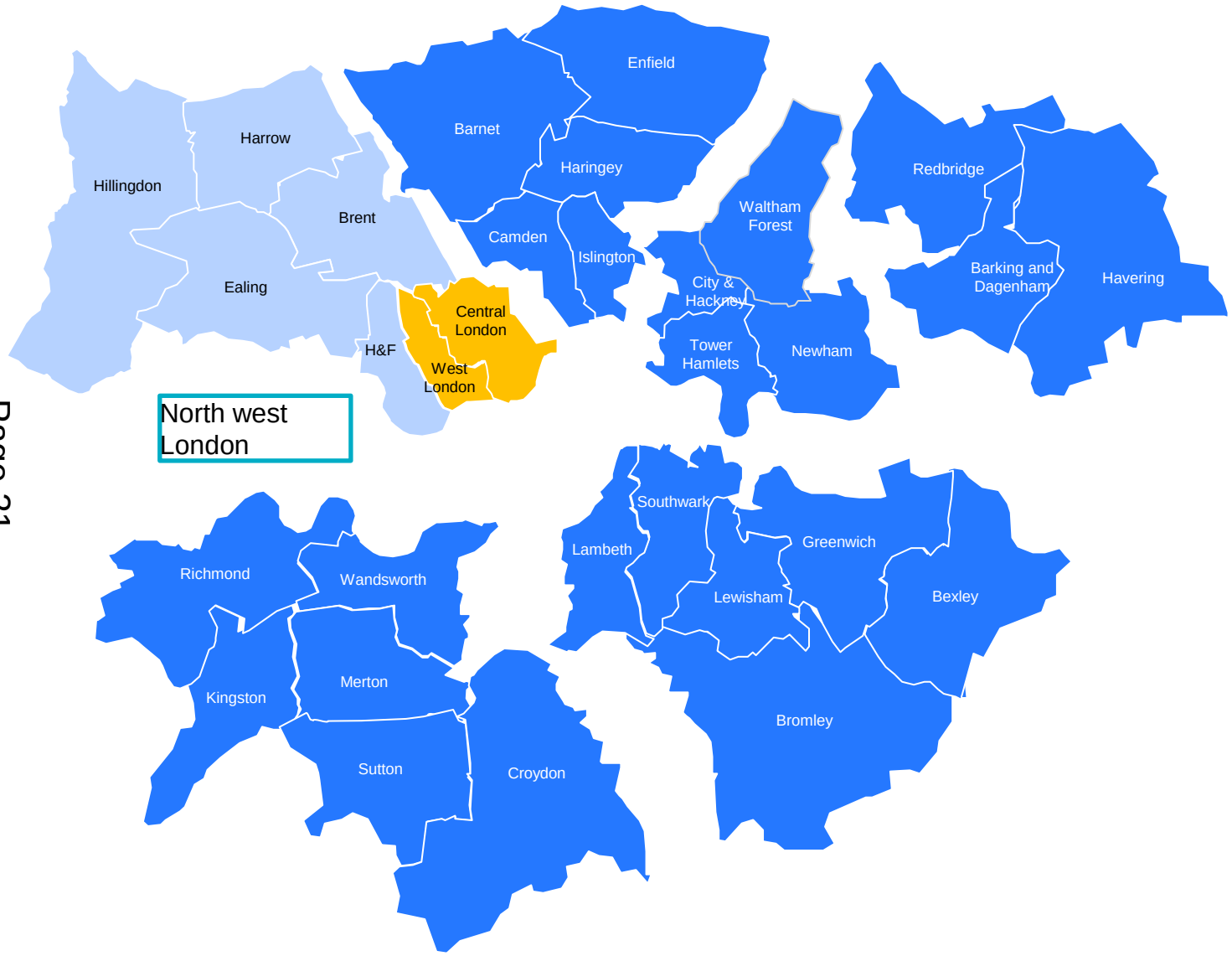


**NHS England (London region)**
**June 2015**

# Structure of the NHS in England



# 32 CCGs in London and clustered by 6 Strategic Planning Groups



# 33 Health and Wellbeing Boards in London

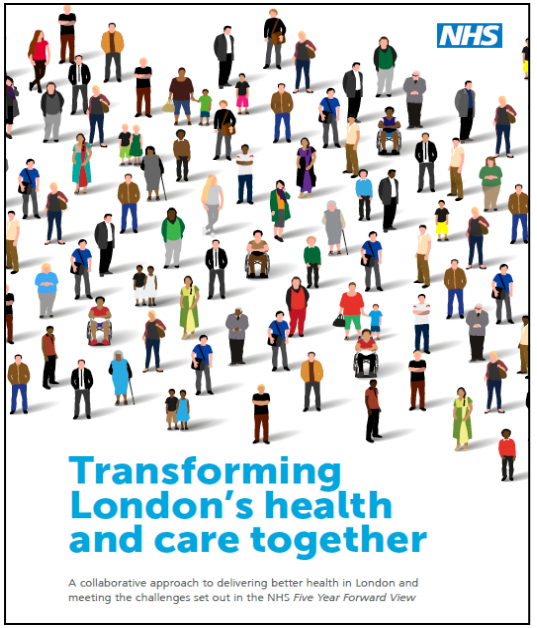
# The challenges facing the health and care system are well rehearsed in key strategy documents

NHS England

**NHS five year strategy**


**London five year strategy**


**CCG and NHS England Collaboration**




- Synergies exist between these documents, with the NHS *Five Year Forward View* setting out a broad strategy for health and care improvement and *Better Health for London* providing recommendations on how to deliver this within the London context
- These are complemented by SPG and CCG strategic and operating plans, that respond more closely to local contexts
- Together, these provide a real platform for long-term change for the better health of Londoners

# London aspires to be the healthiest global city

- The London Health Commission set this overarching goal, recognising that London is currently ranked 7 out of 14 comparable cities for health.
- In March 2015, NHS England, CCGs, local government, the GLA and PHE ratified a collective vision of 10 aspirations to improve the lives of Londoners and achieve this goal:

Give all London's children a healthy, happy start to life

Get London fitter with better food, more exercise and healthier living

Make work a healthy place to be in London

Help Londoners to kick unhealthy habits

Care for the most mentally ill in London so they live longer, healthier lives

Enable Londoners to do more to look after themselves

Ensure that every Londoner is able to see a GP when they need to and at a time that suits them

Create the best health and care services of any world city, throughout London and on every day

Fully engage and involve Londoners in the future health of their city

Put London at the centre of the global revolution in digital health





SOURCE: Better Health for London, 2014; Better Health for London: Next Steps, 2015

# NHS England has a substantial role as a Direct Commissioner of Services

| | | |
|---|---|---|
| **Primary care commissioning** | c.£1.8 bn | • Setting strategic direction for commissioning of primary care in line with national priorities<br>• Contracting<br>• Monitoring, performance management, assurance of primary care providers and CCGs<br>• Intervention where necessary<br>• Ensuring that the commissioned primary care is aligned with best practice |
| **Specialised Services commissioning** | c.£3.5 bn | • Setting strategic direction for commissioning of specialised services in line with national priorities<br>• Contracting with the high density of specialist providers<br>• Monitoring and performance management of providers<br>• Intervening where necessary<br>• Ensuring that the commissioned services are aligned with best practice |
| **Public, Offender & Military Health** | c.£0.34 bn | • Delivering strategic leadership and setting direction for the commissioning services in line with national priorities to improve health, reduce health inequalities and reduce re-offending<br>• Contracting with the high density of providers and ensuring robust links with Military health commissioning lead Area Team<br>• Monitoring and performance management of providers<br>• Intervening where necessary<br>• Ensuring commissioned services are aligned with best practice |

# The Mandate to NHS England contains the governments priorities for 15/16

| Priority | Update for 15/16 |
|---|---|
| Mental health | Access and waits - Introducing new access and waiting time standard for people experiencing first episode psychosis (FEP) by April 2016.<br><br>IAPT - Achieve new standards of 75% of people referred to IAPT programme treated within 6 weeks of RTT and min of 95% treated within 18 weeks.<br><br>Liaison psychiatry – ensuring adequate and effect levels of provision are in place in acute settings<br><br>Choice of provider – using levers in the contract to ensure choice for patients<br><br>Crisis – support implementation of crisis care concordat with mental health support integral part of 111<br><br>Young people – Improvements to commissioning of CAMHs specifying use of outcomes in contracts |
| BCF | The requirement to ring-fence £3.46bn to establish the Better Care Fund, and lead its effective implementation to join up health and social care services |

There is also a continued focus on **Performance and delivery**

# NHSE: Improving quality of services

NHS England

**Primary Care Infrastructure Fund**

- £1bn four year investment
- Investment in infrastructure in General Practice

**Prime Minister's Challenge Fund**

- £100m 2015/16 (£50m 2013-2014)
- Improving access to GPs
- Out of hospital services for LT conditions and patients >75 years

***AND …..Quality Assurance***

# NHSE: Improving  population health

## Health Visiting Programme

DoH, PHE, NHSE, HEE

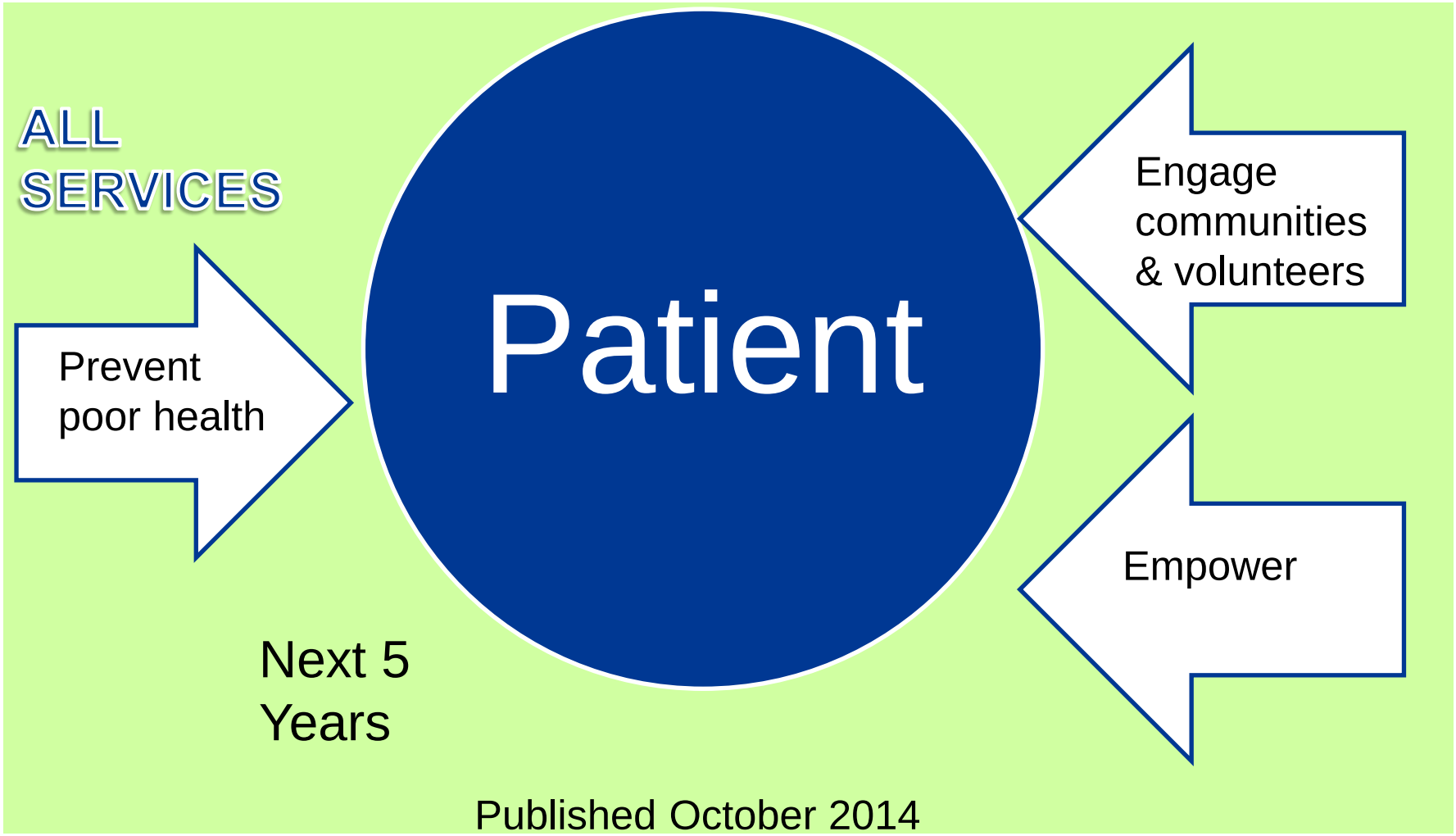
Commissioning public health services for children 0-5 will transfer to LA's in Oct 2015

## Learning Disabilities

Enhanced service : LD Health checks

New integrated models of care being tested in a small number of cities

# Five Year Forward: Transforming NHS service delivery to improve patient care, health and experience



# Five Year Forward View for London: New Models of Care

**Multispecialty Community Providers (MCPs)**

- Out of Hospital services
- Multi-disciplinary 'expert generalists' focusing on patients with complex needs and long term conditions
- Formed by larger GP practices; federations, networks or large single organisations
- Employ, partner or subcontract specialists and allied professionals to work in out-of-hospital settings
- Integrated access to diagnostics

**Primary and Acute Care Systems (PACS)**

- In certain areas where GP demand outstrips supply, organisations such as hospitals will be permitted to open their own GP surgeries with registered lists.
- May include other services such as community care and mental health
- 'Vertically' integrated pathways for patients; all of their healthcare (+/- social care) needs are provided by the PACS

# Five Year Forward View: New Models of Care

**Urgent and Emergency Care Networks**

- Evening and weekend access to GPs or nurses working from community bases with ability to make referrals, arrange tests and provide treatments
- Greater use of Pharmacies for minor ailments
- Networks of linked hospitals. Serious needs seen at specialist emergency centres
- 7 day services in hospitals
- Vertically integrated clinical triage and advice service to navigate patients
- Integration of mental health crisis services

**Viable smaller hospitals**

- Create sustainable small hospitals
- E.g. sharing back office, outsourcing some services to a specialist provider who has achieved EoS (competitive rate), vertical integration

# Five Year Forward View: New Models of Care

**Enhanced health in Care Homes**

- NHS, social care, care homes developing models to provide support and in-house care to care homes (Integration around the patient)

**Modern Maternity services**

- Review of future models for midwife led units and midwife networks to provide NHS funded midwifery services

# Five Year Forward View: The Forward View into Action


Vanguard sites will receive tailored support, learning and sharing of intelligence

Alignment of Quality assurance between NHSE, Monitor & TDA

# Thank You

City of Westminster

# Westminster Health & Wellbeing Board

| | |
|---|---|
| **Date:** | 9th July 2015 |
| **Classification:** | **General Release** |
| **Title:** | Joint Strategic Needs Assessment (JSNA) Update |
| **Report of:** | Acting Director of Public Health |
| **Wards Involved:** | All |
| **Policy Context:** | To support the Health and Wellbeing Board statutory duty to deliver a Joint Strategic Needs Assessment |
| **Financial Summary:** | N/A |
| **Report Author and Contact Details:** | Colin Brodie, Public Health Knowledge Manager cbrodie@westminster.gov.uk T:02076414632<br><br>Jessica Nyman, JSNA Manager. Email: jnyman@westminster.gov.uk, tel: 0207 641 8461 |

## 1. Executive Summary

1.1 This paper reports on the progress made on the specific Joint Strategic Needs Assessment (JSNA) products since the last Health and Wellbeing Board meeting on the 21 May, and includes a presentation on the development of the Evidence Hub.

1.2 This report also includes progress made to date against evidence set out in deep dive JSNAs published in 2013-2014 (as an appendix), and considers how the future JSNA work programme can support the Health and Wellbeing Board priorities and Joint Health and Wellbeing Strategy.

## 2. Key Matters for the Board

2.1 The Health and Wellbeing Board are invited to consider progress on the current work programme and the Evidence Hub.

2.2 The Health and Wellbeing Board is invited to consider how the JSNA can best support the priorities and work of the Health and Wellbeing Board?

2.3 The Health and Wellbeing Board are invited to consider the proposal to incorporate a refresh of the data contained in the Carers JSNA 2012, into the Evidence Hub and whether there are any further information gaps which require an application for a new deep-dive Carers JSNA?

2.4 The Health and Wellbeing Board are invited to consider the report on progress made from the JSNA Work Programme 2013/14 (i.e. Physical Activity JSNA; Employment Support JSNA; Learning Disabilities JSNA; Child Poverty JSNA; and Tuberculosis JSNA

2.5 The JSNA programme team recommend that future JSNA Leads, and appropriate commissioners, report to the Health and Wellbeing Board on (1) how JSNA findings and recommendations will be taken forward when the JSNA is completed, and (2) progress made on implementation one year after completion.

## 3. Background

3.1 JSNAs provide a detailed picture of the health and wellbeing needs of the local population. They are developed jointly by local NHS and council partners and identify actions that local commissioning organisations will need to take to improve the design, delivery and effectiveness of services that improve the health and wellbeing of individuals and communities, and reduce health inequalities. Other partners are also involved in the process, including service providers, voluntary organisations and Healthwatch

3.2 Local authorities and Clinical Commissioning Groups (CCGs), through the Health and Wellbeing Board, have a legal duty to prepare a JSNA.

3.3 The City of Westminster Health and Wellbeing Board has delegated the prioritisation of the JSNA workplan and the day-to-day management of the programme to a sub-group of the Health and Wellbeing Board, the JSNA Steering Group. This group consists of representatives from the CCGs, Public

Health, Children's Services, Adult Social Care, Community and Voluntary Sector, and Healthwatch. The Health and Wellbeing Board remain accountable for the JSNA and are required to agree and sign-off the JSNA work programme and the final JSNA products, and monitor delivery of the programme.

3.4 The JSNA work programme currently contains two main workstreams:

(a) highlight reports for each borough, and
(b) 'deep dive' JSNAs which produce topic-specific needs assessments to inform particular commissioning questions.

3.5 There are currently four deep dive JSNAs in progress covering the following topics – Dementia, Childhood Obesity, End of Life Care and Housing.

3.6 In addition, the development of an Evidence Hub has been added to the future JSNA work programme. The Evidence Hub will provide a tool which brings together a broad base of information and which will allow access to a range of data and evidence. The aim is for this to be easy to use and understand and so will facilitate and inform the refresh of the borough-specific JSNA Highlight reports.

## 4. Current work programme

***Dementia JSNA***

4.1 The Dementia JSNA Task & Finish Group received a large volume and range of feedback from the consultation with key stakeholders on the JSNA. These comments have been reviewed and appropriate changes are currently being made to the final version of the report.

4.2 A revised timetable for the publication of the JSNA has been scheduled, which allows sufficient time for full consideration of the comments received and for council and CCG leads to develop a joint approach to local implementation within the context of the North West London Dementia Strategy. These will be presented together at the September meeting of the Health and Wellbeing Board.

***Childhood Obesity JSNA***

4.3 This JSNA describes the prevalence of childhood obesity in Westminster, Hammersmith and Fulham, and Kensington and Chelsea, and examines the factors which are known to influence levels of obesity in our population.

4.4 A first draft has been circulated to the Tackling Childhood Obesity Team (TCOT) for review and feedback. Following any necessary revisions a second draft will then be circulated to a wider group of stakeholders for engagement and comment. The JSNA will inform and support the next phase of the Childhood Obesity Programme, and the final draft report will be presented to the Health and Wellbeing Board in November 2015 alongside Year 2 plans for the Childhood Obesity Programme.

***End of Life Care JSNA***

4.5 A first draft of the JSNA report and supplementary Technical Document has been circulated to the three borough End of Life Steering Group to consider at their meeting on the 8th July and to assist with gaps in data and information.

4.6 The views of key stakeholders currently are being sought through a combination of interviews (e.g. with commissioners and clinicians) and workshop events (e.g. BME Health Forum).

4.7 Following this consultation and engagement period a final draft is expected to be completed at the end of September 2015.

***Housing JSNA***

4.8 The Housing JSNA is being developed alongside key stakeholders to support their key business needs, and to support the new duties for local authorities around prevention contained within the Care Act. In Westminster, the JSNA will support the delivery of a coordinated approach, as outlined in the Westminster Housing Strategy, to address the housing needs and preferences of vulnerable people and inform the effective delivery of services to meet that need.

4.9 Since the last meeting of the Health and Wellbeing Board work has progressed on engagement with key stakeholders in Housing and Adult Social Care across

the three Boroughs to build capacity around the Task and Finish Group and identify specific outputs from the work.

***Evidence Hub***

4.10 The aim of this Evidence Hub 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. One function of the Evidence Hub will be to inform a refresh of the JSNA Highlights Report.

4.11 Building on consultation with a range of stakeholders, a proof of concept has been developed which has been presented to a number of forums such as the Public Health Integration and Transformation Board, the Public Health Leadership Forum and the JSNA Steering Group.

4.12 A demonstration of the Evidence Hub proof of concept is presented at the meeting today to provide an insight into the work to date, visualise how the Evidence Hub might look and to help show the value that it might add.

4.13 **The Health and Wellbeing Board are invited to consider progress on the current work programme and the Evidence Hub.**

## 5. Considerations for the JSNA work programme

5.1 In order to support the Health and Wellbeing Board work programme, the JSNA Steering Group discussed alignment between the JSNA work programme and Health and Wellbeing Board priorities at their meeting on the 4 June. The Steering Group noted that the Westminster Joint Health and Wellbeing Strategy (JHWS) is due to be updated in the near future. The JSNA will inform this process and presents an opportunity for close alignment.

5.2 The JSNA Steering Group also requires appropriate senior representation and membership to ensure that it can be fully aligned to the Health and Wellbeing Board priorities.

5.3 **The Health and Wellbeing Board is invited to consider how the JSNA can best support the priorities and work programme of the Health and Wellbeing Board?**

5.4 A number of topics for deep dive JSNAs were suggested by the HWB on 21 May including carers (incl. young carers), mental health of children and young people, and the personalisation agenda. To date no further applications have been submitted to the JSNA Steering Group for consideration. Having reviewed these topics, it is proposed that the Evidence Hub will incorporate updated information on carers and young carers (last Carers JSNA was published 2012). An application for a Children's and Adolescents Mental Health Services JSNA is currently being scoped and is expected in the near future (last CAMHS JSNA published 2013). Where appropriate, the personalisation agenda will be included within the scope of future deep dive JSNAs, and the potential for further work on this topic will be given due consideration by the JSNA programme team.

5.5 **The Health and Wellbeing Board are invited to consider the proposal to incorporate a refresh of the data contained in the Carers JSNA 2012, into the Evidence Hub and whether there are any further information gaps which require an application for a new deep-dive Carers JSNA?** .

5.6 To inform the future JSNA work programme it is worth considering how previous JSNAs have informed commissioning, strategy and service development. The report attached at Appendix 1 has been provided by the JSNA Steering Group and JSNA Project Leads. It provides a summary of progress on the findings/recommendations of the deep dive JSNAs published in the 2013/14 work programme. These were **Physical Activity; Child Poverty; Tuberculosis; Learning Disabilities** and **Employment Support**.

5.7 **The Health and Wellbeing Board are invited to consider the report on progress made from the JSNA Work Programme 2013/14**

5.8 **The JSNA programme team recommend that future JSNA Leads, and appropriate commissioners, report to the Health and Wellbeing Board on (1) how JSNA findings and recommendations will be taken forward when the JSNA is completed, and (2) progress made on implementation one year after completion**.

5.9 Please see attached report at Appendix 1.

## 6. Legal Implications

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

6.2 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)

## 7. Financial Implications

7.1 The current JSNA projects are scoped and progressed within existing resources and capacity. The individual JSNAs largely draw on existing staff capacity from across the key departments and stakeholders involved, and from the JSNA team within the Public Health department.

7.2 The 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 a future meeting alongside other potential draws on the Joint Strategic Needs Assessment resource.

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

**Jessica Nyman**

**Email: jnyman@westminster.gov.uk**

**Telephone: 0207 641 8461**

**APPENDICES:**
Appendix 1: JSNA Deep Dive update and Progress Review, June 2015

**BACKGROUND PAPERS:**
N/A

# Appendix 1 - JSNA Deep Dive Update and Progress Review June2015

## COMPLETED JSNA DEEP DIVES PRODUCTS 2013/14– Update on Progress

The following deep-dive JSNAs were completed and published in 2013/14. Below is a reminder of the summary of the key findings for each JSNA, and an update on progress since they were published.

1. Employment Support – August 2013
2. Learning Disabilities – January 2014
3. Tuberculosis – March 2014
4. Child Poverty – April 2014
5. Physical Activity – May 2014



### 1. Supported Employment JSNA (published August 2013)

| | |
|---|---|
| Summary | Unemployed individuals have a higher risk of poor physical and mental health compared with those in employment. The health and social impacts of a long period of unemployment can last for years.<br><br>Some key findings reported in the JSNA:-<br><br>• Unemployed people have higher levels of GP consultations and longer in-patient stays. Extrapolating from national figures, the cost of mental illness locally is approximately £300 million in H&F, £250 million in K&C and £350 million in Westminster. Over a third of this is due to loss of economic output (over £80million per borough) and a fifth due to health and social care costs (over £5million per borough). These figures are probably underestimates due to high local prevalence of severe mental illness and a larger working age population than the national average.<br><br>• Paid employment rates for clients with severe mental illness in Kensington and Chelsea (K&C) and Westminster, [*at time of JSNA reporting*], were below the London and England averages. This was despite the fact that nationally up to 90% of all mental health service users want to work (3) and at least a third of those currently unemployed due to SMI would like to find work.<br><br>• Clients with learning disabilities were noted to have worse employment prospects than other disability groups. The employment rate [*at time of JSNA reporting*] for disabled people nationally had risen to 48% overall but remained only 10% for those with |

| | |
|---|---|
| | learning disabilities. The report also noted that 65% of people with learning disabilities nationally would like a paid job .<br>• Sickness absence and presenteeism (reduced productivity at work related to ill health) are also likely to have major impacts in the Tri-borough area, based on what we know nationally. Mental illness is the number one cause of long-term sickness absence, closely followed by musculoskeletal problems.<br>• There is substantial evidence that specialist employment support, tailored to the needs of clients with mental illness or disabilities, can deliver jobs. The most cost effective models of support include Individual Placement and Support (IPS) for mental health clients and Supported Employment (SE) in the disabilities field.<br>• There is also evidence to support a role for 'Very Supported' employment opportunities (such as social enterprises) for clients with very complex needs.<br>• In addition, Government policy advocates early intervention in-work support to help individuals to retain employment, to prevent the 'revolving door' of sickness absence and to avoid the negative health impacts of unemployment.<br>• Evidence shows that these approaches to employment support can deliver:<br>Improved individual health and wellbeing<br>Increased personal income<br>Reduced use of health and social care services<br>• Evidence-based employment support is, at least, cost neutral. At best it can generate significant cost savings to local commissioners. |
| Purpose | To implement a needs assessment to inform Adult Social Care and CCG planned commissioning and to implement a recommended JSNA approach advocated by the London Mental Health and Employment Group.<br><br>The JSNA profiled prevalence of mental illness, physical disabilities and learning disabilities; employment rates; mapped service provision, outlined evidence base and made recommendations for evidence based future service provision. |
| Recommendations | See 'Progress to date' section for synopsis. |
| Lead responsibility | Public Health; Adult Social Care; CCG Mental Health Commissioning Support |

<table>
<tr>
<td>Progress to date</td>
<td>The JSNA outlined elements of good practice to be considered by local commissioners, please see below some examples with summary of progress to date:-
<table>
<tr><th>Elements of good practice</th><th>Progress to date</th></tr>
<tr><td>• Evidence-based approaches to employment support. For example IPS in the mental health field and SE in the disabilities field<br>• Regular review of progress to ensure that clients progress towards paid employment and do not get stuck at earlier stages along the pathway to work<br>• A single point of referral into the system and clear pathways within it</td><td>JSNA has informed:-<br>• ASC service design and specification for new supported employment service for individuals with learning disabilities/disabilities to be commissioned<br>• Public Health Investment Fund Employability Programmes including Supported Employment Service as noted above; Supported Employment Broker (WCC); Central London Forward Working Capital (Westminster and Kensington and Chelsea)</td></tr>
<tr><td>• Partnership work and effective communication between employment support providers, care managers, health care and benefits advisors<br>• Co-location of employment support within social and health services (e.g. IAPT). This can improve the effectiveness of support for clients and may be cost saving</td><td>• Co-location pilot CNWL Vocational Services and Job Centre Plus in Westminster</td></tr>
<tr><td>• Employer engagement so that more high quality job opportunities are available to clients. Fewer people will fall out of employment when employers know what to expect when they employ individuals with mental illness or disabilities.<br>• High quality work opportunities</td><td>• Public Health Investment Fund: Supported Employment Broker programme in Westminster<br>• Public Health Investment Fund: London Healthy Workplace Charter -Environmental Health Teams working with local businesses to support healthy workplace practice and work</td></tr>
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| | | |
|---|---|---|
| | • **Provision of early intervention support for job retention supporting employees and employers** | towards achieving Charter accreditation<br><br>• **Commissioning of Social Enterprise**, designed to form part of the new model of employment support provision and offering supported work opportunities for individuals with disabilities and learning disabilities.<br><br>• **One year Fit for Work Service (2013-2014)**, following on from DWP & DH funded 3 year pilot (2010-2013). |
| | • **The local Councils and CCGs leading by example as employers.** | • **Supported Employment Broker (WCC)** includes creation of work related opportunities within the Council and facilitating access to these |
| Future delivery | Commissioning of Supported Employment service (ASC): (Tri-B)- The new service is expected into place in December 2015. | |
| Risks and issues | None identified | |
| Actions for Health and Wellbeing Board | **The local Councils and CCGs leading by example** as employers<br>Raise awareness and encourage Health and Wellbeing Board representative's organisations to:-<br><br>• Identify and facilitate work related opportunities within the organisation and additional opportunities that could be offered via commissioning (i.e. providers/contractors) for identified target groups<br>• Participate in the London Healthy Workplace Charter | |

| 2. Learning Disabilities JSNA (published January 2014) | |
|---|---|
| Summary | This report assesses and develops local strategy around support for people with learning disabilities, alongside a range of other information, such as other specific needs assessments, strategies, action plans and routine monitoring.<br><br>Some detail has been provided in this report on Tri-borough services and how they are responding to local needs, but it is envisaged that this detail will predominantly be captured in resulting action plans and strategies, which will ensure that issues from this report are addressed. |
| Purpose | Describe the needs of people with learning disabilities locally and be used to assess and develop local strategy around support for people with learning disabilities. |
| Recommendations | • Ensure that cross-organisational systems are in place to **identify those with learning disabilities**, in order to tackle potential under-diagnosis in the local population, and do early assessments of those with learning disabilities likely to be transitioning into adult services, to ensure that referrals are received in a timely fashion. This will also support professionals to better plan for the young people who are assessed as not eligible and therefore will not receive a service.<br><br>• **Ensure that local services plan** for expected increases in numbers of complex clients in transition, as well as numbers reaching old age, and the specific requirements that these groups have, such as planning for more and more varied models of accommodation and support.<br><br>• To work with housing, leisure services and care providers around issues relating to the promotion of leisure facilities and the **tackling of obesity for** people with learning disabilities<br><br>• Continue working with GPs and hospitals to **ensure reasonable adjustments are made to enable people to access services** easily for those with learning disabilities and autistic spectrum disorders. A Tri-borough inpatient audit into service users' experiences is currently being carried out which will help to improve the quality of the service. Work with dentistry services in the community and secondary services to make further adjustments to enable service users with complex and challenging behaviour to access the service e.g. designated slots when there are fewer patients and minimise waiting time<br><br>• To **address data quality issues,** around numbers attending cervical and breast screening and develop actions to improve uptake where necessary, reporting causes of death of those with learning disabilities, to give indications of possible preventability (e.g. lung problems/epilepsy). Need to improve systems around health checks to address the recent drop in uptake.<br><br>• There needs to be access to **high quality care and support services and suitable accessible housing** in order to ensure that tri-borough |

| | |
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| | Adult Social Care departments keep people in the community rather than placing them in residential care. Examine residential care placement costs in Kensington and Chelsea and Westminster, which routine data suggests are high. Extra Care Sheltered (ECS) placements, and more accessible accommodation is likely to be needed across all the boroughs. In accordance with the Winterbourne View Concordat, those in hospital placements should be moved out of hospitals by June 2014, unless being actively treated in hospital<br><br>• The recent drop in existing clients **receiving a review** needs to be examined and addressed<br><br>• Ensure that work with general practice and hospital trusts is **addressing issues raised by local families** and review current local strategies and action plans around **carers** |
| Lead responsibility | Adult Social Care, The Joint Commissioning Team |
| Progress to date | In response to the findings from the JSNA the following information has been provided:<br><br>Work is well underway in both local acute trusts on **identification of people with Learning Disabilities.** Work has been undertaken to identify the numbers of people with learning disability coming through transition, each team is aware of the numbers expected and is currently mapping out specific levels of need. There has been a significant increase in primary care identification of people with learning disabilities in Hammersmith and Fulham to more than 80%, the model is currently being explored in Westminster and Kensington and Chelsea.<br><br>Work to **tackle obesity** is being completed through primary care and the local community learning disability teams in conjunction with local leisure providers. The Health Action Plan from the annual health check identifies specific area of health need including obesity and this will drive opportunities for exercise.<br><br>A Secondary care Referral addendum has been developed to link flagging and identification of **reasonable adjustments** between primary and secondary care for people with learning disabilities.<br><br>Too **address data quality issues** around numbers attending cervical and breast screening, data is collected via SystmOne reports, so there is a systematic approach, CCGs are looking at further validating this data in the coming year through the LD SAF action plan.<br><br>**Those people that are safe to move out of inpatient hospital services have been moved**. A recent report to the adult safeguarding board has provided assurance. Independent care and treatment reviews (CTR) have been completed for those without discharge dates and this is now |

| | |
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| | due to be used for the wider cohort of people still in these settings. Quantitative and qualitative information is reported back to CCG Quality patient Safety and Risk Committees on a quarterly basis.<br><br>Plans have been produced in Westminster to **address the drop in existing clients receiving a review**, Kensington and Chelsea continue to provide 100% of people with Learning Disabilities with a review and Hammersmith and Fulham achieved more than 80% of reviews in 2014/15.<br><br>**Carers** attend local hospital learning disability steering groups and people that use services and carers regularly attend and contribute to the Learning Disability Health Steering Group across the three local authority and CCG areas. This is starting to address issues raised by local families including accessible information (including appointment letters), employment, reasonable adjustments and housing. Carer primary care navigators have been piloted across the three local authority areas to help identify **carers** early vis NHS routes, putting in place systems and support to support GP practice staff to identify, signpost and support carers. |
| Future delivery | Review and recomissioning of Carer services. Learning Disability housing options such as Extra Care. |
| Risks and issues | None identified |
| Actions for Health and Wellbeing Board | None identified |

| **3. Tuberculosis JSNA** (published March 2014) | |
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| Summary | The main concern with regards to TB strategy and management is the lack of clarity surrounding the strategic planning of services. The TB Action group, which used to bring together commissioners and service providers is no longer in existence and there is no obvious successor.<br><br>The commissioning of TB services across Tri-borough now falls to the Clinical Commissioning Groups (CCGs) with input from the Health and Wellbeing Boards. This new arrangement provides opportunities for Adult Social Care, CCGs and Public Health to join up thinking and provide a TB service which addresses current issues around provision of housing for TB patients without recourse to public funds and operate across boundaries. However, currently there is no clear arrangement with regards to the TB strategy. A London TB Control Board (LTBCB) has been set up by Public Health England London and NHS England (London Region) in order to provide strategic oversight and direction and a whole systems approach. |
| Purpose | This TB needs assessment supports the development of a tri-borough strategy and Clinical Commissioning Group (CCG) commissioning intentions. |
| Recommendations | Recommendation 1: Pool staff, clinics and resources where appropriate<br><br>Recommendation 2: Consider how hospital and community services can be provided more effectively and efficiently. Strengthen the community aspect of TB management<br><br>Recommendation 3: Review current commissioning arrangements and establish specific service specification and service level agreements for TB<br>- Unbundle the components of TB service costs and establish clear service specifications and service level agreements<br>- Unify services under one provider<br>- Consider joint TB funding across regions<br><br>Recommendation 4: Establish a local pathway and programme for the management of latent and active TB<br>- Establish a latent TB screening programme<br>- Establish a clear pathway for the management of acute and latent TB in the community involving all stakeholders |

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| Lead responsibility | Connie Junghans, Public Health Analyst |
| Progress to date | In response to the findings from the JSNA, the following changes have been implemented in cooperation with the CCGs and Imperial and NHS England:<br><br>(1) The **tertiary service has been reorganised** – the JSNA found that the arrangement of providing the tertiary service via the CLCH service in particular caused concerns in terms of clinical safety as well as efficiency. Analysis showed that providing TB clinics from St Mary's was the most advantageous for patients as well as staff and substantially reduced travel time for some patients. All services have now been reconfigured to provide TB clinics out of St Mary's as well as Chelsea and Westminster hospital, with increased cooperation between the two sites to provide economy of scale in terms of specialty clinic provisions.<br><br>(2) A primary care **Latent Tuberculosis Infection (LTBI) pathway has been implemented** and started running in April to systematically identify those at highest risk of having LTBI and developing active TB in the future. |
| Future delivery | Monitoring demand and supply, particularly with regards to patients with LTBI picked up in the community by the LTBI screening programme. |
| Risks and issues | It remains to be seen how the detailed funding structure of the tertiary service will meet the challenges of community service provision such as TB incident management, contact tracing and DOT provision. Additional community service capacity may be needed in the future.<br><br>The TB Action group for the tri-borough could be re-instated for monitoring services.<br><br>There is an opportunity for Public Health to lead on coordinating TB services across council departments, CCGs and hospitals. |
| Actions for Health and Wellbeing Board | None identified |

| **4. Child Poverty JSNA** (published April 2014) | |
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| Summary | Evidence has shown that the foundations for virtually every aspect of human development are laid in early childhood, and that this has a lifelong impact on health and wellbeing, from obesity, heart disease and mental health through to educational achievement and economic status.<br><br>National research has found that child poverty in the UK results in additional public spending of £12 billion a year, 60% of which is spent on personal social services, school education, the police and criminal justice.<br><br>The report identified several key priorities for tackling child poverty:<br><br>Priority 1- Supporting families to engage with services<br>Priority 2 – Promoting parental employment<br>Priority 3 – Access to quality/affordable childcare, for all families<br>Priority 4 – Supporting the role of the school community<br>Priority 5 – Appropriate healthcare, at the right time<br>Priority 6 – All families have access to housing of a reasonable standard |
| Purpose | Discover what causes child poverty, what works in tackling child poverty, what is being done locally to alleviate the effects of it and what further opportunities there are to support those affected, beyond what is already being done. |
| Recommendations | All recommendations are linked to above priorities. |
| Lead responsibility | Children's Services with Public Health, Economic Development and Housing |
| Progress to date | Westminster is working to incorporate the findings of the JSNA into existing policy and strategy to ensure that addressing the needs of children in low incomes families is appropriately woven throughout.<br><br>*Priority 1- Supporting families to engage with services*<br>• Development of Family Information Service (FIS) is underway<br>• City for All will ensure that 50% of families on the Troubled Families programme will have resolved their re-offending, anti-social behaviour and poor school attendance.<br>• The Your Choice programme worked with over 100 gang members and at-risk young people to help them access support and |

mentoring, get into employment and training, and exit gangs.

*Priority 2 - Promoting parental employment*

- The Public Health Investment Fund is supporting the continuation and extension of the Welfare Reform Team which works with households in housing need who are affected by welfare reform, to support access to employment and prevent homelessness
- Westminster's Families and Communities Employment Service (FACES) was designed in partnership between the council, local job centres and key partners to help provide a solution.

*Priority 3 - Access to quality/affordable childcare, for all families*

- The council is working to increase availability of the national entitlement to free childcare for up to 15 hours a week for all 3-4 year olds, and for those 2 year olds from eligible families (parents on low incomes).
- The national entitlement of 30 hours of childcare a week once a child reaches their 3rd birthday will begin in September for working parents.
- The Family Information Service are planning for the take-up of tax free childcare which will be launched in Autumn 2015, targeted at working families with children under the age of 12 or with children with disabilities under the age of 17.

*Priority 4 – Supporting the role of the school community*

- The Play Service is working with Head Teachers to ensure greater access to the targeted places scheme for children in need.
- The Early Help Strategy has been agreed across all three boroughs and is informing the development and recommissioning of the new school health service
- The On Track programme is using predictive modelling to identify children (older primary and early teens) who are at risk of poor outcomes and on the cusp of care, and putting in school and family based interventions
- As part of the School Food Plan, funding was allocated to Magic Breakfast to pilot and evaluate a number of models of school breakfast club provision. Public Health worked with Magic Breakfast to identify and contact eligible schools. 12 schools with high Free School Meal eligibility across the Tri-borough have taken the opportunity to take part in this 2 year pilot, including four primary schools, six secondary schools and one Pupil Referral Unit. It will significantly expand the number of free breakfasts available to pupils.

*Priority 5 – Appropriate healthcare, at the right time*

- The CCGs launched a programme called Connected Care for Children promoting and facilitating paediatricians to share knowledge

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| | with GPs.<br>• The Community Champions project is piloting the first 'Maternity Champions' in Westminster to increase access to maternity and postnatal services to improve outcomes for women and children, particularly for BME women.<br>• Keep Smiling oral health improvement programme for 3-7 year olds has been delivered in 15 schools in Westminster. The Community Champions have provided training around oral health including sign posting residents to the dentist, and Health Visitors give Brushing for Life packs at 8/9 months and 2 ½ years and encourage the positive messages around oral health and attending a dentist.<br><br>*Priority 6 – All families have access to housing of a reasonable standard*<br>• Westminster's draft Housing Strategy sets out a commitment to reduce overcrowding through the increased supply of affordable family sized housing, and to work with the most vulnerable council tenants to reduce poor housing conditions. This includes £12m investment to address structural damp and cold in over 5,800 properties. The Strategy references the importance of sustaining programmes supporting residents into work highlighting the Families and Communities Employment Service (FACES).<br>• An award from the PHIF is being used to add capacity to enable the residential environmental health teams in all three boroughs to enable a focus on whole systems approaches to the provision of advice and support for vulnerable residents living in poor housing conditions, working in partnership with health and social care professionals and other front line providers.<br>• A separate PHIF award is being used to pilot a mechanism to ensure a similar service is systematically available for vulnerable council tenants in Westminster. |
| Future delivery | • In July the Play Service will be circulating a newsletter to all parents and service users to advise on how they will be able to access the tax-free childcare scheme that is being launched in September. We will be working in partnership with the FIS to ensure consistency in communications.<br>• The Play Service is currently developing a Summer Holiday Childcare and Play programme that will provide flexible childcare for working parents or parents seeking employment to use the service either for shorter or extended days.<br>• An innovative programme of initiatives has been approved by cabinet members in Westminster, and the detail is currently being worked up for sign off at the beginning of July. The programme comprises of a childcare academy, flexible childcare solutions and work to improve the numbers of employment opportunities with family friendly terms and conditions. Additionally, council staff are working with employment brokers to support them to improve their offer of employment for parents seeking work. |
| Risks and issues | None identified |
| Actions for Health and Wellbeing Board | None identified |

| 5. Physical Activity JSNA (published May 2014) | |
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| Summary | The estimated direct cost of physical inactivity to the NHS across the UK is £1.06 billion. This is based upon five conditions specifically inked to inactivity – coronary heart disease, strokes, diabetes, colorectal cancer and breast cancer – and this is likely to be a conservative estimate, as it does not include a range of other health conditions likely to be accountable to physical inactivity.<br><br>The data analysis indicates that although the percentage of people meeting the DH recommended levels of physical activity are higher in the three compared to England and London, there is evidence of inequalities in physical activity levels. In particular, BME groups, women, people with long term conditions and those living in the most deprived areas have low participation rates.<br><br>Nearly 250 premature deaths and 3000 new cases of diabetes per year could be prevented if all the population of the three boroughs met the recommended levels of physical activity. This would have represented a saving of over £5m for healthcare costs in 2010/11. |
| Purpose of JSNA | Designed to inform the promotion of physical activity into policies and strategies and to guide local implementation of the government programme 'Let's Get Moving – the Physical Activity Care Pathway'. |
| Recommendations | 1. In order to identify how existing community assets can be best utilised to improve participation in physical activity, an **asset mapping** approach/exercise should be undertaken in each of the boroughs to address specific or targeted needs . The community should be engaged in this exercise.<br>2. **Communications and messaging**. In order to promote physical activity participation effectively there is a need for consistent messaging pertaining to:<br>a) The definition of physical activity<br>b) Key messages regarding Department of Health recommended levels of physical activity for all age groups<br>c) The promotion of physical activity as part of everyday life including active play and transport i.e. 'everyday activity'<br><br>3. Local authorities, the NHS, and the Third Sector should take a **lead in promoting participation in physical activity across the three boroughs**. Physical activity messages should be embedded in all local statutory and voluntary sector strategies and policies that relate to health and wellbeing.<br><br>4. To ensure consistency of messaging and to improve participation levels, **GPs and other front-line health and social care workers should be offered training on giving advice on physical activity**: what it is, the benefits of physical activity, recommended levels, |

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| | and the promotion of physical activity as part of everyday life.<br><br>5. There is strong evidence that school based strategies, particularly with a family or extracurricular component, are effective in improving physical activity uptake among children and young people. In order to best inform strategy development, target and evaluate interventions, and monitor trends over time, a process should be established to **capture data in levels of physical activity and physical education in schools**.<br><br>6. Local analysis indicates that certain communities and population groups have low participation rates of physical activity, and do not meet the Department of Health recommendations. **Specific communities and groups should be targeted around the promotion of physical activity**, and access to opportunities for physical activity.<br><br>7. National guidance endorses the delivery of brief interventions for physical activity in primary care as both clinically and cost effective in the long term. The **implementation of the Lets Get Moving Physical Activity Care Pathway should be facilitated** across the Tri-borough, with the appropriate monitoring and evaluation. |
| Lead responsibility | Mary Russell, Public Health Commissioner |
| Progress to date | The Shared services physical activity action plan has been developed addressing the recommendations from the JSNA the implementation of which is overseen by the Shared Services Physical Activity Steering Group, and is also linked in with the work of each of the three local Community Sport and Physical Activity Networks (CSPANs).<br><br>The **physical activity asset mapping pilot** as part of 'Active Communities' in Westminster has been carried out in South Westminster, and is currently being undertaken in the North of Westminster and the asset mapping tool developed.<br><br>The 'f-activity' sheet with **key messages on physical activity** has been developed and there is ongoing work on a communications strategy in order to ensure consistent messaging and language pertaining to the promotion of physical activity as part of everyday life.<br><br>**Physical activity promotion training** has become an integral part of the specification for the re-commissioned Childhood Obesity Prevention Service.<br><br>**Active Champions training to support the roll out of the Lets Get Moving** (adapted from the Health Improvement Team's Making Every Contact Count Training) has been developed and the first cohort of Active Champions Trained. |

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| | The Annual Public Health Report (Shared Services) 2014/15 has a focus on physical activity. |
| Future delivery | Progress will continue through the delivery of the Physical Activity Action Plan. |
| Risks and issues | Some departments or organisations may not yet see the relevance of physical activity promotion to their work. This can be mitigated through consistency in promoting the wide ranging benefits of physical activity, as per the action plan and communications plan. |
| Actions for Health and Wellbeing Board | Support the identification of a physical activity champion, or champions, for example and elected member or other member of the HWB to ensure physical activity is embedded in all strategies and policies that relate to health and wellbeing. |

City of Westminster

# Westminster Health & Wellbeing Board

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| **Date:** | 9th July 2015 |
| **Classification:** | **General Release** |
| **Title:** | Westminster Housing Strategy Draft for Consultation |
| **Report of:** | Julia Corkey – Director of Policy, Performance and Communications<br><br>Ben Denton – Strategic Director of Growth, Planning and Housing |
| **Wards Involved:** | All |
| **Policy Context:** | Housing Strategy |
| **Financial Summary:** | There are no financial implications at this stage as the strategy is for consultation only |
| **Report Author and Contact Details:** | Cecily Herdman cherdman@westminster.gov.uk<br>020 7641 2789 |

## 1. Executive Summary

1.1 The City Council is consulting on its draft Housing Strategy until 31st July 2015 and the Board is asked for its comments. The final strategy will be published in December 2015. It has been developed over the past year with the Cabinet Member for Housing and other stakeholders. The themes were discussed with the Board in April 2014.

1.2 The strategy is closely aligned with the council's City for All vision and it is directed at encouraging prosperity for all in Westminster. It acknowledges that Housing cuts across every aspect of life and plays a key role in having a healthy, economically active and successful life and in creating high quality neighbourhoods.

1.3 Proposals include; developing 250 new affordable homes each year to meet high demand (which is above historic levels of delivery); changing planning policy so

that in new developments 60% of new affordable housing is intermediate[1] and 40% is social rented (planning policy currently asks for the reverse); addressing overcrowding in 1,000 properties over the next five years; stimulating a London wide debate on the best way to tackle homelessness in the capital; investing £12m in council housing to tackle damp and cold; working with 450 council tenants that are at risk of poor health, carrying out a review of our sheltered housing portfolio to ensure it is fit for the future and a programme of tailored intensive support to address high levels of worklessness amongst social housing tenants and applicants.

## 2. Key Matters for the Board

2.1 Health and Wellbeing Board is asked to give their views on the draft housing strategy. They are invited to answer some specific questions (set out in section 4) or to comment on any aspect of the strategy, including anything that has not been addressed.

2.2 In particular they may wish to focus on proposals which impact on health and wellbeing which are summarised in section 4. A particular challenge for the Board is how CCGs and NHSE support those in temporary accommodation better in terms of getting access to GPs and outreach services.

## 3. Background

3.1 The draft strategy has been developed over the past year with the Cabinet Member for Housing. It is not intended to review or cover aspect of housing but to make proposals where a new approach is needed. It has benefitted from review and input by the Growth Board, Health and Wellbeing Board (in April 2014 where the key themes were discussed), Executive Management Team and other stakeholders. The consultation runs until 31st July and the final strategy will be published in December 2015.

3.2 The strategy responds to independent research on the housing market, employment in social housing and on the relationship between poor quality council housing and poor health which was carried out by Public Health. It is aligned with the council's City for All vision and is directed at encouraging prosperity and choice for all in Westminster, contributing to the city's growth and enabling all residents to enjoy the benefits of that growth.

[1] Intermediate housing is housing for working households that cannot afford market housing but do not have priority for social housing

3.3 It acknowledges that Housing cuts across every aspect of life and that a good home enables a healthy, economically active and successful life and that it is important in supporting the most vulnerable and in tackling disadvantage. Also it plays a key role in creating high quality neighbourhoods.

## 4. Considerations

4.1 The Board is asked to consider the proposals in the strategy. The main proposals which relate to health and wellbeing are summarised below under each of the four themes (Homes, People, Places, Prosperity).

4.2 **Homes** – a target of 1,250 new affordable homes over five years is proposed, which is beyond past levels of delivery which average at around 180 homes each year. This will help to address high demand for all types of affordable housing[2]. Over and above this, it is proposed some out of borough affordable housing is investigated, as supply will never meet demand in Westminster. A more strategic capital-wide approach to affordable housing would improve customer choice, help to meet need and contribute to meeting London's chronic housing shortages.

4.3 A greater focus on intermediate housing[3] is proposed and it is suggested that planning policy is changed so that in future 60% of new affordable housing is intermediate and 40% is social[4]. This responds to new research which finds that 240 new intermediate homes are needed each year compared with 180 new social homes. Currently there are 3,800 households waiting for intermediate housing and 4,500 for social housing, however intermediate housing makes up only c1.5% of the stock compared with social housing which makes up 25%. The strategy also proposes new types of intermediate particularly to assist households with lower incomes that are currently not well catered for.

4.4 The aim of this policy shift is to grow the intermediate sector from this low base and to help provide a more balanced housing market which will in turn support the local and London economy.

***The Board may wish to consider if:***

- This focus on intermediate housing is right?
- The target of 1,250 new affordable over five years is reasonable? How could we do more?

[2] There are two types of affordable housing; social housing and intermediate. Intermediate housing is defined below

[3] This is housing for working households that cannot afford market housing but do not have priority for social housing

[4] Currently planning policy requires the reverse i.e. 60% of new affordable housing is social rented and 40% is intermediate

4.5 **People** – this theme considers the impact of housing on different aspects of a person's life. Two reviews are proposed; into the future housing/support needs of vulnerable people and of the council's portfolio of sheltered housing. The sheltered housing review responds to the predicted growth in the older population and issues with the stock (for example only 6% of units are wheelchair accessible and 42% are studios which are not popular). The review will look at whether sheltered housing could play a greater role in reducing cost pressures on Adult Social Care and health services in future. Discussions are underway with Public Health colleagues on incorporating these reviews into the planned Joint Strategic Needs Assessment on Health and Disability Housing Needs.

4.6 The strategy seeks to tackle poor housing conditions and acknowledges the impact they can have on health. Public Health research into whether council properties with the worst thermal performance were giving rise to the poorest health outcomes in Westminster found there to be no relationship which was unexpected. The strategy therefore proposes a two pronged approach; investing £12m to tackle cold and damp in 5,800 council homes and alongside this, working with 450 council tenants at particular risk of poor health and helping them to improve their living conditions. It also sets out how Housing will work with partners to respond to the Care Act and considers how housing services are delivered to vulnerable people and if they can be more efficient and joined up with other services.

4.7 A range of measures to tackle overcrowding in 1,000 social homes over five years is proposed and a London wide debate on the best way to manage homelessness is suggested. Westminster accepts 600 – 700 homeless households each year and has statutory duties to accommodate them. However given the high cost and shortage of land in the city, there are limited opportunities to develop new social homes to meet demand. This results in very long waits in temporary accommodation which is often out of Westminster.

***The Board may wish to consider:***

- How can housing services best help to reduce the burdens on adult social care and health services?
- How do we ensure that people in temporary accommodation, particularly those with a range of needs, are fully supported?
- Are there better ways to address London's homelessness problem? If there were a more pan London approach what would the challenge be for health services?

4.8 **Places** – this theme highlights the benefits of the current housing renewal programme, which not only provides better quality and more energy efficient

homes, but also better shops, business workspace infrastructure and community facilities. It proposes that estate renewal should become “business as usual” in future.

4.9 The strategy suggests that CityWest Homes, our housing management provider, explore partnerships with a range of organisations such as healthcare and social and employment organisations to look for ways in which customer needs could be met in one place - as housing services are often located in places where residents have a range of needs. It also proposes a “preferred partner” system whereby housing associations operating in Westminster become affordable housing partners with the council. This would mean they are supported to develop affordable housing in the city if they sign up to meeting certain standards including standards on housing condition.

***The Board may wish to consider:***

- If there are any estates that they would suggest for inclusion in a future estate renewal programme?

4.10 **Prosperity** – this theme looks at the connection between housing and the local and London economy and at ways of supporting social housing residents and applicants into jobs, as this is viewed as the best way of lifting people out of poverty. Social housing residents have lower rates of employment than people in other tenures and evidence shows they are more likely to have a physical or mental health condition which can be a barrier to employment. So, in line with the council’s wider Public Service Reform agenda, we will be providing targeted, tailored support to help the long term unemployed move towards work, with a focus on those with health conditions that have left the national Work Programme without getting work.

***The Board may wish to consider:***

- What other approaches could we consider to help address long term unemployment?

## 5. Legal Implications

5.1 A full assessment of any legal implications will be undertaken before the strategy is finalised. Initial implications are as follows:

5.2 A full Equalities Impact Assessment will need to be completed alongside the final strategy.

5.3 Out of borough temporary accommodation housing can be financed by Housing Revenue Account monies but this is controversial and not straight forward as a result of this recent case of ours.

5.4 The Supreme Court has handed down judgment in the case of *Nzolameso v City of Westminster* [2015] UKSC 22 on the question of when a local authority may lawfully provide accommodation outside its district to a household owed the 'main housing duty' under Part 7 of the Housing Act 1996. It held that it could if it had good reasons and could not offer accommodation in borough.

5.5 A local authority may only discharge its homelessness duties by securing that "suitable" accommodation is available for the applicant. Accommodation must be provided within the district of the authority "so far as reasonably practicable". The question of what is suitable has been fleshed out in the Code of Guidance (2006), the Homelessness (Suitability of Accommodation) (England) Order 2012, and associated Supplementary Guidance. The combined effect of the 2012 Order and Guidance is that local authorities are under a duty to accommodate homeless households within their district as far as reasonably practicable, and where that is not practicable must (where possible) try to secure accommodation as close as possible to where the applicant was previously living.

5.6 Section 11(2) of the Children Act 2004 requires local authorities to ensure that their functions are discharged having regard to the need to safeguard and promote the welfare of children.

5.7 As a result of this case, decision letters will need to set out what accommodation is available in borough, or nearer to the applicant's previous address and, if that accommodation is not to be offered, should set out detailed reasons for this.

## 6. Financial Implications

6.1 There are no direct financial implications as the strategy is currently a draft. A full assessment of the financial implications will be undertaken before the strategy is finalised.

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

**[Cecily Herdman – Principal Policy Officer]**

**Email: [cherdmaan@westminster.gov.uk]**

**Telephone: [ 020 7641 2789 ]**

## APPENDICES:

Westminster Housing Strategy – Draft for public consultation, Westminster City Council June 2015

Westminster Housing Strategy Summary – Draft for public consultation, Westminster City Council June 2015

## BACKGROUND PAPERS:

Ecorys: Westminster Housing Market Study. Final report to Westminster City Council
www.westminster.gov.uk/housingstrategy

Wessex Economics: Westminster Housing Market Analysis: Final Report December 2014
www.westminster.gov.uk/housingstrategy

Wessex Economics: Westminster Housing Market Analysis: Summary Report December 2014
www.westminster.gov.uk/housingstrategy

Centre for Economic and Social Inclusion Social tenants and economic wellbeing in Westminster June 2014 (this is available on request).

Public Health research into the relationship between poor health and poor quality council housing locally (this is available on request).

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City of Westminster

# Westminster Health & Wellbeing Board

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| **Date:** | *9th July 2015* |
| **Classification:** | **General Release** |
| **Title:** | *Update on the transition arrangements for the transfer of Public Health 0-5 Services - Health Visiting (HV) and Family Nurse Partnership (FNP)* |
| **Report of:** | ***The Executive Director of Adult Social Care and Health*** |
| **Wards Involved:** | *All* |
| **Policy Context:** | **The commissioning responsibility for HV and FNP services is transferring from NHS England to Local Authorities on October 2013. This follows a five year national programme of investment in health visiting and marks the final part of the overall public health transfer to local authorities.** |
| **Financial Summary:** | *The annual funding allocation for these services was published and signed off in February 2015 and will be paid as part of WCC's Public Health Grant. The annual contract value for WCC HV services is £4.1M. The annual contract value for the three borough FNP service is 350K, and has been apportioned according to each Local Authority's level of need. For 2015-16 the WCC FNP allocation is £118.7K. Additionally a recurrent commissioning resource of £30K PA has been allocated to LAs to reflect this additional new responsibility.* |
| **Report Author and Contact Details:** | *Julia Mason Families & Children's Public Health Commissioner*<br>*Tel: 020 7641 4653*<br>*E-mail: jmason@westminster.gov.uk* |

## 1. Executive Summary

1.1 Health Visiting is a universal preventative service that delivers the Healthy Child Programme 0-5 (HCP) and provides expert health and wellbeing advice, support and interventions to families with children in the first years of life. Family Nurse Partnership is a targeted programme providing intensive support to vulnerable first time young mothers from early pregnancy to when their child is two.

1.2 In January 2014 the Government confirmed that the Healthy Child Programme (HCP) for 0-5 year olds, which includes the commissioning of health visitors and family nurses, would transfer to local government on 1st October 2015. These services are now referred to as Public Health Children's Services for 0-5 year olds.

1.3 It is only the commissioning that will transfer and not the workforce. Health Visitors and Family Nurses will continue to be employed by the same provider organisation, which for WCC is Central London Community Healthcare NHS Trust (CLCH).

1.4 The transfer marks the final part of the overall public health transfer and will join up commissioning for 0 to 19 year olds to improve service continuity for children and their families. It also presents a unique opportunity to support delivery of WCC's Health Well Being Board's 'Best Start in Life' priority to transform and integrate early years' services to improve outcomes for pregnant women, children and families

## 2. Key Matters for the Board

2.1 HWBB Members are asked to note the progress update and to consider the opportunities provided by the transfer of these services to support the Council's 'Best Start in Life' strategic ambitions.

## 3. Background

3.1 The Department of Health has mandated local authorities to provide five universal elements of the Healthy Child Programme (HCP) to ensure a national, standard format for universal coverage of these elements

- antenatal health promoting visits
- new baby review six to eight week
- maternal mood assessment
- one year assessment
- two to two and a half year review

3.2 These requirements will be subject to a 'sunset clause' at 18 months. A review involving Public Health England will be undertaken in October.

3.3 The following commissioning responsibilities will be retained by NHS England:

- Child Health Information Systems (CHIS) in order to improve systems nationally. The CHIS ensures that each child in England has an active health care record and supports the delivery of national screening and immunisation

programmes as well as the Healthy Child Programme. This will be reassessed in 2020.

- The six to eight week GP check (also known as the Child Health Surveillance) because of its complex commissioning arrangements.

3.4 A national Health Visitor Transition task and finish group has been leading on the transfer arrangements. The Executive Director of Children Services has been part of this group since its establishment. NHS England London Area Team and London Councils also recruited a transition lead to support the process.

3.5 A local transition team of Public Health and Family and Children's Senior Managers and Commissioners has worked with the London Area Team lead since July 2014 to establish the local contract transfer arrangements.

3.6 Locally, a multi-agency Health Visitor Partnership Group of representatives from Clinical Commissioning Groups, NHS England London Area Team, LA Public Health and Children Services is overseeing the safe transfer of the service and contributing to the development of commissioning intentions for a new integrated service model.

3.7 Information governance arrangements are in place so that our provider CLCH is able to share information and data submitted to NHS England about the current level of performance, enabling WCC to know the pre-transfer baseline. The performance data is currently provided on a CCG basis, but from October 1st the requirement is that it will be reported on a local authority basis. Initial analysis of the 2014-15 Q4 data shows that the WCC health visiting service is meeting performance requirements for the mandated elements of the HCP.

3.8 The regulations make it clear that there is no expectation of an uplift in performance at the point of transfer, and that councils will only be expected to take a reasonably practicable approach to delivering the mandated elements of the Healthy Child Programme and to continuous improvement over time.

3.9 The Family Nurse Partnership reports directly to the National FNP Unit and their performance data is made available and reviewed quarterly through the local multi-agency FNP Advisory Board. The FNP has demonstrated significantly improved outcomes for vulnerable young mothers and their children and performance is good.

## 4. Options / Considerations

4.1 From the 1st October both HV and FNP will be commissioned to deliver against the standard national service specification, which include clear outcome measures and KPIs, until a new service is re-commissioned during 2016-17.

4.2 WCC's HWBB's Best Start in Life and Early Help Strategy are informing the development of an integrated early years' service model for future 0-5 services with a shared outcomes framework. This is being developed jointly with CCGs, Local Authority Public Health and Children's and Families' Services, service providers and other key stakeholders.

4.3 The proposed model will bring together a universal, targeted and enhanced offer into a single pathway, with an emphasis on identifying need much earlier and more systematically across all early years' services.

4.4 It is proposed that a range of targeted services will be part of the Children's Centre core offer, providing a resource to the universal early years' service, and be an integral part of the early years' pathway. An enhanced pathway will also be developed for families under pressure.

4.5 An integrated early years' service will work closely with maternity and primary care services and continue to provide a named HV and regular liaison with GPs

4.6 Benefits of this approach will include an integrated approach to supporting families from an early stage, a team of staff wrapped around GP practices that can provide extra support, and improved outcomes for maternal well-being and child development, with fewer consultations on non-medical issues and less pressure on A&E and out-patient appointments.

4.7 The Best Start in Life Programme Board is overseeing the strategic development of this work and the LBHF Best Start in Life Work Group is reviewing current care pathways, customer journeys and good practice to develop a local multiagency service offer with shared aims and outcomes.

4.8 A series of Best Start in Life Partner Workshops, facilitated by the Early Intervention Foundation, have been arranged to support engagement of all partners in developing an integrated model and pathways.

## 5. Legal Implications

5.1 NHSE issued contract transfer guidance in February 2015 and based on legal and contractual advice it was agreed that WCC would issue a new local authority contract for these services from 1st October 2015.

5.2 Approval of a direct contract award to the current provider is being sought to allow sufficient time for a review of current services and the development of commissioning intentions for a new integrated early years' model.

## 6. Financial Implications

6.1 In December 2014 the Department of Health published the proposed half year funding allocations for HV and FNP services on transfer to LAs in October 2015. The final WCC HV annual funding allocation of £4.1M was published and signed off in February 2015.

6.2 The contract value matches expectations and is considered sufficient to deliver the mandated elements of the service. It includes a growth element for increased HV workforce for 2014 -15 as part of the Government's Agenda for Change. A recurrent commissioning resource of £30K PA per borough is also included in the allocations, proportionately 15K for WCC in 2015-16.

6.3 Additionally, the total funding allocation of £350K PA for the three borough West Central London FNP service is being apportioned to reflect each local authority's level of need, based on a three year average of the number of births to teenage mothers in each local authority. It will be adjusted annually where there is a significant change in proportion. For WCC the annual contribution to this shared service is £118,788.

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

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**BACKGROUND PAPERS:**

National Health Visiting Core Service Specification
http://www.england.nhs.uk/wp-content/uploads/2014/12/hv-serv-spec-dec14-fin.pdf

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City of Westminster

# Westminster Health & Wellbeing Board

| | |
|---|---|
| **Date:** | **9th July 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**<br>**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 brief reminder of the context of the BCF, an update on progress is provided against the six national conditions specified as expectations for BCF implementation. An overview of the way that progress with local plans will be reported nationally is then given, along with a summary of spend against the additional funds provided in Westminster for BCF implementation planning in 2014/15 and a reminder of funding arrangements in 2015/16.

## 2. Key Matters for the Board

*2.1* The Health and Wellbeing Board is asked to note:

a) progress of the BCF programme against the national conditions;

b) expectations for local reporting to inform national progress;

c) focus of spend for additional funds for the BCF programme in 2014/15.

## 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. It is a national initiative to improve health and social care outcomes and cost-effectiveness, with an emphasis on more care at and near home.

## 4. Progress Update

*4.1* Reviewing progress against six national conditions is an important measure of delivery, and is one of the ways in which success of the BCF will be monitored.

***Background to the National Conditions***

*4.2* The national conditions were set out as requirements for BCF plans, and help to shape the focus for BCF delivery. They reflect national policy and priorities but need to be achieved through local implementation planning.

*4.3* The ability of BCF plans to fulfil these conditions informed the *Nationally Consistent Assurance Review*, which was the process by which plans were approved. This update reflects on progress in the Triborough against each of the conditions. A full description of the conditions can be found in Appendix 1.

***Condition 1: Are plans jointly agreed between health and social care?***

*4.4* The Triborough BCF plan is owned by the Health and Wellbeing Boards and overseen by a local BCF Board, comprising Cabinet Members for Health & Social Care, CCG Chairs, the Director of Adult Social Care and the Chief Officer of the CCGs. The Chief Executive of the acute provider leading delivery of the principal scheme (with partners across acute, community and primary healthcare) also attends part of the regular board meetings. Delivery is led by the executive teams for health and social care, which regularly meet jointly and are supported by a steering group of the officers responsible for BCF schemes.

***Condition 2: Are Social Care Services (not spending) protected?***

*4.5* The Triborough plan seeks to protect social care services by ensuring that those most in need within the local communities continue to receive the necessary support, despite growing demand and budgetary pressures. To do this, new forms of joined up care are being developed which help ensure that individuals remain healthy and well, and have maximum independence. The main focus for this is additional investment in health and social care through the Community Independence Service (CIS) to enhance rapid response, hospital in-reach, rehabilitation and reablement services, reducing hospital admissions and residential / nursing home admissions. There is additional health investment in social care in 15/16 to support this programme.

***Condition 3: Are 7-day services to support patients being discharged and prevent unnecessary admission at weekend in place and delivering?***

*4.6* An overarching 7-day services programme is in progress across CCGs in North West London. Extended hours for CIS access in the three boroughs complements this, and has been supported by alignment of winter resilience funding with investment in CIS requirements since April.

*4.7* CIS rapid response, reablement and hospital in-reach staff across the three boroughs already work on a 7-day rota, but the new integrated service aims to develop a single model of care to replace variable specifications across existing services which will help to achieve a joint approach to assessments and care planning. Further 7-day working requirements will be agreed and rolled out after CIS service design and staff consultation.

*4.8* BCF planning for 7-day services to support CIS is also supporting review of enhancements to social work components of hospital discharge. Again, 7-day social work and health discharge processes are already in place but further work is underway to enhance and standardise some of the processes across the three boroughs and integrate health and social care functions. The BCF 7-day social work discharge project is currently piloting some of these enhancements and a decision will be taken in summer 2015 as to how and what to roll out more widely.

***Condition 4i: In respect of data sharing, is the NHS Number being used as the primary identifier for health and care services?***

*4.9* There has been good progress, and work is nearing completion to link the principal adult social care system (Frameworki) with the NHS Spine, a set of national services used by the NHS Care Record Service. However, there is more to do to enable seamless working across core systems in health and social care.

***Condition 4ii: In respect of data sharing, are open APIs being pursued (i.e. systems that speak to other each)?***

*4.10* Systems inter-operability is being pursued and ways of increasing information flows are being developed to address practical issues associated with implementation of different BCF schemes. This includes identifying the steps towards an integrated patient record for CIS and a common assessment process for hospital discharge. However, there are not simple solutions to some systems differences and there is more to do to enable seamless working across core systems in health and social care.

***Condition 4iii: In respect of data sharing, are appropriate information governance controls in place for information sharing in line with Caldicott 2?***

*4.11* A programme of work has been undertaken to achieve Level 2 compliance with the Department of Health's Information Governance Toolkit across the Triborough. This will be supported by further training and audit. BCF funding is helping to enable appointment of a Caldicott Support Manager to assist joint working, and ongoing work is identifying and finding ways to resolve information governance issues arising from increased integration. Where necessary, this includes additional documentation to support effective data sharing.

***Condition 5: Is a joint approach to assessments and care planning taking place and, where funding is being used for integrated packages of care, is there an accountable professional?***

*4.12* In progress: joint processes are developing to assess risk and plan care across health and social care teams, with review by multi-disciplinary groups followed by implementation of care planning and case management where appropriate. Our integrated plan envisages GPs taking a lead in coordinating care as the agreed accountable lead professionals for people at high risk of hospital admission, but there are details to work through and the delivery model needs agreement with stakeholders including Cabinet Members. CIS aims to develop a single model of care to replace variable specifications across existing services which will help to achieve a joint approach to assessments and care planning.

*4.13* From April 2015, CIS Single Point of Referral (SPoR) teams have been co-located and aligned, with health and social care staff working together on assessments, care planning and tasking. CIS service design is ongoing and a single assessment form which incorporates health and social care functions will be in place and incorporated into SPoR by September 2015.

*4.14* A pilot has also started to assess the benefits of a common assessment process and more integrated working between health and social care to support hospital discharge. There is currently joint assessment and care planning in place as part of the hospital discharge pilot. The team are developing an integrated discharge pathway including acute, community health and adult social care staff. This pathway will include an integrated discharge function, with a lead professional coordinating integrated assessments and care packages in the community.

***Condition 6: Is there an agreement on the consequential impact of changes in the acute sector in place?***

*4.15* BCF plans have been developed in conjunction with providers and are based on commissioning expectations for acute admission reductions. There is a clear history of non-elective reduction with main acute providers: 14/15 contracts with both main acute providers have included transformation incentives and risk sharing through income guarantees. For BCF deployment, the implementation and delivery model of transition to the integrated Community Independence Service has Imperial College Healthcare NHS Trust as the lead health provider, supported by partners that include Chelsea & Westminster Hospital NHS Trust.

## 5. National Reporting Expectations

*5.1* NHS England is coordinating receipt of quarterly progress updates on delivery of BCF plans. This will be via standardised templates which will vary each quarter, but will maintain a core focus on the national conditions and the BCF's key outcome measures (such as reduction in non-elective admissions).

*5.2* The next template will be circulated in early July for return by the end of August. As the Westminster Health and Wellbeing Board is not due to meet again until after submission of the next quarterly return, it is proposed that a draft of the template response will be prepared for review and approval by the Health and Wellbeing Board Chair. An update on the response will be provided to the Board in September.

## 6. Expenditure in 2014/15

*6.1* The BCF did not come into full effect until April 2015/16, but £200m of NHS funding was made available to Health and Wellbeing Boards in 2014/15 to plan changes to health and social care that would support the expectations of the BCF plan.

*6.2* Westminster Health and Wellbeing Board's share of this £200m was £1.103m, and the table below shows how this funding was used (together with allocations for Kensington & Chelsea and Hammersmith & Fulham) to support planning and implementation across the schemes in the Triborough BCF plan in 2014/15. Part of the total has been carried over from 2014/15 to continue with implementation planning in 2015/16:

| **BCF 14/15 Spend** | **£k** |
|---|---|
| Implementation Planning | |
| Group A - Integrated Operational Services (CIS, Neuro Rehab, Homecare, Hospital Discharge) | 366 |
| Group B - Patient / Service User Experience (Patient/Service User Experience, Self-Care, Personal Health Budgets, Community Capacity) | 87 |
| Group C - Integrated Commissioning / Contracting (Nursing/Residential Contracting, Jointly Comissioned Services, Integrated Commissioning) | 92 |
| Group D - Delivery Enablers (IT Integration, Information Governance, Care Act Implementation) | 166 |
| Programme Management | 241 |
| ***Sub-total*** | 952 |
| **BCF 14/15 Carry Over to 15/16** | |
| Implementation Planning | |
| Group A - Integrated Operational Services (CIS, Neuro Rehab, Homecare, Hospital Discharge) | 17 |
| Group B - Patient / Service User Experience (Patient/Service User Experience, Self-Care, Personal Health Budgets, Community Capacity) | 30 |
| Group C - Integrated Commissioning / Contracting (Nursing/Residential Contracting, Jointly Comissioned Services, Integrated Commissioning) | 13 |
| Group D - Delivery Enablers (IT Integration, Information Governance, Care Act Implementation) | 91 |
| ***Sub-total*** | 151 |
| **Total** | 1,103 |

## 7. Funding in 2015/16

*7.1* Under the NHS Mandate for 2015/16, NHS England was required to ring-fence £3.46 billion within its overall allocation to Clinical Commissioning Groups to establish the BCF (adding to the Social Care Capital Grant and the Disabled Facilities Grant, both of which are paid directly from the Government to local authorities). BCF allocations to local areas are based on a framework agreed with Ministers, and the local share for Westminster is £18.203m. This local share of the fund flows via CCG allocations (£13.553m from Central London CCG and £4.650m from West London CCG) into a pooled budget that may then be dispersed to individual organisations to carry out their parts in the BCF plan. An update on use of the 15/16 fund will be provided to the next meeting.

**If you have any queries about this Report please contact:**

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## Appendix 1: The 6 National Conditions – Full Descriptions

### 1) Plans to be jointly agreed

The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Round, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and councils should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.

### 2) Protection for social care services (not spending)

Local areas must include an explanation of how local adult social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013/14: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

### 3) As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The recent national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England provided guidance on establishing effective 7-day services within existing resources.

**4) Better data sharing between health and social care, based on the NHS number**

The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.

Local areas should:

• confirm that they are using the NHS number as the primary identifier for health and care services, and if they are not, when they plan to;

• confirm that they are pursuing open APIs (i.e. systems that speak to each other); and

• ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place.

NHS England has already produced guidance that relates to both of these areas. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by DH).

**5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional**

Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals. The Government has set out an ambition in the Mandate that GPs should be accountable for co-ordinating patient-centred care for older people and those with complex needs.

**6) Agreement on the consequential impact of changes in the acute sector**

Local areas should identify, provider-by-provider, what the impact will be in their local area, including if the impact goes beyond the acute sector. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans must not have a negative impact on the level and quality of mental health services.

*Descriptions are taken from the NHS England Quarterly Data Collection Template.*

City of Westminster

# Westminster Health & Wellbeing Board

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|---|---|
| **Date:** | Thursday 9 July 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 has brought CCGs into the commissioning of local GPs services and, through this, enables them 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<br>Lead for primary care co-commissioning, North West London primary care transformation programme<br>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 May 2015. The report submitted to that month's meeting explained the policy context for co-commissioning, including the vision for primary care development across North West London, and described the governance arrangements and next steps.

*1.2* The first meeting of the Central London CCG joint co-commissioning committee took place on 21 May 2015 as a private seminar, in common with the meetings of the joint committees of the other CCGs in North West London.

*1.3* An invitation has been extended by the CCG to Westminster Health & Wellbeing Board to nominate a representative to attend future meetings as a non-voting advisor.

## 2. Key Matters for the Board

*2.1* Board members are asked to note the topics covered at the seminar on 21 May 2015 and 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

*3.1* Primary care co-commissioning launched in Westminster (and across North West London) on 1 April 2015. This followed a period of intense engagement with local GPs and a CCG membership vote emphatically in favour of taking this step.

## 4. Considerations

*4.1* Dr Amol Kelshiker who is clinical co-lead for co-commissioning in NWL, ahead of the appointment of a permanent Lay Member Chair to the Primary Care Co-commissioning Joint Committees, chaired the Joint Committees seminar on 21 May 2015. He opened the session by reminding members that the scope of the committees' work has the potential to drive forward radical change in local primary care, in terms both of service improvement and support of other transformational work. He also set out the committees' approach to declarations of interests.

*4.2* Dr Ruth O'Hare, who is Dr Kelshiker's co-lead, then gave a presentation on the local context and purpose of primary care co-commissioning in North West London. This set out why the CCGs have pursued co-commissioning and what patient benefits should be anticipated.

*4.3* The committees also discussed a series of proposed revisions to their terms of reference, designed to reflect updated national guidance and conversations across the CCGs that have taken place since the original version was agreed in March 2015. At all times, the terms of reference is reviewed and agreed jointly amongst the CCGs including Lay Members, Londonwide Local Medical Committee (LMC) and NHS England (NHSE).

*4.4* Finally, NHSE presented its plans for implementing the national review of Personal Medical Services (PMS) contracts in North West London, including patient benefits, engagement, timelines, and proposed next steps.

*4.5* Members of the public are invited to observe future meetings of the co-commissioning joint committee and can submit in advance questions related to agenda items. Full details are contained within the meeting agendas, which are contained in the co-commissioning section of the CCG's website.

## 5. Legal Implications

*5.1* The co-commissioning structures 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 of this report (although the co-commissioning joint committee 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

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# Westminster Health & Wellbeing Board
# Work Programme
# 2015 / 2016

**KEY**
**FOR DECISION**
**FOR DISCUSSION**
**FOR INFORMATION**
**PLANNING**

| Agenda Item | Summary | Lead | Item |
|---|---|---|---|
| **Meeting Date 9th July 2015: JSNA, WIDER DETERMINANTS** | | | |
| NHSE England | Presentation on implementing the Five Year Forward View, NHSE priorities and maximising the role of NHS England on Health and Wellbeing Boards | NHS England | For discussion |
| WESTMINSTER HOUSING STRATEGY | Discussion on the consultation draft of the Westminster Housing Strategy | Exec Director of GPH | For discussion |
| JSNA PROGRAMME | Discussion of the current JSNA programme and the use of remaining resource. | Deputy Director of Public Health | For discussion |
| PRIMARY CARE CO-COMMISSIONING | Update on Primary Care Co-Commissioning | Chair of CLCCG | For information |
| BETTER CARE FUND | Update on implementation Better Care Fund | Exec Director of ASC | For information |
| TRANSFER OF PUBLIC HEALTH 0 – 5 YEARS | Preparations underway for the transfer of health visiting from NHS England to the local authority | Public Health | For information |

**PRIVATE WORKSHOP (July 9th)**

| | | | |
|---|---|---|---|
| HEALTH AND WELLBEING BOARD DEVELOPMENT | Roles and responsibilities of members and developing system leadership | Chairman | For discussion |

| Agenda Item | Summary | Lead | Item |
|---|---|---|---|
| **Meeting Date TBC September 2015: 2016/17 COMMISSIONING** | | | |
| COMMISSIONING AND VISION WORKSHOP | Key commissioning themes from CCG and local authority | Exec Director of ASC | Presentation and guided discussion |
| | Key messages from Adult and Children Safeguarding Boards, Children's Trust and other partnership groups | | |
| | Key messages from Patients and Service Users | | |
| | Refreshing the Joint Health and Wellbeing Strategy | | |
| DEMENTIA | Review and endorsement of Dementia JSNA<br><br>Discussion about how this informs the North West London Dementia Strategy | Director of Public Health and Chairs of CCGs | For decision |
| END OF LIFE CARE | Review and endorsement of Joint Strategic Needs Assessment | Director of Public Health | For decision |
| *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* |
| BETTER CARE FUND | Update on implementation Better Care Fund | Exec Director of ASC | For information |
| PRIMARY CARE CO-COMMISSIONING | Update on development of Primary Care Co-Commissioning | Chairs of CCGs | For information |

| Agenda Item | Summary | Lead | Item |
|---|---|---|---|
| **Meeting Date 19th November 2015: SYSTEM IMPROVEMENT** | | | |
| MENTAL HEALTH | Case for change - NWL Mental Health and Wellbeing Strategic Plan (If ready)<br><br>Update on the developing vision for Children and Young People's Mental Health and Wellbeing | NWL CCGs | For discussion |
| BETTER CARE FUND 2016/17 | Discussion around developing a local plan for the Better Care Fund 2016/17 | Exec Director of FCS | For discussion |
| SAFEGUARDING | System change required as a result of the LSCB Annual Report and the ASB Annual Report | Chairs of Safeguarding Boards | For discussion |
| WHOLE SYSTEMS AND BETTER CARE FUND PERFORMANCE | First report on metrics and performance data relating to delivery of the Better Care Fund Plan and Whole Systems Integration | Exec Director of ASC<br><br>CCGs | For discussion |
| WORKING IN PARTNERSHIP ACROSS SUB-REGIONAL LEVEL | Discussion to identify how the Health and Wellbeing Board can take responsibility for developing sub-regional partnerships | Chairman | For discussion |
| BETTER CARE FUND | Update on implementation Better Care Fund | Exec Director of ASC | For information |
| PRIMARY CARE CO-COMMISSIONING | Update on development of Primary Care Co-Commissioning | Chairs of CCGs | For information |
| PRIMARY CARE PROJECT | Update on the Westminster HWB Primary Care Modelling Project | TBC | For information |

| 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 decision |
| HEALTH AND WELLBEING HUBS | Discussion on the Outline Business Case for the development of Health and Wellbeing Hubs in Westminster | Chairman of the Health and Wellbeing Board | 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* | | | |
| BETTER CARE FUND | Update on implementation Better Care Fund | Exec Director of ASC | For information |
| PRIMARY CARE CO-COMMISSIONING | Update on development of Primary Care Co-Commissioning | Chairs of CCGs | For information |
| **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 in 2015/16 and sign-off of Better Care Fund plan for 2016/17 | Exec Director of ASC | For decision |
| *AVAILABLE SLOT* | | | |
| *AVAILABLE SLOT* | | | |
| *AVAILABLE SLOT* | | | |
| BETTER CARE FUND | Update on implementation Better Care Fund | Exec Director of ASC | For information |
| PRIMARY CARE CO-COMMISSIONING | Update on development of Primary Care Co-Commissioning | Chairs of CCGs | For information |