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City of Westminster

Committee Agenda

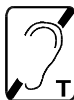
Title:	**Health & Wellbeing Board**
Meeting Date:	**Thursday 26th May, 2016**
Time:	**4.00 pm**
Venue:	**Rooms 3 and 4, 17th Floor, City Hall, 64 Victoria Street, London, SW1E 6QP**

Members:

Name	Role
Councillor Rachael Robathan (Chairman)	Cabinet Member for Adults & Public Health
Dr Neville Purssell	Central London Clinical Commissioning Group
Councillor Danny Chalkley	Cabinet Member for Children and Young People
Councillor Barrie Taylor	Minority Group
Eva Hrobonova	Tri-borough Public Health
Liz Bruce	Tri-borough Adult Social Care
Melissa Caslake	Tri-borough Children's Services
Barbara Brownlee	Housing and Regeneration
Dr Philip Mackney	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.



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Tel: 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 - 20)**

I) To agree the Minutes of the meeting held on 17 March 2016.

II) To note progress in actions arising.

4. DRAFT JOINT HEALTH AND WELLBEING STRATEGY AND NORTH WEST LONDON SUSTAINABILITY AND TRANSFORMATION PLAN UPDATE **(Pages 21 - 70)**

To consider an update on the draft Joint Health and Wellbeing Strategy Refresh and the North West London Sustainability and Transformation Plan.

5. BETTER CARE FUND PROGRAMME 2016/17 **(Pages 71 - 128)**

To consider an update on the Better Care Fund Programme 2016/17.

6. PRIMARY CARE MODELLING **(Pages 129 - 136)**

To consider an update on the Primary Care Modelling project.

7.	**HEALTH AND WELLBEING HUBS** To consider an update on the Health and Wellbeing Hubs programme.	**(Pages 137 - 144)**
8.	**SHARED SERVICES FEMALE GENITAL MUTILATION PREVENTION PROJECT** To consider a report on the Shared Services Female Genital Mutilation Prevention Project.	**(Pages 145 - 156)**
9.	**COMMUNITY INDEPENDENCE SERVICE PROCUREMENT** To consider a report on the Community Independence Service procurement.	**(Pages 157 - 162)**
10.	**MINUTES OF THE JOINT STRATEGIC NEEDS ASSESSMENT STEERING GROUP MEETING HELD ON 4 APRIL 2016** To note the Minutes of the Joint Strategic Needs Assessment Steering Group meeting held on 4 April 2016.	**(Pages 163 - 166)**
11.	**WORK PROGRAMME** To consider the Work Programme for 2016/17.	**(Pages 167 - 170)**
12.	**ANY OTHER BUSINESS**	

Charlie Parker
Chief Executive
19 May 2016

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CITY OF WESTMINSTER

MINUTES

Health & Wellbeing Board

MINUTES OF PROCEEDINGS

Minutes of a meeting of the **Health & Wellbeing Board** held on **Thursday 17th March, 2016**, Rooms 3 and 4 - 17th Floor, City Hall, 64 Victoria Street, London SW1E 6QP.

Members Present:
Chairman: Councillor Rachael Robathan, Cabinet Member for Adults and Public Health
Clinical Representative from the Central London Clinical Commissioning Group: Dr Paul O'Reilly (acting as Deputy)
Cabinet Member for Children and Young People: Councillor Karen Scarborough (acting as Deputy)
Minority Group Representative: Councillor Barrie Taylor
Acting Director of Public Health: Eva Hrobonova
Tri-borough Director of Children's Services: Liz Bruce
Clinical Representative from West London Clinical Commissioning Group: Dr Philip Mackney
Chair of the Westminster Community Network: Jackie Rosenberg

1 MEMBERSHIP

1.1 Apologies for absence were received from Janice Horsman (Healthwatch Westminster), Dr David Finch (NHS England) and Dr Eva Larsson (NHS England).

1.2 Apologies for absence were also received from Dr Neville Purssell (NHS Central London Clinical Commissioning Group) and Councillor Danny Chalkley (Cabinet Member for Children and Young People). Dr Paul O'Reilly (NHS Central London Clinical Commissioning Group) and Councillor Karen Scarborough (Deputy Cabinet Member for Children and Young People) attended as their respective Deputies.

1.3 Matthew Bazeley (Managing Director, Central London Clinical Commissioning Group) and Louise Proctor (Managing Director, West London Clinical Commissioning Group) also gave their apologies for absence. Philippa Mardon (Interim Deputy Managing Director, NHS Central London Clinical Commissioning Group) and Simon Hope (Deputy Managing Director, West London Clinical Commissioning Group) attended as their respective Deputies.

1.4 In recognising that many areas of the Board's work involved housing matters, Members agreed that the Director of Housing and Regeneration be appointed onto the Board.

1.5 **RESOLVED:**

That the Director of Housing and Regeneration be appointed onto the Westminster Health and Wellbeing Board.

2 DECLARATIONS OF INTEREST

2.1 No declarations were received.

3 MINUTES AND ACTIONS ARISING

3.1 **RESOLVED:**

1. That the Minutes of the meeting held on 21 January 2016 be approved for signature by the Chairman; and

2. That progress in implementing actions and recommendations agreed by the Westminster Health and Wellbeing Board be noted.

3.2 The Board noted that it had received a briefing providing an update on the Shaping a Healthier Future programme prior to the start of this meeting.

4 WESTMINSTER HEALTH AND WELLBEING STRATEGY REFRESH UPDATE

4.1 The Chairman introduced the item and emphasised that the strategy refresh was particularly critical in terms of the need for it to feed into NHS England's five year Sustainability and Transformation Plan (STP). Members then received a detailed presentation from Philippa Mardon (Interim Deputy Director, NHS Central London Clinical Commissioning Group), Meenara Islam (Principal Policy Officer) and Phoebe Morris-Smith (Policy Officer). The Board heard that the strategy identified North West London as its 'place' and there would be close collaboration, co-design and co-development of services between the Board and its partner organisations. The strategy was to be considered in the context of the Council's City for All vision, the STP, devolution of health services at pan London and North West London levels, and population changes which would influence the disease burden.

4.2 In terms of the strategy's direction of travel, Members noted that prevention and a whole systems approach would be taken and the Board was to have greater system leadership to ensure that the strategy was being developed. The strategy was to remain consistent with the national vision for health and wellbeing. A population group approach was also to be taken with life stage and health status helping to identify those groups that should be prioritised and the appropriate action taken. Robust evidence also needed to be collected and this would be achieved through measures such as deep drive

joint strategic needs assessments and the primary care modelling project. Both health sector intelligence and community sector intelligence, such as from Healthwatch, would also be used to gather relevant data and the evidence base was expected to be completed by the end of March. Members were informed that use of technology would be maximised to help move services forward, such as GPs using Skype to talk to patients, and it was recognised that a large segment of the population wanted to use technology in accessing services.

4.3 Meenara Islam then drew Members' attention to the timetable for completing the strategy refresh as circulated at the meeting. There were three phases to completing the refresh, with phase 1, evidence analysis and theme development, largely completed. Phase 2 would seek to agree and finalise content themes and priorities and provide targeted engagement with a view to producing the first draft of the strategy refresh for the next Board meeting on 26 May. During the course of phase 2, a Health and Wellbeing Board workshop would take place on 5 April and a stakeholders meeting, including service users and patient groups, on 13 April. Phase 3 would involve consultation on the draft strategy and culminate in the publication for the final strategy refresh which was due in mid-October or early November.

4.4 During discussion, the Chairman acknowledged that the timescales for completing the strategy refresh were tight, however this was due to it having to also meet the STP deadlines. She emphasised that phase 2 was particularly critical in developing the strategy refresh and advised that the evidence base would be available before the Health and Wellbeing Board workshop. In noting that the strategy refresh's link to NHS England's STPs, a Member emphasised the importance in ensuring that the Westminster voice was heard. Another Member commented that the long term future for carers should be mentioned in phase 2 of the strategy refresh. In respect of drug and alcohol services, he acknowledged that there were budgets for these for both the NHS and Public Health. However, Public Health was not bound by the same consultation requirements as the NHS and he felt that it was desirable that the Public Health consultation be reasonably similar. He also suggested that Queens Park Community Council be approached in respect of providing intelligence from the community sector.

4.5 A Member acknowledged that sound self-management was fundamental to the success in delivering services. She felt that the strategy refresh lacked setting out the significant role that voluntary and community organisations could play in helping to deliver services. Whilst NHS West London Clinical Commissioning Group (CCG) did engage with voluntary and community organisations, she felt that there was room for improvement for NHS Central London CCG in this area.

4.6 In reply to the issues raised, Philippa Mardon advised that the tri-boroughs and the CCGs were both working together and separately in terms of developing health and wellbeing strategies. The Chairman advised that three priorities needed to be submitted in respect of the STP by 24 March. However, this presented an opportunity for the Westminster voice to be heard and in order to achieve this, a strong and robust piece of work with significant

engagement was required. The Chairman reiterated that Members should take into consideration the challenging timescales and she emphasised the importance of attending the health and wellbeing workshop. Meenara Islam agreed to circulate details of the proposals discussed at an engagement plan meeting involving Council and CCG colleagues.

5 NHS CENTRAL LONDON CLINICAL COMMISSIONING GROUP INTENTIONS

5.1 Philippa Mardon presented the report and advised that the allocation of funding for NHS Central London CCG for 2016/17 meant that there was a financial gross gap of £17m that needed to be met which would present a considerable challenge. The CCG would need to address both short term and long term problems, however it was working closely with its partners in its commissioning intentions and efforts were being focused in areas such as mental health and new models of care. Philippa Mardon emphasised that the CCG was committed to creating a sustainable future.

6 NHS WEST LONDON CLINICAL COMMISSIONING GROUP INTENTIONS AND CORPORATE OBJECTIVES

6.1 Simon Hope (Deputy Managing Director, NHS West London Clinical Commissioning Group) presented the report and advised that initial commissioning intentions for 2016/17 had been produced in October 2015. The commissioning intentions were similar to those in 2015/16 and were part of a five year plan. Simon Hope advised that the final corporate objectives, including the commissioning intentions, would be presented to the CCG's Governing Body in April 2016.

6.2 Members then discussed both NHS Central London and NHS West London CCGs' commissioning intentions and plans. Mike Robinson (Tri-Borough Director of Public Health) commented that the two CCGs' reports differed quite considerably in format and content and in noting the financial details contained in the NHS Central London CCG report, he enquired whether there was a standard format for CCGs in reporting their commissioning intentions. Members sought further explanation as to the £17 million funding gap for NHS Central London CCG. It was also commented that the NHS West London CCG report did not have any specific reference to children's mental health, although this was a Board and Government priority.

6.3 In response to the issues raised, Philippa Mardon advised that the reasons for the £17 million financial gap for NHS Central London CCG were being investigated and was partly attributable to the level of funding it had received for 2016/17, the increases in the critical care bill and in activity generally across the CCG. She added that possible explanations would continue to be scrutinised. Simon Hope advised that the NHS West London CCG report did not include all details of commissioning intentions and plans, however he would feedback to the CCG the point raised by Members in respect of children's mental health. He advised that it was down to the CCGs as to how they reported their commissioning intentions and corporate objectives, however efforts had been made to make the NHS Central London and NHS

West London CCG reports broadly similar. In respect of NHS West London CCG, the financial details had not yet been to the Governing Body and so this is why they had not been included in the report.

6.4 The Chairman advised that she had discussed the issue of the CCG reports with Dr Neville Purssell (NHS Central London Clinical Commissioning Group) and there would be further consideration of how these reports would be presented in future, with the aim of producing reports that were more similar in format and also more user friendly.

7 BETTER CARE FUND UPDATE

7.1 Liz Bruce (Tri-Borough Executive Director of Adult Social Care) provided an update on the Better Care Fund and advised that technical guidance had been received in respect of allocations for 2016/17 through the publication of the Government's Better Care Fund Policy Framework. She advised that the Council had agreed a council tax increase of 2% in respect of the adult social care precept.

7.2 Members sought more details on the 2% increase in respect of the adult social care precept and how was it intended to be used. It was suggested that the additional funding could be used in respect of discharge arrangements. Liz Bruce advised that the adult social care precept amounted around an additional £900,000 and there would be further consideration as to how it would be used.

8 PRIMARY CARE MODELLING PROJECT UPDATE

8.1 Rosalyn King (Director of Health Outcomes, NHS Central London Clinical Commissioning Group) introduced the report and advised that NHS Central London CCG was seeking to appoint an analyst to work on modelling the data obtained and progress was expected to be made on this in the next few months. It was hoped that there would be sufficient financial resources in 2016/17 to support the project.

8.2 Damien Highwood (Evaluation and Performance Manager) then informed Members that the care models had been presented to the London boroughs in January 2016, following a request from the Greater London Authority (GLA). The Council and other London boroughs also had the possibility of using WITAN, a city planning platform and demographic modelling tool that had been developed for the GLA. The Council was working with the GLA to see ways in which its models could be used in areas such as migration assumptions and in anticipating where new housing would be built, including the specific wards. Potentially this may also include details of the type of housing being developed. Damien Highwood added that the demographic models being developed were able to provide figures, however it was hoped that in future they would also be able to identify future needs. Mike Robinson commented that models were developing well and work would focus on forecasting key outcomes.

8.3 Rianne Van Der Linde (Public Health Analyst) then gave a presentation updating Members on progress in primary care modelling. She advised that 71% of Central London CCG registered patients were in its catchment area, 14% in NHS West London CCG's, 6% in Hammersmith and Fulham CCG's and 12% within other London CCG's catchment area. Rianne Van Der Linde advised that a patient survey undertaken in 2012-13 to identify the reasons why patients registered outside their catchment area had shown that 33% had done so because it was convenient to them, 26% had moved home and did not want to change practice, 23% had moved to the area but registered with a GP out of the catchment area, whilst 14% were dissatisfied with the practice in their area or they wanted a specific service or a particular GP. The next steps would involve analysing past trends in individual level data of NHS Central London CCG's registered population by age, sex and place of residence and developing a GP registered based primary care forecasting model.

8.4 Members enquired whether data was available on the number of patients registered under multiple identities and the reasons why 5% of the population in Westminster were not registered with GPs. Clarification was sought as to whether the models of care were being developed for NHS Central London CCG only or for the whole of Westminster. A Member commented that some of the patients who for example attend St. Mary's Hospital Accident and Emergency department may differ considerably to those who took part in the patients survey. It was also asked whether polling district specific data could be drawn up and if was possible to determine the percentage of residents who are registered with GPs by postcode.

8.5 In reply to the issues raised, Mike Robinson stated that the percentage of patients with multiple IDs was not known and this would be difficult to calculate, however sharing information with other organisations may assist. Rianne Van Der Linde advised that the 5% of residents not registered with GPs could be attributable to the high flow of migration in Westminster. Damien Highwood added that the percentage of unregistered residents may actually be higher, however the figure set was influenced by how the City Survey was undertaken. Rosalyn King commented that it may be possible to calculate the percentage of residents registered with GPs by postcode.

8.6 The Chairman confirmed that the models of care were for the whole of Westminster and the project was overseen by the Board. She advised that although the GLA had expressed interest in using the models, NHS Central London and NHS West London CCGs and the tri-borough local authorities felt that it was better at this stage to continue independently joint development of the models.

RESOLVED:

1. That progress on the primary care modelling project be noted; and

2. That the close collaboration between the Council's and the Clinical Commissioning Groups' officers be noted and that it be agreed to provide continued support for the project.

9 CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH TRANSFORMATION PLAN UPDATE AND NEXT STEPS

9.1 The Chairman introduced the report and welcomed the update which sought to demonstrate how the different programmes pulled together and she emphasised the desire for a more joined-up approach, as existed in the work taking place in mental health for older people.

9.2 Steve Buckerfield (Head of Tri-Borough Children's Joint Commissioning) then presented the report and began by highlighting the need for the creation of a forum that met regularly to discuss children and young people's mental needs, as already existed for older people's health needs. He drew Members' attention to the achievements of the plan to date as set out in the report, including work with the North West London CCGs. Steve Buckerfield advised that NHS England had agreed to relinquish control of hospital beds on 10 March and the likely outcome would be that a collaboration of CCGs would be able to control bed allocation, which would be beneficial as it would allow for greater flexibility. The North West London collaboration of CCGs were to request that they be amongst the first to take this forward. Steve Buckerfield advised that the mental health transformation plan sought to address the mental health needs of children and young people across Westminster and the other tri-boroughs. He remarked that Westminster currently lacked a lead organisation for young people and mental health from the voluntary sector and he welcomed any attempts to fill this gap. He also stated that consideration could be given as to whether to extend children and young people's mental health services up to the age of 25. Steve Buckerfield concluded by requesting that the Board support the work being undertaken to transform mental health services for young people.

9.3 During discussion, Members enquired whether the North West London collaboration of CCGs had already approached NHS England about taking control of hospital beds. A Member suggested that a way voluntary organisations could contribute in providing mental health services for children and young people is to take part in mentoring. In respect of the lack of voluntary organisations leading on mental health for children and young people in Westminster, Jackie Rosenberg (Westminster Community Network) stated that many voluntary organisations were unable to afford the rates in the borough. However, there were plenty of voluntary organisations that could be interested in helping to co-design such a service and larger voluntary organisations, such as MIND, may be interested in providing input. Jackie Rosenberg also asked whether there were any plans for services in respect of post-traumatic stress disorder which may in particular affect refugees arriving in Westminster. Liz Bruce welcomed the report and supported the request that the Board support the children and young people's mental health transformation, however she suggested that more details be discussed before a further report was considered at a future Board meeting.

9.4 Mike Robinson also felt there was merit in the Board continuing to support the transformation plan, however he suggested that there be greater focus on looking at what outcomes and ambitions should be achieved for children and young people. In respect of post traumatic stress disorder, he suggested that

this area could be covered by a Joint Strategic Needs Assessment and a response to the Board would be provided.

9.5 In reply to the issues raised, Steve Buckerfield stated that the North West London collaboration of CCGs were already in conversation about taking control of hospital beds and that there would be a financial advantage to CCGs each time a community initiative prevented the need to use beds. It was hoped that voluntary organisations would attend the Young People's Conference in the summer of 2016.

10 HEALTH AND WELLBEING HUBS

10.1 Eva Hrobonova (Deputy Director of Public Health) presented the report updating Members on progress on the Health and Wellbeing Hubs programme. A review of the Older People hubs had concluded that a pro-active, evidence-based approach was being taken, whilst opportunities to further increase access had also been identified. In respect of the Newman Street pilot hub, the Chairman had visited the site in February and the outcomes of the pilot were in the process of being measured. It was hoped that positive results would soon be realised. Eva Hrobonova advised that the Church Street Health and Wellbeing Community Hub was due to come into operation in 2021. Members also heard that a stakeholders workshop was planned for early April and would include a run through the Logik model.

10.2 A Member commented that both the voluntary sector and Healthwatch wanted to be more involved in the Health and Wellbeing Hubs and it was noted that they would be invited to the stakeholders workshop.

11 INNOVATION IN RAISING PARENTAL EMPLOYMENT RATES

11.1 Anna Waterman (Strategic Public Health Adviser) presented the report and began by advising that the child poverty rate in Westminster had been calculated to be 37%. A Task and Finish Group had been set up to consider how to best use funding from the Public Health Investment Fund to improve parental employment rates among low income families in order to address child poverty. The Task and Finish Group had proposed a programme of initiative that were agreed by the Cabinet Member for Adults and Public Health and the Cabinet Member for Children and Young People in October 2015. Anna Waterman referred to the objectives of the Parent Employment Programme as set out in the report which sought to address problems both in the short, medium and long term and there would be investment in both new and existing initiatives.

11.2 Anna Waterman explained that some of the barriers parents from low income families faced included lack of qualifications, childcare issues and irregular pattern of work. To tackle these, a whole systems approach was being taken and Council departments were working closely together on the programme. A Steering Committee was also to be created to give the programme more direction and focus.

11.3 Mike Robinson advised Members of two initiatives, the first being a trial project in providing vocational based adult education training for adults not yet ready for employment where childcare was also provided on site. The second initiative involved the creation of a register of child minders willing to look after children outside of normal working hours.

11.4 During discussion, Members considered how the CCGs could assist the programme and it was suggested that GP surgeries could display advertisements to raise awareness of the programme. It was remarked that the increase in self-esteem in finding employment would also lead to health benefits. In welcoming the programme, a Member commented on the difficulties single parents faced, such as travel costs, difficulties in taking time off during school holidays and affordability of childcare. Mike Robinson responded that the Family and Childcare Trust and the Council had looked into this matter and the register of child minders available for extended hours beyond normal working hours was one of the measures introduced to address this issue.

12 PRIMARY CARE CO-COMMISSIONING

12.1 Rosalyn King (Director of Health Outcomes, NHS Central London CCG) introduced the report that focused in particular on the review of GPs' Personal Medical Services (PMS) contracts. She advised that funding for PMS was routinely higher than other types of contracts and the review had given the opportunity to consider to use the premium funding. Following the review, NHS Central London CCG had submitted its recommendations for its commissioning intentions in late February to NHS England, who had subsequently approved them on 15 March.

12.2 Simon Hope advised that NHS England had raised a couple of queries in respect of NHS West London CCG's commissioning intentions and so the CCG would be making a further submission on 18 March. He commented that the review provided opportunities for cost benefits to the CCGs, although the processes involved were challenging. Although some GPs would lose their PMS contracts, transitional funding and support in changing the way they provided services would be available. There would also be the opportunity to standardise and equalise primary care across Westminster. The commissioning of services over the next three years would concentrate on the key performance indicators (KPIs) and a small amount of additional services in the first year, KPIs and a larger amount of additional services in the second year and on premium services in the third year.

12.3 During discussion, Members asked whether the changes in funding would be phased in and whether there would be sufficient resources to support those GPs who faced challenges during the changes. In respect of the potential for change, an explanation was sought as to what the impact would be on patient care. A Member advised that the proportion of NHS West London CCG GPs in Westminster who were to lose their PMS contracts was low. It was remarked that community stakeholders were pleased to hear that patient access was at the top of the agenda at a recent meeting with NHS West

London CCG. A Member enquired how the commissioning intentions in respect of immunisations complemented the 0 to 5 Healthy Child Programme.

12.4 In reply, Simon Hope advised that changes to funding would be phased over a two to three year period and making immediate recoveries of funding from GPs would be impractical. NHS England had already started identifying those GPs that were vulnerable during the changes and the CCGs were working with NHS England and GP federations in addressing this issue. GPs that would be affected by the changes this year were being looked at so that they could be advised and supported accordingly. Simon Hope added that working groups on areas such as accessible care were being set up to consider the impact on changes to services on patients.

12.5 Rosalyn King advised that detailed modelling in respect of practices uptake of services was being undertaken and a further report on this could be produced for the Board at a future meeting. She added that new services addressing the KPIs would commence from July 2016. Mike Robinson advised that the 0-5 Healthy Child Programme was in respect of health visitors encouraging immunisations as opposed to carrying out delivery of this treatment.

12.6 The Chairman expressed support for the direction the changes were going in and she emphasised the importance of the PMS review in dovetailing well with primary care co-commissioning overall.

13 NORTH WEST LONDON TRANSFORMING CARE PARTNERSHIP PLAN

13.1 The Board noted the report on the North West London Transforming Care Partnership Plan.

14 MINUTES OF THE JOINT STRATEGIC NEEDS ASSESSMENT STEERING GROUP MEETING HELD ON 26 JANUARY 2016

14.1 The Board noted the Minutes of the last Joint Strategic Needs Assessment Steering Group meeting held on 26 January 2016.

15 WORK PROGRAMME

15.1 Meenara Islam advised that the main substantive item for the next Board meeting on 26 May would be the Joint Planning item that would include updates on the Joint Health and Wellbeing Strategy refresh and on the North West London Sustainability and Transformation Plan.

16 ANY OTHER BUSINESS

16.1 There was no additional business for the Board to consider.

The Meeting ended at 6.06 pm.

CHAIRMAN: ______________________ **DATE** ____________________

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WESTMINSTER HEALTH & WELLBEING BOARD
Actions Arising

Meeting on Thursday 17th March 2016

Action	Lead Member(s) And Officer(s)	Comments
Westminster Health and Wellbeing Strategy Refresh Update		
Members requested to attend Health and Wellbeing Board workshop on 5 April.	All Board Members	Workshop to take place on 5 April.
Meenara Islam to circulate details of proposals discussed at an engagement plan meeting between Council and Clinical Commissioning Group colleagues.	Meenara Islam	
NHS Central and NHS West London Clinical Commissioning Group Intentions		
Clinical Commissioning Groups to consider how future reports are to be presented with a view to producing reports more similar in format and more user friendly.	Clinical Commissioning Groups	On-going.

Meeting on Thursday 21st January 2016

Action	Lead Member(s) And Officer(s)	Comments
Commissioning Intentions: (A) NHS Central London Clinical Commissioning Group; (B) NHS West London Clinical Commissioning Group		
Update on the Clinical Commissioning Groups' intentions to be reported at the next Board meeting.	Clinical Commissioning Groups	To be considered at the 17 March 2016 meeting.
Westminster Health and Wellbeing Strategy Refresh		
Draft proposals for the strategy refresh to be considered at the next Board meeting	Adult Social Care, Clinical Commissioning Groups and Policy, Performance and Communication	To be considered at the 17 March 2016 meeting.

Meeting on Thursday 19th November 2015

Action	Lead Member(s) And Officer(s)	Comments

Westminster Health and Wellbeing Hubs Programme Update		
Update on the Programme to be reported at the next Board meeting.	Adult Social Care	To be considered at the 21 January 2016 meeting.
Like Minded – North West London Mental Health and Wellbeing Strategy – Case for Change		
Board to receive report on Future In Mind programme to include details of how it will impact upon Westminster and how the Board can feed into the programme to provide more effective delivery of mental health services.	Children's Services	To be considered at earliest opportunity.
Board to receive report on young people's services, including how they all link together in the context of changes to services.	Children's Services	To be considered at earliest opportunity.

Meeting on Thursday 1st October 2015

Action	Lead Member(s) And Officer(s)	Comments
Central London Clinical Commissioning Group – Business Plan 2016/17		
West London Clinical Commissioning Group to circulate their Business Plan 2016/17 to the Board.	West London Clinical Commissioning Group	
Westminster Health and Wellbeing Hubs Programme Update		
Board to nominate volunteers to be involved in the Programme and to be on the Working Group.	Meenara Islam	
Update on the Programme to be reported at the next Board meeting.	Adult Social Care	To be considered at the 19 November 2015 meeting.
Dementia Joint Strategic Needs Assessment – Commissioning Intentions and Sign Off		
Board to receive and update at the first Board meeting in 2016.	Public Health	To be considered at the 21 January 2016 meeting.

Meeting on Thursday 9th July 2015

Action	Lead Member(s) And Officer(s)	Comments

Five Year Forward View and the Role of NHS England in the Local Health and Care System		
That a document be prepared comparing NHS England's documents with the Clinical Commissioning Groups to demonstrate how they tie in together.	Clinical Commissioning Groups/NHS England	To be considered at a forthcoming meeting.
Board to receive regular updates on the work of NHS England and to see how the Board can support this work.	NHS England	To be considered at future meetings.
Westminster Housing Strategy		
Housing Strategy to be brought to a future meeting for the Board to feed back its recommendations.	Spatial and Environmental Planning	To be considered at a forthcoming meeting.
Update on Preparations for the Transfer of Public Health Responsibilities for 0-5 Years		
Board to receive an update in 2016.	Public Health	To be considered at a meeting in 2016.

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 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 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 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 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	Adult Social Care	Completed

integrated whole systems working and the wider health landscape in Westminster, to be referred to the Board for discussion and approval.		

Meeting on Thursday 22nd January 2015

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

Health & Wellbeing Board.	NHS England	
Work Programme		
A mapping session to be arranged to look at strategic planning and identify future agenda issues.	Health & Wellbeing Board	Completed.

Meeting on Thursday 18th September 2014

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

Meeting on Thursday 19th June 2014

Action	Lead Member(s) And Officer(s)	Comments
Whole Systems		
Business cases for the Whole Systems proposals to be submitted to the Health & Wellbeing Board in the autumn.	Clinical Commissioning Groups.	Complete.
Childhood Obesity		

A further report to be submitted to a future meeting of the Westminster Health & Wellbeing Board by the local authority and health partners, providing an update on progress in the processes and engagement for preventing childhood obesity.	Director of Public Health.	To be considered at a forthcoming meeting
The Health & Wellbeing Strategy		
A further update on progress to be submitted to the Westminster Health & Wellbeing Board in six months.	Priority Leads.	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. *Note: Recommendations to be put forward in next year's programme.*	Public Health Services Senior Policy & Strategy Officer.	Completed

Meeting on Thursday 26th April 2014

Action	Lead Member(s) And Officer(s)	Comments
Westminster Housing Strategy		
The consultation draft Westminster Housing Strategy to be submitted to the Health & Wellbeing Board for consideration.	Strategic Director of Housing	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

Date:	Thursday, 26 May 2016
Classification:	General release
Title:	Draft Joint Health and Wellbeing Strategy and Sustainable Transformation Plan Update
Report of:	Councillor Rachael Robathan, Chairman, Health and Wellbeing Board and Cabinet Member for Adults and Public Health
Wards Involved:	All
Policy Context:	N/A
Financial Summary:	N/A
Report Author and Contact Details:	Chris Neill, Director Whole Systems, Hammersmith & Fulham, Kensington & Chelsea and Westminster Chris.Neill@lbhf.gov.uk Philippa Mardon, Interim Deputy Managing Director, Central London CCG. Philippa.Mardon@nhs.net Phoebe Morris-Jones Policy Officer, Westminster City Council. pmjones@westminster.gov.uk

1. Executive Summary

1.1 Westminster's first Joint Health and Wellbeing Strategy (JHWS), "*Healthier City, Healthier Lives*", is currently being refreshed. In March 2016 the Board received an update on the progress of this refresh. The update centred on a proposed direction of travel for the strategy including ensuring it would be consistent with

national and sub-regional policy development, particularly the emerging North West London Sustainable Transformation Plan (STP).

1.2 This paper also provides a summary of engagement events that took place throughout April 2016, and included at Appendix A, and the first draft of the refreshed strategy included as Appendix B. This draft is provided for the Board to consider alongside the proposed next steps between now and public consultation on the draft.

1.3 Concurrently, this paper updates the Board on the latest development of the North West London STP, and notifies the Board of the proposed development of a vision for Public Health.

2. Key Matters for the Board

2.1 The Health and Wellbeing Board is asked to:

- Reflect and comment on the first draft of the strategy (attached as Appendix 1); and
- Consider and feedback on the STP update.

3. Background

3.1 The NHS Planning Guidance[1] released in December 2015 provides a clear mandate for local health and care systems to move to a place-based approach to strategic planning. This reflects the reality that local challenges cannot be effectively addressed by any one organisation alone. Collective action and cooperation is required between commissioners, providers and local authorities to jointly manage resources to secure a financially sustainable system. STPs are backed by potential funding from 2017/18 onwards to support future transformation.

3.2 At its January and March meetings, the Health and Wellbeing Board considered papers outlining the refresh process of the strategy and the STPs. The Board endorsed an approach to the development of both the strategy and the STP that was consistent with strategic documents such as City for All[2] and the Better Care Fund. The Board agreed that the JHWS should continue to emphasise the importance of integration, collaboration, prevention, independence and community resilience in addressing to health and care challenges.

[1] Delivering the Forward View, NHS Planning Guidance 2016/17 – 2020/21", Dec 2015
[2] Westminster City for All Year Two

4. Refreshing Healthier City, Healthier Lives - update

4.1 Refreshing Healthier City, Healthier Lives is an opportunity for the Health and Wellbeing Board and partners to set out a joint local vision for health and wellbeing in Westminster, and respond to local challenges.

4.2 In March, the Board agreed a programme of three workshops for Board members, commissioners and service user representatives.These workshops were hosted by Cllr Rachael Robathan and Dr Neville Purssell in April 2016

4.3 The Board members at their workshop identified priorities based on current and future need. Members also discussed the specific value that the Health and Wellbeing Board can add as an integrated and collaborative governance body for the health and care system.

4.4 Commissioners at their workshop considered the use of an outcomes framework (using the North West London Whole Systems Integrated Care framework as a model[3]) to structure the refreshed strategy. They felt that it was useful in encouraging a preventative and early intervention focus by ensuring that the health and care system was incentivised to approach strategic issues as a system. For example, this included looking at how leadership, education and training across the health and care system could help embed a collaborative, integrated and multi-skilled workforce across all levels of health and care organisations.

4.5 Service user representatives at their workshop considered the role of the Joint Health and Wellbeing Strategy in improving the quality of life for service users and their quality of experience of services. Service users representatives highlighted the need for identifying, supporting and championing the role of community groups and peer networks in improving health and wellbeing in Westminster.

4.6 There were some recurring themes and consistent priorities emerging from the workshops. There was support for the following:

- Improving and supporting positive outcomes for children and young people (including mental health and tackling obesity);
- Reducing the risk factors for and improving management of long term conditions such as dementia;
- Improving and supporting mental health outcomes through prevention and self-management;

[3] North West London Outcomes Framework

- Leading and creating the health and care system fit for the future.
- Structuring the outcomes of the refreshed strategy around five key population groups:
    - Conception to 5 years;
    - Children and young people;
    - Working age adults;
    - Adults over 65; and
    - Adults over 85.

- Ensuring outcomes are underpinned by:
    - A whole-system and whole place approach;
    - Embedding an outcomes framework relevant to people and communities;
    - Approaching health and wellbeing from a preventative and early intervention perspective;
    - Addressing the wider determinants in health and wellbeing; and
    - Productive and collaborative relationships between individuals, communities, and health and care professionals/organisations;

4.7 Further to these workshops, officers will be seeking feedback on the draft strategy at community organisation committees and governance meetings in Westminster including the North Westminster Community Network meeting, the Westminster Community Network meeting, and the South Westminster Health and Wellbeing Network in May and June.

4.8 It is proposed that a final draft of the strategy be circulated to the Board offline in June for its consideration prior to a public consultation launched in early July. The final strategy following public consultation and feedback will be presented to the Board for their final formal approval at or before the meeting on 17 November 2016.

5 Sustainability and Transformation Plans (STPs)

5.1 The development of the Joint Health and Wellbeing Strategy has continued alongside the development of the North West London (NWL) Sustainability and Transformation (STP) plan.

5.2 Council officers have been engaged in the weekly Integration and Collaboration Working Group (ICWG) to take forward the development of the STP. The group's membership includes representatives from the three CCGs, the local acute, community and mental health trusts and the three borough councils. The role of the group has been to collaboratively develop the individual Borough and

Triborough contribution to the STP including how the area will contribute to addressing the three key questions outlined in the NHS Planning Guidance in November 2015:

- How will you close the health and wellbeing gap?
- How will you drive transformation to close the care and quality gap?
- How will you close the finance and efficiency gap?

5.3 The ICWG have drafted an initial “base case” submission outlining the vision and priorities for the area based on existing commitments and data. This submission was used to develop the North West London base case which addresses not only the Strategic North West London priorities but also local needs. The priorities addressed in the North West London base case include:

- Supporting people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthy choices and look after themselves;
- Reducing social isolation;
- Improving children’s mental and physical health and wellbeing;
- Ensuring people access the right care in the right place at the right time;
- Reducing the gap in life expectancy between adults with serious and long-term mental health needs and the rest of the population;
- Improving the overall quality of care for people in their last phase of life and enabling them to die in their place of choice;
- Improving consistency in patient outcomes and experience regardless of the day of the week that services are accessed;
- Reducing unwarranted variation in the management of long term conditions – diabetes, cardio vascular disease and respiratory disease; and
- Reducing health inequalities and disparity in outcomes for the top three killers: cancer, heart disease and respiratory illness.

5.4 The ICWG is developing the next stage of documents for submission to the North West London steering group for the development of the final STP document. This includes an opportunity for localities to identify any priorities that they feel are not

reflected within the initial “base case” submission. The ICWG are also planning engagement activities with local residents and groups to ensure that priorities and documents reflecting the needs of the local population.

5.5 The key upcoming milestones for the development of the STP include:

- **May**
    - Developing a draft local tri-borough STP for submission to the North West London steering group to incorporate into their final draft of the overall North West London STP. There will be further opportunity for additions to this local STP at a later date as this is an initial submission.
    - Initiating consultation and engagement activities with the local population.
- **June**
    - On-going consultation and engagement activities.
    - Submission of North West London sustainability and transformation plans to NHS England on 30 June.

6 Legal Implications

6.1 The duty in respect of Joint Health and Wellbeing Strategies is set out in s116A of the amended Local Government and Public Involvement in Health Act 2007.

6.2 There is also statutory guidance, the “Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies” issued in March 2013. The Guidance states at paragraph 3.5 that Joint Health and Wellbeing Strategies are continuous processes and that it is a decision for the Health and Wellbeing Board to decide when to either update or refresh their JHWS or undertake a fresh process. There is not a requirement that the JHWS be undertaken from scratch each year so long as the Board is confident that their evidence based priorities are up to date and informing local commissioning plans.

6.3 The process being followed to refresh the Council’s JHWS “Healthier City, Healthier Lives” is set out in detail above at paragraph 4 of this report, which includes a proposed public consultation commencing in July 2016. Legal Services will have an opportunity to comment on the proposed consultation documentation and consultation process.

6.4 The requirements in respect of the timing and content of Sustainability and Transformation Plans ("STPs") are set out in Delivering the Forward View: NHS Planning Guidance 2016/17. The Guidance was augmented by a Letter dated 16th February 2016 which included additional information about the purpose of STPs and a timeline for the STP process, including key dates.

6.5 The STP will cover the period October 2016 to March 2021. Deadline for submission of the STP is 30th June 2016 and the STP will be formally assessed in July 2016.

7 Financial Implications

Not applicable

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

Philippa Mardon, Interim Deputy Managing Director, Central London CCG

Email: Philippa.Mardon@nhs.net

Telephone: 07973 747488

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Refreshing Westminster's Joint Health and Wellbeing Strategy

Introduction

Our local health and care system consists of Westminster City Council, Central and West London Commissioning Groups, health and care providers, and the voluntary and community sector, individuals and communities. It is a whole system, with many moving parts, with different functions but with one sole purpose – to help all of us be well and stay well. This refreshed strategy represents the whole system's commitment to prioritising prevention and early intervention. When you experience mental or physical ill health and require support, the whole system will come together to work with you to ensure you experience high quality care in a setting that is appropriate and convenient for you and delivered by a caring, talented and diverse workforce.

For decades, the health and care system has been geared towards treating people during illness and poor health and in many cases medicalising people's conditions and lifestyles. In parallel, nationally and locally, we are seeing a significant population increase, a rise in people experiencing preventable long term and multiple conditions and ever increasing expectations of public services. We can no longer afford to deliver services in a way that is expensive, inefficient and is framed by organisational boundaries and conveniences. Locally, we have known this for a long time.

Now we have the mandate to act, backed by government support, which was provided by the NHS Five Year Forward View[1] and the London Health and Care Devolution Agreement[2]. The Five Year Forward View signalled a significant shift in attitude towards prevention and called for local systems to move to new models of care while the devolution agreement has pledged greater flexibility and freedoms for the future, encouraging ambitious localities such as Westminster to prepare for the possibility of devolution.

If we are to address robustly the challenges of decreasing finances, increasing demands for services and having to assure the sustainability of the health and care system, we need to integrate our services to deliver them to you in a joined-up way so you have a good experience that is built around you and in your communities. The North West London Sustainability and Transformation Plan (STP)[3], will locally bring the NHS Five Year Forward View to life and will set out the vision and commitment of the eight clinical commissioning groups and corresponding local authorities including Westminster. It will implement an integrated health and care system that is weighted towards upstream prevention and earlier intervention and care in the community by 2021. *Our Joint* Health and Wellbeing Strategy is our local health and wellbeing plan which sets out how we will meet national commitments (including those set out in the STP) and deliver local priorities for the people of Westminster.

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[1] NHS Five Year Forward View 2014
[2] London Health and Care Devolution Agreement (2015)
[3] Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21 (2015)

We all know that there are broader socio economic and environmental factors that can affect our health and wellbeing and those factors cannot be tackled alone through clinical interventions. It requires everyone to ensure that businesses and communities are doing their bit to reduce pollution levels to improve air quality that the neighbourhoods we live in are clean, accessible and welcoming and support and look out for each other particularly in times of vulnerability.

We will do all we can to ensure that the built environment enables you to make positive choices and the housing people live in is appropriate for their needs and life stage. We will ensure that schools and other educational establishments support children and young people to bewell and stay well through educating them about making positive choices and providing access to physical activity and healthy meals.

In Westminster we are proud of our community establishments and assets. We have 11 libraries, 9 leisure centres, 18 community centres, over 21 attractive open and green spaces comprising over 250 hectares of open space, friendly cycling and walking routes and world class heritage sites and the best cultural offer in the Country. These community assets can and will help people to remain healthy and engaged. We commit to ensuring that we improve the quality of these assets so that everyone can access and enjoy them throughout their time in Westminster as a resident, worker or visitor.

We have much to celebrate and be proud of in our city. However, we have several serious challenges that we must tackle in partnership with you. We want to support people to live healthy and fulfilled lives as active participants in their families, neighbourhoods, communities and workplaces. This involves tackling a range of issues that can be barriers to finding and maintaining long term occupations (including volunteering). Worklessness can be associated with poorer physical and mental health and wellbeing and evidence shows that work or an equivalent meaningful occupation can alleviate physical and mental symptoms of ill health[4]. We will continue to support the long term unemployed in Westminster to address complex barriers to change and maximise people’s contributions to their communities and, therefore, improve their chances to be well and stay well.

Children and young people in Westminster live, grow and learn in an international hub of culture, heritage and opportunity. However, to focus on the opportunities alone would be to ignore the real challenges that will face children and young people as they grow and transition into adulthood. Ensuring that children and young people are supported to have healthy relationships and to make positive decisions about their own lives and be confident to seek help when they need it.

Westminster is also blessed with an increasingly older population. Retaining so much life experience and knowledge in our borough adds immense value to our communities. However, we are also presented with challenges – particularly around how we adequately

[4] “Is work good for your health and well-being?” The Stationary Office, 2009

support older adults. An ageing population does not necessarily mean older people in ill health. People over 65 are economically, culturally and socially engaged, and often make up a largely unrecognised workforce in their provision of volunteering, caring (for both peers and children) and civic support. Working with service users, communities, carers and professionals, we want to empower people over 65 to maintain their independence, their roles in their communities and their health and wellbeing. We will do this through encouraging and supporting lifestyle changes and enabling self-management of conditions.

Adults aged over 85 are more likely to have longer term and more significant health and care needs, particularly related to ageing. They may require more intensive support to ensure they are able to remain independent and be treated with dignity, whether in their own homes and communities, or in residential care. Adults aged over 85 may need help to remain or to be more engaged with community networks around them, to ensure that they do not feel isolated or excluded from society.

Organisations can only do so much. We can equip people with information and tools to enable them to take charge of their own health and wellbeing and develop their communities to support those who need extra support to make positive choices. When people need extra help or experience periods of ill physical or mental health then we will provide high quality, timely and person-centred support.

Enabling people to make responsible and positive choices to enhance their own wellbeing and providing high quality, timely and patient centred services when people need them is important to ensuring Westminster is a city for all. Our most significant and most valuable asset which will help us to achieve this mission is not buildings or budgets – it is you. Engaging communities in the design and delivery of the services they use is crucial to not only ensuring services are meeting local needs but to also actively involve them as equal partners in shaping local services and building resilient and cohesive communities. Local people are the experts of their own localities and communities. We will continue to work with communities and with Health and Wellbeing Board partners such as Westminster Healthwatch, the voluntary sector, our community champions, and patient and service user panels to make sure you have a voice in developing the services and support that will keep the people of Westminster healthy and well.

We want to empower people to access information, manage their conditions and have a say in their treatment. This is not only for the mostly healthy, but must be cascaded to ensure that all people, particularly those who might be vulnerable, isolated, or excluded, feel that the health and care system treats them with dignity and as autonomous individuals. For our large homeless and rough sleeping population, providing services that address their specific needs, reaches out to them, and empowers them to make healthy choices is important. *Healthier City, Healthier Lives 2013-2016* aimed to ensure that everyone in Westminster had the opportunity to start well, stay well, get better and age well. We are refreshing Healthier City Healthier Lives for 2016-2021 with four targeted priorities, which are based

on evidence of need and what we have heard from partners, local groups and communities and people. We will base the delivery of our priorities on solid outcomes which are based on achieving quality of life, experience, system and financial sustainability[5]. They are:

- Improving outcomes and life chances for children and young people;
- Reducing the risk factors for and managing long term conditions such as dementia;
- Improving mental health outcomes through prevention and self-management; and
- Creating and leading a local health and care system fit for the future.

The outcomes for each priority will provide a focus for our joint working to achieving them over the next five years. We will develop a detailed joint implementation plan that will identify how we will put into action the commitments made in this strategy. The implementation of the Strategy will be overseen by the Health and Wellbeing Board as the system leader of Westminster's health and care system.

Our four priorities will be areas of focus for the Westminster Health and Wellbeing Board but this does not mean that other priorities and fresh challenges and issues will not be addressed. This strategy is not an extensive list of things that are important or actions we will take. Instead it focuses on the most complex and critical needs identified where the Health and Wellbeing Board can take action quickly and effectively.

Health and wellbeing is everyone's business – the council's, the GPs', the hospitals', the care workers', the communitys', yours.

[5] North West London Outcomes Framework (2015)

Our communities

[INFOGRAPHIC TO BE ADDED]

Westminster is a global city and it is also home to a highly diverse resident population of around 233,290 people. Unlike the majority of areas, our resident population is heavily weighted towards younger people, with 49% of our resident population aged between 18 and 44 years old.

Almost half of households are single person households, the third highest proportion in London. We have the fourth highest proportion in the country of pensioner households that are occupied by lone pensioners. This means that a high proportion of our older people may feel isolated from their families, friends and communities and reliant on services.

At the heart of the nation's capital, and easily accessible for people who are seeking a new life both domestically and from abroad, Westminster is home to a vibrant and diverse set of communities. We have the highest level of international migration of any place in England.

Just over half of our population were born outside of the UK, compared to 9% for the rest of England. 30% of our population are from Black, Asian, Arabic or other minority ethnic groups and there are estimated to be over 10,000 lesbian, gay, bisexual or transgender (LGBT) people.

Westminster has the highest level of rough sleepers of anywhere in the country with over 2570 people being identified in 2014/15[6]. There are also tens of thousands of people who live in the city for short-periods or on a part-time basis who are not included in the resident population. This means that the Westminster population is more transient than any other area.

Looking at likely demographic, economic and social trends over the next 15 years, we estimate that the following changes will affect how people live and work in Westminster and how this might affect their health and wellbeing:

- There will be a 60% increase in the number of people living in Westminster aged over 85. While a large proportion of this group will age in good health, there will be a significant rise in the number of older people living with long term conditions that will cause both minor and severe impacts on their mobility, care needs, health service needs and wider role in the community. Over the next five years alone we expect the annual cost of care for older people living with severe physical disabilities to grow by £10.4m.
- There will be fewer children and young people living in Westminster in 2036 with the proportion of people aged under 16 as part of the overall population expected to decline from 16% to 14%.

[6] CHAIN Annual Report Bulletin Greater London 2014/15

- The city will be busier than ever with more commuters coming to work in Westminster every day, putting tremendous pressure on transport and public realm. While these people will be less likely to drive and will make more use of walking, cycling and taxis (particularly though the shared economy) we do not expect a reduction in the number of vehicles on the roads due to factors such as an increasing need for movement of goods (logistics) driven by public expectation of rapid delivery and 'just in time' delivery of goods.
- People working in the city will be more likely to be employed in high skill, high wage jobs linked to the knowledge, digital and creative economy or jobs that provide personalised services within the service economy. There will be fewer jobs in the traditional professions driven by increasing automation and digitisation.
- If nothing else changes, more young people will be growing up with long term health conditions, particularly obesity and mental health issues, that will likely follow them into adulthood. This could have significant impact on their ability to make the most of the opportunities of a changing social, economic and technological landscape.

Our diverse communities make it all the more important that the health and care system provide tailored services which accommodate the wide range of needs that our residents experience.

Westminster has a clear sense of place and prides itself on its reputation as a truly global city which attracts tourists, students and businesses from the UK and the world. One million people enter the borough every day and use our services either as a visitor, worker or student. This creates a unique buzz in the city, but also brings with it significant challenges and responsibilities that we acknowledge and will seek to mitigate and address.

Our unique health challenges

The vitality of Westminster is part of its appeal, but this leads to a challenging landscape in which to help people to be well and stay well.

The life expectancy of our population can vary dramatically depending on whether people live in our most affluent or most deprived areas. Men living in the 10% least deprived areas live nearly 17 years longer than men living in the most deprived areas. For women this gap is nearly 10 years. In addition, the most deprived fifth of the population live with disability 10 years sooner than those in the least deprived. This is because our population's health is not just related to the services they can access but also to wider determinants including housing, education, employment and the environment, as well as the choices individuals make.

Westminster has a high level of population "churn" as people enter and leave the Borough rapidly. Every year over 20,000 people leave and approximately the same number of new people move in. This high level of population churn and our rich cultural diversity can make it more difficult for people to access services and for services to deliver the right outcomes.

Westminster has high numbers of children and young people experiencing conditions relating to lifestyle, particularly diet and physical activity, including unhealthy weight and tooth decay, than both the London and national average[7]. 40% of children in Westminster are obese by the time they reach the end of primary school, and similar numbers have decayed, missing or filled teeth[8]. For children and young people, the most common reason for hospital admission due is tooth decay[9]. There is evidence that children and young people in Westminster attend A&E departments more frequently than is typical for London or England, and this could be related to low levels of registration with GPs due to high levels of population "churn"[10].

Our large business, visitor and commuter populations are the cornerstone of the local and regional economy and also significantly contribute to the national economy but they also put pressure on services and the environment. Services are often funded on the basis of resident population and so do not reflect the realities of our place where our population quadruples each day from 250,000 residents to over 1,000,000 people including residents, workers and visitors

We have unique challenges as a result of our location at the centre of a national and global economic hub. Westminster falls within the worst 20% of areas nationally for outdoor living environment, road traffic accidents, and parts of the city are among the worst performers in air quality tests in Europe[11].

[7] Public Health Outcomes, Children and Young People's Health Benchmarking Tool
[8] Ibid
[9] Ibid
[10] Ibid
[11] Westminster Greener City Action Plan 2015

Westminster has the highest recorded population of rough sleepers of any local authority in the country, and this population has higher rates of physical and mental health problems[12], and are at risk of experiencing complicating alcohol and or drug dependency[13]. Rough sleepers attend accident and emergency approximately seven times more often than the general population, and are generally subject to emergency admission and prolonged hospital stays more often also[14]. However, Westminster also has a wealth of knowledge and expertise in supporting and treating homeless people and rough sleepers. We aim to build on this expertise at pace and deliver better outcomes for those individuals and groups who are not in or have access to stable and appropriate accommodation. Westminster has disproportionate levels of both common and severe and enduring mental health conditions. These conditions have an impact across our communities, from individuals who find it more difficult to obtain or retain employment, to children and young people who do not feel able to discuss their concerns due to stigma associated with mental health conditions.

Westminster also has an ageing population – both a larger demographic cohort and a cohort which that is expected to live longer on average than any previous generation. However, longer years of life do not necessarily correlate to longer years of life spent in good health, and there are and will be an increasing number of older people living with long-term conditions including both physical disability and mental health conditions.

[12] CHAIN Annual Report Bulletin Greater London 2014/15
[13] Rough Sleepers Health and Healthcare JSNA
[14] Rough Sleepers Health and Healthcare JSNA 2013

Our vision and goals

Overall vision – all people in Westminster are enabled to be well, stay well and live well, supported by a collaborative and cohesive health and care system.

Long Term Goals (2013-2028)	Improving the environment in which children and young people live, learn, work and play	More people live healthily for longer and fewer die prematurely	A safe supportive and sustainable Westminster where all are empowered to play as full a role as possible	People living with injury, disability, long-term conditions, and their careers have quality of life, staying independent for longer
Strategic Priorities 2016-2021(date TBC)	1) Improving and supporting positive outcomes for children and young people; 2) Reducing the risk factors for and improving the management of long term conditions with a focus on dementia; 3) Improving mental health outcomes through prevention and self-management; and 4) Creating and leading a local health and care system that is relevant and fit for the future.			

Building on the principles set out in the Marmot Review (2010) and the long term goals set in our *Healthier City, Healthier Lives (2013)* for 2013-2028, we will be focusing on the following four priorities over the next five years:

- Improving and supporting positive outcomes for children and young people;
- Preventing and managing long term conditions – with a focus on dementia;
- Improving and supporting positive mental health outcomes through prevention and early intervention; and
- Creating and leading a local health and care system fit for the future.

These areas are priorities the Westminster Health and Wellbeing Board will be specifically steering and challenging the local health system to address and realise the associated outcomes. They represent a fundamental shift in how we should be viewing health and wellbeing. Instead of focusing on how to cure and respond to ill health and poor wellbeing after the fact, we will be taking a strategic approach to gradually moving our collective energy and assets to focus on prevention and intervening early when risks of poor health and wellbeing are indicated.

Each priority will be framed by the outcomes we aim to achieve rather than focus on delivering lists of activities. Please see appendix A for the outcomes framework this strategy is based on.

PRIORITY 1: Improving outcomes and life chances for children and young people

PRIORITY VISION: children and young people transition into healthy and well adults who contribute to society and share their learning and experiences with others.

Children born and young people have different experiences and attitudes to accessing information, support and care. It is important to embed preventative healthy lifestyle behaviours early and enable young people to support each other, make informed choices and manage their own independence where appropriate. We will support this generation and future generations to remain healthy, well and active and enable them to make the most of their opportunities to live, learn and prosper.

We will build on the North West London *Like Minded*[15] strategy which recognises the role of wider determinants in the mental and physical health and wellbeing of children and young people. We value the role of schools and communities in supporting prevention and early intervention in mental health for children and young people. There is a continued need for localism, collaboration and joint working that the Westminster Health and Wellbeing Board, and this refreshed strategy, is well placed to lead on.

The approach of this strategy is to address the holistic health and wellbeing of children and young people. We want the services they interact with to treat them as individuals capable of making decisions about their lives, health and care. We recognise the role of existing networks that can influence their health and wellbeing. We want to ensure that the environments which children and young people grow up in support them to be mentally and physically healthy and form and maintain good personal relationships. We want to prevent children and young people becoming ill wherever possible. However, if they do experience poor mental or physical health or they perceive a threat to their wellbeing we want to empower children and young people to access information, advice and care in ways that are convenient and suited to them.

We have a number of assets in Westminster which children and young people, and their families will be encouraged to use to maximise their physical and mental health. These include the assets we hold as organisations (such as our leisure centres) but also wider community assets such as the wealth of clubs and societies that support people to be socially and physically active. We have a large number of parks but only 15% of our population use them for health and physical activity[16]which is below the national and London average. Additionally our current and future provision of children's and youth services provide key opportunities for both public sector collaboration and community and

[15] North West London Like Minded (2016)
[16] Public Health Outcomes Framework

voluntary services to support children, young people and their families to live healthy, engaged and full lives.

We also want to make sure that our libraries remain vital and vibrant centres of community life for our population, as well as continuing to support and championing of increased access to public spaces. A range of library programmes invite local people to use spaces in libraries for music and arts events, their own community clubs as well as health and wellbeing activities such as smoking cessation. It is a good example of using the assets we already have to make sure individuals and communities can engage and support one another.

Family and relationships

A number of early and lifetime health outcomes are significantly impacted by parental (and in particular maternal) mental and physical health. Ensuring children are given the best start in life, during pregnancy and the first five years of life, is crucial to addressing health inequalities, and improving life chances and quality of life children, young people and their families.

Approximately 30% of children and young people at schools in do not live in the borough and we currently engage with these children as coordinators and commissioners of services such as school nursing. Building on this we want to provide emotional wellbeing support in school such as mindfulness and nurture groups. We also support the voluntary and third sector who provide activities and support in school and after school, and ensure that the city is a healthy and safe place in which to learn.

Healthy Diet and Physical Activity

Levels of unhealthy weight and obesity remain high for children in Westminster. Around one in ten Reception year children in Westminster are obese. By Year 6 around a quarter of children are obese. Being overweight or obese as a child or young person has been linked to significant detriment to self-esteem and mental health. The National Obesity Observatory estimated that the health related quality of life for severely obese children is similar to those diagnosed with cancer[17]. There are a number of risk factors for increasing obesity in children and young people, and these often relate to issues that children and young people themselves are not in control of including the access to healthier foods and drinks at school and at home and the opportunity to remain physically active throughout the day.

Being active is important for both physical and mental health[18]. There are links between increased physical activity and a reduction in depression and anxiety for children and young people. It is also important for self-esteem and has been shown to improve academic

[17] Public Health England – Health Risks of Childhood Obesity 2013
[18] Westminster Physical Activity JSNA (2014)

performance[19]. Studies also show there is a strong link between poorer mental health and sedentary behaviour[20]. It is important to provide a range of physical activities that address barriers to physical activity that some children and young people might face including cost, transport and availability of local open and green spaces.

There is national evidence that physical activity is in decline amongst teenagers, with the decrease being larger among boys than girls. However the proportion of girls achieving guideline amounts for physical activity was already at a low baseline with only 16% achieving the recommended levels in 2012 nationally[21].

Westminster has an effective programme of joint working in place to[22] halt and reverse the rising trend in childhood obesity in Westminster by focusing on the range of factors that can impact healthy weight including physical activity and diet. This programme brings together a range of partners including in education, health and care, the voluntary sector, as well as departments such as sports, leisure and wellbeing, parks and transport. The programme seeks to make the most of existing assets, including our community and open spaces. This collaborative partnership takes a “whole place” approach and in the context of education a “whole school” approach to ensure that messages to children and parents about diet and physical activity were consistent and frequent. We will continue this programme and share and apply the knowledge gained.

Mental Health

There is evidence that, nationally, common mental conditions are rising among adolescents, and that rates of self-harm, eating disorders and body image issues have increased (particularly among young women with 2015 national estimates suggesting that 1 in 3 15-year-old girls reported self-harming in the previous year[23]). Across London approximately 7% of the population have an eating disorder[24]. The prevalence of mental health disorders, both common and specific including hyperkinetic (ADHD), emotional (depression and anxiety), and conduct disorders (severe behavioural problems), is higher in Westminster than the London and national average. Approximately one in ten children and young people have a mental health disorder, such as anxiety, self-harm or attention deficit hyperactivity disorder (ADHD) in Westminster[25].

Healthy Behaviours

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[19] “A meta analysis of the relationship between children’s physical activity and mental health”, Journal of Paediatric Psychology, 2011
[20] “Physical activity and mental health in children and adolescents, a review of reviews”, British Journal of Sports Medicine, 2011
[21] “Social attitudes of young people”, Cabinet Office, 2014
[22] Tackling Childhood Obesity in the Tri-Borough 2014
[23] “Social attitudes of young people”, Cabinet Office, 2014
[24] “Mental Health Problems in Children and Young People”, Annual Report of Chief Medical Officer, 2012
[25] Report of the Tri-Borough Children, Young People and Mental Health Task and Finish Group, 2014

National evidence suggests that "risky" behaviours such as smoking, drinking, drug use and teenage pregnancy have declined significantly in populations born since 1985[26]. However, whilst the overall trend is a reduction in these behaviours, children and young people amongst at risk and vulnerable groups (such as those in care or those involved in gangs) are more likely to participate in these behaviours with more regularity and to a higher degree[27]. New lifestyle risks have emerged. For example shisha smoking is twice as popular among young people and students as cigarette smoking, and it may be that a lack of specific education on the risks of shisha might allow young people to believe it is a healthier alternative to cigarettes[28].

While general patterns of risky behaviour among children and young people was declining in between 2001/02 and 2011/12, alcohol related admissions to hospital and deaths from alcohol poisoning rose. This means that while there has been a general trend of healthier lifestyles among younger people, for a smaller cohort of some of our most vulnerable people, their engagement in risky behaviours and lifestyles has become more severe and poses more risks for their future[29].

There is evidence that this generation of children and young people are engaged and socially and civically minded. 80% of 16 to 24 year olds volunteered in 2014/15, and children and young people attach as much value as previous generations to improving the welfare of the people around them, including their family and people in their wider community. Young people place significant value on belonging to their local community and they value and recognise the contributions of older generations[30].

Outcomes

Population Group	Outcome Domain	Outcome
Conception to 5 years	**Quality of life**	I have good nutrition and a healthy diet.
		I am not harmed by alcohol, tobacco or drugs during pregnancy.
		I have a safe and warm place to live.
		I have a safe, stable, stimulating and nurturing relationship with those close to me.

[26] "Social attitudes of young people", Cabinet Office, 2014
[27] Ibid
[28] "Reducing the Harm of Shisha: Towards a Strategy for Westminster", 2015
[29] "Social attitudes of young people", Cabinet Office, 2014
[30] Ibid

Children and young people	**Quality of experience of services**	At school I learn a variety of skills that integrate my social and emotional development. These skills include problem-solving, conflict management/resolution, and understanding and managing my feelings.
		My community and its workforce are trained to recognise and support my holistic health and wellbeing needs, which are discussed with me. I am referred on to specialist services where appropriate.
		I have, and am aware of, opportunities to be involved in the design, delivery, management or review of services that I use.
	Quality of life	I feel respected, valued, and supported by family/carers and professionals.
		I understand how to identify and develop healthy relationships.
		I have one or more friends I feel close to and I am free from emotional abuse and violence (bullying) at school and negative social influences.
		I understand how to eat healthily and am able to access a healthy diet for myself.
		I am trusted and given opportunities to use green and open spaces and attend physical and social activities.
		I am given opportunities to engage in physical activity every day.
		I have family members or peers who understand my emotional, mental health and physical health needs and are able to support me.
		I understand how to provide support to my peers about their emotional and physical health and where to direct them for further support.
		I am able to sustain a good level of mental health.
		I am able to sustain a good level of physical health including a healthy weight.

		I have aspirations and feel positive about my future.
Working age adults (as parents/guardian, carers, educators)	**Quality of experience of services**	I am supported to provide a safe, healthy and stable home for my family.
		As a pregnant woman I have access to information and support (including health visitors and maternity and midwives) to help me and my partner to prepare for parenthood, and develop and maintain a healthy lifestyle during my pregnancy.
		As a pregnant woman, I have access to information and support about developing and maintaining healthy relationships as partners and parents.
		I am involved and contribute to my child's learning.
		I am supported to access employment training and flexible, accessible and affordable childcare.
		As a carer for a child with mental or physical health needs, I am supported to understand my child's needs. My needs as a carer are assessed and addressed by services.
		As an educator, I have been trained to recognise, support and refer mental and physical health issues of children in my care.
		I feel able to access community services and resources to support myself and my children, including opportunities to socialise at local libraries, community centres and outdoors in local parks and open spaces.
		I have or know where to find, support for my family or can access a community support network.

We will fulfil these outcomes by:

- supporting children and young people to lead healthy and full lives;
- ensuring children and young people are given the best start as individuals, and as part of wider networks including healthy families and communities;

- use opportunities including and outside of formal settings to education children and young people and provide them with care and information in a way that is convenient to them including using technology;
- ensuring that all children and young people receive education and support to engage in healthy lifestyles, form healthy relationships and support them to make informed decisions about their future; and
- supporting children and young people to be able to engage in positive peer support, and know where to turn or where to refer their peers for further information or advice.

Priority 2: Reducing the risk factors for and managing long term conditions such as dementia

PRIORITY VISION: We want to work with people and communities to reduce the likelihood of people developing long term conditions, particularly with those at risk due to lifestyle factors such as diet and physical activity. We want to work with people, carers, communities, health and care and other public sector professionals to prevent or alleviate symptoms and co-morbidities associated with long term conditions to improve quality of life and ensure everyone remain an active member of their communities.

Our focus for long term conditions is three-fold – (1) reducing the risk of developing long-term conditions; (2) reducing the risk of complications of long term conditions; and (3) improving the support of people with long-term conditions. We will look at these three strands of work through the lens of dementia, as a complex and challenging condition that affects all elements of the health and care system.

Long term and multiple conditions in Westminster

Transforming care and support for people with long term conditions and their carers is vital in ensuring quality of life and improved life chances. Our analysis[31] suggests that by 2020 the cost of care for people with severe physical disability (approximately 2,700 people) will match the cost of treating the entire population of mostly healthy working age adults (approximately 139,000 people).

Westminster has the highest population of rough sleepers in the country, and many of these people have complex and multiple long-term conditions that encompass both mental and physical conditions[32]. Evidence shows that 42% of the people who sleep rough in Westminster have one or more support needs including alcohol/drug dependency and/or mental health conditions[33]. As a product of complex health, behavioural and socio-economic factors, rough sleeping is a unique challenge to Westminster's health and care system and one that we can best understand and address through collaboration and integration. We will work across organisations as part of the forthcoming Rough Sleeping Strategy to address the complex health conditions associated with rough sleeping and homelessness.

The largest growth in prevalence and costs to the health system are related to long term conditions (including mental and physical long-term conditions) mostly relating to adults aged over 65. These groups of people are also likely to have multiple and complex conditions that are linked to the wider determinants of health including their housing,

[31] Primary Care Modelling, 2016
[32] Rough Sleepers Health and Healthcare JSNA 2013
[33] CHAIN Annual Report Bulletin Greater London 2014/15

relationships, lifestyle (including risk behaviours such as alcohol or substance misuse) diet and physical activity.

Behaviour change and prevention

The health and care we receive has been estimated to determine up to only 15% of our life chances and outcomes. In contrast, our lifestyle behaviours (such as diet and physical activity) and our social circumstances and environment (such as levels of deprivation, social interaction and access to local green and open spaces) can determine up to 85% of our general wellbeing[34]. Improving lifestyles and wider environmental factors can result in a radical improvement in people's general health and wellbeing.

Where people do develop long-term conditions such as diabetes, hypertension or cardio-pulmonary disease (COPD), these conditions are often risk factors for developing other long term conditions such as dementia[35]. Reducing instances of long-term conditions for all ages, therefore, will ensure that more people can live well and age well.

Vascular dementia is a long term and complex condition which can be decelerated or mitigated by addressing preventable lifestyle factors (such as diet and physical activity) and preventing or mitigating other long-term conditions, such as diabetes. A recent study linked improved healthy lifestyles among men to a 20% decrease in the predicted incidence of dementia amongst men over 65[36]. In addition to this, the quality of life of people with dementia will often be significantly diminished because they experience co-morbidities including diabetes, Cardio Pulmonary Disease (COPD), and respiratory conditions that limit their ability to be active, social and maintain or regain their general physical health. Studies have estimated that 61% of people with Alzheimer's disease, which is a type of dementia, have three or more co-morbidities[37].

The focus, therefore, must necessarily be on changing behaviours to mitigate lifestyle risk factors and reduce the risk of developing long-term conditions which would cause or contribute to developing further serious conditions such as dementia, and contribute to poor quality of life. Focusing on improving lifestyles for people at risk of developing dementia, alongside those with the condition already, would not only potentially reduce the prevalence of a range of long term conditions, but would also improve the quality of life of those who have or could have dementia in the future.

We can facilitate behaviour change by empowering people to make healthy and positive choices in what they eat and the amount of physical activity they undertake. We, as people and communities, can influence the lifestyle risk factors to (such as those of vascular

[34] "Future trends: broader determinants of health", Kings Fund, 2012
[35] "Vascular Dementia", Alzheimers Research, Jan 2016
[36] "A two decade dementia incidence comparison from the Cognitive Function and Ageing Studies I and II", Journal of Nature, Medical Research Council's Biostatics Unit, April 2016
[37] "Dementia and comorbidities – ensuring parity of care" (2016), ILC UK

dementia) mitigate the increase or severity of dementia symptoms among our population. We can ensure, by living well ourselves and helping the people around us to be healthy and stay healthy, that everyone in our City has the greatest chance of ageing well as healthy and active members of our communities.

Focus on dementia

Dementia is an umbrella term used to describe the symptoms resulting from diseases and conditions that affect the brain. There are many types of dementia; common types include Alzheimer's disease and vascular dementia.[38] Dementia, regardless of type, can have devastating effects on lives – of those who experience it as well as carers, families, friends and communities. Not only can dementia drastically reduce quality of life, it can also reduce life expectancy for the individual (with someone diagnosed between age 70-79 losing on average 5.5 years of life)[39]. People with dementia are over three times more likely to die during their first admission to hospital for an acute medical condition[40]. Westminster has a high number of people with dementia dying in hospital rather than at home or in a care home. Only 11% of people with dementia in Westminster end their lives at home[41].

People with dementia are likely to have significant physical and mental co-morbidities, such as depression, hypertension and diabetes. In 2014/15, there was an additional 24,201 deaths among those aged over 75 compared to the previous year in England and Wales. The single largest cause of death among these additional deaths was attributed to Alzheimer's disease, which accounted for nearly 10,000 deaths (approx. 41%) and this was despite a peak in influenza admissions (which was the second largest cause of death)[42].

Westminster has and will continue to have a rapidly ageing population. Our recent Joint Strategic Needs Assessment on Dementia[43] indicated that, correspondingly, diagnoses of long term conditions associated with ageing, such as dementia and Alzheimer's, will see an increase of 56% between 2013 and 2033. Since 2015 we have a diagnosed population of 1,806 people and if we do not act now we will be facing an increase in the population with dementia of 2,626 by 2030 with over 760 new cases of dementia each year after 2030[44]. The cost of treating dementia and associated co-morbidities will be an increasing financial and organisational burden to our health and care system over the next decade and beyond.

Westminster has been successful in ensuring people with dementia are diagnosed as early as possible. We have not achieved the same success in ensuring that people with dementia and their carers feel engaged and supported in our communities to live healthy and full

[38] Alzheimer's Society
[39] Dementia JSNA 2015
[40] "Dementia and comorbidities – ensuring parity of care" (2016), ILC UK
[41] Dementia JSNA 2015
[42] ONS, April 2016, Principal Population Projections, Life expectancy figures 2016
[43] Dementia JSNA 2015
[44] Ibid

lives. Dementia is a long-term condition that presents a fundamental challenge to our families, our communities, and our system to provide sustainable, dignified and person-centred care and support. For this reason we believe that addressing dementia in particular, as one of a range of long-term conditions, is a defining priority for our health and care system.

The cost of dementia

The largest cost of dementia is borne by families and friends who on average, provide unpaid care representing 45% of the estimated cost of dementia, with adult social care contributing approximately 40% by comparison (with the remaining 15% of costs borne by health services). The cost of caring for someone with dementia in London is currently approximately £37,000 per annum, but for some people with co-morbidities and corollary health issues the cost can rise to £70,000 per annum[45]. The total cost of dementia care in Westminster, Hammersmith and Fulham and the Royal Borough of Kensington and Chelsea is estimated to be currently £161m per year[46].

Early escalation of care to the right levels at the right time has been noted as a problem in Westminster, with higher rates of emergency and inpatient admissions for people with dementia[47]. At any one time, a quarter of acute hospital beds are in use by people with dementia. The acute medical setting is not ideal for the person and their families and friends particularly if they are not at crisis point and would prefer to be at home. Four out of the five most common comorbidities for people with dementia are admitted to hospital for are preventable conditions – a fall, broken/fractured hip, and urine or chest infections[48].

Being dementia friendly

Research has indicated that nationally 75 % of people with dementia do not feel that society around them is organised to support or understand people with dementia and as a result feel isolated from their local communities.[49]It is therefore not surprising that people fear dementia as a condition more than any other disease. 39% of over 55s are most worried about developing dementia, compared to 25% who worry most about cancer. Local clinicians provide anecdotal evidence that in Westminster there are a number of people with dementia who do not want to be diagnosed or discuss the possibility of already experiencing symptoms of dementia with their health care professionals[50].

Westminster has a number of programmes that engage older people with our major artistic and cultural institutions in the City, including the Royal Academy and MCC Lords. It is

[45] Ibid
[46] Ibid
[47] Public Health England Dementia Profile (2015)
[48] "Dementia and comorbidities – ensuring parity of care" (2016), ILC UK
[49] Department of Health, State of the Nation report on dementia care and support in England (2013)
[50] Dementia JSNA 2015

important that these highly visible organisations are showing leadership in making dementia and reducing social isolation part of their work and role in the community. It will be important to continue this work to cascade this across all organisations and businesses to make sure they know that making Westminster a dementia-friendly city is everyone's role.

We want to reduce the stigma and fear attached to dementia, through creating dementia friendly communities which support and embrace people with the condition and their carers. It would not only improve quality of life and of experience, but also encourage people, families and friends to discuss their concerns about their health and how they can self-manage in their communities.

Valuing and empowering people and communities

Evidence shows that risk factors (such as diet, physical activity and lifestyle factors such as smoking) can slow down the progress of long-term conditions and improve the quality of life for people with long-term conditions. By enabling and empowering those at risk of developing dementia to make healthy choices and to be involved and contribute to local communities and environments, we ensure that they have the highest quality of life, and the best opportunity to maintain or improve their health.

Westminster is a place that values and celebrates the contributions of all people. We are committed to supporting and encouraging retired people to volunteer and contribute their knowledge and expertise to Westminster through the Spice Time Credits scheme, which incentivises and rewards participants. Based on what we have heard from people, communities and professionals we know that making an active contribution to your community makes people feel more engaged and invested in place they live, work or learn. This in turn helps to prevent and alleviate short and long term mental and physical health conditions and can aid the improvement of wellbeing.

Outcomes we will aim for

Population Group	Outcome Domain	Outcome
Working age adults (as front-line workers, volunteers and carers)	**Quality of life**	I/my carer can access advice and support to remain independent and engaged in my/our community (e.g. dementia cafes and befriending services).
		I/my carer feel that the wider community has an understanding of dementia and my/our experiences.
		I/my carer feel that the services and workers I/we engage with have been trained to understand my/our specific needs.

Working age adults	**Quality of life**	I am empowered to live a healthy lifestyle and make positive choices, including about my diet, physical activity and risk behaviours (such as smoking) that contribute to a reduction in the likelihood of my developing long-term conditions.
	Quality of experience of services	I can access services which address my needs as an individual, and which have an awareness of how my lifestyle (including my housing situation) impacts my health and my access to services;
Adults aged over 65 / Adults aged over 85	**Quality of experience of services**	I/my carer have the opportunity to be involved in the design, delivery, management or review of services that I use.
		I/my carer feel that the services I/we use understand my/our specific needs as an individual, including my cultural background.
		I/my carer feel that I can communicate effectively with the services supporting me about my needs.
		The services supporting me and/or my carer make me/us feel safe and secure.
		I/ my carer have developed my care plan in conjunction with my family and carer (as much as I want) and my carers are supported to care for me and their own needs recognised.
		I/my carer have a named point of contact who understands me/us and my conditions.
		I/my carer believe that the professionals involved in my care talk to each other and work as a team.
		My wider health needs, including accessing opportunities for physical activity, are addressed and supported.
	Quality of life	I/my carer am/are able to live the life I/we want to the best of my ability.
		I am supported to remain independent and stay at home where possible.
		I and/or my carer know what to do to keep myself/ourselves active and well, including understanding how to improve my physical and mental health through diet, physical activity and lifestyle choices (such as smoking).

		I/my carer are supported to prevent/manage any long-term comorbidities that may affect me.
		I/my carer feel able to access community services and resources, including opportunities to socialise at local libraries, community centres and outdoors in local parks and open spaces.

To fulfil these outcomes we will:

- be a dementia-friendly community, with an understanding of dementia and the contributions and capacities of people with dementia and their carers recognised and supported;
- support community resilience and ensure that a range of complementary and local services are provided that support social engagement and represent diversity of experience and background of people with dementia and their carers;
- support working age adults to develop and/or retain active lifestyles, and mitigate those lifestyle risk factors that might contribute to the development of dementia;
- consider the experience, needs, capacities and contributions of people with dementia and their carers when developing services and plans; and
- ensure health and care services continue to work closely together to improve the quality of life and quality of experience of care of people with dementia and their carers.

PRIORITY 3: Improving mental health outcomes through prevention and self-management

Amongst people under 65, nearly half of all ill health is mental illness[51].Poor mental health can affect quality of life, our life expectancy and our ability to participate in and contribute to the local community. People in vulnerable or excluded groups such as the homeless or rough sleepers are often more likely to experience severe mental health conditions and associated physical health conditions[52]. It can have varying degrees of impact on an individual's relationships and employment. The effects of poor mental health are far reaching and can be potentially devastating to individuals and those around them.

Mental health problems can be placed into two main categories:

- common mental health problems (such as mild to moderate anxiety and depression); and
- severe and enduring mental illnesses (such as bipolar and schizophrenia).

Common mental health problems affects around 1 in 6 people at any one point in time and is one of the leading causes of disability nationally. The World Health Organisation (WHO) has predicted that by 2020 depression will be the second most common health condition worldwide[53]. Westminster self-reported prevalence of anxiety and depression was above the national average in 2014, and estimates suggest this may rise steeply over the next 10 years.

In regards to **severe and enduring mental illnesses**, Westminster has an estimated incidence of new cases of psychosis of approximately 40 people per 100,000[54], which is comparable to the London average but significantly above the national level. Westminster also has more emergency admissions for schizophrenia than the national and local average. People with a Severe and Mental Illness die on average 10 years' earlier than the general population and this includes a higher rate of suicide compared to the national average for healthy populations[55].

Improving the quality of life and life expectancy for people with severe and enduring mental health conditions requires us to treat and support them as whole individuals, and this means looking at wider issues that may affect them including their housing, employment, healthy relationships, diet, physical activity, and risk behaviours (such as smoking and alcohol consumption)[56]. People with mental health conditions often receive poorer acknowledgement and treatment of concurrent physical health conditions. Conversely people with physical conditions often receive poorer treatment of their mental health[57].

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[51] "How mental health loses out in the NHS", Centre for Economic Performance, 2013
[52] Rough Sleepers Health and Healthcare JSNA 2013
[53] "Depression: A global crisis", World Federation for Mental Health, 2012
[54] Public Health Outcomes, Severe Mental Illness, 2015
[55] Kings Health Partners 2010
[56] "Recognising the importance of physical health in mental health and intellectual disability", BMA Board of Science, 2014
[57] "Better outcomes, better value: integrating physical and mental health into clinical practice and commissioning", NHS Improving Quality, June 2014

We must ensure that as a health and care system, we are joining up mental and physical health treatment by treating people as individuals and not by their conditions.

People with severe and enduring mental health illnesses often come into contact with public services other than, or instead of, health and care services. For example, staff of police and fire services, housing and probation encounter people with SEMIs during the course of their work. It is important that there is an awareness of mental health issues across public service commissioners, providers and staff to ensure that we can refer and support each other to provide the most effective and timeliest interventions.

Compared to neighbours, Westminster has more people receiving mental health social care services[58]. However, there is evidence that support for Westminster carers of people with severe and enduring mental illness is lower than in neighbouring boroughs, with fewer carers receiving assessments[59]. By looking at mental health within a wider context, and recognising the complex interaction of factors such as relationships, housing, education, and lifestyle, we will not only improve health and wellbeing, but reduce the stigma associated with mental health conditions.

Compared to neighbours however, Westminster has more people receiving social care mental health services. There is evidence that support for Westminster carers of people with severe and enduring mental illness is lower than in neighbouring boroughs, with fewer carers receiving assessments.

Focus for Westminster

Mental health can be influenced by genetic predisposition, poor physical health social and environmental factors and psychological factors. Risk factors in Westminster include unemployment, low educational attainment, deprivation, homelessness, isolation and substance misuse and family or relationship issues.

The Westminster Health and Wellbeing Board endorsed and support the implementation of *Like Minded,* a sub-regional strategy spanning eight boroughs and their corresponding CCGs in North West London. The strategy is predicated on working in partnership to deliver high quality joined up mental health services to improve the quality of life for individuals, families and communities who will or are experiencing mental health issues.

The Westminster Health and Wellbeing Board is not seeking to replicate work on mental health that has been set out in *Like Minded.* The Board will instead focus on, and supplement the ambitions embodied in the strategy including:

"We will improve wellbeing and resilience, and prevent mental health needs where possible by:

- ***supporting people in the workplace***

[58] Public Health Outcomes, Severe Mental Illness, 2015
[59] Ibid

- ***giving children and young people the skills to cope with different situations***
- ***reducing loneliness for older people."***

This ambition resonates with the Board because there is evidence of significant local need in the three above areas but also throughout our engagement with community groups, service users and patients, these three areas were recurring themes

The Board, in its local leadership role, will use its collective influence and energy to accelerate progress of this ambition in Westminster through prioritising and embedding prevention, early intervention and a whole systems approach to stop and reverse the negative trends of poor mental health and wellbeing.

Mental health and employment (working age adults)

Unemployment and worklessness is a known cause for poor mental health illness in Westminster. Mental health can be a barrier to employment and meaningful occupations (such as volunteering). Some Westminster wards fall into the highest 10% in London for incapacity benefit and/or employment support allowance claimant rates for mental health reasons[60]. Conversely, stress at working is also a common reason for long term sickness absence in Westminster. Stress and mental health disorders are one of the biggest causes of long-term absence and is increasing as a reason for short-term absence[61]. We must work to champion a range of activities, from volunteering to part-time and full-time work, that are welcoming and supportive to people with mental health conditions. We will work to ensure the definition of "meaningful occupation" becomes wider, not narrower.

Westminster has a daytime population of approximately 1,000,000 people compared to a resident population of approximately 225,000 people[62]. A large number of these people are in the Borough due to employment and our largest source of opportunity to engage with them to improve their mental health as a health and care system will be through our universal services, and through our engagement with their employmers.

Loneliness and isolation (adults over 65 and adults over 85)

Social skills and interactions are crucial to the mental and physical health and wellbeing of people. Older adults tend to suffer more from long term and multiple conditions which can reduce mobility and, therefore, limit interactions. Sustained loneliness and lack of interaction with others can lead to poor mental health which can cause poor physical health.

[60] Public Health Outcomes Framework, Wider Determinants of Health
[61] Westminster City Council adults, Health and Public Protection Committee, Strategic Approaches to Mental Health in Westminster, 2016
[62] City of Westminster Economic Report 2014, LEA Baseline Study

Personal and community resilience through education and empowering people and communities to self-manage

An integral part of managing mental health illnesses is self-management. Those who are vulnerable will need extra support. Most people with common mental health problems have the capacity and independence to self-manage if they are empowered and equipped with the right information at the earliest opportunity. They may need some low level support such as talking therapies but largely people can help to reduce the risk factors and prevent stress through self-management and building person resilience. Those with more severe and enduring mental health conditions may need support to ensure they are able to manage the side effects of their medication, eat healthily and stay active.

Outcomes

Population Group	Outcome Domain	Outcome
Conception to 5 years	Outcomes for this group are covered on pg. 11 onwards as part of Priority 3.	
Children and young people	**Quality of experience of services**	I am educated and supported to understand and maintain my mental health as a child and young person.
		My transition from care for children and young people to adult care is planned and supported with my involvement.
Working Age Adults	**Quality of experience of services**	I am supported by the health and care services to achieve my personal goals.
		I am supported to maintain and improve my mental health and wellbeing, and to understand how to access information and support when I need it.
		I am involved in the design, delivery, management or review of services that I use, and I have a level of control over the support I receive.
		I feel that the services I use understand my specific needs as an individual, including my cultural background.
		I have received enquiries/information/advice about wider issues such as my finances, housing, relationships and benefits.
		I am treated and cared for as an individual, and I feel that my unique challenges and skills are recognized and acknowledged in plans for my care.

	Quality of life	I am supported to engage in my wider community through meaningful occupation (including volunteering and employment).
		I am supported in my workplace to maintain my mental health or seek information and care when necessary.
		I feel comfortable discussing my mental health with my employer.
		I have improved quality of life, confidence, and self-esteem.
		I feel an increased ability to manage instances of mental distress.
		I know where to access support and the people around me understand my health and support needs, and are able to find information and support themselves.
		I am able to manage and improve my physical health and I can take regular and appropriate physical activity.
		I am able to engage in purposeful activities including training, education, employment or volunteering.
		I have a strong social network and I am able to maintain relationships and engage in community activities.
		I/my carer feel able to access community services and resources, including opportunities to socialise at local libraries, community centres and outdoors in local parks and open spaces.
Adults over 65 years / Adults over 85 years	**Quality of life**	I feel that my mental health needs are assessed separately from any preconceptions about conditions that may be associated with my age.

To fulfil these outcomes, we will:

- addressing the stigma associated with mental health conditions (both common and severe) by treating and caring for people as individuals and recognising the complex factors that impact mental health;
- go above and beyond and say that we will support people in the workplace and diminish the barriers into work for people;
- empower and support communities to build resilience and cohesion so individuals and families can support and look out for each other; and
- we will encourage and develop local 'untapped' community resources such as front line workers, local shop managers and workers or community pharmacists to provide a new "front line" of health and care.

Priority 4: Creating and leading a local health and care system fit for the future

Priority vision: we will be an integrated, collaborative system that uses our resources (technology, estates and workforce) to deliver information and care in the right place at the right time, and in a way that maximises convenience for our population and efficiency and sustainability for the system.

We in Westminster have a bold vision for health and care in our city. We want to transform rapidly the health and care of our population and build a clinically and financially sustainable model of health and care. We see this as a huge opportunity to transform the life experiences of people living in and visiting our city. But we also know that delivering on this opportunity will require greater responsibility from us all locally.

We are already engaged in determining the way resources are directed and spent in the city. We see the transformation of primary care, the bedrock of the health and care system, as fundamentally important to achieving our aims and primary care co-commissioning is part of the process of helping us to deliver rapidly across the whole city. Looking ahead , this strategy sets out the basis on which we will take greater responsibility for services locally. We believe that having the freedom to transform radically the health of our population will enable us to take a whole place and whole community view and will be key to helping us tackle some of the underlying aspects of health inequality in Westminster.

In order to deliver on this aspiration, we will need to change the way we think about health and care locally so that we are able to deliver greater local responsibility and accountability across health and care budgets and services. We need to see a shift in culture and move to shared responsibility.

The Leadership Challenge

The London Health and Care devolution agreement reached in 2015[63] identified the basis on which there will be greater scope for decision making in health and care locally. It describes the framework within which decisions on a range of public services including transport, employment, planning and other areas would be delivered to London local authorities. This will give people and their local representative's greater control over decisions which have hitherto been taken at a national level.

The reform of health and social care is a key part of delivering on the national policy shift toward greater devolution of control to local communities. Westminster has a range of statutory and community based organisations coming together to tackle issues of common concern and interest, and this is a good basis for moving forward as a system to take more control over the public money being spent on health and social care. We will need to work

[63] London Health and Care Devolution Agreement (2015)

together to deliver rapid and radical improvements in health and care in Westminster over the next five years.

One of our first tasks will be to put in place the leadership and governance arrangements which will be required to deliver these improvements at the pace and scale needed to ensure that we as a system are able to reach decisions together in a robust, fair and equitable way. We need to be able to share executive decision making across our organisations, and position the Health and Wellbeing Board to continue to have the central coordinating and stewardship role that will enable us to deliver effective leadership and decision making locally.

Our early implementation priorities:

- **Agreeing the creation of this unified Joint Health and Wellbeing strategy**
  The strategy refresh process has been an opportunity for us to set out what we will all work together on and will directly inform how we commission services. It will set a template for our joint strategic work moving forward.
- **Putting in place the governance and accountability arrangements which will help us to deliver our strategy**
  In Westminster, we have a strong history of joint working across health and care and this strategy builds on that learning and experience. As we work to deliver greater improvements in health and care locally, we will need to strengthen and update our governance and accountability arrangements. A key priority for us will be designing in the processes by which local people are engaged as active contributors to the decision making process.
- **Starting to view our budgets and services in a single joined up way**
  To achieve the kind of radical changes in outcomes which local people expect us to deliver it is vitally important that we begin to look at our budgets "as one" in the same way as we have begun to view our priorities as common challenges. We will do this by modelling our spend and priorities over the lifetime of this strategy, setting out how much we anticipate we will spend over this period and on what. We will then need to consider how best we can incentivise our whole system to deliver on this by learning from best practice elsewhere.

The Workforce Challenge

In Westminster, we have an ageing population, an increase in the number of people with multiple long-term conditions and a growing burden of chronic disease (including mental illness) which place the greatest demands on services now and in the future. The changing nature of need in our population means that we need to transform a workforce that has been trained to work on single episodes of care in hospital into one that is trained and equipped to work in integrated and multi-disciplinary ways in community settings.

We need to invest in multi-skilled training of nurses and allied health professionals which will help to deliver person-centred care in the community. The number of district nurses fell by 38% between 2001 and 2011 [64] and there is a large and growing mismatch between the demand and expectations of care and the supply of health and social care workers who will be able to deliver this, including a large undersupply of GPs.

We also need to address key social and economic trends that might affect our workforce in the future, including the cost of living in central London. Improved connections into the City from wider areas (as a result of infrastructure projects such as Crossrail and Highspeed 2) mean more of our workforce will be able to commute into the city. We need to work together to create the conditions the to ensure that Westminster remains an attractive and viable place for health and care workers to live and work.

Strategic workforce planning is therefore crucial to delivering our ambitions for a financially sustainable and safe integrated health and social care system providing quality services to people. If we do not act there is a danger that the available workforce will drive the design of our health and care system rather than the other way around. Planning the workforce we need for the future will require local organisations and patients in Westminster to come together to understand the impact of technologies on the role of the health and care workforce in the future and understand the areas of demand growth in our system. It will require us to work with partners such as Health Education England and Public Health England to access funding streams and work with professional colleges and other bodies to offer more generalist training courses that focus on multidisciplinary work in team-based settings.

Our early implementation priorities:

- **Map our current workforce**
  One of the key tasks for us will be to work with our partners to undertake a local workforce mapping exercise looking at the needs of our population locally and mapping these against projected demand for health and care services. This will help us to understand gaps in our workforce now and in the future, as well as the skills required to meet changing needs. We have begun to map our demand in the future as part of the Primary Care Modelling project undertaken by the Health and Wellbeing Board[65], and we will use this template alongside scenario planning (including looking at the potential impact of technology) to create a robust response to a range of potential future issues. There needs to be a shift to a multi-disciplinary and multi-professional approach to care.
  New technologies and ways of working will profoundly affect the nature of future health and care work, where it is done and by whom. Technology has the power to

[64] "NHS and social care workforce: meeting our needs now and in the future", Kings Fund, 2013
[65] Westminster Primary Care Modelling Project

place more power in the hands of patients to self-manage their own conditions outside of hospital settings and tele-care will enable greater remote monitoring of patients by specialists. These will all be key considerations in workforce planning.

- **Work with partners to redesign the training and development system**
  Once the workforce supply need is understood, we must work with Royal Colleges, Health Education England and other teaching institutions to refocus local health and care worker training programmes towards the workforce needed for the future. This is likely to include more specialist skills in primary and community care, more generalist skills in hospital care and more collaboration across hospital and community and mental health and physical health workers. We need to change the training curriculum to develop the skills to care for people with multi-conditions that span physical and mental health.

- **Provide the right reward structures and contract flexibility to incentivise the creation of the right workforce**
  Retention of current staff is vital. Greater flexibility of pay and terms of conditions must be addressed to incentivise the supply of staff where demand is greatest. Training also needs to prepare staff for multidisciplinary team working rather than the roles of professional groups.

  We also need to support and better harness the power of the informal workforce by creating a 'social movement' to support those in need, including a more strategic approach to the support and development of volunteers.

The changing role of communities and individuals

In Westminster we have a diverse and mobile population and we must be ambitious in our attempts to affect a change in culture so that people are better supported to take more responsibility for their own care.

Our early implementation priorities:

- **Capitalise on the benefits of self-care**
  The extent to which a person has the skills, knowledge and confidence to manage their own health and care ("patient activation") is a strong predictor of better health outcomes, healthcare costs and satisfaction with services. As approximately 80% of our population is mostly healthy, 80% of health and care should be self-care. Small shifts in self-care have the potential to impact significantly the demand for professional care. Some experts argue that as little as a 5% increase in self-care could reduce the demand for professional care by 25%[66]. In Westminster we need to identify

[66] "NHS and social care workforce: meeting our needs now and in the future", Kings Fund, 2013

and capitalise on people who are strongly committed to managing their own care and work with them to find ways to influence others who are less so to do the same.

The infrastructure opportunity

The rising cost of space in Westminster means that models of care built around specific locations for specific services are unsustainable and will exacerbate existing health inequalities. Instead, partners in Westminster need to work together to share land and buildings, and build the estate required to respond to clinical need and the changing needs and demands of our population. Our infrastructure is not just a challenge but an opportunity. The constraints of our dense urban environment incentivise us to think creatively about how health care, social care, housing and other providers of care and related services in Westminster can co-locate and collaborate in ways that create value for the wider community. Both in the short and long term, we must think about how we will provide sustainable services to our population, and this will require us to act quickly and creatively as a system.

Our early implementation priorities:

- **Increase value from our estate in Westminster**
  Westminster partners should work together to audit the extent of the Westminster estate, its use and state of repair across health, social care, housing and the voluntary and community sector. Better strategic management of our estate could realise multiple benefits including the removal of fixed running costs that contribute to our financial challenge, the release of land for housing our workforce and reinvestment of disposal proceeds back into the health and care system. A grasp of use and utilisation can also enable us to become more efficient in how we use our precious resource and identify opportunities for co-location and asset sharing across health and care.

- **Developing the estate required to facilitate new models of care and support**
  A new approach is needed that looks across the whole system and brings services together to improve access and experience for patients and opportunities for provider innovation and collaboration. This approach would offer ways to reduce costs and improve efficiency, improve the quality and appropriateness of care settings, and to generate income for reinvestment. There is a strong case for creating more multi-purpose flexible facilities. A strategic approach to the Westminster estate has the potential to help break down barriers between health and social care, mental and physical health and primary and secondary care.
  There are opportunities, for instance, for mental health providers, housing and employment services to explore integrated approaches that would better support service users and address discharge issues. A more flexible approach involving co-location of NHS and social care staff in non-NHS buildings would make services more flexible and accessible and would release savings that could be reinvested in patient

care, staff and technology. School premises, for instance, are underutilised as settings for providing child health services despite being ideal.

The information and digital challenge

Investing in information technology and data analytics will all be crucial to enable a successfully integrated health and social care system in Westminster that provides patients with a good experience of care. We must work together to facilitate and enable information exchange between organisations in a way that respects patient preferences and information governance protocols. Not doing so will hinder inter-organisation collaboration and innovation.

We must seek to develop shared digital patient records that are updated in real-time and shareable across organisational and sector boundaries. Better information collection and management will also enable better retrospective and predictive modelling and both professional and strategic decision making allowing us to understand how efficiently we are utilising our resources and improve quality and safety standards for people.

Our early implementation priorities:

- **All partners across Westminster must agree to share information**
  A first crucial step in building our health and social care system will be for local organisations to commit to collect, share and pool information in a way that links data at an individual level and organises it into a format which enables better analysis and decision making by all organisations. It will be vital that data sharing agreements recognise patient preferences and information governance protocols. Ensuring interoperability between different organisation's systems will be a second crucial step.

- **Investigate the role of technology in enabling people to manage their own care**
  Westminster should look to work with local and national partners to explore opportunities to utilise the power of technology to facilitate self-management of care. Remote monitoring of conditions and tele-health (remote consultations) are promising areas where technology could reduce demand on the health and care system and improve patient experience. More should be done to investigate the viability of these approaches locally and scale up what works.

The financial challenge

To encourage integrated care, payment incentives and planning cycles need to be aligned. There is an urgent need for experiments in changing the nature of tariffs for NHS care, to enable greater investment in primary and secondary prevention, alongside delivering community and acute health services where needed. Commissioners also need to increase

the use of pooled budgets as a way of enabling closer health and social care collaboration. Using quality-based incentive payments across pathways of care might likewise incentivise best practice models and partnership working, while ensuring that providers are incentivised to make a contribution to the health and wellbeing of the whole population. Personal health budgets, too, might enable some patients and service users to commission their own care in ways that better meet their needs.

Appendix A: Population and Outcomes based commissioning

It is one of the priorities of the Health and Wellbeing Board as a leader of the health and care system in Westminster to focus not only on instances of ill health but also on addressing the health and wellbeing of the population as a whole. The Board wishes to understand and address the health and wellbeing of this population as the result of a wide range of determinants, and improve general health, quality of life and quality of experience of services, is one of the overarching priorities of the Health and Wellbeing Board as a leader of the health and care system in Westminster.

In 2002 the Institute of Medicine stated the advantage of taking a population health approach as follows:

> "[population health approaches build on] a new generation of intersectoral partnerships that draw on the perspectives and resources of diverse communities and actively engage them in health action[67]"

The population groups that have been identified as key by the Health and Wellbeing Board and key partners and stakeholders, are grouped based on a number of factors including future projections relating to health and demography, the multiple determinants of health, how an integrated system can best support the whole population, and how the behaviours of these groups might impact their health and wellbeing.

The population groups identified are listed below:

- Conception to 5 years;
- Children and young people;
- Working age adults;
- Adults over 65 years;
- Adults over 85 years;

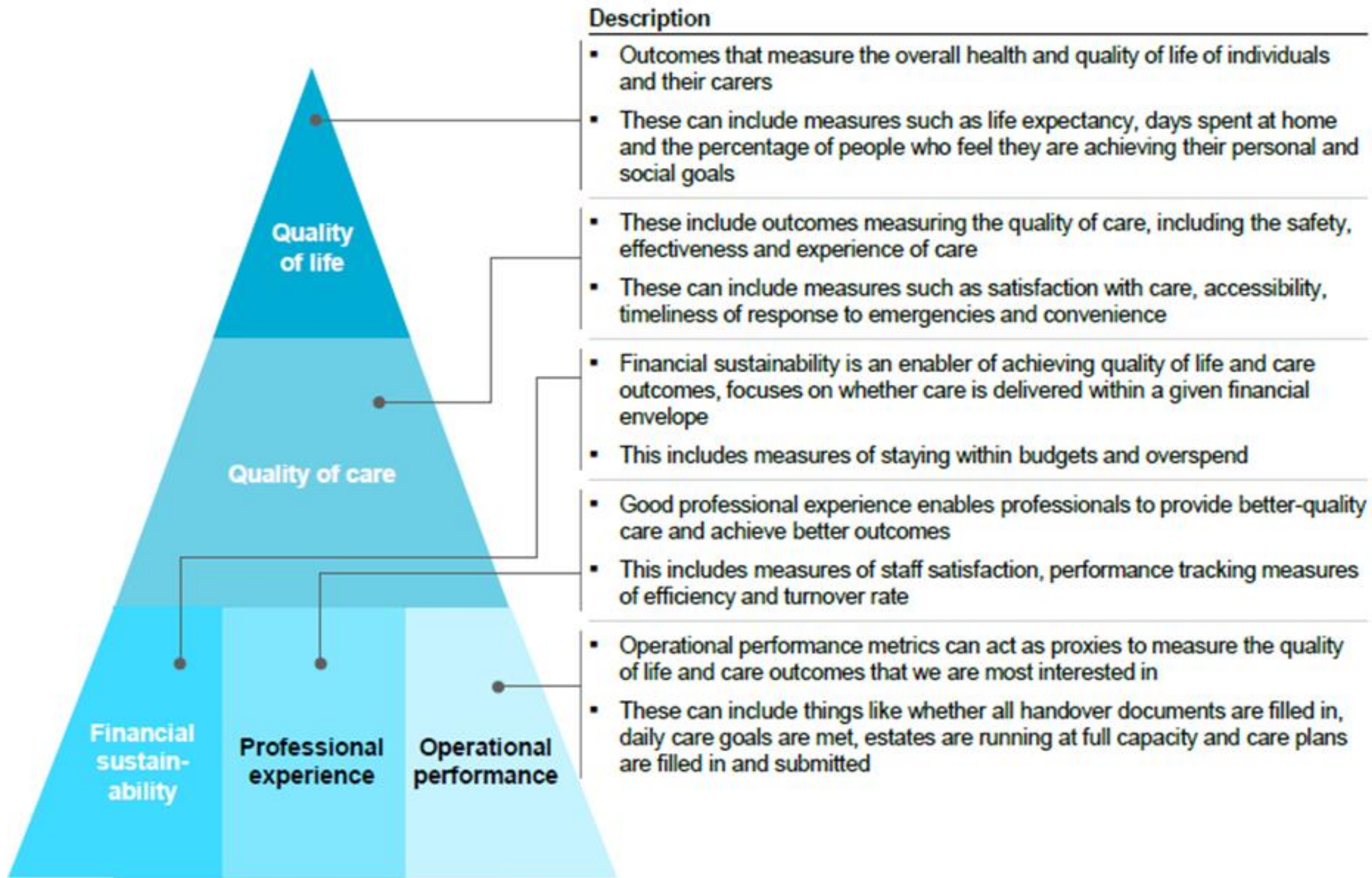
These groups will in turn inform the commissioning of services both to prevent ill-health support their needs. Traditional ways of buying health and social care services ("commissioning") have tended to focus on processes, individual organisations and single inputs of care. For example, the people who buy services have tended to pay the people who provide services based on the number of instances of treatment. This focuses the health and care system on completing individual tasks rather than focusing on a person's overall wellbeing.

"Outcomes" are the end results we aspire to achieve for people, their families and their carers. For example, ensuring more people feel satisfied, safe and happy as a result of the treatment or care they receive. Outcomes-based commissioning allows both commissioners

[67] The Future of Public's Health and the 21st Century, the Institute of Medicine, November 2002

and providers to focus on the important aspects of care - the result from a patient's perspective. Outcomes based commissioning incentivises shifting resources to community services, a focus on keeping people healthy and in their own homes and co-ordinated care across settings and regions.

The North West London Outcomes Framework is set out below. It summarises the key outcomes to be achieved into five domains, as follows:



Source: Whole Systems Integrated Care module working group

Page 68

The Westminster Health and Wellbeing strategy uses the North West London outcomes framework to ensure that there is a consistent approach to understanding people's needs and buying services in support of them across the sub-region. Being consistent across larger geographies including North West London is important, particularly in London, because so many providers of health and care operate across borough boundaries and because people access services outside of Westminster. Basing our future commissioning on a shared framework in this way allows us to deliver scale to the range of services we have on offer for people and it means that we can make a shift, across the whole system, in the way that health and care is organised, bought, delivered and measured.

In this outcomes framework and hierarchy, the most important perspective is the well-being of the person who is receiving services and, as such, the first two domains - quality of life and quality of care (what we have termed quality of experience of care) - are the most important. The other three outcomes domains – financial sustainability; professional experience; and operational performance – are all crucial enablers for delivering quality care and quality of life for people and are addressed holistically in the systems section.

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

The approach can help rather than hinder provider coordination and collaboration; incentivise a focus on prevention; allow providers, the experts in their field, the freedom and flexibility to innovate and personalise care according to what is best for patients' outcomes (rather than sticking rigidly to service specifications); and incentivise providers to manage overall system costs (because providers are accountable for the end-to-end costs of care for a group there is no advantage in passing on costs to another organisation in the system).

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City of Westminster

Westminster Health & Wellbeing Board

Date:	26th May 2016
Classification:	General Release
Title:	Better Care Fund Programme 2016/17
Report of:	Liz Bruce, Executive Director Adult Social Care and Health
Wards Involved:	All
Policy Context:	Development of an integrated Better Care Fund Plan is a requirement of the Department of Health and the Department for Communities and Local Government. Funding allocations to the Local Authority and to the local NHS in 2014-16 are dependent on agreement between the parties on the BCF Plan. In addition, the programme of work is consistent with the stated vision and objectives of the partners within the Westminster Health and Wellbeing Board, and is a mechanism for delivering the outcomes and efficiencies required from City For All.
Financial Summary:	The BCF brings together a number of existing funding sources for savings, summarised in Table 1.
Report Author and Contact Details:	Chris Neill, Director of Whole System

1. EXECUTIVE SUMMARY

1.1 Following on from the BCF Quarter 3 report presented to the Board on 9th March this report sets out the process for agreeing the Better Care Fund 2016/17 programme.

1.2 In recognition of the emerging NHS Sustainability and Transformation Plan (STP), the proposal is that the BCF 2016/17 will be a continuation of the 2015/16 programme and will be revised during the course of the year to reflect the requirements of the STP which is not planned to be completed until the Autumn.

2. RECOMMENDATIONS

2.1 The Board is asked to note the arrangements for the 2016/17 Better Care Fund.

3. BCF 2016/17: THE NATIONAL CONTEXT

3.1 The Department of Health (DH) and the Department for Communities and Local Government (DCLG) have published the local allocations, a detailed policy framework and guidance for the implementation of the Better Care Fund in 2016/17, developed in partnership with the Local Government Association, Association of Directors of Adult Social Services and NHS England.

3.2 For 2016/17 it has been agreed that the BCF planning and assurance process should be integrated as fully as possible with the core NHS operational planning and assurance process and requires the plans to be jointly developed with local government partners, and approved by Health and Wellbeing Boards..

3.3 The policy framework signals the need for stability in 2016/17, and a reduction in the overall planning and assurance requirements on local areas.

3.4 Whilst the policy framework remains stable in 2016/17, local areas are expected to be mindful in developing their plans to ensure linkages with NHS Sustainability and Transformation Plans which NHS partners are required to produce in 2016, and the Government's Spending Review requirement to produce a whole system integration plan for 2017. Both planning requirements will require a whole system approach from 2017-20.

4. BCF 2016/17; Planned Schemes

4.1 Locally, across the three boroughs, minimal change in scope and approach in 2016/17 and a roll forward of 2015/16 funding levels is being proposed. With an expectation that it will be revised in year to reflect the Sustainability and Transformation Plan in Autumn 2016.

4.2 NHSE London region have requested from CCGs a narrative document setting out progress to date and future direction for using the BCF to facilitate integration. (Appendix A).

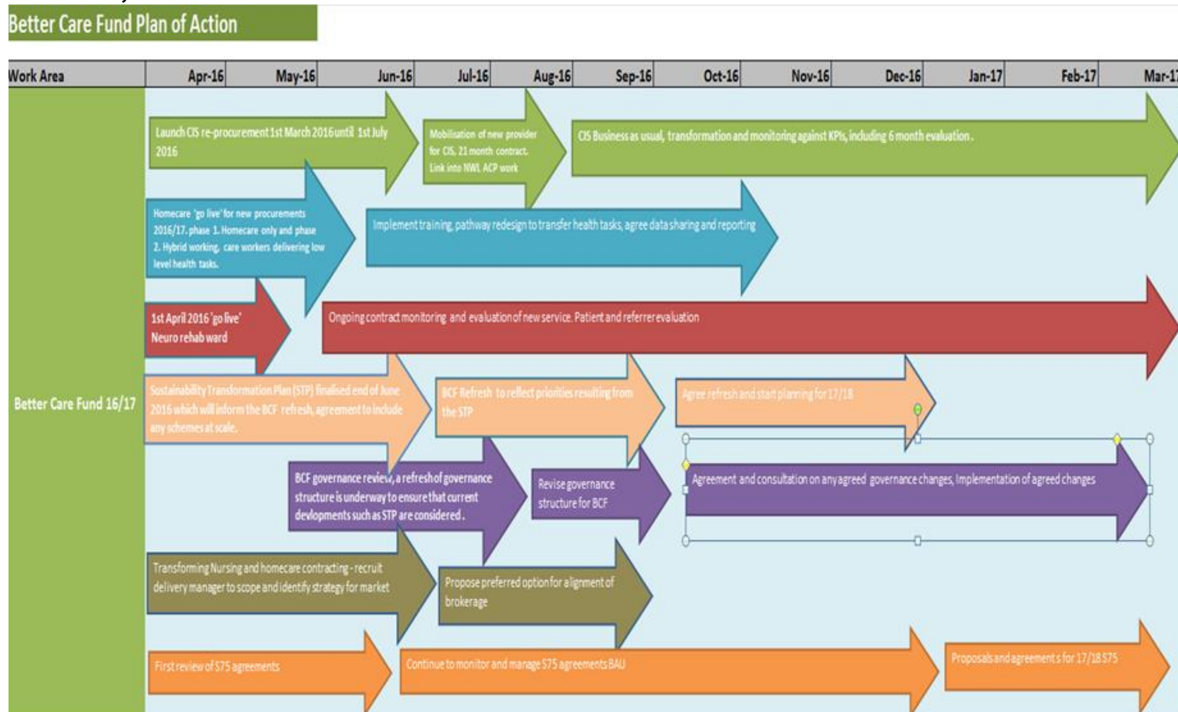
4.3 The schemes set out and approved by Cabinets, Governing Bodies and Health & Wellbeing Boards in 2014 have been updated and are listed in Table 1 and further detail is attached as Appendix B. The scheme areas remain the same, slight changes in 2016/17 in two areas (patient and public engagement and personal health budgets). The aim is to mainstream these as approaches rather than having them as separate projects.

Table 1: Summary of 2016/17 planned BCF Schemes

Ref no.	Scheme	Non recurring Investment (£000s)	New delivery cost (£000s)	Existing Costs (£000s)	Total costs (£000s)
A1	*Community Independence Services*	2,688	-	17,221	**19,909**
A2	*Community Neuro Rehab Beds*	-	2,117	1,562	**3,679**
A3	*Homecare*	-	1,600	-	**1,600**
	- *Low level health tasks*	-	-	-	**-**
A4	*Integrated Hospital Discharge and 7 Day Working*	-	-	938	**938**
B1	*Patient/Service User Experience and Care Planning – including self management and peer support*	-	-	200	**200**
B2	*Personal Health and Care Budgets*	-	30	20	**50**
C1/C3	*Transforming Nursing and Care Home*	-	-	721	**721**
C2	*Review of Jointly Commissioned*	-	-	127,062	**127,062**
D1	*Information Technology*	-	-	201	**201**
D2	*Information Governance*	-	-	-	**-**
D3	*Care Act Implementation*	-	-	1,750	**1,750**
D4	*BCF Programme Implementation and Monitoring*	**-**	**-**	350	**350**
	Disabled Facility Grant	**-**	**-**	2,867	**2,867**
	TOTAL	**2,688**	**3,747**	**152,892**	**159,327**

4.4 The summary plan in Table 2 shows a high level timeline of the main milestones to be delivered over the course of the 2016/17 BCF plan. Achievement against this schedule will be closely monitored as part of the BCF Programme Implementation and Monitoring. Appendix C shows further detail of the breakdown across the three CCGs and Local Authorities.

Table 2; Better Care Fund Plan of Action



4.5 None of the above precludes us from making changes to the BCF and planning is already underway for the BCF in 2017/18 and beyond; however the narrative document has been shared with NHSE London region with the aim of starting the financial year with clarity about the size and scope of the fund.

5. LEGAL IMPLICATIONS

5.1. Under the Health and Social Care Act 2012 the Health and Wellbeing Board has a duty to make it easier for health and social care services to work together. Section 3 of the Care Act places the Local Authority under a duty to carry out its care and support functions in a way that promotes integrating services with those of the NHS or other health-related service. The Better Care Programme as outlined in this report discharges those duties.

6. FINANCIAL AND RESOURCES IMPLICATIONS

6.1. In total across the three boroughs, the BCF plan for 2016/17 proposes a budget of £159,327m, which reflects existing pooled budgets or jointly commissioned services, as well as additional investment. In addition Health cost pressures of up to £3m have been identified, this will be risk managed and reviewed through governance processes in year. Mitigating actions will be taken to manage these cost pressures but it may be necessary to offset these against the wider S75 agreements. BCF in 2016/17 ensures that the three boroughs receive funding for the Care Act (£1.75m), investment costs of the new Community Independence Service (£2.7m) and it protects social care by continuing to pass through the

Social Care to Benefit Health funding, currently worth £14.2m across the three boroughs. Further there is £1.6m of home care investment but this is subject to internal CCG governance processes.

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

Chris Neill, Director of Whole System

Email: chris.neill@lbhf.gov.uk

Telephone: 07825 851604

APPENDICES:

Appendix A: Three boroughs (3B) Better Care Fund Plan for 2016/17

Appendix B: Summary of 2016/17 planned BCF Schemes

Appendix C: BCF 16-17 Plan - Three Boroughs Summary

Appendix A

Three boroughs (3B) Better Care Fund Plan for 2016/17

Updated Summary of Plan 16/17

Local Authorities	City of Westminster London Borough of Hammersmith and Fulham Royal Borough of Kensington and Chelsea
Clinical Commissioning Groups	Central London Clinical Commissioning Group Hammersmith & Fulham Clinical Commissioning Group West London Clinical Commissioning Group
	The Three Borough (3B) *Draft Addendum* 16/17 BCF Plan is being reviewed as part of the formal governance process by the 3B Health and Wellbeing Board Chairs and CCG Chairs and this process will be finalised by Friday 13th May 2016.
Date agreed at Health and Wellbeing Boards:	Original plan agreed 24.03.2014, 2nd revised plan agreed 19.09.2014

1. About this document

This summary narrative document for the 16/17 BCF Plan provides an addendum to the previously agreed 15/16 BCF Plan and summarises our proposed action to take forward the three borough (3B) BCF ambitions for the year ahead. The aims and principles of the original submission remain the same, however the plan is updated to reflect the changes in Health and Social Care since the plan was developed. Together Health and Social Care continue to work towards realising our ambition and moving towards full integration of our services that will enable the creation of local single pooled budgets to work more closely together around people, placing their well-being as the focus of health and care services. This draft narrative for the 3B BCF Plan has been requested by NHS England for assurance purposes and has been prepared alongside early work to create a NWL Sustainability and Transformation Plan (STP) across NW London. Although the STP is not due to be completed and discussed by organisations until June, in line with the government's expectation that health and care services are fully integrated by 2020 the STP will emphasise our approach to integration and collaboration across organisations. The evidence base to support the case for change and support the identification of our agreed BCF schemes was provided in the 15/16 BCF plan.

Integration across the health and social care system is a key priority in each borough's current Joint Health and Wellbeing Strategy (JHWS) and will be so in the creation of refreshed strategies being compiled during early 2016. Each of the JSNAs for the boroughs identifies strategic priorities for which the portfolio of projects in the Better Care Fund Programme is a crucial enabler. Overall there is commonality across health and care in terms of our local strategic priorities and together we are committed to ensuring transformational change that benefits our residents, particularly in out of hospital services. Our vision can be summarised by borough as:

- *Westminster; ensuring access to appropriate care at the right time and supporting people to remain independent for longer*
- *Hammersmith and Fulham; the development of integrated health and social care services which support prevention, early intervention and reduce hospital admissions*
- *Kensington and Chelsea; ensuring safe and timely discharge from hospital.*

2. Better Care Fund Delivery in 16/17

In the main we have agreed a rollover of the approved BCF programme from 15/16 into 16/17, including the agreed investment and the BCF Schemes and their scope. Our vision remains the same but we have updated the range of things we need to do in order to continue to deliver on our original ambition. Updated schemes have been appended to this narrative document (see appendix 1).

2.1 Links to Sustainability and Transformation Planning (STP)

A key part of our collaboration and integration across health and social care is demonstrated in the work we have been developing together to develop our Sustainability and Transformation Plan (STP). An STP base case was submitted to NHSE on 15 April, with a final plan due to be finalised by the end of June 2016. This will support a refresh of our current Better Care Fund (BCF) to ensure that the STP and BCF align and support the realisation of the aims and objectives of the BCF. This presents an opportunity for us to identify some of our BCF schemes that would be better delivered at scale such as Personal and Health Care Budgets (PHB) and Patient and Public Engagement (PPE).
The NHS Five Year Forward View (FYFV), published in October 2014, set out a shared vision for the

future of the NHS, which aligns to our strategic objectives in NW London. Planning Guidance released in December 2015 sets the requirement to develop a shared five-year plan. This should describe how areas will locally deliver the requirements of the Five Year Forward View. Boroughs in NW London will collaborate as 'place based systems' across health and local government, to address the ambition set out in the FYFV. For NW London we are committed to a five year plan that is based on the principle of subsidiarity, where things that can be decided and done locally, The NWL STP will describe plans at different levels of 'place'– across the whole system in North West London, from the local to the sub-regional, as appropriate.

The purpose of our STP is for NW London to:

- Describe clear plans to address the three aims of the Five Year Forward View of improving health and wellbeing, improving care and quality and achieving financial sustainability ;
- Set out a shared vision for health and care services;
- Confirm and align activity, finance, capital and workforce requirements across the region and over the next five years;
- Describe the implementation steps required to deliver the vision and plans at a local and NWL level;
- Be the primary route to accessing Sustainability and Transformation Funding from 2017/18

Once the Sustainability and Transformation Plan is finalised, the 3Bs will review the potential this brings for our BCF and how we further develop our ambition and delivered our stated outcomes.

2.2 Adult Social Care Transformation Programme

In adult social care, the transformation programme which was initiated in 2014 based on customer feedback and views, and which supports the delivery of the Better Care Fund plan, continues in three parts - as follows:

1. The customer journey project is now in full scale delivery - building on the priorities of the department and this plan, this is seeing us implement customer views in the way services are organised and respond to need. Customers wanted clarity of offer, accessibility of services, upfront information and advice and a focus on prevention, wellbeing and independence. Through the customer journey, adult social care are working with health partners to reshape the Community Independence Service (CIS), develop an improved online offer and deliver personalisation, independence, choice and wellbeing in the way individuals with long term needs are supported. This is engaging the department in changes to job roles and the standardisation of social care related practice across population and service groups

2. Commissioning intentions have been established for adult social care, working alongside health, and these are providing the basis for making a marked shift towards delivering outcomes based commissioning. We are moving away from traditional procurement and purchasing (based on units of cost and activity) to more of a focus on driving overall spend and budgets to deliver improving outcomes for users. There are four commissioning intentions (integrated information, advice and prevention, integrated intermediate care services, ongoing support in the community and buildings based support to ongoing care needs). These have all been developed against a baseline and, taken together with a wider review of the care market locally; they are forming ASC's contribution to the development of out of hospital services across the three boroughs.

3. Whole systems working - this area of work falls squarely within the remit of the Better Care Fund plan and is increasingly supporting adult social care and health partners focus on further opportunities to work together in the way services are commissioned, reviewed and delivered.

2.3 Whole Systems Integrated Care (WSiC)

NWL is one of 14 pioneer sites working to implement integrated care at scale and pace. Across the 8 boroughs, 31 partner organisations have agreed to work together in pursuit of a shared person-centred vision for integrated care. All CCG areas are developing their own approach to whole-

systems (with local authorities), however, the principles, which underpin these approaches, are shared.

As part of our BCF the Community Independence Service will work to integrate with and support WSIC Early Adopters and develop a seamless interface during the contract period. This will include responding to the different requirements of each CCG and local authority model and contributing to service developments as the WSiC programme is embedded across the area.
The three clinical commissioning groups are at differing stages of developing and mobilising primary care models for Whole Systems Integrated Care. The principle of each model is the same in which primary care teams will proactively work with patients (who will mostly be over 65 and have one or more long term condition) with the aim of promoting intensive care planning, self-management of conditions and maintenance of long term independence. The aim is for better coordinated, proactive and accessible care.

The WSIC programme aims to bring together planned and unplanned care, including the functions of the CIS, into an overall pathway of care, which enables healthy ageing, improved quality of life and maintains independence. WSIC principles endorse primary care leading intensive case management and care planning as the heart of this integration, organised at both practice and hub/village/locality level.

3. Our vision for health and social care locally

The BCF remains one of the key transformational programmes that aim to improve experience of, and outcomes from, health and social care provision for the populations we serve. As part of our BCF Vision; we have identified some of the key transformation programmes that will support the delivery of the BCF and integrated care. We continue to develop strong alignment in the visions of these programmes which will;

- encourage working as a single team across adult social care, public health, housing, mental health, primary care, community care, hospital care and other allied services
- Are dedicated to improving the health and wellbeing of the 600,000 people who live in Hammersmith & Fulham, Kensington & Chelsea and the City of Westminster.

3.1 Three boroughs (3Bs)

The previously agreed vision across the three borough (3B) is founded on population needs assessment and patient, service user and carer feedback, which has developed over the long-term through a broad spectrum of engagement and consultation.

This approach supports the highest risk proportion of the population who consume the majority of resources, this is a particular focus, and the consequences of these changes in need and environment are already evident. Critical services have been centralised where necessary to deliver higher quality care, (including Major Trauma and Stroke services) and improvements are being made to the way services are delivered in the community so care is delivered as close as possible to where individuals live and is integrated with local hospitals. Drawing on insights from the three JSNAs, we are using the BCF as an opportunity to accelerate the integration of patient-centred delivery across health and social care. Our schemes support a co-commissioning approach that encourages co-ordinated operational management across different service providers to best meet the needs of patients and service users.

We recognise that more must be done to prevent ill health in the first place; to provide easy access to high quality GPs and their teams; to support individuals with long term conditions; and to enable older people to live more independently. Our shared vision for whole systems integrated care is that we want to improve the quality of care for individuals, carers and families, empowering and

supporting people to maintain independence and to lead full lives as active participants in their community. It is based on what people have told us is most important to them. Through patient and service user workshops, interviews and surveys, we know that people want choice and control and for their care to be planned with people working together to help them reach their goals of living longer, staying and living well. They want care delivered by people and organisations that show dignity, compassion and respect at all times.

In order to achieve this approach we are committed to ensuring that;

- **People will be empowered to direct their care and support**, and to receive the care they need in their homes or local community
- **GPs will be at the centre** of organising and coordinating people's care
- **Our systems will enable and not hinder** the provision of integrated care. Our providers will assume joint accountability for achieving a person's outcomes and goals and will be required to show how this delivers efficiencies across the system.

Our aim is to provide care and support to the people of Westminster, Hammersmith & Fulham and Kensington & Chelsea, in their homes and in their communities, with services that:

- **Co-ordinate around individuals**, targeted to their specific needs
- **Improve outcomes**, reducing premature mortality and reducing morbidity
- **Improve experience of care**, with the right services available in the right place at the right time
- **Maximise independence** by providing more support at home and in the community, and by empowering people to manage their own health and wellbeing
- **Through proactive and joined up case management**, avoid unnecessary admissions to hospitals and care homes, and enable people rapidly to regain their independence after episodes of ill-health.

As part of the agreed 15/16 BCF plan we provided detailed information in the form of 'personas' to highlight the engagement and value we have placed upon our patients, service users and carers to ensure that changes to our services and the desired outcomes are co designed. This work continues as we move into the second year of the plan.

3.2 Primary care transformation

The three boroughs (3Bs) CCGs have been jointly co-commissioning primary care with NHS England since April 2015. This approach is one of three different models of co-commissioning available to CCGs and was selected following close engagement with GPs across the three boroughs, as well as with other clinicians, lay members, and other relevant stakeholders. It means that NHS England remains the accountable commissioner for primary care but shares decision-making with the CCGs. This is done through a NHSE/CCG joint committee in each CCG, on top of the close day-to-day working between the NHSE and CCG primary care teams. The joint committees have Health and Wellbeing Boards and Healthwatch representation.

A core task of the co-commissioning joint committees is to design and implement new local models of primary care that meet the specific needs of communities within each CCG, whilst building on local progress with whole-systems integrated care and BCF. This work is now under way in all three boroughs and will deliver local primary care that is accessible, co-ordinated, and proactive.

Having GP practices work together is vital to this, as it is to delivering safe co-ordinated and

proactive care with maximum efficiency. This is why the three CCGs are continuing to support their local GP federations to develop into robust providers of a wider range of primary care services. This is also a critical aspect of the development of Accountable Care Partnerships, which to deliver maximum benefits require general practice voice to play a strong and coherent role.

4. Progress made in 15/16 about the differences to patient and service user outcomes?

Our approved 15/16 BCF Plan identified a number of common challenges for those in greatest need, which if addressed, would genuinely transform the quality of life and wellbeing. These include:

- Mental health problems (diagnosed and undiagnosed)
- Unsuitable housing leading to and exacerbation of conditions/capacity
- The need for reablement now or in the near future
- Mobility and transport issues
- Significant life impacting event e.g. bereavement
- Frequent and unplanned use of multiple services
- Social isolation
- Multiple long term conditions.

Our vision to achieve by 2018/19 is built around tackling these issues, empowering and supporting individuals to live longer and live well. This is about creating services that enable frontline professionals to work with individuals, their carers and families to maximise health and wellbeing and address specific individual needs.

5. Our programme delivery through the BCF in 15/16

As outlined in the 15/16 BCF Plan, we have a broad range of transformational changes across acute and primary care and adult social care – as well as overarching developments towards a whole system approach that have been in place in the three boroughs (3B) over the past few years, the BCF schemes further enhance this strategic change as they are a balanced mix of on the ground operational changes to key services; further understanding of patient and service user needs; more effective joint commissioning; and development of key enablers including systems infrastructure, therefore the BCF schemes continues to support our ambition in 2016/17.

Within the 3Bs, the customer journey project has moved to full scale delivery - building on the priorities of the department and this plan, this is supporting us to implement customer views in the way services are organised and respond to need. Customers wanted clarity of offer, accessibility of services, upfront information and advice and a focus on prevention, wellbeing and independence. Through the customer journey, adult social care are working with health partners to reshape the Community Independence Service, develop an improved online offer and deliver personalisation, independence, choice and wellbeing in the way individuals with long term needs are supported. This is engaging the department in changes to job roles and the standardisation of social care related practice across population and service groups.

Our innovative schemes (See Appendix 1, BCF Schemes 16/17) are driving consideration of new approaches to operational governance, such as the contracting approach we are taking to the Community Independence Service (CIS) reprocurement – that support rather than hinder integration. Over the next 3 years, community healthcare, primary care, hospital and social care teams will work together in an increasingly integrated way, with single assessments for health and social care and rapid and effective joint responses to identified needs, provided in and around the home. We will design and implement new ways of ensuring clarity of delivery responsibility across commissioners and providers – ensuring that there are feedback loops, so that we continue to understand patient and service user perspectives and share learning across the delivery chain

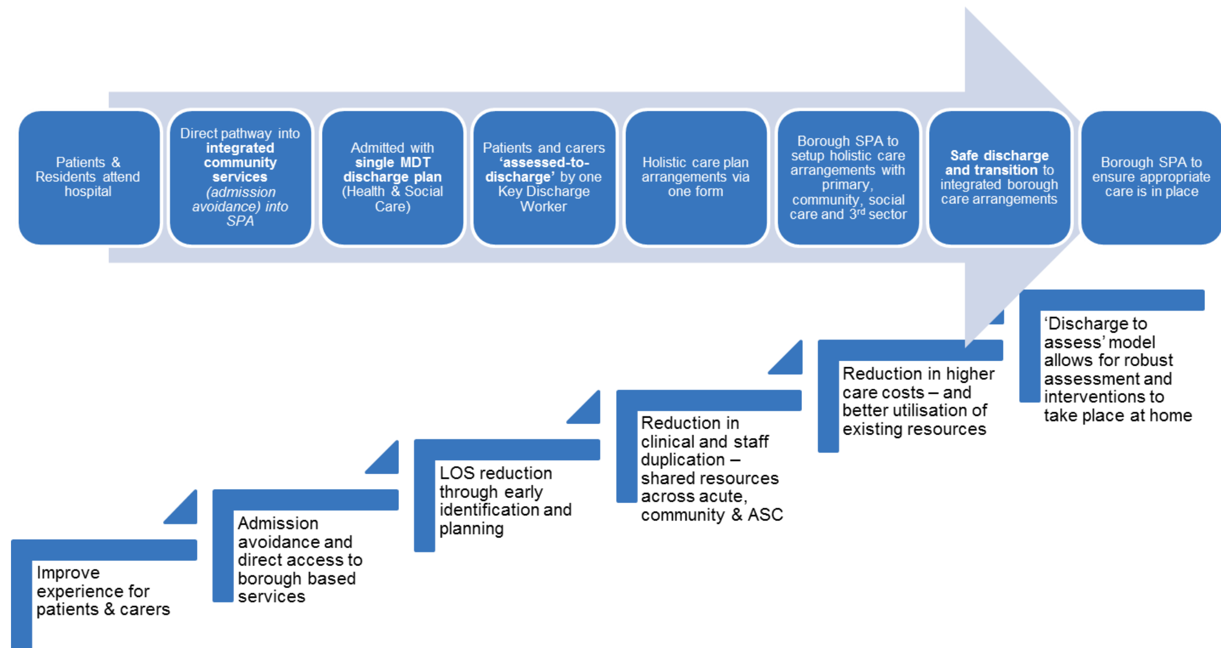
5.1 Development and implementation of 7 day working across Health and Social Care

North West London was awarded “Early Adopter” status by the NHS England/NHSIQ Seven Day Services Improvement Programme in November 2013. In October 2015 we then accepted the opportunity as a sector, to be a national First Wave Delivery Site for the refreshed 7 day services programme (as launched by the PM at the conservative party conference).

The NHS England Seven Day Services Programme centres on delivery of a set of 10 Clinical Standards for Acute Care. Standard 9 sets out the requirement for a 7 day discharge pathway:

Support services, both in the hospital and in primary, community and mental health settings must be available seven days a week to ensure that the next steps in the patient’s care pathway, as determined by the daily consultant-led review, can be taken.

Through the three boroughs (3B) and the BCF we have continued to invest in the development of 7 day service programme from 15/16 and beyond to embed 7 day services in health and social care. Part of this work has been to work towards ONE 7 day single health and social care discharge pathway, not just across the 3Bs, but also across the wider North West London footprint. The following outlines the vision:



Delivery to date has included the development of one agreed health and social care needs based assessment form which will be used across the three boroughs (3B) and the wider North West London sector, to manage referrals from hospitals into community and social services from 1st May 2016.

5.2 Community Independence Service (CIS)

In 15/16 we undertook a transitional year for the Community Independence Service (CIS). This included working to align the service across the 3Bs to deliver, Rapid Response, In-reach, Rehabilitation and Reablement services. Year one was supported by the appointment of a Lead Health Provider working in partnership with Adult Social Care and our Community Services provider to implement the model of care. In 16/17 the CIS service is being reprocured and the new provider should be in place by 1st July 2016. In establishing a new service across Health and Social Care, anticipated

year one benefits were not achieved, this was due to the speed of roll out and the challenges of recruiting the required workforce. In 16/17 we have further enhanced our CIS model and anticipate our ambition for the release of the planned benefits.

5.3 Neuro-rehabilitation

The Neuro-rehabilitation service was reporocured in 15/16 and went live on 1st April 2016 this commission has resulted in an annual efficiency savings for the three boroughs (CCG, Health efficiency) through reduction in DTOCs for neuro-rehab patients and an improved patient pathway.

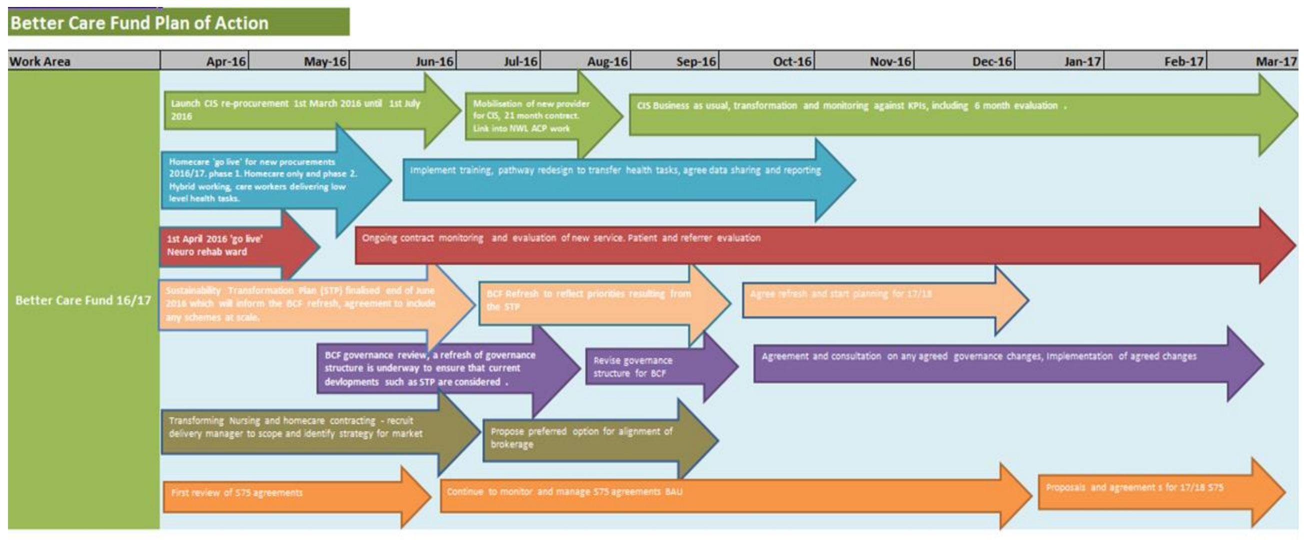
6. Summary of 16/17 planned BCF schemes

The agreed schemes for the15/16 will continue in 16/17 in line with the rollover and continuation of our BCF plan, this includes the same schemes and the overall an agreed investment, £159.3m. We have also identified that there is an additional Health cost pressure of up to £3m, this will be risk managed and reviewed through governance processes in year. We will work together to ensure that mitigating actions are taken in year to manage these cost pressures and these costs may have to be offset against the wider S75 agreements.

Group	Ref no.	Scheme
A	A1	Community Independence Services- *including 7 day services, rehabilitation and reablement*
	A2	Community Neuro Rehab Beds
	A3	Homecare
	A4	Integrated Hospital Discharge and 7 Day Working
B	B1	Patient/Service User Experience and Care Planning – *including self-management and peer support*
	B2	Personal Health and Care Budgets
C	C1	Transforming Nursing and Care Home Contracting
	C2	Review of Jointly Commissioned Services
	C3	Integrated Commissioning
D	D1	Information Technology
	D2	Information Governance
	D3	Care Act Implementation
	D4	BCF Programme Implementation and Monitoring

6.1 Summary of Plan of Action 16/17

The summary plan below shows a high level timeline of the main milestones to be delivered over the course of the 16/17 BCF plan. Achievement against this schedule will be closely monitored as part of the BCF Programme Implementation and Monitoring. For full details see (Appendix 2).



7. How our BCF meets National Conditions for 2016-17

As part of our 16/17 BCF plan we will continue to monitor, develop and meet the requirements of the National Conditions as outlined in the 15/16 BCF Plan. The BCF is now in its second year, the BCF includes national conditions and locally set requirements, this approach continues in to 16/17 with the following national conditions as outlined. Details of the metrics that underpin these are provided within the 16/17 BCF template outlining the agreed ambition, confirming that we have met the 8 required National Conditions and confirmation of the agreed funding levels for 16/17 that is, roll over of the 15/16 BCF investment at £159.3m.

The 16/17 conditions include;

1. Plans to be jointly agreed

The agreed BCF plan for 15/16 was jointly agreed and as outlined includes robust governance and reporting mechanism. In 16/17 this updated narrative and the required template has been agreed across the 3Bs. This includes the detail of the schemes that underpin our BCF, the summary narrative and the investment required to deliver the ambition of our 16/17 BCF plan.

2. Maintain provision of social care services (not spending)

As outlined in the agreed 15/16 BCF plan we will continue to maintain provision of social care services at the same level and all BCF schemes have been carried over (In total we are investing overall £159.3m for our BCF, this is in line with the agreed investment in 15/16. A key component of the 3B BCF plan is the additional investment in social care through the Community Independence Service, which will enhance rehabilitation and reablement services, leading to a reduction in hospital readmissions and residential/nursing home admissions.

3. Agreement for delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate

Through the three boroughs (3B) and the BCF we have continued to invest in the development of 7 day service programme from 15/16 and beyond to embed 7 day services in health and social care. Part of this work has been to work towards ONE 7 day single health and social care discharge pathway, not just across the 3B, but also across the wider North West London footprint, with NWL acting as an early implementer. The Community Independence Service (CIS), also supports this

National Condition with a model that includes Rapid Response, In-reach, Rehabilitation and Reablement.

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

In summary during 15/16 our services implemented the NHS number as the single identifier for our patients, having delivered this ambition we now are developing a single integrated IT platform initially as part of the Community Independence Service (CIS). Furthermore, this project will integrate ASC and GP IT systems. The project rational is based on the assumption that sharing of medical and social records across different settings of care reduces risk, reduces duplication and improves outcomes and speed in both assessment and care of the individual, as well as enhancing the client's experience.

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

To build upon the approved 15/16 BCF plan, across the 3B an integrated care programme has been implemented that includes assessment and provision of integrated packages of care. This includes care planning, case management and the provision of an accountable professional. Our integrated care pathway and delivery puts GPs at the centre of care (e.g. WSiC) and the CIS with GPs taking the lead in coordinating care as the agreed lead professional.

6. Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans

Across NWL and the 3Bs transformation plans have been developed and consulted upon with the Local Authority, hospitals, community and mental health services and other local stakeholders. As part of the Sustainability and Transformation Planning (STP) we have representation from all organisations. As part of the agreed 15/16 BCF and the 16/17 BCF plan our operating plan agreements have been or are being negotiated with regards to the impact of reductions in activity. Reductions in activity are within CCG QIPP plans that will be reported via our NHSE Operating Plan.

7. Agreement to invest in NHS commissioned out-of-hospital services

In NWL and the 3Bs we continue to develop and invest in our out of hospital services at levels above the mandate. This supports our Out of Hospital strategy to deliver care to our patients closer to home and in the right setting to ensure that we reduce dependency on our hospitals and acute settings.

8. Agreement on a local action plan to reduce delayed transfers of care (DTOC) and improve

We are committed to continuously developing our response to delayed transfers of care. This includes an understanding of our local issues relating to DTOC, a local action plan (see appendix 3, DToC draft local action plan),clear ambition and a trajectory to reduce DToC has been developed to clearly outline what we need to undertake as part of the BCF in 16/17 to address DTOC.

Delayed Transfer of Care (DToC)

As part of our BCF schemes in project A's we recognise the interdependency that supports our ambition for reducing DToC and the principle of quality care is delivered in the right place. Looking to 16/17 both nationally and locally in 3B we recognise the importance of further reduction in DToCs and therefore our BCF plan will continue to priorities delivery against this ambition. The CCGs, Local Authorities and provider partners recognise that any stay in hospital can be a stressful and uncertain time for patients and their families and carers and their experience of being discharged from hospital is often not positive. The BMA in its report on *Hospital Discharge: the patient, carer and doctor perspective (January 2014)* highlighted many of the poor experiences reported on by patients and their families.

It is widely agreed that effective discharge planning and management plays a vital part in ensuring capacity is available for patients needing to access acute care beds, and supporting a resilient

system. In addition the Care Act reinforces the need for the system and people to work together to ensure timely discharge and transfer of people as soon as they are medically optimised and safe to transfer.

Addressing the complexities of hospital discharge processes requires a system response from commissioners and providers. Our aim is to ensure that people in hospital have a timely discharge, and are able to receive the ongoing care they need at home or in the community that enables them to meet their health and wellbeing outcomes. We wish to reduce the current fragmentation of the discharge processes so that people have a positive experience of their discharge from hospital in which they and their family/carers are clear of the process, the multi-disciplinary team involved in their discharge, and are fully involved in the decisions affecting their ongoing care. We believe this is a critical requirement in terms of providing continuity of care once back home or in the community, and to prevent further unnecessary admissions to hospital. This has led to our collective work on Enabling Positive Discharges which started in October 2015 and has generated a willingness to develop common approaches and processes and a system wide DTOC action plan and programme.

The CCGs, Local Authorities, acute providers and community health providers across Tri-borough have therefore formed the Tri-Borough Integrated Hospital Discharge Steering Group to align all the projects concerning hospital discharge into a single programme structure.

The Steering Group will report into the BCF Implementation Board as well as the Tri-borough System Resilience Group who will be identifying positive hospital discharge as one of its 2016/17 priorities. The Steering Group is currently developing an overarching action plan reflecting all the individual projects against key themes and which will enable prioritisation. It will also identify benefits to be achieved through these actions and measurement of these benefits. A summary report will be developed to present a monthly update across the programme and outcomes/benefits being delivered

We have identified a number of priority areas within our DTOC work programme so far which enable improvements both in the processes within hospitals and the capacity available to support people at home and in the community. They include:

- Development of integrated hospital discharge teams and pathways within a number of hospital wards to provide a common discharge approach across the 3 borough (project A2)
- Increased provision of interim beds to enable step down from hospital and to allow for full assessments of people’s needs to be undertaken in the community
- Alignment of organisational Choice policies supported by information for patients, families and carers on the local options available for community or home based care upon discharge

Our DTOC work programme therefore has a number of interdependencies with other strategic initiatives including:

- Re-procurement of our Community Independence Service which includes In Reach to facilitate early discharge from hospital
- Review of our provision of Intermediate Care beds to ensure we can meet local needs for step down and step up provision in the community

Disabled Facilities Grant (DFGs)

Housing departments in 2 boroughs administer the DFGs and ASC in one. The plans are developed by Housing and ASC and the agreed funding will be allocated to the Housing depts. However, as Social Care capital and DFG capital funding has been combined from 2016/17, the DFG will be influenced by the Housing plan, spending patterns and commitment and ASC need for capital.

8. BCF Programme arrangements including governance and financial arrangements

Across the three boroughs (3B), we have invested significantly in building strong governance arrangements to support the Better Care Fund. As outlined previously, the governance arrangements described below are designed to ensure all 6 sovereign entities are central to decision making without creating unnecessary delays or blockages.

A BCF Board provides a forum for Cabinet members and CCG Chairs (described in Section 4c below). The BCF Board makes recommendations to HWB members, particularly in relation to the large scale integrated initiatives that require a joint approach. The HWBs meet on a quarterly basis.

The Health and Wellbeing Board in each of the boroughs has continued to develop and mature. We have a joint monthly meeting between the executive teams in CCGs and Local Authorities. Our transformational plans and programmes are formally discussed and approved at local borough governance levels within each Local Authority and CCG.
We continue to have formal Health and Wellbeing Partnership Agreements in place between each borough and CCG providing a legal framework for closer integration of commissioning and an established programme of jointly commissioned services, which are already overseen by the Joint Executive Team (JET). This will enable us to review pooled budget requirements for the new financial year 16/17. We will continue arrangements for hosting with the LA, in view of the practical advantages which this offers in relation to treatment of VAT and the carrying forward of funding, but the pooling agreement will recognise that each scheme will be led by the most appropriate commissioner, be that Local Authority or CCG.

As aforementioned, the Sustainability and Transformation Plan (STP) is currently being developed, the plan is due for completion by the end of June 2016 and following this we will look to refresh the Better Care Fund and also amend the current governance arrangements as required.

9. Risk management and contingency planning

In line with our 15/16 BCF Risks and Contingency we have refreshed our risk plan, (a detailed BCF Risk Log is provided in Appendix 5) we continue to manage these in line with ensuring that all risks are identified and plans are in place to help mitigate these to support delivery against our BCF Plan 16/17. In summary our BCF plan will continue to be developed with providers and is based on the principles of achieving a reduction of acute admissions.

The same core principles of risk sharing have been agreed within the BCF programme:

- Organisations take responsibility for the services they sign-up to deliver (against agreed specification of service quality, type and volume)
- Organisations take responsibility for the benefits that are expected to be realised in their organisation
- Effective monitoring arrangements to identify where there are variances and to reconcile back to the original budget (similar to s.75 arrangement)
- Commitment to a shared approach to resolving variances and amending service model and share of costs if required.

The BCF is based on an agreement to share the financial risks and rewards of new out-of-hospital services between CCGs and Local Authorities. The agreement is based on estimates of activity,

costs and benefits of those services and the previous year's activity has supported us to develop plans that reflect actual activity. There is of course the risk that, if the planned net benefits are not delivered, there will have to be a call on existing resources in the CCGs and Local Authorities. The CCGs have identified contingency funds should the expected benefits not be realised, this demonstrates the strong commitment we have to develop our integrated working under the BCF.

10. Summary of BCF engagement

The agreed 15/16 BCF plan outlined our engagement process in relation to developing our BCF. We continue to work together to support patient, service user and public engagement, develop our service provider engagement and identify the implications for acute providers.

The process of engagement across these stakeholders is iterative and responsive to the live BCF schemes that we continue to develop and implement as highlighted in the schedule. Our BCF progress continues to report to our Health and Well-Being Boards, including this16/17 BCF implementation plan and link to our Strategic Partnership Group (SPG). The development of the Integration and Collaboration Working Group reports to the JET and steers the NWL STP to ensure place based commissioning and transformation for the three boroughs, this new forum is being used to engage all providers in the ambitions of the BCF and scheme progress within the overarching context of the STP.

This year's BCF is a continuation of the agreed 15/16 plan. As this is year 2 of the BCF, the consequential impact to providers is being negotiated via our current QIPP plans as part of the contract negotiations. The activity reduction linked to the CIS, 7 day services and neuro-rehab are part of the 16/17 contract negotiations that reflect the ambition of the BCF and the reduction of activity in these areas.

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APPENDIX B

Summary of 2016/17 planned BCF Schemes

Ref no.	**Scheme**	**Non recurring** Investment (£000s)	**New delivery cost** (£000s)	**Existing Costs** (£000s)	**Total costs** (£000s)
A1	*Community Independence Services*	2,688	-	17,221	**19,909**
A2	*Community Neuro Rehab Beds*	-	2,117	1,562	**3,679**
A3	*Homecare*	-	1,600	-	**1,600**
	- *Low level health tasks*	-	-	-	**-**
A4	*Integrated Hospital Discharge and 7*	-	-	938	**938**
B1	*Patient/Service User Experience and Care Planning – including self-management and peer support*	-	-	200	**200**
B2	*Personal Health and Care Budgets*	-	30	20	**50**
C1/C3	*Transforming Nursing and Care Home*	-	-	721	**721**
C2	*Review of Jointly Commissioned*	-	-	127,062	**127,062**
D1	*Information Technology*	-	-	201	**201**
D2	*Information Governance*	-	-	-	**0**
D3	*Care Act Implementation*	-	-	1,750	**1,750**
D4	*BCF Programme Implementation and Monitoring*			350	**350**
	Disabled Facility Grant			2,867	**2,867**
	TOTAL	**2,688**	**3,747**	**152,892**	**159,327**

Three Borough (3B) Better Care Fund Schemes – 2016/17

Group	Ref no.	Scheme
A	A1	Community Independence Services- *including 7 day services, rehabilitation and reablement*
	A2	Community Neuro Rehab Beds
	A3	Homecare
	A4	Integrated Hospital Discharge and 7 Day Working
B	B1	Patient/Service User Experience and Care Planning – *including self-management and peer support*
	B2	Personal Health and Care Budgets
C	C1	Transforming Nursing and Care Home Contracting
	C2	Review of Jointly Commissioned Services
	C3	Integrated Commissioning
D	D1	Information Technology
	D2	Information Governance
	D3	Care Act Implementation
	D4	BCF Programme Implementation and Monitoring

Scheme ref no
A1
Group A: Community Independence Service
Original Intention
The Community Independence Service is a rapid response and reablement service for older people. It aims to support people in the community and avoid the need for unplanned hospital admissions. The service provides fast and responsive care to support patients at risk of admission to hospital and enables hospital inpatients to be transferred in a timely manner to community settings to ensuring a full recovery whilst retaining independence and remain in their own home. The CIS represents a single model of care, working across the three boroughs to replace a range of often duplicated services. The model encompasses multi-disciplinary integrated health and social care and (nursing, medical, therapies and social care) and operates 7 days a week. The service is jointly commissioned across health and social care and delivered across the three boroughs. The service has four core elements: • Rapid Response • In-Reach • Non-Bedded Intermediate Care/Rehabilitation • Reablement The target patient cohort includes individuals: • With long term care requirements who need support to prevent crises or deterioration • Who require support following discharge from hospital • Who need support to prevent (or delay) admission into hospital. • Who want to regain their independence at home or in another community setting. • Who require urgent care.

Progress and Delivery to date

The CIS is based on our shared belief in delivering joined up care to people when they need it in the community. It will drive clear clinical benefits for patients in a sustainable way across the health and care system as a whole.

The CIS has been recognised nationally for successfully bringing together a range of services and skills to support people in the community by working work across primary, secondary care, community nursing, therapy and social care.

The benefits delivered in 2015-16 are:

- User satisfaction with the CIS service is very high across health and social care.
- GPs rate the service very highly, however, between a quarter and a third do not refer in. This is probably due to a lack of awareness of the service.
- Delivery of a seven day service for In-Reach, Rapid Response Nursing, Rehabilitation and Reablement.
- Improved partnership working between healthcare organisations across the three boroughs, including establishment of a Partnership Board led by Imperial College Healthcare.
- Establishment of a multi-service clinical redesign group to create more cohesive pathways of care across health and care services.
- Operational staff have made inroads to integration using practical approaches like stronger working networks with colleagues, made possible from co-location, sharing IT/ clinical information and through work to streamline processes.
- CIS is dealing with a high level of acuity, particularly the H&F service – probably more so than in the other two CCGs/ LAs. The service offers a genuine alternative to hospital, although high acuity comes at a cost, with double-up care/ large packages increasingly common.

Challenges experienced in 2015-16, with plans for resolution.

- Further integration and effective working has been hampered by delays in implementing an integrated IT system which is due for delivery in July 2016.
- High turnover of staff and use of agency staff is hampering planning for future service development. A fully integrated service on a 21 month contract with clear plans for the future is currently being procured and will help to address some of these issues.
- Intermediate ‘step-down’ beds are a service gap that could be a safe alternative for medically stable but unwell patients.
- Mental health is also a gap in the service offer, as well as memory assessment services and end of life care which is being addressed in the current procurement.
- High expectations of commissioners and the BCF Programme Board regarding the level and speed of change in the first year has been a challenge for the Lead Health and Social Care Providers.
- The objective of increasing referrals and activity remains a challenge. Feedback suggests that increased activity has been reliant on increasing GP confidence, knowledge and awareness of the service. The introduction of Rapid Response GPs and Consultant Geriatrician cover across the three boroughs will help to improve confidence in the service (as in H&F).

Delivery

Commissioners

- West London CCG
- Royal Borough of Kensington and Chelsea
- Central London CCG
- Westminster City Council
- Hammersmith and Fulham CCG
- London Borough of Hammersmith and Fulham

Providers:

- Central London Community Healthcare NHS Trust
- Westminster City Council
- Royal Borough of Kensington and Chelsea
- London Borough of Hammersmith and Fulham
- London Central and West Urgent Care Centre
- Central and North West London NHS Foundation Trust
- West London Mental Health NHS Trust
- Allied Healthcare
- GP Federations (West London, Central London and Hammersmith & Fulham)
- Imperial College NHS Healthcare Trust
- Chelsea & Westminster NHS Foundation Trust

Investment Requirements

A1 Community Independence Service (ex BCF08)	
	£'000
Investment	2,688
New Delivery Costs	
Existing Costs	17,221
Total	**19,909**

Changing Context
The development of Accountable Care Partnerships within North West London has shaped the procurement for the delivery of the CIS. The contract has been set for a period of 21 months to align with the North West London ACP timetable.
BCF Scheme Plans 2016/17
The CIS is being recommissioned with a planned start for the new service from 1st July 2016. In line with NW London wide outcomes, the new provider will be working to deliver the following local outcomes. • High quality, effective care delivered within available resources (financial, estates and human resources). • Reduced time (counted as non-elective bed days) our residents are spending in institutional care (acute hospitals, nursing and care homes and long term care). • Improved patient/customer satisfaction in relation to treatment outcomes. • Improved Friends/Family/Carer satisfaction in relation to treatment outcomes. • Financial sustainability of the health and social care system and support the development of an evidence base that informs the future development of the service. • Add value by increasing links between the CIS and other services, through improved system-wide working that supports further integration across social care, community and primary care as a Whole System.

Scheme ref no.
A2
Community Neuro Rehab Beds
Original Intention
To commission additional rehabilitation capacity across the three boroughs with the objective of providing interventions to restore a patient's optimal functioning (physically, psychologically and socially) to the level they are able or motivated to achieve. This will lead to an anticipated reduction in DTOCs and reduction in LOS for neuro-rehab patients
Progress and Delivery to date
The target cohort are patients who require rehabilitation services to regain a loss of physical, mental or social functionality. Lack of step down neuro-rehab options means that the system is unable to provide informed and cost effective services when a person is experiencing a wait for specialist neuro-rehab intervention. This leads to longer lengths of stay in costly specialist centres for some people as they become more debilitated and dependent whilst waiting for specialist services. In 2015/16, the referral and delivery pathway for bedded and non-bedded community rehabilitation /neuro-rehabilitation services was established with subsequent investment in additional community and bed based capacity (9 additional neuro beds; 5 physical beds and 4 virtual beds) and the extension of the community rehabilitation period up to 12 weeks in the community, including Homecare. From April 2016 the new neuro-rehabilitation service (15-bedded and 4 virtual beds for community neuro-rehabilitation) commenced, provided by Imperial College Healthcare NHS Trust as the lead provider, with Hillingdon Hospitals NHS Trust and Central London Community Health Trust. The contract will be initially for 3 years, with an option to extend for 2 more years.
Delivery
Commissioners: • Central London CCG (Lead Commissioner) • West London CCG • Hammersmith and Fulham CCG **Providers:** • Imperial College Healthcare NHS Trust (Lead Provider) • Central London Community Healthcare NHS Trust • Hillingdon Hospital NHS Trust

Investment requirements

A2	Community Neuro Rehab Beds (ex BCF10)
	£'000
Investment	
New Delivery Costs	2,117
Existing Costs	1,562
Total	**3,679**

Changing context

Not applicable

BCF Scheme Plans 2016/17

It is estimated that the scheme will deliver an estimated annual efficiency saving of £369k for the tri-borough CCGs for 202016/17 through reduction in DTOCs, which represents 1300 days or 12 days per neuro-rehab patient.

It is anticipated that additional patient benefits will include improved social and economic, health & quality outcomes which will be evaluated over the course of 202016/17 as they emerge with the progression of the scheme.

Scheme ref no.

A3

Scheme name Homecare

Original Intention

To successfully commission, procure and implement a new Homecare service in the three boroughs that will better enable our patients and service users to remain independent in their own homes.

Progress and Delivery to date

The programme aims to deliver a new and improved homecare service across the three local authorities based on:

- Achieving outcomes, rather than "time and task" based provision
- Integration of health and social care tasks over the life of the contract (hybrid working)
- Providers working directly with customers to agree details of care and how outcomes will be achieved
- Ensuring dignity and compassion as core values
- People being helped to feel a part of their local community

A patch based approach to care has been developed across the three boroughs, with one provider delivering all the care in one patch. This allows providers to establish strong connections to existing community assets and offers a greater consistency of care to service users. Contracts for 8 of the 9 patches have been awarded, with the award for the final patch expected for early July 2016.

Delivery

Commissioners:

- West London CCG
- Royal Borough of Kensington and Chelsea
- Central London CCG
- Westminster City Council
- Hammersmith and Fulham CCG
- London Borough of Hammersmith and Fulham

Investment requirements

A3 Homecare	
	£'000
Investment	1,600
New Delivery Costs	
Existing Costs	
Total	**1,600**

Changing context
One of the objectives of the model is the integration of health and social care tasks over the life of the contract. There is agreement to pilot the hybrid working model (for care workers to carry out low level health tasks) in Kensington and Chelsea. However, this has been delayed whilst issues with provider performance and service quality are resolved and will impact on the overall mobilisation and implementation timeline for hybrid working.
BCF Scheme Plans 2016/17
Subject to the successful mobilisation of all Homecare providers, key activities for 202016/17 include: • Provider assurances over training / competency and clinical governance for health tasks • Pathway redesign to transfer health tasks from CLCH to three Local Authorities • Establishing a data sharing agreement between CLCH and three Local Authorities • Establishing a reporting mechanism to monitor health tasks

Scheme ref no.
A4
Scheme name
Integrated Hospital Discharge and 7 Day Working
Original Intention
The scheme aims to implement a single Hospital Discharge function across health and social care. The scheme will build upon 2015/16 work to further embed and scale up the implementation of the integrated discharge function.
Progress and Delivery to date

The two key objectives of the scheme have been delivered in 2015/16:

1. Integration across the three local authorities to provide a single discharge function
   - Implementation of a single hospital discharge team across the three boroughs managing all three boroughs patients who present at hospital
   - Streamlined hospital discharge processes, implemented across the hospital team
   - A new streamlined assessment tool, implemented on Frameworki and used across the hospital team

2. Integration with health partners to fully achieve an effective, efficient and consistent service to residents.
   - Hospital discharge process co-designed with health to work effectively with acute sites
   - Single three boroughs teams providing onsite support to acute sites within the three boroughs
   - Support of key wards (wards with high numbers of discharges) with allocated social workers, working closely with ward staff and supporting the MDT process

The initial pilot showed evidence of improvements within the system:

- 89% of NHS and 79% of Local Authority staff believe the pilot has been effective in improving the patient/carer experience with discharge – a 63-68% improvement on Friends and Family Tests on two wards
- 89% of NHS ward staff and 79% ASC staff believes the new model and approach has significantly improved the overall discharge process
- 63% of NHS staff believe the pilot has reduced the LOS of patients
- Approximately 5-10% decrease in referrals into higher levels of care (e.g. increase in home care support, reablement, placements)
- Some of the wards have shown between 5% and 10% reduction in re-admissions in the same period compared to the previous year

Key challenges of the scheme during 2015/16 include:

- Delays in providing cross organisational access to patient data due to the complexity of the required Information Governance arrangements (with no significant agreements between the organisations previously in place)
- Ongoing staffing challenges to support the transition periods and wider change program (primarily due to shortages of staff in the wider health and care system)

Delivery

Commissioners:

- West London CCG
- Royal Borough of Kensington and Chelsea Central London CCG
- Westminster City Council Hammersmith and Fulham CCG
- London Borough of Hammersmith and Fulham

Providers:

- Imperial Healthcare NHS Trust
- Chelsea & Westminster NHS Foundation Trust
- Westminster City Council
- Royal Borough of Kensington and Chelsea London Borough of Hammersmith and Fulham
- Central London Community Healthcare

Further sub-regional working:

We are working with the CCGs and Councils in Ealing, Brent and Hillingdon to roll-out this model across North West London as part of the West London Alliance (WLA) Hospital Discharge programme.

This will integrate ASC hospital based functions across the six 6 boroughs in the wider North West London sub-region. It will enable seamless discharge for patients across the sub-region – no matter which borough they live in and which hospital they attend.

Investment requirements

7 Day Social Work Hospital Discharge (ex BCF01)	
	£'000
Investment	
New Delivery Costs	
Existing Costs	938
Total	**938**

The scheme for 2015/16 achieved its expected outcomes as per the programme plan. The key changes to the scheme include:

- Early implementation of a single Tri-borough adult social care team due to strategic willingness and operational readiness
- Delays in providing access to hospital systems for adult social care staff and access to Frameworki to hospital staff due to complexity issues regarding information governance

BCF Scheme Plans 2016/17

To achieve the plans for 202016/17 and the benefits associated with these plans the programme will focus on the following key success factors:

- Partnership working between Acute trusts and Local Authorities – to further integrate functions including staff and processes
- Further development of commissioning models for discharge – as part of WLA and NWL work with CCGs and Commissioners
- Information Sharing – ensuring staff from different organisations can access the appropriate information and not duplicate work.

The following focus will be required to address the challenges and support the plans for 202016/17:

- Further service development
- Further health and social care organisational development/training
- Additional pump-priming of staff to facilitate change (e.g. Social Workers)

Our aims for 2016/17 include

- Establish one key discharge worker who has accountability for individual cases from discharge to home.
- Improved patient and carer experience through the Friends and Family Test (FFT)
- Early identification of patients/customers who require social care, community health and 3rd sector services
- Improve sharing of staff & resources across LAs and Hospitals – improving skills and capacity
- Embed one hospital discharge process across health and social care from 1st May 2016
- Improve throughput and decrease of acute capacity
    - Reduced DTOC (related to delayed assessments) – deliver a 785 day reduction in DTOC days (H&F – 344, Kensington & Chelsea – 274, Westminster 177)
    - Reduced Bed day costs (related to delayed assessments) - £278K based on £350/day costs (H&F - £120,472, Kensington & Chelsea - £95,877, Westminster - £61,968)
    - Reduced Emergency Re-admissions (early benefits of holistic discharge planning) – 4-5% reduction of total readmissions

Scheme ref no.

B1

Scheme name: Patient/Service User Experience and Care Planning

Original Intention

The original focus of this scheme was on developing two key aspects of care delivery:

- Patient and Service User Experience
- Self-management and Peer Support

The intention remains unchanged; however, greater clarity has been developed on the intentions and implementation within the current strategic direction of commissioners. Commissioners have agreed that in order to deliver this project at scale we will engage with the wider Sustainability and Transformation Plan (STP) and align it with our journey towards Accountable Care Partnerships by April 2018, this will ensure that the aims, objectives and outcomes are developed across NW London.

Progress and Delivery to date

In 2015/16, further clarity has been developed on the scope of the scheme making it relevant to the current commissioning strategies and landscape.

Delivery

Commissioners:

- West London CCG
- Royal Borough of Kensington and Chelsea
- Central London CCG
- Westminster City Council
- Hammersmith and Fulham CCG
- London Borough of Hammersmith and Fulham

Investment requirements

B1 Patient/Service User Experience and Care Planning (ex BCF02, 06 & 12 combined	
	£'000
Investment	
New Delivery Costs	
Existing Costs	200
Total	**200**

Changing context

The three boroughs' commissioners have independently developed good patient and public engagement and involvement functions, which has resulted in strong engagement and qualitative feedback on patient experience. There have also been developments on the whole systems integrated care programmes which have resulted in extensive engagement and movement towards monitoring and reporting patient experience.

However, within this context the commissioners feel that there is a need to provide an overarching framework within which engagement, involvement and experience is captured and informs commissioning practices. The intention is to deliver this scheme within the context of our STP, so that it can be delivered at scale and also align it with our journey towards developing Accountable Care Partnerships by April 2018.

BCF Scheme Plans 2016/17

The key aims for implementation for 202016/17 include:

- Develop and embed a standardised framework for Patient and Service User Experience to effectively capture, analyse and inform commissioning decisions. It will aim to enable patients and communities to have greater involvement and understanding of their health and wellbeing.
- Develop focused self-management and peer support for Whole Systems and integrated care programmes, enabling a positive impact on patient experience and for the health and care outcomes of service users.

Initial focus for developing self-management and peer support interventions shall be on:
- Whole Systems Integrated Care (WSIC) for frail and elderly patients; and
- Long term enduring mental health conditions.

This scheme will provide Patient/Service User Experience and Care Planning support to:

- Service users, carers and adults with a long term condition, or at risk of a long term condition
- All GP practices within the three borough localities
- Hard to reach communities particularly those in deprived areas
- Enable self-management and Peer Support to be focused on patients over the age of 65 years old and patients with long term enduring mental health conditions

Scheme ref no.
B2
Scheme name
Personal Health and Care Budgets
Original Intention
To extend our current arrangements for personal health budgets, working with patients, service users and front line professionals to empower people with long term conditions to make informed decisions around their care.
Progress and Delivery to date
The Personal Health Budget programme for continuing healthcare was rolled out across all care groups in a consistent manner, with evaluation and quality assurance mechanisms developed and monitored during 2015/16. The programme built on existing arrangements, by developing an integrated approach to the provision of personal care budgets and personal health budgets, including direct payments, so that eligible customers could commission an integrated package of services. The evidence and best practice gathered enabled the three CCGs to develop a Personal Health Budgets policy for identified service user groups
Delivery
The commissioners and providers involved in delivery of the scheme are: • West London CCG • Royal Borough of Kensington and Chelsea • Central London CCG • Westminster City Council • Hammersmith and Fulham CCG • London Borough of Hammersmith and Fulham
Investment requirements

B2 Personal Health & Care Budgets	
	£'000
Investment	
New Delivery Costs	30
Existing Costs	20
Total	**50**

Changing context

The NHS Mandate and NHS Planning Guidance re-affirmed the Government and NHS England's commitment to the roll-out of personal health budgets.

During 15/16 work was undertaken to review emerging best practice and work across the CWHHE collaborative to develop appropriate approaches to delivering PHBs. Work to deliver appropriate initiatives at scale (including internal management arrangements) will be developed through Sustainability and Transformation Plans (STPs) in line with planning guidance.

BCF Scheme Plans 2016/17

Continue to implement Personal Health Care Budgets for Continuing Healthcare across all Children's and Adult Care Groups as required by NHS Operating Plan

Continue to consolidate arrangements for care management and financial management of direct payments of customers with PHBs.

Work through the Integration and Collaboration Board which oversees the development of a wider PHB policy under the Sustainability and Transformation Plan

Gather evidence and best practice from elsewhere which will inform the development of a PHB service offer, which can be delivered at scale.

Integrate Social Care Personal Budgets and Personal Health Budgets for Long Term Conditions through Integrated Care Pathways and Provision

Scheme ref no.
C1
Scheme name
Transforming Nursing and Care Home Contracting
Original Intention

The strategic objectives of this project are:

- To work across health and social care to improve alignment of processes, practices and contracting for funded placements and packages of care to ensure efficiency of process.
- To develop a market strategy for care homes across health and social care to achieve delivery of efficient, high quality placements for local residents underpinned by a sustainable market.

The scheme is to address the approaches to brokerage, commissioning, placement and quality management of care home placements between the LAs and CCGs. These are complex, fragmented and reactive, which impacted the capacity of commissioners to manage a challenging care home market and inhibited the quality of care delivered. This also put pressure on other areas of the care pathway through DTOCs and increased emergency admissions.

The intended outcomes of the scheme are:

- Enhanced service quality through better sharing of information and intelligence, and joint learning between operational teams
- Improved 'soft' market knowledge in operational teams
- A single, best practice, approach to brokerage to be developed if recommended
- Best use of existing joint capacity in services that are stretched
- A clearly defined approach to the future integrated commissioning of residential and nursing care that acknowledges both current pressures and the strategic direction for health and adult social care
- Clarity for CCGs, Local Authorities and providers on the processes and procedures for funded placements and packages of care across all adult health and social care client groups
- Learning from best practice across our current client groups and funding streams to, where possible, align practices and procedures
- Embedding positive joint working relationships through jointly agreed processes, protocols and policies that reflect the holistic needs of our local patients and residents
- Ensuring that across all organisations our increasingly limited resource base is able to work efficiently avoiding duplication or lack of clarity arising from processes or pathways
- Positive experiences for people who need funded placements or packages of care and their families/carers and no delays faced in these processes or from issues resulting from inter-agency working
- Development of a joint market strategy is undertaken as a priority and aligned with wider work around accommodation based care and support across the Local Authorities and CCGs.

Progress and Delivery to date
In 2015/16 a business case was produced based on detailed analysis of the brokerage, commissioning and contracting functions for placements and packages of care for health and adult social care. The recommendations identified in the business case were: 1. Options for co-locating the health placements team and Adult Social Care placements teams are explored to identify a location that best meets the needs of the teams (based on a feasibility study) 2. Options for the brokerage of Adult Social Care (ASC), Funded Nursing Care (FNC) and Continuing Health Care (CHC) placements being channelled through a single brokerage team are developed which would need to be designed collaboratively to ensure it has the necessary capabilities and capacity 3. Development of a joint market strategy is undertaken as a priority and is aligned with wider work around accommodation based care and support across the Local Authorities and CCGs There have been difficulties in recruiting to the Delivery Manger role, which has delayed progress on this scheme. It is now intended to appoint on an interim basis to scope the project and then review on-going resource requirements.
Delivery
Commissioners: • West London CCG • Royal Borough of Kensington and Chelsea Central London CCG • Westminster City Council Hammersmith and Fulham CCG • London Borough of Hammersmith and Fulham
Investment requirements
Investment is required for a delivery manager post initially for 6 months at Band 8b but then with consideration for the on-going implementation of the recommendations.
Changing context
During 2015/16 the CCGs with their Local Authority partners identified the need to review the processes and procedures for funded placements and packages of care across all care groups and funding streams (excluding children) and therefore have added the requirements for this review into this project. This will also enable the CCGs, with partners, to meet the actions identified through its internal audit of placements, and NHSE Deep Dive into Continuing Healthcare.

BCF Scheme Plans 2016/17

In 202016/17 the project will deliver the following objectives:

- Co-location of the health placements team and Adult Social Care placements teams (based on a feasibility study)

- The brokerage of Adult Social Care (ASC), Funded Nursing Care (FNC) and Continuing Health Care (CHC) placements are channelled through a co-designed single brokerage team

- As a priority, deliver a joint market strategy which is aligned with wider work around accommodation based care and support across the Local Authorities and CCGs

Furthermore, we will review funded placements and packages of care including:

- A single overview of the different processes and procedures for each client group or funding stream related to assessment, decision making and ratification including panel processes. The overview will cover older people, physical disabilities, learning disabilities, mental health and adult social care pathways and panels.

- Common documentation, based on best practice from our existing processes or wider, that is jointly agreed and adopts similar or aligned approaches across the client groups and funding streams:
  - Identification of training needs around the NHS Continuing Healthcare and Funded Nursing Care Framework, Mental Health Act, Care Act and other relevant legal and statutory frameworks to enhance the draft training plan for 202016/17
  - Development of Joint Dispute Resolution Policy and Joint Funding Policy, based where possible on current good practice, that can be used across the client group pathways and processes
  - Development of Joint Operational Policy (if deemed relevant)

Scheme ref no.
C2
Scheme name
Review of Jointly Commissioned Services
Original Intention
The original intention of the scheme in 2015/16 was: • To review all existing jointly commissioned services with S75 and S256 partnership arrangements, to ensure services provide value for money and are aligned with the objective of integrated working. • Each CCG and Local Authority has an existing S75 Partnership Agreement in place with an agreed service schedule of jointly commissioned schemes. The majority of these are lead commissioning arrangements where the Local Authority contracts on behalf of the CCG. There are a small number of pooled budgets, in particular Community Equipment. • This project will review all of the schemes within these programmes to evaluate the outcomes being achieved and the effectiveness of the commissioning and contracting approach in order to inform commissioning intentions and recommend how these services should be commissioned in future.
Progress and Delivery to date
In 2015/16 a savings target of £1,385m was identified against the Joint Commissioning Services as part of the BCF programme. Proposals were identified to achieve these savings from within existing services, either through reduction in contract value, service redesign/transformation or de/re-commissioning. However, a double count with savings already attributed to Local Authority savings strategies was subsequently identified. A revised savings target of £634k was agreed and these savings were delivered jointly by CCG and LA commissioners.
Delivery
Commissioners: • West London CCG • Royal Borough of Kensington and Chelsea Central London CCG • Westminster City Council Hammersmith and Fulham CCG • London Borough of Hammersmith and Fulham

Investment requirements

C2 Review of Jointly Commissioned Services (ex BCF07)	
	£'000
Investment	
New Delivery Costs	
Existing Costs	127,062
Total	**127,062**

Changing context

Since the inception of this project there is further need to ensure alignment of our jointly commissioned services to both our overarching BCF objectives and also those of our Sustainability and Transformation Plan (STP).

BCF Scheme Plans 2016/17

In 202016/17, it is recognised that further review of Jointly Commissioned Services is required to ensure alignment with key strategic objectives and in recognising the financial context of all organisations.

It is proposed that the project will deliver:

- Recommendations for each CCG and Local Authority on the schemes currently being jointly commissioned, comprising an evaluation of the services and the way in which they are being commissioned or contracted
- Setting the schemes within the context of BCF priorities and STP direction of travel indicating how they should be incorporated within commissioning plans going forwards
- Recommendations for those services suitable for a pooled budget and how this could be created

Scheme ref no.

C3

Scheme name

Integrated Commissioning

Original Intention

The original intention of the scheme in 2015/16 was:

- To address the current fragmentation in commissioning across three borough health and social care commissioners. In designing the new commissioning structures, the project will seek to understand, validate and address existing issues.
- This scheme will ensure that these developments contribute to the overall objectives of the Better Care Fund and are linked to make most effective use of resources and systematically review those associated aspects (such as assistive technology and housing support) which will add value to the programme.

Progress and Delivery to date

Key project objectives include:

- Review the as-is model for ASC joint commissioning
- Develop shared understanding between LA and CCGs of current issues
- Design and implementation of new commissioning structures

The key benefits include better value for money and improved efficiency through integrated commissioning. They will have a positive impact on service users and provide an accurate understanding of current risks and issues as well as opportunities for improvement.

In 2015/16, the CCGs and Local Authorities reviewed the issues and structures for Joint Commissioning. However, implementation of the review recommendations have not been progressed pending the outcome of ongoing discussions concerning the future structures and functions of the joint commissioning team, particularly the Mental Health team.

Revised funding contributions for the joint commissioning teams across the six organisations have been agreed and reflected in Section 75 schedules. These were based on the findings of the review concerning the split of health and social care tasks being undertaken by the teams.

Delivery

Commissioners:

- West London CCG
- Royal Borough of Kensington and Chelsea
- Central London CCG
- Westminster City Council Hammersmith and Fulham CCG
- London Borough of Hammersmith and Fulham

Investment requirements

C1 / C3 Transforming Nursing and Care Home Contracting (ex BCF03) & Integrated Commissioning (ex BCF09)	
	£'000
Investment	
New Delivery Costs	
Existing Costs	721
Total	**721**

Changing context

2015/16 has seen a turnover in staff across the CCGs and Local Authorities, which has delayed the process.

Furthermore, the developments made in CCG and LA Whole Systems Integrated Care programmes have merited renewed consideration of the longer term vision for integrated commissioning and the required structures and functions to deliver this. The ongoing validity of the findings from the previous review need to be considered in light of the longer term vision.

BCF Scheme Plans 2016/17

In 202016/17 the project will review how services are currently commissioned and contracted across the organisations and identify better ways to achieve integrated commissioning and the functions and structures that support this in light of the development of Whole Systems Integrated Care models.

Key project objectives include:

- Develop a shared understanding between LA and CCGs of current issues
- Understand direction of travel for the integrated commissioning vision under WSIC, STP and BCF
- Design and implementation of new integrated commissioning structures

Scheme ref no.

D1

Scheme name

Information Technology

Original Intention

To continue to implement IT solutions to link the three boroughs Adult Social Care systems to the GP systems and to ensure consistent use of the NHS number as primary identifier.

Progress and Delivery to date

Preparatory work was undertaken in 2015/16 to improve readiness for our ambition to integrate ASC and GP IT systems. This included developmental work to establish NHS numbers within the ASC Frameworki system and business plan development.

Delivery

Commissioners:

- West London CCG
- Royal Borough of Kensington and Chelsea
- Central London CCG
- Westminster City Council
- Hammersmith and Fulham CCG
- London Borough of Hammersmith and Fulham

Investment requirements

D1 IT Integration (ex BCF05)	
	£'000
Investment	
New Delivery Costs	
Existing Costs	201
Total	**201**

Changing context
There is a growing understanding of the importance of integrated systems working from developmental work in other schemes including hospital discharge and CIS. Further managing dual dependencies across health and ASC means time frames for delivery are longer than originally anticipated.
BCF Scheme Plans 2016/17
The key deliverables for 202016/17 are: • Implement a mechanism to ensure NHS numbers are up-to-date, validated and available in the ASC. This will be a key identifier which will facilitate creating a single view of a client's record • Identify the data sets to be shared by ASC and Health Care with lead users from LA and Health Care providers (and potentially users and carers themselves) • Agree through robust options analysis, the most appropriate manner of achieving IT integration. There are a number of options available, for example: • Building direct interfaces to ensure systems are fully integrated • Data warehouses which hold information centrally to create a 'single view of a client' • Middleware which views information centrally to create a 'single view of a client' Once the options are agreed there will be a need to specify and procure for relevant providers, pilot for a service specification and test and implement the new model.

Scheme ref no.
D2
Scheme name
Information Governance
Original Intention
To continue to implement IG solutions to link three borough social care systems to the GP systems and to ensure that other schemes have robust IG arrangements.
Progress and Delivery to date
An Information Governance and Caldicott Support Manager has been appointed to lead on IG issues and to provide direct support to the Caldicott Guardians for Adult Social Care and Public Health and for Children's Services. An IG Training Strategy is being developed in conjunction with Corporate Information Management leads. An Information Governance Training Needs Analysis has been undertaken and on line training made available across all three boroughs. A number of Information Sharing Agreements have been established, including the WSIC Information Sharing and Hosting Agreement including the overarching North West London Information Sharing Protocol. Access to the WSIC Data Warehouse has been established although data has yet to be transferred. Pooled data from Health and Social Care Providers across North West London will be available to support integrated commissioning and contracting. In order to provide a safer mechanism for sharing data with independent providers of services, the Egress email system has been integrated within the mailboxes of LBHF staff. Plans have been developed to extend availability to staff in RBKC and WCC and a roll out programme has been initiated.

Delivery
Commissioners: • West London CCG • Royal Borough of Kensington and Chelsea Central London CCG • Westminster City Council • Hammersmith and Fulham CCG • London Borough of Hammersmith and Fulham **Others:** • Caldicott Guardians • IT leads within Local Authority and NHS IG leads within Local Authority and NHS
Investment requirements
N/A
Changing context
As the scheme is mainly designed to underpin and enable other schemes in the BCF programme and is designed to ensure continuous improvement in IG policies, practice and culture, it is not directly affected by strategic or delivery changes. There may be impact on available resources or on timescales as a result of the effect of any strategic or delivery changes on other schemes. The WSIC Data Warehouse implementation has been affected by a reticence on the part of some GP Practices to sign up to the agreements and to share data. A great deal of effort has been put in to obtaining sign up and steady progress is being made in obtaining a more extensive buy in.

BCF Scheme Plans 2016/17
Work will continue to regularise the submission of data to the WSIC Data Warehouse and the Information Sharing and Hosting Agreement will be kept under review to ensure that any amendments required by any new signatories are appropriately risk assessed and signed off. This will include full participation in the design and development of enhanced sharing arrangements introduced through the adoption of the Patients Know Best integrated sharing system, although it is not yet certain when access and integration will be proposed for Local Authorities. Information Sharing Agreements are being developed to support the Community Independence Service (A1) and Integrated Hospital Discharge and 7 Day Working (A4) schemes. All new initiatives will be supported and regulated through the use of Privacy Impact Assessments to ensure that IG solutions are designed in to solutions and that Information Sharing Agreements are deployed as appropriate. Building on the Training Needs Analysis and the IG Training Strategy, there will be an audit of current compliance with the baseline training requirements for IG with a full campaign to ensure that all staff requiring refresher training is supported in accessing and completing the required courses. The Egress secure Email System will be rolled out across RBKC and WCC in order to improve the resilience of information sharing arrangements with independent providers of services.

Scheme ref no.
D3
Scheme name
Care Act Implementation
Original Intention
To continue to ensure the key statutory requirements of the Care Act 2014 (detailed in the Care Act Impact Analysis) can continue to be delivered following successful implementation from 1st April 2015. This includes continuing consolidation and bedding down of the changes working closely with Health, Housing and other partners.
Progress and Delivery to date
The Care Act Part 1 set out a range of substantial reforms to the way in adult social care (ASC) is provided, impacting on duties and functions provided by ASC services. Processes and practices were reviewed and changed in the lead up to 1st April 2015 and all requirements were successfully delivered including. • Duties on prevention and wellbeing • Duties on information and advice (including advice on paying for care) • Duty on market shaping • A national minimum threshold for eligibility for care and support services for adults and carers and associated outcomes as the basis for service delivery • Assessments (including carers assessments) • Promoting and progressing Whole Systems Integration between social care and health • Personal budgets and care and support plans • Safeguarding • Universal deferred payment agreements The key challenge was the scale and range of work required to assure compliance including partnership working with health and housing. This is a continuing challenge in terms of consolidating and bedding down the change and understanding the impact.
Delivery
Commissioners: • Royal Borough of Kensington and Chelsea Westminster City Council • London Borough of Hammersmith and Fulham

Investment requirements

D3 Care Act Implementation (ex BCF18)	
	£'000
Investment	
New Delivery Costs	
Existing Costs	1,750
Total	**1,750**

Changing context

The Care Act has led to significant increased demand for in-depth carers reviews and there are signs that demand for lower level care is increasing. These demands will need to continue to be met.

Part 2 of the Care Act which was focused on the funding of long term care and including a capped charging system and care accounts was due to go live in April 2016 , this has now been deferred by the Government until 2020. However there is substantial work to do to develop the personalisation of services offered and to increase uptake of Direct Payments.

BCF Scheme Plans 2016/17

- Following successful delivery of the changes the programme was closed in October 2015.
- Portfolio Deliver Steering Group and Portfolio Review Board chaired by the Director of Finance and Resources and the Executive Director, continue to monitor impact and progress delivering the work plan returns to the Department of Health to track impact on demand, activity and costs and continued implementation on a quarterly basis.
- Staff will need to undergo continued training. Legal expertise will continue to be required to deliver some of this training.
- In order to meet the requirements of the Care Act and support its implementation several projects and working groups are continuing that are tied to the wider ASC Transformation Portfolio, particularly the Customer Journey Programme, these are:
    - Front door, information and advice and prevention offer development.
    - Outcomes based assessment, review and support planning.
    - Market management development.
    - Safeguarding and provider failure development.
    - Personalisation and Direct Payments

Scheme ref no.
D4
Scheme name
BCF Programme Implementation and Monitoring
Original Intention
To successfully programme manage the BCF schemes, ensuring each scheme delivers the agreed outcomes on time and to the right standard.
Progress and Delivery to date
The programme management scheme is an enabler to delivering the agreed BCF ambition. This scheme sits at the centre of the three boroughs (3Bs) BCF and acts as the coordination point for all current schemes. This support enables timely coordination and monitoring of the agreed BCF plan and delivery against the total budget of £157.5m. In 15/16 it is acknowledged that this scheme experienced some challenges with a change in-year from external PMO support to agreed internal support. During this period there was a focus on BCF Project A schemes, particularly the Community Independence Scheme, which is a high priority in order to support delivery of the BCF. The internal PMO linked to the CIS supported the development and distribution of flash reports that provided monthly updates about progress on each scheme; these were provided to JET and HWB Boards. In 15/16 delivery of the CIS was particularly challenging in relation to planned and actual activity. This was closely monitored and provided data and analysis to support reprocurement of the service in 2016/17. The reprocurement of neurorehab and the shift from acute to community resulted in the expected benefits being realised.
Delivery
Commissioners: • West London CCG • Royal Borough of Kensington and Chelsea • Central London CCG • Westminster City Council • Hammersmith and Fulham CCG • London Borough Hammersmith and Fulham

Investment requirements

D4 BCF Implementation/Monitoring (ex BCF04)	
	£'000
Investment	
New Delivery Costs	
Existing Costs	350
Total	**350**

Changing context

We are currently establishing a revised approach to BCF Programme Implementation and Monitoring, this is to build on our experience in 15/16 and ensure that we have the right support to ensure continued delivery against our BCF ambition in 2016/17.

The BCF has an established SRO and additional management capacity to support delivery, engagement and reporting of the BCF in 2016/17

BCF Scheme Plans 2016/17

The 2016/17 BCF plan is a rollover of the previous year's plan 15/16. All schemes have remained the same and the governance and reporting structure to support the delivery is now embedded in the development, delivery and monitoring of the schemes.

We are continuously reviewing how we can support SROs and implementation leads for the BCF schemes to ensure that we deliver the agreed visions and ambitions related to the BCF. The Sustainability and Transformation Plan (STP) will further support the integration and collaboration and where appropriate we have identified work that can be done at scale via the STP.

Together we have agreed joint resource to work across the BCF to support implementation and monitoring.

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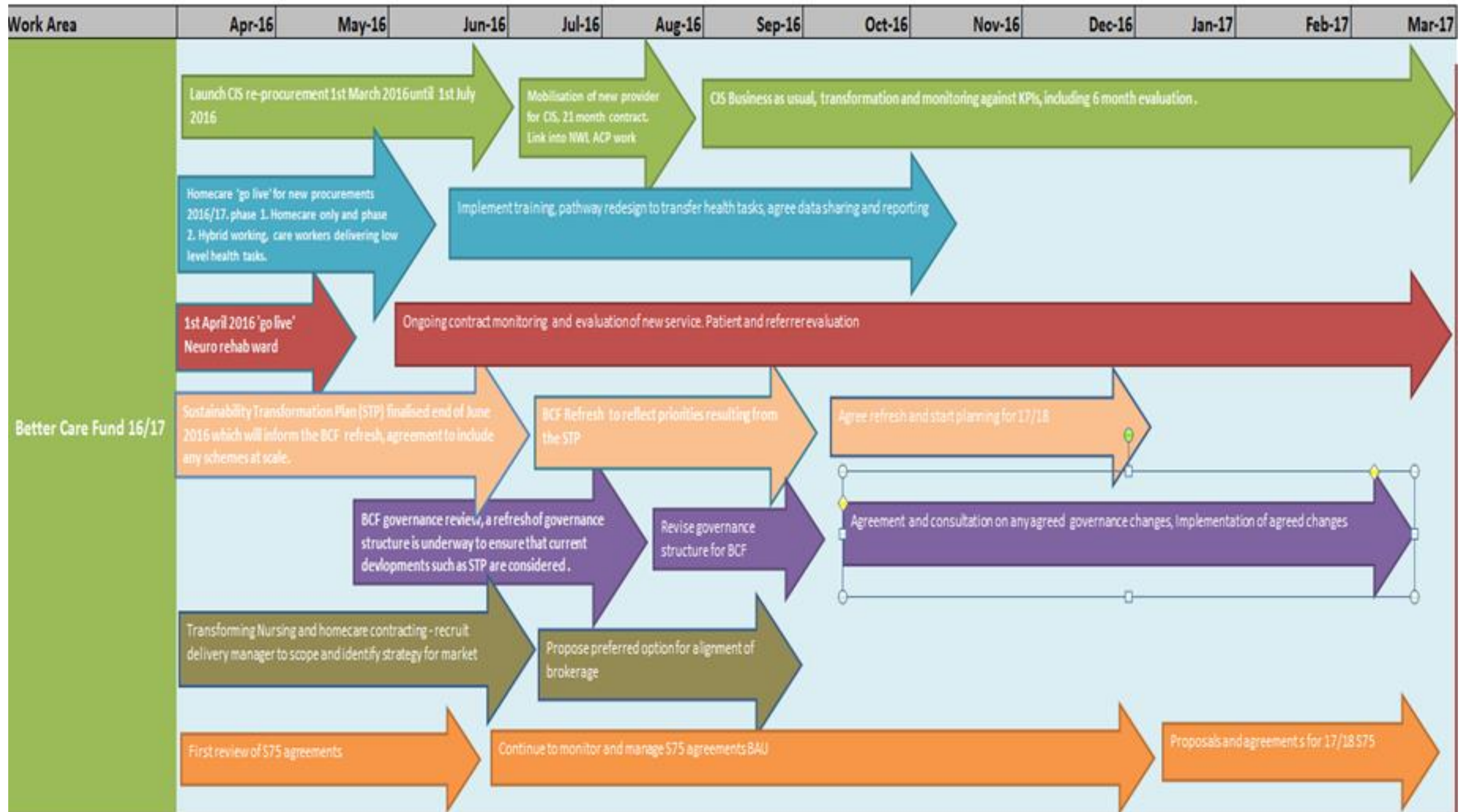
Appendix C

BCF 16-17 Plan - Three Boroughs

Scheme	H&F CCG	LBHF	Total H&F	WL CCG	RBKC	Total RBKC	WL & CL CCG	WCC	Total WCC	Three Boroughs Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
A1 Community Independence Service	4,962	1,115	6,077	4,725	1,148	5,873	6,961	998	7,959	19,909
A2 Community Neuro Rehab Beds	1,103		1,103	720		720	1,856		1,856	3,679
A3 Home Care	800		800	200		200	600		600	1,600
A4 7 Day Social Work Hospital Discharge	313		313	313		313	312		312	938
B1 Patient/Service User Experience and Care Planning	59		59	63		63	78		78	200
B2 Personal Health & Care Budgets	15		15	16		16	19		19	50
C1/C3 Transforming Nursing and Care Home Contracting & Integrated Commissioning	453		453	268		268			0	721
C2 Review of Jointly Commissioned Services	24,652	6,128	30,780	24,976	24,661	49,637	28,558	18,087	46,645	127,062
D1 IT Integration	59		59	63		63	79		79	201
D3 Care Act Implementation	517		517	527		527	706		706	1,750
D4 BCF Implementation/Monitoring	103		103	110		110	137		137	350
Joint Contracts		1,019	1,019		667	667		1,182	1,182	2,868
Total	**33,036**	**8,262**	**41,298**	**31,981**	**26,476**	**58,457**	**39,306**	**20,267**	**59,573**	**159,328**

Appendix D
Better Care Fund Plan of Action



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Westminster Health & Wellbeing Board

Date:	26 May 2015
Classification:	General Release
Title:	Primary Care Modelling
Report of:	Councillor Rachael Robathan, Chairman, Health and Wellbeing Board
Wards Involved:	All
Policy Context:	Population modelling for primary care
Financial Summary:	NA
Report Author and Contact Details:	Rianne Van Der Linde - rvanderlinde@westminster.gov.uk Damian Highwood – dhighwood@westminster.gov.uk

1. Executive Summary

1.1 This report sets out the progress made by Westminster City Council (WCC), Central London Clinical Commissioning Group (CLCCG) and West London Clinical Commissioning Group (WLCCG) with the Primary Care Modelling project.

2. Key Matters for the Board

2.1 It is requested that the Westminster Health and Wellbeing Board:

- reviews progress to date and notes the close collaboration between council and Clinical Commissioning Groups (CCG) officers in developing the model; and

- agrees to provide continued support to the project.

3. Background

3.1 It was agreed that the joint project team will be undertaking the work in three phases:

- **Phase 1**: Establishing a borough-wide base set of projections and subsequent disease burden that all agencies are content to use as a single agreed set of figures. This will take into account the different populations supported by both the NHS and the Local Authority to maximise the use of the data for both sectors.

- **Phase 2**: Overlay the impacts of regeneration, housing and infrastructure plans and proposed local authority and health policy on the estimates modelled and build a tool that enables the manipulation of these impacts according to a number of variables. This will include the mapping of primary care and community based services.

- **Phase 3**: A programme of joint analysis of how the needs of the Westminster population will impact on the demand for primary care health services. In the first instance, the aim is for this to inform the analysis that will be used by the local authority, NHS England, Central London CCG and West London CCG to plan for future primary care provision before being rolled out to be used to inform the shape of other service provisions.

3.2 The importance of forward planning for primary care is highlighted in a recent report by the King's Fund showing that GP workload has grown hugely, both in volume and complexity[1].

3.3 At a joint workshop run by the Council and CCG (27 January 2016) it was agreed that the next steps should focus on aligning data, sources and assumptions across health, local authority and other data.

3.4 To improve utility for health bodies, it was agreed to produce a variant of the current resident model showing estimates for patients registered with a GP in the Central London CCG area.

4. Progress to date

4.1 Initially, we analysed data of the GP registered population to understand the characteristics of patients who register with a GP in Central London CCG. This is to help establish a common understanding of how and why the current resident population and GP population differs.

4.2 We found that:

- Not all patients registered with a CCG live within its geographic area. For example, of the patients registered with a GP in CLCCG, only 81% are resident in the geographical area of Westminster Council, while 6% of patients are resident in Camden, 4% in Kensington and Chelsea, 2% in Hammersmith and Fulham, 2% in Southwark and 5% elsewhere in London.

  Of Westminster residents, 30% do not register within CLCCG but with GP practices elsewhere in London (24% register with WLCCG, 3% with Camden CCG and 2% with Brent CCG).

[1] *Source: The King's Fund, Understanding pressures in general practice, 5 May 2016*

The WLCCG registered population is resident in Kensington & Chelsea (63%), Westminster (25%), Hammersmith & Fulham (6%) or elsewhere in London (6%).

- In terms of difference, the population registered with a GP in CLCCG has more people of working age and more students than the local authority population. From Westminster City Council's annual residents' survey in 2015, we know that of Westminster residents 5% are unregistered and 2% use a private GP.

- The two last points need further consideration once we have more detailed age and spatial area breakdowns from Systm One[2] to compare against the resident population. The City Survey results produce figures that members of the Board have queried as being low, and intuitively 5% does appear suppressed given the youth, huge turnover, and migratory nature of population. It may be an issue of bias in the City Survey. The GP registered population can only be higher than the registered population in reality if the numbers of people living outside Westminster registering with a GP in the City exceeds the number of residents not registering. Alternatively, we need to consider whether there is an issue of not all GP's cleaning lists quickly when registered people move away – particularly when they move to live abroad.

4.3 To add a variant of the current resident model showing estimates for patients registered with a GP in CLCCG, we have produced local projections of the registered population.

The findings include:

- National projections of the CCG registered population are not available. Therefore, we have used the resident population projections (based on the GLA Strategic Housing and Landing Availability Assessment (SHLAA)) to project the number of CLCCG registered patients by age group and ward. Once a methodology has been agreed and tested this will be replicated for the registered populations of WLCCG and Hammersmith & Fulham CCG.

- Preliminary findings based on local data show that the CLCCG registered population is expected to increase from 215,650 in 2016 to 241,100 in 2030, a 12% increase. The largest increase is expected in older people aged 65 years and over (a 40% increase) followed by young people aged 13-17 years (a 27% increase).

- Limitations and assumptions of the methodology used to project the registered population are being investigated. We need to understand better why the GP and resident population varies in Westminster in order to understand the suitability of applying the resident based population growth to a GP registered base. Once the methodology has been agreed, the

[2] Systm One is a central clinical database used predominantly by primary care professionals. It is **one** of the accredited **systems** in the government's programme of modernising IT in the **NHS**.

population projections will be used to produce a variant of the current resident model showing estimates for patients registered with a GP in CLCCG.

- When the analysis of the GP registered population is complete we will need to understand exactly what the impact of a different definitional (resident or GP) starting point is on projected results. We will need to consider whether the difference is sufficiently significant for two models to be required, and if that is the case, which should be deployed in which circumstances.

4.4 Current and future estimates of the healthcare cost of using the 15 patient group model from the London Health Commission[3] have now been added to the resident based model (including hospital care, GP visits, prescription cost, mental health care and social care based on the current average cost per patient in London).

5. Application of model and sharing best practice

5.1 We have also led collaborative work with the 8 CCGs and the corresponding 8 local authorities that make up the North West London Collaborative of Clinical Commissioning Groups to inform the North West London Sustainability and Transformation Plan[4]. The primary care model has been expanded to incorporate the local authority resident populations of these 8 CCGs to create a multi Borough model, and our methodology is now being used by others.

5.2 The work is informing the Westminster Joint Health and Wellbeing Strategy refresh. Population segmentation is used to describe the health issues and need across the population in the Strategy. The Primary Care Modelling work has been used to identify population groups with a high health need and/or health cost, and to estimate the future need and cost.

5.3 To share best practice, we have submitted an abstract for a poster presentation at the annual Public Health England conference in September to present our work to colleagues across the country.

6. Next steps

6.1 The translation of population estimates in the model to the 15 patient groups (appendix A) is currently based on London data. While the age and general health of the population has been taken into account, there is a risk that the profile in Westminster is different, given in particular the different community groups and lifestyles of people in Westminster. One of the next steps currently being investigated is to determine whether it is possible to ascribe CLCCG patients to each of the 15 groups in order to provide assurance that the London data is applicable or whether that local data is needed.

6.2 We will need to extract and analyse the GP registered data at a more detailed level (single age, sex and location) in order to provide a fuller understanding of the differences between the two population cohorts.

3

4

6.3 We will also need to revisit some of the costs and activity estimates associated with each of the 15 patient groups that are currently lifted from the original London Health commission work and validate them using the expertise of Health and Wellbeing Board members as well as local CCG data where available.

7. Legal Implications

N/A

8. Financial Implications

8.1 N/A

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

Meenara Islam, Principle Policy Officer

Email: mislam@westminster.gov.uk

Telephone: 020 7641 8532

Appendix – 15 population group model

Segmentation of the population: 15 patient groups

Health group

Age	"Mostly" healthy (rest of the population)	One or more physical or mental long-term condition	Cancer	Severe and enduring mental illness	Learning disability	Severe physical disability	Advanced dementia, Alzheimer's etc.	Socially excluded groups
0-12	1 "Mostly" healthy children	5 Children and young people with one or more long-term condition or cancer		9 Children with intensive continuing care needs			N/A	15 Homeless individuals and/or families (including children, young people, adults and older people), often with alcohol and drug dependencies
13-17	2 "Mostly" healthy young people			10 Young people with intensive continuing care needs				
18-64	3 "Mostly" healthy adults	6 Adults with one or more long-term condition	8 Adults and older people with cancer	11 Adults and older people with SEMI	12 Adults and older people with learning disabilities	13 Adults and older people with physical disabilities	14 Adults and older people with advanced dementia and Alzheimer's	
65+	4 "Mostly" healthy older people	7 Older people with one or more long-term condition						

Healthy (80%) | Unhealthy (20%)

City of Westminster

Westminster Health & Wellbeing Board

Date:	26 May 2016
Classification:	General Release
Title:	Health and Wellbeing Hubs
Report of:	Liz Bruce, Executive Director of Adult Social Care
Wards Involved:	All
Policy Context:	The Health and Wellbeing Hubs programme explores the potential for using our estate to greater effect, developing multi-disciplinary, person-centred service hubs which increase access to prevention and early intervention services, particularly among those at risk of developing multiple needs.
Financial Summary:	NA
Report Author and Contact Details:	Steven Falvey - Steven.Falvey@lbhf.gov.uk Helena Stephenson – hstephenson@westminster.gov.uk Rebecca Ireland – rireland@westminster.gov.uk

1. Executive Summary

1.1 The Health and Wellbeing Hubs programme was initiated to test how best to improve the lives and outcomes of disadvantaged groups and individuals through changing the way we work within the Council and with our partners. The focus is on improving the use of our estates so as to increase access to preventative services for those at risk of experiencing multiple needs. The programme aims to prevent the development of complex issues that are costly to individuals, families and public services to resolve. This paper builds on the previous Health and Wellbeing Board paper on this topic considered on 17 March 2016[1].

1

2. Key Matters for the Board

2.1 The Health and Wellbeing Board is asked to note the progress the Council and partners have made in this programme thus far and its further proposals and next steps. The Board is also asked to consider how:

- This programme of work relates to projects currently underway or being planned by partners; and
- Partners can contribute to the future development of this programme of work.

3. Background

3.1 The approach of Health and Wellbeing Hubs is based on public service reform principles around co-location; joint working between multiple sectors and professions to build services around individuals. The overarching mission of the programme is to intervene with high risk cohorts at early stages to prevent them from requiring complex and often costly public services, such as admissions to Accident and Emergency departments, emergency service call outs or long term social care. We will do this through changing the way we work to deliver existing services, rather than by developing new ones.

3.2 There are three work streams within the Health and Wellbeing Hubs programme:

- Testing out new approaches to improving health and wellbeing outcomes and reducing dependency on public services among single homeless adults in temporary accommodation;
- Refreshing the existing older people's hubs to improve access for those who need the services most and to reduce social isolation; and
- Developing upon the nascent plans within the Church Street Renewal Programme for a health and wellbeing community hub on the site of 4 Lilestone Street / Penn House.

4. Refreshing Older People's Hubs

4.1 The Council has four contracts for the provision of preventative services to older people. These contracts, located in the wards with the greatest need; Queens Park/ Harrow Road, Westbourne, Church Street, and Churchill, are jointly funded with the Central London and West London Clinical Commissioning Groups (CLCCG/WLCCG). Originally let in 2012 they were extended through a direct letting in June 2015 for the period up to July 2017.

4.2 The hubs provide a diverse range of activities to the local community which are aimed at improving or maintaining good mental and physical health and reducing social isolation. A range of activities are offered in a number of sites in Westminster.

4.3 Early findings of a detailed review of the hubs (available upon request) were presented to the Health and Wellbeing Board. These findings confirmed that a pro-active, evidence-based approach is being undertaken as part of the programme.

4.4 Extensive mapping work has been undertaken to establish the full range of services being provided for older people, and the sites and buildings from which they are being offered. Geographic focus is currently on the south of the city, specifically in and around the Churchill area.

4.5 Since the Board last met, all of the venues and locations utilised by the Churchill hub and others identified by Adult Social Care (ASC) have been subjected to an initial summary appraisal around cost and suitability. Initial findings have suggested that the financial benefits of relocation may be relatively small in the south. Further in-depth analysis is on-going.

4.6 Connection with the work of Growth, Planning and Housing will be key to the success of this work. Productive discussions are already underway between the council and City West Homes, to understand some specific ways in which we could work together to take full advantage of our collective assets and resources to meet local need.

4.7 Library locations have been mapped but obtaining a more in depth understanding of what they already offer and potentially could offer is required. In particular a more detailed understanding of libraries as venues for services to support older people will enable us to consider in detail what potential there is (and what the comparative benefits and challenges may be) of re-location or clustering of services in those buildings. Early analysis has shown that there is not much duplication with libraries in terms of service offer but there might be in terms of cohort e.g. some people attending hubs may also attend libraries for health related interventions.

4.10 Discussions are underway to look at the use of the mainstream offer to promote health, wellbeing and continuing independence and develop low/no cost initiatives that can help with more targeted prevention work e.g. extending use and offer of the mobile library service, developing digital services, creating adaptable space to host events and activities. Discussions around opportunities

to develop an innovative service offers that provide better value for money in the market (e.g. community based day centre alternatives), which provide a more vibrant offer, and attract users with direct payments to spend their money with libraries is also underway.

4.11 Critically important is the need to map the physical assets owned and operated by our health partners, initially in the south of Westminster. GP surgeries are the first element of this. The key will be in successfully capturing this additional information in a way that is useful and meaningful in analysing opportunities and developing specific proposals and ideas for improvement. Beyond simply mapping where GP surgeries are, specific consideration will need to be given to whether they may have space that could be put to different or better use, and if so where, what is the nature of that capacity. This will require focused joint working with our health partners with a clear mandate to collaboratively develop and deliver joint service delivery solutions.

4.12 To date a successful meeting has been held between ASC, Open Age (the provider of three of our hubs) and nine CCG Care Navigators. A detailed overview of the current older people's hub offer was provided, with particular reference to the work in the south of the city, and the current activity programme outlined. In addition, the Churchill hub manager also joined ASC at a recent South Westminster CCG Village Meeting. The purpose of the meeting was to promote the older people's hub offer, explore opportunities to work together/co-locate and identify areas where there could be duplication.

4.11 Next steps involve a multi-stakeholder workshop for mid-May where Westminster City Council, the CCG, housing providers and others can discuss in more detail, and in more specific terms, the potential for greater joint service delivery, including the potential for sharing of space and resources.

4.12 The implementation of the CCG's Whole Systems Social Prescribing pilot in the south of the City will also be discussed. The intended purpose of the session is to further develop momentum and buy-in for this work, and support a clear and shared understanding of what we would like to achieve by optimising older people's services, in terms of the outcomes we seek to achieve and what it will take to deliver this collaboratively. The proposed agenda will also focus on identifying key drivers (contextual and policy conditions) and working collaboratively to achieve outcomes.

5. Newman Street

5.1 One of four general needs temporary accommodation facilities for single adults located within Westminster, Newman Street is a mixed-sex facility comprising of 77 self-contained studio flats. The majority of Newman Street residents are vulnerable adults with complex multiple needs, which include substance and alcohol addiction, significant mental and physical health issues and history of crime and/or anti-social behaviour. The ambition for this project is to target existing preventative services at a cohort of individuals who require early intervention to prevent them from experiencing greater difficulties and decline.

5.2 Together with our providers, CLCCG and Great Chapel Street Primary Care Centre, we have jointly developed a model to improve how we target existing services and improve residents' life chances. This addresses people's multiple needs in parallel and proactively takes services to them in order to facilitate access and engagement. Ultimately, the model will seek to enable residents to become self-reliant, to enter, re-enter or engage in employment activities and other meaningful occupation and to become financially independent.

5.3 The data on residents at Newman Street shows a high-level of vulnerability and multiple complex needs. Support to this cohort was enhanced through the deployment of floating support workers and pathways officers, who were introduced into the building in September 2015 to increase resident engagement with relevant services, such as primary care.

5.4 We recently conducted a preliminary evaluation of the floating support services. This showed a high engagement rate with support services, a reduction in safeguarding alerts and a consistent number of pathways placements. Residents are better linked to health services and the multi-agency approach provides more holistic support for the very vulnerable and complex cases. They are being supported to better manage their physical and mental health, as well as better managing substance misuse issues. They are also being supported to have their benefits issues resolved thus enabling them to maximise their incomes and develop budgeting skills. This has had a positive impact on their tenancy sustainment at Newman Street as well improving their mental and emotional wellbeing. These benefits will be felt beyond their stay at Newman Street.

5.5 Going forward, we need to consider whether we track individuals beyond Newman Street to see the whole benefits of this intervention. We need to refocus on skills training and volunteering to improve employment outcomes for residents. We also need to consider how we can capture more reflective data on the softer elements of 'life outcomes' such as personal motivation, self-

confidence, enhanced social life and a greater sense of empowerment and personal independence for each resident.

5.6 All of the work in this area has shown how we've improved our services to these households. We expect continued improvement with the adoption of clearly defined KPIs, further learning from hostel best practice, and the overall transformation of our offer for singles.

6. Church Street Health and Wellbeing Community Hub

6.1 Westminster City Council's Futures Plan[2] set out a 15 – 20 year vision for the development of the Paddington Green, Church Street and Lisson Grove locality. Urban Initiatives, the council's appointed urban planning and design specialists produced the plan following extensive consultation with local residents and stakeholders. In it were recommendations to deliver better homes, parks and open spaces, cultural, economic and enterprise opportunities, improved retail, better connections and community facilities.

6.2 A key project proposed within the plan was the development of a health and wellbeing hub that would accommodate health centre facilities, childcare provision, office space for appropriate council services and flexible community space. The original proposal included provision of residential flats above the community and health facilities on the ground floor, however later iterations of the concept replaced this with additional office space. This project enjoys strong support amongst residents and is a critical piece of social infrastructure to support the transformation of the neighbourhood.

6.3 Development of the Lilestone Street site is dependent on the demolition of Penn House, a block of council-owned sheltered accommodation and relocation of the 44 residents to new accommodation currently being built at Lisson Arches (which will complete in late 2018). It is anticipated that the Lilestone Street build will not be completed until 2021.

6.4 The Church Street Regeneration project team have met with NHS colleagues twice in 2016 to progress with development plans. Initial massing studies have indicated the building will provide c80,000sqft of space, with c25,000sqft to be for NHS use. Feedback from NHS is that space will be required for GP and community healthcare services (such as podiatry, dentistry, IAPT) and Out of Hospital services, as well as a potential need for office space.

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[2] https://www.westminster.gov.uk/futures-plan-for-housing

6.5 Alongside the development of the physical hub space, the project team is developing a vision for how the services and facilities within the hub should operate, as well as identifying activities that need to be undertaken now to pave the way for this. This offers an exciting opportunity to think strategically about how to meet the health and wellbeing challenges in the locality.

6.6 The Church Street Futures Steering Group (FSG) grew out of development of the Futures Plan and is supported by 10 working groups including:

Futures Steering Group			
Health and Wellbeing	Arts and Culture	Infrastructure and Public Realm	Employment & Skills
Luton Street	Finance & Viability	Cosway Street	Market & Retail
Lisson Arches	Communications		

6.7 The Health and Wellbeing Working Group[3], chaired by Ruth Runciman (local resident and former Chair of the Central & Northwest London NHS Foundation Trust) - has been developing a 'Theory of Change[4]' for Church Street. Work undertaken so far has focused on identifying responses to the following questions:

- What are the issues and problems that we are trying to address?
- What are the types of change that we are hoping to promote?
- How is this change likely to happen?
- How will the change be measured?

6.8 The group has drafted an Outcomes Framework that comprises qualitative and quantitative measures sitting under thematic headings focussed on the outcomes we are trying to achieve, all of which reference the ambition in the Futures Plan to make Church Street 'London's Most Liveable Neighbourhood'. This will be aligned as appropriate with other relevant strategies and outcomes frameworks, such as the Health and Wellbeing Strategy. This work will underpin the social and economic development activity that we do in the locality, and will inform the work plans for the various working groups listed above.

6.9 In March 2016, the project team hosted a well-attended workshop with senior managers and commissioners from the council and NHS to develop this thinking

[3] The group is seeking **new members with a clinical background** – please contact Helena Stephenson if interested
[4] **Theory of Change** is a specific type of methodology for planning, participation, and evaluation that is used in the philanthropy, not-for-profit and government sectors to promote social change. **Theory of Change** defines long-term goals and then maps backward to identify necessary preconditions.

and to get feedback on the logic model already developed for the hub. A similar workshop with local community organisations and FSG members is planned for May 2016. Local residents will be consulted on these issues via a peer research project scheduled to run over the summer of 2016.

7. Legal Implications

None at this time

8. Finance Implications

None at this time

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

Meenara Islam, Principal Policy Officer, Westminster City Council

Email: mislam@westminster.gov.uk

Telephone: 020 7641 8532

Westminster Health & Wellbeing Board

Date:	26 May 2016
Classification:	General Release
Title:	Shared Services Female Genital Mutilation Prevention Project
Report of:	Andrew Christie Executive Director of Children's Services
Wards Involved:	All
Policy Context:	
Report Author and Contact Details:	Debbie Raymond Head of Safeguarding, Review and Quality Assurance debbie.raymond@rbkc.gov.uk Steve Bywater Children's Services Commissioner Service Manager, Strategy and Partnerships steve.bywater@rbkc.gov.uk

1. Executive Summary

1.1 Female Genital Mutilation (FGM) refers to "procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons"[1].

1.2 The Shared Services Female Genital Mutilation Prevention Project ("FGM project) aims to prevent FGM and to ensure effective, specialist and sensitive services for those women who have suffered it offered in way that they can access. The project was initially based on a model devised by Westminster City council in 2014 which has been subsequently rolled out across the Tri-Borough.

1.3 The Shared Services FGM Project has been running across the Tri-Borough from May 2015 to May 2016. Evidence from 2014 in Westminster suggested that there were 770 girls and young women in the Borough at potential risk of FGM, however no referrals had been received to Children's Services in that or

[1] Female Genital Mutilation, NHS Choices

previous years. The pilot FGM project to address this in 2014 in Westminster chose to work closely with local ante-natal clinics because pregnancy provides an opportunity for women to seek specialist advice regarding FGM.

1.4 In March 2016, the Mayor of London called the project a "ground-breaking initiative". The project was also recognised within the "outstanding" award given to Westminster City Council Children's Services by Ofsted in 2016 which stated that the project is "outstanding, sensitive and culturally creative"[2].

2. Key Matters for the Board's Consideration

2.1 The Board is invited to:

- Consider the report outlining the project, its identified outcomes and performance;
- Discuss the project as a successful model of joint and collaborative working between local authority (Children's Services) health (midwifery services) and the voluntary and community sector, and consider how learning from this project may be applied by the Board in future projects; and
- Consider how the Board, particularly health and voluntary sector partners, can support the work and the sustainability of the project in the future.

3. Background

3.1 The Shared Serviced FGM project is currently operational across the tri-borough including Westminster. The pilot project was successful in attracting funding from the Department of Education's Innovation Fund, and it is now part of Mayor's Office for Policing and Crime (MOPAC) and London Local Authority's prototype for an Early Intervention Model to prevent FGM. It is part of the Harmful Cultural Practices Pilot in partnership with MOPAC - a capacity building project that provides enhanced training for practitioners and onsite "educator advocates" from the voluntary sector.

3.2 The project is currently funded by a Department of Education innovation grant which was awarded after the successful pilot phase. The Department of Education made an initial award, and have since granted a further £90,000 transitional fund to enable the project to run until December 2016. The transitional grant was made on the basis that the local authorities will use the additional time to work with local CCGs to establish a sustainable future for the project beyond that point.

4. Project Aims and Outcomes

[2] Westminster City Council Ofsted Report February 2016

4.1 The aim of the FGM project is early identification of girls, who might be at risk of FGM in order to work with their families to assess risk and undertake preventative work, and to improve the quality of services provided to adult survivors in order to promote their long term health and wellbeing. The premise is that children at greatest risk of FGM are the female children of FGM victims; therefore, the FGM maternity clinic is an effective way of identifying women who have had FGM and are expecting or already have female children.

4.2 Data from Imperial College Healthcare Trust shows that across St Marys and Westminster Hospital sites, these providers are in contact with 900 women per year who have suffered FGM.

4.3 The team consists of a specialist midwife, specialist social worker, trauma therapist (currently provided by CNWL forced migration service), a health advocate and specialist male social worker.

4.4 Part of the project aims include community engagement and awareness raising with families and communities, with the aim of supporting families to choose not to have their daughters subject to FGM.

4.5 The key outcomes identified for the project are as follows:

a. There should be fewer instances of FGM in children, alongside promoting the physical and mental health of the mother so that she has better long term health outcomes.

b. Statutory agencies will work together to identify and safeguard girls at risk of FGM through early help, providing the foundation for long-term safeguarding approaches to be developed.

c. Models of assessment and intervention co-constructed with community groups will have been developed, codified and implemented. Resulting high quality social work practice and multi-agency holistic responses will improve outcomes for both women and children.

d. Measurable behavioural change in communities, which will result in decrease of the prevalence of FGM and other Harmful Cultural practices over time.

5. Project Approach

5.1 The FGM Project aims to introduce an innovative approach in identifying and working with potential and current FGM victims. The critical aspect is the multi-agency work, and a specialist social worker co-located and embedded within existing health provision. Moreover, the approach has been co-constructed with

the community organisation Midaye Somali Development Network from the outset. This grass-roots approach has been the main driver of success.

5.2 The project has adopted a holistic approach for its delivery. It emphasizes support and empowerment of the FGM victims. When women attend the FGM clinic, they are provided with therapeutic trauma support by trauma therapists, and emotional support (and translation where necessary) by health advocates. The project has also recruited a male social worker who works directly male family members including husbands and fathers.

5.3 When pregnant women book in for antenatal care at the hospital, all are asked whether they have been victims of FGM. Those who have had FGM are then referred to the FGM clinic and receive a joint assessment from the specialist team. The project identifies adult FGM victims through a joint approach between midwifery and social care services in order to offer timely and proactive intervention and future FGM prevention for the expected or existing children. This sits alongside an offer to the mother of specialist physical and mental health care, as well as practical support and advice from health advocates.

5.4 FGM maternity clinics already exist in many hospitals, however the pilot provides an additional service such that women are jointly assessed by a midwife and social worker to provide both health and social care services. The clinics are run by midwives and the pilot introduces a multi-disciplinary team within the clinic. The project is currently being implemented in two clinics in the tri-borough, St Mary's Hospital and Queen Charlotte's Hospital, with the potential to expand to Westminster and Chelsea Hospitals in the next few months. The FGM Team Around is a "virtual "team which meets on a monthly basis to discuss the cases and discuss the multiagency assessments.

6. Key Achievements

6.1 The project has produced a substantial increase in the number of families where FGM has been identified to be an issue, enabling a proportionate response at an early help stage or through Child in Need or Child Protection services. Since May 2014 to March 2016, 77 women from RBKC, WCC and LBHF have been referred and seen in both clinics, who are receiving support/offers of early help. 26 families have been referred to Children's Services for further risk assessment by the project and 39 families are still under assessment/being tracked within the pilot process (pre-referral). All women who have daughters or are going to give birth to girls have agreed to social work visits.

6.2 At St Mary's FGM clinic, which operates weekly, the team see approximately 10-12 women per clinic. 3-7 cases are from the Westminster and wider Tri-Borough area and the rest being from outside the area (mainly Brent). At the Queen Charlotte's Hospital where an FGM clinic operates fortnightly, the team sees

approximately 5-10 women per clinic, with 4-5 women being from Westminster and the wider Tri-Borough area.

6.3 In comparison to 2013, when Children's services were not receiving any FGM referrals, 77 cases have now been referred and tracked. In addition, the project has generated a number of "milestone" cases such as: self-referrals by pregnant mothers where an older child has been cut; child protection investigations (including cases that have led to a child Protection plans). One case has also been referred to the Crown Prosecution Service for potential criminal action. The experience of working with these cases is enabling front-line practitioners, with the guidance of the lead worker, to enhance their skills and build experience in assessing risk in a way that enables them to act to prevent FGM in addition to providing services to women who have been subject to FGM.

6.4 Where girls have been identified as already being subject to FGM, existing Child Protection procedures are followed. Additionally, a pilot "Clinic for Children and Adolescents affected by FGM" has been developed to offer specialised services to support these girls and young women. This team consists of a consultant paediatrician, consultant gynaecologist, health advocate, therapist and specialist social worker, and has been planned in conjunction with the Police to ensure the clinic meets medico-legal standards. So far two medical assessments have taken place in the clinic.

Figures from pilot (October 2014-2015)	
Number of women seen at the FGM clinics (all cases receive early help offers)	68
Number of families referred to Children's Services for risk assessment by the pilot	21
Number of families still under assessment within the pilot process	34
Deliverables to date (April 2016)	
Number of women seen by both clinics	77
Girls referred to Child and Adolescent FGM clinic	3
Community Engagements by Midaye	20
Number of community members (women) engaged	450
Community Engagement by male community worker	21
Number of male engaged	210
Planned community Engagements(incl. with male)	3
Number of young people engaged	200
Multi-agency and Specialist Training	99
Figures from Children Services (referrals not from the hospital pilot, but overseen by the lead worker)	

Borough	**Children in Need**	**Child Protection**

WCC	14	2	
RBKC	10	2	
LBHF	3	8	

7. Assessment of Impact

7.1 There is currently an independent evaluation taking place by OPCIT Research, University of Lancashire which will highlight the key learning points. Some of the preliminary findings have identified good practice in creating clear pathways for FGM referrals, successful information sharing between midwifery. Opcit Research have also conducted qualitative interviews with the project practitioners, allied professionals such as midwives and clinicians working in maternity/ante natal care as well as women who have been supported. Further information on the emerging findings of the Opcit research is included in Appendix A.

8. Future Work Programme and Project Funding

8.1 The project has been awarded a transition fund by the Department of Education, to extend the project for six additional months, until sustainable funding is secured. There is a future proposal that this project could in future be jointly funded by Children Services, the CCGs, with the Acute Trusts meeting the cost of midwifery care and the physical clinical environment, but this is an initial proposal at this stage.

8.2 On 5th May 2016, Midaye delivered FGM Champion Volunteer training. Further to that the FGM Community Forum event will take place on the 10 May 2016 at Wood Lane Community centre and Debbie Raymond (Head of Safeguarding) will be delivering a FGM Mandatory Reporting awareness workshop/event on 13 May 2016.

8.3 The Harmful Practices Steering Group has engaged safeguarding and social work stakeholders from neighbouring boroughs to address cross-boundary cooperation beyond the Tri-Borough. One of the identified issues was the large number of clients seen by the clinics from neighbouring boroughs as clinics are based on the territory of Tri-borough. The referral pathways to Social Services in Brent and Ealing are currently being reviewed and the project is working towards sharing good practice with our neighbouring boroughs' partners. The community organisation Midaye is currently engaging with the group leaders of two informal groups operating in Brent.

9. Legal Implications

Not applicable

10. Financial Implications

Not applicable

If you have any queries about this Report or wish to inspect any of the Background Papers please contact:
Debbie Raymond
Head of Safeguarding, Review and Quality Assurance
debbie.raymond@rbkc.gov.uk

BACKGROUND PAPERS:
Appendix A – Preliminary findings from Opcit Research
Appendix B – Current Project Cost

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Appendix A

Emerging findings from Opcit research

What is sustainable about the Shared Services FGM project model?

- The projects operates on an interventionist model by linking women who have experienced FGM with social workers, providing advice and support to professionals and avenue for support to women who have experienced FGM, beyond health and ante natal care. It provides a direct line of communication and engagement between social work professionals and communities in which FGM is practiced.
- The FGM model positions social workers as a source of early help within the framework of child welfare – a difficult characteristic to achieve despite being attempted nationally.
- The project uses woman-centred community engagement to achieve outcomes.
- The project includes creates a positive experience for families who in many instances have never previously engaged with statutory services, and builds their confidence to access the health and psychological support that they need.
- Many women who have been supported have been socially isolated. They have never received support or counseling for FGM.
- There has been positive joint working between the specialist social workers and their colleagues in Midaye and Ashiana to gain women's trust. Additionally social workers are well placed to broker access to support services and, potentially, give credibility to the message that FGM is illegal and actionable.
- Business processes are in negotiation to facilitate automatic referral from the FGM clinics or midwifery to the duty team and from there to the specialist FGM social worker. The pilot has encouraged the development of such solutions, which are slightly different in each pilot area and there appears to be potential for such practices to become embedded and 'mainstreamed'.
- The project has created new avenues for identifying and addressing risk within the community by engaging with education providers which are the places most likely to pick up on risk of FGM outside of an ante-natal health setting.

Emerging potential impacts:

- It is reported that amongst health and care services there was insufficient awareness of the resources or an understanding of what actions should be taken when FGM is identified as a risk. Following the pilot, these routes are clearer: all FGM cases identified should be referred to the FGM social worker. The project has created a clear pathway for referral.
- The knowledge that there are dedicated professional available in itself raises the awareness level. The FGM social workers are able to inform other professionals about the impact of FGM on other presenting factors including other mental and physical health conditions related to FGM.
- Many women that have been supported have spoken of the value of being provided emotional and advocacy support which has allowed them to develop a voice in decisions about FGM.

- Basing the model firmly within the social work context encourages continued engagement and this is done within the context of an offer of support rather than in an adversarial or threatening way.
- The continuation of the pilot will provide opportunity to address important questions such as: how professionals can work with families that are hostile to intervention (and therefore, potentially at greater risk), and how to engage at risk cases where there is no health intervention route (i.e in schools).

Apart from the increase in referrals which this project has produced one of its major successes is the increased understanding about the complexity of FGM – this is enabling us as a service to develop more effective methods of assessing future risk to children.

The learning from this innovation project was presented to a pan-London audience at a conference chaired by Stephen Greenhalgh, Deputy Mayor of London on 1st February 2016. The Deputy Mayor attended a visit with the project delivery team and met a group of students at St Marylebone School to discuss what they have learned about FGM during the awareness raising sessions that has been undertaken with them.

Appendix B

Current Project Costs

	LBHF	RBKC	WCC
Specialist CPA (3BW)	£ 15,833	£ 15,833	£ 15,833
Male Worker (5BW)	£ 7,917	£ 7,917	£ 7,917
x2 Community Mediators (3BW)	£ 20,000	£ 20,000	£ 20,000
Psych Support	£ 15,000	£ 15,000	£ 15,000
	£ 58,750	£ 58,750	£ 58,750

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Westminster Health & Wellbeing Board

Date:	26 May 2016
Classification:	General Release
Title:	Community Independence Service Procurement
Report of:	Community Services Programme Director Central London, Hammersmith & Fulham and West London CCGs
Wards Involved:	All
Policy Context:	City for Choice
Report Author and Contact Details:	**Matthew Bazeley, Managing Director, Central London CCG** m.bazeley@nhs.net **Chris Neill, Director of Whole Systems Integrated Care** chris.neill@lbhf.gov.uk **Anne Elgeti , Community Services Programme Manager** anne.elgeti@nw.london.nhs.uk

1. Executive Summary

The Community Independence Service provides integrated community and social care through one multidisciplinary team in each borough. The service operates seven days a week enabling people to regain their independence and remain in their own homes following illness and/or injury. The service provides a patient-centric experience with as few separate interactions or home visits as possible. Services are currently delivered by a multidisciplinary team of community nurses, social workers, occupational therapists, GPs, geriatricians, mental health workers, reablement officers and others providing a range of functions which aim to:

- Avoid hospital admissions where clinically appropriate care can be provided in the community;
- Facilitate early supported discharge from hospital;
- Maximise independence; and

- Reduce dependency on longer term services.

The CIS provides an opportunity for commissioners to negotiate contracts with acute trusts that reflect penalties to offset investment made in community services. The introduction of the consequence of breach against KPIs will ensure commissioners are only spending against activity delivered.

The Community Independence Business Case 2014, described 2015-16 as an intermediate development year for the service using a dual lead provider model (Health and Social Care) and set out a further proposal to use an open market tender to procure a fully integrated CIS with a single lead provider model from 2016.

2. Key Matters for the Committee's Consideration

- The Board are asked to consider the background to and the progress of the Community Independence Service procurement process.

3. Background

Intermediate care and re-enablement services are a key plan of government healthcare policy to provide health and care closer to home. Intermediate care services are key to reducing the financial, quality and activity pressures being experienced in secondary care and the care service sector. The National Audit of Intermediate Care (2015) provides a comprehensive analysis of models and performance of services which support, typically older, frail people with high levels of need and complex comorbidities, after leaving hospital or at risk of being sent to hospital or long term care. Evidence from this audit (to which CLCH and Central London CCG are contributors) indicates that CI services improve the independence of frail, older people and that reduce the cost of delivering care.

The CIS delivers the following key functions:

- A Single Point of Referral, Assessment & Rapid Response
- In-Reach/Supported Discharge
- Rehabilitation & Reablement

The Community Independence Service Business Case (Nov 2014) presented the case for an integrated Community Independence Service to be managed by lead providers from health and social care. The procurement was undertaken as a restricted tender between existing providers delivering services to tri-borough CCGs. The advertised restricted tender was for a one-year contract with no extension as with the intention of using the transition year to procuring a full lead provider model for 2016.

The timescale for procurement was delayed to allow an evaluation of the current model in October 2015. The evaluation process included 1:1 and group meetings with commissioners, provider teams, GPs and Clinical leads for the service as well as patient feedback and surveys. Following the evaluation commissioners agreed to move to procurement of an integrated CIS under a partnership of providers using

either a lead provider or alliance model. Learning from the evaluation has been discussed during Market Engagement and taken into consideration when developing the service specification.

The objectives of the service are to:

- Enable people to direct their own care to achieve identified and agreed goals.
- Support integration across health & ASC, through a jointly commissioned service that brings the elements of care into one service, which will reduce fragmentation and delays across the health and social care pathway.
- Supports behaviour change across the system to promote independence in patients and a reablement approach to care which should lead to better patient outcomes, right care in the right place (this also supports Out of Hospital)
- Compliments and supports whole systems integrated care and primary care transformation by providing supporting GPs to manage patients in the community by provision of a step-up service when required as part of a proactive approach to managing patient care and avoiding admission to hospital where conditions can be safely managed in the community.
- Maximise independent living by supporting care at home, delaying possible admission to long term care, avoiding inappropriate admission to a hospital or long-term care institution, and achieving earlier discharge;
- Improve the transition for patients between acute hospital services, community services and primary care;
- Improve value for money by lowering the costs of unscheduled care and care placement admissions as a consequence of reduced unnecessary hospital and long-term care admissions and readmissions;

In autumn 2015, a triborough programme team was established to identify the requirements of the service for 2016-18 and develop the tender documentation including PQQ and ITT questions, Memorandum of Information and Service Specification. An evaluation of CIS performance including discussions with patients, clinical and non-clinical staff was undertaken in November and December 2015 and a full market engagement exercise undertaken with providers in January 2016.

4. Procurement Process

Phase 1 – Market Engagement

In December 2015 Triborough Health commissioners authorised a three month extension of the Lead Health Provider Contract to cover the anticipated procurement timeline.

A Memorandum of Information was published on the EU Portal on 13th January 2016 to advertise that a potential health & social care procurement of a fully integrated community independence service was being considered. The advertisement offered providers the opportunity to comment on the proposed service design and timescale for procurement through i) written response to a series of questions regarding future development of the Community Independence Service and ii) an opportunity to participate in 1:1 interviews with commissioners.

Commissioners received 11 expressions of interest, 8 written responses and undertook 7 provider meetings. Responses were positive and all provider written responses contained confirmation of ability to bid and mobilise services within the timeframes indicated in the Memorandum of Information.

Following a review of the market engagement exercise commissioners agreed to proceed to Phase 2 of this project, an open tender process.

Phase 2 - Procurement

Following completion of the market engagement exercises commissioners across health and social care jointly revised the CIS service specification. The intention was to strengthen the service model, building upon the first 12 months of the development of the CIS and enhance delivery to patients and residents across the three boroughs. The key service lines within the CIS model remain unchanged and areas identified for immediate improvement and development included:-

Phase 3 - Advertising the Opportunity

Following development and agreement of a joint service specification, finance and procurement documentation, an advertisement was placed on Contract Finder (EU Procurement Portal) on 4th March 2016. Interested parties were given 6 weeks to provide a written submission to bid for delivery of the service with final deadline of noon on 15th April 2016.

5. Outcomes of Tender Process

Following development and agreement of a joint service specification, finance and procurement documentation, an advertisement was placed on Contract Finder (EU Procurement Portal) on 4th March 2016. Interested parties were given 6 weeks to provide a written submission to bid for delivery of the service with final deadline of noon on 15th April 2016.

A number of bids were received and marked by a multi-commissioner evaluation team. Commissioners hope to be in a position to appoint a lead provider in the near future with service commencement in July 2016.

The intention is to consolidate and improve the current service delivered by integrated community and social care by creating multidisciplinary health and social care teams to work across the boroughs, which operate seven days a week, enabling people to regain their independence following illness and/or injury and remain in their own homes. Healthcare teams must have the ability to flex across borough boundaries for delivery of services to ensure the ability to meet fluctuations in demand.

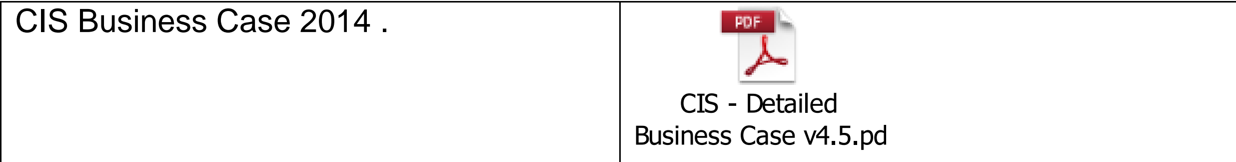
The new service procured will be contracted for an interim period of a maximum of 21 months (July 2016-March 2018) which will:

- Provide an opportunity to further develop the service whilst commissioners develop and procure Accountable Care Partnerships (as set out in Commissioning Intentions 2015).
- Allow the existing provider network to develop to a suitable level of competence for involvement in Accountable Care Partnerships.

If you have any queries about this Report or wish to inspect any of the Background Papers please contact Anne Elgeti 020 3350 4108 anne.elgeti@nw.london.nhs.uk

APPENDICES:
Not applicable

BACKGROUND PAPERS

CIS Business Case 2014 .	 CIS - Detailed Business Case v4.5.pd

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Joint Strategic Needs Assessment (JSNA) Steering Group

Monday 4th April 2016 2.00-4.00pm

Hanham Room, Freeman Suite, Kensington Town Hall

Notes

In attendance	
Mark Jarvis (chair)	Head of Governance & Engagement, H&F CCG
Angela McCall (AMc) (minutes)	Business Support Officer, Public Health
Jessica Nyman (JN)	JSNA Manager, Public Health
Colin Brodie (CB)	Public Health Knowledge Manager
Jackie Rosenberg (JR)	CEO, One Westminster
Angelica Silversides (AS)	Healthwatch K&C
Samar Pankanti (SP)	Public Health Project Manager, CLCCG
Shad Haliban (SH)	Head of Organisational Development, Sobus
Thilina Jayatilleke (TJ)	Senior Health Intelligence Analyst, Public Health
Phoebe Morris-Jones (PMJ)	Policy Officer, Westminster
Steve Comber (SC)	Policy Officer, Triborough Children's Services
Kerry Doyle (KD)	Head of Corporate, WL CCG
Jonathan Lillistone	Head of Commercial Innovation and Insight, Triborough Adult Social Care
Apologies: Stuart Lines, Daniella Valdes; Shelley Prince	

Minutes

1. Welcome and introductions

-

2. Online JSNA demonstration and feedback

TJ presented his work on the Online JSNA Highlight Reports. Key point included:

- Cover for TJ's BAU work was recruited a month ago to enable him to focus on the Online JSNA.
- Technical aspects are to be completed late April and the refresh of the Highlight Report by late May, going to consultation in the next 2 months to enable stakeholders to feedback.

- This project will be a priority for the Public Health Intelligence team and link to other pieces of work.
- Easy access is important – the online JSNA will be publicly available and use publicly available data. There will be a standalone app which can be accessed directly from people's phones.
- The tool will be dynamic so that data can be played with and downloaded for a variety of uses
- The tool will not replicate data that is already produced but will link into the existing data sources
- To ensure data quality the online JSNA will link to existing sources which are accountable and have to be accurate.
- Training will be provided once the tool is rolled out, which will be built in as part of the programme.
- Key facts in the Highlight Reports will link to external data and will be aligned with PH main themes. Key data for the Highlight Reports will be refined over the next 2 months but over the next 6 months there should be individual pages for each team, department and service which is all linked to the database in the backend and will be constantly updated which will keep it future-proof and up to date.
- Toby Hyde will be the H&F CCG link; WL CCG is Glen Monks; CL CCG – Samar offered to be the contact

Risks discussed:

- Data not being kept up to date: Low risk, as this will underpin a lot of the PHI work and is considered a departmental priority by the Director of Public Health, so resource will be allocated to the Online JSNA's ongoing maintenance. There is now a budget to bring in people if something breaks. As it links with more departments, the database will be uploaded by those teams.
- Cost: low risk, as it is based on software the council already has a corporate subscription to.

The tool encompasses the key elements of other JSNA tools. A hands-on demonstration would be helpful to show how people could use it, as well as a session at the CCG, with the locality support managers who know practices, GPs and practices well.

- **TJ to circulate link and feedback form to JSNA Steering Group when online JSNA is ready.**

3. Minutes of last meeting and matters arising

Minutes agreed as accurate.

Matters arising:

- **End of Life Care JSNA – a project lead for the NWL Last Phase of Life programme is due to start in April. CB to arrange meeting with End of Life JSNA Lead, Bridgitte Moess, and NWL lead in May. The service directory will be part of this work. CB to propose inclusion of 3rd sector services funding information.**
- **JN to send comms to CCGs on the publications of End of Life Care and Childhood Obesity JSNAs.**
- **JSNA newsletter – all who aren't signed up to this should do so.**

4. JSNA Review – presentation of findings and proposed changes

JN introduced the JSNA Review paper and confirmed that the proposed approach as outlined in the paper will have to go through formal discussion and approval at the H&WBBs.

The JSNA Review proposes 3 new areas of improvement for the JSNA Work Programme:

1. Selecting the right topics for Deep Dive JSNAs. Deep Dives should be on areas highlighted in the joint H&WB Strategies. In addition, there should be some flexibility for small reactive pieces of JSNA work.

2. Widening the range of JSNA products - i.e. factsheets, evidence briefings and work that is already done as essentially JSNAs but haven't gone through the formal governance, and the JSNA website could share this. At the moment the governance structure doesn't allow for this.

3. Change of governance. Smaller pieces to be published on the website but with approval of PH SMT who meet weekly. This will allow more quick and reactive work for smaller pieces. Under the new proposal the H&WBB will sign off the JSNA proposals for big Deep Dive projects

Once the Joint H&WB strategies are developed and finished in June a forward plan for JSNA Deep Dives topics will be designed with commissioning managers, with clear links to procurement. .

The Steering Group discussed these proposals:

- As Deep Dives timescales don't always fit with the commissioning cycle, this proposal would work better from a CCG perspective, and smaller pieces of work fit with this too. Members are maximising opportunities by extending our academic links i.e. taking on PHD students etc.

- MJ asked the group to be aware of the proposal to change the way the group works with governance. The group agreed to this change. This group will continue to oversee the process, and will have a role of assuring the H&WBB on the outcomes of JSNA products and that the recommendations should be accepted.

- Terms of Reference will need to be reviewed and will come to a later meeting.

- Engagement is likely to be better and recommendations more likely to be successfully implemented with the new proposals.

❖ **MJ asked for a rolling programme of products that are likely to be branded as JSNAs. JN will provide a list when the new process is in place, pending H&WBB approval.**

CB ran through the JSNA Internal Audit which was part of the internal audit for the Councils.

❖ **CB to find out which committees of the Councils this will go to – feedback to MJ.**
❖ **JN/CB to include an indication of resource and cost need in future JSNAs.**

4. Health and Wellbeing Strategy Refresh update and discussion

PMJ updated the group on the Strategy refresh.

Officer's on the operational group also sit on the Sustainability & Transformation Programme (STP) and a high level vision document has been submitted to the SGP. The H&WBB Strategy is not in a state to report priorities to the STP at the moment. AS raised a concern that she has had no opportunity for her 5 boroughs to report into this and has not seen any proposals on the local areas.

- **PMJ to take AS's concern back to the STP development group.**
- **PMJ to circulate slides.**

5. Updates from current JSNAs

Health and Disability related Housing

Progressing slowly as a complex piece of work and following changes in leadership. Draft expected to be completed and shared with critical friends and stakeholders in a workshop setting late May / early June.

- **Housing associations have places for step down and transitional care. Properties are available and there is funding but CCGs and LA commissioning can be an issue. AS to contact JN with details of**

Young Adults

A number of key lines of enquiry have developed:

- Students
- Care leavers (15/16-25)
- Transition health and care needs of young people moving from children's / paediatrics to adult services
- Mental health (including eating disorders)
- Urgent care
- Substance misuse and sexual health
- Local services and asset mapping

Interesting data has been collected from the Community Safety team but there have been delays in getting NHS data.

The current Project Lead has many other work commitments and has not been able to dedicate time to this project. This was identified as a potential risk, and it is hoped that she will be able to support the project from next month.

6. AOB

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Date and time of next meeting: 16th June, Holland Room, Kensington Town Hall

Westminster Health & Wellbeing Board
Work Programme
2016/17
DRAFT

KEY
FOR DECISION
FOR DISCUSSION
FOR INFORMATION
PLANNING

Agenda Item	Summary	Lead	Item
BUSINESS ITEMS			
Meeting Date: 14 July 2016			
STRATEGIC ITEMS			
JOINT HEALTH AND WELLBEING STRATEGY AND STP UPDATE		**ASC/CCG**	**For decision**
ANNUAL PUBLIC HEALTH REPORT 2016/17 + ONLINE JSNA	For approval ahead of publication	**PH**	**For decision**
DISCUSSION ITEMS			
HOUSING JSNA	For approval ahead of publication		**For noting**
CHILDHOOD OBESITY: ONE YEAR ON	For approval ahead of publication	**PH**	**For discussion**
HEALTH HUBS		**ALL**	
PRIMARY CARE UPDATE	comprising: • Co-commissioning • Primary care modelling	**CCG**	
NHS 111 AND INTEGRATED URGENT CARE MODEL		**NWL CCGs**	**For discussion**
HEALTH VISITING PROGRAMME		**PH**	**For discussion**
BUSINESS ITEMS			
Meeting Date: 15 September 2016			

STRATEGIC ITEMS			
INTEGRATION, ACCOUNTABLE CARE AND DEVOLUTION	including CCG commissioning intentions17/18 and beyond	**CCG/ASC**	**For decision**
TRANSFORMING PRIMARY CARE	Primary care co-commissioning and transformation plans	**CCG/NHSE**	**for discussion**
MENTAL HEALTH	Update on tackling mental health in the borough	**CCG/PH**	**for discussion**
DISCUSSION ITEMS			
JOINT HEALTH & WELLBEING STRATEGY	focused discussion on a particular aspect of the strategy tba	**ASC/CCG/PH**	**For discussion**
YOUNGER ADULTS 18-15 JSNA DEEP DIVE	to consider findings of the JSNA deep dive and approval ahead of publication	**PH**	**For discussion**
HEALTH HUBS			
PRIMARY CARE UPDATE	comprising: • Co-commissioning • Primary care modelling	**CCG**	
BUSINESS ITEMS			
Meeting Date: 17 November 2016			
STRATEGIC ITEMS			
STP DELIVERY PLANING UPDATE	6 month post-implementation update	**NWL CCG**	**For discussion**
DISCUSSION ITEMS			
SAFEGUARDING CHILDREN BOARD ANNUAL REPORT 2015/16	Consider strategic alignment and lessons for integrated commissioning	**Independent Chair**	**For discussion**
SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2015/16	Consider strategic alignment and lessons for integrated commissioning	**Independent Chair**	**For discussion**
JOINT HEALTH AND WELLBEING STRATEGY	discussion focusing on a particular aspect of the strategy tba	**ASC/CCG/PH**	**For discussion**
HEALTH HUBS			

PRIMARY CARE UPDATE	comprising: • Co-commissioning • Primary care modelling	**CCG**	
	BUSINESS ITEMS		
	Meeting Date: 19 January 2017		
	STRATEGIC ITEMS		
BETTER CARE FUND PLANNING UPDATE + ALLOCATIONS 2017/18		**ASC**	**For decision**
JOINT HEALTH AND WELLBEING STRATEGY	discussion focusing on a particular aspect of the strategy tba	**ASC**	**For discussion**
	DISCUSSION ITEMS		
HEALTH HUBS			
PRIMARY CARE UPDATE	comprising: • Co-commissioning • Primary care modelling	**CCG**	
	BUSINESS ITEMS		
	Meeting Date: 23 March 2017		
	STRATEGIC ITEMS		
HEALTH + SOCIAL CARE INTEGRATION PLANS	Update on planning for full integration by 2020	**CCG/ASC**	**For decision**
LEARNING FROM THE LONDON DEVOLUTION PILOTS	review learning from first year of London devolution pilots	**ASC**	**For discussion**
JOINT HEALTH AND WELLBEING STRATEGY	discussion focusing on a particular aspect of the strategy tba	**ASC**	**For discussion**
CCG OPERATING PLANS 2017/18	operating plans for 2017/18	**CCG**	**For discussion**
	DISCUSSION		
HEALTH HUBS			
PRIMARY CARE UPDATE	comprising: • Co-commissioning • Primary care modelling	**CCG**	
	BUSINESS ITEMS		

KEY

STRATEGIC ITEMS – items concerning system level issues (e.g. health and care integration, devolution, primary care transformation)

DISCUSSION ITEMS – items of interest focusing on a specific part of the system such as a specific health condition, service or population group (e.g. JSNA deep dives)

BUSINESS ITEMS – items for the board's approval or information but which do not require a discussion (e.g. items that have been agreed offline but require formal approval by the Board)