Public Document Pack

City of Westminster

Committee Agenda

Title:	**Health & Wellbeing Board**
Meeting Date:	**Thursday 16th November, 2017**
Time:	**4.00 pm**
Venue:	**Rooms 3.6 and 3.7, 3rd Floor, 5 Strand, London WC2 5HR**

Members:

Councillor Heather Acton (Chairman)	Cabinet Member for Adult Social Services and Public Health
Dr Neville Purssell	Central London Clinical Commissioning Group
Councillor Richard Holloway	Cabinet Member for Children, Families and Young People
Councillor Barrie Taylor	Minority Group
John Forde	Tri-borough Public Health
Bernie Flaherty	Bi-borough Adult Social Care
Melissa Caslake	Bi-borough Children's Services
Tom McGregor	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
Dr Joanne Medhurst	Central London Community Healthcare NHS Trust
Anne Mottram	Imperial College NHS Trust
Maria O'Brien	NW London NHS Foundation Trust

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 5 Strand from 3.30pm. If you have a disability and require any special assistance please contact the Committee Officer (details listed below) in advance of the meeting.

An Induction loop operates to enhance sound for anyone wearing a hearing aid or using a transmitter. If you require any further information, please contact the Committee Officer, Toby Howes, Senior Committee and Governance Officer.
Tel: 020 7641 8470; Email: thowes@westminster.gov.uk
Corporate Website: www.westminster.gov.uk

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

AGENDA

PART 1 (IN PUBLIC)

1. MEMBERSHIP

To report any changes to the Membership of the meeting.

2. DECLARATIONS OF INTEREST

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

3. MINUTES AND ACTIONS ARISING **(Pages 1 - 20)**

(a) To agree the Minutes of the meeting held on 14 September 2017.

(b) To note progress in actions arising.

PART A

4. CHAIRMAN'S VERBAL UPDATE

Chairman to provide a verbal update on health and wellbeing matters.

5. PHARMACEUTICAL NEEDS ASSESSMENT **(Pages 21 - 138)**

To consider an update on progress on developing the Pharmaceutical Needs Assessment.

6. ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH 2016-17 **(Pages 139 - 162)**

To consider the annual report of the Director of Public Health 2016-17.

7.	**CHILD AND ADOLESCENT MENTAL HEALTH SERVICES TRANSFORMATION PLAN** To consider a report on the Child and Adolescent Mental Health Services Transformation Plan.	**(Pages 163 - 192)**
8.	**ANNUAL REPORT OF THE SAFEGUARDING ADULT EXECUTIVE BOARD 2016-17** To consider the annual report of the Safeguarding Adult Executive Board 2016-17.	**(Pages 193 - 226)**
PART B		
9.	**NEXT STEPS WITH INTEGRATED HEALTH AND SOCIAL CARE IN WESTMINSTER** To consider the next steps for integrated health and social care in Westminster.	**(Pages 227 - 328)**
10.	**ANY OTHER BUSINESS**	

Charlie Parker
Chief Executive
10 November 2017

This page is intentionally left blank

CITY OF WESTMINSTER

MINUTES

Health & Wellbeing Board

MINUTES OF PROCEEDINGS

Minutes of a meeting of the **Health & Wellbeing Board** held on **Thursday 14th September, 2017**, Rooms 3.6 and 3.7, 3rd Floor, 5 Strand, London WC2 5HR.

Members Present:
Chairman: Councillor Heather Acton, Cabinet Member for Adult Social Services and Public Health
Clinical Representative from the Central London Clinical Commissioning Group: Dr Paul O'Reilly (acting as Deputy)
Cabinet Member for Children, Families and Young People: Councillor Karen Scarborough (acting as Deputy)
Minority Group Representative: Councillor Barrie Taylor
Tri-Borough Adult Services: Dylan Champion (acting as Deputy)
Tri-Borough Children's Services: Annabel Saunders (acting as Deputy)
Clinical Representative from West London Clinical Commissioning Group: Dr Naomi Katz (acting as Deputy)
Healthwatch Westminster: Janice Horsman
Chair of Westminster Community Network: Jackie Rosenberg
Central London Community Healthcare NHS Trust: Basirat Sadiq (acting as Deputy)

Also in attendance: Councillor Paul Church (Deputy Cabinet Member for Adult Social Services and Public Health), Maria O'Brien (North West London NHS Foundation Trust), Chris Neill (Interim Deputy Director, NHS Central London Clinical Commissioning Group) and Louise Proctor (Managing Director, NHS West London Clinical Commissioning Group).

1 MEMBERSHIP

1.1 Apologies for absence were received from Barbara Brownlee (Director of Housing), Andrea Luker (Head of Strategy and Quality, Housing) and Anne Mottram (Imperial College Healthcare NHS Trust).

1.2 Apologies for absence were also received from Dr Neville Purssell (NHS Central London Clinical Commissioning Group), Councillor Richard Holloway (Cabinet Member for Children, Families and Young People), Sue Redmond (Tri-borough Adult Social Care), Melissa Caslake (Tri-borough Children's Services), Dr Philip Mackney (NHS West London Clinical Commissioning Group) and Dr Joanne Medhurst (Central London Community Healthcare NHS Trust).

1.3 Dr Paul O'Reilly (NHS Central London Clinical Commissioning Group), Councillor Karen Scarborough (Deputy Cabinet Member for Children, Families and Young People), Dylan Champion (Head of Health Partnerships, Adult Social Care), Annabel Saunders (Interim Tri-borough Director of Commissioning, Children's Services), Dr Naomi Katz (NHS West London Clinical Commissioning Group) and Basirat Sadiq (Central London Community Healthcare NHS Trust) attended as Deputies respectively for Dr Neville Purssell, Councillor Richard Holloway, Sue Redmond, Melissa Caslake, Dr Philip Mackney and Dr Joanne Medhurst.

1.4 The Chairman proposed that Anne Mottram (Imperial College Healthcare NHS Trust) and Maria O'Brien (North West London NHS Foundation Trust) be appointed to the Board as non-voting Members.

1.5 **RESOLVED:**

1. That Anne Mottram be appointed onto the Westminster Health and Wellbeing Board as a non-voting Member in her capacity as the representative of Imperial College Healthcare NHS Trust.

2. That Maria O'Brien be appointed onto the Westminster Health and Wellbeing Board as a non-voting Member in her capacity as the representative of North West London NHS Foundation Trust.

2 DECLARATIONS OF INTEREST

2.1 There were no declarations of interest.

3 MINUTES AND ACTIONS ARISING

3.1 **RESOLVED:**

That the Minutes of the meeting held on 13 July be signed by the Chairman as a correct record of proceedings.

3.2 **RESOLVED:**

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

4 SUSTAINABILITY AND TRANSFORMATION PLAN: A) SUSTAINABILITY AND TRANSFORMATION PLAN UPDATE; B) MENTAL HEALTH TRANSFORMATION

4.1 Jane Wheeler (Programme Director, Mental Health and Wellbeing, North West London Collaboration of Clinical Commissioning Groups) gave a presentation providing an update on the North West London Sustainability and Transformation Plan (STP) that had been submitted in October 2016. She explained that there had been a number of changes in respect of health and social care since the STP had been submitted. Jane Wheeler referred to the various ways in which the Council had a voice on how the STP operated,

including through the Joint North West London Health and Care Transformation Group, of which the Chairman of the Board and the Council's Chief Executive were members. The Council also had officer representation on the North West London Strategic Finance and Estates Group, and the Programmes Boards for delivery areas 1 and 2 of the STP respectively (radically upgrading prevention and wellbeing and improving outcomes for children and adults with mental health. Local providers such as the Central London Community Healthcare (CLCH) NHS Trust, the Central and North West London (CNWL) NHS Foundation Trust and St Mary's Hospital of the Imperial College Healthcare NHS Trust were also represented throughout the governance structure, whilst the citizen voice was represented through the various partner forums.

4.2 Jane Wheeler stated that the STP vision was to help people both be well and live well and to help achieve this integrated out of hospital care services would be delivered across a range of local services based on 4 key components, these being personalised, localised, integrated and specialised. Jane Wheeler referred to the STP's triple aim, this being:

- Improving health and wellbeing
- Improving care and quality
- Improving productivity and closing the financial gap.

4.3 Jane Wheeler advised that there were 9 priorities, underpinned by a number of projects, to help achieve the triple aim. Every effort was being made to produce more user friendly documents to explain the aims of the STP and what this would mean in terms of changes to services and Jane Wheeler circulated an example of this to Members. Since the STP had been submitted, there had been a number of significant changes, amongst these was the 8 boroughs of the STP coming together to oversee the work and jointly agree priorities and how to resolve challenges. Workstreams for health and social care were also being processed as joint priorities, with teams across agencies working together. There had also been some success in securing national funding where it was available, for example in mental health, diabetes and cancer. Jane Wheeler added that there was much improved access to mental services in general.

4.4 Turning to some of the highlights since the introduction of the STP, Jane Wheeler informed Members that over £500k had been invested in staff for mental health services and £2m had been awarded to boost talking therapies support for patients with diabetes and chronic obstructive pulmonary disease who may also have mental health needs. Phase 2 of Change Academy had led to 8 applicants being trained as part of the 'High Performing Care and Leading Transformation' Programme. The Making Every Contact Count programme was due to be rolled out to help frontline staff encourage changes to clients' behaviour and lifestyle to improve health and wellbeing being. In respect of diabetes, a £2.3m award had been achieved to transform patient's treatment and care and increased awareness to prevent people developing this condition. All 8 boroughs were also now testing their 'Home First' pathways to get people home from hospital as soon as they no longer required medical care. Additional funding had had also been provided to

support the first step in creating a single point of access 24/7, 365 days a year for people in mental health crisis as part of an Urgent Care pathway.

4.5 To build on progress to date, Jane Wheeler advised that there would be a reassessment of priorities, finding better ways to communicate the STP's projects and to keep engaging the population and key partners. There would also be regular reviews of governance structures, a building of relationships with other London STPs and key stakeholders, introducing a consistent way of reporting across the STP's projects and programmes and further dialogue with partners to identify what is needed or desired and what areas were particularly challenging.

4.6 Chris Neill (Interim Deputy Director, NHS Central London Clinical Commissioning Group) added that the STP was at an important review stage a year into its submission. Internal reviews and discussions with partners were taking place and Chris Neill advised that Healthwatch members were playing a role in helping to make language more accessible for patients. There would also be monthly updates on the progress of implementing the STP.

4.7 During Members' discussions, the Chairman thanked Healthwatch for the role they were playing in helping to make the language on STP documents more user friendly. She felt that the STP had provided the opportunity for partners to work together more closely and valuable lessons were also being learnt by looking at other STPs. The Chairman asked if there were any papers available detailing comparisons with other STPs.

4.8 Members commented that they would like to see more details about working arrangements for emergency admissions and discharges in respect of mental health cases. There was also the need for a proper community infrastructure to be in place to meet the STP's aims, including in respect of mental health, to ensure that people were well. Isolation for some residents was also an issue and it was important to have proper networks around such people. Members stressed that children's mental health was also an important area for the STP to address.

4.9 Dr Naomi Katz (NHS West London Clinical Commissioning Group) stated that her practice had a number of homeless patients, many of whom were alcohol and drug users. The Point of Access Team had a backlog of such patients needing to be seen as there were certain pathways that these patients could not be directed to and this issue needed to be looked into further. Members commented that there were situations where residents may have problems accessing certain primary care services, particularly in situations where they did not qualify for personal budgets and discussions on the appropriate navigating were taking place on ensuring residents had access to services and were aware of the existence of facilities such as 'safe spaces' in community centres.

4.10 In noting that the STP referred to commissioning on a larger scale, it was queried what steps would be taken to ensure that the co-designing potential of services with other partner organisations, such as voluntary organisations,

was not lost. It was suggested that lessons learnt from longer running programmes were used to ensure that the right questions were asked during the development of new programmes. Members expressed that they had been impressed by the way health services had responded to the Grenfell Tower fire. It was also requested that the Board be provided with information on how the STP's investment in Westminster would change things from the residents' perspective.

4.11 In reply to issues raised by Members, Jane Wheeler advised that a paper was being produced that provided cross comparisons between STPs and that North West London STP colleagues did regularly meet with their counterparts of other STPs. She emphasised that arrangements in the community were critical in helping the STP deliver outcomes and additional resources were also being put into Urgent Care. Primary mental health care services would also be supporting GPs to address capacity issues. Consideration was being given in ensuring that mental health services were pitched at the right level and many things could be improved by being done in a more joined-up manner.

4.12 Robert Holman (Head of Commissioning for Mental Health, NHS Central London Clinical Commissioning Group) advised that most people now had access to a 24 hour response in respect of mental health, however the number of people still visiting Accident and Emergency was not reducing and work was taking place with partner organisations to address this. In respect of closure of day services, he advised that NHS Central London CCG had worked with the Abbey Community Centre and the Beethoven Centre to create 'safe spaces' in their centres.

4.13 Chris Neill advised that the London Wide London Healthy Partnerships would also be taking a focus on comparing STPs. He acknowledged that more action needed to be taken on identifying appropriate pathways for homeless people and residents who needed primary care, but did not have access to personal budgets, including those with mental health issues and discussions with Adult Social Care were taking place on this. The STP's Governing Body was having discussions in respect of level of scale in delivering services and there would be a local focus in terms of the primary care homes.

4.14 Dr Naomi Katz stated that NHS West London CCG was learning from its experiences across a number of work areas and it was acknowledged that one size does not fit all in respect of mental health. Activities had also taken place in mental health in the aftermath of the Grenfell Tower fire.

4.15 Chris Neill suggested that the Board could link its work on mental health with the Community Safety Partnership which also focused on this area. The Chairman agreed that this would be desirable and that the presentation should be made available to the Community Safety Partnership. She also informed the Board that councillors were attending training on suicide prevention on 14 September that had been organised by Councillor Paul Church, Deputy Cabinet Member for Adult Social Services and Public Health.

5 BETTER CARE FUND PLAN FOR 2017/19

5.1 Dylan Champion (Head of Health Partnerships, Adult Social Care and Health) presented the report which set out how the Better Care Fund (BCF) Plan would be achieved through collaboration with partner organisations. The BCF Plan complemented the Health and Wellbeing Strategy and funding would be allocated to the CCGs and the Council. A two year financial agreement had been made with the CCGs and also funding from the Government to Adult Social Care. The Improved BCF had also secured an additional £8.7m for social care.

5.2 Members welcomed the BCF Plan and commented that such a plan could also be drawn up in respect of Children Services, and furthermore it was suggested that ways of integrating BCF commissioning with Children's Services commissioning could be looked at. The Chairman concurred that this suggestion could be considered further. A Member advised that the Adults, Health and Public Protection Overview and Scrutiny Committee had raised the issue of patients' rights with Imperial College Healthcare NHS Trust and he suggested that something similar to the rights set out for those with Special Educational Needs could be undertaken. It was commented that Healthwatch could assist in respect of drawing up patients' rights.

5.3 In reply to issues raised by the Board, Chris Neill also welcomed the possibility of undertaking joint commissioning with Children's Services. In respect of the BCF financial agreement, he advised that there needed to be a review of what could be jointly procured.

5.4 Dylan Champion advised that the high impact discharge model involved addressing patients' rights and there were also discussions taking place concerning the creation of a patients' charter.

5.5 **RESOLVED:**

1. That the Integration and Better Care Fund Plan for 2017-19 be endorsed.

2. That the ongoing development and delivery of the Better Care Fund Plan continue to be overseen.

6 DRAFT ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH 2016-17

6.1 Mike Robinson (Director of Public Health) presented this item and advised that the draft report was near completion. The theme of the report was mental wellbeing and consideration was being given as to whether there were any gaps in services and also to the future direction of accountable partnerships in the longer term. Mike Robinson advised that the title of the report was to be "The Roads to Wellbeing." He informed Members that the report would have links to a website of the same title which provided a directory of services available geographically that he hoped would benefit the community as a

whole. Mike Robinson then referred to the recommendations in the draft annual report and welcomed Members' comments and suggestions.

6.2 During Members' discussions, Members welcomed the draft annual report and its focus on mental health and wellbeing and it was acknowledged that this was a very important issue to address. However, it was suggested that the people most likely to benefit from the initiatives were least likely to be involved and so the role of professionals in using resources was vital. Members also indicated their support for the 5 Ways to Wellbeing framework. In respect of the Roads to Wellbeing website, Members also welcomed this, however it was acknowledged that the challenge was to incorporate additional resources to ensure its effectiveness. It was commented that it was important to ensure that the website was up to date and this would require dedicated support. Patients also needed to be encouraged more to use online resources as often they were reluctant to do so. It was suggested that friends and family of patients could also use the website if the patients themselves did not. The importance of changing people's behaviour was emphasised, and an example of reluctance to use online services included Westminster Community Network receiving over 200 referrals asking for help to use the Disclosure and Barring Service, even though this was a straightforward service to use. Members suggested that ways of ensuring the website was effective also included ensuring that all the information was in one place and a targeted approach should be taken.

6.3 Members felt that the draft annual report highlighted the main challenges and it was acknowledged that the website was not the sole solution to everything. Consideration also needed to be given on the challenges to parents posed by the focus on young people and children, as well as the role that schools can play in improving resilience and the importance of early intervention was acknowledged. Members commented that the annual report had a role in provoking debate and it was important that it was placed in the public domain.

6.4 The Chairman advised that the next Stakeholders' Group Meeting to consider the Mental Wellbeing Campaign was taking place on 21 September and Members were welcome to attend. Louise Proctor (Managing Director, NHS West London Clinical Commissioning Group) stated that there was an opportunity to connect the draft annual report and the Mental Health Strategy and the Like Minded Strategy and she suggested that Jane Wheeler could attend the Stakeholders Group meeting on 21 September. Members also suggested that links could be made to the Council's objectives concerning community resilience and the importance of having engagement at neighbourhood level to build on this resilience was highlighted. It was also suggested that there could be a half day session with colleagues from partner organisations from health and the community and community sectors and the Council to consider how mental wellbeing could be enhanced. The Board agreed that a recommendation on this be added to the draft annual report. Michael Robinson added that Members could make any further suggestions concerning the annual report, including its recommendations, prior to the next Board meeting.

7 HEALTH AND WELLBEING STRATEGY - A) ENGAGEMENT PLAN; B) WHOLE SYSTEMS DASHBOARD

7.1 Harley Collins (Health and Wellbeing Manager) presented the Engagement Plan and began by advising that it was a joint paper devised by the Council and the Central and West London CCGs. Under the Social Care Act 2012, CCGs and local authorities had a duty, and it was considered best practice to, involve local people in the area for the preparation of both Health and Wellbeing Strategies and Joint Strategic Needs Assessments. This included engaging people in respect of commissioning, including any changes to commissioning that are likely to have a significant impact on health or the services available. In addition, the Best Value Duty requires local authorities a 'Duty to Consult' representatives of a wide range of people. Healthwatch also had particular duties in relation to public and patient engagement and advocacy.

7.2 Harley Collins then drew Members' attention to the benefits of good public engagement as set out in the report, including:

- Improved understanding of community expectations, needs, concerns and aspirations
- Improved understanding of the role and contribution of the community
- Ability to build community support and trust and improve stakeholder relationships
- Improved community understanding of the Board's responsibilities and plans
- Improved credibility of the Board within the community
- Improved quality of decision-making by the Board
- An enhanced and informed political process
- Greater prospects for compliance through increased ownership of a solution and greater community advocacy for a course of action
- Greater access to community skills and knowledge
- Improved community understanding of health and wellbeing issues and responsibility for health and wellbeing outcomes.

7.3 Harley Collins stated that public and patient engagement had been a key feature in developing the Health and Wellbeing Strategy, which had included over a hundred responses to the online and postal consultation survey and 12 community events and public meetings. Overall he felt that the level of engagement had been good and it had been undertaken in a fairly informal manner. The report outlined the framework and principles for all engagement and set out how the performance in delivering the strategy was measured. This includes an 'Engagement Protocol' that would enable the Board to be held to account. Harley Collins informed Members that there were 7 engagement principles, these being:

- Timely
- Inclusive
- Transparent
- Adaptive

- Co-operative
- Accountable
- Continuously improving

7.4 Harely Collins advised that the approach to engagement had been informed by the International Association of Public Participation and wherever possible, those affected by a decision have a right to be involved in the decision-making process. This would include providing people with the information they require to participate in a meaningful way and to let participants know how their input has affected the decision. To oversee engagement, an Engagement Steering Group would be set up which would include leads from the organisations that were Board Members. Harley Collins then welcomed Members' comments.

7.5 During Members' discussions, it was noted that Healthwatch had contributed to the report and the approach to engagement was welcomed. Members commented that there should be further consideration in respect of qualitative issues when measuring performance. The public should be informed about what services are being invested in and given the opportunity to hold the Board to account with regard to the spending. It was suggested that the public should be given the opportunity to provide a response on an annual basis. Members commented that there should be more specific details about engagement activities with younger people. Members welcomed proposals to create an Engagement Steering Group and the Chairman suggested that membership should include a lead from NHS West London CCG. The importance of engaging with those with disabilities was emphasised. Members remarked that the practical experiences of the public should be captured when seeking their responses and a collaborative approach needed to be taken to ensure statutory requirements were met. In welcoming the engagement model, Members expressed support for the intention to maximise transparency, however it was also important to manage expectations. It was also commented that engagement prior to the strategy being produced had been sound, however the challenge was to maintain good engagement in delivering the strategy and measuring its performance.

7.6 In reply to some of the issues raised by Members, Harley Collins concurred that the public should be given the opportunity to review progress in delivering the strategy on an annual basis. Louise Proctor welcome the Chairman's suggestion that a lead from NHS West London CCG be on the Engagement Steering Group and she stressed the importance of continuous conversation with the public.

7.7 Chris Neill (Interim Deputy Director, NHS Central London Clinical Commissioning Group) advised that the Whole Systems Dashboard had been deferred to the next meeting as an improved version was being developed. It was also noted that Whole Systems Commissioning Intentions was to be considered at the next meeting.

7.8 **RESOLVED:**

1. That it be agreed to commit to the principles and approach to all Board engagement activity moving forward.

2. That list of engagement networks and groups operating in Westminster be noted.

8 ANY OTHER BUSINESS

8.1 The Chairman advised that it was likely that the Board meeting scheduled for 22 March 2018 would be brought forward and an alternative date would be confirmed in due course.

The Meeting ended at 6.02 pm.

CHAIRMAN: _____ **DATE** _____

WESTMINSTER HEALTH & WELLBEING BOARD
Actions Arising

Meeting on Thursday 14th September 2017

Action	Lead Member(s) And Officer(s)	Comments
Sustainability and Transformation Plan		
Presentation on Sustainability and Transformation Plan to be circulated to the Community Safety Partnership.	Jane Wheeler / Chris Neill	
Draft Annual Report of the Director of Public Health 2016-17		
Members to make any further comments and suggestions about the draft annual report to Mike Robinson prior to the next Board meeting.	All Board Members / Mike Robinson	Any comments and suggestions to be provided before 16 November. .

Meeting on Thursday 13th July 2017

Action	Lead Member(s) And Officer(s)	Comments
Update on Development of Better Care Fund Plan 2017-19		
Better Care Fund Plan for 2017-19 to be circulated to Members for further comments and final approval to be delegated to Councillor Heather Acton and Dr Neville Purssell before the 11 September deadline.	Councillor Heather Acton / Dr Neville Purssell / Dylan Champion	Completed.
Work Programme		
Clarification to be provided on whether the meeting scheduled for 22 March 2018 needs to be moved forward.	Councillor Heather Acton / Dylan Champion	To be clarified.

Meeting on Thursday 25th May 2017

Action	Lead Member(s) And Officer(s)	Comments
Delivering the Health and Wellbeing Strategy for Westminster		
Information dashboard being developed by North West London Clinical Commissioning Groups'	Harley Collins (Health and Wellbeing Manager)	To be provided at a future meeting.

Strategy Transformation Team to be circulated at next meeting.		
Healthwatch to circulate research undertaken on behalf of the North West London Sustainability Transformation Plan that identified gaps in the Community Independence Service to Members.	Healthwatch	Completed.
Specific priorities and projects within the Strategy to be updated to incorporate suggestions made by Members.	Dylan Champion	To be provided at a future meeting.
Work Programme		
Updated work programme to be circulated to Members.	Dylan Champion	To be provided at a future meeting.
Primary Care Strategy to be circulated to Members.	Chris Neill (NHS Central London Clinical Commissioning Group)	

Meeting on Thursday 2nd February 2017

Action	Lead Member(s) And Officer(s)	Comments
Health and Wellbeing Strategy for Westminster 2017 – 2022 Implementation		
A joint implementation paper setting out a clear governance structure and providing details of actions being taken by NHS Central London and NHS West London Clinical Commissioning Groups to help deliver the implementation plan to be provided at next meeting.	Ezra Wallace, Chris Neill (NHS Central London Clinical Commissioning Group) and Louise Proctor (NHS West London Clinical Commissioning Group)	Completed.
Pharmaceutical Needs Assessment – Introduction		
Report on implications for funding for community pharmacies being reduced for 2016/17 and 2017/18 to be provided at a future meeting.	Colin Brodie	To be provided at a future meeting.

Extraordinary Meeting on Tuesday 13th December 2016

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

NHS Central London and NHS West London Clinical Commissioning Groups' Commissioning Plans		
Members to provide any further comments on the Commissioning Plans by 20 December.	All Board Members	Completed.

Meeting on Thursday 17th November 2016

Action	Lead Member(s) And Officer(s)	Comments
Update on the North West London Sustainability Transformation Plan and Westminster's Joint Health and Wellbeing Strategy		
Board's comments in respect of the North West London Sustainability Transformation Plan to be fed back to the NHS Central and NHS North West London Clinical Commissioning Groups.	Chris Neill (NHS Central London Clinical Commissioning Group)	Completed.
Work Programme		
Board to receive first report on the next Pharmaceutical Needs Assessment at next meeting.	Mike Robinson / Colin Brodie	Completed.

Meeting on Thursday 15th September 2016

Action	Lead Member(s) And Officer(s)	Comments
Draft Westminster Health and Wellbeing Strategy Refresh		
Final strategy to be put to the Board at the next meeting.	Meenara Islam	Completed.
Housing Support and Care Joint Strategic Needs Assessment		
Board to look at the Housing Support and Care Joint Strategic Needs Assessment in more detail and to support the recommendations, subject to any concerns raised by Members in the next two weeks.	All Board Members / Anna Waterman	Completed.

Meeting on Thursday 14th July 2016

Action	Lead Member(s) And Officer(s)	Comments
Draft Westminster Health and Wellbeing Strategy Refresh		
Meenara Islam to circulate the dates that the consultation events and meetings are taking place to Members.	Meenara Islam	Completed.

Tackling Childhood Obesity Together		
Progress on the programme to be reported back to the Board in a year's time.	Eva Hrobonova	
Health and Wellbeing Hubs		
Details of the children's workstream to be reported to the Board at the next meeting.	Melissa Caslake	Completed.

Meeting on Thursday 26th May 2016

Action	Lead Member(s) And Officer(s)	Comments
Draft Westminster Health and Wellbeing Strategy Refresh		
Members to provide any further input on the strategy before it goes to consultation at the beginning of July.	All Board Members	Completed

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	Completed.
Meenara Islam to circulate details of proposals discussed at an engagement plan meeting between Council and Clinical Commissioning Group colleagues.	Meenara Islam	Completed.
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	Completed.

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	Completed.

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	Completed.
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	Completed.
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	Completed.

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	Completed.
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	Completed.
Update on the Programme to be reported at the next Board meeting.	Adult Social Care	Completed.
Dementia Joint Strategic Needs Assessment – Commissioning Intentions and Sign Off		

Board to receive and update at the first Board meeting in 2016.	Public Health	Completed.

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	Completed.
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	Completed.
Update on Preparations for the Transfer of Public Health Responsibilities for 0-5 Years		
Board to receive an update in 2016.	Public Health	Completed.

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	Completed.
Adult Social Care representative to be appointed onto the Transformation Board.	NHS North West London Adult Social Care	Completed.
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	Completed.

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	Completed.
Joint Strategic Needs Assessment		
Consideration be given to ensure JSNAs are more line with the Board's priorities.	Public Health	Completed.
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.		Completed.
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	Completed.
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	Completed.

Meeting on Thursday 19th March 2015

Action	Lead Member(s) And Officer(s)	Comments
Pharmaceutical Needs Assessment		
Terms of reference for a separate wider review of the role of pharmacies in health provision, and within integrated whole systems working and the wider health	Adult Social Care	Completed

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 Health & Wellbeing Board.	Clinical Commissioning Groups NHS England	Completed

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

Meeting on Thursday 18th September 2014

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

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.	Completed.
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.	Completed.
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	Completed.
Child Poverty Joint Strategic Needs Assessment Deep Dive		
A revised and expanded draft recommendation report to be brought back to the Health & Wellbeing Board in September.	Strategic Director of Housing Director of Public Health.	Completed.
Tri-borough Joint Health and Social Care Dementia Strategy		
Comments made by Board Members on the review and initial proposals to be taken into account when drawing up the new Dementia Strategy.	Matthew Bazeley Janice Horsman Paula Arnell	Completed.
Whole Systems		
A further update on progress to be brought to the Health & Wellbeing Board in June.	Clinical Commissioning Groups	Completed.

City of Westminster

Westminster Health & Wellbeing Board

Date:	16 November 2017
Classification:	General Release
Title:	Pharmaceutical Needs Assessment
Report of:	Director of Public Health
Wards Involved:	All
Policy Context:	Health and Wellbeing Boards are required to publish and maintain a Pharmaceutical Needs Assessment by virtue of Section 128a of the National Health Service Act 2006 (Pharmaceutical Needs Assessments) and the Health and Social Care Act 2012
Financial Summary:	Not applicable
Report Author and Contact Details:	Colin Brodie E: cbrodie@westminster.gov.uk T: 02076414632

1. Executive Summary

1.1 This report sets out the progress being made to develop the Health and Wellbeing Board's Pharmaceutical Needs Assessment (PNA) for Westminster and requests agreement to undertake the required statutory consultation.

2. Key Matters for the Board

2.1 The Health and Wellbeing Board is invited to:

- Note the progress in preparing the draft PNA for publication (as outlined in Appendix A); and
- Agree that the PNA Task and Finish Group should commence with the 60 day statutory consultation from 1 December 2017.

3. Background

3.1 Health and Wellbeing Boards are required to publish and maintain a PNA by virtue of section 128A of the National Health Service Act 2006 (Pharmaceutical Needs Assessments) and the Health and Social Care Act 2012.

3.2 PNAs are a statement of the need for pharmaceutical services of the population in a defined geographical area.

3.3 PNAs are used by commissioners to make decisions on which funded services need to be provided by local community pharmacies. They are also an important tool in market entry decisions, in response to applications from businesses, including independent owners and large pharmacy companies.

3.4 The responsibility for producing and managing the content and update of PNAs transferred from Primary Care Trusts to Health and Wellbeing Boards on 1st April 2013.

3.5 All Health and Wellbeing Boards were required to publish a fully revised PNA by 1st April 2015. Westminster Health and Wellbeing Board published their first PNA on 31st March 2015 to meet this requirement

3.6 The NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 require that the PNA is updated every 3 years, and so a new PNA is due to be published by the end of March 2018

4. Progress to date

4.1 A provider, Healthy Dialogues, has been commissioned to undertake the revised PNA for Westminster. Healthy Dialogues have produced a draft PNA for the Health and Wellbeing Board. The PNA Task and Finish Group has provided a steer for this work, and includes representation from Public Health, the CCGs, Healthwatch, and the Local Pharmaceutical Committees

4.2 Health Dialogues has undertaken an analysis of the needs of the local population; have mapped current pharmacy service provision; and engaged with pharmacies as well as residents and local communities in order to provide a picture of pharmacy provision in the borough.

4.3 A survey of all community pharmacies in the borough was undertaken which generated a 86% response rate. This provides a picture of access to, and services provided by, pharmacies in the Borough.

4.4 A community pharmacy questionnaire was used to engage with 180 people to understand their use and experience of local pharmacies from September to October 2017. Information obtained from these surveys informed the analysis of the use and views of pharmacies by people from the protected characteristics and vulnerable groups.

- Community survey respondents stated that they are happy with the pharmacy services they receive in the borough.
- Respondents to a community mostly use the pharmacies obtaining prescription medication, repeat prescriptions and obtaining over the counter medication
- The top three services respondents would use if provided were health checks, home delivery and prescription collection services.
- Suggestions for improvement included providing longer opening hours, more Sunday opening hours and option of basic blood tests and scans/x-rays at their local pharmacies.

4.5 The draft PNA report is included as background paper to this report

5. Consultation

5.1 Health and Wellbeing Boards are required by law to consult a specified list of bodies at least once during the process of developing the PNA. These bodies are:

- The Local Pharmaceutical Committee;
- The Local Medical Committee;
- Any persons on pharmaceutical lists and any dispensing doctors;
- Any Local Pharmaceutical Services chemist in the area with whom the NHS Commissioning Boards has made arrangements form the provision of any local pharmaceutical services;
- Any local Healthwatch or any other patient, consumer and community group which (in the opinion of the Health and Wellbeing Board) has an interest;
- Any NHS Trust of Foundation Trust
- The NHS Commissioning Board (NHS England); and
- Any neighbouring Health and Wellbeing Boards

5.2 There is a minimum period of 60 days for consultation.

5.3 Appendix B provides an overview of the consultation plan for the PNA for the Westminster HWB to review.

5.4 The PNA is a technical and factual document, which provides a statement of pharmaceutical need in the area (following strict regulatory guidelines) for use by NHS England. It is not a description of policy or intent, or a document which sets out any changes to pharmaceutical services in the area. However, consultation will be undertaken with resident, patient and consumer groups to ensure that the user's perspective is referenced where appropriate within the PNA. The draft PNA will also be available on-line (with a hard copy on request) for members of the public who may have a particular interest. This approach is in-line with the regulations and guidance.

5.5 The PNA Task and Finish Group will be ready to begin the consultation on the draft PNA by the beginning of December. This will allow for the consultation to be completed early Feb 2018, with a final PNA to be completed and endorsed by the Westminster HWB for publication by 1st April 2018 in-line with legislation

6. Legal Implications

6.1 Health and Wellbeing Boards are legally required to publish and maintain a PNA for their local area by virtue of Section 128a of the National Health Service Act 2006 (Pharmaceutical Needs Assessments) and the Health and Social Care Act 2012.

6.2 All Health and Wellbeing Boards were required to publish a PNA by 1 April 2015. After it has published its first PNA, each HWB must publish a statement of its revised assessment within 3 years of its previous publication of a PNA.

6.3 PNAs must be developed in line with the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013

6.4 Verified by Kevin Beale, Senior Corporate Lawyer, Shared Legal Services

7. Financial Implications

7.1 Funds required to produce the Westminster PNA were identified from the 2017/18 Public Health budget and have been costed at £23,600.

7.2 Verified by Richard Simpson, Public Health Finance Manager

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

Colin Brodie

cbrodie@westminster.gov.uk

Telephone: 02076414632

APPENDICES:
Appendix A: Westminster PNA outline and progress update
Appendix B: Pharmaceutical Need Assessment Statutory Consultation Plan

BACKGROUND PAPERS:
Draft PNA Westminster

Appendix A

Westminster PNA outline and progress update

Chapter	Description	Current state
1 - Introduction	Role of Pharmacies Purpose of the Pharmaceutical Needs Assessment Policy Background Relating to the PNA	Draft Complete
2 – Local Health and Wellbeing Priorities	Includes local drivers	Draft Complete
3 – Pharmacy Needs Assessment Process	Includes: • Methodological considerations • Governance and steering group • Regulatory consultation process and outcomes	Draft Complete
4 – Demographics and Health Needs	Includes: • Population Characteristics and Projections • Wider Determinants of Health and Inequalities • Risk Factors for Mortality and Morbidity	Draft Complete
5 - Patient and Public Engagement and the Protected Characteristics	Includes: • Results of the Community Pharmacy Questionnaire • Protected Characteristics	Draft Complete
6 - Access to Pharmaceutical Essential Services	Features such as private consultation rooms, handwashing, wheelchair access etc	Draft Complete
7 - Advanced, Locally Enhanced and Locally Commissioned Services Provided by Pharmacies	Includes: Categorisation of pharmaceutical services Advanced Services Locally Enhanced Commissioned Services Public Health Commissioned Services Improvements and gaps in access to Public Health Services Other skills and services identified in the Pharmacy Contractor Survey	Draft Complete
Appendices	Appendix A – Terms of Reference Appendix B – Community Questionnaire Appendix C – Community Engagement Plan Appendix D - Pharmacy listings	

Appendix B

Westminster Health and Wellbeing Board
PNA Statutory Consultation Plan

Revision History

Date of this revision: 01 November 2017
Date of next revision: 17 November 2017

Revision Date	Previous revision date	Summary of Changes	Changes marked
1 November 2017	First version	First versions	First Version

1. Objectives of the consultation

The high-level objective of the Westminster Pharmaceutical Needs Assessment (PNA) statutory consultation is to ensure that statutory consultees are provided with a 60 day period between December 2017 and January 2018 in which to consider the draft PNA for Westminster and provide their views to the PNA Task and Finish Group. The list of statutory consultees are:

- The Local Pharmaceutical Committee;
- The Local Medical Committee;
- Any persons on pharmaceutical lists and any dispensing doctors;
- Any Local Pharmaceutical Services chemist in the area with whom the NHSE has made arrangements for the provision of any local pharmaceutical services;
- Any local Healthwatch or any other patient, consumer and community group which (in the opinion of the Health and Wellbeing Board) has an interest;
- Any NHS Trust of Foundation Trust
- The NHS Commissioning Board (NHS England); and
- Any neighbouring Health and Wellbeing Boards

2. Key Audiences

Audience	Approach	Responsibility
Local Pharmaceutical Committee	▪ Letter and Email (on behalf of the Health and Wellbeing Board) ▪ LPC are represented on the PNA Task and Finish Group	PNA Task and Finish Group
Local Medical Committee	▪ Letter and Email (on behalf of the Health and Wellbeing Board) ▪ Offer of a meeting if required	PNA Task and Finish Group
Individual Pharmacies (93 in Westminster)	▪ Email and link to the online PNA ▪ Support from the Local Pharmaceutical Committee if required (through their membership on the PNA Task and Finish Group)	PNA Task and Finish Group
Dispensing GPs (0 in Westminster)	▪ Email and link to the online PNA ▪ Work with CCGs to put out information through their channels of communication with GPs	PNA Task and Finish Group WLCCG
Healthwatch	▪ Letter and Email sent to the Chair and support team ▪ Offer to attend meetings or public events if required	PNA Task and Finish Group

CCG user panels	▪ Information provided to any user panel through CCG channels ▪ Offer to attend meetings if required	PNA Task and Finish Group
Other patient or consumer group	▪ Healthwatch to support the provision of information to their organisation or institutional members	Healthwatch
One Westminster	▪ Letter and Email sent to the Chair ▪ Offer to attend meetings or public events if required	PNA Task and Finish Group
Chelsea and Westminster NHS Trust	▪ Letter and Email sent to the Chief Executive and Chair, and communications team ▪ Offer to attend meetings if required ▪ Request that the information is shared with the trusts patient user groups	PNA Task and Finish Group
Imperial NHS Trust	▪ Letter and Email sent to the Chief Executive and Chair, and communications team ▪ Offer to attend meetings if required ▪ Request that the information is shared with the trusts patient user groups	PNA Task and Finish Group
University College London Hospitals	• Letter and Email sent to the Chief Executive and Chair, and communications team ▪ Offer to attend meetings if required ▪ Request that the information is shared with the trusts patient user groups	PNA Task and Finish Group
Guy's and St Thomas' NHS Foundation Trust	• Letter and Email sent to the Chief Executive and Chair, and communications team ▪ Offer to attend meetings if required ▪ Request that the information is shared with the trusts patient user groups	PNA Task and Finish Group
Royal Free Hospital NHS Foundation Trust	▪ Letter and Email sent to the Chief Executive and Chair, and communications team ▪ Offer to attend meetings if required ▪ Request that the information is shared with the trusts patient user groups	PNA Task and Finish Group
Central London Community Healthcare	▪ Letter and Email sent to the Chief Executive and Chair, and communications team ▪ Offer to attend meetings if required	PNA Task and Finish Group

	▪ Request that the information is shared with the trusts patient user groups	
Central North West London NHS Trust	▪ Letter and Email sent to the Chief Executive and Chair, and communications team ▪ Offer to attend meetings if required ▪ Request that the information is shared with the trusts patient user groups	PNA Task and Finish Group
City of London Health and Wellbeing Board	▪ Letter and Email sent to the Chair and support team	PNA Task and Finish Group
Southwark Health and Wellbeing Board	▪ Email sent to the Chair and Board Members	PNA Task and Finish Group
Lambeth Health and Wellbeing Board	▪ Email sent to the Chair and support team	PNA Task and Finish Group
Wandsworth Health and Wellbeing Board	▪ Email sent to the Chair and support team	PNA Task and Finish Group
Camden Health and Wellbeing Board	▪ Email sent to the Chair and support team	PNA Task and Finish Group
Brent Health and Wellbeing Board	▪ Email sent to the Chair and support team	PNA Task and Finish Group
RBKC Health and Wellbeing Board	▪ Email sent to the Chair and support team	PNA Task and Finish Group
NHS England	▪ Letter and Email sent to NHS England London Region	PNA Task and Finish Group

4. Communicators

Communicator	Responsibilities
Westminster Health and Wellbeing Board	All communications to statutory consultees will be delivered in the name of the Westminster Health and Wellbeing Board
Public Health	Communications to residents will be delivered in the name of the Public Health Department via the RBKC Communications Team
Healthwatch	Support communication with wider patient and consumer groups
NHS Trusts	Support communication with their patient and consumer groups
CCGs	Support communication with individual dispensing GPs Support communication with their patient and consumer groups
Local Pharmaceutical Committee	Support communications with individual pharmacies

4. Communicators	
Communicator	**Responsibilities**
One Westminster	Support communications with relevant community groups

6. Methods of Communication	
Email	Emails will be the primary form of communication to statutory consultees, alongside a letter.
Presentation	May be used occasionally to support communications with patient and consumer groups (if required)
Website	The draft PNA, details on the scope of the consultation and how to provide feedback will be place on the Westminster council website, and the www.jsna.info website
Social media	Social media will be the primary form of communication to residents, alongside any resident e-newsletters or Westminster newspaper which coincide with the consultation period
E-newsletters	Potential to be used alongside the Westminster newspaper if these forms of communication coincide with the consultation period
Reports	Available on request (for example by NHS Trusts, Healthwatch and CCG governing body) A report will be presented to neighbouring Health and Wellbeing Boards for information
Stakeholder Group Meetings	Available on request.
Other meetings	Available on request
One-to-One meetings	Available if required due to concerns

This page is intentionally left blank

Pharmaceutical Needs Assessment for Westminster

2018-2021

City of Westminster

Compiled by Healthy Dialogues Ltd

Healthy Dialogues LTD

Behaviour Change Solutions For Health

Table of Contents

Executive Summary

Community pharmacies provide a range of services including dispensing medicines, promoting health and wellbeing and early detection of diseases. They can offer long opening hours and are situated in local communities, which means they can be more easily accessible than most other community health services. They are key to connecting local people and communities to healthcare and public health services that they need.

There is a strong network of community pharmacies located throughout Westminster. This Pharmaceutical Needs Assessment (PNA) reviews the need for Pharmacy Services and assesses the current service provision to identify gaps. The PNA is a statutory responsibility of the Health and Wellbeing Board. It is used for informing decisions on applications for new pharmacies, changes in premises and services of existing pharmacies.

This PNA assesses the health and wellbeing needs of the population Westminster with respect to pharmacy services. The current pharmacy provision and their services have been examined in detail, including users' views. Key findings are outlined below.

Key demographics and health needs

- Westminster is a vibrant and densely populated borough with a daytime population nearly four times that the size of the resident population. The population is expected to rise substantially in the coming years.
- Nearly half of the population were born abroad and nearly one-third identify as from BME groups. The highest proportion of whom live in Church Street.
- Circularity diseases, cancers and respiratory diseases are the biggest causes in the differences in life expectancy between the least and most deprived.
- Recorded mental illness, sexually transmitted infections and smoking are high in the borough.
- Excess weight in children and dental decay are high and childhood vaccination coverage is low.

Key findings from user views

- Community survey respondents stated that they are happy with the pharmacy services they receive in the borough.
- Respondents mostly use the pharmacies to obtain prescription medications, repeat prescriptions and over the counter medications.
- The top three services respondents would use if provided were health checks, home delivery and prescription collection services.
- Suggestions for improvement included providing longer opening hours, more Sunday opening hours and option of basic blood tests and scans/x-rays at their local pharmacies.

Health and Wellbeing Board Statements on Service Provision

The categorisation of these services into those stipulated by the PNA regulations are summarised in the table that follows.

Necessary services: current provision (Schedule 1, paragraph 1)	Necessary services: gaps in provision (Schedule 1, paragraph 2)
Essential Services (see Chapter 6)	No gaps in provision of necessary services (see Chapter 6)
Other relevant services: current provision (Schedule 1, paragraph 3)	
• Medicine Use Review service • New Medicine Service • Appliance Use Reviews • Stoma Appliance Customisation Service	
Other services (Schedule 1, paragraph 5)	
• Flu Vaccination -NHS • Minor Ailment Schemes • End of Life Care service • Care Home Advice service • Medicines Assessment and Compliance Support Service • NHS Health Checks • Supervised Administration • Needle Exchange Services • Stop Smoking Services • Emergency Hormonal Contraception • Alcohol Misuse Services • Weight Management Services • Other Sexual Health Screening and Treatment Services	
Improvements and better access: gaps in provision (Schedule 1, paragraph 4)	
There are no gaps in provision of services.	

Necessary Services

These services are fundamental for patients to obtain prescribed medicines in a safe and reliable manner. All pharmacies are required to deliver and comply with the specifications for all essential services.

The range of options for dispensing NHS prescriptions, facilities within pharmacies, the range of opening hours and the close proximity of pharmacies to local residents are sufficient for supplying a necessary pharmaceutical service with no gaps in the Westminster.

Other Relevant Services

These are services provided which are not necessary to meet the need for pharmaceutical services in the area, but which nonetheless have secured improvements or better access to pharmaceutical services. They include Medicine Use Reviews, New Medicines Service, Appliance Use Reviews and Stoma Appliance Customisation service:

- Most Westminster residents live close to a pharmacy that provides Medicine Use Review services and New Medicine Services. Therefore, they are found to be sufficient for supplying a relevant service with no gaps.
- Stoma Customisation Services and Appliance Use Reviews are supplied by four pharmacies in the borough, which is sufficient for supplying a relevant service with no gaps.

Other Services

Other services are services that are provided or arranged by a local authority, NHS England, the CCG, an NHS trust or an NHS foundation trust which affects the need for pharmaceutical

services in its area or where future provision would secure improvement, or better access to pharmaceutical services specified type, in its area. In Westminster these include:

- Flu Vaccination
- Minor Ailment Schemes
- End of Life Care service
- Care Home Advice service
- Medicines Assessment and Compliance Support Service
- NHS Health Checks
- Supervised Administration
- Needle Exchange Services
- Stop Smoking Services
- Emergency Hormonal Contraception
- Alcohol Misuse Services
- Weight Management Services
- Other Sexual Health Screening and Treatment services

Improvements and better access

There are no services or gaps in services which the Health and Wellbeing Board is satisfied would, if they were provided, may secure improvements, or better access to pharmaceutical services of a specific type.

In summary, Westminster Health and Wellbeing are satisfied that the **current pharmacy provision is sufficient for supplying a necessary and relevant pharmaceutical service with no gaps in the in the borough.**

Chapter 1 - Introduction

Role of Pharmacies

1.1 Community pharmacists and their teams work at the heart of communities and are trusted professionals in supporting individual, family and community health. Community pharmacies are often patients' and the public's first point of contact and, for some, their only contact with a healthcare professional. Community pharmacies are not only a valuable health asset, but also an important social asset because often they are the only healthcare facility located in an area of deprivation.

1.2 Pharmacies provide a range of care responsibilities for patients and the public including dispensing mediations, providing basic health checks, healthcare and preventative care and educating patients on the use of prescriptions and over-the-counter medications.

Purpose of the Pharmaceutical Needs Assessment

1.3 The Pharmaceutical Needs Assessment (PNA) identifies the key health needs of the local population and how those needs are being fulfilled, or could be fulfilled, by pharmaceutical services in different parts of the borough. The role of the PNA is twofold:

- to inform local plans for the commissioning of pharmaceutical services and
- to support the 'market entry' decision making process (undertaken by NHS England) in relation to applications for new pharmacies or changes of pharmacy premises.

1.4 As outlined in the 2013 regulations, this PNA describes pharmaceutical services in terms of the following summary categories:

A. **Necessary Services – Current Provision:** services currently being provided which are regarded to be "necessary to meet the need for pharmaceutical services in the area". This includes services provided in the Borough as well as those in neighbouring Boroughs

B. **Necessary Services – Gaps in Provision:** services *not* currently being provided which are regarded by the HWB to be necessary "in order to meet a current need for pharmaceutical services".

C. **Other Relevant Services – Current Provision:** services provided which are not necessary to meet the need for pharmaceutical services in the area, but which nonetheless have "secured improvements or better access to pharmaceutical services". This includes services provided in the Borough as well as those in neighbouring Boroughs.

D. **Improvements and Better Access – Gaps in Provision:** services *not* currently provided, but which the HWB is satisfied would "secure improvements, or better access to pharmaceutical services" if provided.

E. **Other NHS Services**: any services provided or arranged by a local authority, NHS England, the CCG, an NHS trust or an NHS foundation trust which affects the need for pharmaceutical services in its area or where future provision would secure improvement, or better access to pharmaceutical services specified type, in its area.

Policy Background Relating to the PNA

1.5 From 2006, NHS Primary Care Trusts (PCT) had a statutory responsibility to assess the pharmaceutical needs for its area and to publish a statement of its assessment and of any revised assessment. This was generally undertaken by public health teams within the PCTs.

1.6 With the abolition of Primary Care Trusts and the creation of Clinical commissioning groups in 2013 Public Health functions were transferred local authorities. Health and Wellbeing boards were introduced and hosted by local authorities to bring together Public Health, Adult Social Care, Children's services and Healthwatch.

1.7 The Health and Social Care Act of 2012 put responsibility of the developing and updating the Pharmaceutical Needs Assessments and Joint Strategic Needs Assessments on the Health and Wellbeing boards.

1.8 The 2018-21 Pharmaceutical Needs Assessment must be produced and published by 1st April 2018. The Health and Wellbeing Board are also required to revise their latest PNA publication if they deem there to be significant changes in pharmaceutical services within the 2018-21 timeframe.

1.9 The PNA must be put out for consultation for a minimum of 60 days prior to its publication. The 2013 Regulations list those persons and organisations that the HWB must consult, which include:

- Any relevant local pharmaceutical committee (LPC) for the HWB area
- Any local medical committee (LMC) for the HWB area
- Any persons on the pharmaceutical lists and any dispensing GP practices in the HWB area
- Any local Healthwatch organisation for the HWB area, and any other patient, consumer and community group, which in the opinion of the HWB has an interest in the provision of pharmaceutical services in its area
- Any NHS Trust or NHS Foundation Trust in the HWB area
- NHS England
- Any neighbouring Health and Wellbeing board.

1.10 The NHS Pharmaceutical Services and Local Pharmaceutical Services Regulations of 2013 and the Department of Health Information Pack for Local Authorities and Heath and Wellbeing boards provide guidance as to the requirements that should be contained in the PNA publication and the process to be followed to develop the publication. The development and publication of this PNA has been carried out in accordance with these Regulations.

1.11 Joint Strategic Needs Assessments are a strategic valuation of the health and wellbeing needs of the local population, and this PNA builds on the findings of the JSNA by supporting the commissioning and the development of appropriate, sustainable and effective pharmacy services. For further information on the JSNA please refer to http://www.jsna.info.

CHAPTER 2 - LOCAL HEALTH AND WELLBEING PRIORITIES

2.1 All Health and Wellbeing boards are required to produce a Health and Wellbeing Strategy that sets out how partners will meet local health needs, improve outcomes and reduce health inequalities within the borough.

2.2 The **Joint Health and Wellbeing Strategy for Westminster 2017 – 2022** outlines the commitment of the Health and Wellbeing Board and partners including voluntary and community groups, businesses and people to ensure people are enabled to be well, stay well and live well, supported by a collaborative and cohesive health and care system. Its vision is that all people are able to enjoy a healthier city and healthier life and it addresses physical and mental ill health by making improvements to employment, housing, education, community resilience, safety and the environment within Westminster.

There are four priorities for the local area:

1. Improving outcomes for children and young people
2. Reducing the risk factors for, and improving the management of, long term conditions such as dementia
3. Improving mental health through prevention and self-management
4. Creating and leading a sustainable and effective local health and care system.

2.3 Alongside this, the Westminster Health and Wellbeing board are working with Kensington and Chelsea and Hammersmith and Fulham to pool together budgets to support health and social care services to work together more closely. This budget is called **Better Care Fund** which aims to support to residents in Westminster by providing people with the right care, in the right place, at the right time, including expansion of care in community setting. This includes:

- Helping people self-manage, providing care navigation, working in partnership with the local community and voluntary sector and local faith groups.
- Investing in locality-based social work, working alongside GPs and care navigators to prevent reliance on expensive health and social care packages.
- Reducing delayed discharges from hospital through strengthening 7-day social care provision.
- Integrating NHS and social care systems around the NHS number through a single point of access across health and social care, to ensure those frontline professionals, and ultimately all patients and service users, have access to all of the records and information they need.
- Improving outcomes through transforming the quality, consistency and coordination of care across nursing and care homes in Westminster and improving primary care support to our care homes.
- Coordinating dementia support across health and social care ensuring an effective pathway from early diagnosis to end of life care.

2.4 **Northwest London Sustainability and Transformation Plans (STP)** outline how the Local Authorities and NHS within the sub-region including Westminster, will work together to radically transform the way they provide health and social care for the population. Their aim is to provide excellent quality care in the right place and when needed, help people to look after themselves and maximise opportunities to keep the healthy majority healthy. There are five delivery areas the STP will focus:

1. Radically upgrading prevention and wellbeing
2. Eliminating unwarranted variation and improving long-term condition management
3. Achieving better outcomes and experiences for older people
4. Improving outcomes for children and adults with mental health needs
5. Ensuring we have safe, high quality sustainable acute services

2.5 In November 2017, it is anticipated that the Westminster Health and Wellbeing Board and the Central London CCG Governing Body will consider the Case for Change and an Outline Commissioning Strategy to establish in Westminster **an Accountable Care Partnership** from April 2019. It is envisaged that rather than a range of different providers delivering health and social care services in the community an integrated arrangement will be established where GPs, community nurses, social workers and other health and social care professionals will work together as a part of single multi-disciplinary teams, utilising a single contract framework to deliver better and more joined up health and social care services.

2.6 It is anticipated that this programme will play a key role in the work required to develop additional health and social care capacity within the community in order to reduce pressure on hospital services and to improve services for older people and people with multiple long term conditions.

2.7 This programme is at an early stage but it is currently envisaged that the scope of this new contractual arrangement will be agreed in January 2018 and a full Business Case considered in May 2018. A procurement process will then take place which should result in the identification of a preferred provider in November 2018 and the new arrangements beginning to be rolled out in April 2019.

CHAPTER 3 - THE PHARMACEUTICAL NEEDS ASSESSMENT PROCESS

3.1 This PNA has been developed using a range of information sources to describe and identify population needs and current service provision from the network of community pharmacies (see table 3.1). This includes:

- Nationally published data
- Joint Strategic Needs Assessment
- A survey to Westminster pharmacy providers
- A survey to the Patients and Public of Westminster
- Comments made during the consultation process

Table 3.1 PNA 2018-21 data sources

Health need and priorities	National benchmarking ward and borough-level data from Public Health England Westminster City Council Joint Strategic Needs Assessment (JSNA) Office of National Statistics 2014 mid-year estimates Synthesis from national datasets and statistics
Current Pharmaceutical Services	Commissioning data held by the NHS England Commissioning data held by Westminster City Council Questionnaire of community pharmacy providers
Patients and the Public	Community questionnaire

3.2 These data have been combined to describe the Westminster population, current and future health needs and how pharmaceutical services can be used to support the Health and Wellbeing Board (HWB) to improve the health and wellbeing of our population.

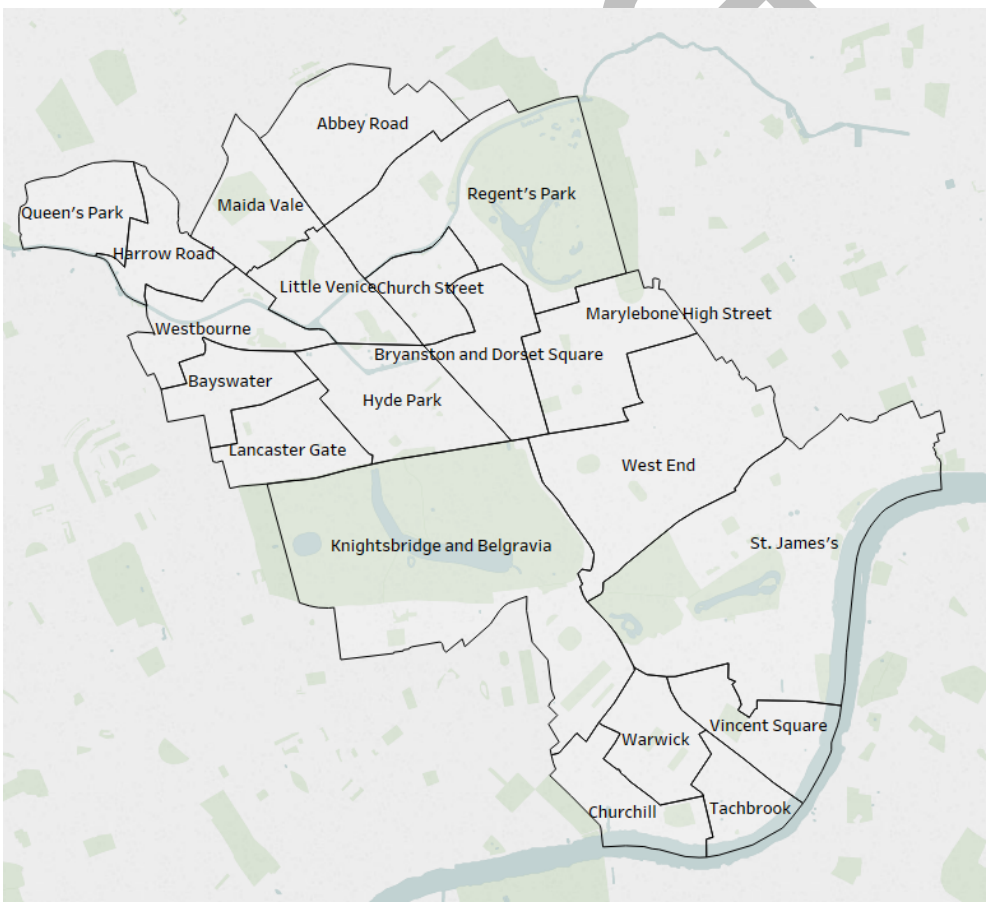
Methodological considerations

Geographical Coverage

3.3 For the purposes of the PNA the geographical area of Westminster City Council are presented using to approaches to define localities:

- **Electoral wards** are used to summarise demographic and health need. Westminster has 20 electoral wards in total (illustrated in figure 3.1).
- Provision and choice of pharmacies is determined by using a **500 meters radius** from the centre of the postcode of each pharmacy. This is considered to be approximately a 10-minute walk from the outer perimeter of the buffer zone created.

Figure 3.1 Westminster City Council Electoral Wards



3.4 The rationale for using the more detailed 500m-radius approach was to identify the range of access and service provision in a far more precise fashion than ward averages would allow. For example, where boundaries of wards are main roads, pharmacies on the opposite side of the road would not be counted towards the ward's provision, thereby giving an inaccurate picture of provision; use of the more detailed 500m-radius approach avoids this. It also allows the PNA to

assess the impact of pharmacies in surrounding boroughs that are within 500m of the borough border.

3.5 The 500m-radius approach illustrates where there is at least one pharmacy within 500m and where there is no pharmacy within 500m. The distance of 500m was chosen by the Steering Group as being a reasonable measure to identify variation and choice. However, whilst highlighting variation, it is not always used to determine gaps in services; in some instances, wider measures are more appropriate (e.g. where there is lower patient demand for services, such as needle exchange and dispensing outside normal working hours). These instances have all been stated in the relevant sections of the report.

Pharmacy Contractor Survey

3.6 The contractor survey was sent to the pharmacies within Westminster and the response rate was 86% (80/93) for Westminster. The results from this survey are referred to throughout this document.

Patient and Public Engagement

3.1 A community pharmacy questionnaire was used to engage with 180 people to understand their use and experience of local pharmacies from September to October 2017. Information obtained from these surveys informed the analysis of the use and views of pharmacies by people from the protected characteristics and vulnerable groups.

Governance and steering group

3.7 The development of the PNA was advised by a Task and Finish group whose membership included representation from the following organisations:

- Westminster City Council Public Health team
- Clinical Commissioning Group
- Westminster and Kensington Chelsea Local Pharmaceutical Committee (LPC)
- Healthwatch.

The membership and Terms of Reference of the steering group can be found in Appendix A.

Regulatory consultation process and outcomes

3.8 This PNA is published for public consultation in November 2017 for 60 days. All comments will be considered and incorporated into the final report to be published by 1st April 2018.

Chapter 4 - Health Needs and Population Changes

4.1 Much of the demographic and health information included here is covered in detail in this chapter as well as in the Joint Strategic Needs Assessment (JSNA) and the Annual Public Health Report for the City of Westminster. The JSNA identifies current and future health and social care needs of the borough's population and analyses whether these needs are being met locally. For the borough's highlights report please see https://www.jsna.info/online/highlightreports.

4.2 The analysis of health needs and population changes are outlined in three sub-sections of this chapter: Population Characteristics and Projections; Wider Determinants of Health and Inequalities and Risk Factors for Mortality and Morbidly.

4.3 The aim of this chapter is to present an overview of health and wellbeing in Westminster, particularly the areas likely to impact on needs for community pharmacy services. This includes an analysis of the latest Westminster population and inequalities projections.

4.4 All the maps that follow present the size of population in relation different factors such as population density, wellbeing and smoking prevalence. They are displayed in gradients, whereby the lowest figures have the lightest colour and the highest figures have the darkest colour. Each map is supplemented with a legend that outlines the distances between these gradients.

4.5 The City of Westminster is situated in the heart of London. The borough covers eight and a half square miles and extends to Regent's Park in the north, Hyde Park in the west and Covent Garden in the east. The southern boundary follows the north bank of the River Thames. The borough has main town centre areas in Mayfair, Victoria, Maida Vale, Paddington, Marylebone and Bayswater.

Population Characteristics and Projections

4.6 Characteristics of the local population have been summarised in Table 4.1.

Table 4.1: Population Characteristics at a Glance

The borough at a glance…			
242,100	Residents	**11,049**	New migrants registered with local GPs
247,614	Registered with local GPs	**£42,141**	Average annual pay
897,293	Daytime population in an average weekday	**8.8%**	Unemployment rate (JSA) (London 3.1%)
118,975	Households	**Ranked 98th**	Most deprived borough in England (out of 326) (20th in London)
920,000	Median house price	**Ranked 33rd**	Income Deprivation Affecting Children Index (out of 326) (14th in London)
71.1%	Renters	**7 (7.42)**	Live births each day
38.8%	From BME groups	**3 (3.22)**	Deaths each day
49.8%	Born abroad (2011 Census)	**55,385**	Local businesses
30.8%	Main language not English	**13.4%**	Local jobs in Public Sector
52.6%	State school pupils whose main language not English	**Ranked 1st**	For high carbon emissions in London
38.2%	of the borough is green space		

4.7 Westminster is a densely populated and vibrant Central London borough, with a daytime population nearly four times the size of the resident population. The area has a large proportion of young working age residents and very few children, as well as high levels of international migration and cultural diversity, with rich and poor living side by side.

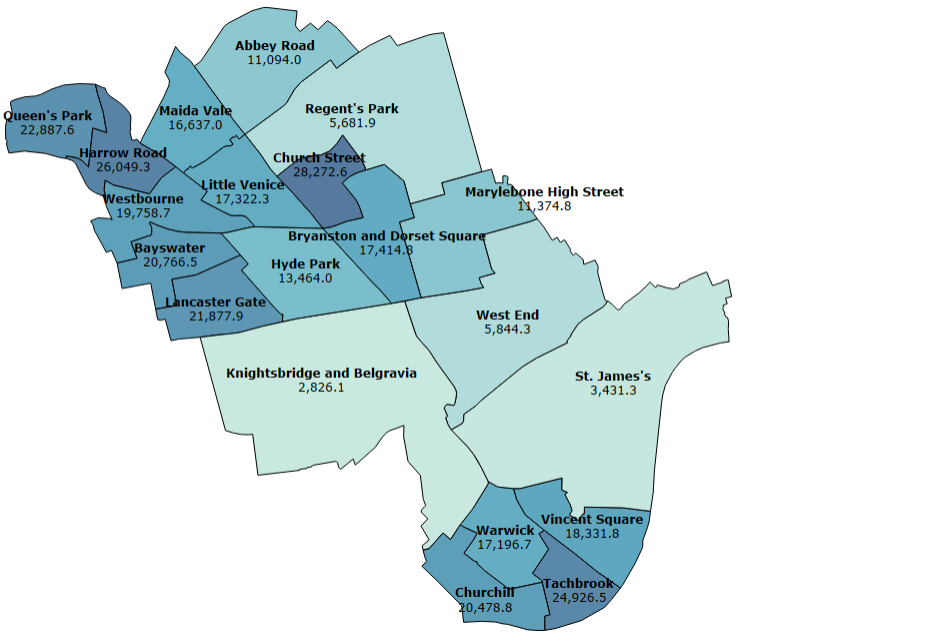
4.8 The Office for National Statistics estimates the Westminster **resident population** in 2014 mid-year estimates to be 242,100 and the **daytime population** as 897,293.

4.9 **Population density** is high in Westminster at an average of 112 per hectare. This is double that of London at an average 56.2 residents per hectare. The high density wards are mainly in the northern deprived parts in Westminster. The most densely populated wards include Church Street, Harrow Road and Tachbrook (Figure 4.1).

Daytime population

The day time population of Westminster is much higher than the numbers of usual residents and the flow of these people into Westminster needs to considered when planning for pharmacy provision, although there is no evidence that this significantly affects service provision at present.

Figure 4.1 Population Density of Westminster per square kilometer by Ward, mid 2014 estimates.



Source: ONS, 2015

Age and Gender Structure

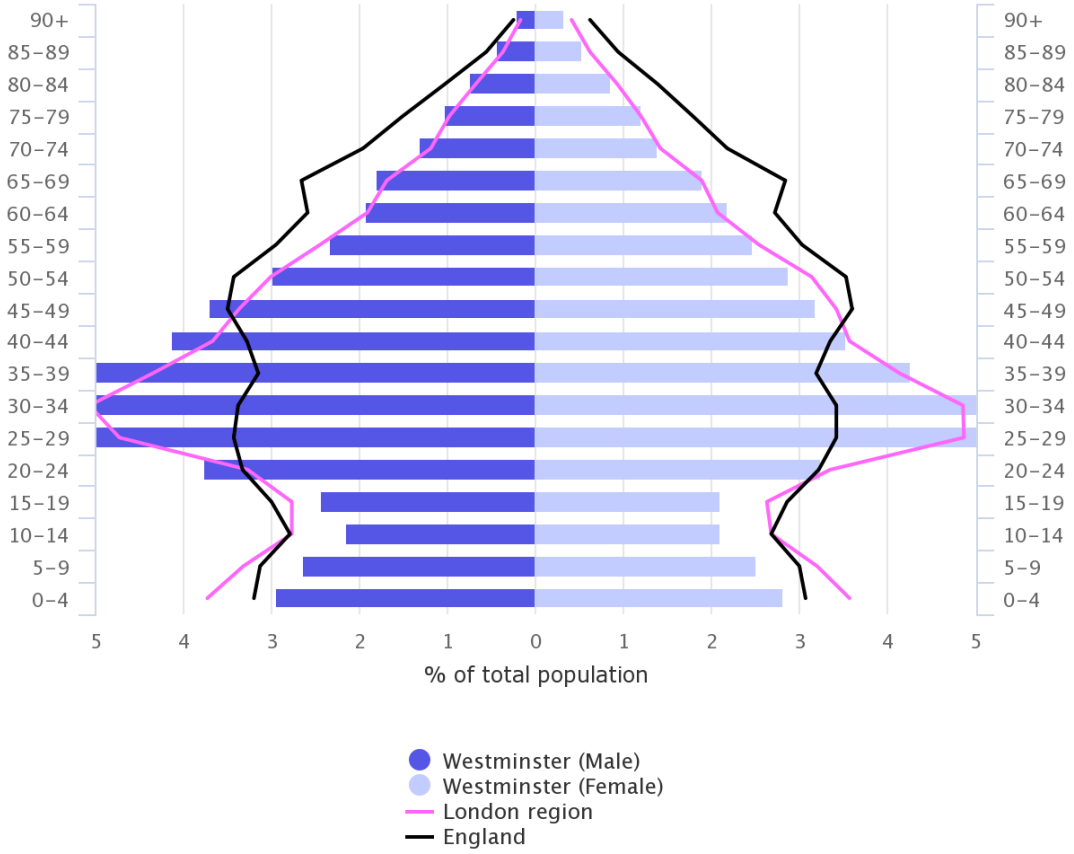
4.10 The **gender** split is unusual, with more men than women. This is particularly the case in the 20-50 year old age groups, but there are more women in the 50+ groups (see Figure 4.2).

4.11 The **age** profile in Westminster is typical of inner city areas, with a very high proportion of young working age adults, and a smaller proportion of older people. Westminster has the smallest proportion of children age 0-15 in London (not including City of London).

4.12 The 198,100 residents aged 16 to 64 represent 74.1% of the total population. The average is 37.7 years, slightly older than London at 36 years.

4.13 The proportion of the total population aged 65+ is similar to London, but not as large as England. Compared to London, the borough has the 5th highest proportion of younger working age residents (Figure 4.2).

Figure 4.2: Proportion of resident population by age-band and gender, Mid-2014 estimates for Westminster, 2015



Source: ONS 2015

4.14 Most of the 0-15 and population live in the northern deprived wards, while a high proportion of older people live in affluent parts including Knightsbridge & Belgravia (Figure 4.3 to 4.6).

Figure 4.3: % of 0-15 Population by Ward, 2015.

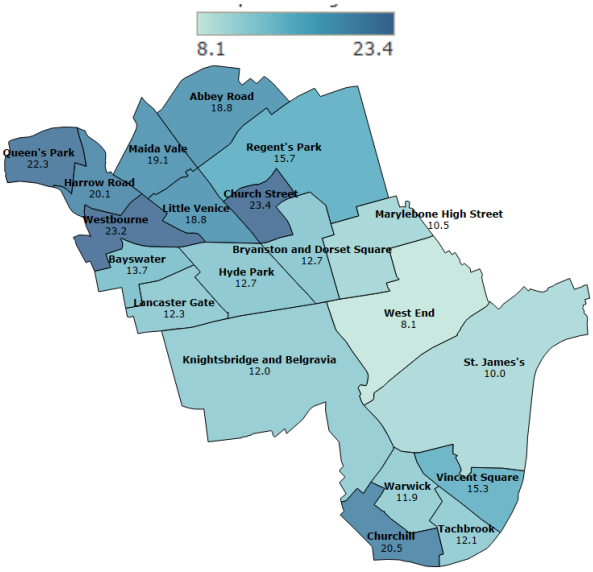


Figure 4.4: % of 16-24 Population by Ward, 2015.

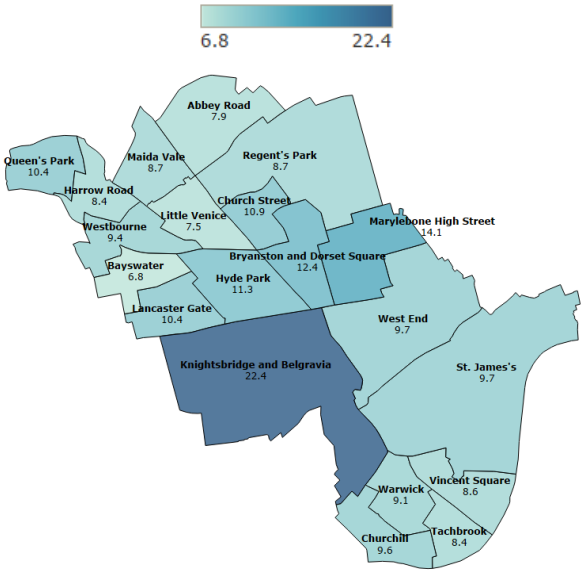


Figure 4.5: % of 25-64 Population by Ward, 2015.

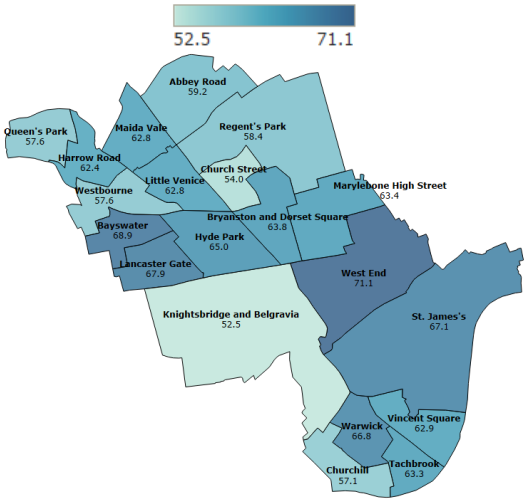
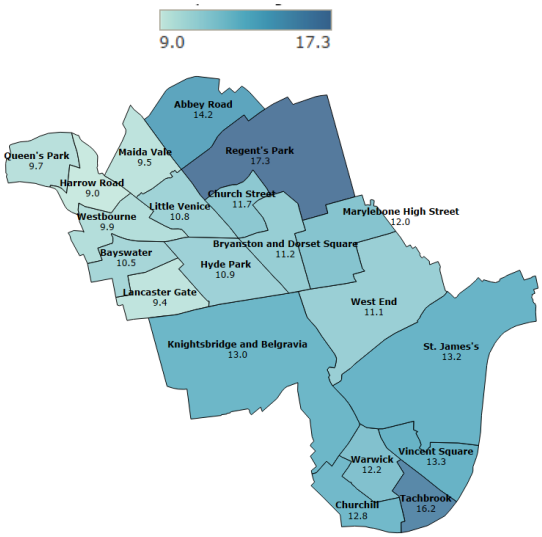


Figure 4.6: % of 65 + Population by Ward, 2015.



Source: ONS, 2017

4.15 The older population of expected Westminster is expected to increase in the next two decades. Predictive modeling that estimates that there will be a 14% increase of residents who are aged 65 and over by 2034 due to improvements in the life expectancy of the baby-boom generation. Table 4.2 outlines projected **population growth in the older age groups** over the next two decades.

Increasing elderly population

As the population ages, the demand on health care and dispensing services increases. Accessibility is an important factor for the elderly population.

Table 4.2 Projected population growth by age group for Westminster

	2014	2024	2034
65-74	9,824	10,322	13,231
75-84	5,523	6,837	7,439
85+	2,230	3,117	4,512
Total 65+	17,577	20,277	25,182

Source: PHE, 2017, based on ONS 2011 census

Ethnicity and diversity

4.16 Nearly half, 49.8% of the borough's population were **born abroad** according to ONS census 2011. The largest migrant populations by country of birth are United States (3.6%), France (2.6%) and Iraq (2.1%).

4.17 38.3% of the population is from **Black, Asian and minority ethnic (BME) groups**. Westminster has a smaller Black population and Asian population than the London average, but the largest proportion nationally from the 'Arab' group (e.g. Middle East & North Africa) and the 14th highest from 'Mixed' groups (Table 4.3).

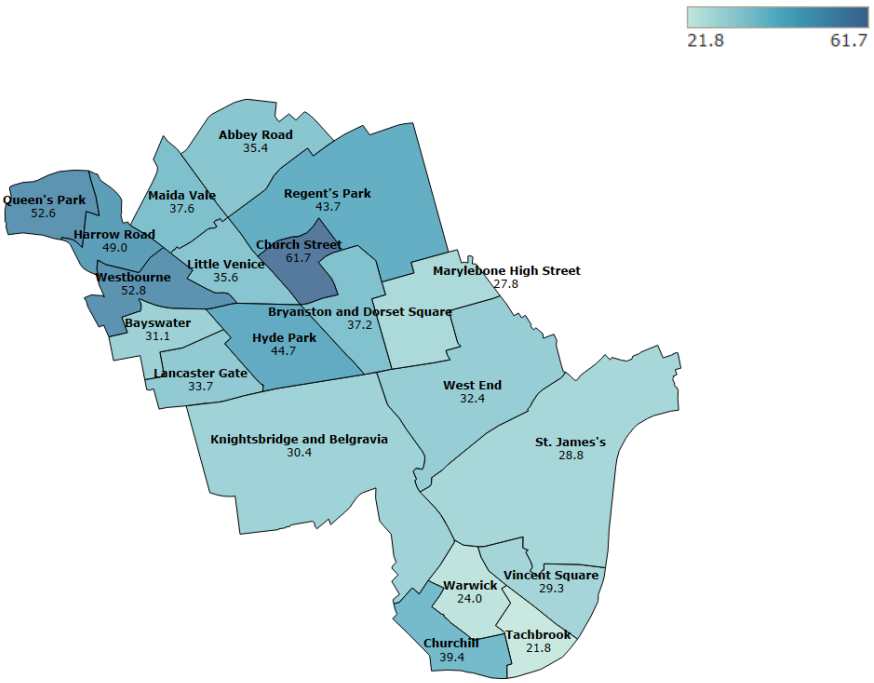
Table 4.3 Black and Minority Ethnic population breakdown for Westminster, London and England and Wales

Region	White	Mixed	Asian or Asian British	Black or Black British	Other
Westminster	61.68%	5.19%	14.52%	7.51%	11.09%
London	59.79%	4.96%	18.49%	13.32%	3.44%
England and Wales	85.97%	2.18%	7.51%	3.33%	1.01%

Source: ONS, 2011

4.18 Most of the minority ethnic groups in Westminster reside in the northern deprived wards. Church Street, Westbourne and Queen's Park have the highest percentage of Black and Minority Ethnic residents (Figure 4.7).

Figure 4.7: Percentage of black and ethnic minority groups by wards in Westminster, 2016



Source: PHE, 2016

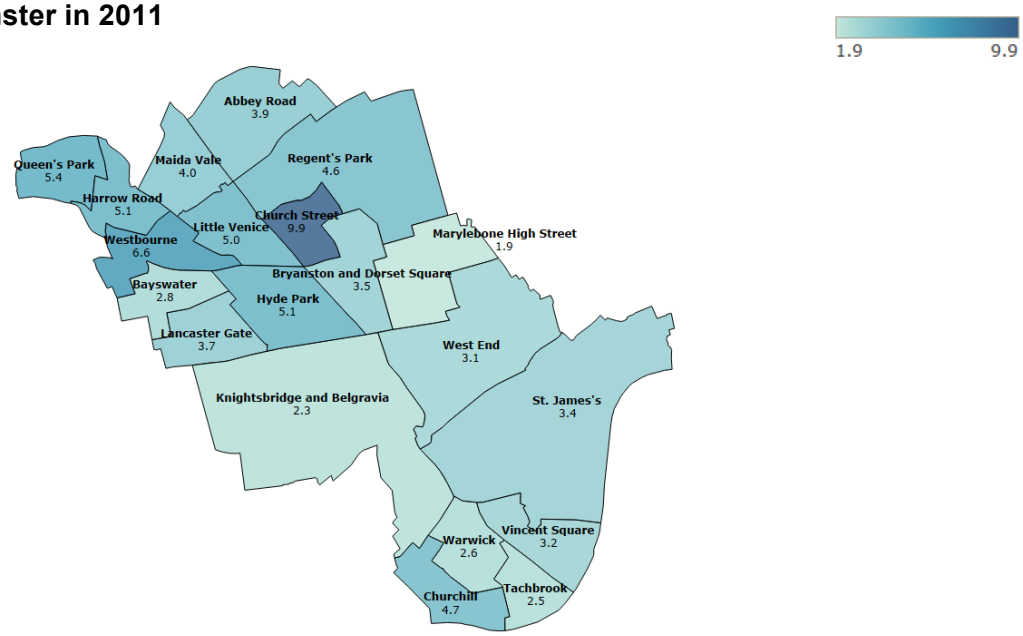
4.19 Just under a third (30.8%) of the borough's residents state their **main language is not English**. A breakdown by ward in Figure 4.8 show percentages of residents who do not speak English well. Nearly 10% of residents in Church Street do not speak English well or at all. High numbers of residents in Harrow Road, Hyde Park, Queens Park also do not speak English well or at all.

Pharmacy provision for cultural and language barriers

Areas where diversity is higher correlate with areas of higher levels of deprivation and poorer health. For example, Ethnic minority communities have higher incidence of long-term conditions such as diabetes and cardiovascular disease.

Cultural and language barriers can create problems for people who wish to engage with healthcare services. Pharmacies employ staff from diverse backgrounds who may be able to speak multiple languages.

Figure 4.8: Percentage of people that cannot speak English well or at all by ward in Westminster in 2011



Source: PHE, 2016

4.20 Arabic is by far the most common language after English, followed by French, Spanish, and Italian (Table 4.4).

Table 4.4: Proportion of languages spoken in Westminster

Languages spoken as a first language	
English	69%
Arabic	5.7%
French	3.0%
Spanish	2.2%
Italian	1.8%
Portuguese	1.7%
Bengali	1.4%
Greek	1.1%
German	1.1%
Russian	1.0%

Source: ONS, 2015

4.21 Over half (52.6%) of the state school pupils' first language is not English.

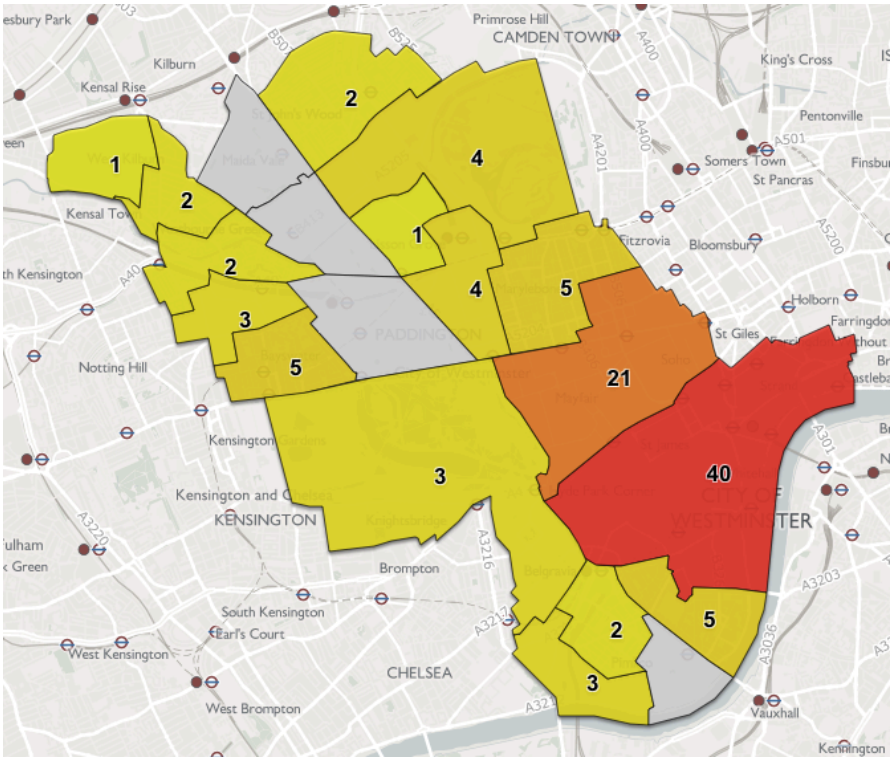
Population Increase

4.22 There are quite a few proposed large-scale development sites in the borough, which will likely result in significant and concentrated increases in population if completed. At present,

timescales for some developments are likely to be longer than the timescale of the 2018-2021 PNA.

4.23 According to Greater London authority, there are 56 major and medium-sized construction sites have started construction while another 47 have obtained planning permission (Figure 4.9 and). A high majority of these are situated within St James's and West End. Table 4.5 outlines the number of units of all of the development sites that have acquired planning permission.

Figure 4.9: Number of medium and large-scale housing development sites that have acquired planning permission in Westminster from October 2018



Source: Local Government Association, 2017

Table 4.5: Construction sites by number of units within each ward in Westminster

Ward	Construction not started	Construction started	All developments
Abbey Road	101	204	305
Bayswater	60	67	127
Bryanstan and Dorset Square	214	141	355
Church Street	261	18	279
Churchill	395	570	965
Harrow Road	18	261	279
Hyde Park	288	942	1230
Knightsbridge and Belgravia	120	70	190
Lancaster Gate	217	145	362
Little Venice	48	693	741
Maida Vale	85	201	286
Marylebone High Street	304	407	711
Queen's Park	30	120	150
Regent's Park	153	133	286
St. James's	1486	1273	2759
Tachbrook	12	8	20
Vincent Square	483	443	926
Warwick	219	25	244
West End	1106	937	2043
Westbourne	214	68	282
Total	6727	12540	19267

Source: Westminster City Council, 2017

4.24 The population of the borough is expected to increase by 1.86% by 2021 to 246,091 residents. By 2031 it is expected to increase by 7.48% to 259,656 residents. These figures are based on mid-year population estimates and assumptions such as future fertility, mortality and migration.

Changes in populations
Sustained population increases and development will increase demand on community pharmacy services, and different population groups will have different needs.

Wider Determinants of Health and Inequalities

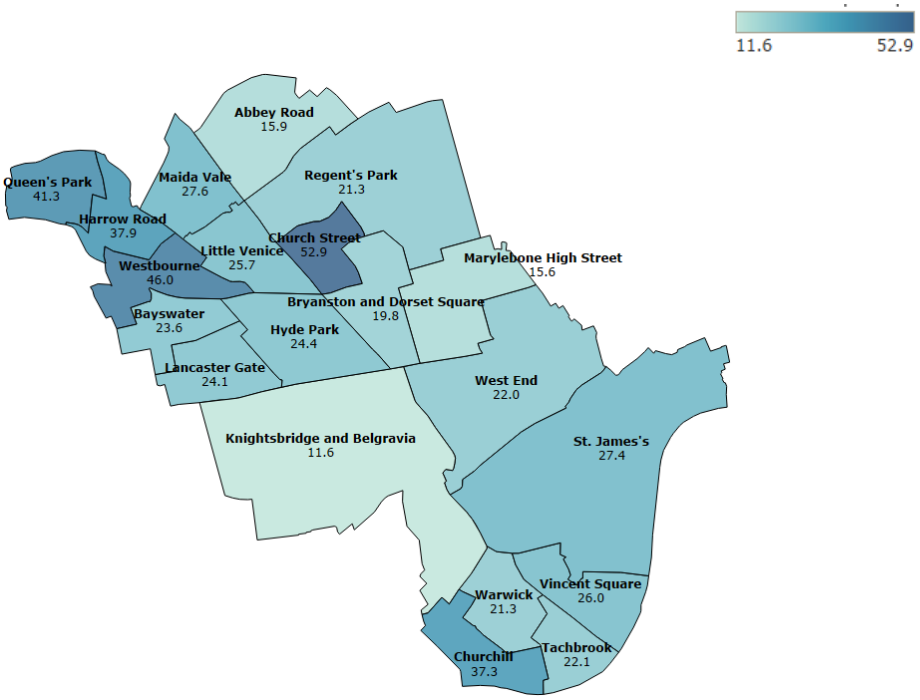
4.25 There are a range of social, economic and environmental factors that impact on an individual's health behaviours, choices and goals and ultimately their health outcomes. These are outlined in Fair Society, Healthy Lives: The Marmot Review report and include life expectancy, healthy life expectancy, education, employment and fuel poverty to name a few, which we explore in this chapter.

4.26 The **Index of Multiple Deprivation** is a combined measure of deprivation based on a total of 37 separate indicators that encompass the wider determinants of health and reflect the different

aspects of deprivation experienced by individuals living in an area. The 37 indicators fall under the following categories: Income Deprivation, Employment Deprivation, Health Deprivation and Disability, Education, Skills and Training Deprivation, Barriers to Housing and services, Living Environment Deprivation and Crime.

4.27 Figure 4.10 illustrates the vast differences between the wards of the borough. Church Street has the highest multiple deprivation scores while Knightsbridge and Belgravia have the lowest.

Figure 4.10 The Index of Multiple Deprivation scores in Westminster by ward in 2015



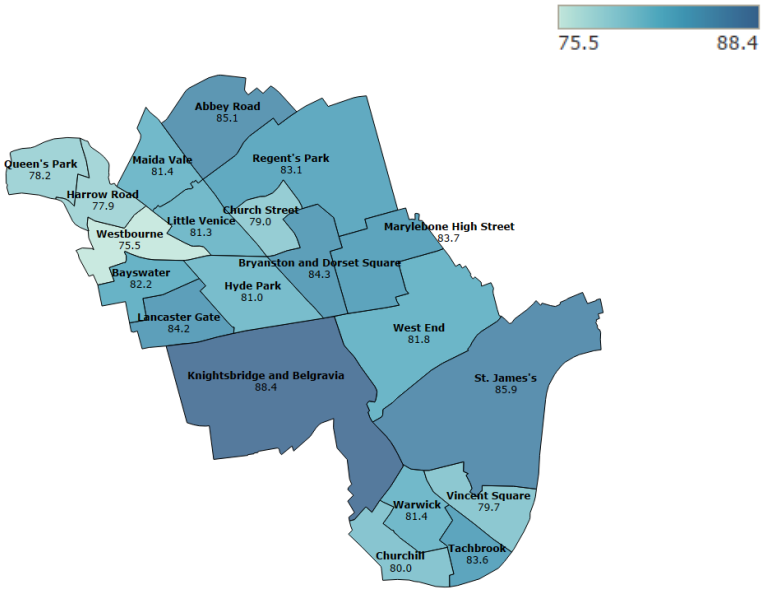
Source: PHE, 2016

4.28 Life expectancy for males at birth in Westminster is 82.2, and 86 years for females. This is among the highest nationally and nearly three years higher than the national figures for **life expectancy**.

4.29 The **Slope Index of Inequality** measures the absolute difference in life expectancy between the most and least deprived areas. In Westminster there is a significant variation in life expectancy across the social gradient with an 11.3 year life expectancy gap for men and a 7.1 year gap for women between those who live in the most deprived areas and the least deprived areas.

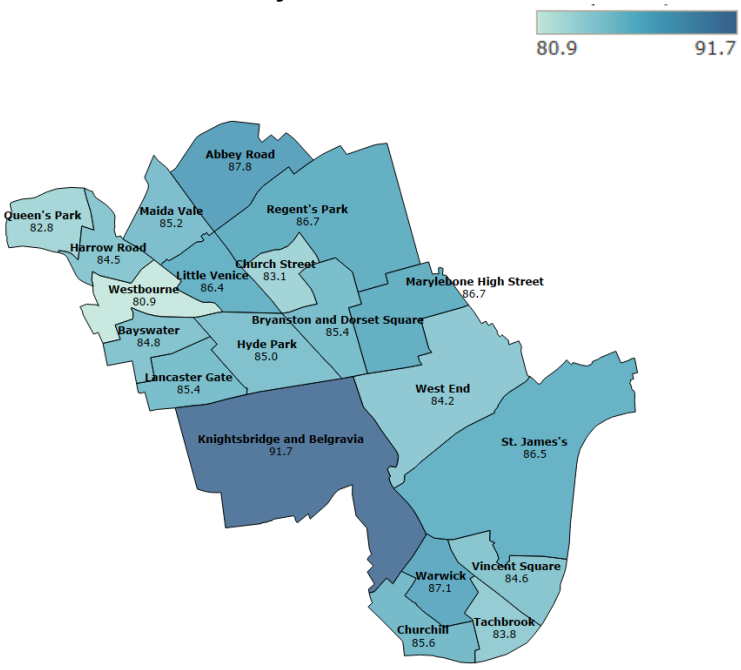
4.30 Knightsbridge and Belgravia has the highest life expectancy and Westbourne has the lowest in the borough for both genders (see Figures 4.9 and 4.10).

Figure 4.9: Life expectancy at birth of Males by Ward in Westminster in 2015



Source: PHE 2016

Figure 4.10: Life expectancy at birth of Females by Ward in Westminster in 2015

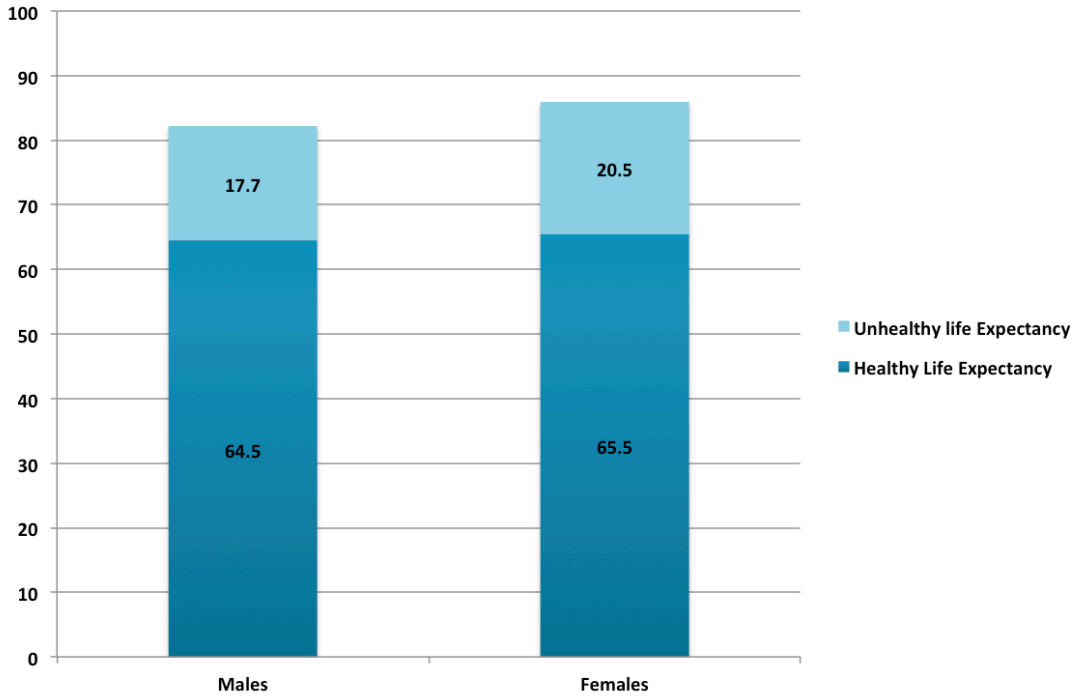


Source: PHE, 2016

4.31 **Healthy life expectancy at birth** is the average number of years an individual should expect to live in good health considering age-specific mortality rates and prevalence for good health for their area.

4.32 The latest figures (2015) for residents in Westminster show that males have a healthy life expectancy at birth of 64.5 and females, 65.5 years. This is better than the England healthy life expectancy of 63.5 and 64.8 years respectively. These figures indicate that males living in Westminster could live with ill health for 17.7 years and females for 20.5 years (see figure 4.11).

Figure 4.11 Life expectancy and Healthy life expectancy for Males and Females in Westminster in 2015



Source: PHE, 2016

4.33 Compared to the rest of England, Westminster has a low **dependency ratio** of 39.9%. A dependency ratio compares the estimated number of people who are less likely to be working (such as children and people of state pension age) with the number of people of working age. A low ratio indicates that the working population has fewer dependants. It is estimated that 60.7% of the national population are dependents.

Pharmacy provision within deprived communities

Access to community pharmacy services in the communities where there is high deprivation is important in addressing health inequalities.

The PNA will need to take into account whether the services provided by pharmacies are available in our most deprived communities and are sufficient to meet their local

4.34 650 residents are **long-term unemployed**, this equates to 3.7% of the working-age population (based on 2016 figures), similar to national figures.

4.35 Nearly a third (32.2%) of under 16s, 8,465 children residing in Westminster are from **low-income families**. This is significantly higher than England here one fifth of children are from low-income families.

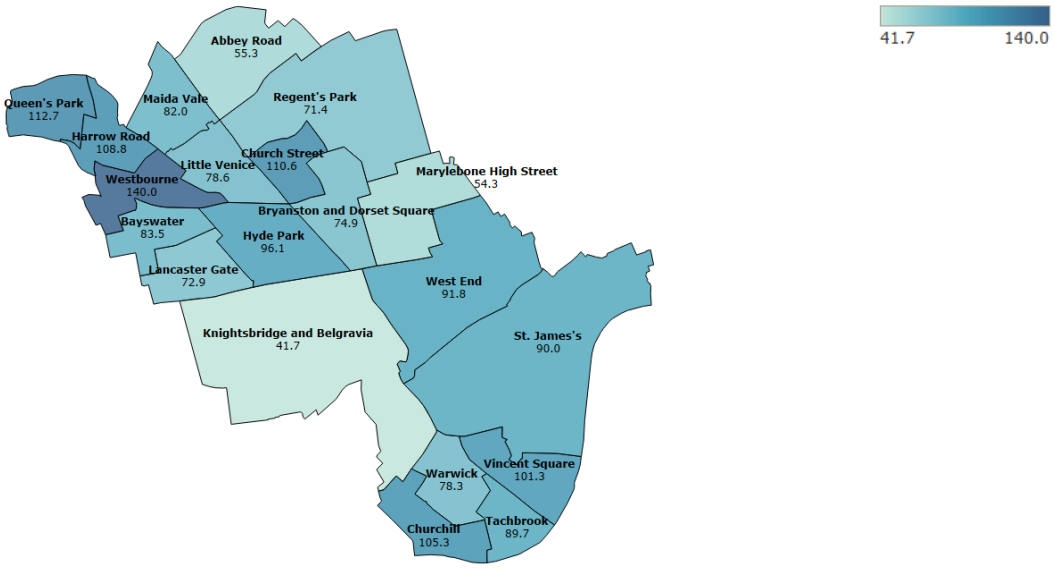
4.36 A higher rate of people living in Westminster experience fuel poverty, 12.9% of people did not have enough income to afford sufficient fuel in 2014, higher than the national rate of 10.6% and an increase from 9.9% from the previous year.

Premature Mortality

4.37 The **standardised mortality ratio** is a good indicator for the effect of the prevalence of risk factors, prevalence and severity of disease, and the effectiveness of interventions and treatment. The differences of early mortality rates in different areas can reveal where focus is needed to reduce variation in life expectancy and health inequalities.

4.38 Figure 4.12 presents the standardised mortality ratio for deaths from all causes aged under 75, otherwise known as premature mortality. This measure is used to identify deaths usually considered 'avoidable'. Premature mortality is higher in the north of the borough, among the more deprived wards.

Figure 4.12 Standardised mortality ratio 2010-2014 by Ward in Westminster in 2015

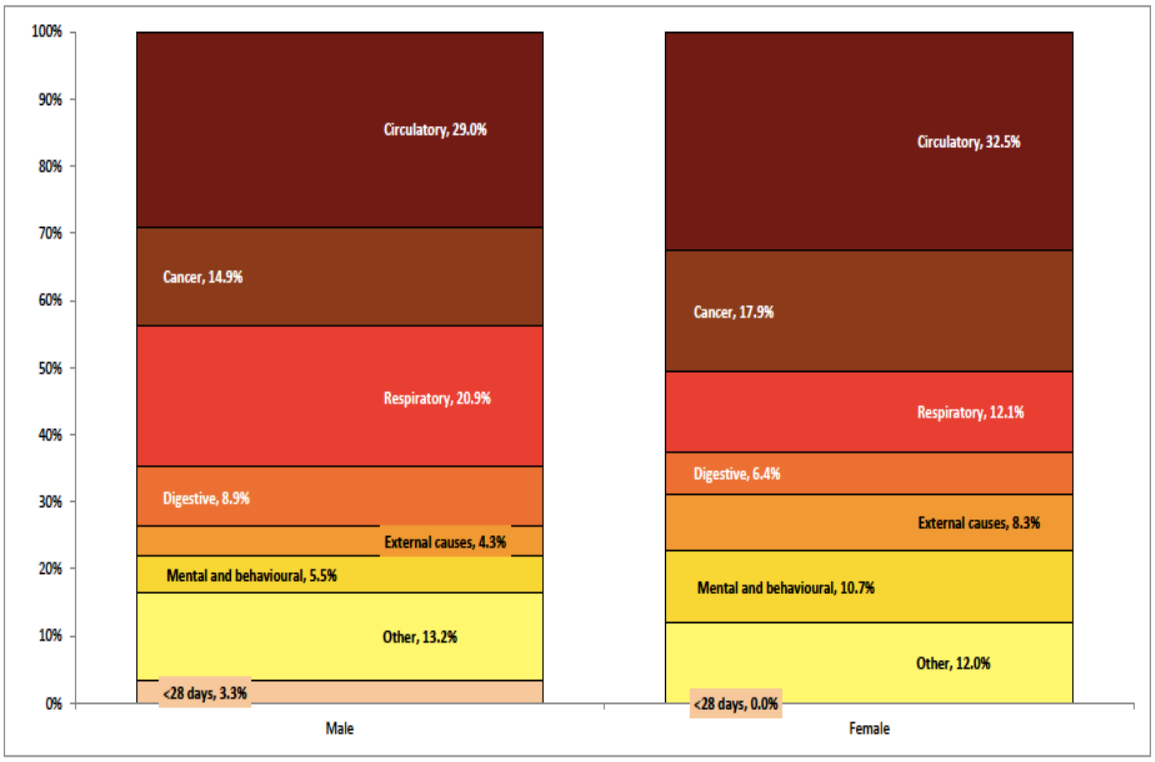


Source: PHE, 2016

4.39 A closer look at where the causes of the **life expectancy gap** lie show that circulatory diseases such as coronary heart disease and stroke are the biggest cause of the differences in life expectancy in Males. They account for 29% of the life expectancy gap between the most deprived quintile and least deprived quintile in the borough. Following that is digestive disease (which includes alcohol related conditions such as chronic liver disease and cirrhosis) that accounts for 20.9% of the gap and cancer that accounts for 14.9% of the gap.

4.40 Circulatory diseases are also the biggest cause of the differences in life expectancy between deprivation quintiles in women, accounting for 32.5%. Cancer accounts for 17.9% of the life expectancy gap followed by respiratory diseases at 12.1%. Figure 4.13 presents the differences in life expectancy by cause between the most deprived and the least deprived quintiles of the borough.

Figure 4.13: Life expectancy gap between the most deprived quintile and the least deprived quintile for Westminster by broad cause of death, 2012-2014



Source: PHE, 2016

Medicine Use Reviews and the New Medicine Service

Many long-term conditions such as circulatory or respiratory diseases and cancers, are managed with medication. Pharmacy services play an important part of the long-term conditions pathway by ensuring that medicines are used effectively and safely and therefore improving outcomes for patients.

Pharmacies can support patients, clinicians and carers to achieve the maximum benefit from medicines whilst reducing the risks associated with treatment.

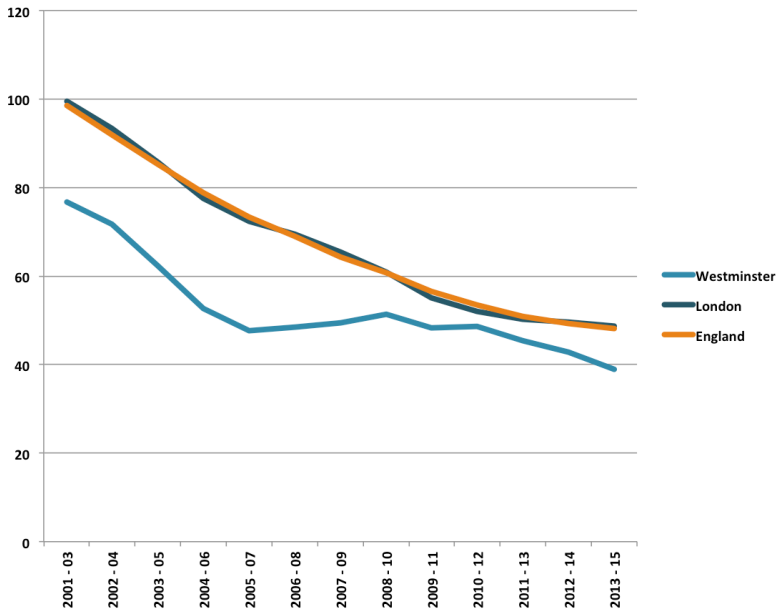
Targeted Medicine Use Reviews and the New Medicine Service can encourage patients to adhere to their prescribed regimen, help to manage medicines related risks and reduce re- admissions to hospital. It is recommended that patients with long-term conditions with multiple medicines should be reviewed at regular intervals.

Circulatory Diseases

4.41 The borough's premature death rate from **cardio-vascular disease** considered preventable is the 4th lowest in London. In Westminster, 91 people or 27.2 per 100,000 residents die from CVD considered preventable. This is substantially lower than London and England rates of 48.7 and 48.1 deaths per 100,000 population respectively.

4.42 These rates have been lower than London and England since 2001 and have been reducing over the years (see Figure 4.14) and this is likely due more timely high quality treatment, effective prescribing, and a reduction in the number of smokers.

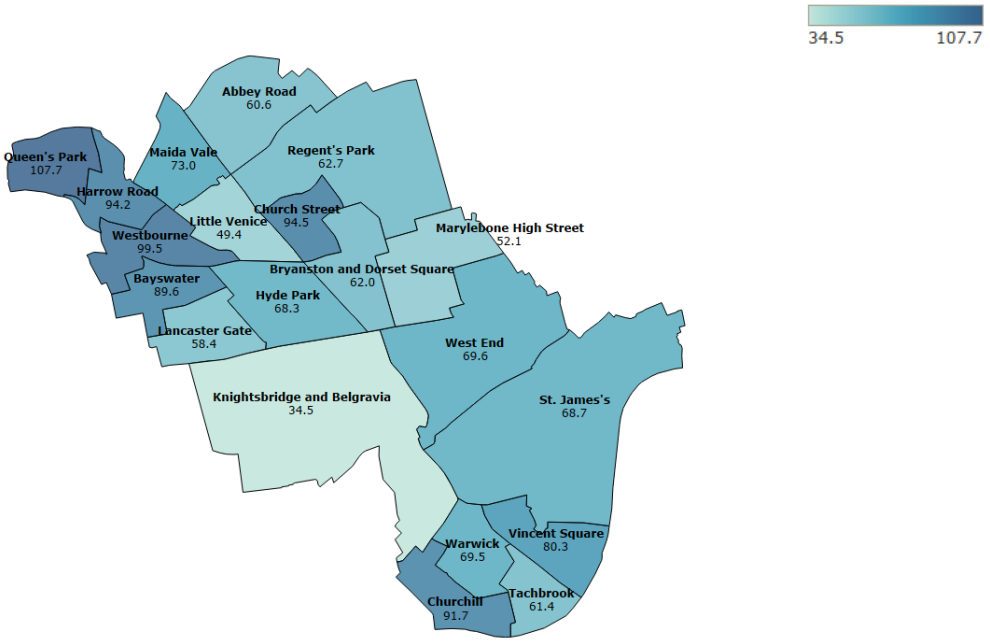
Figure 4.14: Under 75 mortality rate per 100,000 from cardiovascular disease for Westminster, London and England from 2001 to 2015



Source: PHE, 2016

4.43 Currently, the under 75-mortality rate consider preventable and non-preventable is highest in the boroughs where deprivation is highest. These include Queen's Park, Westbourne, Church Street and Churchill.

Figure 4.15: Under 75 mortality rate from circulatory disease by ward in Westminster, London and England from 2013 to 2015



Source: PHE, 2016

4.44 Currently 27.8 per 100,000 residents of the borough die prematurely each year from **coronary heart disease** and 15.5 people per 100,000 die of a stroke. These rates are relatively similar to national figures.

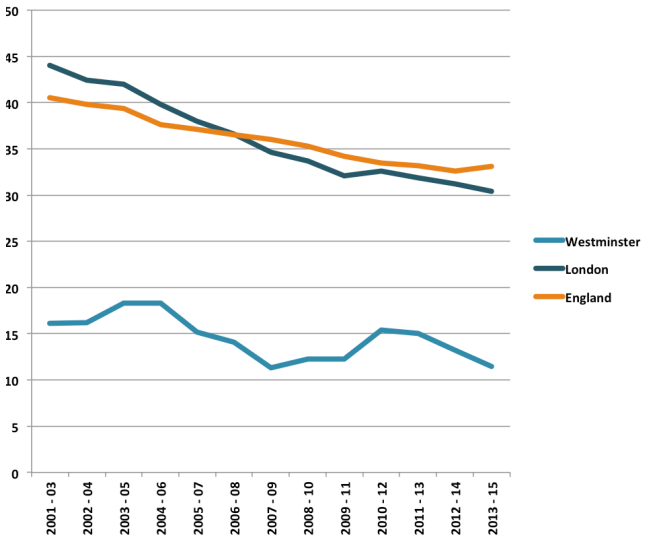
NHS Health Checks
Pharmacies may provide NHS Health Checks for people aged 40-74 years. This includes providing a full vascular risk assessment and along with advice and support to help reduce the risk of heart disease, strokes, diabetes and obesity.

Respiratory Diseases

4.45 Westminster has a substantially lower death rate caused by **respiratory diseases** considered preventable. 11.5 per 100,000 residents die each year from preventable respiratory disease.

4.46 The rates of deaths by respiratory disease considered preventable have reduced in the last few years and remained lower than regional and national figures since 2001.

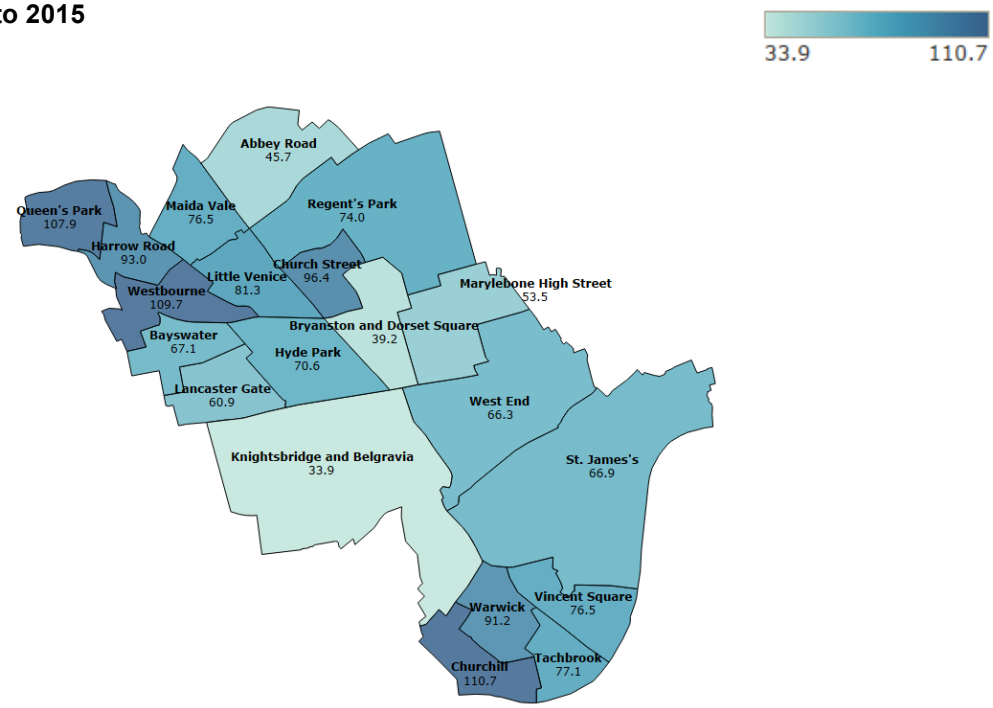
Figure 4.16: Under 75 mortality rate from respiratory disease for Westminster, London and England from 2001 to 2015



Source: PHE, 2016

4.47 The Under 75 mortality rate from respiratory disease including those considered preventable and not preventable is higher in the wards where deprivations is highest, i.e. Westbourne, Churchill, Church Street and Queens Park (see Figure 4.17).

Figure 4.17: Under 75 mortality rate from respiratory disease by ward in Westminster, London and England from 2013 to 2015



Source: PHE, 2016

4.48 **Chronic Obstructive Pulmonary Disease** (COPD) is a highly preventable cause of morbidity and mortality that sits within respiratory diseases. Prevalence rates and hospital admission rates for COPD in Westminster are similar to that of London and lower than England.

4.49 **Tuberculosis** is on the decline in Westminster. Westminster CCG recorded a three-year crude rate of 17.5 per 100,000 population diagnosed with TB. This is lower than the rest of London (30.4 per 100,000 population).

Cancer

4.50 The overall prevalence of new cases of all **cancers** is 1.7% for Central London CCG. This is similar to the regional figure of 1.7% and lower than the national figure of 2.4%. This may be a reflection of poor early diagnosis of cancer where chances of survival much poorer in areas of deprivation.

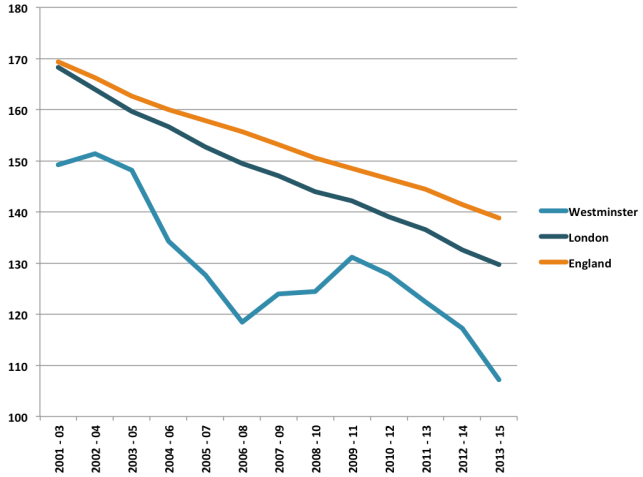
4.51 NHS Central London **screening** coverage is low compared to the rest of London. It is the poorest performing CCG for breast, bowel and cervical cancer screening coverage. Population diversity, migration and high use of private services create a constant challenge to improvement.

4.52 Despite this the premature mortality rate for cancer, i.e. under 75 years, is low when compared with regional and national figures. Currently 107.2 per 100,000 residents of the borough die prematurely each year from cancer, compared with 129.7 for London and 138.8 for England. This is the 2nd lowest figure of the London boroughs. Premature mortality has been substantially lower than England and London overall since 2001 (see Figure 4.18).

Early detection and diagnosis of cancers
Pharmacists can play in an important role in the early detection and diagnosis of cancer.

Raising awareness and talking to patients about signs and symptoms of different cancers can result in earlier diagnosis and therefore better treatment options for patients.

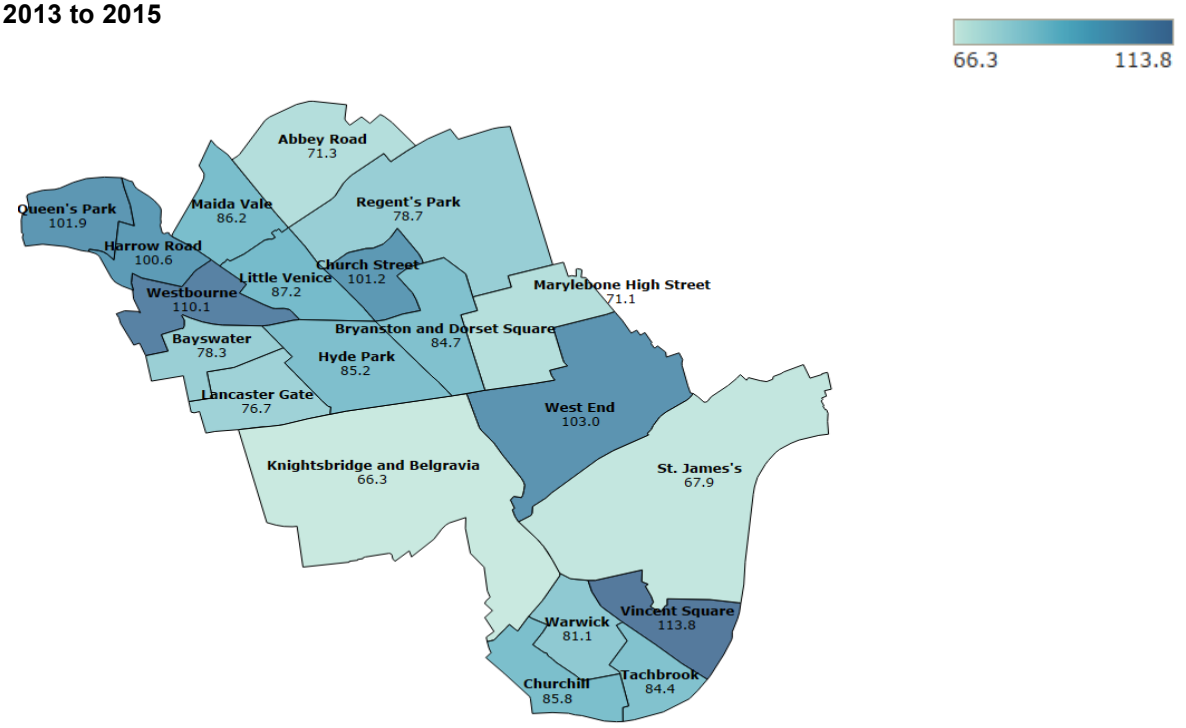
Figure 4.18: Under 75 mortality rate from cancer for Westminster, London and England from 2001 to 2015



Source: PHE, 2016

4.53 Standardised mortality by cancer is highest within the more deprived wards of the borough, specifically Westbourne and Church Street (see Figure 4.19).

Figure 4.19: Under 75 mortality rate from cancer by ward in Westminster, London and England from 2013 to 2015



Source: PHE, 2016

Risk Factors for Mortality and Morbidity

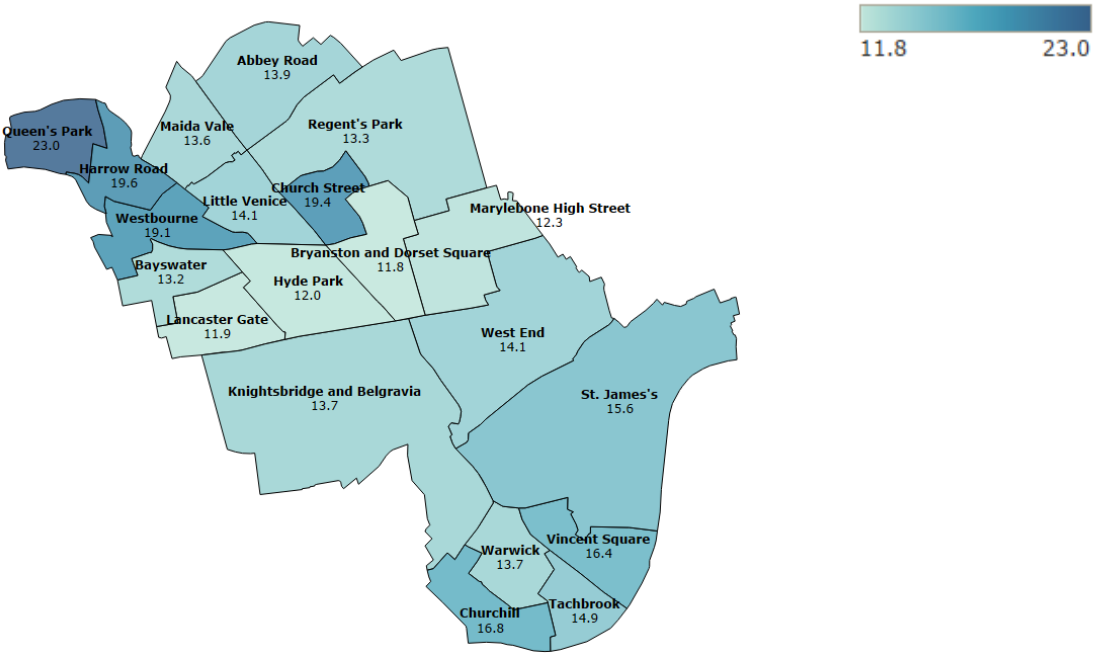
Risk Factors in Adults

4.54 **Smoking** is the leading cause for preventable death in the world. 18% of adults surveyed in Westminster smoke. This is a higher rate than for London and England.

Stop Smoking Services
Pharmacies may provide proactive promotion of smoking cessation through to provision of full NHS stop smoking programme.

4.55 Over half (54.5%) of adults are **overweight or obese** in Westminster, this is lower than regional and national figures. Obesity is recognised as a major determinant of premature mortality and avoidable ill health. There are marked differences in levels of obesity between wards in the borough, 11.8% of adults are obese in Bryanstown and Dorset Square, whereas Queens Park has more than double the rate at 23%.

Figure 4.20: % of adults who are obese by ward in Westminster in 2015



Source: PHE, 2016

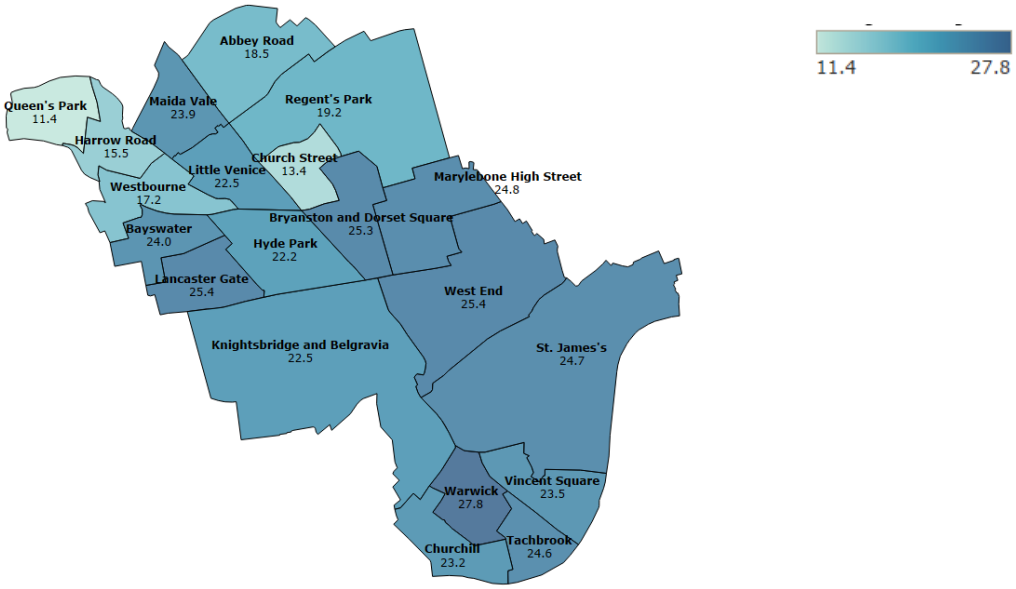
4.56 Over one fifth (22.2%) of adults residing in the borough are considered **physically inactive**, meaning they engage in less than 30 minutes of moderate physical activity per week. This is similar to London levels. People who are physically inactive increase their chances of cardiovascular disease, coronary heart disease and stroke. People who have a physically active lifestyle reduce their risk of obesity, diabetes, osteoporosis and some cancers and improved mental health.

Weight Management Services
Pharmacies can provide services that can promote healthy eating and physical activity, weight management services for adults who are overweight or obese or brief interventions to signpost patients towards increasing their physical activity and improving their diet.

4.57 **Alcohol consumption** contributes to morbidity and mortality from a diverse range of conditions. 36.1 per 100,000 deaths are alcohol-related and 501 Westminster per 100,000 residents were admitted to hospital in 2015/16, lower than regional and national figures. Modelled estimates show that binge drinking is highest in Warwick, Lancaster Gate and Bryanstown and Dorset Square (see figure 4.16).

Alcohol Misuse Services
Pharmacies may provide Alcohol misuse services that include proactive brief interventions and advice on alcohol with referrals to specialist services for problem drinkers.

Figure 4.16: % of adults (16+) who binge drink in Westminster in 2015



Source: PHE, 2016

4.58 There are currently 1,445 residents in Westminster diagnosed with **HIV**, the 5th highest rate aged 15-59 in the region. A quarter (25.9%) of cases in 2014-16 were diagnosed late, compared to the London average of 33.7%. Late diagnosis carries with it an increased risk of poor health and death and it increases the chances of onward transmission.

Sexual Health Services
Pharmacies can provide Sexual health services such as emergency hormonal contraception services; condom distribution; pregnancy testing and advice; chlamydia screening and treatment; other sexual health screening, including syphilis, HIV and gonorrhea.

4.59 Of those who are tested for **Sexually Transmitted Infections (STIs)**, 5.4% tested positively for an infection (excluding chlamydia) in Westminster, the third highest rate in London. Rates of Chlamydia among 15-24 year olds are less high but still slightly above the national average.

4.60 One-fifth (21.5%) of those registered with a GP in Westminster have a **common mental illness**, this is the highest rate in London (16.4%) and England (15.6%). The high rate is likely due to good identification and reporting by GPs in the borough.

Medicine adherence
Medicines are a key component of mental health care and pharmacists have the expertise required to improve adherence to medication support the reduction of inappropriate use of medicines.

4.61 Westminster has the 4th highest percentage (1.34) of people registered with a GP who are known to have a **severe mental illness**, markedly higher than London (1.03%) and England (0.83%).

Risk Factors in Older Adults

4.62 The proportion of older population is rising and older people are the biggest and costliest users of healthcare. The biggest costs are for those with complex needs, long-term conditions, and functional, sensory or cognitive impairment including Dementia.

4.63 Health-related quality of life gives an indication of levels of good health, wellbeing and independence. This is measured using a health status score in the over 65s and looks at Mobility, Self-care, Usual activities, Pain / discomfort and Anxiety / depression. In Westminster the average score is 0.741, close to the national norm of 0.733.

4.64 Loneliness and isolation of older people is a risk factor for ill-health and premature mortality. People who are lonely and social-isolated are more likely to need healthcare resources and long-term care. Nearly half (45.3%) of Westminster's older generation (65+) are living alone and are at risk of loneliness and isolation.

4.65 The number of people living with dementia is increasing. Approximately 1300 people (5% of over 65s) are living with dementia in Westminster today, half of whom are over 85 years of age. This is predicted to rise to 2320 by year 2025. This can have an impact on levels of paid and unpaid health and care provision.

Dementia Friendly pharmacies
Pharmacies can be a very important place that people living with dementia need to access. Dementia friendly pharmacies can support people living with dementia to feel confident and empowered to do things that they have always been able to do such as collecting a prescription.

4.66 Falls are the largest cause of emergency hospital admissions and a major cause of loss of independence, disability or death in older people. 2,214 per 100,000 emergency admissions for the over 65s were due to falls in 2015/16 in Westminster, lower than London overall and similar to national rates.

Falls Prevention
Pharmacy services can support people to manage their medicines and signpost them to services that can assist them to live independently, prevent falls thereby prevent hospital admissions.

Risk Factors in Children and Young People

4.67 The younger working population are usually considered to be low users of the healthcare system. However, pharmacies may provide enhanced services such as immunisations, minor ailment services and sexual health services which may be more accessible than GPs and secondary care and also reduce the demand on these services.

4.68 Just over one in ten (11.6%) of 15 year olds with a long-term illness, disability or medical condition diagnosed by a doctor in London. Young people from the more deprived areas are more likely to report poor health and this can have a significant impact on overall life chances.

4.69 There were 34 under 18 conceptions in the borough in 2015, this is slightly lower than our regional and national comparators. Teenage mothers nationally are three times as likely to suffer from post-natal depression, are less likely to breastfeed and more likely to smoke.

4.70 Based on the 2015/16 latest GCSE figures pupils in Westminster are doing well. 63.6% of pupils achieved 5A*-C GCSEs, this is a small decline from the previous year and yet significantly better than the national percentage of 57.8%.

4.71 Childhood obesity is on the rise and can have significant impact on health outcomes. A child who is overweight or obese can have increased blood lipids, glucose intolerance, Type 2 diabetes, hypertension, increases in liver enzymes associated with fatty liver, exacerbation of conditions such as asthma and psychological problems such as social isolation, low self-esteem, teasing and bullying.

Health Champions and Health Trainers

The 'walk-in' nature of pharmacies mean that they are ideally placed to offer opportunistic screening and brief interventions for a better health and wellbeing. People can be supported to make positive health behaviour changes on topics such as smoking, alcohol, weight management, sexual health, physical activity and mental health.

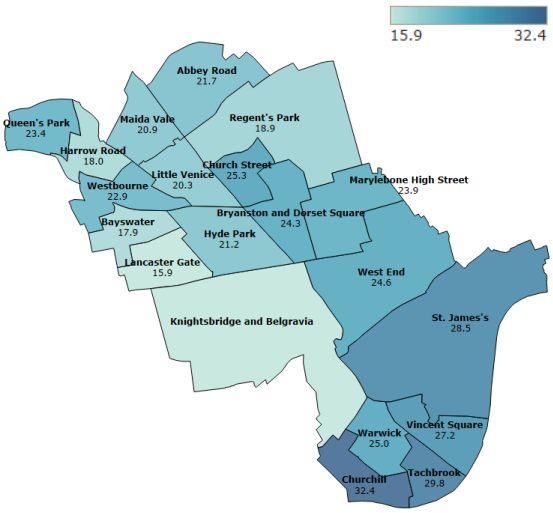
Healthy Champions and Health Trainers situated within pharmacies in areas of high deprivation and can bridge the gap between healthcare and the community and voluntary services that can support it.

4.72 Nearly one-quarter of Reception age children (23.7%) and two out of every five (39.7%) Year 6 children are overweight or obese, this is higher than regional and national figures.

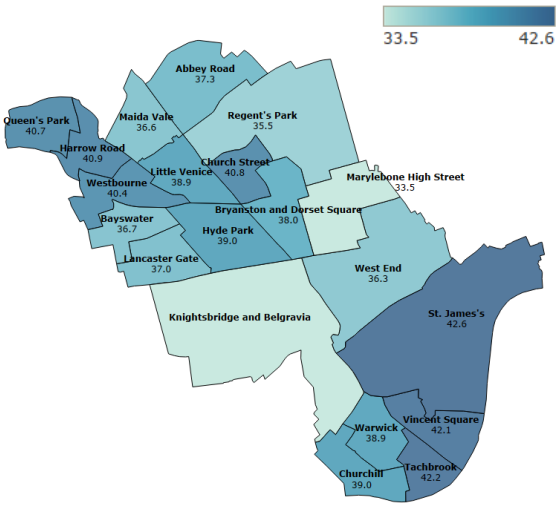
4.73 Churchill and Tachbrook wards have the highest rates of overweight and obesity in Reception age children and St James's, Tachbrook and Vincent Square have the highest rates of excess weight in Year 6 children the borough (see Figure 4.17).

Figure 4.17: % of children who are overweight or obese in Reception and Year 6 by ward in Westminster

Reception Year



Year 6



Source: PHE, 2016

4.74 Dental decay is a highly preventable disease, caused by a high-sugar diet. Over a third (35.1%) of children have decayed, missing or filled teeth in Westminster, this is substantially worse than regional than national figures.

Dental Health Promotion
Due to the frequency of their contact with the public and in promoting health and wellbeing, pharmacists can be effective in raising awareness of oral health.

4.75 Vaccinations help prevent serious illness in children, especially potentially severe disease such as meningitis, whooping cough, and tetanus. Yet Westminster has poorer coverage rates than the rest of England in all childhood vaccinations for which there is data.

Vaccinations
Due to better flexibility of opening hours and convenient locations, pharmacies can improve uptake of some vaccinations.

4.76 Substance misuse in young people is linked to mental health issues such as depression, disruptive behaviour and suicide. It is also linked to adverse experiences and behaviours such as truancy, exclusion from school, homelessness, time and care and serious or frequent offending. 54.3 per 100,000 hospital admissions for 15-24 year olds in Westminster (2013/14 to 2015/16) are due to substance misuse, this is lower than England figures.

Substance misuse services
Pharmacies can increase accessibility to a range of substance misuse services including needle and syringe services; supervised consumption of medicines to treat addiction, e.g. methadone; hepatitis testing and hepatitis B and C vaccination; HIV testing; provision of naloxone to drug users for use in emergency overdose situations.

Summary of demographics and health needs of Westminster

The City of Westminster is situated in the heart of London. It is a densely populated borough with a daytime population nearly four times the size of the resident population, likely a result of tourism and people who commute to work. The population is expected to rise substantially in the coming years.

Westminster has a large proportion of young working age residents and comparatively fewer children. The average age is 37.7 years.

Nearly half of the population was born abroad and nearly one-third identify as being from Black or Minority Ethic groups, the highest proportion of whom live in Church Street ward.

There are vast differences inequalities in deprivation and life expectancy. Church Street and Westbourne have the highest levels of deprivation and the lowest life expectancy, whereas deprivation levels are markedly lower in Knightsbridge and Belgravia and Marylebone High Street, where life expectancy is highest.

Circulatory diseases, cancers and respiratory diseases are the biggest causes in the differences in life expectancy. Overall mortality rates for these diseases have been declining in the last five years. Premature mortality is highest in Westbourne, Queen's Park and Church Street.

Although smoking rates are declining through the years, 18% of adults in Westminster smoke, this figure is higher than regional and national figures.

Overall the proportion of adults who are overweight or obese is lower than regional and national figures, however obesity figures are markedly different between wards. Nearly one-quarter of adults residing in Queens Park are obese.

Rates of excess weight in children are very high, particularly in Year 6 pupils residing in St James's, Tachbrook and Vincent Square. The proportion of children who have dental decay is also high and the coverage of Vaccinations in children are low.

The proportion of adults who are diagnosed with a mental illness are high in comparison to London and England, this may be a result of successful efforts by GPs to identify mental illness.

Rates of STIs including chlamydia and HIV are also high and an area of concern.

Chapter 5 - Patient and Public Engagement and the Protected Characteristics

5.1 This section discusses the results of the patient and public engagement that was carried out from September to October 2017. We also examine the health needs specific to protected characteristics and vulnerable groups that we have engaged during this process and the implications they may have on the PNA.

5.2 A "protected characteristic" means a characteristic listed in section 149(7) of the Equality Act 2010. There are also certain vulnerable groups that experience a higher risk of poverty and social exclusion than the general population. These groups often face difficulties that can lead to further social exclusion, such as low levels of education and unemployment or underemployment.

5.3 A community questionnaire was used to engage with residents to understand their use and experience of local pharmacies. The PNA task and finish group and the communications team of the City of Westminster approved this questionnaire for use with the local population. This questionnaire is available as Appendix B.

5.4 The engagement plan and methods of dissemination of the survey are referenced in Appendix C. We identified six pharmacies to carry out some outreach; some of which were in the most deprived wards of the borough. We were able to conduct outreach in four community pharmacies. Adult services supported residents in their sheltered schemes to fill out these community questionnaires.

5.5 We engaged with about 180 residents in Westminster. Paper copies and an online version were used for the purposes of this engagement. Fifty-eight questionnaires across the three West London Boroughs could not be used as the information provided was insufficient for analysis. We cannot assign an exact number of these partial questionnaires to this Borough as postcodes and Pharmacy names were not mentioned, but through engagement numbers, we estimate this to be about 18.

Results of the Community Pharmacy Questionnaire

5.6 A total of 162 usable questionnaires were collected between 23rd Sept 2017 and 20th October 2017; 161 complete and one partial.

5.7 The two main sources of questionnaires in this sample were those returned by Adult services which were completed by their service users (74) and about 60 that were collected through

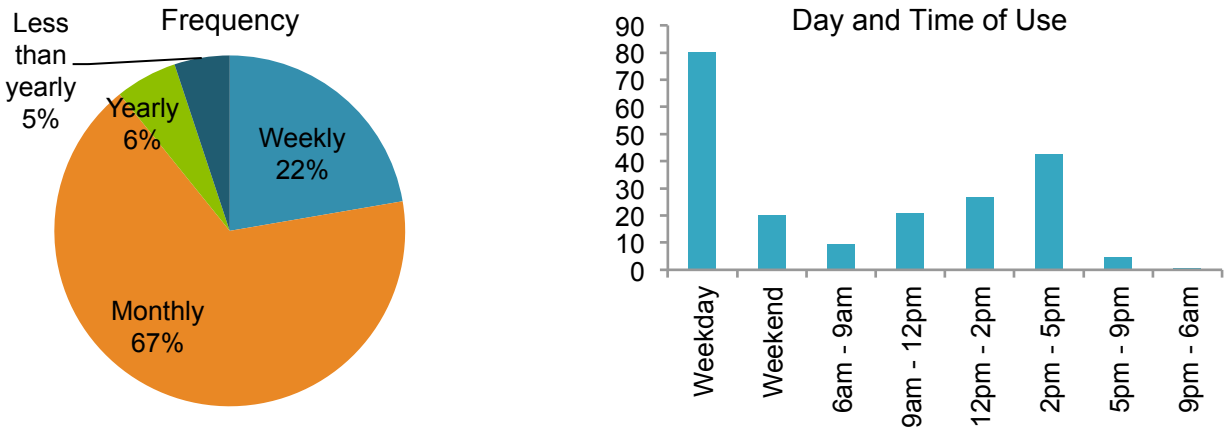
outreach at community pharmacies in Queen's Park, Harrow Road and Church Street wards. We were unable to secure outreach in South Westminster pharmacies. Community and maternity champions in Westminster encouraged their teams and service users to complete the questionnaires and we were able to engage with local residents in Westbourne Ward at an event at the Stowe Centre organised by Westbourne community champions. In addition to this online questionnaire links were disseminated through several newsletters and mailing lists.

Results of the Community Pharmacy Questionnaire

Use of Pharmacies

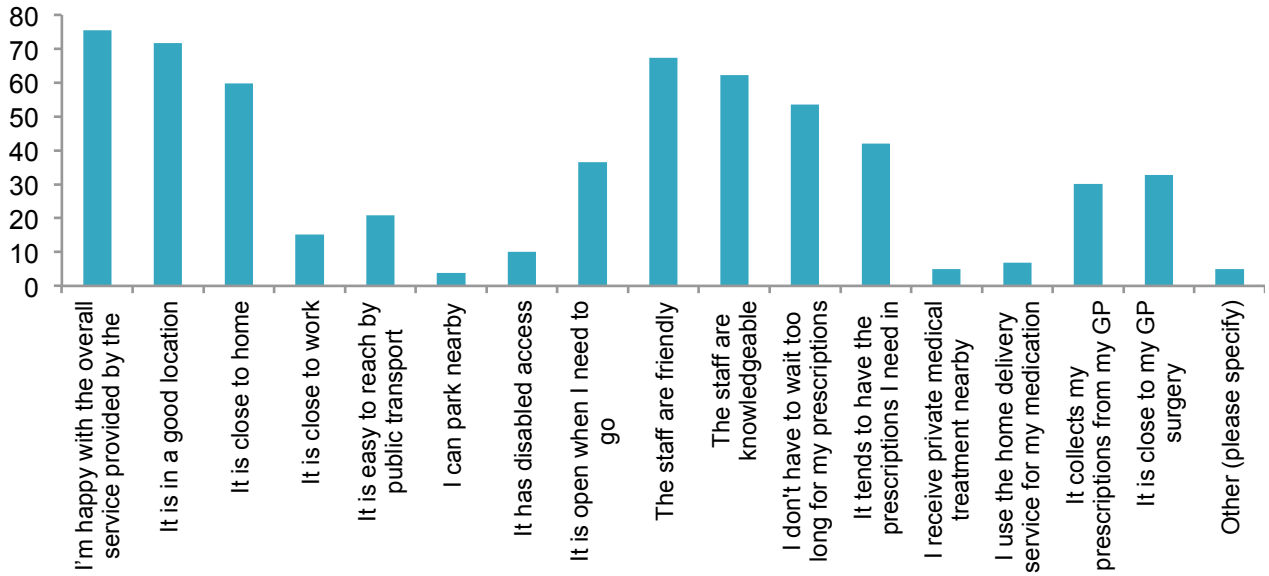
5.8 **Times and frequency** of pharmacy use was explored. 67% of the sample population visit the pharmacy monthly and 22% weekly. 80% of them used the pharmacy on weekdays and 43% visit the pharmacy between 2-5 pm (see Figure 5.1).

Figure 5.1: Times and frequency of use of Westminster pharmacies



5.9 75% of the sample population were happy with the overall service they received from the pharmacies. Friendly staff was the main reason respondents use a pharmacy. Good location was the second most important factor for people choosing a particular pharmacy. Other reasons why people chose to use their pharmacy included friendly and knowledgeable staff, closeness to home and not having to wait too long for their prescriptions (see Figure 5.2).

Figure 5.2: Reasons why people use their pharmacy most often



5.10 The **feedback** in the open text boxes was mainly positive with respondents saying they were generally happy with the services being provided and they found the staff quite friendly and helpful.

5.11 The **top three pharmacy services** used by respondents were obtaining prescription medication, repeat prescriptions, and obtaining over the counter medication.

5.12 The top three services respondents would use if provided were home delivery and prescription collection service, health checks including blood glucose, cholesterol, blood pressure and BMI (height and weight), and blood pressure measurement service.

5.13 Suggestions for improvement were mainly around longer opening hours and pharmacies being open on Sunday. A few respondents mentioned that it would be good to have basic blood tests and scans/x-rays at their local pharmacies (presented in Figure 5.3).

Figure 5.3: Word cloud of feedback from respondents on services in pharmacies.

Protected Characteristics

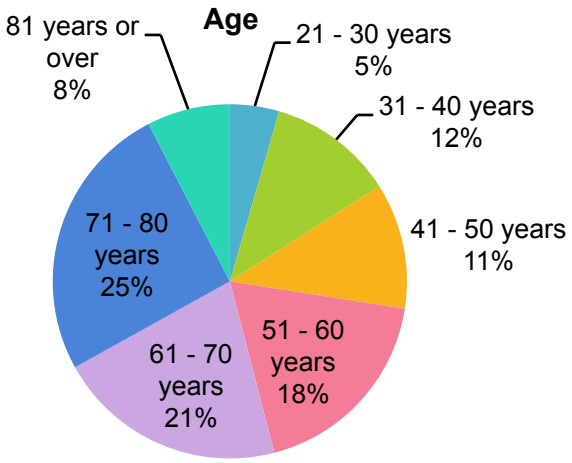
Age

5.14 The current age profile and projections of the borough are discussed in the chapter on population statistics.

5.15 Pharmacies provide essential services to all age groups such as dispensing, promotion of healthy lifestyles and signposting patients to other healthcare providers. Pharmacies providing services to vulnerable adults and children are required to be aware of the safeguarding guidance and local safeguarding arrangements.

5.16 The single biggest age group in the sample population were the 71-80 year olds at 25%, followed by the 61-70 year olds at 21%. This is probably explained by the high number of returns from adult services and the sheltered residential schemes (see Figure 5.4).

Figure 5.4: Age profile of survey respondents



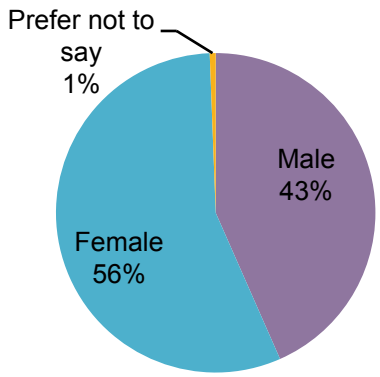
5.17 The use of pharmacies by the over 60s is similar to those of the other age groups, except that they use pharmacies more frequently.

5.18 Based on the sample that we surveyed, we did not identify any gaps in access to the provision of pharmaceutical services based on age.

Gender and gender reassignment

5.19 Eighty-nine of our respondents were female, 69 were male and one respondent did not disclose their gender. Gender reassignment was not captured on the questionnaire (Figure 5.5).

Figure 5.5: Breakdown survey respondents by Gender



5.20 As compared to women, more men in our sample use the pharmacy weekly. Men tend to use the pharmacy mainly for themselves, but a greater percentage of women use the pharmacy for their children, spouses and parents.

5.21 Other than that, the use and experience of pharmacies across genders was quite similar. Both men and women were satisfied with the overall service provided and good location was important to them when choosing their pharmacy.

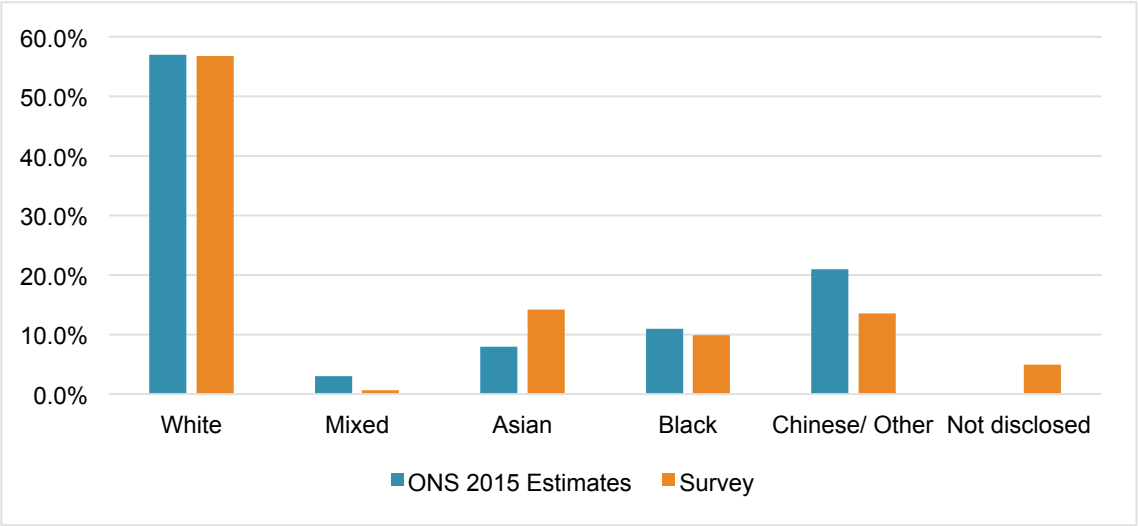
5.22 Based on the sample that we surveyed, we did not identify any gaps in access to the provision of pharmaceutical services based on gender.

Ethnicity

5.23 The ethnicity breakdown of the sample population was not very different from the general population in the borough, making the sample quite representative in this aspect (see Figure 5.6).

5.24 Ninety-two of the respondents identified as White and 62 respondents identified as belonging to Black and other ethnic minority groups. White English was the single largest ethnic group followed by Asian.

Figure 5.6: Comparison of breakdown of Ethnicity between ONS mid-year estimates and Patient and Public Survey respondents



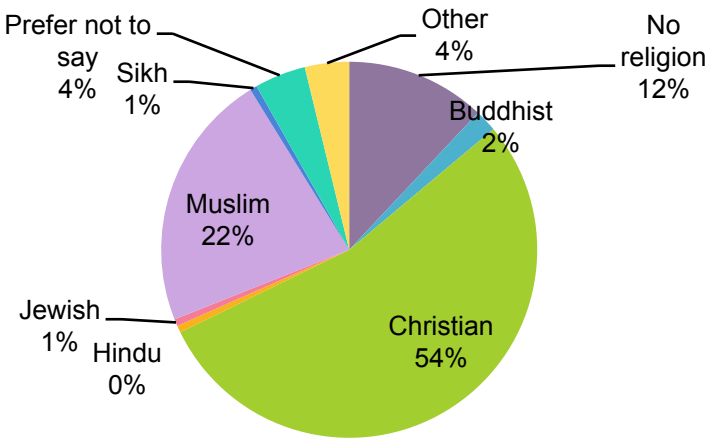
5.25 Within the sample population it was noted that respondents from BME groups were more likely to use the pharmacies for their spouses, children or parents when compared to those from White ethnic groups. Other than that, the use and experience of pharmacies did not differ between ethnic groups.

5.26 The questionnaire responses have not identified any gaps in access to the provision of pharmaceutical services to the different ethnic groups.

Religion and belief

5.27 The City of Westminster has a diverse population as noted in previous chapters and multiple religions are practiced within the borough. Eighty-five respondents identified as Christian, 35 as Muslim and 19 as having no religion (see Figure 5.6).

Figure 5.6: Breakdown of religion of survey respondents



5.28 No differences were noted in the experience and use of the pharmacies based on religion and relief and no gaps have been identified in the provision of services with respect to faith or belief.

Employment Status

5.29 Seventy-four respondents were retired, 40 employed (either part or full time), 34 unemployed and two were students.

5.30 Employed respondents use the pharmacies on the weekend more than those who are unemployed or retired. Other than that, no significant differences are noted in the use and overall experience of local pharmacies.

5.31 Retired respondents are overall quite happy with the services being provided and are less likely to want new services. Other than that no significant differences were noted and no gaps in the provision of pharmacy services were identified.

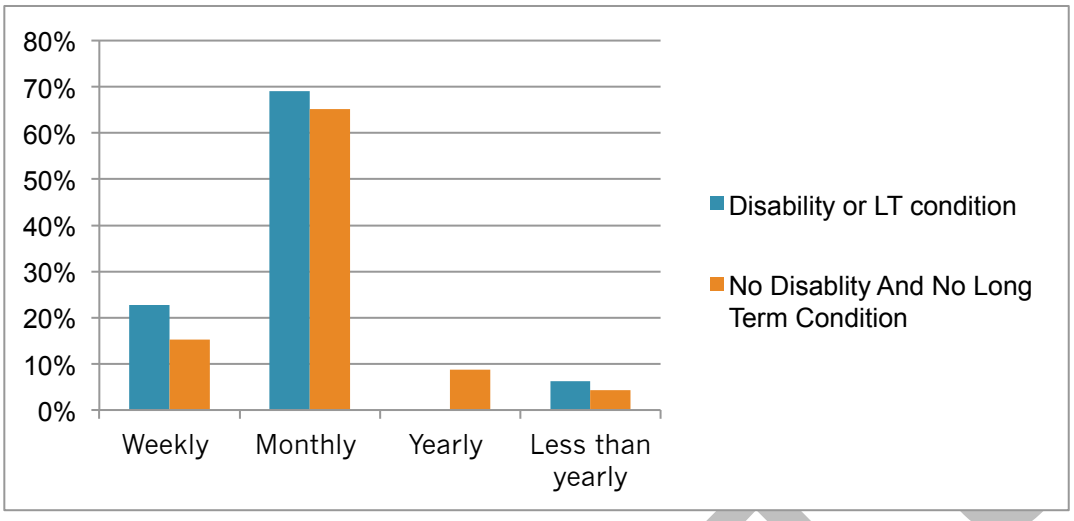
Disability and Long-Term Conditions

5.32 All pharmacies must comply with the Disability Discrimination Act 1995 (now superseded by the Equality Act 2010). Pharmacy contractors may have assessed the extent to which it would be appropriate to install hearing loops, or provide access ramps wide aisles to allow wheelchair access. Accessible information formats are alternatives to printed information, used by blind and partially sighted people, or others with a print impairment.

5.33 Fifty-seven identified as having a disability and 94 said they had a long-term condition. Fifty-four said they had both a long-term condition and a disability. Types of disability listed by participants ranged from those impacting on mobility such as osteoarthritis and stroke to sensory impairments and mental health disorders such as bipolar. In terms of long-term conditions, ten respondents mentioned diabetes as a stand alone or with other co-morbidities. Heart disease, blood pressure were the second most mentioned long-term conditions.

5.34 The frequency of pharmacy use by the group with disability and long-term conditions is mainly weekly and monthly. Yearly or less than yearly use is lower in this group as compared to the rest of the sample population (see Figure 5.7).

Figure 5.7: Frequency of pharmacy use by survey respondents with and without a long-term condition or disability



5.35 Their overall satisfaction of using pharmacy services was similar to the rest of the sample and their top criteria for choosing the pharmacy they visited was whether the pharmacies were meeting their overall need and their location. There were no comments on disability specific access requirements by the respondents themselves. The top three services being used and will use if available were in line with the whole sample.

5.36 Survey responses identified no gaps in the provision of pharmacy services for people with disabilities or long-term conditions.

Sexual orientation

5.37 127 respondents identified as heterosexual, eight as LGBT and 15 respondents preferred not to disclose their sexual orientation. The sample size was too small to comment on any differences in the use of pharmacies by people of different sexual orientations. No gaps in the provision of pharmacy services were identified for this protected characteristic.

Marital Status

5.38 Eight-four respondents identified themselves as single, 53 as married, five as co-habiting and three in a civil partnership.

5.39 No differences were noted in the use and experience of those who are single and those who are married, co-habiting or in a civil partnership and therefore there were no identified gaps in service provision.

Pregnancy and maternity

5.40 Our sample had only five respondents (3.4%) who were pregnant or breastfeeding. The sample size is too small to note any differences in their use or experience of using community pharmacies and therefore no gaps in service provision were identified.

5.41 The patient and public engagement undertaken as part of the PNA 2018-2021 process, shows that the current provision of pharmaceutical services is sufficient to meet the current needs of the population.

Summary of the Patient and Public Engagement and the Protected Characteristics

Patient and public engagement was undertaken to understand how people use their pharmacies, what they use them for and their views of the pharmacy provision. It included an exploration of the health needs specific to protected characteristics and vulnerable groups.

Findings showed that generally people are happy with the pharmacy services in the borough and found staff to be friendly. Respondents mostly use the pharmacies for obtaining prescription medication, repeat prescriptions and obtaining over the counter medication.

The top three services respondents would use if provided were health checks and home delivery and prescription collection services.

Suggestions for improvement included providing longer opening hours, more Sunday opening hours and option of basic blood tests and scans/x-rays at their local pharmacies.

Overall findings show that the pharmacy provision is sufficient for supplying a necessary service with no gaps in the borough.

Chapter 6- Access to Pharmaceutical Essential Services

6.1 All pharmacy contractors must provide Essential services, but they can choose whether they wish to provide Advanced, Enhanced or Locally Commissioned services. All pharmacies are required to deliver and comply with the specifications for all essential services, these are:

a. Dispensing
b. Repeat dispensing
c. Disposal of waste medicines
d. Support for self-care
e. Public health
f. Signposting
g. Clinical governance

6.2 This chapter assesses of the adequacy of provision of essential services by considering:

h. Distribution and choice
i. Geographical distribution of pharmacies, within and outside the borough
j. Distribution in relation to health services and transport links
k. Opening hours
l. Accessibility

Pharmacy Distribution and Choice

6.3 There are currently 93 pharmacies in Westminster as of October 2017. These have been marked on Figure 6.1, listed in Appendix D. One of these pharmacies (Bullen & Smears) is not considered a community pharmacy as it is an appliance-only contractor and therefor excluded from much of the analysis in the PNA.

6.4 Central Pharmacy (ODS code FLH24) is listed in the NHS England pharmaceutical list as being part of Kensington & Chelsea though geographically it lies within Westminster borough. For the purposes of this PNA, it has been considered as part of Westminster.

6.5 Day Lewis pharmacy on the other hand, is listed as being part of the Westminster in the NHS list but in actual fact lies within Kensington and Chelsea and so is excluded from the list of pharmacies in Westminster.

6.6 There are 38 community pharmacies per 100,000 resident population within Westminster (based on a 2018 population estimate of 241,952). This is almost twice the London and England averages, both of which are 22 (General Pharmaceutical Services in England 2006/07 to 2015/16). The high density of pharmacies is well suited to meet the demand from the daily influx of the commuting population during weekdays.

6.7 The PNA examines the geographical accessibility of pharmaceutical services and has hence used the postcode of the pharmacy to consider which borough the pharmacy belongs to. Due to use of a 500m radius buffer, the services that these pharmacies provide are still taken account of for the Westminster PNA.

6.8 There are 48 pharmacies outside the Westminster located within 500m of its border. These have been included in the pharmacies shown in Figure 6.1 and also in Appendix D.

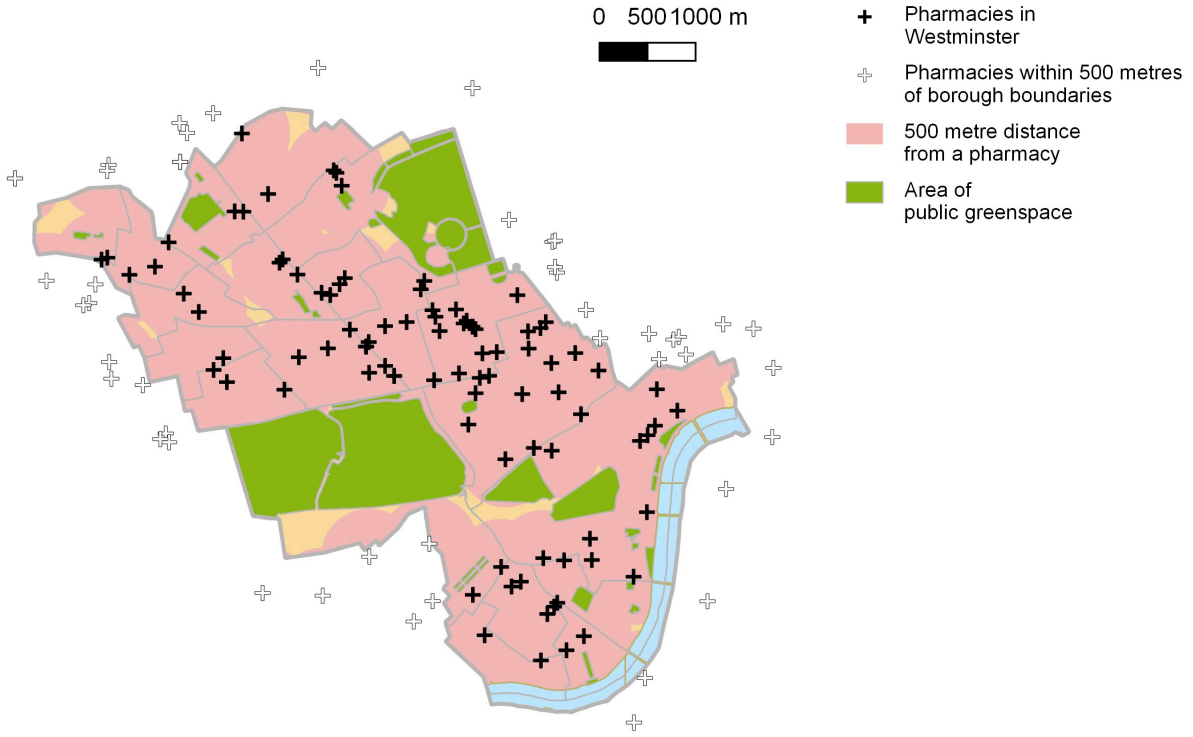
6.9 The geographical distribution of the pharmacies by electoral ward is shown in Figure 6.1 and Table 6.1. All electoral wards have a pharmacy within them.

6.10 As seen on Figure 6.1, a 500m radius buffer has been drawn from the centre of each pharmacy postcode. This shows that most of the borough is within 500m of at least one pharmacy. The small areas not within a 500m radius of a pharmacy are only a short distance further from a pharmacy either within or outside the borough.

6.11 There is one distance selling pharmacy based within Westminster (Pharmacierge). There are no dispensing doctors, mail order or internet based pharmacies in the borough.

6.12 As per the contractor survey responses, 31 pharmacies in Westminster have a Local Pharmaceutical Service (LPS) contract with NHS England as of October 2017. 13 pharmacies are entitled to Pharmacy Access Scheme payments.

Figure 6.1: Distribution of pharmacies in Westminster and within 500 meters of the borough boundaries, with 500 meter radius coverage



Source: Contractor Survey and NHS England, 2017

Table 6.1: Distribution of pharmacies by ward

Westminster Ward	Number of Pharmacies	Westminster Ward	Number of Pharmacies
West End	16	Lancaster Gate	3
Marylebone High Street	12	Little Venice	3
St James's	11	Knightsbridge and Belgravia	2
Hyde Park	9	Churchill	2
Warwick	6	Westbourne	2
Bryanston and Dorset Square	5	Abbey Road	2
Church Street	4	Tachbrook	2
Regent's Park	4	Bayswater	1
Harrow Road	3	Vincent Square	1
Maida Vale	3	Queen's Park	1

Source: Contractor Survey and NHS England, 2017

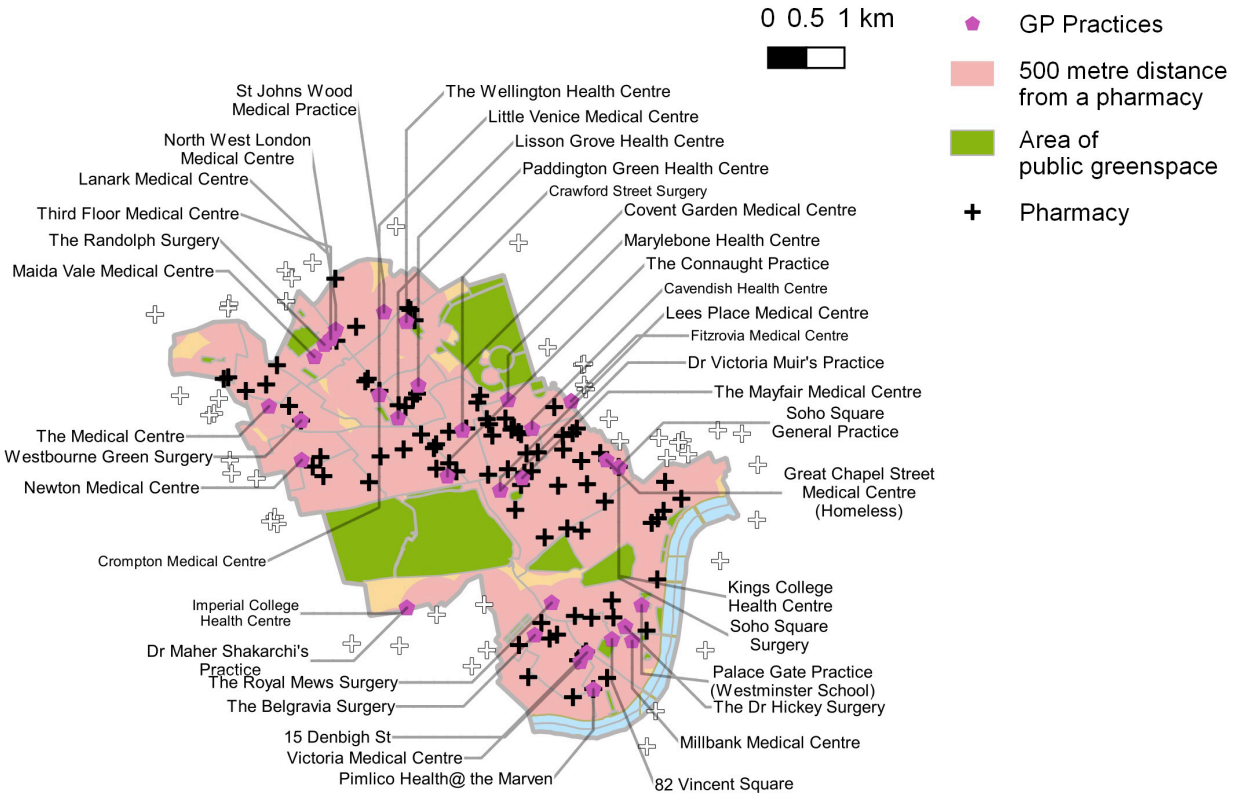
Pharmacy Distribution in relation to Primary Care

6.13 The NHS Central London Clinical Commissioning (CL CCG) Group was set up in 2013 following the Health and Social Care Act of 2012. CL CCG is responsible for the planning and commissioning of health services for people living in Westminster or registered with Westminster GP practices (apart from Queen's Park and Paddington, which is covered by West London CCG).

6.14 Its aim is to improve the care provided to patients, reduce health inequalities and raise the quality and standards of GP practices within its allocated budget.

6.15 Altogether there are 39 GP practices located within Westminster, these are displayed in Figure 6.2, which shows that there is a pharmacy within 500 meters of all GP practices in the borough.

Figure 6.2. GP practices in Westminster and 500 meter pharmacy coverage, 2017

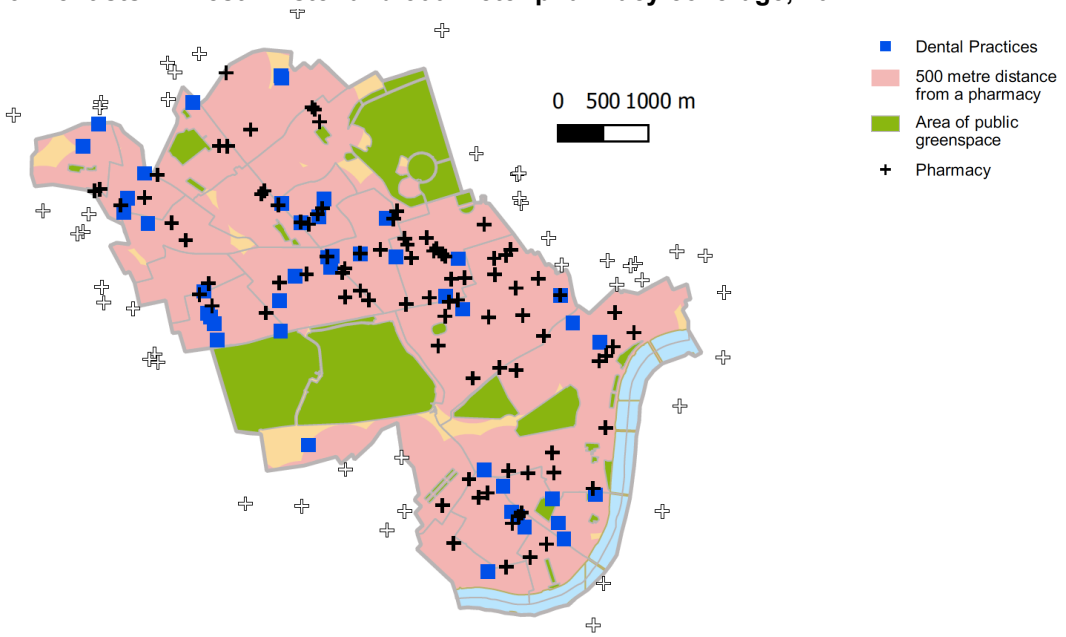


Source: Ordnance Survey, NHS England and Contractor Survey, 2017

Pharmacy distribution in relation to Dentists

6.16 There are 61 dental practices in City of Westminster area, this is a substantial increase since the previous PNA was published when there was 40 Dental Practices. Figure 6.3 shows that there is a pharmacy within 500 meters of all dentists in the borough.

Figure 6.3. Dentists in Westminster and 500 meter pharmacy coverage, 2017



Source: Ordnance Survey, NHS England and Contractor Survey, 2017

Acute Care, Mental Health Care and Community Health Services

6.17 The main secondary care provider for the Central London CCG population are Chelsea & Westminster Hospital and St. Mary's Hospitals. Mental health services are provided by Central and North West London Mental Health NHS Foundation Trust.

6.18 Central London Community Healthcare (CLCH) is the NHS community healthcare provider for Kensington and Chelsea. It provides range of services including adult community nursing, children and family services, rehabilitation, End of Life care and long-term condition management. They provide a walk-in centre at the Soho Centre for Health and Care for treatments for a range of conditions including:

- minor ear, nose and throat problems
- sprains and strains
- wound infections
- minor burns and scalds
- minor head injuries
- skin conditions
- minor respiratory conditions such as cough
- mild abdominal pain or discomfort

- insect and animal bites and stings
- minor eye injuries
- minor injuries to the back, shoulder and chest

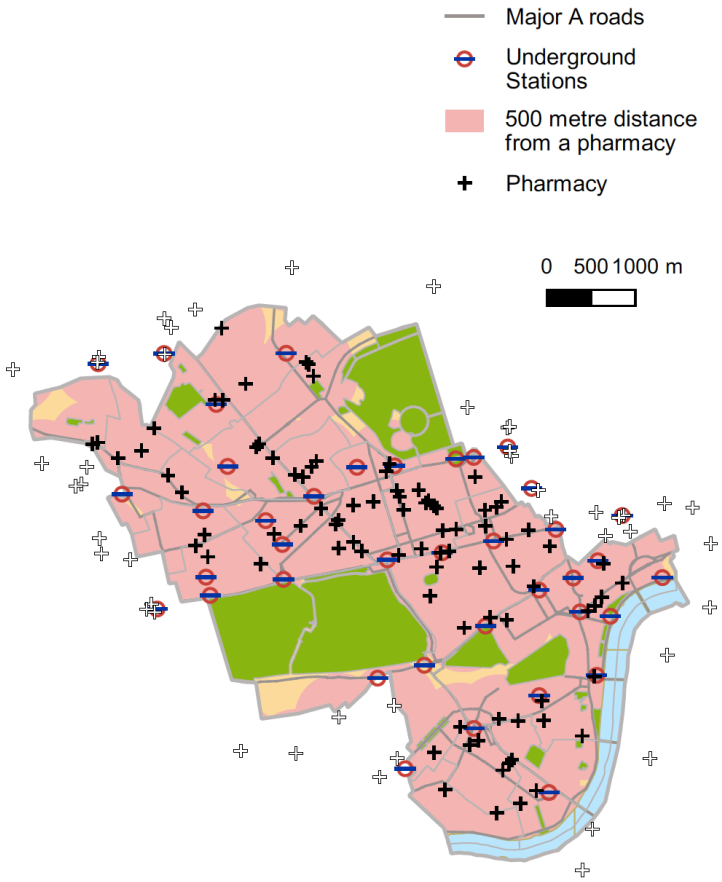
Transport Networks

6.19 The local population is not bound by electoral ward or borough boundaries when accessing pharmaceutical services. The excellent travel infrastructure available within central London places many more pharmacies, both inside and outside the borough, within convenient access to our local population.

6.20 According to the 2011 census, the main forms of transport that residents aged 16–74 used to travel to work were: underground, metro, light rail, tram (23.6%); driving a car or van (8.2%); on foot (8.2%); bus, minibus or coach (8.0%); work mainly at or from home (7.0%); bicycle (3.1%); train (2.1%).

6.21 Altogether there are 31 tube and rail stations in Westminster, all of which are within 500 meters of a pharmacy (see Figure 6.4).

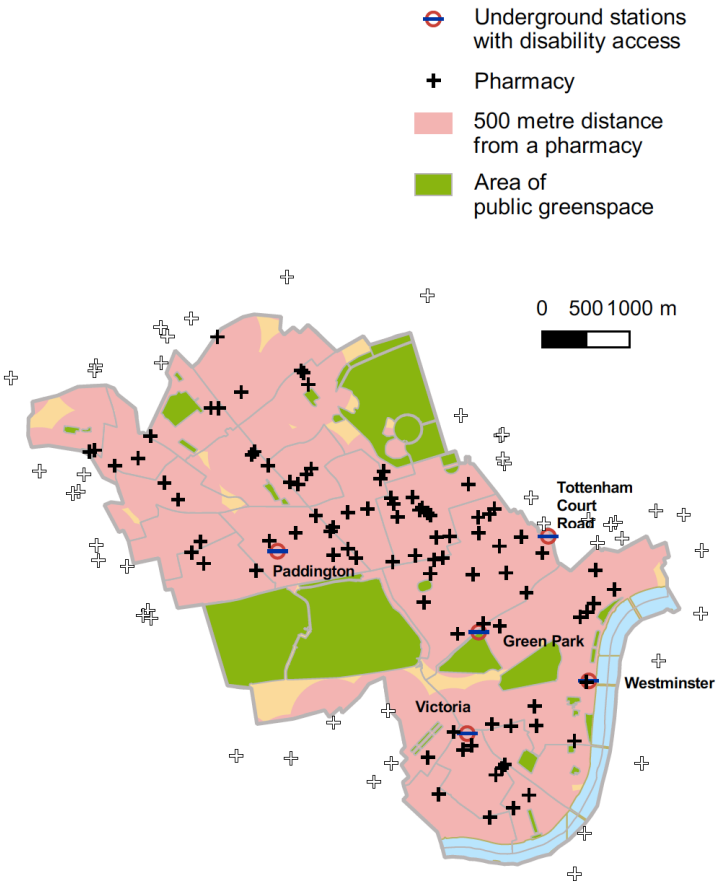
Figure 6.4 Transport links and pharmacy coverage



Source: Contractor Survey, Transport for London and NHS England, 2017

6.22 There are five Underground stations that are wheelchair accessible; these are Westminster, London Victoria, Green Park, Paddington and Tottenham Court Road, Earl's Court and Kensington (Olympia). Of these all are within 500 meters of a pharmacy. These are shown in Figure 6.5.

Figure 6.5 Tube stations that are wheelchair accessible and pharmacy coverage



Source: Contractor Survey, Transport for London and NHS England, 2017

Parking

6.23 Only five of the 80 pharmacies that responded have free car parking. Sixty-five have paid car parking nearby. Forty-three pharmacies have disabled parking close to the premises. All major A roads are within 500 meters of a pharmacy (see Figure 6.4).

Opening times

6.24 Pharmacy contracts with NHS England stipulate the core hours during which each pharmacy must remain open. A pharmacy may stay open longer than the stipulated core opening hours, these are called supplementary hours.

6.25 Opening times were obtained from NHS England in August 2017. Additionally, marketing entry updates to the NHS England pharmaceutical list were reflected on the original list. Opening times were also collected as a part of the pharmacy contractor survey.

6.26 This PNA has used the core and supplementary hours reported by pharmacies from the contractor survey to produce the figures below. For pharmacies that did not respond and for pharmacies in surrounding boroughs, we have used the opening times as held by NHS England on October 2017.

6.27 NHS England has seven 100-hour pharmacies (core) on their list for Westminster. They are listed in Table 6.2 below.

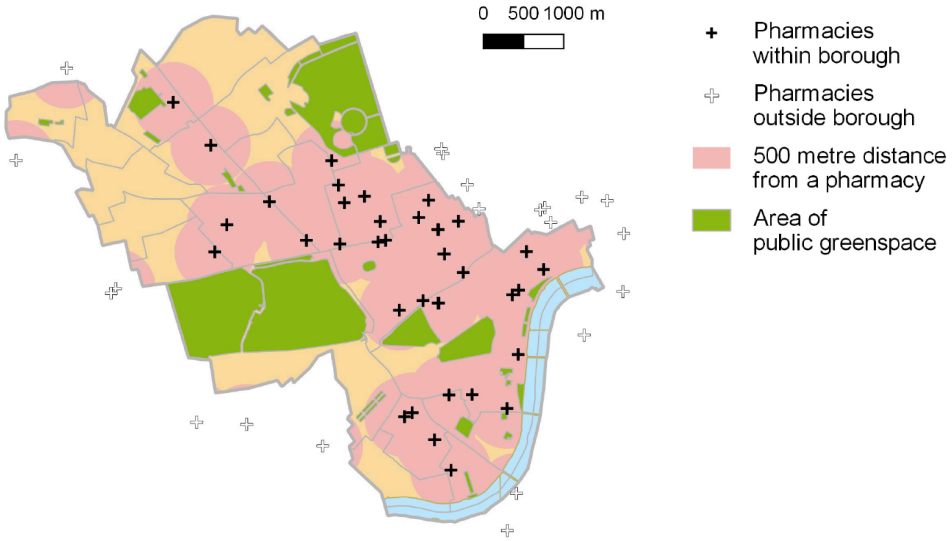
Table 6.2: 100 hour pharmacies

Pharmacy	Address	Ward
Devonshire Pharmacy	215 Edgware Road	Hyde Park
Nasslam Pharmacy	19 Edgware Road	Hyde Park
Nashi Pharmacy	55 Westbourne Grove, Bayswater	Lancaster Gate
Boots The Chemist	100 Oxford Street	West End
Bin-Seena Pharmacy	73 Edgware Road	Hyde Park
Alrasheed Pharmacy	39 Edgware Road	Hyde Park
Safeer Pharmacy	194 Edgware Road	Bryanston and Dorset Square

Source: Contractor Survey and NHS England, 2017

6.28 Thirty-five pharmacies are open before 9am on weekdays within the borough with a further 21 open in boroughs around Westminster within 500m outside the border. These are presented in Figure 6.6 and Table 6.3.

Figure 6.6: Pharmacies that are open before 9am on a weekday



Source: Contractor Survey and NHS England, 2017

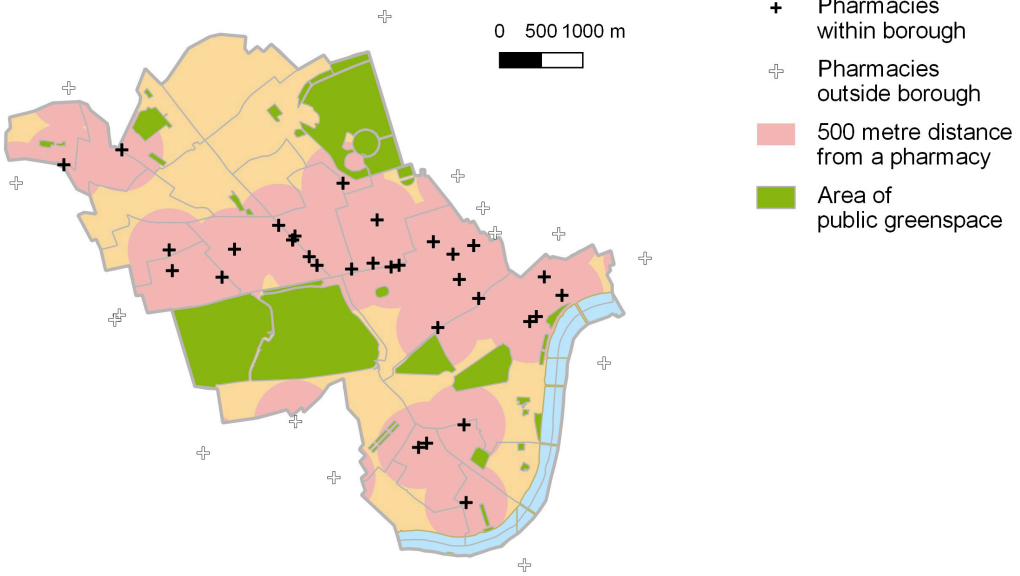
Table 6.3: Pharmacies open before 9am on weekdays by ward

Westminster Ward	Number of Pharmacies	Westminster Ward	Number of Pharmacies
West End	10	Maida Vale	1
St James's	8	Vincent Square	1
Marylebone High Street	4	Regent's Park	1
Warwick	3	Lancaster Gate	1
Hyde Park	3	Little Venice	1
Bryanston and Dorset Square	1	Tachbrook	1

Source: Contractor Survey and NHS England, 2017

6.29 There are 33 pharmacies still open after 7pm on weekdays with a further 15 in other boroughs within 500m of Westminster (see Figure 6.7 and Table 6.4).

Figure 6.7: Pharmacies that are open after 7pm on weekdays



Source: Contractor Survey and NHS England, 2017

Table 6.4: Pharmacies closing after 7pm by ward

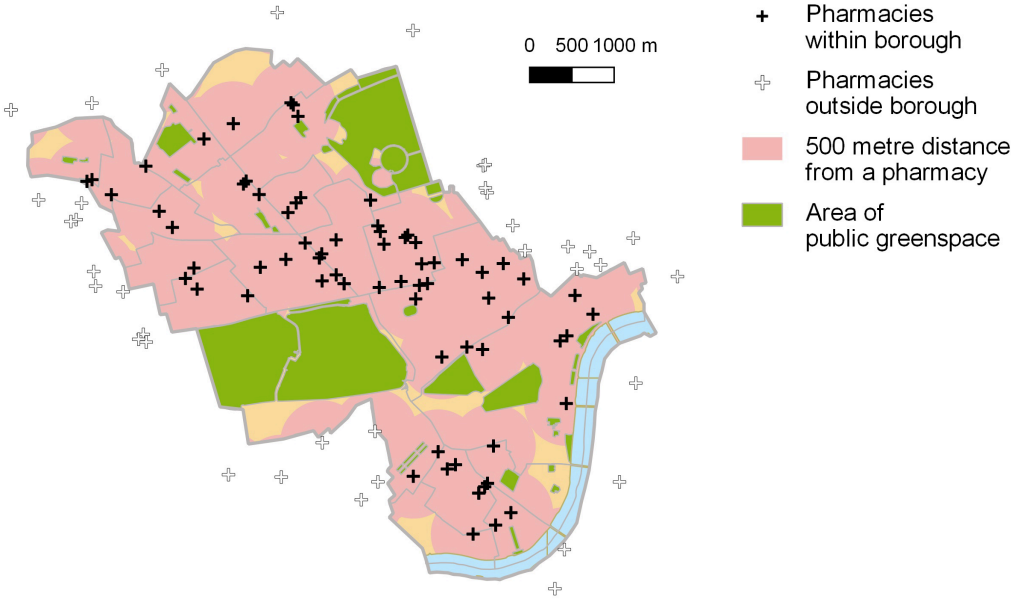
Westminster Ward	Number of Pharmacies	Westminster Ward	Number of Pharmacies
West End	8	Marylebone High Street	2
Hyde Park	7	Vincent Square	1
St James's	4	Bayswater	1

Warwick	2	Maida Vale	1
Bryanston and Dorset Square	2	Harrow Road	1
Lancaster Gate	2	Regent's Park	1
Tachbrook	1		

Source: Contractor Survey and NHS England, 2017

6.30 A vast majority of the pharmacies in Westminster are open on Saturday (72/92). A further 39 outside the borough but within 500m of Westminster are open on Saturday (Figure 6.8 and Table 6.5).

Figure 6.8 Pharmacies open on Saturday and 500-meter coverage



Source: Contractor Survey and NHS England, 2017

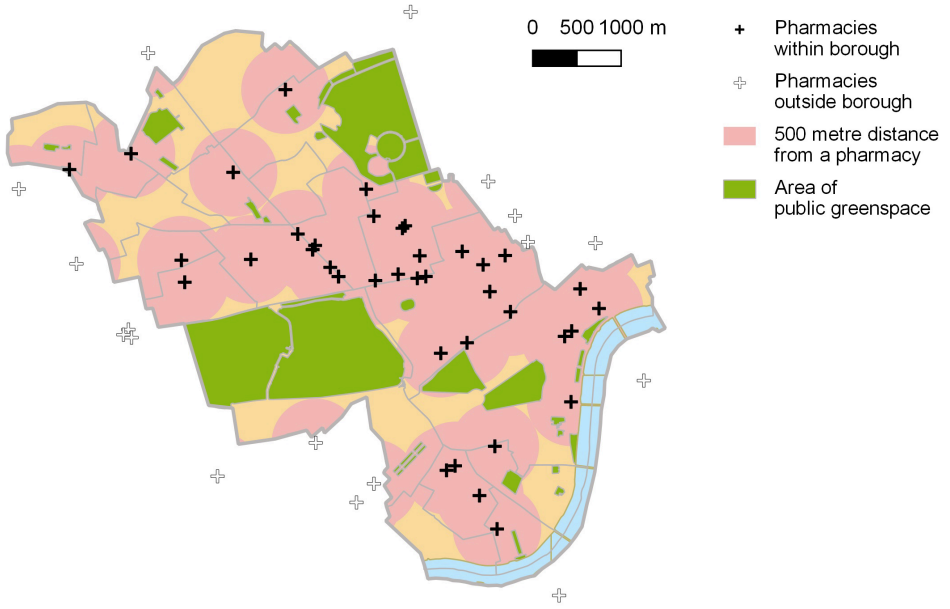
Table 6.5: Pharmacies open on Saturday by ward

Westminster Ward	Number of Pharmacies	Westminster Ward	Number of Pharmacies
West End	11	Tachbrook	2
Marylebone High Street	9	Maida Vale	2
Hyde Park	9	Westbourne	2
Warwick	6	Harrow Road	2
St James's	6	Knightsbridge and Belgravia	2
Regent's Park	4	Abbey Road	1
Bryanston and Dorset Square	3	Bayswater	1
Church Street	3	Queen's Park	1
Lancaster Gate	3	Vincent Square	1
Little Venice	3	Churchill	1

Source: Contractor Survey and NHS England, 2017

6.31 There are 40 pharmacies open on a Sunday within the borough with a further 17 open in boroughs around Westminster within 500m of the border (Figure 6.9, Table 6.6).

Figure 6.9: Pharmacies open on a Sunday and their 500 meter coverage



Source: Contractor Survey and NHS England, 2017

Table 6.6: Pharmacies open on Sunday by ward

Westminster Ward	Number of Pharmacies	Westminster Ward	Number of Pharmacies
West End	9	Tachbrook	1
Hyde Park	7	Lancaster Gate	1
Marylebone High Street	5	Vincent Square	1
St James's	5	Harrow Road	1
Warwick	3	Little Venice	1
Regent's Park	2	Bayswater	1
Bryanston and Dorset Square	2	Maida Vale	1

Source: Contractor Survey and NHS England, 2017

Appliance contractors

6.32 Appliance contractors provide services to people who need appliances such as stoma and incontinence care aids, trusses, hosiery, surgical stockings and dressings. They range from

small sole-trader businesses to larger companies. They do not supply drugs. However, pharmacies and dispensing doctors can also supply appliances.

6.33 There are is one appliance-only contractors in Westminster: Bullen & Smears on Broadwick Street

6.34 Forty-six of the pharmacies that responded to the survey supply stoma care aids with a further six intending to begin within the next 12 months.

6.35 Fifty-one of the pharmacies that responded to the survey supply incontinence aids with another four intending to begin within the next 12 months.

6.36 Sixty-six of the pharmacies that responded to the survey supply dressings with none intending to begin within the next 12 months.

Communication

6.37 Pharmacies hire staff from a variety of ethnic backgrounds and who speak a variety of languages. The most common **languages** spoken other than English in Westminster pharmacies are Gujarati, Hindi and Arabic.

Table 6.7: Top 10 languages spoken by a member of staff at the pharmacies in Westminster

Language	Number of Pharmacies
Gujarati	42
Hindi	37
Arabic	29
Urdu	17
Swahili	16
Spanish	16
Bengali	15
French	13
Italian	13
Polish	12

Source: Contractor Survey, 2017

6.38 The top three languages spoken by residents in the borough (other than English) are French, Arabic and Spanish. All of these are spoken by at least one member of staff from a range of pharmacies across the borough. Table 6.7 lists the most common languages spoken by a member of staff in the pharmacies that responded to the survey.

Consultation Rooms

6.39 Ideally, pharmacies should have consultation areas or rooms with wheelchair access in order to be able to offer a broad range of services.

6.40 Sixty-six of the community pharmacies that responded to the survey reported having a clearly signposted private consulting room. 4 pharmacies report having an offsite consulting room/area.

6.41 Sixty-four of the pharmacies report having consulting rooms that comply with MUR/NMS requirements with six more planning some for the future.

6.42 Sixty-five pharmacies report having **hand washing facilities** close to the consultation room. Patients have access to **toilet facilities** in 24 pharmacies.

Disability Access

6.43 Fifty-two of the pharmacies with a consultation room indicated that they were **accessible to wheelchair users** and another four are planning for such access.

6.44 Accessible information formats are alternatives to printed information, used by blind and partially sighted people, or others with a print impairment. More than half of the pharmacies that responded to the survey provide **printed information in large print format** (46/80) and 34 provide it in **Easy Read format**. Three pharmacies within the borough provides information in **Braille**.

Collection and Delivery of medication

6.45 **Repeat dispensing** allows patients to collect their repeat prescriptions from a pharmacy without having to request a new prescription from their GP. The benefits of repeat dispensing include reduction of medicine waste, reduction in GP practice workload, improved predictability of pharmacy workload and greater convenience for patients. Thirty-four of the pharmacies surveys reported that they offer a repeat prescription service.

6.46 Pharmacies in Westminster further improve access by providing delivery services to the local population. Seventeen of the pharmacies surveys reported that they **deliver dispensed medicines**, free of charge (see Table 6.8).

Table 6.8: Collection of prescriptions and delivery of medication

Type of collection or delivery service	Number of pharmacies
Collection of prescriptions from surgeries	57
Delivery of dispensed medicines - free of charge on request	43
Delivery of dispensed medicines - free of charge to selected patient groups only	42
Delivery of dispensed medicines - chargeable	19

Source: Contractor Survey, 2017

Information Technology

6.47 IT can improve high quality care by enabling storage accessibility of patient records, electronic prescribing and improve medicines management. Twenty-seven of the pharmacies surveyed reported to have access to an **IT system** within the consultation room and another six more are intending one within the next 12 months. Five of these pharmacies have access to patient records from this IT system.

6.48 Seventy of the surveyed pharmacies are currently **Release 2** enabled, with two others intending to be enabled in the next 12 months.

6.49 45 pharmacies reported that they have access to **Microsoft Office applications** and 33 pharmacies have access to **NHS.net email**.

Summary of necessary services: current provision (Schedule 1, paragraph 1) Necessary services: gaps in provision (Schedule 1, paragraph 2)

Necessary services are fundamental for patients to obtain prescribed medicines in a safe and reliable manner. All pharmacies are required to deliver and comply with the specifications for all essential services.

Dispensing NHS prescriptions, access (both location and hours of opening) and facilities (including provision of suitable consultation areas and disability access) were considered in the evaluation of essential services for this PNA.

The Westminster Health and Wellbeing Board believes that the range of opening hours, options for delivery of medications and the close proximity of pharmacies to local residents and transport facilities is **sufficient for supplying a necessary pharmaceutical service with no gaps in the borough.**

Chapter 7- Advanced, Locally Enhanced and Locally Commissioned Services Provided by Pharmacies

Categorisation of pharmaceutical services

7.1 Pharmaceutical services in relation to PNAs include:

- **Essential services** which every community pharmacy providing NHS pharmaceutical services must provide and is set out in their terms of service
- **Advanced services** - services community pharmacy contractors and dispensing appliance contractors can provide subject to accreditation as necessary
- **Locally Enhanced Services** - services commissioned locally by NHS England's area teams
- **Other Locally Commissioned Services** - Public Health Services commissioned by the Local Authorities in order to meet the needs of the population.

7.2 The categorisation of these services into those stipulated by the PNA regulations (defined in Chapter 1) for Westminster are summarised in Table 7.1 below.

Table 7.1: Summary of categorisation of services into those stipulated by PNA regulations

Necessary services: current provision (Schedule 1, paragraph 1)	**Necessary services: gaps in provision (Schedule 1, paragraph 2)**
Essential Services (see Chapter 6)	No gaps in provision of necessary services (see Chapter 6)
Other relevant services: current provision (Schedule 1, paragraph 3)	
• Medicine Use Review service • New Medicine Service • Appliance Use Reviews • Stoma Appliance Customisation Service	
Other services (Schedule 1, paragraph 5)	
• Flu Vaccination -NHS • Minor Ailment Schemes • End of Life Care service • Care Home Advice service • Medicines Assessment and Compliance Support Service • NHS Health Checks • Supervised Administration • Needle Exchange Services • Stop Smoking Services • Emergency Hormonal Contraception • Alcohol Misuse Services	

• Weight Management Services • Other Sexual Health Screening and Treatment Services
Improvements and better access: gaps in provision (Schedule 1, paragraph 4)
There are no gaps in provision of services.

7.3 This chapter outlines the Other Relevant Services, Other Services and Improvements and better access of pharmacy services in Westminster.

Other Relevant Services: current provision (Schedule 1, paragraph 3).

There are four services within the NHS community pharmacy contractual framework considered relevant. Community pharmacies can choose to provide any of these services as long as they meet the requirements set out in the Secretary of State Directions.

Medicines Use Reviews (MURs)

7.4 The Medicines Use Review and Prescription Intervention Service (MUR) as part of the community pharmacy contractual framework was the first advanced service to be introduced. The purpose of the MUR service is, with the patient's agreement, to improve their knowledge and use of medicines, through a specific consultation between the pharmacist and the patient. In particular, by:

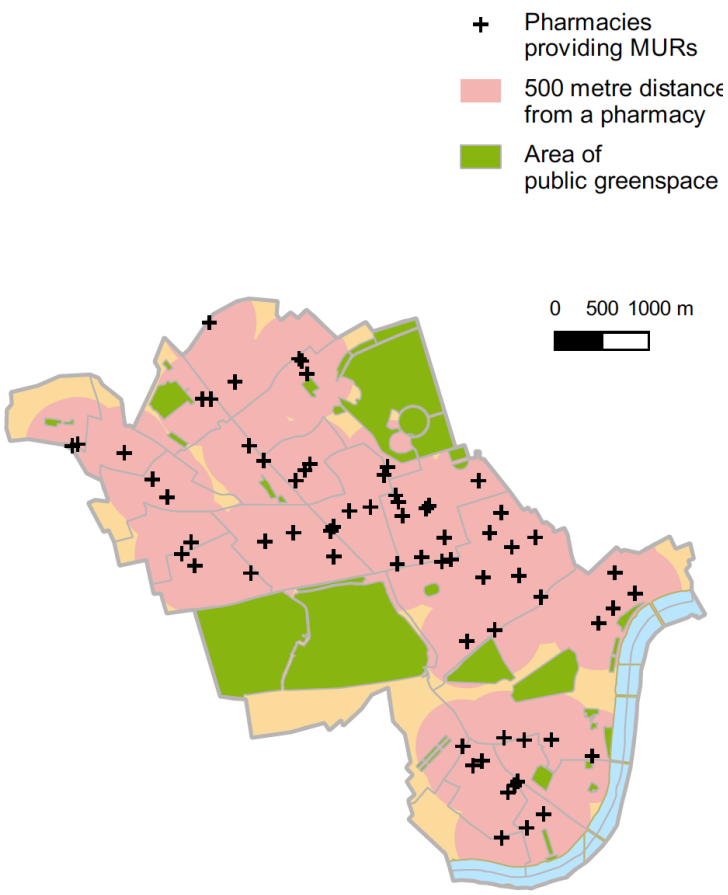
- establishing the patient's actual use, understanding and experience of taking medicines
- identifying, discussing and resolving poor or ineffective use of medicines
- identifying side effects and drug interactions that may affect the patient's compliance with the medicines prescribed for them
- improving clinical and cost effectiveness of medicines prescribed also helping to reduce medicines wastage

7.5 MURs improve adherence with the prescribed regimen, help to manage risks related to poor medicines management and therefore improve patient outcomes and reduce hospital admissions.

7.6 Sixty-two pharmacies in the borough that responded to survey reported proving MURs with a further seven indicating they were intending to do so in the next 12 months. Some of the respondents did not fill out this section of the questionnaire so NHS England data was used to supplement the data indicating that in total 68 pharmacies in the borough provide an MUR service. These Pharmacies and their reach are displayed in Figure 7.1 and listed in Appendix D)

7.7 Given the wide distribution of MUR services across the borough the Health and Wellbeing Board are satisfied that there is sufficient for supplying a relevant service with no gaps.

Figure 7.1: Pharmacies that provide MURs in the Westminster and their 500 meter coverage, October 2017



Source: Contractor Survey and NHS England, 2017

New Medicines Services (NMS)

7.8 The New Medicine Service (NMS) supports patients with long-term conditions, who are taking a newly prescribed medicine, to help improve medicines adherence. The service is focused on the following patient groups and conditions:

- asthma and chronic obstructive pulmonary disease (COPD)
- type 2 diabetes
- antiplatelet/anticoagulant therapy
- hypertension

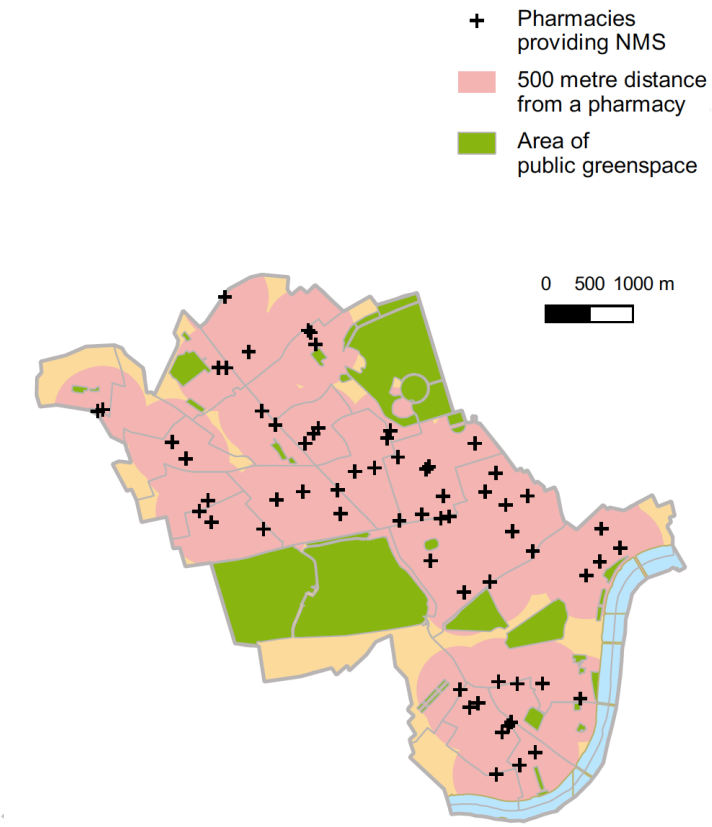
7.9 This service is designed to improve patients' understanding of a newly prescribed medicine for their long-term condition, and help them get the most from the medicine.

7.10 New Medicines Service can only be provided by pharmacies only and is conducted in a private consultation area to ensure patient confidentiality.

7.11 Fifty-nine pharmacies that responded to the survey said they provide NMSs with another four indicating they were intending to do so in the next 12 months. Some of the respondents did not fill out this section of the questionnaire so NHS England data was used to supplement the data, indicating that in total 64 pharmacies in the borough provide an NMS service. These are presented in Figure 7.2 and listed in Appendix D.

7.12 NMS are supplied widely across the borough, therefore the Health and Wellbeing Board are satisfied that this is sufficient for supplying a relevant service with no gaps.

Figure 7.2: Pharmacies that provide NMS in Westminster and their 500 meter coverage, October 2017



Source: Contractor Survey and NHS England, 2017

Appliance Use Reviews (AURs)

7.13 Appliance Use Review (AUR) is another advanced service that community pharmacy and appliance contractors can choose to provide so long as they fulfil certain criteria.

7.14 AURs can be carried out by, a pharmacist or a specialist nurse either at the contractor's premises or at the patient's home. AURs help patient's to better understand and use their prescribed appliances by:

- Establishing the way the patient uses the appliance and the patient's experience of such use

- Identifying, discussing and assisting in the resolution of poor or ineffective use of the appliance by the patient
- Advising the patient on the safe and appropriate storage of the appliance
- Advising the patient on the safe and proper disposal of the appliances that are used or unwanted

7.15 Currently four of the pharmacies that responded to the survey provide AURs with 19 intending to begin within the next 12 months (outlined in Table 7.2 and detailed in Appendix D). There is only one appliance only contractors in Westminster.

7.16 Three pharmacies in West End and one in Westbourne, on the east side of the borough provide AURs. Given the flexibility of how this service can be delivered, and the low volume of use, the Health and Wellbeing board are satisfied that the AUR service is sufficient for supplying a relevant service with no gaps.

Table 7.2: Locations of AUR provision by ward in Westminster, October 2017

Westminster Ward	Number of Pharmacies
West End	3
Westbourne	1

Source: Contractor Survey and NHS England, 2017

Stoma Appliance Customisation service (SAC)

7.17 The SAC service involves the customisation of a quantity of more than one stoma appliance, based on the patient's measurements or a template. The aim of the service is to ensure proper use and comfortable fitting of the stoma appliance and to improve the duration of usage, thereby reducing waste.

7.18 Four of the pharmacies that responded to the survey provide SACs (outlined in Table 7.3 and detailed in Appendix D) with 12 intending to begin the service within the next 12 months.

Table 7.3: Locations of SAC provision by ward in Westminster, October 2017

Westminster Ward	Number of Pharmacies
Maida Vale	2
West End	1
Little Venice	1

Source: Contractor Survey and NHS England, 2017

7.1 Residents can access the SAC service either from non-pharmacy providers within the Borough (e.g. community health services) or from dispensing appliance contractors outside of the Borough. Four pharmacies is therefore sufficient to meet the current and future needs of this borough.

Summary of Other Relevant Services: current provision (schedule 1, paragraph 3).

Community pharmacies can choose to provide any or all of the four Other Relevant Services within the NHS community pharmacy contractual framework, as long as they meet the requirements set out in the Secretary of State Directions. The advanced services are:

- Medicine Use Review service (MURs)
- New Medicine Service (NMS)
- Stoma Customisation Service (SACs)
- Appliance Use Reviews (AURs)

The number and proximity of pharmacies locally means the vast majority of residents in the borough live close to a pharmacy that provides Medicine Use Review services and New Medicine Services. The Health and Wellbeing Board believes that the **current provision of Medicine Use Review services and New Medicine Services is sufficient for supplying a relevant service with no gaps.**

Both the Stoma Customisation Service and Appliance Use Reviews are supplied by four pharmacies in the borough and can be provided by community health services and specialist nurses. In considering the low volume of use of this service the Health and Wellbeing Board are satisfied that the **Stoma Customisation Service and Appliance Use Review service is sufficient for supplying a relevant service with no gaps.**

Other Services: current provision (schedule 1, paragraph 5).

7.2 Certain enhanced services are commissioned by NHS England Regulations 2013. The responsibilities for commissioning some of the locally enhanced services under the previous regulations now sits within public health and are commissioned by Local Authorities.

7.3 The following section outlines the enhanced services currently commissioned and explores their relevance to the local population and their current and future commissioning.

Flu Vaccinations

7.4 Flu vaccination by injection, commonly known as the "flu jab" is available every year on the NHS to protect certain groups who are at risk of developing potentially serious complications, such as:

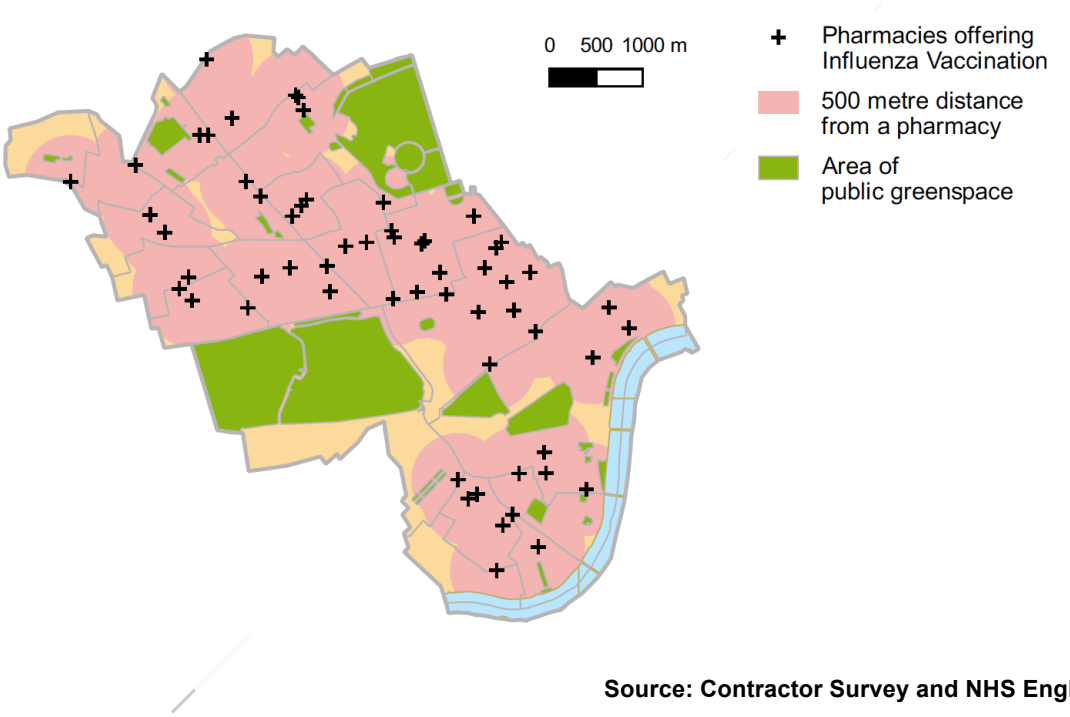
- anyone over the age of 65
- pregnant women

- children and adults with an underlying health condition (particularly long-term heart or respiratory disease)
- children and adults with weakened immune systems

7.5 GPs currently provide the majority of flu vaccinations and pharmacies can help improve access to this service given their convenient locations, extended opening hours and walk-in service.

7.6 Pharmacies have been commissioned to provide flu vaccination across the borough. Sixty pharmacies in the borough indicated in the survey that they provide a flu vaccine (Figure 7.3 and Table 7.4). Another 13 pharmacies indicated that they were willing to be commissioned to offer the vaccination.

Figure 7.3: Pharmacies that provide Flu Vaccinations in Westminster and their 500 meter coverage, October 2017



Source: Contractor Survey and NHS England, 2017

Figure 7.3: Pharmacies that provide Flu Vaccinations in Westminster by ward, October 2017

Westminster Ward	Number of Pharmacies	Westminster Ward	Number of Pharmacies
West End	10	Westbourne	2
Marylebone High Street	7	Abbey Road	2
St James's	6	Little Venice	2
Hyde Park	5	Bayswater	1
Regent's Park	4	Churchill	1
Warwick	4	Knightsbridge and Belgravia	1
Maida Vale	3	Tachbrook	1
Bryanston and Dorset Square	3	Harrow Road	1

Church Street	3	Vincent Square	1
Lancaster Gate	3		

Source: Contractor Survey and NHS England, 2017

7.7 As shown in Figure 7.3 and Table 7.4 the pharmacy provision of flu vaccination is is easily accessible throughout the borough. The Health and Wellbeing Board believes that the current provision of flu vaccinations is sufficient for supplying a relevant service with no gaps.

Minor Ailment Scheme

7.8 The Minor Ailment Scheme offers free advice and treatment for minor, self-limiting conditions such as mild skin conditions, coughs and colds and aches and pains. This service helps to relieve pressure from GPs and Secondary Care.

7.9 Fourteen pharmacies reported in the survey that they provide a Minor Ailment Scheme (see Table 7.4) and 50 reported being willing to provide the service if commissioned.

Table 7.4: Locations of Minor Ailment provision by ward in Westminster, October 2017

Westminster Ward	Number of Pharmacies	Westminster Ward	Number of Pharmacies
Marylebone High Street	2	Westbourne	1
Hyde Park	2	West End	1
Church Street	2	Maida Vale	1
Lancaster Gate	2	Abbey Road	1
St James's	1	Bayswater	1

Source: Contractor Survey and NHS England, 2017

7.10 The Minor Ailment scheme is widely spread in Westminster. Although there are no schemes in some of the more densely populated ward such as Queen's Park and Harrow road, there are schemes in the more deprived wards of the borough. In considering these factors, the Health and Wellbeing Board are satisfied that there are no gaps in the current provision of the Minor Ailment Scheme.

Out of Hours Palliative Care Drugs

7.11 In line with providing care closer to home, it is essential that there is good access to drugs used in the palliative environment for those patients choosing to die at home. Pharmacology management and support can support improvements to patients' quality of life while reducing costs and use of unnecessary medications.

7.12 Out of hours palliative care drugs is a locally enhanced service that supports this. Three pharmacies in the borough, Benson Pharmacy In Westbourne, Star Pharmacy in St. James' and Pharmacierge in West End provide this service. These pharmacies

are well positioned across the borough, additionally Pharamcierge is a distance selling pharmacy that offers access to the whole borough.

7.13 The Health and Wellbeing Board therefore identifies the provision of End of Life Care Service to be sufficient for supplying a necessary service with no gap.

The Care Home Advice Service

7.14 The Care Home Advice Service involves providing advice and support to the staff and management within the care home on medicines management, to ensure the proper and effective ordering, storage and administration of drugs and appliances and proper record keeping. This is essential as residents in care homes are often on a large number of medicines that often require additional support with compliance.

7.15 The Care Home Advice Service includes advice on medicines management, best practice guidelines and staff training and signposting.

7.16 Twelve pharmacies responded indicated that they provide Care Home Advice services (outlined in Table 7.5) and another 43 would be willing to provide advice to care homes if commissioned to do so.

Table 7.5: Locations of Care Home Advice Service provision by ward in Westminster, October 2017

Westminster Ward	Number of Pharmacies	Westminster Ward	Number of Pharmacies
St James's	2	Maida Vale	1
Marylebone High Street	2	West End	1
Westbourne	1	Bryanston and Dorset Square	1
Tachbrook	1	Little Venice	1
Lancaster Gate	1	Regent's Park	1

Source: Contractor Survey, 2017

7.17 The Health and Wellbeing Board therefore identifies the provision of the Care Home Advice Service to be sufficient for supplying a necessary service with no gap.

Medicines Assessment and Compliance Support Service

7.18 This service is available to patients who have difficulty complying with their prescribed medications. Community pharmacies assess eligible patients on their knowledge and use of their prescribed medications and the appropriate level of support they may need to help them take their medications as intended. The pharmacist may provide advice, support and assistance to the patient to improve their knowledge of their medications use or make a referral to an appropriate health or social care professional.

7.19 Eight pharmacies in the borough offer the service (detailed on Table 7.6) with a further 47 pharmacies would be willing to provide the service if commissioned.

7.20 In considering the wide distribution of this service in Westminster, the Health and Wellbeing Board identifies the provision of Medicines Assessment and Compliance Support Service to be sufficient for supplying a necessary service with no gap.

Table 7.6: Locations of Pharmacies that provide Medicines Assessment and Compliance Support Service in Westminster, October 2017

Trading Name	Address	Ward
Star Pharmacy	33 Strutton Ground	St James's
Green's Pharmacy	29-31 Ebury Bridge Road	Churchill
Sedley Place	361 Oxford Street	West End
Meacher, Higgins & Thomas	105A Crawford Street	Bryanston and Dorset Square
Madesil Pharmacie	20 Marylebone High Street	Marylebone High Street
Devonshire	215 Edgware Road	Hyde Park
Benson Pharmacy	276 Harrow Road	Westbourne
Vineyard Pharmacy	241 Elgin Avenue	Maida Vale

Source: Contractor Survey, 2017

Screening Service

7.21 Screening services within pharmacies can bring a range of benefits including identifying patients at risk of developing a specific disease or condition and providing advice, screening and signposting or referrals.

7.22 NHS Health Checks is a screening programme set up to identify the risk of vascular disease in the population early and then to help people reduce or avoid it. Generally NHS Health Checks take place as part of general practice services, yet pharmacies are also well placed to play a key role.

7.23 Eight pharmacies in Westminster indicated in the survey that they provide NHS Health Checks across the borough (see Table 7.6), while 46 more would be willing to provide the service if commissioned.

7.24 Most of the GPs in Westminster are commissioned to provide NHS Health Checks and currently pharmacies perform a very small number of health checks. The Health and Wellbeing Board identifies the level of this service to be sufficient, with no gaps.

Table 7.7: Locations of NHS Health Checks provision in Westminster, October 2017

Pharmacy	Address	Ward
Star Pharmacy	33 Strutton Ground	St James's
Portmans Pharmacy	93-95 Tachbrook Street	Tachbrook
Simmonds Pharmacy	105 Lupus Street	Churchill
Keencare Pharmacy	6 Lower Belgrave Street	Knightsbridge and Belgravia
Meacher, Higgins & Thomas	105A Crawford Street	Bryanston and Dorset Square
Curie Chemist	445 Edgware Road	Little Venice

Nashi Pharmacy	55 Westbourne Grove	Lancaster Gate
Bayswater Pharmacy	39-41 Porchester Road	Bayswater
Benson Pharmacy	276 Harrow Road	Westbourne

Source: Contractor Survey and NHS England, 2017

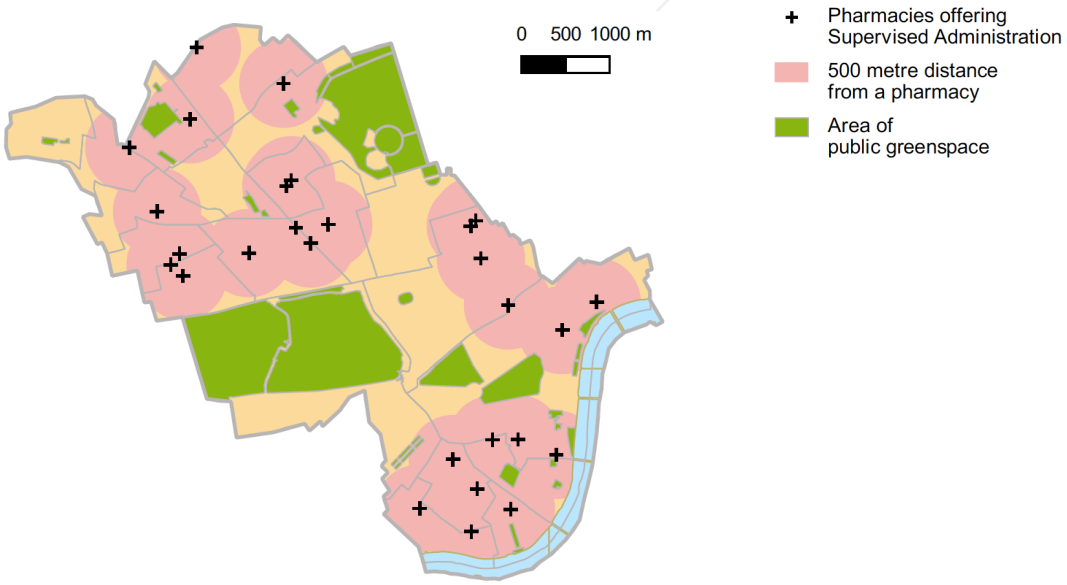
Supervised Administration Service

7.25 Pharmacists providing a Supervised Administration Service supervise the consumption of medicines at the point of dispensing in a pharmacy. It ensures that the correct dosage has been administered properly and provides a confidential, non-judgmental approach for patients who need support to manage their medicines.

7.26 The survey found 29 pharmacies that provide a Supervised Administration Service (shown in Figure 7.4 and Table 7.7). Twenty-two more pharmacies indicated they are willing to be commissioned for the service.

7.27 In considering reach of this service across the borough and within areas of high deprivation, therefore the Health and Wellbeing Board identifies the level of this service to be sufficient, with no gaps.

Figure 7.4: Pharmacies that provide Supervised Administration in Westminster and their 500 meter coverage, October 2017



Source: Contractor Survey, 2017

Table 7.8: Locations of Pharmacies that provide Supervised Administration in Westminster, October 2017

Westminster Ward	Number of Pharmacies	Westminster Ward	Number of Pharmacies
West End	4	Westbourne	1
Marylebone High Street	0	Abbey Road	1
St James's	4	Lancaster Gate	2

Hyde Park	4	Bayswater	1
Regent's Park	1	Churchill	2
Warwick	4	Knightsbridge and Belgravia	
Maida Vale	2	Tachbrook	1
Bryanston and Dorset Square	1	Harrow Road	
Church Street	2	Vincent Square	1

Source: Contractor Survey and NHS England, 2017

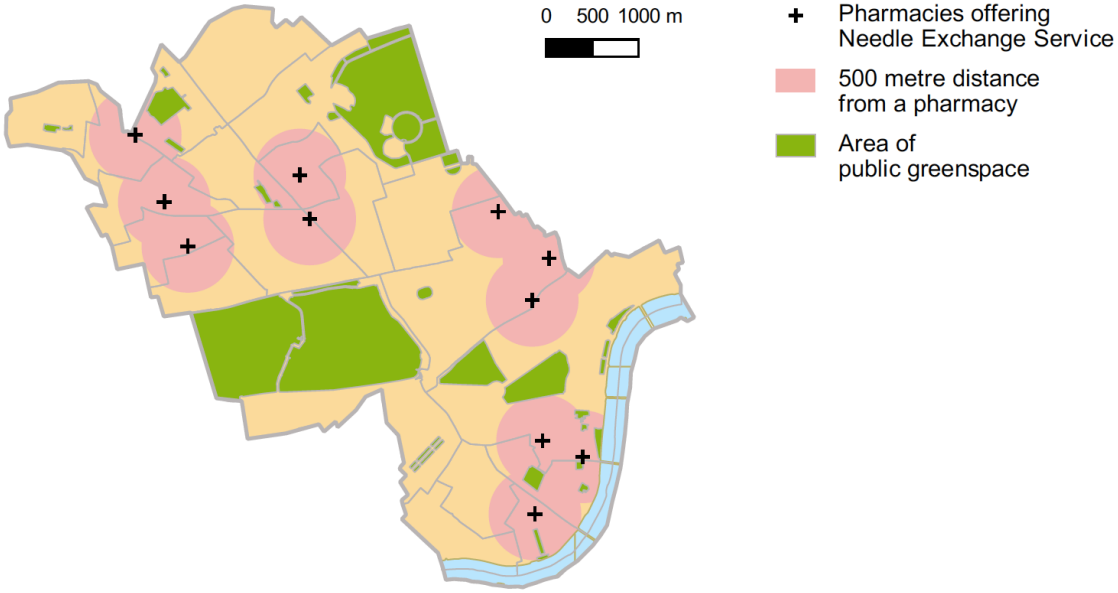
Needle and Syringe Exchange

7.28 Good access to Needle and Syringe Exchange supports safer use of drugs by injecting drug users by reducing the transmission of viruses and other infections caused by needles and syringes, such as HIV and Hepatitis B and C.

7.29 A Needle and Syringe Exchange Service provides sterile needles, syringes and associated materials to drug misusers and disposes of used needles, syringes and associated materials. Additionally the service offers advice to drug misusers and where appropriate makes referrals to other health care professionals or a specialist drug treatment centre.

7.30 The survey identified 11 pharmacies that provide a Needle and Syringe Exchange Service (Figure 7.5 and Table 7.9) and 35 others are willing to be commissioned to the service.

Figure 7.5: Pharmacies that provide a Needle and Syringe Exchange service in Westminster and their 500m coverage, October 2017



Source: Contractor Survey, 2017

Table 7.9: Pharmacies that provide a Needle and Syringe Exchange service in Westminster, October 2017

Pharmacy	Address	Ward
Market Chemist	91-93 Church Street	Church Street
Victoria Pharmacy	58 Horsferry Road	St James's
Star Pharmacy	33 Strutton Ground	St James's
Portman's Pharmacy	93-95 Tachbrook Street	Tachbrook
Boots The Chemist	44-46 Regent Street	West End
Watsons Pharmacy	1 Frith Street	West End
Devonshire	215 Edgware Road	Hyde Park
Bayswater Pharmacy	39-41 Porchester Road	Bayswater
Benson Pharmacy	276 Harrow Road	Westbourne
Browns Chemist	195 Shirland Road	Maida Vale

Source: Contractor Survey, 2017

7.31 The Needle Exchange service is spread across the borough and mapped well to areas of greatest need. Given the specialist nature and low volumes of service use compared to normal dispensing, the Health and Wellbeing Board identifies the level of these services to be sufficient, with no gaps.

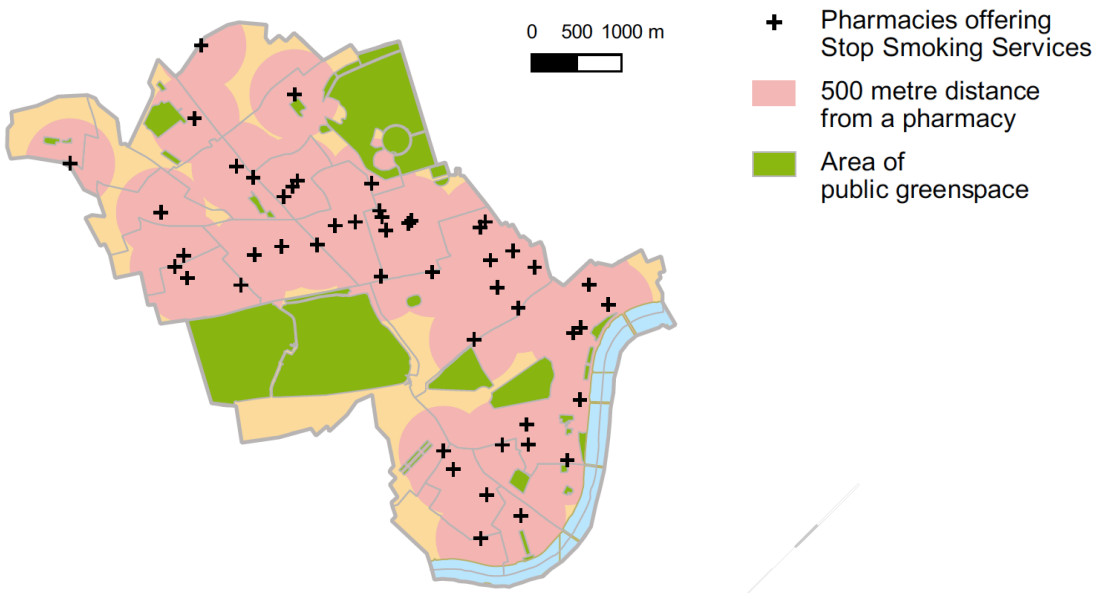
Stop Smoking Service

7.32 Smoking is the single biggest preventable cause of death and inequalities and levels of smoking are high in Westminster. Securing good access to stop smoking services increases the opportunity for the population to benefit from improvements in health including reduced risk of cancers, circulatory diseases and respiratory diseases.

7.33 A stop smoking service within a pharmacy can provide advice and support to patients wishing to give up smoking and where appropriate supply nicotine replacement therapies.

7.34 Figure 7.5 and Table 7.10 outlines the reach of the stop smoking services by pharmacies in Westminster. Forty-nine pharmacies currently offer the service and 20 other are willing to be commissioned.

Figure 7.5: Pharmacies that provide Stop Smoking services in Westminster and their 500m coverage, October 2017



Source: RBKC Public Health Commissioned Data and Contractor Survey, 2017

7.35 In considering the reducing number of smokers in Westminster and the wide reach of Stop Smoking Services on offer, the Health and Wellbeing Board identifies the Service provided in local pharmacies as sufficient for supplying a service with no gaps.

Table 7.10: Locations of Pharmacy providing Stop Smoking services in Westminster by ward, October 2017

Westminster Ward	Number of Pharmacies	Westminster Ward	Number of Pharmacies
West End	9	Little Venice	2
St James's	8	Abbey Road	1
Marylebone High Street	5	Vincent Square	1
Bryanston and Dorset Square	3	Maida Vale	1
Hyde Park	3	Harrow Road	1
Church Street	3	Churchill	1
Lancaster Gate	3	Bayswater	1
Warwick	2	Westbourne	1
Regent's Park	2	Knightsbridge and Belgravia	1

Source: RBKC Public Health Commissioned Data and Contractor Survey, 2017

Emergency Hormonal Contraception

7.36 The Emergency Hormonal Contraception (EHC) service aims to reduce unintended pregnancies. Pharmacies that provide EHC can provide signposting to mainstream

contraception services and provide information in risks associated with sexually transmitted infections.

7.37 Fifty-eight of the surveyed pharmacies provide Emergency Hormonal Contraception within a 72-hour period, these are located throughout the borough (see Table 7.11). Majority of these pharmacies, 56, offer the service privately. Fifty-five pharmacies offer the service within a 120 hour period and again majority of these are offer this as a private service (53/55). These are widely spread across Westminster, including one in Knightsbridge and Belgravia where the population of young people is highest.

Table 7.11 Ward locations of pharmacies that provide EHC in 72 hour period, October 2017

Westminster Ward	Number of Pharmacies	Westminster Ward	Number of Pharmacies
West End	10	Lancaster Gate	2
St James's	8	Westbourne	2
Marylebone High Street	7	Abbey Road	2
Hyde Park	5	Little Venice	2
Regent's Park	4	Church Street	1
Bryanston and Dorset Square	3	Bayswater	1
Warwick	3	Knightsbridge and Belgravia	1
Maida Vale	2	Tachbrook	1
Churchill	2	Harrow Road	1
Vincent Square	1		

Source: Contractor Survey, 2017

7.38 Health and Wellbeing Board is satisfied that the EHC provided in local pharmacies is sufficient for supplying a service with no gaps.

Alcohol Misuse Service

7.39 The Alcohol Misuse Service can provide brief interventions to identify and higher risk and increasing risk drinkers and provide support to motivate individuals to modify their drinking patterns.

7.40 Although alcohol-related hospital admissions and binge drinking rates are lower in Westminster than nationally, binge drinking widespread across the borough.

7.41 Currently six pharmacies identified themselves as providing an alcohol misuse and screening service (shown in Table 7.12) and 51 others would be willing to provide this service if commissioned.

Table 7.12: Pharmacies that provide Alcohol Misuse and Screening services in Westminster, October 2017

Trading Name	Address	Ward
Dolphins Pharmacy	9-11 The Broadway	St James's
Victoria Pharmacy	58 Horsferry Road	St James's
Star Pharmacy	33 Strutton Ground	St James's
Sherlock Holmes Pharmacy	82a Baker St	Marylebone High Street
Nashi Pharmacy	55 Westbourne Grove	Lancaster Gate
Benson Pharmacy	276 Harrow Road	Westbourne

Source: Contractor Survey, 2017

7.42 The Health and Wellbeing Board is satisfied that the Alcohol Misuse Service provided in local pharmacies is sufficient for supplying a service with no gaps.

Weight Management Services

7.43 Obesity in the borough is low in comparison to national figures, however rates are increasing and childhood obesity is high. This likely to have significant impact on healthy-life expectancies and future health costs. Weight management services, particularly for children would expand the health promotion role of pharmacies.

7.44 The contractor survey identified 20 pharmacies that provide weight management services (see Table 7.13) and 41 more willing to provide this service if commissioned. These are strategically placed in areas where childhood obesity is high the borough.

Table 7.13 Location of pharmacies that provide Weight Management by ward in Westminster, 2017

Westminster Ward	Number of Pharmacies	Westminster Ward	Number of Pharmacies
St James's	3	Tachbrook	1
Hyde Park	3	Bayswater	1
Church Street	2	Maida Vale	1
Bryanston and Dorset Square	2	Westbourne	1
West End	2	Lancaster Gate	1
Marylebone High Street	1	Little Venice	1
Churchill	1		

Source: Contractor Survey, 2017

7.45 Health and Wellbeing Board is satisfied that the Weight Management Service provided in local pharmacies is sufficient for supplying a service with no gaps.

Sexual Health Screening and Treatment

7.46 Pharmacies can be commissioned to provide services such as condom distribution; pregnancy testing and advice, Chlamydia screening and treatment and other sexual health screening, including syphilis, HIV and gonorrhea. These services are currently provided by GPs, GUM Clinics and Secondary Care Centres.

7.47 Six pharmacies in the borough offer chlamydia screening (see Table 7.14 below). Five of those also offer chlamydia treatment (see Table 7.15).

Table 7.14 Location of pharmacies that provide Chlamydia Screening in Westminster, October 2017

Trading Name	Address	Ward
Dolphins Pharmacy	9-11 The Broadway	St James's
Victoria Pharmacy	58 Horsferry Road	St James's
Star Pharmacy	33 Strutton Ground	St James's
Sedley Place	361 Oxford Street	West End
Sherlock Holmes Pharmacy	82a Baker St	Marylebone High Street
Nashi Pharmacy	55 Westbourne Grove	Lancaster Gate

Source: Contractor Survey, 2017

Table 7.15 Location of pharmacies that provide Chlamydia Treatment in Westminster, October 2017

Trading Name	Address	Ward
Victoria Pharmacy	58 Horsferry Road	St James's
Portmans Pharmacy	93-95 Tachbrook Street	Tachbrook
Sedley Place	361 Oxford Street	West End
Sherlock Holmes Pharmacy	82a Baker St	Marylebone High Street
Nashi Pharmacy	55 Westbourne Grove	Lancaster Gate

Source: Contractor Survey, 2017

7.48 Three pharmacies in the borough offer gonorrhea screening and they are outlined in Table 7.16 below. Fifty-four pharmacies stated that they would be willing to be commissioned to offer the service.

Table 7.16 Location of pharmacies that provide Gonorrhea Screening in Westminster, October 2017

Trading Name	Address	Ward
Dolphins Pharmacy	9-11 The Broadway	St James's
Sedley Place	361 Oxford Street	West End
Sherlock Holmes Pharmacy	82a Baker St	Marylebone High Street

Source: Contractor Survey, 2017

7.49 Within Westminster there is extensive provision to provide Sexually Transmitted Infections screening and treatment within Local Authority commissioned services. Additionally Westminster City Council is commissioning e-services that will provide remote chlamydia treatment within pharmacies from April 2018. Therefore the Health

and Wellbeing board are satisfied that Sexual Health Screening and Treatment services as sufficient with no gaps.

Improvements and better access: gaps in provision (Schedule 1, paragraph 4)

7.50 There are no services or gaps in services which the Health and Wellbeing Board is satisfied would, if they were provided, may secure improvements, or better access to pharmaceutical services of a specific type.

Summary of Other (Locally Enhanced) Services: current provision (schedule 1, paragraph 5) and Improvements and better access: gaps in provision (Schedule 1, paragraph 4)

The following section defines the enhanced services commissioned and delivered in response to local health and wellbeing needs. It includes Public Health commissioned services. The following services are **sufficient in providing a relevant services with no gaps**:

- Flu Vaccination
- Minor Ailment Schemes
- End of Life Care service
- Care Home Advice service
- Medicines Assessment and Compliance Support Service
- NHS Health Checks
- Supervised Administration
- Needle Exchange Services
- Stop Smoking Services
- Emergency Hormonal Contraception
- Alcohol Misuse Services
- Weight Management Services
- Other Sexual Health Screening and Treatment services

There are **no gaps in services** which the Health and Wellbeing Board is satisfied would, if they were provided, may secure improvements, or better access to pharmaceutical services of a specific type.

Other skills and services identified in the Pharmacy Contractor Survey

Utilisation of Clinical Skills in the Pharmacy

7.51 Fifty-one of the pharmacies reported that that the clinical skills in their pharmacies were “totally utilised”, 22 respondents felt they were “partly utilised” and just one feeling that they were not utilised at all

Pharmacists with a Special Interest

7.52 Four of the pharmacies surveyed have pharmacists with special interests.

Health Champions

7.53 Health Champions are people who, with training and support, voluntarily bring their ability to relate to people and their own life experience to transform health and wellbeing in their communities.

7.54 Forty-six of the pharmacies in Westminster that responded stated that they have a health champion.

Health Trainers

7.55 Health trainers help people to develop healthier behaviour and lifestyles in their own local communities using behaviour change conversations. They offer practical support to change their behaviour to achieve their own choices and goals.

7.56 Twelve of the pharmacies in Westminster that responded stated that they have a health trainer.

Dementia Friendly Environment

7.57 Dementia Friendly environments offer additional support and understanding to people who have Dementia. To achieve Dementia Friendly Status pharmacy staff attend brief training on what it's like to live with dementia and make changes to their pharmacy environment so that it is more welcoming to some who suffers from dementia.

7.58 Fifty-nine of the pharmacies in the reported being a dementia friendly environment.

Appendices

Appendix A – Terms of Reference

Appendix B – Community Questionnaire

Appendix C – Community Engagement Plan

Appendix D - Pharmacy listings and opening times and Essential Services

Healthy Dialogues LTD
— Behaviour Change Solutions For Health —

Community Pharmacy Questionnaire

Introduction

If you live, work or study in Westminster, Kensington and Chelsea or Hammersmith and Fulham we would like to hear from you about your local pharmacies.

We are keen to understand what people use community pharmacies for and how they feel about the services being offered. Community pharmacies provide over the counter medication as well as those that your GP prescribes. They also offer a lot of other services including healthy living advice.

What you tell us will help us in producing a local 'Pharmaceutical Needs Assessment' (PNA). This helps NHS England ensure everyone living in your borough has the right access to pharmacy services. Your view counts and will help shape the way services are being delivered from your local pharmacies.

It should not take you more than 5-10 minutes to complete the survey. Remember there are no right or wrong answers.

The information you provide will only be used for the Pharmaceutical Needs Assessment 2018-2021. Your answers will be kept anonymous and we will not share your information with any third parties.

This survey will be open until the **14th of October 2017**

Please note: throughout this survey, where we refer to pharmacy this means pharmacies (chemists) in shops and also pharmacies located within GP surgeries. It does NOT include hospital pharmacies.

We appreciate you taking time out to complete the survey.

1. **How often do you use a pharmacy?** (please select only one option)

☐ Weekly
☐ Monthly
☐ Yearly
☐ Less than yearly

2. What is the name of the pharmacy you use most often?

---

3. Why do you use this pharmacy most often? (please tick all that apply)

☐ I'm happy with the overall service provided by the Pharmacy
☐ It is in a good location
☐ It is close to home
☐ It is close to work
☐ It is easy to reach by public transport
☐ I can park nearby
☐ It has disabled access
☐ It is open when I need to go
☐ The staff are friendly
☐ The staff are knowledgeable
☐ I don't have to wait too long for my prescriptions
☐ It tends to have the prescriptions I need in stock
☐ I receive private medical treatment nearby
☐ I use the home delivery service for my medication
☐ It collects my prescriptions from my GP surgery
☐ It is close to my GP surgery
☐ Other (please specify) _____

4. **Who do you use the pharmacy mostly for?** (please tick all that apply)

☐ Yourself
☐ Spouse
☐ Child
☐ Parent(s)
☐ Other family member
☐ Friend or neighbour

5. **When do you prefer to go to your pharmacy?** (please tick all that apply)

☐ Weekday ☐ 6am - 9am ☐ 2pm - 5pm

☐ Weekend ☐ 9am - 12pm ☐ 5pm - 9pm
☐ 12pm - 2pm ☐ 9pm - 6am

6 What services do you already use at your pharmacy or will use if they were made available? (please tick all that apply)

Service	**Already use**	**Will use if available**
Obtaining prescription medicines		
Repeat prescriptions		
Over the counter medications		
Home delivery service and prescription collection service		
Prescription collection service		
Electronic prescription service		
Emergency supply of prescription medicines		
Specialist medication service (for example palliative care)		
New medicines service/ Medicine use reviews		
Disposal of unwanted medicines		
Advice from Pharmacist about how to take prescription medication or what over the counter medication to buy		
Advice from Pharmacist on how to manage minor ailments/injuries such as cold, cough etc.		
Advice from Pharmacist on Healthy lifestyles such as alcohol, weight management etc.		
Stop smoking/Nicotine replacement therapy		
Substance misuse services		
Needle exchange		
Health checks including blood glucose, cholesterol, blood pressure and BMI (height and weight)		
Chlamydia screening or treatment		
Condom distribution		
Emergency contraception (morning after pill)		
Flu vaccination service		
Pneumonia vaccination service		
Meningitis vaccination Service		
Travel vaccination service		
StrepA Sore Throat Test and Treat		
StrepB test screening in pregnancy		
Blood Pressure measurement service		
Any other services you would like to see being provided from your local pharmacy		

7 What could be improved about your Pharmacy?

8 Any other comments

Equalities monitoring

So that we can ensure that our survey is representative of the population we would like you to complete the information below. This will only be used for the purposes of monitoring and will not be passed on for use by third parties.

1. **Please state the first 4 letters and numbers of your postcode (Residence/University/College/Place of work) e.g. WC1E 7**

2. **What is your gender?** (please select only one option)
   - ☐ Male
   - ☐ Female
   - ☐ Transgender
   - ☐ Prefer not to say

3. **What age group are you in?** (please select only one option)
   - ☐ 10-18 years
   - ☐ 18- 20 years
   - ☐ 21 - 30 years
   - ☐ 31 - 40 years
   - ☐ 41 - 50 years
   - ☐ 51 - 60 years
   - ☐ 61 - 70 years
   - ☐ 71 - 80 years
   - ☐ 81 years or over

4. What is your ethnic group?
Choose one option that best describes your ethnic group or background

White
- ☐ English
- ☐ Scottish
- ☐ Other British
- ☐ Irish
- ☐ Gypsy/Traveller
- ☐ Polish
- ☐ Any other White ethnic group, please describe_____

Black/ Black British
- ☐ African, African Scottish or African British
- ☐ Any other African, please describe
- ☐ Caribbean, Caribbean Scottish or Caribbean British
- ☐ Black, Black Scottish or Black British
- ☐ Any other Caribbean or Black, please describe_____

Mixed or Multiple ethnic groups
- ☐ Any Mixed or Multiple ethnic groups, please describe_____

Other ethnic group
- ☐ Arab, Arab Scottish or Arab British
- ☐ Any other ethnic group, please describe

_____

Asian, Asian Scottish or Asian British
- ☐ Pakistani, Pakistani Scottish or Pakistani British
- ☐ Indian, Indian Scottish or Indian British
- ☐ Bangladeshi, Bangladeshi Scottish or Bangladeshi British
- ☐ Chinese, Chinese Scottish or Chinese British
- ☐ Any other Asian, please describe

_____

5. What is your religion and belief? (please select only one option)
- ☐ No religion
- ☐ Buddhist
- ☐ Christian
- ☐ Hindu
- ☐ Jewish
- ☐ Muslim
- ☐ Sikh
- ☐ Prefer not to say
- ☐ Other (please specify)

6. Which of the following best describes your working situation? (please select only one option)
- ☐ Work full-time
- ☐ Work part-time
- ☐ Student
- ☐ Unemployed
- ☐ Retired
- ☐ Prefer not to say

7. Do you consider yourself to have a disability?
Disability is defined as a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on your ability to do normal daily activities.

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

If yes, please explain

8. Do you have a long-term condition?
A long-term condition is defined as a condition that cannot, at present be cured; but can be controlled by medication and other therapies. Examples are diabetes, heart disease etc

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

If yes, please explain

9. How would you define your sexual orientation? (please select only one option)

- ☐ Bisexual (an attraction to both men and women)
- ☐ Gay man
- ☐ Gay woman / Lesbian
- ☐ Heterosexual/Straight
- ☐ Transgender
- ☐ Other (please specify)
- ☐ Prefer not to say

10. How would you state your relationship status? (please select only one option)

- ☐ Civil Partnership
- ☐ Married
- ☐ Single
- ☐ Co-habiting
- ☐ Prefer not to say

11. Are you pregnant/breastfeeding?

- ☐ Yes
- ☐ No

Thank you once again for taking the time to complete our survey.

If you would like to get involved in the public consultation of the completed Pharmaceutical Needs Assessment please email PNA@healthydialogues.co.uk.

Pharmaceutical Needs Assessment 2018-2021
Patient and Public Engagement

Name of Group/Activity	Description of group and numbers	Activity	Key contacts
BME Health Forum	BME Total membership not known, newsletter goes out to 700 members across K&C, H&F and Westminster	• Attended BME Health Forum meeting • Online questionnaire link circulated to members via newsletter and included on webpage • Provided information and contacts for possible Grenfell Engagement	Nafsika Thalassis Concia Albert
Community Champions including maternity champions	CC work with diverse groups of residents across the 3 Boroughs	• Email circulated by commissioner as well as Healthy Dialogues to all Community Champion teams • Engaged with White City, Westminster, Addison and Land's End Community Champions • Requested champions to fill out questionnaire and promote to service users • Community champion teams provided outreach support • Attended events	Lesley Derry Various
Age UK	Over 50's	• Requested inclusion of online link in newsletter/mail out to 400 members	Zara Ghods
Adult Services	Various	• Requested circulation of paper copies of questionnaire to all teams particularly in sheltered schemes • Approximately 90 completed questionnaires were returned from Adult services	Kevin Williamson
Kensington and Chelsea Council of Voluntary Sector	Diverse voluntary groups	• KCSC circulated online link to mailing lists and via newsletters • Discussed potential options for Grenfell engagement	Angela Spence

Name of Group/Activity	Description of group and numbers	Activity	Key contacts
Mosaic Community Trust	BME- mainly Bengali and Arabic	• Established contact but they don't have capacity to support this work at the moment having lost funding for their groups	Lena Salter-Chodhury
Action for Disability, Kensington and Chelsea	Access to disabled groups	• Online/paper questionnaires/face to face questionnaire with service users	Jamie Runton Marian O'Donoghue
SASH	LGBTQ	• Information circulated to other organisations and service users by community engagement coordinator	Edem Ntumy
Healthwatch	Diverse user groups	• Support with circulation of questionnaires • Advice and support on engagement with various groups	Olivia Clymer
Library service	Various	• Information circulated to all teams by Health Information Officer	Kate Gieguld
Community Pharmacy outreach	Various	• Based on IMD data, chose 06 pharmacies in different wards and made contact with them to enable Community Researcher to be based in them during different times of the day • Community Researcher was based in 01 pharmacy in Colville Ward for half a day on a weekday from 10.00 to 2.00	Various pharmacies
Grenfell Residents Engagement		• Worked with BME Health Forum, CCG engagement lead and KCSC to identify contacts • We considered outreach at Pharmacies closest to Grenfell but since residents have been re-housed this option was discounted • It was identified that there is an outreach worker who is the most likely to give us a sense of needs; however, it has been	Various

Name of Group/Activity	Description of group and numbers	Activity	Key contacts
		difficult to get their contact details • An officer has been appointed by the Council who carry out needs assessments for this group has been appointed and perhaps, during the consultation phase we will be able to get a sense of needs	

This page is intentionally left blank

Appendix D – Index to pharmacies with opening times information
** Appliance Only Contractor*

ODS Code	Trading Name	Address	Post Code	Borough	Ward	Responded?	Early Opening	Late Closing	Saturday	Sunday	MUR	NMS	AUR	SAC
FLH24	Central Pharmacy	427-429 Harrow road	W10 4RE	Westminster	Harrow Road	Yes	No	Yes	Yes	Yes	Yes	Yes	No	No
FRG14	Market Chemist	91-93 Church Street	NW8 8EU	Westminster	Church Street	Yes	No	No	Yes	No	Yes	Yes	No	No
FN172	Boots	198 Baker St	NW1 5RT	Westminster	Regent's Park	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
FG309	Berkeley Court Pharmacy	5-7 Melcombe Street	NW1 6AE	Westminster	Bryanston and Dorset Square	No	No	No	No	No	Yes	Yes	No	No
FX871	Benjamin Cory Ltd	79 Abbey Road	NW8 0AE	Westminster	Abbey Road	Yes	No	No	No	No	Yes	Yes	No	No
FER86	Courtenay Chemist	3 St Johns Wood High Street	NW8 7NG	Westminster	Regent's Park	Yes	No	No	Yes	No	Yes	Yes	No	No
FT371	St Johns Wood Pharmacy	142 St Johns Wood High Street	NW8 7SE	Westminster	Regent's Park	Yes	No	No	Yes	No	Yes	Yes	No	No
FP835	K.S.C1T Ltd	27-29 Church Street	NW8 8ES	Westminster	Church Street	Yes	No	No	Yes	No	Yes	Yes	No	No
FEF06	Collins Chemist	113 -115 Church Street	NW8 8HA	Westminster	Church Street	Yes	No	No	Yes	No	Yes	Yes	No	No
FVT13	Holmes Pharmacy	6 Nugent Terrace	NW8 9QB	Westminster	Abbey Road	Yes	No	No	Yes	No	Yes	Yes	No	No
FCA00	Boots Uk Ltd	124-126 St Johns Wood High Street	NW8 7SG	Westminster	Regent's Park	Yes	No	No	Yes	Yes	Yes	Yes	No	No
FFF12	D R Harris	29 St James's St	SW1A 1HB	Westminster	St James's	Yes	Yes	No	Yes	No	No	No	No	No

ODS Code	Trading Name	Address	Post Code	Borough	Ward	Responded?	Early Opening	Late Closing	Saturday	Sunday	MUR	NMS	AUR	SAC
FPT14	Boots	11 Bridge Street	SW1 A2JR	Westminster	St James's	Yes	Yes	No	Yes	Yes	No	No	No	No
FHV67	Boots The Chemist	Unit 13, Cathedral Walk, Cardinal Place	SW1 E 5JH	Westminster	St James's	Yes	No	No	No	No	Yes	Yes	No	No
FQT75	Boots UK LTD	107 Victoria Street	SW1 E 6RA	Westminster	Vincent Square	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
FKE09	Dolphins Pharmacy	9-11 The Broadway	SW1 H 0AZ	Westminster	St James's	Yes	No	No	No	No	No	No	No	No
FA467	Victoria Pharmacy	58 Horsferry Road	SW1 P 2AF	Westminster	St James's	Yes	Yes	No	No	No	Yes	Yes	No	No
FRE01	Star Pharmacy	33 Strutton Ground	SW1 P 2HY	Westminster	St James's	Yes	Yes	No	No	No	Yes	Yes	No	No
FLR73	Boots Uk Ltd	Unit 42b, Victoria Station	SW1 V 1JT	Westminster	Warwick	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
FN761	Gees Chemist	27-29 Warwick Way	SW1 V 1QT	Westminster	Warwick	Yes	No	No	Yes	No	Yes	Yes	No	No
FC401	Boots Uk Ltd	42-44 Warwick Way	SW1 V 1RY	Westminster	Warwick	Yes	Yes	No	Yes	Yes	Yes	Yes	No	No
FHT60	Warwick Pharmacy	34-36 Warwick Way	SW1 V 1RY	Westminster	Warwick	No	No	No	Yes	No	Yes	Yes	No	No

ODS Code	Trading Name	Address	Post Code	Borough	Ward	Responded?	Early Opening	Late Closing	Saturday	Sunday	MUR	NMS	AUR	SAC
FYR46	Clinichem Pharmacy	29 Upper Tachbrook Street	SW1V 1SN	Westminster	Warwick	Yes	No	No	Yes	No	Yes	Yes	No	No
FMH15	Portmans Pharmacy	93-95 Tachbrook Street	SW1V 2QA	Westminster	Tachbrook	Yes	No	No	Yes	No	Yes	Yes	No	No
FNW76	Paxall Pharmacy	44 Lupus street	SW1V 3EB	Westminster	Tachbrook	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
FYX89	Simmonds Pharmacy	105 Lupus Street	SW1V 3EN	Westminster	Churchill	Yes	No	No	Yes	No	Yes	Yes	No	No
FER55	Keencare Pharmacy	6 Lower Belgrave Street	SW1W 0LJ	Westminster	Knightsbridge and Belgravia	Yes	No	No	Yes	No	Yes	Yes	No	No
FHD19	Green's Pharmacy	29-31 Ebury Bridge Road	SW1W 8QX	Westminster	Churchill	Yes	No	No	No	No	No	No	No	No
FAT36	Walden Chymist	65 Elizabeth Street	SW1W 9PJ	Westminster	Knightsbridge and Belgravia	Yes	No	No	Yes	No	No	No	No	No
FV172	Victoria Place	Unit 6 Victoria Place, 115 Buckingham Palace Road	SW1W 9SJ	Westminster	Warwick	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
FM507	Selfridges - Lloydspharmacy	Dept 469, 400 Oxford St	W1A 1AB	Westminster	Marylebone High Street	Yes	No	Yes	Yes	Yes	Yes	Yes	No	No
FCR41	Boots	302 Regent Street	W1B 3AS	Westminster	West End	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
FV474	Boots The	44-46 Regent	W1B	Westminster	West End	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No

ODS Code	Trading Name	Address	Post Code	Borough	Ward	Responded?	Early Opening	Late Closing	Saturday	Sunday	MUR	NMS	AUR	SAC
	Chemist	Street	5RA											
FC968	Sedley Place	361 Oxford Street	W1C 2JL	Westminster	West End	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
FM688	Boots	508-520 Oxford Street	W1C 1NB	Westminster	Bryanston and Dorset Square	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
FYN67	Boots The Chemist	385-389 Oxford Street	W1C 2NB	Westminster	West End	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
FKC63	Boots	100 Oxford St	W1D 1LL	Westminster	West End	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
FM364	Boots	193 Oxford Street	W1D 2JY	Westminster	West End	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
FLR52	Watsons Pharmacy	1 Frith Street	W1D 3HZ	Westminster	West End	Yes	No	No	Yes	No	No	No	No	No
FLP44	Boots Uk Ltd	5-7 CarnabyStreet	W1F 9PB	Westminster	West End	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
FJ185	Ainsworths	36 New Cavendish Street	W1G 8UF	Westminster	Marylebone High Street	Yes	No	No	Yes	No	No	No	No	No
FKX76	Dajani Pharmacy	21 New Cavendish Street	W1G 9TY	Westminster	Marylebone High Street	Yes	No	No	No	No	No	No	No	No
FDK02	Meacher, Higgins & Thomas	105A Crawford Street	W1H 2HU	Westminster	Bryanston and Dorset Square	Yes	No	No	No	No	Yes	Yes	No	No
FVX47	Seymour Pharmacie	56 Crawford Street	W1H 4JH	Westminster	Bryanston and Dorset Square	Yes	No	No	Yes	No	Yes	Yes	No	No
FHV04	The Pharmacy At Mayfair	6 Shepherd Market	W1J 7QD	Westminster	West End	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	No

ODS Code	Trading Name	Address	Post Code	Borough	Ward	Responded?	Early Opening	Late Closing	Saturday	Sunday	MUR	NMS	AUR	SAC
FA053	Boots Uk Ltd	73 Piccadilly	W1J 8HS	Westminster	West End	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
FYV08	Audley Pharmacy	36 South Audley Street	W1K 2PL	Westminster	West End	No	No	No	No	No	No	Yes	No	No
FDK54	Nelson Pharmacies Ltd	87 Duke Street	W1K 5PQ	Westminster	West End	Yes	No	No	Yes	No	No	No	No	No
FYR00	C W Andrew	Nash House, St George Street	W1S 2FQ	Westminster	West End	Yes	No	No	No	No	Yes	No	No	No
FX754	Wigmore Pharmacy	23 Wigmore Street	W1U 1PL	Westminster	Marylebone High Street	Yes	No	No	Yes	No	No	No	No	No
FGP84	John Bell & Croyden	50-54 Wigmore Street	W1U 2AU	Westminster	Marylebone High Street	Yes	Yes	No	Yes	Yes	Yes	Yes	No	No
FT352	Peter's Pharmacy	55 Paddington Street	W1U 4HX	Westminster	Marylebone High Street	No	No	No	No	No	No	No	No	No
FLW05	Madesil Pharmacie	20 Marylebone High Street	W1U 4PB	Westminster	Marylebone High Street	Yes	No	No	Yes	Yes	Yes	Yes	No	No
FKL72	Boots	101-103 Marylebone High Street	W1U 4RN	Westminster	Marylebone High Street	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
FQA23	Sherlock Holmes Pharmacy	82a Baker St	W1U 6AA	Westminster	Marylebone High Street	Yes	No	No	Yes	No	Yes	No	No	No
FY188	Boots Uk Ltd	96-98 Baker Street	W1U 6TJ	Westminster	Marylebone High Street	Yes	Yes	No	Yes	Yes	Yes	Yes	No	No
FNF09	Nvs Pharmacy	46 Baker Street	W1U 7BR	Westminster	Marylebone High Street	Yes	Yes	No	Yes	No	Yes	No	No	No
FFH75	Chel Pharmacy	173 Great	W1W	Westminster	Marylebone	Yes	No	No	No	No	Yes	Yes	No	No

ODS Code	Trading Name	Address	Post Code	Borough	Ward	Responded?	Early Opening	Late Closing	Saturday	Sunday	MUR	NMS	AUR	SAC
		Portland Street	5PH		High Street									
FFP11	Healthxchange Pharmacy Uk Limited	79 Great Portland Street	W1W 7LS	Westminster	West End	Yes	No	No	No	No	No	No	No	No
FPV36	Shiv Pharmacy	70 Great Titchfield Street	W1W 7QN	Westminster	West End	Yes	Yes	No	No	No	Yes	Yes	No	No
FNK70	Dales Pharmacy	414-416 Edgware Road	W2 1ED	Westminster	Church Street	No	No	No	No	No	No	No	No	No
FAQ26	Devonshire	215 Edgware Road	W2 1ES	Westminster	Hyde Park	Yes	Yes	Yes	Yes	Yes	No	No	No	No
FY004	Boots Uk Ltd	Unit 51 The Lawn	W2 1HB	Westminster	Hyde Park	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
FE720	Apek Pharmacy	107 Praed street	W2 1NT	Westminster	Hyde Park	Yes	No	No	Yes	No	Yes	Yes	No	No
FX604	Curie Chemist	445 Edgware Road	W2 1TH	Westminster	Little Venice	Yes	No	No	Yes	No	Yes	Yes	No	No
FRD96	Hogg & Son Pharmacy	25 Kendal Street	W2 2AW	Westminster	Hyde Park	Yes	No	No	Yes	No	Yes	Yes	No	No
FRA80	Safeer Pharmacy	194 Edgware Road	W2 2DS	Westminster	Bryanston and Dorset Square	No	No	Yes	Yes	Yes	Yes	No	No	No
FL792	Boots	175 -176 Edgware Road	W2 2HR	Westminster	Hyde Park	Yes	No	Yes	Yes	Yes	Yes	Yes	No	No
FCT73	Pharmacentre	149 Edgware Road	W2 2HU	Westminster	Hyde Park	Yes	No	Yes	Yes	Yes	No	No	No	No
FTK64	Bin-Seena Pharmacy	73 Edgware Road	W2 2HZ	Westminster	Hyde Park	Yes	No	Yes	Yes	Yes	No	No	No	No

ODS Code	Trading Name	Address	Post Code	Borough	Ward	Responded?	Early Opening	Late Closing	Saturday	Sunday	MUR	NMS	AUR	SAC
FK102	Nasslam Pharmacy	19 Edgware Road	W2 2JE	Westminster	Hyde Park	No	No	Yes	Yes	Yes	No	No	No	No
FXH58	Alrasheed Pharmacy	39 Edgware Road	W2 2JE	Westminster	Hyde Park	No	Yes	Yes	Yes	Yes	No	No	No	No
FWN84	Moores Pharmacy	45 Craven Road	W2 3BX	Westminster	Lancaster Gate	Yes	Yes	Yes	Yes	No	Yes	Yes	No	No
FK236	Nashi Pharmacy	55 Westbourne Grove	W2 4UA	Westminster	Lancaster Gate	Yes	No	No	Yes	No	Yes	Yes	No	No
FFN81	Bayswater Pharmacy	39-41 Porchester Road	W2 5DP	Westminster	Bayswater	Yes	No	Yes	Yes	Yes	Yes	Yes	No	No
FR177	Benson Pharmacy	276 Harrow Road	W2 5ES	Westminster	Westbourne	Yes	No	No	Yes	No	Yes	Yes	Yes	No
FM589	Boots Uk Ltd	114 Queensway	W2 6LS	Westminster	Lancaster Gate	Yes	No	Yes	Yes	Yes	Yes	Yes	No	No
FTC02	Williams Chemist	314-316 Elgin Avenue	W9 1JU	Westminster	Maida Vale	Yes	No	No	No	No	Yes	Yes	No	Yes
FC572	Vineyard Pharmacy	241 Elgin Avenue	W9 1NJ	Westminster	Maida Vale	Yes	Yes	No	Yes	No	Yes	Yes	No	Yes
FQ560	Boots Uk Ltd	33 Clifton Road	W9 1SY	Westminster	Little Venice	Yes	Yes	No	Yes	Yes	No	No	No	No
FMT61	Remedys Pharmacy	1 Clifton Road	W9 1SZ	Westminster	Little Venice	Yes	No	No	Yes	No	Yes	Yes	No	Yes
FP414	Browns Chemist	195 Shirland Road	W9 2EU	Westminster	Maida Vale	Yes	No	Yes	Yes	Yes	No	No	No	No
FE354	Sumer Health Ltd	340 Harrow Road	W9 2HP	Westminster	Westbourne	Yes	No	No	Yes	No	Yes	Yes	No	No
FRW51	Pitchkins & Currans	Unit 2, 45-47 Elgin Avenue	W9 3PP	Westminster	Harrow Road	No	No	No	No	No	Yes	No	No	No
FLE65	Prince Chemist	486 Harrow	W9	Westminster	Harrow	No	No	No	Yes	No	No	No	No	No

ODS Code	Trading Name	Address	Post Code	Borough	Ward	Responded?	Early Opening	Late Closing	Saturday	Sunday	MUR	NMS	AUR	SAC
		Road	3QA		Road									
FLW91	Medicare (London) Ltd Pharmacy	570 Harrow Road	W9 3QH	Westminster	Queen's Park	No	No	No	Yes	No	Yes	Yes	No	No
FA906	Boots The Chemist	4 James Street	WC2E 8BH	Westminster	St James's	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
FTA34	Boots	5 Strand	WC2N 5HR	Westminster	St James's	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
FKY87	Boots Uk Ltd	Unit 5 Charing Cross Station	WC2N 5HS	Westminster	St James's	Yes	Yes	Yes	Yes	Yes	No	No	No	No
FL592	Superdrug Pharmacy	50 Strand	WC2N 5LH	Westminster	St James's	No	No	No	No	No	Yes	Yes	No	No
FJJ43	Boots The Chemists	105-109 The Strand	WC2R 0AA	Westminster	St James's	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
FH514	Pharmacierge	9 Candover Street	W1W 7DN	Westminster	West End	Yes	No	No	No	No	No	No	No	No
FJM43	Bullen & Smears*	60-62 Broadwick Street	W1F 7AN	Westminster	West End	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
FGW55	Kilburn Park Pharmacy	Kilburn Park Station, Cambridge Avenue	NW6 5AD	Brent	Kilburn	Outside	No	No	No	No	x	x	x	x
FK708	Queens Park Pharmacy	67 Salusbury Road	NW6 6NJ	Brent	Queens Park	Outside	No	No	No	No	x	x	x	x

ODS Code	Trading Name	Address	Post Code	Borough	Ward	Responded?	Early Opening	Late Closing	Saturday	Sunday	MUR	NMS	AUR	SAC
FTD56	Hyperchem Pharmacy	34 Salusbury Road	NW6 6NL	Brent	Queens Park	Outside	Yes	Yes	Yes	No	x	x	x	x
FVD55	Abc Pharmacies	Kilburn Park Station, Cambridge Avenue	NW6 5AD	Brent	Kilburn	Outside	No	No	No	No	x	x	x	x
FR520	Dollmeads Dispensing Chemist	53 Chamberlayne Road	NW10 3ND	Brent	Queens Park	Outside	No	No	Yes	No	x	x	x	x
FV117	Greenfield Pharmacy	61 Chamberlayne Road	NW10 3ND	Brent	Queens Park	Outside	No	No	Yes	No	x	x	x	x
FDY54	Boots Uk Limited	16-17 Tottenham Court Rd	W1T 1BE	Camden	Bloomsbury	Outside	Yes	Yes	Yes	Yes	x	x	x	x
FCL17	Boots Uk Limited	120-122 Tottenham Ct Rd	W1T 5AP	Camden	Bloomsbury	Outside	Yes	Yes	Yes	Yes	x	x	x	x
FCQ11	Grafton Pharmacy	132/132A Tottenham Crt Rd	W1T 5AZ	Camden	Bloomsbury	Outside	Yes	No	Yes	No	x	x	x	x
FJT00	Boots Uk Limited	211-212 Tottenham Ct Road	W1T 7PP	Camden	Bloomsbury	Outside	Yes	Yes	Yes	Yes	x	x	x	x
FH432	Boots Uk Limited	122 Holborn	EC1N 2TD	Camden	Holborn and Covent Garden	Outside	Yes	No	No	No	x	x	x	x
FC589	Kerrs Chemist	41 Bloomsbury Way	WC1A 2SA	Camden	Holborn and Covent Garden	Outside	No	No	Yes	No	x	x	x	x
FJT53	Boots Uk	24-26 High	WC1	Camden	Holborn	Outsi	Yes	No	Yes	No	x	x	x	x

ODS Code	Trading Name	Address	Post Code	Borough	Ward	Responded?	Early Opening	Late Closing	Saturday	Sunday	MUR	NMS	AUR	SAC
	Limited	Holborn	V 6AZ		and Covent Garden	de								
FKD52	Superdrug Stores Plc	232 High Holborn	WC1 V 7DA	Camden	Holborn and Covent Garden	Outsi de	Yes	No	No	No	x	x	x	x
FT854	Farmacia Chemist Ltd	169 Drury Lane	WC2 B 5QA	Camden	Holborn and Covent Garden	Outsi de	No	No	Yes	No	x	x	x	x
FQC0 6	Kingsway Dispensing Chemist	38 Kingsway	WC2 B 6EX	Camden	Holborn and Covent Garden	Outsi de	Yes	No	Yes	No	x	x	x	x
FN299	Boots Uk Limited	129-133 Aviation House, Kingsway	WC2 B 6NH	Camden	Holborn and Covent Garden	Outsi de	Yes	Yes	Yes	Yes	x	x	x	x
FA485	Abc Drugstores	216 Belsize Road	NW6 4DJ	Camden	Kilburn	Outsi de	No	No	No	No	x	x	x	x
FEC18	Kings Pharmacy	6 Chester Court	NW1 4BU	Camden	Regent's Park	Outsi de	No	No	No	No	x	x	x	x
FEN40	Wm Morrison Supermarkets Plc	Camden Goods Yard	NW1 8AA	Camden	Camden Town with Primrose Hill	Outsi de	No	Yes	Yes	Yes	x	x	x	x
FET01	Superdrug Stores Plc	82-84 High Road	NW6 4HS	Camden	Kilburn	Outsi de	No	No	No	No	x	x	x	x
FFD81	Greenlight Pharmacy	62-64 Hampstead Road	NW1 2NU	Camden	Regent's Park	Outsi de	No	No	Yes	No	x	x	x	x
FJ009	Greenlight Pharmacy	138 Drummond Street	NW1 2PA	Camden	Regent's Park	Outsi de	No	No	Yes	No	x	x	x	x

ODS Code	Trading Name	Address	Post Code	Borough	Ward	Responded?	Early Opening	Late Closing	Saturday	Sunday	MUR	NMS	AUR	SAC
FQ521	Boots Uk Limited	60/62 Kilburn High Road	NW6 4HJ	Camden	Kilburn	Outside	No	No	Yes	Yes	x	x	x	x
FRV52	Chalkgate Ltd	27 - 29 Winchester Road	NW3 3NR	Camden	Swiss Cottage	Outside	No	No	Yes	No	x	x	x	x
FHK56	Boots Uk Limited	120 Fleet Street	EC4A 2BE	City of London	Castle Baynard	Outside	Yes	Yes	Yes	No	x	x	x	x
FEF09	Boots Uk Limited	203-205 Brompton Road	SW3 1LA	Kensington and Chelsea	Brompton & Hans Town	Yes	No	Yes	Yes	Yes	Yes	Yes	No	No
FRP77	Boots Uk Limited	60 Kings Road	SW3 4UD	Kensington and Chelsea	Royal Hospital	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
FN445	Stickland Chemist	4-6 The Arcade, South Kensington Station	SW7 2NA	Kensington and Chelsea	Brompton & Hans Town	Yes	Yes	No	Yes	No	Yes	Yes	Yes	No
FLF10	Boots Uk Limited	Units 30-31, Gloucester Arcade	SW7 4SF	Kensington and Chelsea	Courtfield	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
FD465	Lloyds Pharmacy Ltd	2 Canal Way, Ladbroke Grove	W10 5AA	Kensington and Chelsea	Dalgarno	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
FNC99	Dr Care Pharmacy	73 Golborne Road	W10 5NP	Kensington and Chelsea	Golborne	Yes	No	No	Yes	No	Yes	Yes	No	No
FLV31	Dillons Pharmacy	24 Golborne Road	W10 5PF	Kensington and Chelsea	Golborne	Yes	No	No	Yes	No	Yes	Yes	Yes	Yes
FH396	Golborne Pharmacy	106 Golborne Road	W10 5PS	Kensington and Chelsea	Golborne	Yes	No	No	Yes	No	Yes	Yes	No	No
FHR66	Chana Chemist	114 Ladbroke Grove	W10 5NE	Kensington and Chelsea	Colville	Yes	No	No	Yes	No	Yes	Yes	Yes	No

ODS Code	Trading Name	Address	Post Code	Borough	Ward	Responded?	Early Opening	Late Closing	Saturday	Sunday	MUR	NMS	AUR	SAC
FXP96	Blenheim Pharmacy	202 Portobello Road	W11 1LA	Kensington and Chelsea	Colville	No	No	No	Yes	Yes	No	No	No	No
FF202	Dr Evans Pharmacy	15 Elgin Cresent	W11 2JA	Kensington and Chelsea	Colville	Yes	No	No	Yes	No	Yes	Yes	No	No
FMD23	Baywood Dispensing Chemist	239 Westbourne Grove	W11 2SE	Kensington and Chelsea	Colville	Yes	No	No	Yes	No	Yes	Yes	No	No
FX258	Notting Hill Pharmacy	12 Pembridge Road	W11 3HL	Kensington and Chelsea	Pembridge	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
FX265	Calder Pharmacy Of Notting Hill	55/57 Notting Hill Gate	W11 3JS	Kensington and Chelsea	Campden	Yes	No	No	Yes	Yes	Yes	No	No	No
FF592	Boots Uk Limited	96-98 Notting Hill Gate	W11 3QA	Kensington and Chelsea	Pembridge	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
FP803	Andrews Pharmacy	149B Sloane Street	SW1X 9BZ	Kensington and Chelsea	Royal Hospital	Yes	No	No	Yes	Yes	No	No	No	No
FTH32	A Moore & Co	25E Lowndes Street	SW1X 9JF	Kensington and Chelsea	Brompton & Hans Town	Yes	No	No	Yes	No	Yes	Yes	No	No
FLA76	Boots Uk Limited	Waterloo Station	SE1 7LY	Lambeth	Bishop's	Outside	Yes	Yes	Yes	Yes	x	x	x	x
FAV29	Lloyds Pharmacy Ltd	8 Flagstaff House, St Georges Wharf	SW8 2LE	Lambeth	Oval	Outside	Yes	No	Yes	No	x	x	x	x
FXM20	Lloyds Pharmacy Ltd	62 Wandsworth Road	SW8 2LF	Lambeth	Oval	Outside	Yes	Yes	Yes	Yes	x	x	x	x
FP436	Paterson Heath & Co Ltd	143 Lambeth Walk	SE11 6EE	Lambeth	Prince's	Outside	No	No	Yes	No	x	x	x	x

ODS Code	Trading Name	Address	Post Code	Borough	Ward	Responded?	Early Opening	Late Closing	Saturday	Sunday	MUR	NMS	AUR	SAC
FXY86	Kalmak (Chemists) Ltd	Unit 11, South Bank Tower	SE1 9LP	Southwark	Cathedrals	Outside	Yes	No	No	No	x	x	x	x

This page is intentionally left blank

City of Westminster

Westminster Health & Wellbeing Board

Date:	16 November 2017
Classification:	General Release
Title:	Annual Report of the Director of Public Health 2016-17
Report of:	Director of Public Health
Wards Involved:	All
Policy Context:	The Director of Public Health has a statutory requirement to produce an independent report about the health of local communities
Financial Summary:	Not applicable
Report Author and Contact Details:	Colin Brodie E: cbrodie@westminster.gov.uk T: 02076414632

1. Executive Summary

1.1 The Board reviewed the draft Annual Public Health Report in September 2017. This paper presents the final version of the Director of Public Health's Annual Public Health Report for 2016-17, "The Roads to Wellbeing", that was published on 10th October, World Mental Health Day.

2. Key Matters for the Board

2.1 The Health and Wellbeing Board are invited to note the content of the report, which will inform the communications campaign. The report describes:

- the importance of good mental wellbeing
- factors affecting our mental wellbeing
- mental wellbeing across the life course
- groups who are most at risk of poor mental wellbeing
- how we can promote and maintain our own mental wellbeing
- current strategies and initiatives to promote mental wellbeing

2.2 The Health and Wellbeing Board are invited to consider the recommendations specific to the Health and Wellbeing Board:

- To better understand the mental wellbeing needs and issues for the local population the Health and Wellbeing Boards should commission a Joint Strategic Needs Assessment (JSNA) on mental health and wellbeing in our local population
- Promoting mental health is one of the four priorities of each Joint Health and Wellbeing Strategy. The delivery plans should be checked against this annual report and refreshed when the findings of the JSNA are published
- Members of the Health and Wellbeing Board to explore the feasibility of using the Roads To Wellbeing infrastructure, or a similar geographic approach, to develop an asset based resource

2.1 The APHR promotes a number of key messages:

- Poor mental wellbeing can affect us and those around us at any point in our lives. Mental wellbeing can impact on all aspects of our lives and is 'everyone's business'
- We can all play a role in improving our own and others' mental wellbeing: Connect, Be Active, Keep Learning, Take Notice, and Give
- To help build the mental resilience of our local communities we need to better understand residents' mental wellbeing and what works to improve this.
- We can achieve this by working in partnership with residents and other organisations and considering mental wellbeing when commissioning and evaluating services
- We need to ensure investment is channelled towards prevention and early intervention not just towards treatment

2.2 Public Health have been working with Westminster's Campaigns and Customer Engagement team to plan a communications campaign on the key messages.

2.3 In addition to the printed report presented here an online version of the report has been developed. This incorporates a link to the Roads to Wellbeing website, a tool which can be used to develop an asset based resource to promote mental wellbeing: Jsna.info/roadstowellbeing

3. Legal Implications

3.1 The Director of Public Health for a local authority must prepare an annual report on the health of the people in the area of the local authority Section (Section 31 (5) of the Health and Social Care Act, 2012). Westminster City Council has a duty to publish the report (Section 31 (6) of the Health and Social Care Act, 2012)

Implications verified/completed by: Hazel Best, Senior Solicitor, 07717423421

4. Financial Implications

4.1 There are no financial implications arising from this report. Any future financial implications identified as a result of the report will be presented to the appropriate Board(s) and governance channels in a separate report.

Implications verified/completed by: Brighton Fong, Finance Manager, 02076417634.

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

Colin Brodie

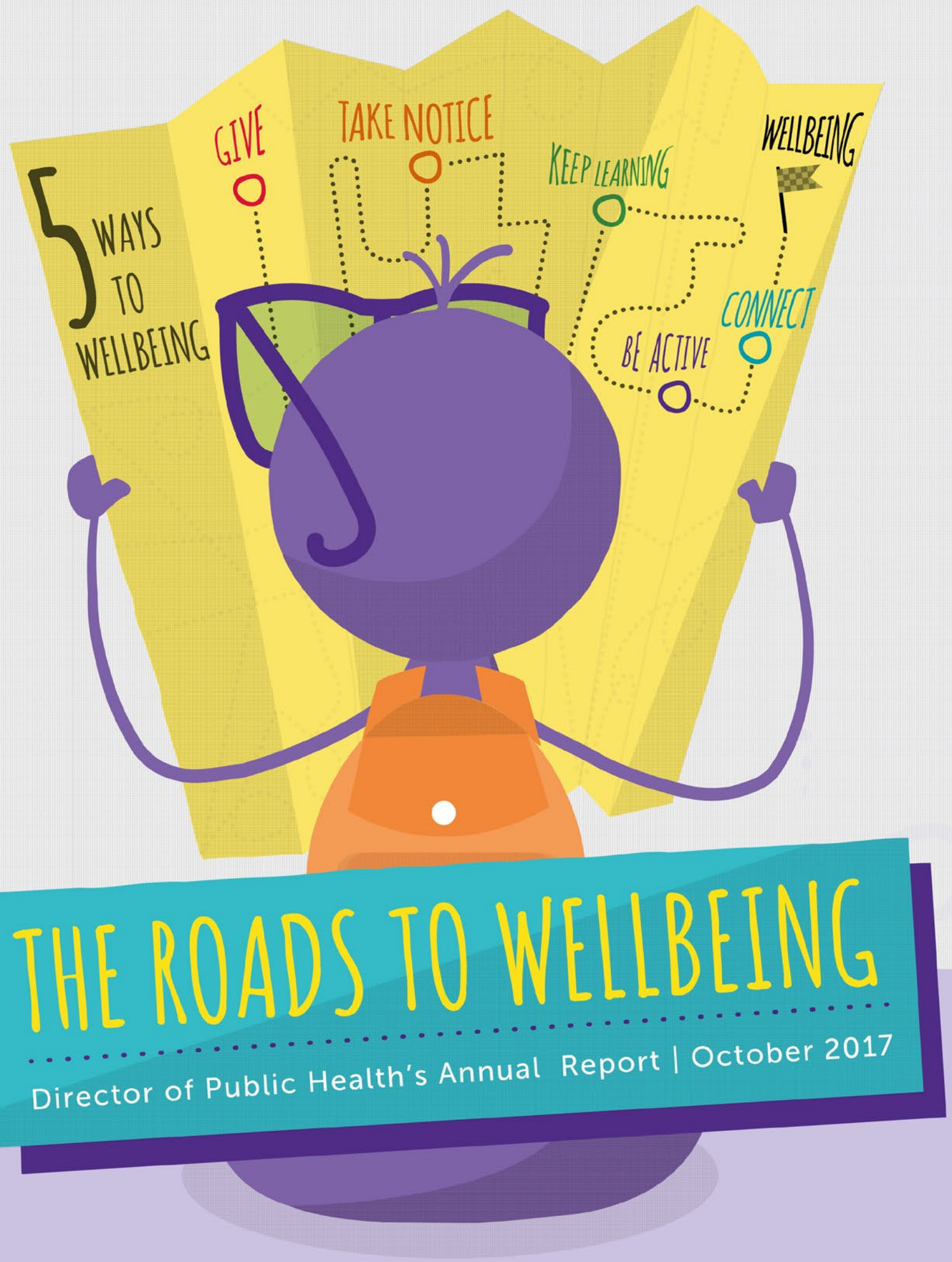
cbrodie@westminster.gov.uk

Telephone: 02076414632

APPENDICES:
None

BACKGROUND PAPERS:
Annual Public Health Report

This page is intentionally left blank



THE ROADS TO WELLBEING

Director of Public Health's Annual Report | October 2017

FOREWORD

Welcome to my annual report for 2016/2017. This year focuses on the importance of protecting and improving our own mental wellbeing, and that of the people around us – our families, friends, neighbours, and local communities.

Dr. Mike Robinson
Director of Public Health
Hammersmith & Fulham, Kensington and Chelsea, and Westminster

Good mental wellbeing is important for us to lead happy, healthy lives. It is often defined as 'feeling good' and 'functioning well' – so is not only about feeling happy or content, but also about how we cope and engage in the world around us. Research shows that good mental wellbeing promotes our overall health, supports recovery from illness, and improves life expectancy.

We are all on a journey to achieve positive mental wellbeing, and the report includes a number of case studies describing steps that local residents have taken. These are based around the Five Ways to Wellbeing, an evidence based framework for actions that anyone can take – Connect, Be Active, Keep Learning, Take Notice and Give.

Locally, we have services and activities in place that can support us on our journey to achieve a positive sense of mental wellbeing. There are many challenges too, and the recent tragic events at Grenfell Tower and terrorist attacks in London and Manchester, have highlighted this. These events, as well as other pressures such as social isolation, financial worries, and physical inactivity can all have an impact on our mental wellbeing.

Mental health and wellbeing has been identified as a priority in all three local Health and Wellbeing Strategies, and through that process we are already working with colleagues from across the local authority, community and voluntary organisations, schools, businesses and NHS partners to improve the mental wellbeing of our residents.

However, there is more that can be done, and this report is a call to action to find new ways to work together, to challenge the stigma that still exists around mental health, and to ensure that promoting our mental wellbeing becomes 'everyone's business'.

Key messages from the report:

- Poor mental wellbeing can affect us and those around us at any point in our lives. Mental wellbeing can impact on all aspects of our lives and is 'everyone's business'
- We can all play a role in improving our own and others' mental wellbeing: Connect, Be Active, Keep Learning, Take Notice, and Give
- To help build the mental resilience of our local communities we need to better understand residents' mental wellbeing and what works to improve this
- We can achieve this by working in partnership with residents and other organisations and considering mental wellbeing when commissioning and evaluating services
- We need to ensure investment is channelled towards prevention and early intervention not just towards treatment

Our commitments

To improve the mental wellbeing of our population the local authority Public Health team will make the following commitments:

- We will offer to work in partnership with commissioning and procurement colleagues across local authority and the NHS to ensure that mental wellbeing is considered in existing and new contracts.
- We will identify and action best practice in gathering and collating data on the mental wellbeing of our local population through existing and new contracts.
- We will innovate and test, thereby contributing to the evidence base about what works to improve mental wellbeing for local communities.
- We will support and drive the implementation of a local 'making every contact count' strategy with a specific focus on mental wellbeing.
- We will support the development of a Health and Wellbeing Board implementation plan for working across the local health system to improve mental wellbeing.

WHAT IS WELLBEING?

Wellbeing is about how we are feeling and how well we function in our daily lives. It often includes subjective notions of happiness, life satisfaction, and 'feeling good'. Our emotional or mental wellbeing is closely linked with our physical health, and is strongly associated with positive relationships and healthier communities.

The focus of this report is on mental wellbeing rather than mental health, although the two are closely linked. The "Better mental health for all" report (Faculty of Public Health, 2016) defines the term mental health as a "spectrum from mental health problems, conditions, illnesses and disorders through to mental wellbeing or positive mental health." Therefore, mental wellbeing can be viewed as a positive state of mental health.

Why focus on mental wellbeing?

Our mental wellbeing is fundamental to all aspects of our lives; it makes up an integral part of an individual's ability to lead a fulfilling life and contribute to society, form positive relationships, study and learn, and take part in social activities; as well as the ability to make decisions and choices (World Health Organisation, 2012).

Positive mental wellbeing strengthens our resilience, improves our ability to recover from illness, and protects our mental health. This is incredibly important as mental health is the single largest burden of disease in the UK (Ferrari, 2013) and is associated with many poor health and societal outcomes. For example, mental health is one of the most common reasons for sickness absence locally (DWP, 2013).

> Mental wellbeing is "...a dynamic state, in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others, and contribute to their community"
>
> (Government Office for Science, 2008)

CASE STUDY:
COMMUNITY CHAMPIONS

Saheda has been involved in the Community Champions project as a volunteer since 2016 where she received training in Understanding Health Improvement, Mental Health First Aid, and Safeguarding Adults Level 1. Saheda has since worked on several activities including winter warmth pop up stalls and Mental Health Awareness stalls - handing out information, signposting to local services and most of all, using her own experience of recovering from mental health issues to help the recovery of others.

WHICH WAY TO WELLBEING:

- CONNECT
- BE ACTIVE
- GIVE
- KEEP LEARNING
- TAKE NOTICE

'THE PROJECT HELPED ME TO GET OUT OF THE HOUSE TO DO SOME ACTIVITIES IN THE COMMUNITY. VOLUNTEERING MADE ME FEEL LIKE GOING BACK TO SCHOOL, MY CONFIDENCE HAS IMPROVED AND NOW I CAN SPEAK TO ANYBODY AND EVERYBODY.'

What can affect our mental wellbeing?

There is evidence that the risk factors for a person's mental health and wellbeing are shaped by various social, economic and physical environments including, for example, family, history, debt, unemployment, isolation and housing. The World Health Organisation considers risk factors in three groups (World Health Organisation, 2012):

Personal, social and economical factors affecting mental wellbeing

1. These relate to a person's innate as well as learned ability to deal with thoughts and feelings to manage him/herself in daily life - 'emotional intelligence'
2. The capacity for an individual to develop and flourish is deeply influenced by their immediate social surroundings
3. Access to basic commodities and services, cultural beliefs, social and economic factors such as the global crash and discrimination

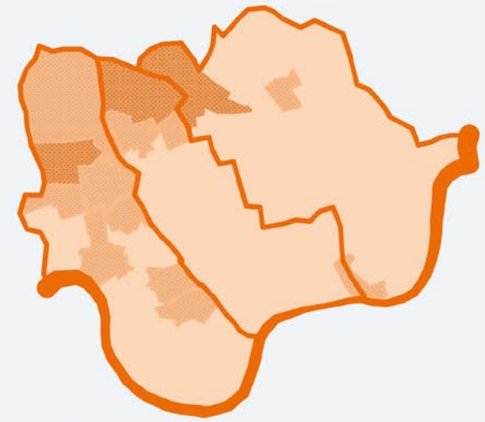
What is mental wellbeing like in the three boroughs?

The London Wellbeing Scores suggest that mental wellbeing differs across the three boroughs, and many of the wider determinants mentioned above do contribute to the areas with lower wellbeing scores.

The London Ward Wellbeing Scores represent overall wellbeing that encompasses wider determinants of wellbeing such as employment, access to green space and happiness. The map displays the three boroughs' wellbeing score against the London average. The darker areas in the north-west of the three boroughs have a significantly lower score than the London average. Around half the population of these wards are black, Asian, and minority ethnic residents (census 2011), these wards also have the highest levels of out of work households with dependent children (around 30%) (HM Revenue and Customs 2014).

However, the three boroughs are a place where there is opportunity in London as all three are in the top ten places in England for social mobility. The social mobility index looks at the chances a child from a disadvantaged socio-economic background has of doing as an adult, and Westminster ranks first in England, Kensington and Chelsea seventh, and Hammersmith & Fulham tenth (The Social Mobility and Child Poverty Commission, 2016).

GLA London Wellbeing Scores



LOWER THAN LONDON AVERAGE
SIGNIFICANTLY LOWER THAN LONDON AVERAGE

MENTAL WELLBEING THROUGHOUT OUR LIVES

Everyone can potentially be affected by poor mental wellbeing at any point in our lives, therefore it is important for all of us to be aware of factors that may affect our mental wellbeing. Taking steps to look after our wellbeing can help us deal with pressure. Mind calls this developing 'emotional resilience – the ability to adapt and bounce back when something difficult happens in your life' (Mind, 2015). This part of the report looks at mental wellbeing at each stage in our lives and common factors that may affect our wellbeing. The latter part of the report suggests how we can all look after our wellbeing through the Five Ways to Wellbeing.

Children and young people

Research tells us that mental health issues frequently develop in our early and teenage years. This indicates the importance of early intervention and addressing the childhood determinants of mental health and wellbeing. Of these, family relationships are pre-eminent, as positive attachments result in good emotional and social development for children, equipping people with the necessary skills and knowledge to achieve resilience and positive mental wellbeing in adulthood.

50% of lifetime mental health problems are established by age 14 and...

75% by age 17

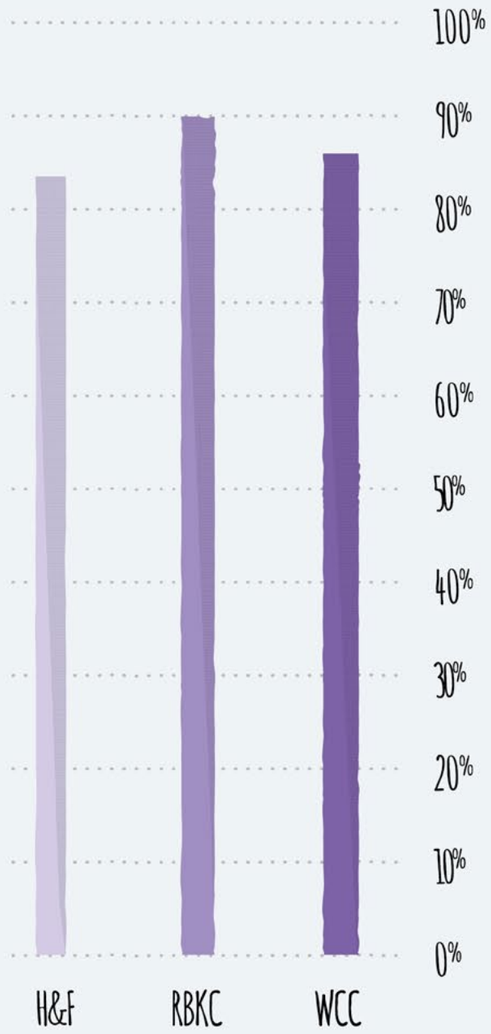
(Kessler R, 2005)

AT LEAST 1 IN 4 of us will experience mental health problems in our life... with wider impacts resulting in around £26billion each year in total economic and social costs to London

(Greater London Authority, 2014)

? Robust data is not available at a local level, partially due to a lack of diversity among survey participants.

Percentage of primary school children reporting that they are very happy or happy with their overall life.



Source: Healthy Schools Partnership: local school survey data, October 2016 to March 2017, pupils from year 3, 4, 5 & 6

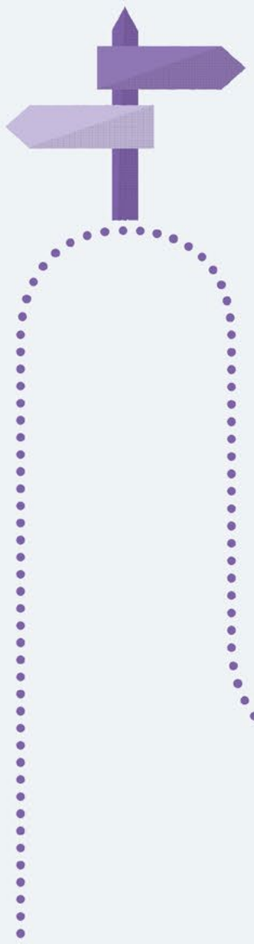
Factors that can affect the wellbeing of children and young people

Many factors affect a person's wellbeing in their early years and later into adolescence. Of these, strong and positive family relationships are key to good emotional and social development for children, and they equip children with the necessary attributes to achieve resilience and positive mental wellbeing in adulthood.

The Children's Society explains that efforts to understand variations in children's subjective wellbeing should focus more on children's own experiences of life than on traditional social indicators (The Children's Society, 2016). Examples of factors that affect the wellbeing of children and young people are shown in the table.

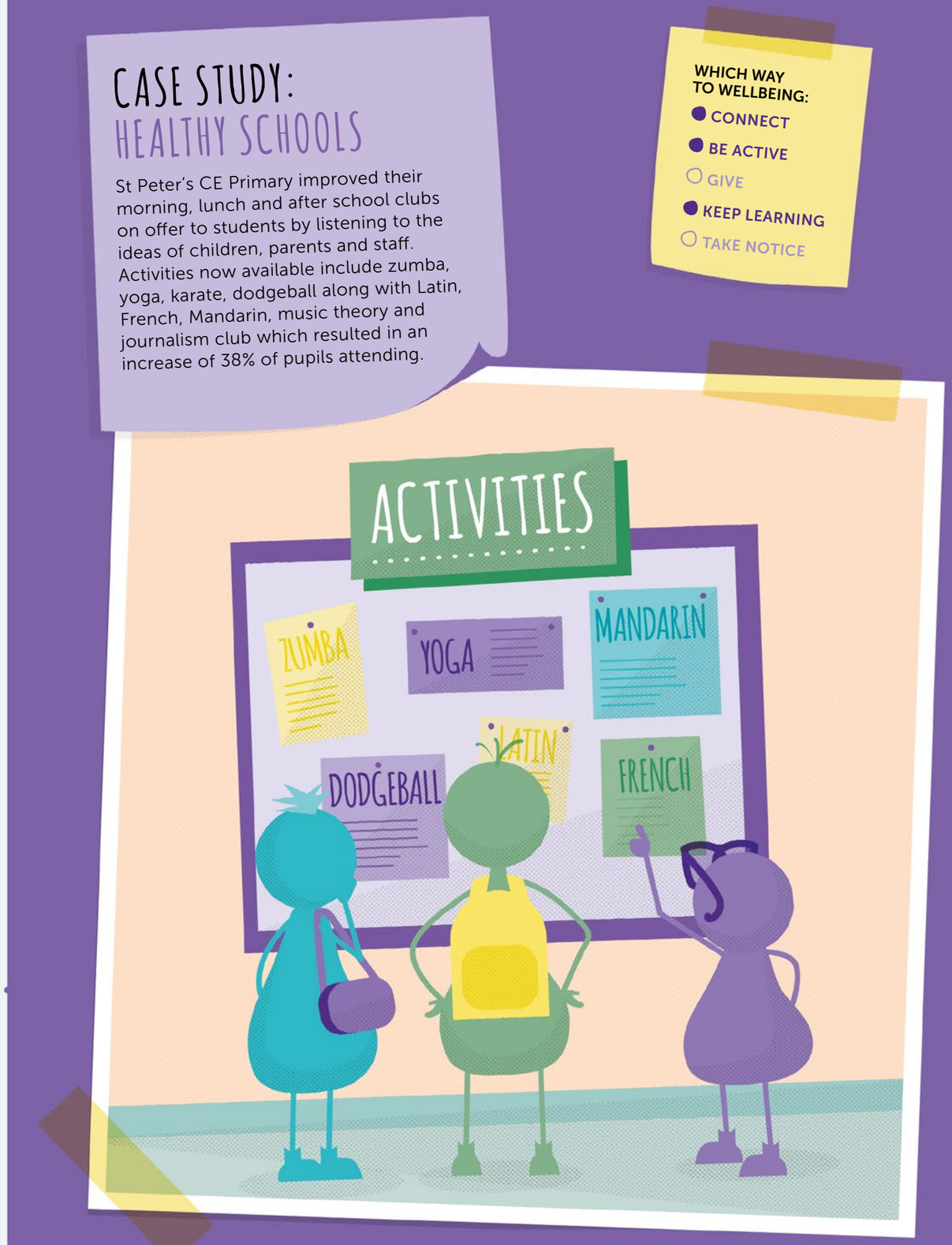
PARENTAL RELATIONSHIPS	A child's relationship with their parents is an important factor associated with overall well-being[1] Maternal depression is associated with a x5 increased risk of mental health illness for the child[2]
BULLYING	Children who had been bullied at age 13 were more than twice as likely to have depression at age 18[3]
SOCIAL MEDIA	Facebook, Instagram, Snapchat and Twitter increases young people's feelings of inadequacy and anxiety[4&5]

[1.] The Children's Society, 2013 [2.] Public Health England, 2016 [3.] BMJ, 2015 [4.] RSPH and Young Health Movement, 2017 [5.] Guardian, 2017



CASE STUDY: HEALTHY SCHOOLS

St Peter's CE Primary improved their morning, lunch and after school clubs on offer to students by listening to the ideas of children, parents and staff. Activities now available include zumba, yoga, karate, dodgeball along with Latin, French, Mandarin, music theory and journalism club which resulted in an increase of 38% of pupils attending.



Adults

As we grow into adulthood we start to experience additional challenges to our mental wellbeing. We may experience the loss of loved ones, job or housing insecurity, financial worries and the stresses of everyday life. Building close relationships with friends, family and our communities is incredibly important as is looking after our workplace health.

Across London and within the three boroughs, when asked "overall, how anxious did you feel yesterday?" only around 30% of respondents said they were not at all anxious the previous day:

Percentage of respondents who felt anxious yesterday, by range

Source: Annual population survey 2016: (sample size: H&F: 840; WCC: 930; RBKC: 970, CV: estimate is reasonably precise)

Factors that can affect the wellbeing of adults

ECONOMIC DEPRIVATION	Having a very low income, or experiencing economic deprivation, is associated with low wellbeing[1]
CLOSE RELATIONSHIPS	People who have good social relationships have higher wellbeing and better mental health[1]
UNEMPLOYMENT	Being unemployed has a negative impact on subjective wellbeing and mental health[1] Only 43% of people with mental health problems are in work in the UK[2] Locally mental health is the most common reason for long term sickness absence[3]
POVERTY AND HOUSING	Living in a house which has pollution, grime, or other environmental problems reduces life satisfaction Housing insecurity impacts life satisfaction[1]

[1] (Brown, Abdallah and Townsley, What works wellbeing, 2017) [2] (Molyneux, (2017)) [3] (DWP, 2013)

? This subjective question asked by the ONS provides a snapshot but we would like to understand if respondents often felt anxious, and why.

CASE STUDY: MACBETH CENTRE

Shamir left higher education due to illness and once recovered felt as though he had gone off track with his goal of becoming an accountant. Shamir took book keeping level 1 and 2 at the Macbeth Centre, he was able to refresh his knowledge and felt confident enough to re-join further education.

WHICH WAY TO WELLBEING:
- ○ CONNECT
- ○ BE ACTIVE
- ○ GIVE
- ● KEEP LEARNING
- ○ TAKE NOTICE

'BY THE END OF THE COURSES, I REGAINED MY CONFIDENCE AND GOT BACK INTO THE RIGHT MIND SET. I AM CURRENTLY STUDYING FOR MY DEGREE IN ACCOUNTING AND FINANCE.'

Older adults

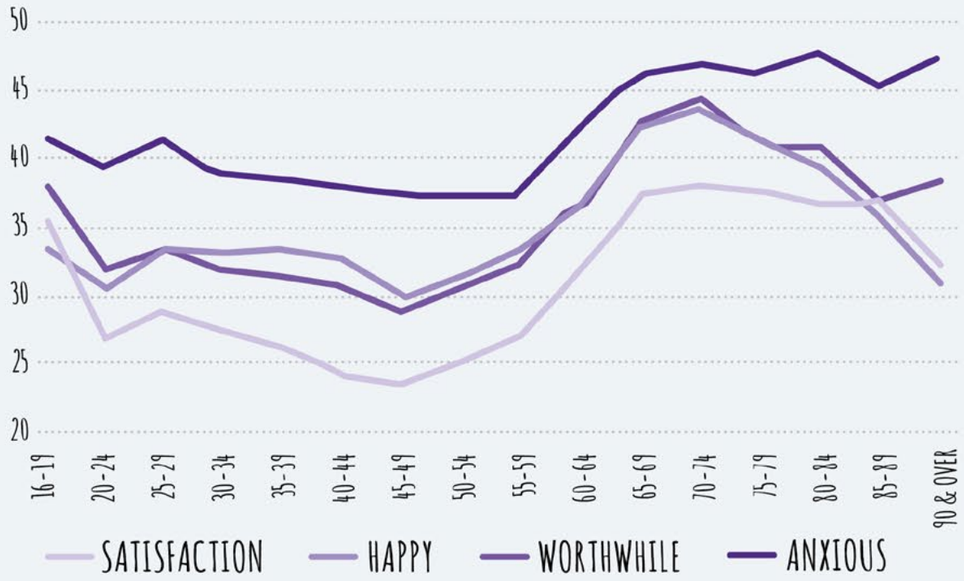
Our mental wellbeing can be challenged as we grow older by events outside of our control, such as the loss of a loved one and reduced mobility. The Mental Health Foundation and Age Concern said "promoting mental health and well-being in later life will benefit the whole of society by maintaining older people's social and economic contributions, minimising the costs of care and improving quality of life" (Mental Health Foundation & Age Concern, 2006).

Life satisfaction, the feeling of being worthwhile, and happiness all increase in the years leading up to and during the first few years of retirement, however so do feelings of anxiety. It is in the later years of retirement, 74 and older, that anxiety stays continuously high, but happiness, life satisfaction and feeling worthwhile decrease.

Factors that can affect the wellbeing of older people

SOCIAL ISOLATION	Social isolation is a well documented cause of poor mental wellbeing Around 1 million older people are affected by social isolation in the UK which has a severe impact on their quality of life There is a greater risk of loneliness in the wards in our three Boroughs that have been identified as having poorer wellbeing than the London average Social isolation can be caused by decline in social actvity, death of friends or relatives, mobility problems and living alone

Wellbeing by age



Source: Wellbeing by protected characteristics 3 years to 2015, Annual Population Survey (ONS)

? National research informs us of the factors that may affect our wellbeing. However, there is a lack of robust information that tells us how many people in our boroughs are affected and what caused their poor mental wellbeing.

CASE STUDY: OPEN AGE

Patricia lost her husband to cancer after 48 years of marriage and started coming to the stretch and tone class. She believes she has 'transformed into a happier soul' as the class has improved her mobility, she can walk longer distances and she feels stronger and more confident.

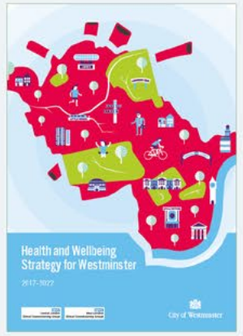
WHICH WAY TO WELLBEING:
- CONNECT
- BE ACTIVE
- GIVE
- KEEP LEARNING
- TAKE NOTICE

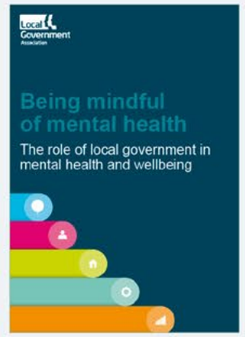
'YOU CAN SIT AT HOME AND GET NOTHING; A GOOD LAUGH IS BETTER THAN ANY MEDICINE IN THE WORLD. THIS HAS GIVEN ME A NEW LEASE OF LIFE, A CHANCE TO LIVE WITHOUT FEELING GUILTY OF DOING SOMETHING FOR MYSELF ...AND LOVING IT''

HOW ARE THE THREE COUNCILS AND PARTNERS ADDRESSING MENTAL WELLBEING AND MENTAL HEALTH?

Mental wellbeing is a priority for all three boroughs, the NHS and central government. As a result there are a number of local, regional and national strategies on mental health. The strategies demonstrate a common consensus about the importance of wellbeing and promoting good mental health, rather than a focus on intervening when an individual becomes mentally unwell.

The Local Authority, with its reach to all sections of our community, is ideally placed to drive these population level improvements while supporting partners with the delivery of responsive and integrated mental health services. We would like this report to renew the focus on mental health and start conversations that will help to bring these strategies into action.





Local initiatives

There is lots of work going on to improve areas that have low wellbeing ranging from regeneration to local activities. We have highlighted three examples of these below:

Go Golborne:

A local campaign led by Kensington and Chelsea Council that is all about supporting children and families to eat well, keep active and feel good.

Create Church Street:

'Create Church Street' Arts and Culture Fund which enables local people to develop creative arts projects that will benefit the wider community.

Rose Vouchers Scheme:

A scheme to help families on low incomes eat fresh fruit and vegetables, organised by the Alexandra Rose Charity and funded by Hammersmith &Fulham Council.

For more information on the strategies above, please visit our website:
jsna.info/roadstowellbeing

HOW IMPORTANT IS PREVENTION AND EARLY INTERVENTION?

Preventing young people from experiencing poor mental health is one of the smartest investments society can make. Research tells us that young people who have good mental wellbeing have less physical illness, they do better at school, they take less time off work, are less likely to become 'burned out', have better social relationships and are more likely to lead healthier lives in general (Maudsley International, 2017).

There are times when our resilience can be challenged. The Mental Health Foundation points out that there are times throughout all our lives where we may run into difficulty, 'particularly at life's pressure points: the crucial times of transition from one life stage to another; from moving away from home for university, to having children or dealing with the loss of a loved one' (Mental Health Foundation, 2016). Stigma and discrimination can impede people seeking the help that they need and can make their difficulties worse and harder to recover (Mental Health Foundation, 2017).

The Early Intervention Foundation estimates that £17 billion per year is spent on late intervention 'addressing the damaging problems that affect children and young people, such as mental health problems, unemployment and youth crime' (Early Intervention Foundation, 2015). Only 1 in 4 people receive treatment for mental health problems, yet research tells us that every £1 invested could return from £5 through early diagnosis and treatment of depression at work, to £84 through school-based social and emotional learning programmes. (Knapp, 2011). Therefore, we want to prevent poor mental wellbeing before needing treatment.

'We can no longer afford to wait for mental health problems to develop before taking action'

(Mental Health Foundation, 2016)

Research tells us that every £1 invested in mental health could return from £5-£84

(Knapp, 2011)

Prevention is a priority at a population level, but it was also found to be the number one priority of individuals during the engagement stage of the NHS England's Mental Health Taskforce (Independent Mental Health Taskforce to the NHS, 2015). Respondents believed that getting help early could stop mental health problems escalating. The specific themes the respondents thought could make a difference included:

STARTING WELL	Support for new mothers and babies can improve maternal health and reduce maternal depression
EDUCATION	Mental health promotion within schools and employers
SELF MANAGE	Being able to self manage mental wellbeing
STAYING ACTIVE	Ensuring good overall physical and mental health and wellbeing

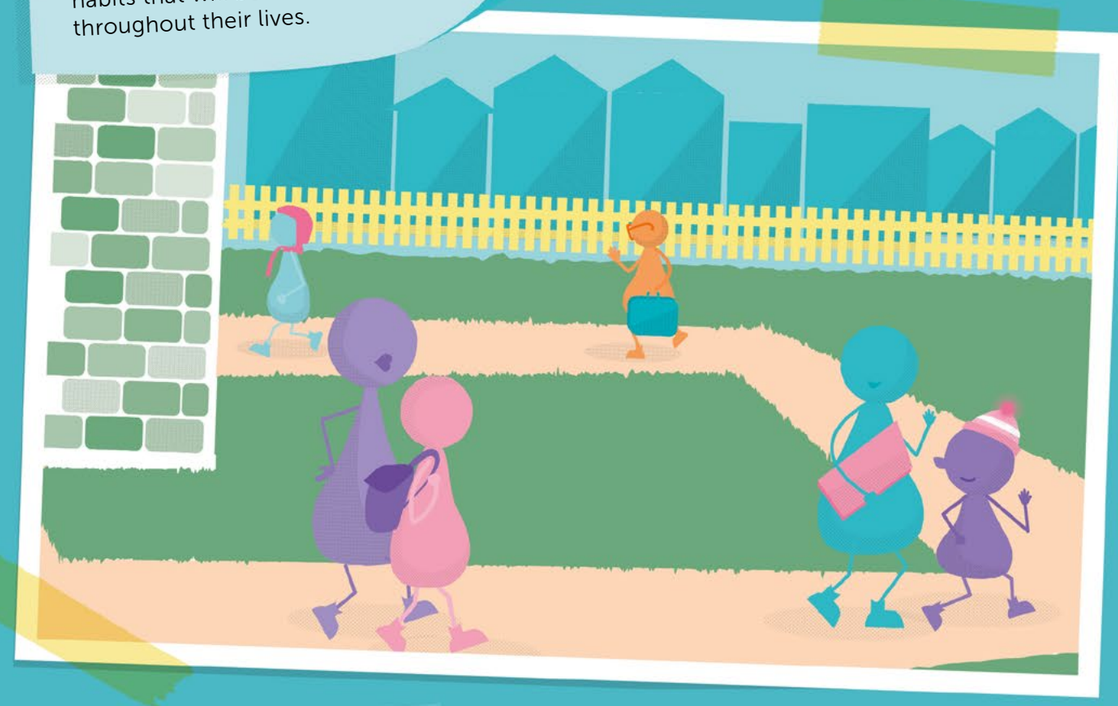
'Support during a time of crisis can prevent deterioration of mental health'

(The BME Health Forum for Hammersmith & Fulham, Westminster and Kensington and Chelsea)

CASE STUDY: DAILY MILE

A simple but effective concept that gets children running outside in the fresh air for 15 minutes each day, improving fitness, concentration, academic performance and wellbeing. Encouraging children to be active from a young age can start good habits that will benefit them throughout their lives.

WHICH WAY TO WELLBEING:
- CONNECT
- BE ACTIVE
- GIVE
- KEEP LEARNING
- TAKE NOTICE



'THE DAILY MILE GIVES MY RESTLESS KIDS THE CHANCE FOR A GOOD ENERGY RELEASE BEFORE WE CONTINUE OUR NORMAL DAY'

Y4 Teacher

'I LIKE THAT WE GET TO TALK TO OUR FRIENDS'

Y3 Student

WHO DO WE THINK IS MOST AT RISK?

Whilst everyone should look after their mental wellbeing, research tells us that some groups are at particular risk of developing mental health problems, including:

BAME residents

All three boroughs have high levels of international migration and cultural diversity with around half of the resident population born outside of the UK. Black, Asian, Arabic and other minority ethnic groups comprises of 33.9% of H&F's population, 30% of WCC's population and 29% of RBKC's population. Around half of the population of the tri-borough wards with the lower than average wellbeing are BAME residents (source: London Borough Profiles and Atlas).

When asked 'how anxious did you feel yesterday?' a slightly higher percentage of ethnic minorities, particularly Asian, Arab and other ethnic groups, scored themselves higher on a scale of 0-10 (10 being very anxious).

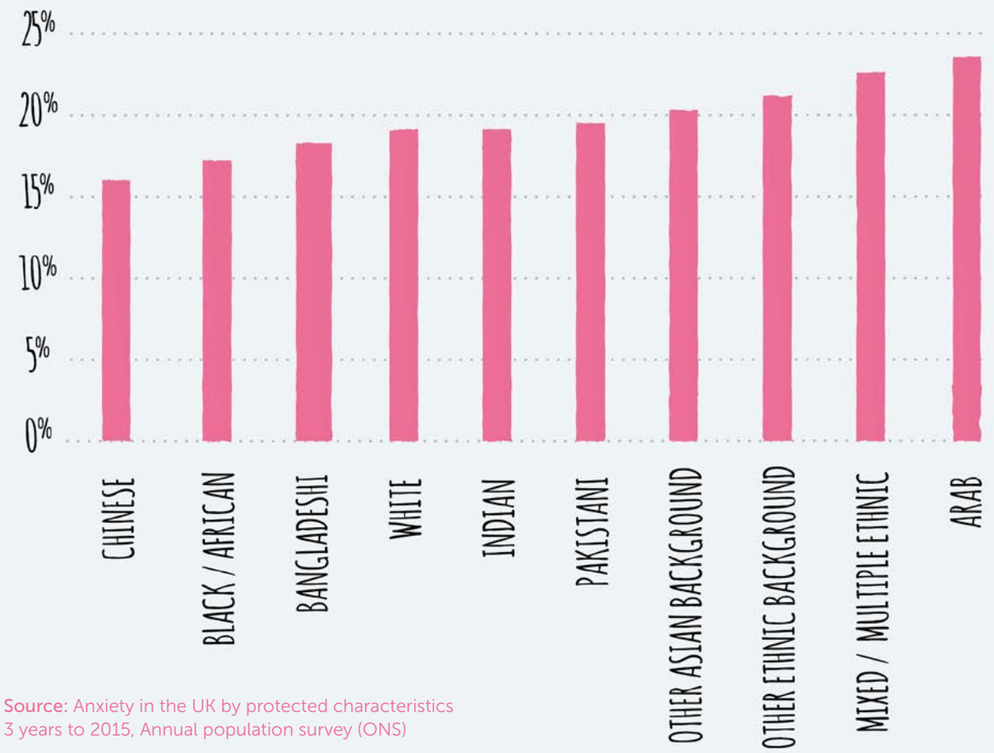
Support for mental wellbeing is one of the most often found needs amongst BME communities[1]

Helping the stigma to decrease will allow ethnic minority communities to reach out for help when needed[2]

Young people who are black are 1.3x more likely to report low life satisfaction compared to young people who are white[3]

[1.] BME Health Forum, 2017 [2.] Independent Mental Health Taskforce to the NHS, 2015 [3.] Public Health England, 2016

Percentages of people who felt anxious the day before, by ethnicity



Source: Anxiety in the UK by protected characteristics 3 years to 2015, Annual population survey (ONS)

LGBT people

London has the highest percentage of LGBT people in the UK, with 3% of the population identifying as LGBT and other in the annual population survey, and a further 7% identifying as 'don't know' or 'refuse'.

The LGBT Foundation suggests 'it is thought that lesbian, gay and bisexual people are at significantly higher risk of mental health problems, suicidal thoughts and deliberate self-harm than heterosexual people' (LGBT Foundation, 2017). Contributing factors include homophobia, isolation and discrimination (LGBT Foundation, 2017).

3.3x

Young people who are bisexual are more likely to report low life satisfaction compared to young people who are heterosexual

(Public Health England, 2016)

Carers

87%

Of respondents* stated that caring had a negative impact on their mental health. Contributing factors included lack of practical support and lack of financial support

*In a survey of 3,400 carers in the UK (Carers UK, 2012).

People living with physical and learning disabilities

There are 7,660 people (3.2% of the population) who are living with a physical or learning disability in Westminster, 6,070 (3.4% of the population) in Hammersmith & Fulham and 4,500 (2.8% of the population) in Kensington and Chelsea (DWP disability living allowance November 2016, ONS).

Findings suggest that having a learning disability increases the likelihood of a mental illness. Contributing factors range from the biological aspects of learning disabilities to environmental and social experiences (The Shaw Mind Foundation, 2017). Researchers also found that 30% of those with a long term physical condition also have a mental health problem and are particularly at risk of anxiety and depression. Contributing factors include financial concerns and increased isolation (The Shaw Mind Foundation, 2017).

Children in care

'The period of time around when young people leave care can also be a particularly challenging time for their emotional wellbeing. Those who participated in interviews and workshops pointed out that care leavers frequently experience many transitions in a short period of time, including leaving their placement (and carer), a change of key worker and, in some cases, moving to a new geographical area to live in new accommodation. Therefore, leaving care can be a particularly stressful time.'

(NSPCC, 2015)

60%

Of looked after children have some form of emotional or mental health illness (Public Health England, 2016). This is about six times higher than all children in the local population

People with long term conditions

Many people with long-term physical health conditions also have mental health problems. These can lead to significantly poorer health outcomes and reduced quality of life.

45%

Co-morbid mental health problems raise total health care costs by at least 45% for each person with a long term condition, estimated to cost between £8bn and £13bn in England each year

(Centre for Mental Health, 2012)

People living in poverty

'Poverty increases the risk of mental health problems, and can be both a causal factor and a consequence of mental ill health. Mental health is shaped by the wide-ranging characteristics (including inequalities) of the social, economic and physical environments in which people live.'

(The Mental Health Foundation: Elliot, 2016)

Locally, the most deprived wards are also the wards with the lowest wellbeing scores as shown in the map in page 4.

People who experience traumatic life events

Around 1 in 3 adults in England report having experienced at least one traumatic event.

The Grenfell Tower Fire was an unprecedented large-scale traumatic event that will have an impact both directly and indirectly, across families, professionals and our diverse communities. I intend to focus on the Grenfell Tower tragedy in more detail in next year's annual public health report.

Our efforts so far have focused on providing coordinated, accessible information and support to all of those who may be affected, including developing and implementing a multi-agency therapeutic phased based approach to health and wellbeing.

Lessons from a number of recent national incidents (e.g. Manchester and Southwark) indicate that initiating such an approach is an extremely useful strategy to employ as part of the overall intervention plan.

'When you experience a traumatic event, your body's defences take effect and create a stress response, which may make you feel a variety of physical symptoms, behave differently and experience more intense emotions. [...]

However, if these feelings persist, they can lead to more serious mental health problems such as post-traumatic stress disorder (PTSD) and depression.'

(The Mental Health Foundation, 2017)

Our approach to support has been based on lessons learned and evidence of what works:

Universal Offer: 'Getting Advice'

For all adults and children who have had direct or indirect involvement. This is disseminated through community, primary care and specialist services to ensure adults, children and young people are able to access advice and support as necessary through universal services.

Targeted Offer: 'Getting Help'

For supporting adults who have been exposed to the trauma of the events and children / young people who continue to experience distress or ongoing symptoms and are not responding to a universal offer. Delivered by various professionals and provider organisations.

Specialist Offer: 'Getting More Help'

For adults exposed to the trauma of the events where symptoms are present between four and twelve weeks and for children / young people experiencing moderate-severe needs (persistent or increasing symptoms, impact on day-to-day living and lack of emotional and social support). Delivered by specialist mental health organisations.

CASE STUDY: SING TO LIVE, LIVE TO SING

Haseena is an elderly woman from the Middle East, who fled from her country in the 1980s and has been a refugee in the UK since.

She loves attending Sing to live, live to sing workshops and enjoys the opportunities that the workshops bring to improve her English and help her learn other languages, such as Spanish through the song "Gracias a la Vida". Singing "This is Home" makes her think about her home which initially she found upsetting, but now she uses singing as a way to express emotions associated with leaving her homeland.

WHICH WAY TO WELLBEING:

- ● CONNECT
- ○ BE ACTIVE
- ● GIVE
- ● KEEP LEARNING
- ○ TAKE NOTICE

'SING TO LIVE, LIVE TO SING MAKES YOU HAPPY... AND JOYFUL'

HOW CAN WE MAINTAIN AND IMPROVE OUR OWN WELLBEING?

There are ways that we can maintain and improve our mental wellbeing. The Five Ways to Wellbeing (New Economics Foundation, 2008), according to research, can really help to boost our mental wellbeing. The NHS suggest if we give them a try, we may feel happier, more positive and able to get the most from life (NHS, 2016):

CONNECT

Connect with the people around you, your family, friends, colleagues and neighbours. Arrange to meet up with family or friends you haven't seen for a while. Or pick up the phone. Speak to someone new today. Building these connections will support and enrich you every day.

TAKE NOTICE

Be aware of the present moment and the world around you. Be curious. Explore your local landrmarks. Visit your local market or festival. Reflecting on your experiences will help you appreciate what matters to you.

BE ACTIVE

Go for a walk, cycle, swim, play a game of football, spend time gardening, join a dance class, or visit your local park. Find an activity that you enjoy and make it a part of your life – exercising makes you feel good.

KEEP LEARNING

Try learning a new skill or rediscover an old hobby. Sign up for that cookery course you have always wanted to do. Learn to play a musical instrument or a new language. Figure out how to fix your bike or put up a shelf. Visit a local gallery or museum. Learning new things will make you more confident as well as being fun.

GIVE

Say thank you to someone, for something they have done for you. Smile. Phone someone who needs your support or company. Volunteer your time at a local community group, or in your local school, library or hospital. Seeing yourself, and your happiness, linked to the wider community can be incredibly rewarding and creates connections with the people around you.

JSNA.INFO/ROADSTOWELLBEING

Help to achieve the five ways to wellbeing

For more examples on how to achieve the five ways to wellbeing if you have few minutes, an hour or longer, visit our website: **jsna.info/roadstowellbeing**

For further help, you can also visit these useful links:

- **People First** is a council resource that provides a wealth of information on all the services available to you to lead a healthy and independent life
- **NHS Choices** is the online 'front door' to the NHS
- **Or visit your GP**

CASE STUDY:
ABBEY COMMUNITY CENTRE

Mrs Abboud* is a mother of two in her mid-thirties from the Middle East. Before she joined ACAL as a member she was looking after her family but not developing her career. She joined ACAL as a member in 2012, where her two boys accessed the after school football sessions and she completed our accredited Culinary Arts and Food Hygiene & Safety courses. Mrs Abboud* was then trained by the BME Health Forum to become a Mental Wellbeing Champion, where she has been working as a sessional worker to support our community members who are experiencing difficult personal circumstances that cause them stress, anxiety and depression. This led to Mrs Abboud* securing part-time employment as a Family Support Worker with St Vincent Family Centre.

*name has been changed

WHICH WAY TO WELLBEING:

- ● CONNECT
- ○ BE ACTIVE
- ● GIVE
- ● KEEP LEARNING
- ○ TAKE NOTICE

"I'M VERY GRATEFUL TO THE ABBEY CENTRE THAT OPENED A NEW OPPORTUNITY FOR ME TO GAIN SKILLS, KNOWLEDGE AND FRIENDSHIPS. I HAVE SECURED A VOLUNTEERING OPPORTUNITY THAT LED TO PART-TIME EMPLOYMENT"

NEXT STEPS AND RECOMMENDATIONS

A key challenge for the local authority and NHS partners is to consider how our services and actions can help improve the mental wellbeing of our local community. The recommendations outlined here are the first step towards achieving this.

Health and Wellbeing Boards

- To better understand the mental wellbeing needs and issues for the local population the Health and Wellbeing Boards should commission a Joint Strategic Needs Assessment (JSNA) on mental health and wellbeing in our local population
- Promoting mental health is one of the four priorities of each Joint Health and Wellbeing Strategy. The delivery plans should be checked against this annual report and refreshed when the findings of the JSNA are published
- Members of the Health and Wellbeing Board to explore the feasibility of using the Roads To Wellbeing infrastructure, or a similar geographic approach, to develop an asset based resource

Local employers

- Public and private sector employers need to promote the importance of mental wellbeing for their staff. The mental wellbeing of staff should be given equivalent status and consideration as physical health and wellbeing
- Council People Services and NHS HR teams should produce a business case for investment in Mental Health Awareness Training programmes for staff

Communications

- Council and NHS communications teams should identify the wellbeing needs for different residents and tailor messages to address these needs. The Five Ways to Wellbeing can help support this
- Each council should endorse Thrive LDN and work in partnership to contribute to the citywide movement to improve the mental health and wellbeing of all Londoners

Schools

- We will work with local schools to explore opportunities to promote Mental Health First Aid training for parents and staff

"These recommendations are a call to action to find new ways to work together, to challenge the stigma that still exists around mental health and to ensure that promoting our mental wellbeing becomes everyone's business."

Dr. Mike Robinson,
Director of Public Health

WORKS CITED

Age UK. (n.d.). Loneliness and Isolation Evidence Review.

Age UK, census 2011. (2011). Risk of loneliness heat map.

BME Health Forum. (2017). Emotional Wellbeing Project.

BME Health Forum. (2017, July 25). Emotional Wellbeing Project.

BMJ. (2015). Peer victimisation during adolescence and its impact on depression in early adulthood: prospective cohort study in the United Kingdom.

Brown, Abdallah and Townsley, What works wellbeing. (2017). Understanding local needs for wellbeing data.

Carers UK. (2012). In Sickness and in Health: A survey of 3,400 UK carers about their health and well-being.

Celia Warin, M. (2013). How to improve and maintain your mental wellbeing.

Department of Health. (2011). No health without mental health.

DWP. (2013, April). Employment and Support Allowance: incapacity benefits reassessment.

Early Intervention Foundation. (2015, February 12). £17 billion annual cost of damaging social problems affecting children and young people.

Faculty of Public Health. (2016). Better mental health for all: a public health approach to mental health improvement. London: Faculty of Public Health and Mental Health Foundation.

Ferrari, A. C. (2013). Burden of Depressive Disorders by Country, Sex, Age, and Year: Findings from the Global Burden of Disease Study 2010. PLoS Med.

Government Office for Science. (2008). Mental Capital and Wellbeing: Making the most of ourselves in the 21st century.

Greater London Authority (2009-2013) London Ward Wellbeing Scores.

Guardian. (2017, May). Facebook and Twitter 'harm young people's mental health'.

Healthwatch Central West London. (2017). Meeting the needs of socially isolated older people in RBKC. London: Healthwatch.

Healthy Schools Partnership (October 2016 to March 2017) Local school survey data, pupils from year 3, 4, 5 & 6.

HM Revenue and Customs (2014) Dependent children (0-18) in out-of-work households, retrieved from London Data Store Ward Profiles.

Independent Mental Health Taskforce to the NHS. (2015, September). The Five Year Forward View Mental Health Taskforce: public engagement findings.

Kessler R, B. P. (2005). Percentage of people with lifetime mental illness who experience symptoms in childhood. Arch Gen Psychiatry.

Knapp, M. a. (2011). Mental Health Promotion and Prevention: The Economic Case. Personal Social Services Research Unit, London School of Economics.

Knapp, Naylor, Parsonage, McDaid, Fossey & Galea (2012) Long term conditions and mental health: the cost of co-morbidities. Centre for Mental Health, The King's Fund.

LGBT Foundation. (2017). Mental Health.

London School of Economics: The Centre for Economic Performance's Mental Health Policy Group. (2012). How mental illness loses out in the NHS. LSE.

Maudsley International. (2017, May). Why promoting mental wellbeing benefits you, your neighbourhood, your workplace and your country... and how Maudsley International can help you do that.

Mental Health Foundation & Age Concern. (2006, June). Promoting mental health and wellbeing in later life.

Mental Health Foundation. (2016). Preventing mental ill health: time to take action.

Mental Health Foundation. (2017). Stigma and discrimination.

Mental Health Foundation. (2017). Mental health statistics: children and young people. (2017).

Mind. (2015, March). How can I be more resilient?

Mind. (2017). 5 ways to wellbeing.

Molyneux, P. (2017). Making a reality of employment for people with mental health problems in London. For Thrive LDN.

National Research Council (US) and Institute of Medicine (US) Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults. (2009). Preventing Mental, Emotional, and Behavioural Disorders Among Young People: Progress and Possibilities. Washington: National Academies Press.

New Economics Foundation. (2008, October). Five Ways to Wellbeing.

NHS. (2016, January). Five steps to mental wellbeing.

NSPCC. (2015). Achieving emotional wellbeing for looked after children.

ONS (2015) Annual Population Survey: Wellbeing by protected characteristics 3 years to 2015.

Public Health England. (2015). Estimated prevalence of mental health disorders in children and young people: % population aged 5-16. Retrieved from Children and Young People's Mental Health and Wellbeing Profile.

Public Health England. (2016). The mental health of children and young people in London.

Public Health England. (2016). The mental health of children and young people in London. London: Public Health England.

RSPH and Young Health Movement. (2017). #StatusOfMind Social media and young people's mental health and wellbeing.

The Children's Society. (2013). The Good Childhood Report.

The Children's Society. (2016). The Good Childhood Report.

The Mental Health Foundation. (2017). The impact of traumatic events on mental health.

The Mental Health Foundation: Elliott, I. (2016). Poverty and Mental Health: A review to inform the Joseph Rowntree Foundation's Anti-Poverty Strategy.

The Shaw Mind Foundation. (2017). Mental health of those suffering with physical or learning disabilities.

The Social Mobility and Child Poverty Commission. (2016). The Social Mobility Index. HM Government.

World Health Organisation. (2012). Risks to Mental Health: An overview of vulnerabilities and risk factors.

WHERE CAN I FIND OUT MORE?

Public Health England publishes numerous data sets and local profiles through its Mental Health, Dementia and Neurology Intelligence Network. Among others, these include profiles on children & young people's mental health, suicide prevention, crisis care and substance misuse.

For up-to-date information on local demographics, health and care, you can find a wide range of data on the online, interactive JSNA Highlight Reports **jsna.info**

This page is intentionally left blank

City of Westminster

Westminster Health & Wellbeing Board

Date:	16 November 2017
Classification:	General Release
Title:	Central London CCG and Westminster City Council Refreshed CAMHS Transformation Plan
Report of:	Rachael Wright-Turner (Director of Commissioning); and Jules Martin (Managing Director of Central London CCG)
Wards Involved:	All
Policy Context:	Following a critical report from the House of Common's Health Select Committee on young people's mental health, the Children and Young People's Health and Wellbeing Taskforce was established in September 2014. The Taskforce report, '*Future in Mind*' contained 49 recommendations for improvement, and there was an undertaking from the Government to increase resources for young people's mental health by £1.25 billion over five years.
Financial Summary:	Central London CCG (CL CCG) invests £2,955,539 commissioning young people's mental health services. Additionally, West London CCG provides a further £795,806 to commission mental health services for young people with a GP in the Queens Park and Paddington area. Total historic CCG funding is £3,751,345. Following the government's publication of *Future in Mind* (Feb 2015) CL CCG was allocated £91,557[1] to establish a community eating disorder service for young people and a further £229,176[2] to transform Child and Adolescent Mental Health Services (CAMHS) for 2015-16, these funds arrived with CCG's in December 2015.

[1] Funding for five years
[2] Funding for five years.

For 2016-17, an uplift to £483,000 was confirmed for transformation of existing and new services, with additional in-year funds to reduce waiting times. The Eating Disorder funding was also increased to £101,000 giving a new total for 2016-17 of £584,000.[3]

For 2017-18, the transformation resources from NHS England have not yet been confirmed, as finance is dependent upon successful submission of the CAMHS Transformation Plan on 31 October 2017. The CCG's expectation is that last year's funding will be matched with the exception of the waiting time resource.

Total expected CCG funding for 2017-18 is therefore:

Existing funding:	£3,751,345
Transformation funding:	£ 553,029[4]
Eating Disorders funding	£ 128,060[5]
Total	**£4,432,434**

Westminster City Council currently invests **£585,380** in young people's mental health services.

Report Author and Contact Details: *Angela Caulder, CAMHS Joint Commissioning Manager. 020 3350 4324. angela.caulder@nw.london.nhs.uk*

1. Executive Summary

1.1 An update report was provided to the Westminster Health and Wellbeing Board in November and March 2016 which outlined in some detail the progress since the CAMHS Task and Finish Group report (November 2014); publication of 'Future in Mind' (February 2015) and the submission of the initial Central London CCG and Westminster Young Person's Mental Health Transformation Plan (October 2015).

1.2 The submitted 2015-16 Transformation Plan resulted in additional funds being released to local Clinical Commissioning Groups (CCGs) in December 2015. NHS England asked for these plans to be "refreshed" annually, and this was successfully completed in 2016-17 securing the funding.

[3] The 'transformation' funding has been included in CCG baseline resourcing so has to be found within CCG 2016-17 and 2017-18 budgets.

[4] This figure includes £106,944 from West London CCG to deliver services to young people with a GP in the Queen's Park and Paddington areas.

[5] This figure includes £27,060 from West London CCG to deliver services to young people with a GP in the Queen's Park and Paddington areas.

1.3 The revised 2017 Westminster plan has been reviewed by Cllr Heather Acton Westminster's Health and Wellbeing Board Chair prior to the sign off deadline. Successful submission of the 'refreshed' CAMHS Transformation Plan secures the next tranche of NHS England funds.

1.4 This report summarises the achievements of the last twelve months and charts the next steps to be taken in Westminster to continue the momentum for improvement already established.

1.5 The ambition for the 'refreshed' transformation plan is that by 2020 local children, young people and their families will be able to:

- access services at the **Right time**,
- be seen in the **Right place** and
- access the **Right offer** in a welcoming environment.

1.6 The focus for 2017-19 will be on planning further **integration** between CAMHS Services, schools, and children's Early Help and Social Care services to reduce duplication, maximising the use of scarce resources by utilising the 'Family Hub' model.

1.7 Mental health **training** for the local children's workforce to increase capacity and skills across the system will continue with preventative and early intervention work in schools increasing.

1.8 The specialist CAMHS team have reduced **waiting lists** and extra resources for this work will continue to be prioritised. Additional funding is also targeted for those young people who are especially **vulnerable**, including young people with eating disorders, those in crisis, youth offenders and children who have autism or a learning disability.

1.9 New for 2017-18 is the implementation of 'Kooth', an **online counselling** platform for young people aged 11 upwards. Through the use of their mobile phones, young people can access bookable telephone counselling, moderated focus groups, 'chats', and text messaging with trained therapists. The service will be available from 11am to 10pm for care leavers and young people living in Westminster, or attending a Westminster schools.

1.10 Please see the attached, 'refreshed', 2017-18 CAMHS Transformation Plan for more detailed information[6]

2. Key Matters for the Board

2.1 The Health and Wellbeing Board is asked to note the achievements to date, the progress in implementing the Central London CCG and Westminster Young People's Mental Health Transformation Plan and the challenges ahead in realising local ambitions to 'transform' Westminster's mental health services for children and young people.

[6] Annex B: Central London CCG Local information and implementation plans for Central London CCG and Westminster City Council. October 2017.

3. Background

3.1 Please see attached report.

4. Options / Considerations

4.1 Option 1

The Westminster Health and Wellbeing Board acknowledges and supports the work being undertaken in relation to transforming mental health services for young people.

4.2 Option 2

The Westminster Health and Wellbeing Board does not support the young people's mental health service Transformation work as summarised above.

4.3 It is recommended that the Westminster Health and Wellbeing Board endorses option 1.

5. Legal Implications

5.1 There are no legal implications for Westminster City Council in this report.

6. Financial Implications

6.1 The Transformation funding for 2017-18 will be released to CCG's subject to NHS England's assurance processes following sign off from the Westminster Health and Wellbeing Board Chair. CCG's have been informed that the Transformation funding committed by Government for five years (2015-2020) has been added to baseline allocations from 2016-17.

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

Angela Caulder, CAMHS Joint Commissioning Manager

Email: angela.caulder@nw.london.nhs.uk

Telephone: 020 3350 4324

APPENDICES: Local Information and Implementation Plans

Annex B: Central London CCG and Westminster City Council, October 2017

Annex H: West London CCG and RBKC (including Queens Park and Paddington)

ANNEX B: Central London Clinical Commissioning Group

Local information and implementation plans for Central London CCG and Westminster City Council

1. Local Vision for Transformation of Children and Young People's Mental Health Services

The ambition for this 'refreshed' Child and Adolescent Mental Health Services (CAMHS) Transformation Plan is that by 2020 local children and young people will be able to:

- access services at the **R**ight time,
- be seen in the **R**ight place and
- access the **R**ight offer in a welcoming environment.

This means that young people's mental health transformation work for 2017-19 needs to focus on delivering patient pathways across agency boundaries, increasing access so that more young people can be seen at school or at home; waiting times for assessment and treatment are reduced and staff capacity across agencies is expanded.

Emotional wellbeing and mental health **is** everybody's business. Front line practitioners in schools, local hospitals and communities see young people with mental health problems in their everyday work. The Westminster children's workforce therefore needs access to expert help, advice and training and this refreshed Transformation Plan sets out the structure for that support.

To improve services, CCG and local authority commissioners and stakeholders need access to good data on incidence, performance and outcomes. Local health providers will be supported to improve the reporting for young people's mental health outcomes so that local and national data is accurate, transparent and timely.

Developments beyond 2020 have to be sustainable hence the plan prioritising an integrated and multi-agency approach to delivering child mental health care with schools, children centres and Early Help Services. Suggested improvements include; comprehensive reminder system, more appointments between the hours of 4-6pm, and later to investigate offering flexible appointments in the evenings or on Saturday mornings; increased use of digital tools such as on-line counselling, and continuing to embed co-production activities with young people (e.g. service reviews, staff recruitment and training).

Work is also underway to embed the Children and Families Act (2014) SEND reforms. For CAMHS this means ensuring that children and young people's mental health needs are appropriately reflected in their SEN support and Education, Health and Care Plans with systems in place to monitor outcomes and good links with school based support e.g. school nurses and SENCOs.

2. Objectives and Expected Outcomes

West London CCG covers the Royal Borough of Kensington and Chelsea and also young people registered with GPs in the Queens Park & Paddington area in Westminster. This is acknowledged by an adjustment to budgets and Westminster young people will therefore benefit from approximately 22.8% of the Transformation funding allocated to West London CCG in addition to

the funding allocated to Central London CCG.

The CL CCG young people's mental health Transformation Plan for 2017-18 has **five objectives:**

1. To reduce **Waiting Lists** for young people's mental health services.
2. To deliver a NICE[1] compliant **Community Eating Disorders Team**
3. To **Redesign Young People's Mental Health Services** – increasing preventative and early intervention work, enhance access; and to implement the *Thrive Model*[2]
4. To focus and enhance support for young people who are particularly **Vulnerable**
5. To improve pathways and access to young people's **24/7 Mental Health Crisis Care**

Several methods are used to assess how successful these initiatives have been. All providers are commissioned to work to a service specification agreed with CCG contact leads. The CNWL service specification has been updated for 2017-19 and key performance indicators (KPIs) track progress and compliance against targets and outcomes.

Goal Based Outcomes are used for the majority of young people accessing CNWL mental health services in Central London CCG. At the first appointment the young person and parent decide how to measure the success of the planned intervention for example: reducing symptoms, returning to school, or improving family relationships etc. These goals are then rated regularly via questionnaires to ensure the work is on track to achieve the intended impact. At the end of treatment the scores of the pre and post questionnaires are combined and reported to illustrate progress achieved. Aggregated data can then be used to inform future commissioning and service development decisions.

To improve communication and stakeholder co-ordination in the last year borough based CAMHS Partnership Groups have been re-introduced. These multi-agency forums include Young Mental Health Champions, local health providers, social care staff, the voluntary sector and parent representatives. This refreshed Transformation plan has been presented to the Westminster CAMHS Partnership Group.

With both local authorities and the NHS continuing to face challenging financial circumstances it is vital that local agencies collaborate and combine to deliver services for vulnerable young people and their families. The details that follow endeavor to set out how the Central London CCG and Westminster CAMHS Transformation Plan for 2018-19 seeks to take forward that ambition.

3. Previous Transformation Funding Allocation

CCG	Eating Disorders 15/16	Transformation Plan 15/16	Eating Disorders 16/17	Transformation Plan 16/17	Waiting List additional funds 2016-17		Totals
Central London	£91,557	£320,732	£101,000	£483,000	£84,000		**£1,080,289**

[1] National Institute for Health and Care Excellence

[2] Wolpert, M., Harris, R., Hodges, S., Fuggle, P., James, R., Wiener, A., Fonagy, P. (2015). THRIVE Elaborated. London: CAMHS Press http://www.annafreud.org/media/3214/thrive-elaborated-2nd-edition29042016.pdf

Hammersmith and Fulham	£100,744	£352,918	£106,000	£488,280	£44,500		**£1,092,442**
West London	£116,621	£408,534	£123,000	£588,129	£102,000		**£1,338,284**
Totals	**£308,922**	**£1,082,184**	**£330,000**	**£1,559,409**	**£230,500**		**£3,511,015**

4. Transformation Funding Allocation (anticipated) 17/18

CCG	Eating Disorders 17/18	Transformation Plan 17/18
Central London	**£101,000**	**£446,085**
Hammersmith and Fulham	**£106,000**	**£421,528**
West London	**£123,000**	**£486,130**
Total	**£330,000**	**£1,353,743**

5. Our local offer

Westminster young people requiring mental health services are supported by the main provider in the Borough, Central and North West London Mental Health Trust (CNWL).

There are a number of CAMHS services in the borough/CCG:

1. **SPECIALIST CAMHS**: Based at 7a Woodfield Road, W9 2NW, for moderate-severe mental health problems. The CNWL team of approximately 30 staff includes psychiatrists, nurses, family therapists, psychotherapists, and psychologists. The team actively supports between 500-600 local young people but see many more in the course of a year.

2. **PRIMARY MENTAL HEALTH WORKER TEAM:** is a jointly funded local authority and CCG early intervention service with approximately 7 staff working in schools and offering home visits.

3. **EATING DISORDER CAMHS:**: Based at Chelsea and Westminster Hospital[3]

4. **CRISIS AND OUT OF HOURS CAMHS**: Based at St Mary's and Chelsea and Westminster Hospitals[4]

The Local Authority also fund a Looked After Children CAMHS team, co-located with the social workers; psychiatry input for the Youth Offending Service; and a full-time Specialist Nurse who works with young people with learning disabilities and mental health problems.

The Local Authority also contributes funding to young people's mental health support in the borough, by directly employing Clinical Psychologists and Systemic Family Psychotherapists. These clinical staff support social workers working with looked after children and staff assisting

[3] St Vincent's Square, 1 Nightingale Place, Kensington & Chelsea, London, SW10 9NG. 020 3315 2711

[4] camhsnurses.cnwl@nhs.net 07834 147047

vulnerable families. Local Authority Early Help teams also provide emotional wellbeing support to children and young people in the borough, offering one-to-one emotional support and parenting interventions.

6. Total Local Investment

	West London Clinical Commissioning Group with CNWL	RBKC Local Authority	CAMHS Transformation including Eating Disorders and waiting list initiatives	Totals
15/16	£3,490,377	£356,385	£525,155	£4,371,917
16/17	£3,490,377	£426,824	£813,129	£4,730,330
17/18	£3,490,377	£415,881	£609,130[5]	£4,515,388
Totals	**£10,471,131**	**£1,199,090**	**£1,947,414**	**£13,617,635**

[5] No detail from NHS E regarding additional waiting list money or uplift for 2017-18.

1. Children and young people's mental health transformation plan

The table below outlines the local transformation Plans specific to CL CCG.

Priority	Current Position of Central London CCG & Westminster City Council:	2017-18 Investment and Implementation Plans
Waiting Times	CNWL received additional CAMHS Transformation funds in 2016-17 to reduce waiting times for treatment for young people in their specialist CAMHS team. Waiting times for treatment have been reduced to meet the national standard of eighteen weeks. In many cases families are seen significantly sooner usually between 8-11 weeks for second appointments. The additional NHS England waiting time funds received in 2016 and 2017 are being used by CNWL in their Child Development Psychology Team to reduce waits for autism assessments.	There is more work to do and CNWL will receive further funds to continue these efforts in 2017-18, particularly for those young people with learning disabilities, autism and coexisting mental health difficulties. The new Behavioural Analyst post and the Transitions worker for this cohort should also reduce waiting times for assessment and follow-up appointments. Please see 'Vulnerable Groups' section (page 7-8) for more details and funding commitment.
Community Eating Disorder Service	A Community Eating Disorder Service for Young People has been established by CNWL and supports local young people as well as those in neighbouring authorities across North West London. The service for Westminster young people can be accessed at Chelsea and Westminster hospital. Young people can self refer and will be seen within 24 hours in an emergency or within one week where urgent.	**2017-18 Investment: £101,000**

Redesigning the System	2017-2020 CAMHS Re-design: The aim is to move away from tiered services to services that are based on meeting the needs of the child/young person, wherever they present. Broadly, the new model is working towards compliance with the **Thrive Model** which has been recommended to by the Anna Freud Centre in the Central London CCG Final Needs Analysis Report[6]. This plan is well underway and includes: • **Evidence based treatments** delivered by all CAMHS services in additional locations such as schools and children's centres. • **Preventative and Early Intervention**: the CAMHS offer is strengthened by the involvement of Early Help, Educational Psychology and the voluntary sector. A specialist CAMHS Attachment Project for Under-Fives is also operating in two local children's centres breaking new ground. • The **Primary Mental Health CAMHS Team** now has a named clinical link for each of the Early Help teams in the Borough. • **School based Mental Health Leads** being trained by 'Healthy Schools' to develop a whole school approach to emotional wellbeing and resilience. This includes **action planning** for bronze, silver and gold awards, and **in-depth support**.	Further work in 2017-20 will include: • Implementation of a **multi-agency risk management** approach with CNWL, to work with high risk, hard to engage young people. • A **Tapered Transition Model** will be further developed for young people 14 -20 years. • There are plans to start a pilot with the **voluntary sector** for young people who have a learning disability or autism, and mental health problems. • **Joint work with GP hubs** has begun but needs to be more robust in delivery. A 12 month pilot to offer CAMHS consultation and input to multi-agency GP hubs in 2018-19 is planned with work this year to design the pilot. • Investigation in to CNWL offering **additional appointments** between 4-6pm, and implementing a **comprehensive reminder system** for 2018-19; and for later years leading to local **Saturday morning** or **evening clinics.** • New Service Specification for the **Primary Mental Health Worker Team** which is jointly funded by the CCG and Local Authority has been drafted and out to consultation with the Trust. Plans include developing named CAMHS links for all secondary schools.

[6] North West London CCG's Children and Young People's mental health and well-being system review, Final Report, Westminster, Anna Freud National Centre for Children and Families, October 2016

	• **Nurseries and Children's Centres** offered training, action planning, and signposting on mental health and emotional wellbeing, from 'Healthy Early Years'. • **School baseline data** on mental health and emotional wellbeing collected by 'Healthy Schools' via a **pupil survey**. 2300 questionnaires returned since September 2016 across Westminster, Kensington and Chelsea and Hammersmith and Fulham. • **The Westminster CAMHS Partnership Group** re-launched early in 2017. Its aim is to spread responsibility and knowledge of young people's mental health across agencies, and to give helpful challenge to our CAMHS providers. • **Digital solutions**, planning App review and development by young people began in the summer of 2017. • Young people from secondary schools are able to access **on-line Counselling,** and text messaging with **Kooth** via their phones from 11am until 10pm. This is a pilot that began in September 2017.	• Further integration for the **Primary Mental Health Team with Early Help**, to include joint assessments, **co-location**, informal and formal consultation and training in the new Local Authority **Family Hubs**. • Westminster schools to be invited to cross borough **Schools Mental Health Conference** to be held locally on 7 March 2018. • Westminster Nurseries and Children's Centres to be invited to cross borough **Early Years Mental Health Conference** to be held locally on 21 March 2018. • More robust engagement by CNWL and commissioners will be made with local **Community Champions** to engage with parents from hard to reach groups and tackle mental health stigma. **2017-18 Investment: £90,000**
Vulnerable Groups	In CL CCG the priorities in 2017-19 for vulnerable groups are those with learning disabilities and neurodevelopmental disorders, young offenders, looked after children and care leavers, and those involved with gang related risk activities. Funding for the Specialist CAMHS worker for the **Integrated Gangs Unit** continues in 2017-18, ensuring that this group of vulnerable young people can access mental health	Further work planned for 2017-20 will include: • **Agreed multi-agency care pathways -** a multi-agency mapping exercise has taken place, and work is now underway with additional CCG resource to lead on negotiating and publishing multi-agency care pathways for Learning Disabilities, autism and ADHD.

	support in a non-stigmatising way. Work is underway in the CCG to align the CAMHS NICE guidance and the adult learning disability programme across North West London, with the assistance of Healthy London Partnership to ensure consistency of care, and smooth transitions. The mapping of local **learning disability and autism** services has been completed. CL CCG has invested in additional capacity for LD and autism pathways by adopting a 'Positive Behavioural Support' approach. A part time 'Behavioural Analyst' is new in post, and is working with schools, paediatrics and social care colleagues, to identify and offer families specialist support in this area, given the success of this post, funds have been made available in 2017-18 for CNWL to recruit a full time worker. CNWL have received additional funds to reduce waiting times for assessment and treatment of young people with learning disabilities and autism. This has been successful in reducing the waits to national waiting times of 18 weeks. There is more work to do and CNWL will receive further funds to continue this work. Earlier in the year a needs assessment was completed which looked at the local health needs of **young offenders** across Hammersmith & Fulham, Kensington and Chelsea and Westminster. The **Youth Offending Service** (YOS) in Westminster has a CAMHS post embedded within the team in place now for several years. This post is funded by the block contract the CCG has with CNWL.	• **Transition.** Transitioning to adult services is particularly challenging for this group of young people who often do not meet the criteria for adult services. Plans are in place to pilot a Transitions Worker to help families navigate the multi-agency systems and services, and to offer individual support to those aged 14-20 years. • **Support to Special Schools -** mapping of the CAMHS support received by the special schools in the CCG area will be undertaken in 2017-18. Consultation with these schools and CAMHS will be undertaken to ensure the staff in these schools have the right advice, and support to ensure pupils receive appropriate mental health and behavioural interventions. • Additional non-recurrent targeted funding from NHS England has been badged against **up-skilling YOS staff** to identify speech and language needs and simple intervention strategies for young offenders. • New funding from NHS England (£47,710) for Central London CCG is being used to establish a **Liaison and Diversion Scheme** for Westminster YOS. • Redesign of the **Looked After CAMHS team,** funded by the Local Authority, is underway, to increase the age seen to 20th birthday, and include care leavers in its cohort.

	This year, the CCG commissioned a multi-agency **co-production review of the CAMHS delivery in YOS**. Rethink Mental Illness and their team of Young Champions (Experts by Experience) have recently completed this co-productive review of the services together with the key stakeholders.	**2017-18 investment: £185,000**
Crisis and Urgent Care	This is delivered across all 8 North West London CCG's and outlined in the overarching transformation plan (page 44). The Westminster Out of Hours Crisis Service has been in place since January 2016 enabling access to specialist CAMHS support. This is now being extended to 24/7.	**2017-18 investment: £66,000**

2. Emerging National and local Initiatives

The table below outlines our progress against emerging National and Local Initiatives.

Emerging National and local Initiatives	Current Position of Central London CCG & Westminster City Council:	2017-18 Investment and Implementation Plans
Out of Area Placement	Central London CCG currently has four young people in specialist placements outside of the borough who receive CAMHS provision. This includes one young person who has a diagnosis of Autistic Spectrum Disorder (ASD). These are collaborative arrangements with Education and Children's Social Care, and care is taken to ensure that	The CCG invests **£77,000** per annum supporting these four young people who receive CAMHS provision as part of their out of area placement. A further **£6,500** supports a young person placed out of area with ASD. All placements are regularly reviewed.

	placements are as close as possible to family members and sources of future support.	

3. Key Enablers

The table below outlines how key enablers will support transformation specific to CL CCG.

Enabler	Current Position	2017-18 Investment and Implementation Plans
Co-production	Over the past two years, the CCG has funded Rethink to recruit, train and support young people to become 'Young Mental Health Champions' (experts by experience) to review CAMHS services'; develop CAMHS co-produced service specifications; and to plan and deliver a training programme, *'Collective Voices'* jointly with CNWL to local schools. 2015-16 was spent planning this work, and 2016-17 began delivery of the training, reviews of CNWL new services by users. Rethink also organised the first cross borough **Young People's Mental Health Conference** which took place locally, and which had highly positive feedback from young people who attended.	For 2017-20, the CCG plans to build on this successful **co-production work,** increasing the numbers of Young Champions to deliver further service reviews of CAMHS; hosting the annual Young People's Mental Health conference (2nd Dec 2017); and undertaking a digital project to look at mental health Apps available on the market. **2017-18 investment: £30,000**
Workforce Development	**The CAMHS training programme** was published online in April 2016, for local professionals across the boroughs of Westminster, Kensington and Chelsea, and Hammersmith and Fulham, for a range of child mental health training events.	For 2017-20, there are plans to widen the local CAMHS programme to include **training parents** to deliver training to other parents. A key training objective identified by staff at our local

	A bespoke training offer is available to all staff in schools in Westminster for inset days and twilight sessions, as well as mentoring training for older pupils in school to support younger peers. There are a variety of providers in the voluntary, independent and statutory sectors working together and individually to deliver these programmes which are in the main sustainable through 'train the trainer' initiatives and options to 'top up' learning. **GP's** have received on-line training from the MinDed[7]site; and some GP's and Paediatricians in the borough have received jointly delivered child mental health training from CNWL and the Charlie Waller organisation.[8] **A new CYP IAPT[9] programme** to train up lower grade CAMHS staff has been launched. Westminster Specialist CAMHS is part of this new initiative and have four new posts which will be co-located with schools and Early Help teams. This pilot project will need funding from commissioners for future years. The **existing CYP IAPT programme** to train up existing CAMHS staff with NICE guidance evidence based treatment programmes is well supported in Westminster CAMHS who are part of the London collaborative and who have been involved in many events run by the collaborative. The CAMHS commissioner has also attended some of these training events and conferences over the past two years.	hospitals is multi-agency learning on ***'Fabricated or Induced Illness'.*** There are key mental health components within this work. Commissioners will work with staff across agencies to assist with collaborative training work during 2017-19. **2017-18 investment: £75,000**

[7] www.minded.org.uk

[8] cwi@reading.ac.uk

[9] Children and Young People's Increasing Access to Psychological Therapies NHS England supported training programme for CAMHS clinicians.

Angela Caulder
CAMHS Joint Commissioning Manager
27 September 2017

This page is intentionally left blank

ANNEX H: West London Clinical Commissioning Group (CCG)
Local information and implementation plans for the Royal Borough of Kensington and Chelsea and West London CCG including Queens Park and Paddington

1. Local Vision for Transformation of Children and Young People's Mental Health Services.

The ambition for this 'refreshed' Child and Adolescent Mental Health Services (CAMHS) Transformation Plan is that by 2020 local children and young people will be able to:

- access services at the **R**ight time,
- be seen in the **R**ight place and
- access the **R**ight offer in a welcoming environment.

This means that young people's mental health transformation work for 2017-19 needs to focus on delivering patient pathways across agency boundaries, increasing access so that more young people can be seen at school or at home; waiting times for assessment and treatment are reduced and staff capacity across agencies is expanded.

Emotional wellbeing and mental health **is** everybody's business. Front line practitioners in Kensington and Chelsea schools, local hospitals and communities see young people with mental health problems in their everyday work. The Kensington and Chelsea children's workforce therefore needs access to expert help, advice and training and this refreshed Transformation Plan sets out the structure for that support.

To improve services, CCG and local authority commissioners and stakeholders need access to good data on incidence, performance and outcomes. Local health providers will be supported to improve the reporting for young people's mental health outcomes so that local and national data is accurate, transparent and timely. The published information on the borough's 'Local Offer' web page sign posts residents and professionals to local CAMHS support.

Developments beyond 2020 have to be sustainable hence the plan prioritising an integrated and multi-agency approach to delivering child mental health care with schools, children centres and Early Help Services. Suggested improvements include; a comprehensive appointment reminder system, more appointments between the hours of 4-6pm, and later to develop flexible appointments in the evenings or on Saturday mornings; increased use of digital tools such as on-line counselling, and continuing to embed co-production activities with young people (e.g. service reviews, staff recruitment and training).

Work is also underway to embed the Children and Families Act (2014) SEND reforms. For CAMHS this means ensuring that children's and young people's mental health needs are appropriately reflected in their SEN support and Education, Health and Care Plans with systems in place to monitor outcomes and good links with school based support e.g. school nurses and SENCOs.

This year has been challenging for Kensington and Chelsea residents with the Grenfell Tower Fire
generating a need for additional mental health support across the community. As well as direct services for individuals and families, support has been offered to pupils and staff in local schools. NHS England has commissioned additional NHS mental health services from the borough's main provider, Central and North West London NHS Foundation Trust (CNWL). Responding to

requests for mental health support in schools, youth clubs and the community has been co-ordinated by the

council, working closely with West London CCG. The Kensington and Chelsea CAMHS Transformation Plan has been flexed to assist in funding these additional mental health services for example engaging MIND and the Octavia Foundation. The support required within the community and the impact this will have on wider provision is still emerging and is likely to have a significant impact on current delivery approaches and priorities. Please see the attached Information Sheet[1] which provides an overview of activity currently underway and ambitions for a wider Health and Wellbeing strategy for the area.

2. Objectives and Expected Outcomes

West London CCG's area includes the Royal Borough of Kensington and Chelsea and young people registered with GPs in the Queens Park & Paddington districts of Westminster. This is acknowledged by a 22.8% adjustment to budgets so that Queens Park and Paddington young people are supported by the West London CCG Transformation funds.

The Kensington and Chelsea and West London CCG young people's mental health Transformation Plan 2017-18 and also 2018-19 has **five objectives:**

1. To reduce **Waiting Lists** for young people's mental health services.
2. To deliver a NICE[2] compliant **Community Eating Disorders Service**
3. To **Redesign Young People's Mental Health Services:** increasing preventative and early intervention work, enhance access and to implement the *Thrive Model*[3] of care
4. To enhance support for **Vulnerable Young People**
5. To improve access and pathways for young people to **Mental Health Crisis Care (24/7)**

Several methods are used to assess how successful these initiatives have been. All providers are commissioned to work to a service specification agreed with CCG contact leads. The CNWL service specification has been updated for 2017-19 and key performance indicators (KPIs) track progress and compliance against targets and outcomes.

Goal Based Outcomes are used for the majority of young people accessing CNWL mental health services in Kensington and Chelsea (and Queen Park & Paddington). At the first appointment the young person and parent decide how to measure the success of the planned intervention for example: reducing symptoms, returning to school, or improving family relationships etc. These goals are then rated regularly via questionnaires to ensure the work is on track to achieve the intended impact. At the end of treatment the scores from the pre and post questionnaires are combined and reported to assess progress made. Aggregated data can then be used to inform future commissioning and service development decisions.

To improve communication and stakeholder co-ordination in the last year borough based CAMHS Partnership Groups have been re-introduced. These multi-agency forums include Young Mental Health Champions, local health providers, social care staff, the voluntary sector and parent

[1] Grenfell Tower Fire Mental Health Support, RBKC, 2017
[2] National Institute for Health and Care Excellence
[3] Wolpert, M., Harris, R., Hodges, S., Fuggle, P., James, R., Wiener, A., Fonagy, P. (2015). THRIVE Elaborated. London: CAMHS Press http://www.annafreud.org/media/3214/thrive-elaborated-2nd-edition29042016.pdf

representatives. This refreshed Transformation plan has been presented to the Kensington and Chelsea CAMHS Partnership Group.

With both local authorities and the NHS continuing to face challenging financial circumstances it is
vital that local agencies collaborate and combine to deliver services for vulnerable young people and their families. The details that follow set out how the West London CCG and Kensington & Chelsea CAMHS Transformation Plan for 2018-19 will take forward that ambition.

3. Previous Transformation Funding Allocation

CCG	Eating Disorders 15/16	Transformation Plan 15/16	Eating Disorders 16/17	Transformation Plan 16/17	Waiting List additional funds 2016-17		Totals
Central London	£91,557	£320,732	£101,000	£483,000	£84,000		**£1,080,289**
Hammersmith and Fulham	£100,744	£352,918	£106,000	£488,280	£44,500		**£1,092,442**
West London	£116,621	£408,534	£123,000	£588,129	£102,000		**£1,338,284**
Totals	**£308,922**	**£1,082,184**	**£330,000**	**£1,559,409**	**£230,500**		**£3,511,015**

4. Transformation Funding Allocation (anticipated) 17/18

CCG	Eating Disorders 17/18	Transformation Plan 17/18
Central London	**£101,000**	**£446,085**
Hammersmith and Fulham	**£106,000**	**£421,528**
West London	**£123,000**	**£486,130**
Total	**£330,000**	**£1,353,743**

5. Our local offer

Kensington and Chelsea young people requiring mental health services are supported by the main
provider in the borough, Central and North West London Mental Health Trust (CNWL).

There are a number of CAMHS services in the borough/CCG:

1. **SPECIALIST CAMHS**: based at the *Parkside Clinic*[4] and offering support to young people with moderate-severe mental health problems. The CNWL team of approximately 25 staff includes psychiatrists, nurses, family therapists, psychotherapists, and psychologists. The team actively supports between 600 - 700 local young people but see many more in the course of a year.

[4] "Parkside",63-65 Lancaster Road, London W11 1QG. Telephone number: 020 8383 6123.

2. **BEHAVIOUR AND FAMILY SUPPORT TEAM**: based at Kensington Town Hall, this jointly

funded service supports young people with learning disabilities, autism and behavioural problems at school and at home. The work of this team joins is a key component of the published *Local Offer* for disabled children[5] and links to other SEND services

3. **EATING DISORDER CAMHS:** based at Chelsea and Westminster Hospital[6]

4. **CRISIS AND OUT OF HOURS CAMHS**: based at St Mary's Hospital[7]

The Royal Borough of Kensington and Chelsea contributes to young people's mental health support in the borough, by funding clinicians working in special schools and employing Clinical Psychologists and Systemic Family Psychotherapists, embedded in the social care. These clinical staff support social workers working with looked after children and staff assisting vulnerable families. Local Authority Early Help teams also provide emotional wellbeing support to children and young people in the borough, offering one-to-one emotional support and parenting interventions.

6. Total Local Investment

	West London Clinical Commissioning Group with CNWL	RBKC Local Authority	CAMHS Transformation including Eating Disorders and waiting list initiatives	Totals
2015/16	£3,490,377	£356,385	£525,155	£4,371,917
2016/17	£3,490,377	£426,824	£813,129	£4,730,330
2017/18	£3,490,377	£415,881	£609,130[8]	£4,515,388
Totals	**£10,471,131**	**£1,199,090**	**£1,947,414**	**£13,617,635**

[5] https://www.rbkc.gov.uk/kb5/rbkc/fis/localoffer.page?localofferchannel=0
[6] St Vincent's Square, 1 Nightingale Place, Kensington & Chelsea, London, SW10 9NG. 020 3315 2711
[7] Camhsnurses.cnwl@nhs.uk 07834 147047
[8] No detail from NHS E regarding additional waiting list money or uplift for 2017-18.

7. Children and young people's mental health transformation plan

The table below outlines the local Transformation Plans specific to Kensington and Chelsea and WL CCG (including Queens Park and Paddington).

Priority	Current Position of West London (& QPP) CCG & Royal Borough of Kensington and Chelsea:	West London 2017-18 Investment and Implementation Plans
Waiting Times	CNWL received additional CAMHS Transformation funds in 2016-17 to reduce waiting times for treatment for young people in their specialist CAMHS team. Waiting times for treatment have been reduced to meet the national standard of eighteen weeks. In many cases families are seen significantly sooner usually between 8-11 weeks for second appointments. The additional NHS England waiting time funds received in 2016 and 2017 are being used by CNWL in their Child Development Psychology Team to reduce waits for autism assessments.	Further work needs to be undertaken to reduce waits and CNWL will receive additional funds to continue reducing waiting times in 2017-18, particularly for young people with learning disabilities, autism and coexisting mental health difficulties. Furthermore, a new Behavioural Analyst post and a Transitions worker for young people with LD and ASD should contribute to reducing waiting times for assessment and follow-up support. Please see 'Vulnerable Groups' section (page 8-9) for more details and funding commitment.
Community Eating Disorder Service	A Community Eating Disorder Service for Young People has been established by CNWL and supports local young people as well as those in neighbouring authorities across North West London. The local service is accessed at Chelsea & Westminster Hospital. Young people can self refer and will be seen within 24 hours for an emergency or within one week if urgent.	**2017-18 Investment: £123,000**

Redesigning the System	2017-2020 CAMHS Re-design: The aim is to move from a traditional tiered service, to support being based on meeting the needs of the child/young person wherever they present. Broadly, the new approach is working towards compliance with the **Thrive Model** as recommended by the Anna Freud Centre in the West London CCG Final Needs Analysis Report[9]. This plan is well underway and includes: • **Evidence based treatments** delivered by all CAMHS services in additional locations such as schools and children's centres. • **Preventative and Early Intervention:** the CAMHS offer is strengthened by the involvement of Early Help, Educational Psychology and the voluntary sector. A specialist CAMHS Attachment Project for Under-Fives is also operating in two local children's centres breaking new ground. • **School based Mental Health Leads** are being trained by 'Healthy Schools' to develop a whole school approach to emotional wellbeing and resilience. This includes **action planning** for bronze, silver and gold awards, and **in-depth support**. • **Nurseries and Children's Centre's** are offered training, action planning, and signposting on mental health and emotional wellbeing, from 'Healthy Early Years'.	Further work in 2017-20 will include: • Implementing a **multi-agency risk management** approach with CNWL, to work with high risk, hard to engage young people. • A **Tapered Transition Model** is being developed for young people 14-20 years for future years. There are developing plans to start a pilot with the voluntary sector for those young people who have a learning disability or autism and mental health problems. • **Joint work with GP hubs** has begun but needs to be more robust in its delivery. A 12 month pilot to offer CAMHS consultation and input to multi-agency GP hubs in 2018-19 is planned with work this year to design the pilot. • Investigation into CNWL offering **additional appointments between 4-6pm,** and implementing a **comprehensive reminder system** for 2018-19; and for later years leading to local **Saturday morning or evening clinics.** • Kensington and Chelsea schools to be invited to a cross borough **Schools Mental Health Conference** to be held locally on 7 March 2018. • Kensington and Chelsea nurseries and Children's Centres to be invited to a cross

[9] North West London CCG's Children and Young People's mental health and well-being system review, Final Report, Kensington and Chelsea, Anna Freud National Centre for Children and Families, October 2016

	• **School baseline data** on mental health and emotional wellbeing collected by 'Healthy Schools' via a **pupil survey**. 2,300 questionnaires were returned since September 2016, across Westminster, Kensington and Chelsea and Hammersmith and Fulham. • **A Tapered Transition Model** is being developed. In West London CCG, young people 16+ now have a choice of accessing services from either young people or adult mental health services. • **The Kensington and Chelsea CAMHS Partnership Group** re-launched in early 2017. Its aim is to spread responsibility and knowledge of young people's mental health across agencies, and to give helpful challenge to CAMHS providers. • **Digital solutions**, planning App review and development by young people began in the summer of 2017. • Young people from secondary schools are able to access **on-line Counselling,** and text messaging with **Kooth** via their phones from 11am until 10pm. This is a pilot that began in September 2017. • **Named CAMHS Link** – excellent progress has been made and every Kensington & Chelsea school now has a named clinician.	borough **Early Years Mental Health Conference** to be held locally on 21 March 2018. • More robust engagement by CNWL and commissioners will be made with local **Community Champions** to engage with parents from hard to reach groups and tackle mental health stigma. **2017-18 Investment: £91,630**

Vulnerable Groups	The priorities for 2017-19 are young people with learning disabilities and neurodevelopmental disorders, young offenders and those affected by the Grenfell Tower Fire. The **Grenfell Tower Fire** has led to requests for additional mental health support in the local community. For young people's mental health, this has included pupils and staff in local schools. The CCG has worked closely with the council to ensure that the CAMHS Transformation Plan has been flexed at a cost of **£40,000** to assist in funding these additional mental health services for schools and youth clubs delivered by voluntary sector CAMHS providers, such as MIND and The Octavia Foundation. Work is underway to align the CAMHS NICE guidance and the adult **learning disability** programme across North West London, assisted by Healthy London Partnership, to ensure consistency of care, and smooth transitions. Mapping of local learning disability and **autism** services has been completed. WL CCG has invested in additional capacity for Learning Disability and Autism pathways by adopting a 'Positive Behavioural Support' approach. A full-time '**Behavioural Analyst'** is new in post for 2017, and is working with schools, paediatrics and social care colleagues, to identify and offer families specialist support. Earlier in the year a needs assessment was completed which looked at the local health needs of **young offenders** across Hammersmith & Fulham, Kensington and Chelsea and Westminster. The **Youth Offending Service** (YOS) in RBKC has a CAMHS post embedded within the team and the post is	Further work planned for 2017-20 will include: • **Agreed multi-agency care pathways -** a multi-agency mapping exercise has taken place, and work is now underway with additional CCG resource to lead on negotiating and publishing multi-agency care pathways for Learning Disabilities, Autism and ADHD. • **Transition.** Transitioning to adult services is particularly challenging for young people with learning disabilities or/and autism and mental health problems. These young people often do not meet the criteria for adult services. Plans are in place to pilot a Transitions Worker to help families navigate the multi-agency systems and services, and to offer individual support to those aged 14-20 years. • **Support to Special Schools -** mapping of the CAMHS support received by the special schools in the CCG area will be undertaken in 2017-18. Consultation with these schools and CAMHS will be undertaken to ensure the staff in these schools have the right advice, and support to ensure pupils receive appropriate mental health and behavioural interventions. • Additional non-recurrent targeted funding from NHS England has been badged against **up-skilling YOS staff** to identify speech and language needs and simple intervention strategies for young offenders.

	funded by the block CCG contract with CNWL. Because of complex employment issues, this post has been vacant for several months. The objective this year has been to resolve these recruitment issues and secure a substantive post-holder to offer youth offenders CAMHS support aligned with the YOS. Kensington & Chelsea YOS also have an existing **Liaison and Diversion scheme** in place. This year, under the CAMHS Transformation plans the CCG commissioned a **multi-agency co-production review** of the CAMHS delivery in **YOS**. Rethink Mental Illness and their team of Young Champions (Experts by Experience) have recently completed this co-productive review of the services together with the key stakeholders.	**2017-18 investment: £143,000** Please see 'supporting co-production' section (page 51) for more details of co-production work and finance to support this.
Crisis and Urgent Care	This is delivered across all 8 North West London CCG's and outlined in the overarching transformation plan (p44). The Out of Hours Crisis Service has been in place since 2016 enabling access to specialist CAMHS support. This is now being extended to 24/7. In addition to this work WL CCG funds a psychiatric nursing post providing in-hours **crisis assessments** for **self-harm** at St Mary's Hospital. Recruitment started in 2015-16, and the post holder began work in early 2016-17.	**2017-18 investment: £130,000**

8. Emerging National and Local Initiatives

The table below outlines progress against emerging National and Local Initiatives.

Emerging National and Local Initiatives	Current Position of West London (& QPP) CCG & Royal Borough of Kensington and Chelsea:	West London 2017-18 Investment and Implementation Plans
Out of Area Placement	West London CCG currently supports ten young people in specialist placements outside of the borough and this includes two young people with Autism Spectrum Disorder (ASD). These are collaborative arrangements with Education and Children's Social Care and care is taken to ensure that placements are as close as possible to family members and sources of future support.	WL CCG invests approximately **£143,000** per annum to support these twelve placements for young people with mental health and/or ASD needs. All placements are subject to regular review.

9. Key Enablers

The table below outlines how key enablers will support transformation specific to WL CCG.

Enabler	Current Position	2017-18 Investment and Implementation Plans
Co-production	Over the past two years, the CCG has funded Rethink to recruit, train and support young people to become 'Young Mental Health Champions' (experts by	For 2017-20, the CCG plans to build on this successful **co-production work,** increasing the numbers of Young Champions to deliver further

	experience) to review CAMHS services'; develop CAMHS co-produced service specifications; and to plan and deliver a training programme, *'Collective Voices'* jointly with CNWL to local schools. Rethink also organised a successful **Young People's Mental Health Conference** which took place in Kensington, and which had highly positive reports from young people who attended.	service reviews of CAMHS; host an annual Young People's Mental Health conference (2nd December 2017); and to undertake a digital project looking at mental health Apps available on the market. **2017-18 investment: £41,500**
Workforce Development	**The CAMHS training programme** was published online in April 2016, for local professionals across the boroughs of Kensington and Chelsea, Hammersmith and Fulham and Westminster, for a range of child mental health training events. A bespoke training offer is available to all staff in schools in Kensington and Chelsea for inset day and twilight sessions, as well as mentoring training for older pupils in a school to support their younger peers. There are a variety of providers in the voluntary, independent and statutory sectors working together and individually to deliver these programmes which are in the main sustainable through 'train the trainer' initiatives and supervision options to 'top up' learning. **GP's** have received on-line training from the MinDed[10]site; and some GP's and Paediatricians in the	For 2017-20, there are plans to widen the local CAMHS programme to include **training parents** to deliver training to other parents. This idea is supported by the 'Full of Life' parents group who are keen to pilot this in Kensington and Chelsea for those families with complex needs, including learning disabilities and autism. A key training objective identified by staff at our local hospitals is multi-agency learning on ***'Fabricated or Induced Illness'.*** There are key mental health components within this work. Commissioners will work with staff across agencies to assist with collaborative training work during 2017-19. **2017-18 investment: £80,000**

[10]www.minded.org.uk

	borough have received jointly delivered child mental health training from CNWL and the Charlie Waller organisation.[11] A new **CYP IAPT programme**[12] to train up lower grade CAMHS staff has been launched. RBKC Specialist CAMHS is part of this new initiative and have four new posts which are planned to be co-located with schools and Early Help teams. This pilot project will need funding from commissioners for future years. The **existing CYP IAPT programme** to train up qualified CAMHS staff with NICE guidance evidence based treatment programmes, is well supported in Kensington and Chelsea CAMHS who are part of the Reading Collaborative and who have been involved in many events run by the collaborative. The CAMHS commissioner has also attended some of these training events and conferences over the past two years.	

Angela Caulder
CAMHS Joint Commissioning Manager
27 September 2017

[11] cwi@reading.ac.uk

[12] Children and Young People's Increasing Access to Psychological Therapies NHS England supported training programme for CAMHS clinicians.

City of Westminster

Westminster Health & Wellbeing Board

Date:	16th November 2017
Classification:	General Release
Title:	Annual Report of the Safeguarding Adult Executive Board (SAEB) 2016/17
Report of:	Independent Chair of the Board, Michael Howard
Wards Involved:	All
Policy Context:	Promoting Healthy and Safe Communities
Financial Summary:	No financial implications
Report Author and Contact Details:	Helen Banham, ASC Strategic Lead Professional Standards and Safeguarding hbanham@westminster.gov.uk

1. Executive Summary

1.1 This is the fourth Annual Report of the Safeguarding Adult Executive Board (SAEB). The multi-agency Board provides leadership of adult safeguarding across the London Borough of Hammersmith & Fulham; the Royal Borough of Kensington and Chelsea; and the City of Westminster.

1.2 It is the second year that the SAEB has operated under Schedule 2 of the Care Act 2014, and overseeing the statutory duties of conducting Safeguarding Adult Enquiries (Section 42) and Safeguarding Adults Reviews (Section 44).

1.3 The report seeks to show how member agencies of the SAEB provide assurance to the SAEB for the ways in which its three strategic priorities (Making Safeguarding Personal; Creating Safe and Healthy Communities; and Leading, listening and Learning) are being promoted within their organisation.

1.4 The report also seeks to demonstrate how the learning from safeguarding enquiries and reviews conducted during the year lead, to changes that benefit the safety, health, and wellbeing of local residents, in all three boroughs. This is

particularly where the learning shows there is room for agencies to work more effectively together to prevent abuse or neglect.

2. Key Matters for the Board

2.1 Members' attention is particularly drawn to the themes that have been the focus of the SAEB's work this year (page 24) and the emerging theme that are the focus of this year's work and to consider if these resonate with its own work strategic priorities, and to what extent the work of the two Boards might further complement each other.

3. Legal Implications

3.1 There are no legal implications

4. Financial Implications

4.1 There are no financial implications

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

Helen Banham, Strategic Lead Professional Standards and Safeguarding

Email: hbanham@westminster.gov.uk

Telephone: 020 7641 4196

APPENDICES:

Safeguarding Adults Executive Board Annual Report 2016-17

BACKGROUND PAPERS:

None

SAFEGUARDING ADULTS EXECUTIVE BOARD

ANNUAL REPORT 2016/17

mistreated?
bullied?
hit?
neglected?
hurt?
exploited?
silenced?

COURAGE
COMPASSION
ACCOUNTABILITY

METROPOLITAN POLICE
TOTAL POLICING

NHS

h&f
hammersmith & fulham

THE ROYAL BOROUGH OF
KENSINGTON
AND CHELSEA

City of Westminster

SAFEGUARDING ADULTS EXECUTIVE BOARD

ANNUAL REPORT 2016/17

CONTENTS

FOREWORD

I am pleased to present the fourth annual report of the Safeguarding Adults Executive Board for Westminster, Kensington and Chelsea, and Hammersmith & Fulham. This report explains the role, functions, and purpose of Safeguarding Adults Boards as they are prescribed by the Care Act 2014. It lists the organisations that are represented on the Board, as well as other groups and agencies who contribute to the Board's work-streams. Everyone, both jointly and independently, works to ensure the safety of those adult residents who are deemed to be most at risk of harm, through the actions of other people, and from self-neglect.

The report contains examples of this collaborative work. The highlight of this collaboration was the hoarding and self-neglect event in March 2017 that had over 180 applicants for 110 places! The report includes a hoarding case study as an example of all the considerations required to ensure that the final outcome meets the needs of the person concerned, whilst removing the risk of harm to others. The Board also considered the response to the harm caused to homeless people who take the drug, Spice. Whilst instigated by the Police, this work actively involved mental health practitioners, housing officers and workers from a number of voluntary organisations.

The Board embraces the concept of Making Safeguarding Personal - 'no decision about me without me'. The case studies show the application of this principle to the lives of four people, demonstrating the difference that safeguarding interventions have made to their lives. Whilst the emphasis of the report is about people, there are statistics about the safeguarding journey. These show the number of concerns, and enquiries resulting in some form of action. To provide context, the data shows the size of the eligible adult population living in the three boroughs, together with those adults who have care and support needs.

In my foreword last year, I mentioned that a major initiative for 2016 was to focus on the mental and emotional harm caused by financial abuse or 'scams'. I believe that we have made significant progress in the past year. The head of Trading Standards is now the Co-Chair of one of the Board's work-streams and by developing links with the Community Champions network, local people have been trained to become SCAMampions or Friends Against Scams. Community Champions are also trained, and play a vital role in spotting adult abuse and neglect, and domestic abuse. The Champions are helping people to understand what help may be available to them. We are also learning from them about how to work sensitively with people who may be reluctant to engage with statutory services.

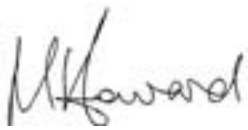
Last year, I also mentioned a high-profile case involving a death at a care home that led to the commissioning of a Safeguarding Adult Review in September 2015. Various delays involving the inquest and staff changes have prevented a full account being published in this year's report. However, a learning event focussing on the range of quality care home provision for dementia sufferers is scheduled to take place in late November. The quality and variety of care for people with Dementia will be one of the Board's themes for 2017/18.

Work will also continue on addressing the challenges posed to staff who work with people who hoard or neglect themselves, and also on increasing practitioners' confidence in applying the Mental Capacity Act 2005 to decision-making. Other themes are to ensure that all organisations work together to improve the physical health outcomes of people with mental health problems and learning disabilities; and finally, scrutinising the discharge pathways from hospital to residential or nursing care, or paid care at home to make sure people are not at risk of dying when they return home.

Whilst the annual report covers the year ending 31st March 2017, it would be remiss of me not to mention the Grenfell Tower fire. Many of the Board's member organisations were involved in the initial response to this tragedy. They continue to provide help, support, and counselling to people affected by the large-scale loss of life. At the July Board meeting, representatives reflected upon their experiences and it was agreed that the Board's role should be a supportive one to the various committees and working groups that have co-ordinated the response to the fire. This approach has been agreed with the Local Safeguarding Children's Board.

One of the key strengths of the Board is the range and the seniority of its members. I am gratified by the willingness of members to find time to attend Board meetings and chair the Board's work-streams. This diversity of experience and knowledge ensures that adult safeguarding is seen as not just the responsibility of the local authorities, but as everyone's responsibility.

Thank you to everyone for your contribution to the work of the Board over the past year.



Mike Howard
Independent Chair of the Safeguarding Adults Executive Board

WHAT IS THE SAFEGUARDING ADULTS EXECUTIVE BOARD?

The Care Act 2014 says that Local Authorities must have a Safeguarding Adults Board from 1st April 2015.

The Safeguarding Adults Executive Board has provided leadership of adult safeguarding across the London Borough of Hammersmith & Fulham, the Royal Borough of Kensington and Chelsea, and the City of Westminster since 2013.

The Board is a partnership of organisations working together to promote the right to live in safety, free from abuse or neglect. It's purpose is to both prevent abuse and neglect, and where someone experiences abuse or neglect, to respond in a way that supports their choices and promotes their well-being.

The Board believes that adult safeguarding takes **COURAGE** to acknowledge that abuse or neglect is occurring and to overcome our natural reluctance to face the consequences for all concerned of shining a light on it.

The Board promotes **COMPASSION** in our dealings with people who have experienced abuse and neglect, and in our dealings with one another, especially when we make mistakes. The Board promotes a culture of learning rather than blame.

At the same time, as members of the Board, we are clear that we are **ACCOUNTABLE** to each other, and to the people we serve in the three boroughs.

The Care Act says key members of the Board must be the Local Authority; the Clinical Commissioning Groups; and the Chief Officer of Police.

The three key members on the Safeguarding Adults Executive Board are:

- The Director of Integrated Care Adult Social Care and Health
- The Deputy Director of Quality, Nursing and Safeguarding, Central Westminster Hammersmith Hillingdon and Ealing Clinical Commissioning Groups Commissioning Collaborative
- the Borough Commander of the Metropolitan Police in the Royal Borough of Kensington and Chelsea

The Care Act says these key members must appoint a chairperson who has the required skills and experience

Mike Howard is the Independent Chair of the Safeguarding Adults Executive Board. He has over ten years experience of chairing children and adult safeguarding boards

The Care Act 2014 states that the Board can appoint other members it considers appropriate with the right skills and experience.

There are senior representatives on the Board, from the following organisations:

- Imperial College Healthcare NHS Trust
- Chelsea and Westminster Hospital Foundation NHS Trust
- The Royal Marsden NHS Foundation Trust
- Central London Community Healthcare Trust
- Central North West London NHS Foundation Trust
- West London Mental Health Trust
- London Ambulance Service
- Central West London London Fire Brigade
- London Probation Service
- Children's Services
- Local Councillors
- Community Safety
- Housing (Local Authority)
- Genesis Housing
- Trading Standards
- Public Health Community Champions Programme
- HM Prison, Wormwood Scrubs
- Royal Brompton and Harefield NHS Foundation Trust
- Healthwatch
- Adult Social Care
- NHS England

Board members are the senior 'go to' person in each of these organisations with responsibility for adult safeguarding. They bring their organisation's adult safeguarding issues to the attention of the Board, promote the Board's priorities, and disseminate lessons learned throughout their organisation.

The Board can use its statutory authority also to assist members in addressing barriers to effective safeguarding that may exist in their organisation, and between organisations.

An even wider group of people, including voluntary sector organisations; housing and homelessness agencies; advocacy and carers' groups; and members of the public all contribute to the Boards four work-streams:

- Community Engagement
- Developing Best Practice
- Measuring Effectiveness
- Safeguarding Adults Case Review

The Board meets four times a year and the work-streams meet more regularly.

The Board recognises that the challenging and complex work of preventing and responding to abuse and neglect is carried out by hard-working staff on the front line of all these organisations, every day of every year.

The Care Act 2014 says members may make payments for purposes connected with the Board.

Most of the funding for the Board comes from the Local Authorities and the Clinical Commissioning Groups.

For the second year running, the Mayor's Office for Policing and Crime has contributed £5,000 per borough to support the work of the Board.

SAFEGUARDING is our number one priority

Safeguarding training has been delivered to all staff in the Metropolitan Police Service. Being actively engaged in the Safeguarding Adult Executive Board and training staff is our number one priority. Metropolitan Police Officers now have a far greater awareness of vulnerability. We have introduced daily 'Pacesetter' meetings to review local risks and vulnerability across a range of situations. Safeguarding has changed the focus of police work from traditional crime fighting to a whole range of meetings and joint work with partners to ensure public safety.

The Borough Commander of Kensington and Chelsea

Also for the second year running, The London Fire Brigade have contributed £1,000 per borough, to be shared between the Safeguarding Adults Board and the Local Safeguarding Children Board.

The Board is using these contributions to fund the independent Chair and a Board Business Manager and administrator, to further improve its effectiveness and efficiency.

The Care Act says members may provide staff, goods, services, accommodation or other resources for purposes connected with the Board.

All member organisations free up staff with the right skills and experience to contribute to meetings and objectives of the four work-streams. Attendance is good and members are committed and work hard to progress the Board's priorities, and safeguard adults at risk of abuse and neglect.

Member organisations have provided venues for Board and work-stream meetings.

Protecting the lives of vulnerable people

Despite the London Fire Brigade's non-statutory status on local safeguarding adult boards, to demonstrate its commitment, the Brigade has made a £1,000 voluntary contribution to the Safeguarding Adult Board in all London boroughs.

Each borough is required to sign a Memorandum of Understanding agreeing:

- to improve the lives of vulnerable persons within the borough by making appropriate safeguarding referrals when a concern is raised by the Brigade in carrying out its fire safety function;
- to agree to consider arranging and holding case conferences on particular cases when a Brigade representative requests following a fatal fire; and
- agreeing to make referrals of vulnerable persons to the Brigade to carry out Home Fire Safety Visits.

Extract from the London Fire Brigade Safeguarding Adults at Risk Audit Tool 2016-2017

All fatal fires are reviewed at the Safeguarding Adults Case Review Group.

In 2016/17 509 referrals were made from the three boroughs to the London Fire Brigade to carry out Home Fire Safety visits.

In response to the learning from Reviews, the Fire Brigade co-hosted the Board Conference on Self-neglect and Hoarding in March 2017 and introduced delegates to the 'clutter rating'. They also demonstrated a range products such as sprinklers, smoke alarms, and fire retardant furnishings.

The Care Act included new categories of abuse, including domestic abuse and self-neglect.

The Board has representatives from the Children Services and Community Safety, and has joint-working protocols with the Violence Against Women and Girls Board and the Local Safeguarding Children Board. This is to make sure that work is joined-up where this is needed, and all the safeguarding requirements of the Care Act are discharged effectively across the three boroughs, making best use of scarce resources and avoiding duplication.

Tackling Domestic Abuse and Coercive Control

The Violence Against Women and Girls Board is committed to making the three boroughs safer for women and girls by preventing harm, reducing risk and increasing immediate and long-term safety for people living, studying, working and travelling to all three boroughs.

Through its coordinated community response, the Violence Against Women and Girl Partnership ensures that all relevant organisations, partners,

communities and residents work together and see it as everyone's responsibility to address violence against women and girls by identifying and supporting survivors and their children, and holding perpetrators accountable.

The Partnership prioritises on-going communication, prevention and awareness-raising activities, creating a menu of options for survivors and their children and continuing to strengthen the coordinated community response.

The success of the Partnership's work is evident through the range of referrals to the Angelou Partnership and to the Multi-Agency-Risk Assessment Conferences; and with joint working with the Metropolitan Central Police to address trafficking for sexual exploitation and prostitution.

"I am in contact with a group…. and they are literally saving my life. I just needed help with all the practical stuff that I don't have a clue about what to do.

But they do…..And if they don't know it, they will actually find it out for you….I really just need someone in one place, in one go. If you have children, you can't just run around. It's just impossible. If you're trying to work and you're trying to take care of your children, and do everything yourself, you just really need one person to call."

Extract from Shared Services Violence Against Women and Girls (VAWG) Strategy 2015-2018

The Care Act says the Board must review cases where a person with care and support needs has died, or experienced serious abuse or neglect, and there is cause for concern about how agencies worked together to safeguard the person.

This is the second year that the Board has carried out its duty to undertake Safeguarding Adults Reviews.

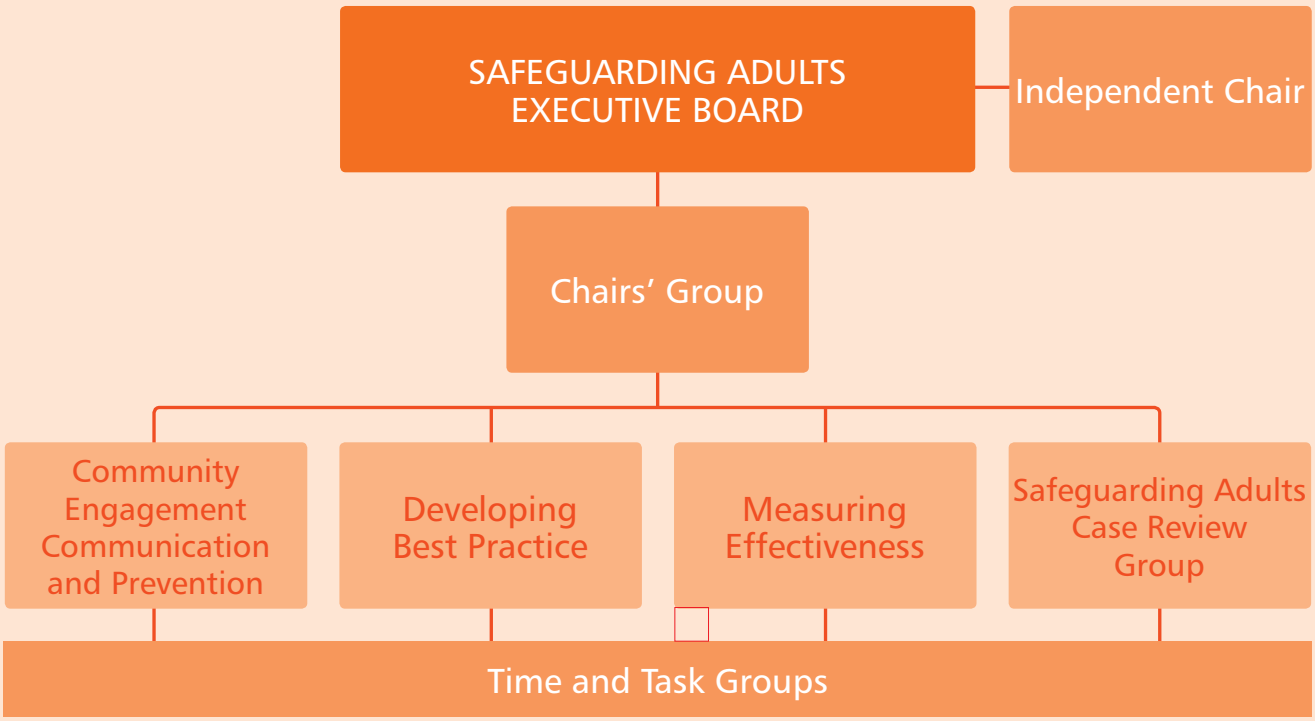
The Safeguarding Adults Case Review Group is made up of representatives of member organisations of the Board. The group recommends to the Chair of the Board the type of review that will provide a proportionate response to the concern, and the opportunity for most learning. This report includes some of the learning from these reviews and some of the changes that have been made to systems and practices as a result of what has been learnt.

What we have learned from Safeguarding Adults Reviews and Safeguarding Enquiries inform the themes that the Board works to address during the year.

The Care Act says the Board must publish a report of what it has done during that year to achieve its objectives, including findings of the reviews arranged by it under Section 44 of the Act.

This is the Annual Report of the Safeguarding Adults Executive Board. It is an account of what the Board has been doing in 2016/17 and examples of how its work has made a difference to people's lives.

The Safeguarding Adults Executive Board and work-streams



ADULT SAFEGUARDING STRATEGY 2015-19

The Care Act says the Board must publish its strategic plan and what members of the Board are doing to implement that plan.

In November 2015, we consulted with people living in the three boroughs, and with organisations working with people who have care and support needs, to develop the Board's four year plan.

From what people told us was important to them, we created the Adult Safeguarding Strategy 2015-2019 'house' below.

People said they do not want to be seen as victims, and said how important it is to be in control of the decisions they make about their life, even when they have experienced abuse or neglect.

Residents said they want to be healthy and safe. They want to know what to do when they themselves, or someone they know, is being neglected or abused, and they want to be listened to.

We said that we want to be leaders who listen and learn from what people are telling us.

This has led the Board to focus all its work this year around these three main themes:

- Making Safeguarding Personal
- Creating a Safe and Healthy Community
- Leading, Listening, and Learning

The things that people told us are most important to them at the consultation event on 24th November 2015 continue to shape the Board's priorities

Making Safeguarding Personal

I am able to make choices about my well-being

Creating a safe and healthy community

I am aware of what abuse looks like and feel listened to when it is reported

I am kept up-to-date and know what is happening

My choices are important

My recovery is important

You are willing to work with me

Leading, Listening and Learning

We are open to new ideas

We are a partnership of listeners

We give people a voice

We hold each other to account

We want to learn from you

WHAT HAS THE BOARD BEEN DOING?

MAKING SAFEGUARDING PERSONAL

YOU SAID:

I want to feel empowered to make choices about my own well-being. My choices are important.

WHAT WE DID:

Through staff training we are promoting the Care Act principle that each of us is the expert in our own life, and this applies equally when we are making choices about our health and well-being, and when we have experienced harm or abuse.

Staff in our organisations are being trained to always ask people who have experienced abuse or neglect, or where appropriate their representative, *'What is important to you?'* and *'What would you like to happen next?'* This is what is meant by **Making Safeguarding Personal**.

We are now recording whether or not each person has achieved what they hoped to achieve, as a result of safeguarding work.

Remaining in control

Adult Social Care have revised how safeguarding information is recorded in its Customer Information System, making sure that the person who has experienced neglect or abuse remains as much in control as possible of what happens next. Staff are prompted to ask what the person wants as an outcome of the safeguarding enquiry, and at the end of the enquiry, if this has been met.

Adult Social Care

'No decision about me, without me'

Emphasis is now placed on the approach to making safeguarding a personalised experience following the principle of 'no decision about me without me' and means that the adult, their families and carers are working together with agencies to find the right solutions to keep people safe and support them in making informed choices.

London Fire and Emergency Planning Authority

MAKING SAFEGUARDING PERSONAL

'Purple Pathway' for patients with a learning disability

In the last year, considerable activity has taken place to improve the care provided to patients with a learning disability. We have introduced the 'purple pathway' to ensure that patients are recognised as having a learning disability and appropriate adjustments are made for their care; for example being given earlier and longer out-patient appointments. Patients attending A&E will be taken to a specifically designed cubicle that is quiet and nicely furnished. They will also be 'fast tracked' through the department. We have been designated a 'Makaton-Friendly' organisation, and have developed a comprehensive suite of easy read documents.

Imperial Hospital NHS Trust

Changing hoarding behaviour and reducing isolation

Our aim is to empower persons experiencing hoarding behaviours to achieve spatial and personal change to reduce isolation and improve their health and well-being. We are a multi-service organisation, helping thousands of people each year through our National Helpline with support groups, information, one-to-one support. We also run a National Training Programme for professionals and organisations. We were pleased to be invited to be part of the Board's Self-Neglect and Hoarding Conference in March 2016.

Hoarding UK

Championing the wishes of vulnerable people

The Trust is rising to the challenge of seeking recording and championing the wishes and feelings of vulnerable people. It now has a Nurse-led Adult Safeguarding service in all three Boroughs, providing advice, support and safeguarding training and supervision to Trust staff.

In March 2017, recruitment was undertaken for additional Safeguarding Adult Advisor Posts. This has increased Adult Safeguarding resources and expertise, providing support to staff in responding appropriately to vulnerability in abusive situations, ensuring the safety and well-being of both children and adults.

Central London Community Healthcare Trust

Embedding Making Safeguarding Personal

During this reporting year the Trust has continued its commitment to raising awareness of safeguarding and related issues. This has been achieved through the provision of a range of training opportunities around safeguarding adults, the mental capacity act, deprivation of liberty safeguards, prevent, learning disabilities, dementia awareness and domestic violence and abuse. This has contributed to ensuring that as a Trust we embed the principle of making safeguarding personal and no decision about me without me.

The Royal Marsden NHS Foundation Trust

CREATING A SAFE AND HEALTHY COMMUNITY

Self-neglect and hoarding

The Clutter Image Rating (CIR)

LFB
LONDON FIRE BRIGADE

CREATING A SAFE AND HEALTHY COMMUNITY

Prompted by themes emerging from safeguarding enquiries and reviews, the Board held a **Hoarding and Self Neglect Conference on 2nd March 2017**.

Approaches to hoarding have often involved short-term crisis responses with little recognition of the individual support that each person affected needs.

The response to the event exceeded all expectations. 0ver 180 people applied for 110 places.

The Conference explored how partners need to work together to reduce the risk to the person who is hoarding or self-neglecting, and to reduce the risk to other people. The Conference also wanted to help delegates to think about why people hoard.

Conference speakers included:

- a person with lived experience of Hoarding
- a representative from Hoarding UK
- an Environmental Health officer
- a member of the London Fire Brigade
- a psychiatrist from an NHS Trust

Delegates watched a powerful video of 'Keith's Story': a man who had been helped to understand why he collected things, and how he was helped to stop.

The Conference promoted the Hoarding Protocol and documents for referring concerns to the Hoarding Panels, including 'clutter rating' and risk assessments. Underpinning this was a shared understanding of the importance of working with partners to share, manage and reduce the risks. The key partners are:

- The person who is hoarding
- Adult Social Care
- Mental Health
- Fire Brigade
- Environmental Health
- Housing

A partner who is increasingly valued, is Hoarding UK who work sensitively with the person to understand why they feel the need to collect things. This is a personalised approach to tackling Hoarding and Self-Neglect which has been shown to result in longer-term reductions in clutter, and happier outcomes for the person themselves

There may be other interested parties who can help such as family, friends and private landlords.

Learning from other Boards Safeguarding Adults Reviews

Conference delegates considered the case of Mr Thomas who was known to Reading Adult Social Care as a 'hoarder'.

Social Care started working with Mr Thomas in July 2012 but his case was transferred between various teams. This lack of continuity, coupled with Mr Thomas's distrust and unwillingness to engage with any service meant that up until his death in June 2015, there had been little meaningful progress in properly safeguarding Mr Thomas.

This case involved a number of different organisations; Adult Social Care, the Police, Mental Health, Care Agencies and the Risk Enablement Panel.

To maximise the learning, delegates were divided into groups and each was assigned a role in Mr Thomas' case and then asked to consider what they did and why. More importantly, what would they have done differently and what lessons can be applied for inter-agency co-operation when dealing with poeple in similar circumstances living in the three boroughs?

The Independent Chair of the Safeguarding Adults Executive Board

CREATING A SAFE AND HEALTHY COMMUNITY

Financial Abuse and Scams

Community Champions becoming 'SCAMchampions'

"I have a huge passion for helping the community, so becoming a Community Champion and then having the support of the project and the resources to really do something has been overwhelming. I love the way it has allowed me to improve things for local people"

Community Champions, End of Year Highlight Report 2016/17

CREATING A SAFE AND HEALTHY COMMUNITY

The growing concerns of 'scamming' and financial abuse of older people, has led the Board to put a renewed emphasis on tackling **financial abuse** together.

On 16th September 2016, the Board held a very successful **Community Engagement** event.

This event updated delegates on how they helped to shape the safeguarding strategy and the 'house'. The event was attended by 56 people, including members of housing, advocacy, voluntary organisations, and local residents.

The focus of the event was 'building safe communities' and the crucial role played by Community Champions.

During 2016/17 Community Champion co-ordinators have been trained to deliver Adult Safeguarding awareness training to 300 Community Champions .

Two Champions talked to delegates about their personal experiences of working with their neighbours to keep their community safe and healthy.

SCAMchampions

Community Champions also talked about their work as SCAMchampions. They help raise awareness of scams and notify the authorities of potential scams. This increases the number of people who can be reached and helped to protect themselves against this very personal type of theft and fraud.

The Board receives regular reports on the joint work being done to tackle financial abuse and scams. This work is led and informed by the expertise and practical help offered by the Trading Standards team, to the Community Champions as well as to residents and colleagues in a wide range of organisations.

Why do scams matter?

Elderly victims are **2.4 times more likely** to die or go into a care home than those who are not scammed.

The average victim loses about **£1,000** to scams but some have lost their homes, their life savings and many thousands of pounds.

Victims don't report being scammed because of shame or intimidation. It is estimated that only **5%** of scams are reported.

Trading Standards

Homelessness, hostels and Spice

The Safeguarding Adults Case Review Group have reviewed a number of deaths related to people who are homeless, or living in hostels, some of whom use substances or may have mental health needs, or both. These reviews have led to better joint work between the police, hostels, mental health and substance use services.

During the year, the police became seriously concerned by the growing number of vulnerable adults suffering serious harm due to taking a drug commonly known as 'Spice'.

Spice is highly addictive and in one weekend last autumn there were nine overdoses, causing major issues for statutory services.

At the Board meeting in October 2016, the Police assisted by housing and voluntary services working with this group of people, gave a presentation on impact of Spice on mental and physical health of homeless people and hostel dwellers.

CREATING A SAFE AND HEALTHY COMMUNITY

YOU SAID:

I want to be aware of what abuse looks like and feel listened to when it is reported.

WHAT WE DID:

The safeguarding information leaflets '**Say NO to abuse**' have been up-dated and a new leaflet, '**Keeping safe from abuse and neglect: what happens after you report abuse**' has been published this year.

Both of these and other information and advice about safeguarding adults are available on the **People First website**. Printed copies are also available on request.

Joined up action by agencies represented on the Board

Westminster Police arrested 18 dealers selling to vulnerable people. One individual dealer who purported to be homeless had a four-bedroom house in Havering and was clearly preying on people living in hostels and on the streets. The Police have successfully obtained a conviction awaiting sentence for Possession with Intent to Supply a Psychoactive Substance.

Through Operation Kaskara, a neighbourhood operation to reduce Anti-Social Behaviour and violence associated with Spice, the Police are supporting community behaviour orders to ban long term dealers from the 'hot spot' areas.

They have also been running outreach events with partners in the worst affected area and distributing support information and engaging the users with NHS and support workers.

The drug usage appears to be concentrated around the West End and Victoria area and work continues to identify 'hot spots'. Forty outreach staff go out daily and work closely with the Police and Substance Misuse Service.

There is a close relationship with eight commissioned providers who undertake regular training programmes.

Message in a bottle

WHAT IS IT?

The scheme is a simple idea designed to encourage people to keep their personal and medical details on a standard form and in a common location - the fridge.

HOW DOES IT WORK?

In the event of a sudden accident or illness while at home, the first emergency service on the scene will be alerted to the bottle by the labels on the inside of your front door and the outside of the fridge door.

WHO WILL BENEFIT?

Paramedics
Police
Fire fighters
Older people
People not in good health
People living alone
People with critical conditions/allergies
People with disabilities

WHERE DO I OBTAIN THE BOTTLE FROM?

Your local pharmacy
Your GP practice

WHO CAN HELP TO COMPLETE THE FORM?

Family, friends, carers, Social Services and the voluntary sector can help you to complete the form. For further advice please contact your GP practice or local pharmacy.

CREATING A SAFE AND HEALTHY COMMUNITY

LEADING, LISTENING AND LEARNING

Learning from Safeguarding Adult Reviews

This year the Board has worked on what safeguarding enquiries and Safeguarding Adult Reviews are telling us needs to change and improve.

Enquiries and Reviews give the Board concrete examples of where we are working well together to prevent abuse and neglect, and where systems or staff practice need to be strengthened and improved.

A Learning Culture

The Trust responds very robustly to lessons from enquiries, both internal and external. A major piece of work in the Trust has been developing a Sexual Safety Guidance document and service user and carer leaflet, accompanied by professional boundaries training for staff. This came out of a commissioned external report into a serious incident at one of our mental health in-patient sites.

West London Mental Health Trust

A key lesson learnt from this year's Safeguarding Adult Reviews is the increasingly important part general practitioners play in safeguarding people from abuse and neglect. This has led to focused work by the Clinical Commissioning Groups, and supported by NHS England, and the Royal College of General Practitioners, to train and support GPs to carry out their safeguarding responsibilities.

In 2016-17 11 cases were accepted by the Safeguarding Adults Case Review Group as meeting the Section 44 Safeguarding Adults Review criteria. A list of the emerging themes from the Reviews is attached as APPENDIX 1.

General Practitioners are key

The Clinical Commissioning Groups are working closely with general practitioners to develop a set of Quality Standards for Primary Care, including safeguarding indicators. Each GP practice has a safeguarding link person to ensure information and updates are cascaded effectively.

NHS England jointly delivered with The Royal College of GPs, a safeguarding event in London early in 2017. This event was a success with demand outstripping supply. The programme included the Learning Disability Mortality Review, the Mental Capacity Act 2005, and Self-Neglect.

The Royal College of GPs also rolled out a tool kit which GPs can use as part of their day-to-day practice.

Safeguarding training take-up is monitored quarterly by the GP Federations, in line with the NHS Standard Contract. Where practices are below target, GP Federations are supporting practices to access statutory training and improve performance.

Public Health funded 'Standing Together' to deliver Domestic Abuse training to Primary Care staff in their local surgeries. Sessions are underway to develop Domestic Abuse champions within Primary Care practices.

Clinical Commissioning Groups
Commissioning Collaborative

LEADING, LISTENING AND LEARNING

These are some of the changes that have happened as a direct result of these Reviews:

- A Joint Health and Social Care Dementia Programme Board is developing the range and variety of provision for people with dementia.
- The police, hostels, homelessness, and substance use services are working together to tackle Spice, and loss of life through substance use.
- A road show on Domestic Abuse and Adult Safeguarding is being developed for roll out to front-line staff.
- The Self-neglect and Hoarding Conference raised delegates awareness of the steps they can take to reduce the risk of fatal fires, and work better with people who are wary of statutory services.
- A high level conference in November 2017 will review how far the learning from the Safeguarding Adults Review in 2015 has changed things for the better with regard to Dementia Care.
- The Board asked members to review their arrangements for applying the Mental Capacity Act 2005 to decision-making. The self-audit showed that member agencies have designated staff, including Mental Capacity Act Champions, who are helping front-line staff to feel more confident in assessing capacity and best interest decision-making.
- The Board is seeking assurances from members that discharge from hospital is safe, particularly for people who have no family, or friends, and also during holiday periods when there may be staff shortages in care and support services.

YOU SAID:

I want to be listened to and for you to be willing to work with me.

WE said:

We are a partnership of listeners. We want to learn from you and we are open to new ideas.

HOW WE KNOW WE ARE MAKING A DIFFERENCE

Here are four examples of how the work of the Safeguarding Adults Executive Board is making a difference to residents.

BETTER PHYSICAL HEALTHCARE FOR MENTAL HEALTH PATIENTS

Mr Williams*

Mr Williams' community care team were concerned about his mental and physical health. His care worker asked Mr Williams about his physical health, but he did not want to talk to him about it. Mr Williams said his physical health needs were a matter for his GP alone. The care worker shared his concerns with Mr Williams GP, who also found it difficult to get Mr Willams to keep appointments and accept his help and advice.

Mr William's poor mental health was affecting his physical health and he was recalled to hospital under the community treatment order. On admission, it was noted his foot appeared infected and swollen. He was immediately taken to A&E for emergency treatment resulting in him having an amputation above the knee.

A safeguarding concern was raised for Mr Williams and enquiries made as to whether or not his physical health had been neglected. His situation was also considered by the Safeguarding Adults Case Review Group.

The learning from the safeguarding enquiry and review prompted the Trust to look for extra resources to ensure all staff are competent and confident in addressing the physical health care needs of patients with poor mental health.

In November 2016, the Trust recruited a Nurse Consultant in Physical Healthcare. They rolled out a training programme in January 2017 which concentrated on inpatient staff. A diabetes procedure was introduced and 90% of current inpatient staff have been trained on the management of diabetes and diabetes emergencies. This includes an escalation process when patients refuse essential medication including insulin and diabetic medication. The Trust has also introduced a 'physical healthcare portal' on the electronic patient data base.

Mr Williams is doing well both mentally and physically and has strengthened his links with family and friends.

West London Mental Health Trust

* Not his real name.

SAFEGUARDING PEOPLE DEPRIVED OF THEIR LIBERTY

Mr Smith*

In 2016, Mr Smith, a bachelor originally from Ireland who had lost touch with his family, was found confused and wandering in the streets by the police. He was admitted to hospital and diagnosed with dementia. He was also visually impaired and had a range of other medical conditions, including hypertension. Mr Smith was treated in hospital and found to be medically fit for discharge, but was still wandering around the ward and appeared confused. It was felt that further assessments were needed, so he was placed in residential care for the time being.

While in residential care, Mr Smith was very unhappy and attempted to end his life. He felt locked in as he was not able to go out when he wanted to. He said he felt "like a dog kept in a home." The care home applied for a Deprivation of Liberty Safeguards (DOLS) authorisation as he was clearly always supervised by staff, and not permitted to leave.

Mr Smith was assessed as not having capacity because he was not able to understand information about the care and treatment he needed to be safe and well.

Mr Smith was entitled to have someone representing him, and because he did not have friends and family, an Independent Mental Capacity Advocate was appointed to help him make decisions, or to ensure that all decisions made about him were in his best interest. This included whether or not Mr Smith should stay in the care home.

Mr Smith often found it difficult to find words to express himself and found it difficult to stay on topic, but having an advocate helped him to make his wishes known. Mr Smith's care plan now includes regular outings, with staff support.

A good outcome

Mr Smith was able to tell his advocate that he no longer feels trapped: he goes out regularly with a member of staff, mainly to the shops and to have a coffee. He has also been reunited with his sister and is enjoying getting to know her better through telephoning and Skype. Recently, Mr Smith told his advocate: "Maybe in the future, I may go to Ireland to see her one day."

Deprivation of Liberty Safeguards Service

* Not his real name.

DECLUTTERING AND REMOVING RISK

Mr Sayed*

Mr Sayed likes reading and has a large collection of CDs and sheet music. He gets very attached to his possessions and has difficulty managing the build-up of his belongings safely. He says that he keeps them as they could be of use later. Mr Sayed is also very keen on re-cycling and says that he will re-cycle things at a later stage.

Mr Sayed has been hoarding for many years. In the past, his flat had been completely cleared without his involvement. This caused him great anxiety and resulted in him being very distrustful of professionals who were trying to help him.

When we started to work with Mr Sayed, his flat was 9 ++ on the Clutter Image Rating scale, which is the highest level and indicated a very high risk to himself and to the other people who lived in his block of flats. He was adamant that he could clear his flat himself and initially refused practical help. By using a multi-agency approach and involving him in the clearance process, he eventually accepted the help he needed.

Through the use of the Self Neglect and Hoarding process, Mr Sayed has been supported both practically and emotionally to clear his accommodation, making it safe and habitable. He is also no longer in breach of his tenancy. Mr Sayed was helped throughout by a social worker from Adult Social Care; City West Homes, Residential Services; the London Fire Brigade; and a specialist hoarding agency called Clouds End.

After a full risk assessment, an injunction was eventually taken to clear the flat. It was agreed that the clearance of Mr Sayed's flat would be co-ordinated by Clouds End as he had established a trusting relationship with them. Unlike the previous clearance, Mr Sayed was fully involved in the process, and care was taken not to remove all of his books and CDs.

A major clearance was eventually completed and his hoard has been reduced from a level 9 on the clutter index scale to a level 3. There is no further risk to himself and his neighbours.

Mr Sayed continues to have weekly hour-long visits from Clouds End to help him maintain a safe and comfortable home.

Adult Social Care

* Not his real name.

ESCAPING DOMESTIC ABUSE

Mrs George*

Mrs George suffers from chronic depression as a result of her home life. She was a prisoner in her own home.

For almost 15 years she was regularly abused, living in a flat with her husband, his family, and their 6 children, all aged under 14. During a safeguarding enquiry, she disclosed years of physical and sexual violence by her husband, including rape in front of her young children. Her movements were tightly controlled by her husband's family, and she was only ever allowed out of the flat to take her children to and from school. She was made to do all of the cooking and cleaning. The family kept her documents locked away so she had no access to them, and she was not allowed any money of her own. She did not know if benefits were being claimed in her name. She was completely isolated, and this was compounded further by the fact that she spoke no English.

Working together, the Trust Safeguarding Manager, the local authority safeguarding lead, a Safeguarding Adults Manager, The Police and Children's Services, managed to help Mrs George to leave the flat with her four youngest children. They have been housed outside London in an area her husband is unlikely to find them. Children's Services are supporting her to maintain contact with her two oldest children, who, at the time, wanted to stay with their father. There was a risk that they might have disclosed their location to their father, if they had left with their mother.

Events unfolded quickly. Mrs George left nine days after concerns were first raised. There was uncertainty about whether her move could be achieved safely. There were concerns throughout that her husband and his family would realise something was going on and this might put her at risk of serious harm.

A good outcome

Mrs George and her younger children are doing as well as might be expected. She is still afraid that her husband may discover where she is and seriously harm her. She continues to receive help from mental health services for herself, and children's services for her children. She has not regretted her decision to flee from her husband and the violence he inflicted on her.

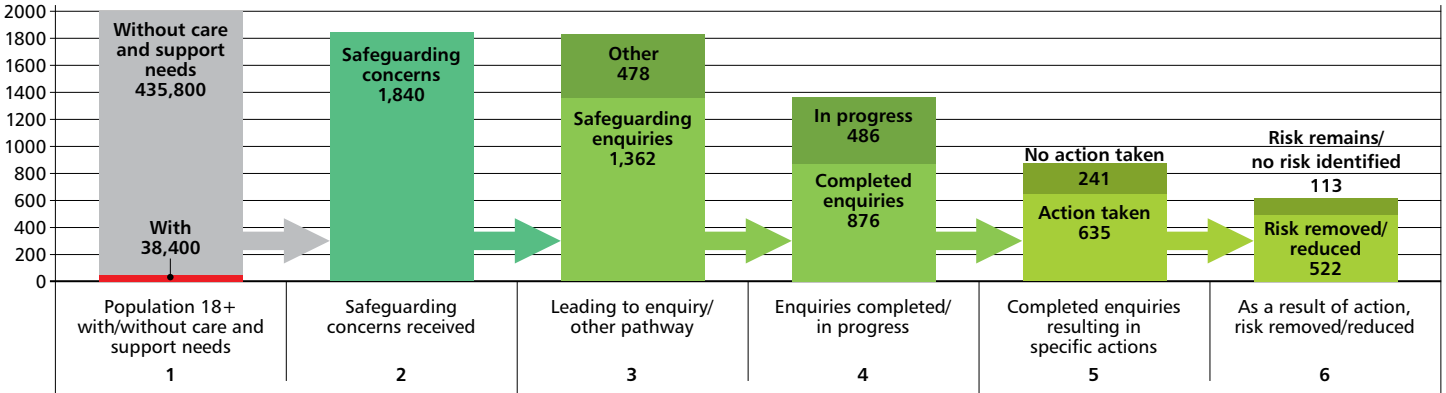
Central North West London NHS Trust

* Not her real name.

WHAT ARE THE NUMBERS TELLING US?

Chart 1

The safeguarding journey, from raising of safeguarding concern to outcome of safeguarding enquiry, 2016/17*



Raising of safeguarding concerns

- Safeguarding focuses on those who have needs for care and support. In national surveys about 8% of adults aged 18+ say that they are unable to manage at least one self-care activity, such as washing or dressing, on their own. If we use this measure as a proxy measure of need for care and support and apply this percentage to combined population of the three boroughs (about 474,200), we can say that at any one time across the three boroughs there are about 38,000 people who have care and support needs. This is nearly three-and-a-half times the number of adults who received on-going support from social services in 2016-17 (11,230).
- In 2016-17 the three boroughs received a total of 1,840 concerns about cases of potential or actual harm or abuse. This is equivalent to about four concerns for every 1,000 adults in the general population, or 48 for every 1,000 adults with care and support needs, or 164 for every 1,000 adults receiving on-going social care
- The majority of concerns (about 80%) were raised by health or social care staff; the remainder were raised mainly by relatives, friends or neighbours, housing agencies, and the police.

Resulting safeguarding enquiry process

- In 2016-17 adult social care made significant changes to the way they respond to safeguarding concerns and the way they record safeguarding information. This was to streamline procedures and ensure they met the requirements of the 2014 Care Act. As a result it is not possible to make comparisons with previous years.
- With this qualification nearly three-quarters (1,362) of the concerns received were assessed as requiring follow-up under safeguarding procedures.
- This is because the people involved were assessed as:
  (a) experiencing, or being at risk of, harm or abuse; and / or
  (b) having care and support needs which prevented them from protecting themselves.
- These concerns became the subject of a safeguarding enquiry to establish what the person wanted to happen in relation to the risk and what needed to be done to achieve this
- Those concerns (478) not followed up as safeguarding enquiries were followed up in other ways, notably referral to trading standards offices, domestic abuse support agencies, the police or the customer services team.

Outcome of enquiry process

- Safeguarding enquiries can take varying lengths of time to complete, depending on the issues and organisations involved. At 31 March 2017 nearly two-thirds (876) of the enquiries that had been started since 1 April 2016 had been completed. The remainder were still in progress.
- Of the safeguarding enquiries which were completed in 2016-17, the majority (635, or about 73%) resulted in specific actions being taken in relation to the risk, such as disciplinary action or removing staff from the situation
- The remaining cases (241) had not resulted in specific actions for a number of reasons, for example because the inquiry had found the risk to be unfounded, or because the adult did not wish any action to be taken
- Where specific actions had been taken, in the great majority of cases (522, or 82%) the risk of harm or abuse was judged by the social worker to have been removed or reduced as a result. In the remaining cases (113) the risk was judged to have remained, for example where the inquiry involved a family member and the adult was accepting of the risk, or no risk was identified.

* Information on safeguarding activity in local authority areas is published annually by NHS Digital and is available at: https://digital.nhs.uk/catalogue/PUB21917

WHAT THE BOARD WILL BE WORKING ON IN 2017/18

EMERGING THEMES AND BOARD PRIORITIES

Variety and Quality of Care Provision

Improving the range of health and care provision for people with different types of dementia.

Hoarding and Self Neglect

Working together to win the trust of people with capacity to make their own decisions and are reluctant to accept care from statutory services, with the result that their health and care needs are not being met.

Mental Capacity Act 2005

Increasing staff confidence with application of the Mental Capacity Act 2005; 'no decision about me, without me'.

Physical Health

Improving the physical health of people with mental health needs and learning disabilities.

Safe Discharge from Hospital

Looking at people's experiences of discharge from hospital to be sure that they are safe.

GLOSSARY OF TERMS

Safeguarding

Safeguarding means protecting our right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and reduce the risk of abuse and neglect. When people have experienced abuse or neglect, safeguarding is about taking actions that are informed by the person's views, wishes, feelings and beliefs.

Making Safeguarding Personal

Making Safeguarding Personal starts with the principle that we are experts in our own life. Things other than safety may be as, or more, important to us; for example, our relationship with our family, or our decisions about how we manage our money. So, our staff are being encouraged to always ask 'What is important to you?' and 'What would you like to happen next?'

An Outcome

An Outcome is what you hope to get out of the conversations we have, and the work we do with you. Measuring outcomes helps the Board to answer the question "what difference did we make?" rather than "what did we do?"

Deprivation of Liberty Safeguards (DoLS)

Deprivation of Liberty Safeguards is when a person in a care, or nursing home, or hospital, is subject to continuous supervision and control from staff, and is not free to leave, under the Supreme Court judgement known as 'Cheshire West', they are deprived of their liberty. Once identified, a deprivation of liberty must be authorised either by the Court of Protection order; or under the Deprivation of Liberty Safeguards in the Mental Capacity Act 2005; or under the Mental Health Act 1983. If it is not authorised, under the law, it is an illegal detention.

SPICE

SPICE is a generic term used to describe a substance which typically contains synthetic cannabinoids. The term synthetic cannabinoid is used to describe a whole raft of compounds which affect the cannabinoid receptors in the human body. Synthetic cannabinoids cause similar side effects to skunk, but these effects are multiplied and can last up to six hours. They are commonly sold in professional looking plastic bags with many different brands names.

Makaton

Makaton is a language programme using signs and symbols to help people to communicate. It is designed to support spoken language and the signs and symbols are used with speech, in spoken word order. With Makaton, children and adults can communicate straight away using signs and symbols.

Self-neglect

Self-neglect covers a wide range of behaviour including neglecting to care for one's personal hygiene, health, or surroundings, and behaviour such as hoarding. The term itself can be a barrier as some people do not identify with this term or description of their situation. It is important that practitioners find common ground and understand the person's own description of their lifestyle rather than making assumptions about how it can be defined.

Hoarding

Hoarding behaviour was previously seen as a symptom of Obsessive Compulsive Disorder but it has now received a separate clinical definition of 'hoarding disorder' and is defined as: 'A psychiatric disorder characterised by persistent difficulty discarding or parting with possessions, regardless of their actual value resulting in significant clutter that obstructs the person's living environment and produces considerable functional impairment.' (Greater Manchester Fire and Rescue Service: Hoarding, Prevention, and Protection)

Clutter Image Rating

Clutter Image Rating a series of pictures of rooms in various stages of clutter – from completely clutter-free to very severely cluttered. People can just pick out the picture in each sequence comes closest to the clutter in their own living room, kitchen, and bedroom. When clutter reaches the level of picture number four, or higher it begins to impact on people's lives and we would encourage the person to get help for their hoarding problem.

APPENDIX

Cases Accepted for Safeguarding Adults Review in 2016-17: emerging themes and changes made

	Date case to SACRG	Emerging themes from Safeguarding Adults Reviews
1	**6 May 2016**	This person did not die but the case raised the issue of police resources used to find a missing person. The Police submitted a breakdown of the cost to the police of missing persons and the value of joint work, such as closer work between hostels, mental health in-patient provision, and the police to reduce the incidence of people going missing. The SAEB made working with people in hostels, homelessness, and substance use (primarily SPICE) a priority this year, to reduce both the risk of loss of life, and policing costs.
2	**6 May 2016**	This was a complex situation of domestic abuse between two people, both with care and support needs, but able to make their own decisions. There is on-going risk of serious harm, and many agencies are involved. Although this case did not meet the criteria for a Review, two members of the SACRG used reflective practice, based on the SCIE Learning Together model, to help all practitioners involved to work together more effectively to manage the on-going risks.
3	**22 July 2016**	Fatal fires are reported to the SACRG. This death raised the continuing need to raise staff awareness of fire risks. The SACRG agreed that the Fire Brigade will alert social services in the event of an adult at risk declines a fire safety check on more than three occasions. A Fire Brigade alert now triggers a referral to the Self Neglect and Hoarding panel. A Hoarding and Self Neglect conference for staff was held on 02/03/2017. Delegates were reminded of the Fire Brigade offer of staff training, and assessment of fire risks in a person's home; and installation of fire alarms, sprinklers and fire retardant fabrics, to reduce risk and prevent serious harm or death.
4	**10 July 2015**	The death of this man was reviewed using information gathered in the Safeguarding enquiry. The review illustrated the need to be diligent in recording and sharing each person's information, especially when there are changes to key workers brought about by re-organisations, or change of contractors.
5	**7 October 2016**	The person in question did not die, but the review illustrated the increased risk to good decision-making when staff are working within tight financial constraints, and also experiencing major re-organisation of their working life. It illustrated the need for careful assessment of a person's needs, prior to placement in a care or nursing home. It also led to the development of a protocol for clarifying decision-making about health and social care funding.

	Date case to SACRG	Emerging themes from Safeguarding Adults Reviews
6	**7 October 2016**	The key learning from this death is the need for organisations to provide culturally appropriate support to staff going through the disciplinary procedures, particularly when a disciplinary is as a response to a safeguarding incident or enquiry, and so involves loss of reputation.
7	**10 March 2017**	This person did not die, but was very close to death. The safeguarding enquiry confirmed that too much weight given to European Court of Human Rights Article 8: The Right to Family Life, balanced against the ability of the family to properly care for the person. It identified the need for robust, multi-agency risk assessment; and risk and case management. It illustrated that not all staff are confident in application of the Mental Capacity Act 2005 when decision-making.
8	**10 March 2017**	This death has caused the Board to consider very carefully, and to challenge senior officers in member agencies, as to whether or not the learning from the formal Review, held between September and December 2015, has had any impact on decision-making around placing robust, active, and sometimes violent people with Dementia, to live alongside physically frail older people, also with Dementia. The Board has commissioned a high-level reflective practice session for senior officers to consider the matter further.
9	**10 March 2017**	The review of three people who died after being discharged from different hospitals over the Christmas and New Year holiday period has led the Board to gain assurances about safe discharge from hospital, particularly of people who may be have no family and be un-befriended, and during holiday periods when staff shortages in community services may occur.
10	**31 March 2017**	This review illustrated the value of working with a person's family at the time of the incident and death. The family were appreciative of the work done with their family member and the Trust's enquiries into the circumstances of the person's death.
11	**31 March 2017**	Two cases illustrated the absence of clarity between agencies about responding to a 'no reply'. The Board has commissioned a 'task and finish' group to work together and develop a multi-agency (social services, the police, mental health and home care providers) simple but effective response to ensuring a person is safe.

City of Westminster

Westminster Health & Wellbeing Board

Date:	16 November 2017
Classification:	General Release
Title:	Next steps with Integrated Health and Social Care in Westminster
Report of:	Cllr Heather Acton, Chairman of the Health & Wellbeing Board Dr Neville Purssell, Chairman, Central London Clinical Commissioning Group
Wards Involved:	All
Policy Context:	Health and wellbeing
Financial Summary:	N/A
Report Author and Contact Details:	Dylan Champion, Head of Health Partnerships, WCC (dchampion@westminster.gov.uk) Chris Neill, Deputy Managing Director, Central London CCG (chrisneill@nhs.net) Jayne Liddle, Assistant Director Whole Systems, West London CCG (Jayne.Liddle@nw.london.nhs.uk)

1. EXECUTIVE SUMMARY

1.1 At its meeting on 13 July the Health and Wellbeing Board considered the draft Primary Care Strategy produced by Central London CCG and the local GP federation, Central London Healthcare (CLH). The strategy described outline plans for transformation beyond primary care able to deliver the final step in achieving the Central Government ambition of delivering integrated health and social care by 2020. The Board requested that the City Council be fully engaged in developing these plans further and since July Central London CCG (CL CCG) and West London CCG (WL CCG) have been working together to develop that thinking.

1.2 Since July, considerable work has been undertaken to develop this work further and this report provides an overview. In particular, each CCG has presented and had approved by its Governing Body its Integrated and Accountable Care Strategy. Kensington and Chelsea Health and Wellbeing Board has also

considered and given its support to the West London Integrated and Accountable Care Strategy.

1.3 In combination, this work and these strategies represent an exciting step change in the work to deliver better health and social care outcomes for Westminster residents and to achieve the Leader's Vision for Westminster and the Central Government Vison for integrated health and social care. The CCGs are looking to fully engage the Council and all partners in the development of more integrated, locally based services available in the community to support residents. The Council is therefore being approached as an equal partner in the development of these plans and its commitment is important to making this work.

1.4 Underpinning both strategies is a people focussed model of care, aimed at reducing the fragmentation of service delivery, improving outcomes, providing better care in the community and delivering the best value for money. This is encapsulated in the accountable care principles of 'one system, one budget, better outcomes'.

1.5 Driving both is also a commitment to deliver a common set of health and social care outcomes for residents whether they live in the south of the borough, the north, or in Kensington and Chelsea, and also a commitment that both approaches will align with and contribute to the London-wide work to establish a common outcomes framework and consistently high quality health and social care outcomes for all London residents. This is a particular issue for Westminster as approximately 50,000 residents who live in the Queens Park and Paddington area fall within the jurisdiction of the West London CCG while the remainder of Westminster residents fall within the jurisdiction of the Central London CCG. In addition, a significant number of residents will also utilise the services of GPs and other health providers in other neighbouring boroughs.

1.6 The proposals set out in both strategies are ambitious and will result in a very different health and social care system in Westminster from April 2019. The changes will only be successful if they are delivered with the full support of the Health and Wellbeing Board, the Council, both CCGs and key partners in Westminster. These initial proposals are presented to the Health and Wellbeing Board for consideration and endorsement and providing the direction of travel is endorsed, progress and key decisions required will be presented to each future meeting of the Health and Wellbeing Board.

2. RECOMMENDATIONS

2.1 The Health and Wellbeing Board is asked to endorse the Central London Accountable Care Commissioning Strategy attached as appendix 1.

2.2 The Health and Wellbeing Board is asked to endorse the West London Integrated Care Strategy attached as appendix 2.

2.3 The Health and Wellbeing Board is asked to recognise and require the need for a whole system solution which will ensure that all Westminster residents whether they live in the north of the borough or the south receive a high quality and consistent health and social care service.

2.4 The Health and Wellbeing Board will play the lead role in shaping and overseeing the delivery of both strategies, receiving regular updates and providing endorsement to proceed following the achievement of key milestones.

3. BACKGROUND

3.1 In response to the Central Government vision to deliver integrated health and social care by 2020, WCC, health commissioners and local partners have for a number of years being working to improve joint working between health and social care services in order to deliver better outcomes for residents. In particular:

- Tri-Borough partners have produced and submitted 3 Better Care Fund Plans setting out how work will take place to deliver more integrated working between the CCGs and local authorities
- In November 2016, partners produced the NW London Sustainability and Transformation Plan
- In the first quarter of 2017, the Westminster Health and Wellbeing Board agreed a Joint Health and Wellbeing Strategy 2017-21.

3.2 This work culminated in the development and agreement of a shared vision, which was set out in the Joint Health and Wellbeing Strategy. That vision is that:

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

3.3 At its meeting in July, the Health and Wellbeing Board considered the draft Primary Care Strategy, which had been produced by CL CCG and CLH. It welcomed the strategy and requested that the outline plans for transformation beyond primary care be further developed into a comprehensive local response to the Central Government requirement for integrated health and social care by 2020, and that this be presented to the Board in November 2017.

3.4 Since then considerable work has taken place and in accordance with guidance from NHS England, CL CCG and WL CCG have produced draft Integrated Care Strategies. These are attached as appendix 1 and appendix 2.

3.5 It is important to note that whilst both strategy documents describe, to some extent, the different local starting points of both programmes of work, the aims and objectives are common across both and this is the first in a series of updates to the Health and Wellbeing Board which reflects early thinking to date before further work is done and brought forward for discussion and consideration.

Case for Change

3.6 Underpinning both strategies is a compelling case for change:

- Westminster is a borough of significant health inequality and this must be addressed: as the number 96 bus crosses the borough, life expectancy for men increases from 76 years old on the Harrow Road, to 89 years old in Knightsbridge and Belgravia, before falling again to 83 years on in the south of the Borough;
- By 2021, there will be a £1.4b shortfall in the resources to deliver existing levels of health and social care in North West London and partners in Westminster need to make their contribution to closing this gap by transforming local health and social care services;
- The existing health and social care system is fragmented, with duplicated effort and complicated pathways. There are 45 GP practice, 2 community trusts, 1 main mental health trust, over 50 providers of care services and within the BCF Section 75 Agreement alone, over 100 contracts;
- There are significant skill shortages, but at the same time considerable evidence that the skills available are not being utilised efficiently or effectively
- There is considerable opportunity to increase resident and patient satisfaction with health and social care services in order to achieve the City's ambition to be a World Class City.

Central London CCG Integrated and Accountable Care Strategy

3.7 Working with the Council, CL CCG have developed ambitious plans to establish a collaborative and cohesive health and care system in Westminster by 2020 and ensure that as a system, Westminster responds positively to the direction set in the NHSE Five Year Forward View and the ambition set in its own Sustainability and Transformation Plan.

<u>Proposed Care Model</u>

3.8 While more work is required to develop the care model to deliver integrated health and social care and an ambitious programme of engagement and co-design is planned to achieve this it is envisaged that the new model will be underpinned by the concept of:

'One system, One budget, Better outcomes'.

3.9 The strategy also commits partners to a set of guiding principles:

- ✓ **Resident-focussed** – we expect all our residents to be supported by a single health and social care team, using a single assessment and support process, supported by a single care plan if necessary

- ✓ **Community-focussed** – the care system will by default provide support in the community and make use of hospital or other bedded care only when necessary
- ✓ **Geographically relevant** – the approach to care must recognise the unique geography of Westminster and provide tailored solutions for people living in the north, centre, and south of the borough
- ✓ **Collaborative** – local approaches to care must be co-designed with local people and a wide range of local interest groups
- ✓ **Preventative** – the care model will focus on prevention and self-help, giving residents power over their own choices, health, and wellbeing

3.10 These principles are supported by the following approach to the delivery of care:

- tackling the root causes of inequalities that affect health and wellbeing;
- focussing on the way that local people want to live their lives and experience services where they need them;
- prioritising the prevention of ill health, as well as providing high-quality services when these are needed;
- supporting, through our commissioning, better coordination of care;
- moving much more of the focus of support into the community, closer to people's homes;
- improving local networks of care, with the right level of expertise available in the community; and
- looking to the future – including embracing new technologies and digital developments and continually adapting our services and the way people can access them.

What residents will see?

3.11 From a resident perspective, both strategy documents focus on improving access to and the provision of out of hospital and community services. As the CLCCG strategy sets out, this is because:

- this is where care is most fragmented and the benefits of integration for local people are greatest;
- this is where many types of care can be wrapped around primary care and tailored to each community's specific needs;
- this is where holistic care can focus on the long-term support of people in their own surroundings;
- this is where care can best encourage prevention, self-care, and the wider wellbeing agenda; and
- the flow of local people into hospital care involves a much wider area and must therefore be brought into an integrated system with a larger group of partners.

3.12 Delivering this approach will mean moving away from the existing arrangements whereby the CCG and the Council let and manage a large number of individual contracts to a range of NHS, private and community providers to support a health

and social care system where often there are many and complex patient or resident pathways which span a number of different organisations.

3.13 What should replace it is an arrangement which will involve a more consolidated approach to commissioning whereby a far greater range of out of hospital will be delivered through a single, outcomes based contract by a new organisation responsible for a greater proportion of residents health and social care needs and more able to provide more appropriate, integrated and responsive care.

3.14 On a practical basis, commissioning partners (the CCGs and City Council) will need to work with the providers of local care, including local trusts and primary care and others, to work towards integrating services on the ground. Ultimately residents will see an integrated community health and social care team made up team members with a range of different skills and expertise supporting a population grouping of between 40 and 60,000 people. Central to the team will be groups of GP practices who will work together in 'Primary Care Homes', or hubs.

Scope of new proposals

3.15 A key issue for commissioning partners will be agreeing the scope of the new proposals.

3.16 In the draft Commissioning Strategy, CL CCG have identified all existing out of hospital spend (with the exception of core GP contracts) as within scope of the new proposals. This includes spend on the Community Independence Service (where the existing contract comes to an end in July 2018) and the Community Nursing Services (where the existing contract comes to an end in March 2019). In addition, spend on out of hours and urgent care services and community mental health and learning disability services will initially be placed within scope. In total, the annual value of these contracts is in the region of £122m per year.

3.17 In parallel, the Council will also need to consider which of its services it places within scope of the new arrangements. These could include all elements of adults, children's and public health services but in reality it is likely the Council will wish to or be required to retain some of these functions, including safeguarding and others required by statute. The current net spend on Adults, Children and Public Health services by the Council is in the region £147m per year. Of this approximately 75% will be spent on residents within the jurisdiction of CL CCG and 25% within the jurisdiction on WL CCG.

3.18 For all parties, the next stage in the development of the proposals set out in this paper and the attachments will be further work to define the scope, outcomes, programme plan and approach. This will be developed by early in the New Year.

Key milestones

3.19 Within the Commissioning Strategy, an ambitious timescale is set out for designing and delivering the new arrangements. If the Commissioning Strategy is endorsed by key stakeholders and all goes to plan, a detailed Business Plan will be presented to the Council, CCG and NHSE in June 2018, with a view (if agreed) to identifying a preferred provider by November 2018 and beginning new arrangements in April 2019.

Engagement and co-design

3.20 Key to the success of the programme will be comprehensive engagement and co-design and the involvement of all key partners in the development of a Care Model to inform the procurement and agreement of an outcomes framework to measure the effectiveness of the new arrangements. Supporting and overseeing this work will be the Westminster Integrated Care Partnership Board, which has recently been formed and is made up of a range of providers, key stakeholders and patient representatives. It is anticipated that the Health and Wellbeing Board will play a key role in overseeing this work and will receive an update on progress at its January meeting.

West London CCG Integrated Care Strategy

3.21 In theme, timeframe, delivery model and in its focus on integrated local services, the two strategies presented are common. The aim of the WL CCG Integrated Care Strategy is over the next two years to focus on how people work together at a local level to support people better to live independently. The strategy builds on the innovative work that has taken place over the past two years in developing My Care My Way (MCMW) service and more recently the Community Living Well (CLW) service.

Proposed Care Model

3.22 The aim of the strategy is to have established a network of fully integrated Community Teams serving the whole population's health and care needs by April 2019 and elements of this in place sooner where possible. The Integrated Community Team will be responsible for the delivery of a single set of outcomes including:

- Proactive care to maintain good health
- Diseases well managed
- Care tailored to local need
- Reduced health inequalities
- Residents able to live independently at home but not isolated.
- Acute flow reduction
- Value for money from each intervention

3.23 Each community team will support a local population and a key element will be groups of GP practices who will work together as part of a 'Primary Care Home', or hub.

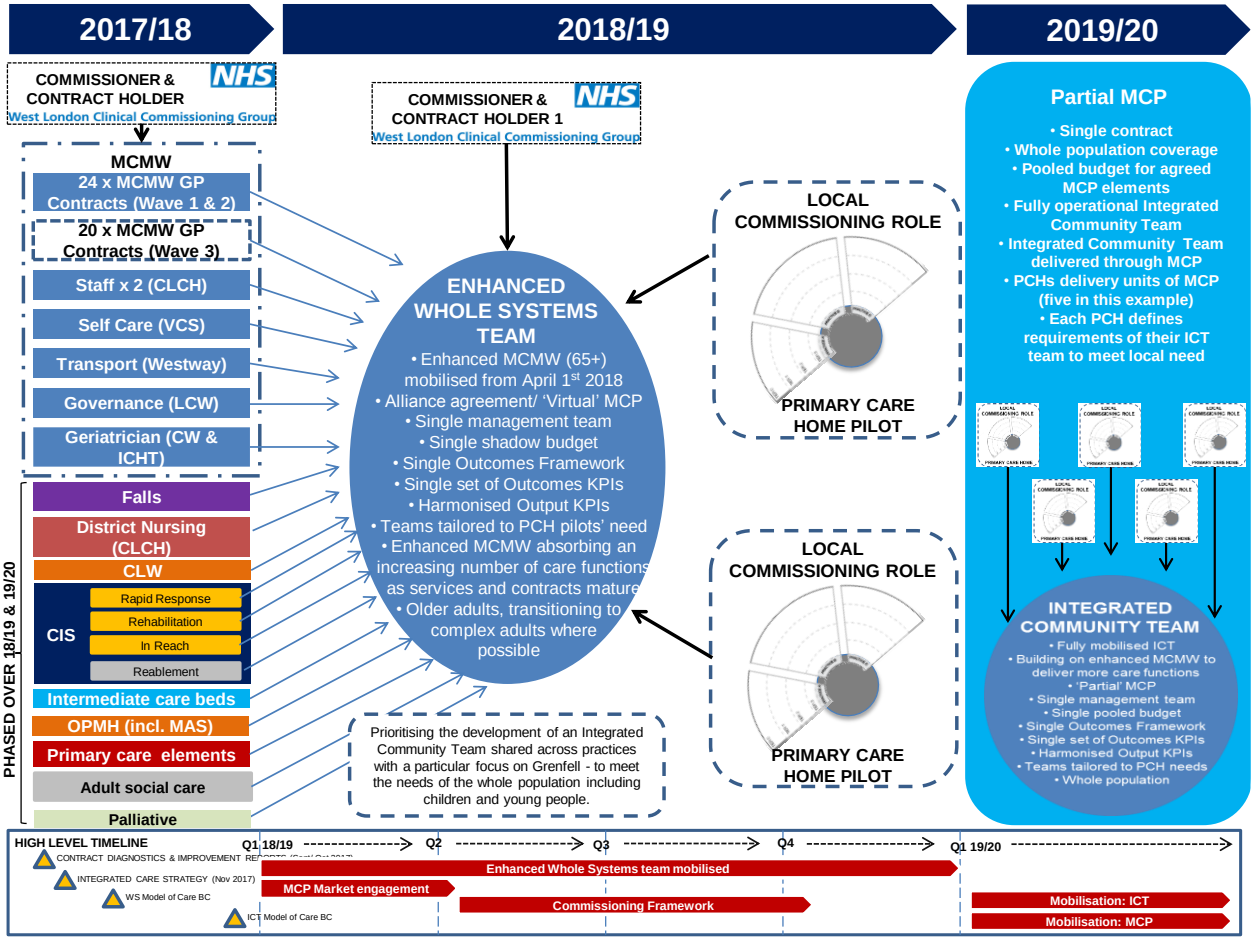
What residents should see?

3.24 What Westminster residents should see is a service and approach very similar to that being developed by CL CCG. Within each Integrated Community Team will be a similar mix of skills and expertise and also a much more integrated approach to care and support than is delivered today with fewer care plans and fewer organisations delivering care.

Scope of new proposals

3.25 The diagram below provides an overview of the proposed scope of the WL CCG proposals.

3.26



Key milestones

3.27 In common with the CL CCG timetable, the WL CCG strategy aims to achieve major transformational change by April 2019 and key to this is an extensive programme of co-design and the development of a detailed business case by April 2018 and a procurement process. This should result in the identification of a preferred bidder around about November 2018 and the mobilisation of a new contractual arrangement from April 2019.

3.28 In parallel to this process some practical changes to existing arrangements are also planned during 2018. These will be delivered through existing providers and commissioners working together through an alliance or collaborative arrangement.

Co-design and engagement

3.29 Central to the West London approach is an extensive programme of co-design and user and engagement and to provide a focus for this work an Accountable Care Reference Group and an Alliance Leadership Group has been established to shape the proposals. These groups will oversee an extensive programme of work looking at each element within the scope of the new model.

Non co-terminus boundaries: WCC, CL CCG and WL CCG

3.30 A key issue for the Health and Wellbeing Board is that approximately 75% of Westminster residents (34 GP practices) have their health needs commissioned by CL CCG and 25% by WL CCG WCC (11 GP Practices). This means that there is risk that residents could receive different levels of service and different approaches to service delivery depending on where in the borough they live. In addition, for the Council, it could mean that it will have to work with two different health providers rather than one.

3.31 Each commissioner (CL CCG, WLCCG, WCC and NHSE) recognises the importance of Westminster residents receiving a high quality and consistent level of service and also ensuring that Westminster City Council and other partners are able to operate effectively and efficiently in any future scenario. To this end all partners have committed to addressing this issue and consideration of potential solutions will form a key element of future business cases and ongoing work. All partners have also given a commitment to achieving a common set of London wide health and social care outcome targets for all residents.

4. FINANCIAL IMPLICATIONS

4.1 There are no financial implications arising directly from this report. Detailed financial implications will be assessed as part of developing and considering the business case required in order to take implementation proposals forward.

5. LEGAL IMPLICATIONS

5.1 The proposals set out in this paper are likely to have a significant impact on the existing contractual arrangements for providing health and social care services in the borough and at this time careful consideration will be required of the legal implications. In addition, in considering options for the future delivery of services the Council will need to ensure that it is able to continue to fulfil its statutory obligations.

6. EQUALITIES IMPLICATIONS

6.1 Considering the impact of these proposals on Westminster residents will form a key part in developing and considering the business case and making future decisions about these services. The challenges of providing a consistent level of service across the borough has also been highlighted as a key risk. In any case for a proposal of this type a full equality impact assessment (EIA) would form a key part of the development process and it is proposed that the Health and Wellbeing Board plays the key role in considering this and overseeing it for the programme.

Background papers:

Westminster Joint Health and Wellbeing Strategy 2017-21
Integration and Better Care Fund Plan 2017/18
NWL Sustainability and Transformation Plan
NHSE: Five Year Forward View

LIST OF APPENDICES:

APPENDIX 1: Central London CCG Integrated and Accountable Care Strategy

APPENDIX 2: West London CCG Integrated Care Strategy

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

Dylan Champion

Interim Head of Health Partnerships

Email: dchampion@westminster.gov.uk

NHS
Central London
Clinical Commissioning Group

Appendix 1: Delivering better outcomes for people in Central London

Our plan for accountable care 2017-2020

November 2017

Draft for discussion

Version 1.0
08.11.17

NHS
Central London
Clinical Commissioning Group

Contents

Please see page 53 for a disclaimer covering the information in this document.

Section 1: The purpose of this document

1. The purpose of this document

A commissioning plan for better outcomes for local people

NHS Central London CCG is delighted to present this plan for improving the health and wellbeing of local people. It has been developed with input from colleagues in Westminster City Council and aligns with its City for All strategy.

Improving outcomes with local people

This plan sets out how we can support local people to improve their outcomes. We have a clear vision for how we want to work across services and organisations to better support residents. We will achieve this through a more singular commissioning perspective, uniting our requests of care professionals delivering services in Westminster around a common set of outcomes that matter most to residents. We will bring our services together much more clearly and at a much greater pace. We will be tackling areas of local inequality, prioritising the prevention of ill health and building a new system based on the principles of accountable care. As we work further with colleagues in Westminster City Council, we intend this to develop into a shared plan that encompasses both health and social care.

Our plan for 2017-2020

This is an ambitious plan for changing the way local care is commissioned and delivered. Our aim is that all of the services we offer are more aligned to focussing on people's expectations. To achieve this, we will be shifting away from the commissioning of individual services and focussing on the wider needs of our population. This plan describes how we intend to deliver on our ambition, based on a shared understanding of the nature of the problems we face and the way we intend to work in future.

Our approach

Our approach is based on:

- tackling the root causes of inequalities that affect health and wellbeing;
- focussing on the way that local people want to live their lives and experience services where they need them;
- prioritising the prevention of ill health, as well as providing high-quality services when these are needed;
- supporting, through our commissioning, better coordination of care;
- moving much more of the focus of support into the community, closer to people's homes;
- improving local networks of care, with the right level of expertise available in the community; and
- looking to the future – including embracing new technologies and digital developments and continually adapting our services and the way people can access them.

This plan describes the system that we wish to create and how we will work with all local partners to deliver it. The CCG is committed to providing system leadership and working increasingly in partnership to deliver the outcomes that matter to local people.

NHS
Central London
Clinical Commissioning Group

Section 2: Summary

2. Summary

Plan on a page

This plan is based on five key points, which are summarised here.

1. Residents have consistently told us what they want their care services to look and feel like.

- "I am cared for as a whole person rather than a series of conditions, with continuity of care if this is important to me."
- "A range of people provide my care but they all work together, communicate effectively, and have clear roles that I understand. Together, they provide me with seamless care."
- "More of my care needs can be delivered closer to my home, without the need to visit the hospital."
- "I can access care easily and in the way most convenient for me, either in person or by using technology."

However, there remains a range of health and wellbeing issues that must be tackled. Health inequalities in Westminster are marked and persistent.

- Some aspects of care have improved over the past ten years, including immunisation and the management of common conditions.
- Specific issues that must be addressed include the needs of the growing number of older people, childhood obesity, and the burden of mental illness.
- Health and wellbeing is still characterised by deep inequality, including in life expectancy, early death, quality of life and the welfare of socially excluded groups.

3. How care is organised has already changed to improve health and wellbeing and deliver better experiences of care.

This has been through the development of the primary care village system and more joint working in the community.

4. But there are still problems with how care is organised.

- Even though many people need support from a range of care services, these services are mostly commissioned and delivered separately.
- This means that care is not always experienced as 'joined up'.
- It also means missed opportunities to deliver the right care in the right place at the right time.
- This impacts on people and their health and wellbeing as well as the efficiency and financial sustainability of the whole care system.

5. Further change is needed and the outcomes to which we aspire can be delivered through a 'One system, One budget, Better outcomes' approach.

- This is also known as 'accountable care', which means organising care so that it delivers the integrated and person-centred services necessary to improve health and wellbeing. It means:
  - a culture that overcomes artificial boundaries between organisations and teams;
  - all care professionals working towards a single outcomes framework, co-designed with local people, and incentivised to achieve the outcomes that matter most; and
  - organisations working under a single budget, with investment distributed to best meet people's needs.

If necessary, this will be delivered through a new contracting framework that will support providers to deliver this approach by ensuring that money flows and organisational structures help rather than hinder local professionals to deliver the best care possible.

2. Summary

The high-level timeline for this work

2017

2018

2019

Integrated Support and Assurance Process

May 2017 – the CCG and CLH published their draft primary care strategy, which set out the ambition to develop primary care homes as the delivery vehicles for a local Multispeciality Community Provider partnership

July 2017 – the Health and Wellbeing Board endorsed this direction of travel

August to September 2017 – the CCG developed a first draft of this plan, with input from Westminster City Council

October 2017 – the CCG's governing body further discussed its approach to this work

We're up to here

November 2017 – the CCG's governing body authorises the programme to progress to gateway 2 (see the programme plan)

January 2018 – the MCP outcomes framework, scope, and system design principles are finalised following a process of co-design with partners through the Westminster Partnership Board for Health and Care and other stakeholders

June 2018 – business case approved

August and September 2018 – PQQ issued and responses evaluated; ITT issued

November and December 2018 – ITT responses received and evaluated; preferred bidder announced

December 2018 to February 2019 – commissioner due diligence

March 2019 – approval of the contract award

March 2019 – contract award and signature → MCP mobilisation

NHS
Central London
Clinical Commissioning Group

Section 3: The case for change

3. The case for change – from the population perspective

Health and wellbeing inequalities in Westminster are marked

Some aspects of health and wellbeing in Westminster have improved over the past ten years. Recent advances include improvements in childhood immunisation and the identification and management of common conditions like asthma.

However, health and wellbeing in the borough is still characterised by inequality. This includes:

- **life expectancy** – people in the most deprived parts of the borough have shorter lives: 17 years shorter for men and 10 years shorter for women than those in the wealthiest wards;
- **early deaths** – approximately 213 per year, including from cancer, cardiovascular disease, and chronic obstructive pulmonary disease (and not including deaths from accidents and injuries);
- **quality of life** – there is a significant burden of disability on quality of life in Westminster, including from mental disorders, substance misuse, musculoskeletal disorders, and falls; and
- **the welfare of socially excluded groups** – difficulties in accessing and navigating the local care system can be profound for people who are homeless, some people with mental health conditions, and some older people.

The snapshots below show some of the disparities in health and wellbeing across the borough:

Harrow Road

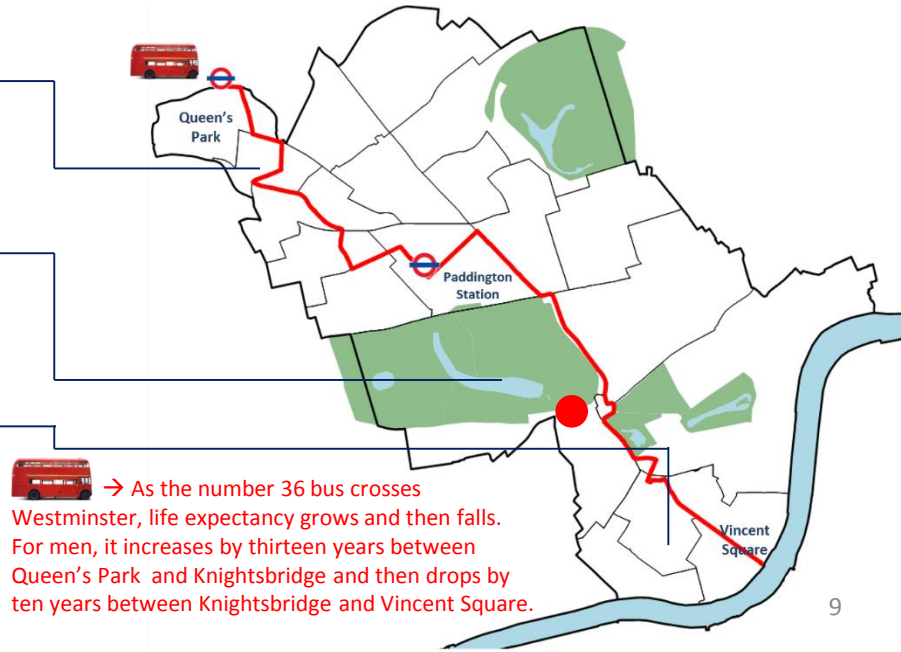
Life expectancy: Men – 76 Women – 85	People in bad or very bad health: 8%	People with a long-term limiting illness: 18%	Ranking in the GLA well-being index: 466/625

Knightsbridge and Belgravia

Life expectancy: Men – 89 Women – 92	People in bad or very bad health: 2%	People with a long-term limiting illness: 6%	Ranking in the GLA well-being index: 1/625

Tachbrook

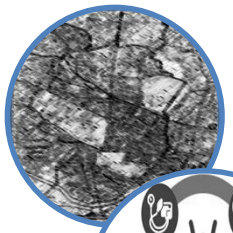
Life expectancy: Men – 83 Women – 84	People in bad or very bad health: 6%	People with a long-term limiting illness: 15%	Ranking in the GLA well-being index: 135/625



→ As the number 36 bus crosses Westminster, life expectancy grows and then falls. For men, it increases by thirteen years between Queen's Park and Knightsbridge and then drops by ten years between Knightsbridge and Vincent Square.

3. The case for change – from the individual perspective

There are also health and wellbeing issues that need to be tackled



By 2030 there will be a 15% increase in the number of **people aged over 85**, who have a variety of needs relating to frailty, dementia, and long-term conditions

Up to 30% of people with **long-term conditions** remain undiagnosed

22% of children in Westminster are **overweight** by the time they start school and 39% are overweight by year 6

Westminster has the one of the highest rates of **serious mental illness** in the country

Westminster has 27% of London's **rough sleepers** and high numbers of **homeless people** and **socially excluded adults**

Dementia in Westminster is higher than the national average, with only 11% of people with dementia dying at home

3. The case for change – from the system perspective

The way the care system is organised can disincentivise joined up care for people

Fragmentation	People often need care from a range of providers, such as GPs, social care, community services, mental health teams, voluntary organisations, and hospitals. These services are mostly commissioned and delivered separately, which means: missed opportunities for the right care in the right place at the right time through integrated care teams, uneven quality of care, and ultimately some poor outcomes.
Misaligned incentives	Commissioners' fragmented approach to contracting means that local care providers face different sets of incentives and constraints. Consequently, each part of the system works best to look after its own service users and staff without needing to fully understand or assess the impact on other parts of the care system.
Duplication of efforts	Record systems that don't join up mean that care providers often don't know a person's full story, such as medical history, test results, lifestyle, and home situation. This can mean that people receive multiple requests for the same information and the system duplicates effort, impacting on resources.
A confusing system	Our local care system can be accessed in many ways, through both health and social care. With these numerous entry points, people and care professionals are often unclear about how to obtain the best care and how to coordinate care to achieve the best possible health and wellbeing outcomes.
Workforce challenges	With fragmentation, duplication, and various operational constraints comes a workforce challenge. Based on current ways of working, we cannot staff or resource all the services we need to provide, leading to gaps in provision and lower quality or unsustainable staffing costs.
Financial sustainability	All of the issues above drive inherent inefficiencies and spending on care that does not contribute to the health and wellbeing of local people – and at the same time threatens the long-term sustainability of the local care system.

3. The case for change – from the workforce perspective

Westminster is not yet making best use of its skilled workforce

Westminster needs a care workforce with the skills and capacity to deliver care in the right place at the right time.

We have not yet achieved this. The themes in the boxes below show some of the current workforce challenges in Westminster, many of which are common across health and social care.

- recruitment
- vacancies
- availability of local housing
- a retirement bubble
- morale
- turnover
- costs of temporary staff
- skills gaps

These issues all impact on the quality of care delivered in Westminster and, in turn, the health and wellbeing of local people.

We want every care professional working in Westminster to be able to say:

"I am part of a team built around each person's individual needs"	"I understand the professional network around me"	"I know who to else to contact for my patient or client"	"I have time to focus on prevention as well as cure"
"I am able to flex my skills and experience to meet people's needs"	"I can work with others to be creative about how I deliver the best care"	"I have access to the data about my patients and clients required to do my job"	"I work in premises that support the delivery of good care"

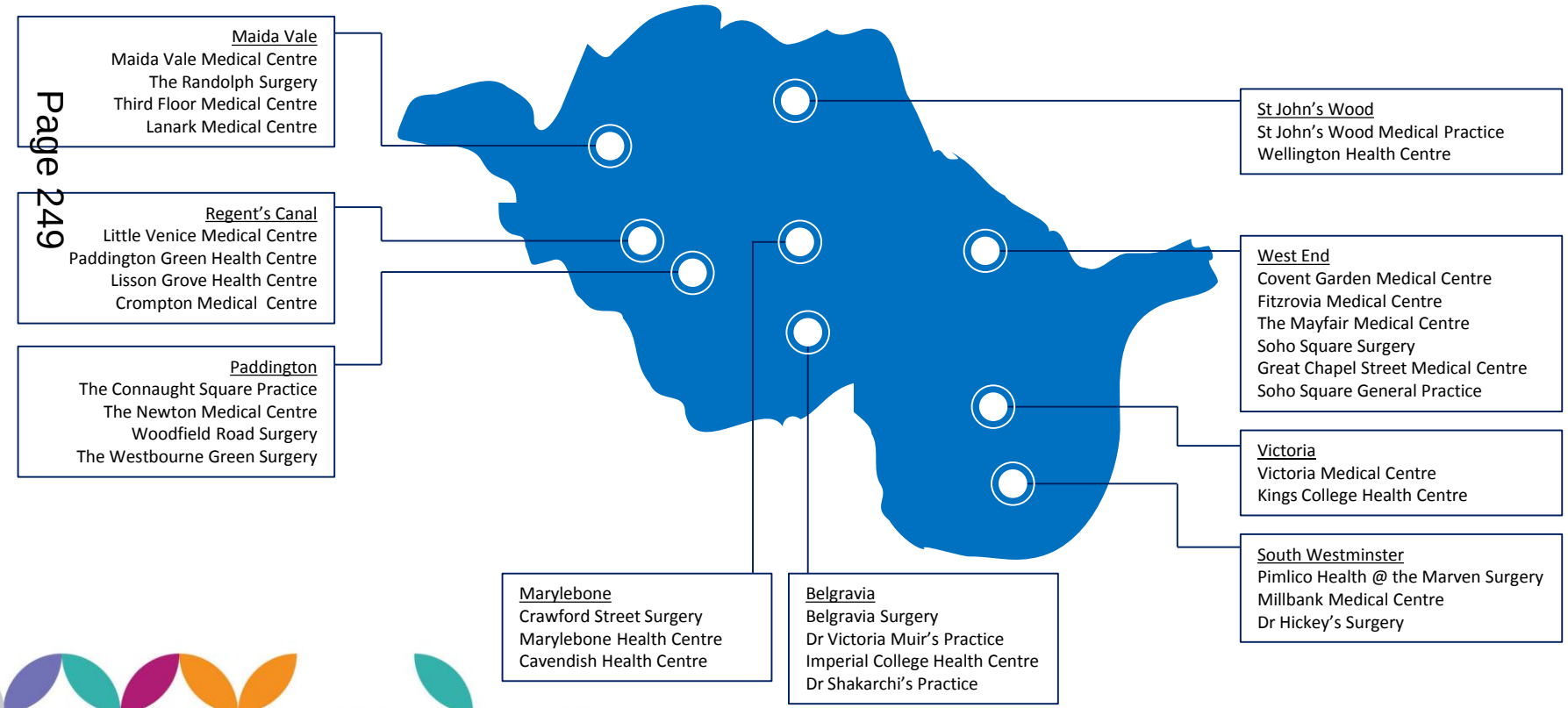
3. The case for change – progress to date

We have already started to change how care is organised to improve health and wellbeing and to deliver better experiences of care

The CCG and Westminster City Council are already working together to join up services more effectively.

There have so far been two key stages:

- the formation of nine villages, shown on the map below – groups of general practices working together to share expertise and each with a care navigator to oversee community referrals and to help support people after they leave hospital; and
- the current development of primary care homes – larger groups of practices working more formally together and with community services, social care, and the voluntary sector to develop a single integrated offer for care delivered outside of hospital.



3. The case for change – accountable care in theory

We now need to go further and faster to deliver the improvements required

Accountable care is based on the principle of '**One** system, **One** budget, **Better** outcomes'.

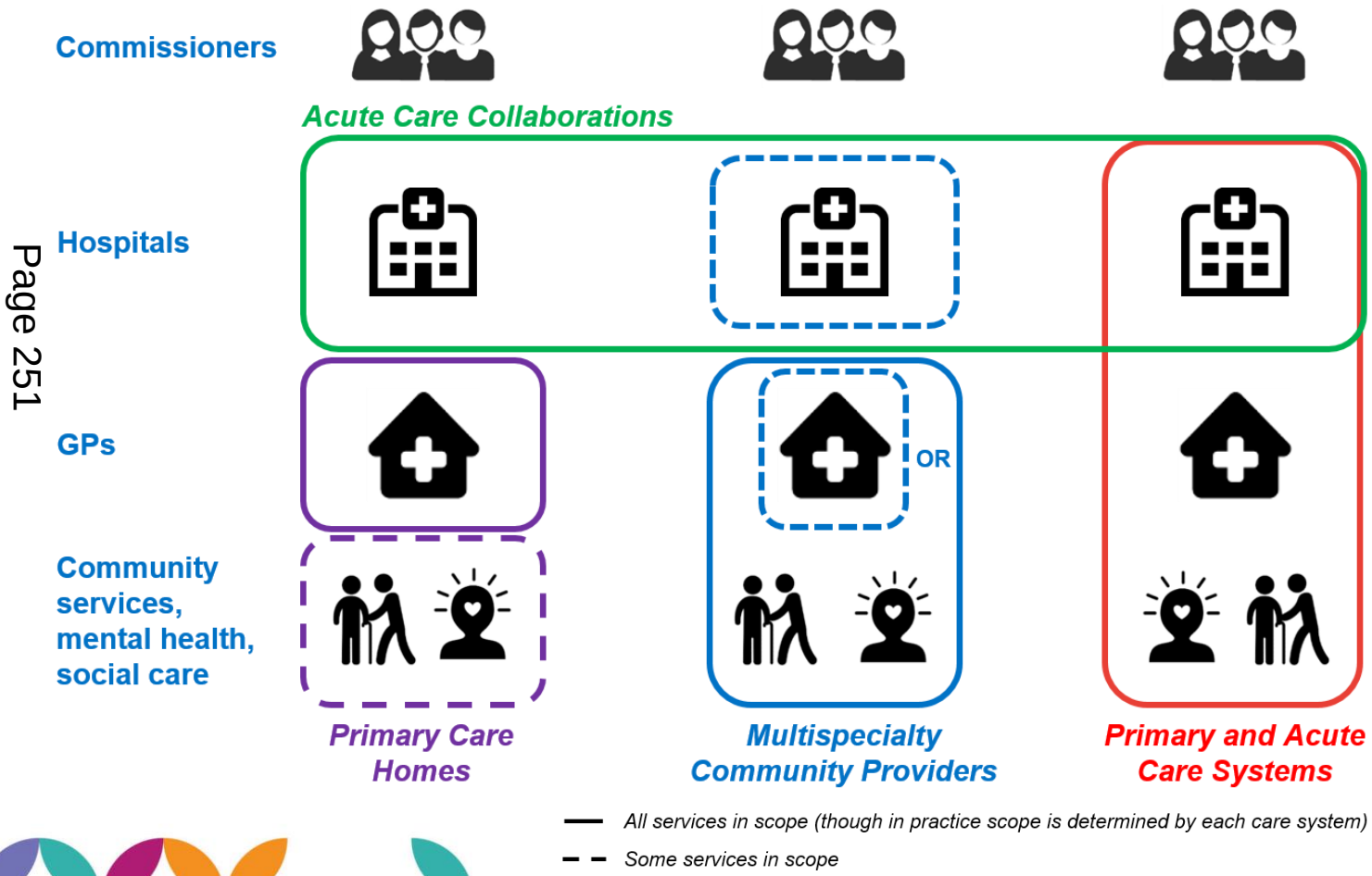
One system, **One** budget, **Better** outcomes

One system	**One** budget	**Better** outcomes
→ a one-system and one-team culture designed to overcome the artificial barriers between care organisations in the current system and to enable the sharing of expertise across all local organisations for the benefit of our whole population	→ organisations working together under a single capitated budget (potentially from multiple commissioners) and distributing investment across the system according to how it best meets people's needs	→ teams and organisations delivering care in Westminster working towards a single outcomes framework, co-designed with local people, and incentivised to support people to achieve the outcomes that matter most

3. The case for change – accountable care in practice

The *Five Year Forward View* sets out options for implementing accountable care

The NHS's *Five Year Forward View* describes a range of new care models, two of which in particular reflect the principles of accountable care. These are Primary and Acute Care Systems and Multispeciality Community Providers. The next page explains why a Multispeciality Community Provider, which is focussed on care delivered outside of hospital, is the form of accountable care most suited to Central London.



3. The case for change – focussing on care provided in the community

A Multispeciality Community Provider (MCP) will improve local outcomes

A Multispeciality Community Provider, which is focussed on care delivered in the community, is the form of accountable care most suited to Central London.

Our focus is on care delivered in the community because:

- this is where care is most fragmented and the benefits of integration for local people are greatest;
- this is where many types of care can be wrapped around primary care and tailored to each community's specific needs;
- this is where holistic care can focus on the long-term support of people in their own surroundings;
- this is where care can best encourage prevention, self-care, and the wider wellbeing agenda; and
- the flow of local people into hospital care involves a much wider area and must therefore be brought into an integrated system with a larger group of partners.

An MCP is multispecialty, community-based provider of a new integrated care model, potentially implemented through a new contract that formalises the new '**One** system, **One** budget, **Better** outcomes' approach.

It will deliver a wide scope of out-of-hospital care, based on a close partnership of organisations working under a single budget and delivering locally devised outcomes. It will operate through the primary care homes.

→ One issue that must be resolved through this work is the impact of the non-coterminous boundaries of Central London CCG and Westminster City Council, due to the Queen's Park Paddington (QPP) area sitting with West London CCG. The CCG and WCC will work with their partners to ensure that the benefits of accountable care are enjoyed by all of the people in Westminster.

3. The case for change – the accountable care model

We have a three-stage journey to an accountable care system

As our primary care strategy set out, accountable care through an MCP is an extension of the transformation of local primary care already under way:

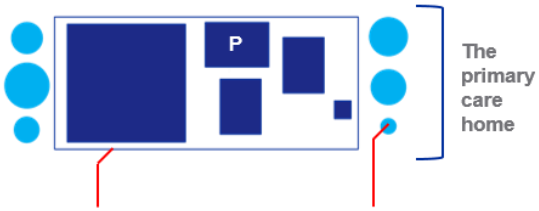
DONE ✓

Stage 1: embedding effective village working

- practices work together effectively in local groups
- MDT working is established
- working across organisations is established, including social care and the third sector

IMPLEMENTATION UNDER WAY ✓

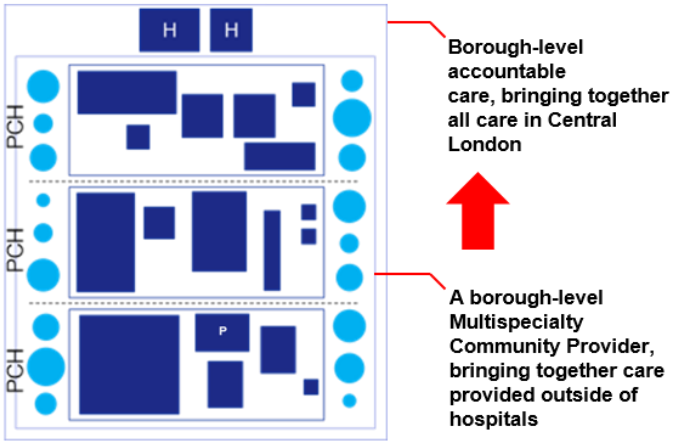
Stage 2: forming primary care homes



- practices are working in larger established units
- this way of working is more formal
- the sharing of skills and experience for the benefit of people receiving care is routine
- defined roles and responsibilities mean that who does what, and how, is clear
- primary care homes are capable of providing services at scale

PLANNING UNDER WAY ✓

Stages 3: forming an MCP and accountable care



Note: these diagrams shows an illustrative number of practices within a primary care home and number of primary care homes

- principles of joint working are well established
- there is clarity about local need and local resources and agreements are in place which facilitate local flexibility
- integration of services around people across health and social care

NHS
Central London
Clinical Commissioning Group

Section 4: Focusing on outcomes that matter

4. Focusing on outcomes that matter

The approach set out in this plan supports the delivery of local priorities

The CCG's **Sustainability and Transformation Plan**

click here

→ *three core aims*

- Improving health and wellbeing
- Improving care and quality
- Improving productivity and closing the financial gap

→ *five new delivery areas*

- Radically upgrading prevention and wellbeing – supporting everybody to play their part in staying healthy
- Eliminating unwarranted variation and improving the management of long-term conditions – everyone having the same high-quality care wherever they live and every patient with a long-term condition having the chance to become an expert in living with their condition
- Achieving better outcomes and experiences for older people – caring for older people with dignity and respect and never caring for someone in hospital if they can be cared for in their own bed
- Improving outcomes for children and adults with mental health needs – no health without mental health
- Ensuring that there are high quality and sustainable acute services – high-quality specialist services when people need them

Westminster City Council's **A City for All** plan

click here

→ *three new priorities*

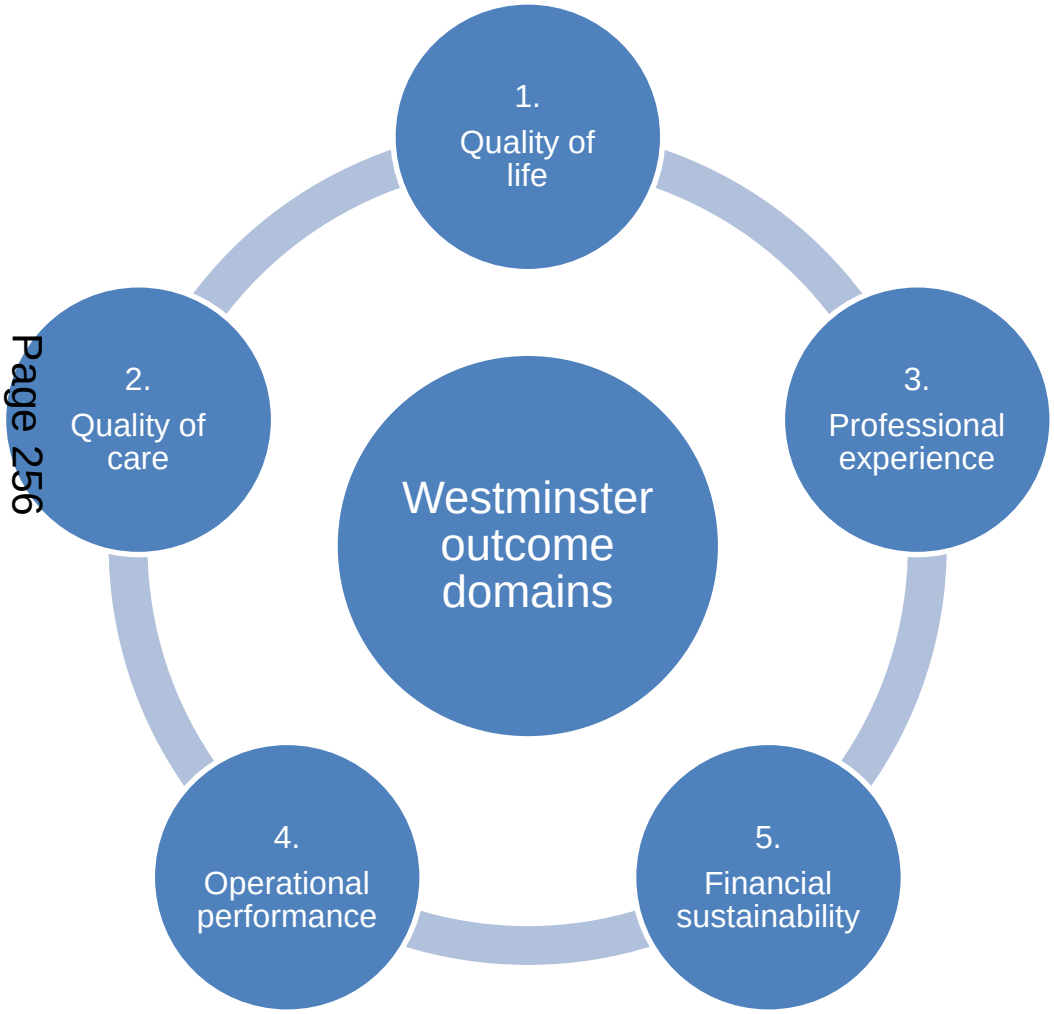
- Civic leadership and responsibility at the heart of all we do – ensuring that the council acts as a custodian of the city
- Opportunity and fairness across the city – including through housing and education and by supporting the most vulnerable people in the city
- Setting the standards for a world-class city – promoting the good practice of businesses that operate responsibly and tackling negative impacts of the sharing economy and anti-social behaviour on residents and business

→ *five new programmes*

- Civic leadership – giving everybody a stake in the future of our great city
- Building homes and celebrating communities – providing good quality and truly affordable housing
- Greener city – cleaner air and widely prized open spaces that are the envy of the world
- World-class Westminster – giving everyone in our community a stake in making Westminster a world-class city
- Smart Council – providing the best customer experience for our residents

4. Focusing on outcomes that matter

A key part of delivering the new approach is basing it on outcomes that matter



The objective of implementing accountable care in Westminster is to improve local people's health and wellbeing outcomes.

This work will, through a process of co-design, finalise the outcomes that we are aiming for and how they will be measured.

Outcomes are the benefits people gain from receiving care. This is in contrast to receiving a service, which should be considered an output. A course of physiotherapy is an output, whereas the fact that the person who received the treatment can now walk without pain, play with her grandchildren, and start swimming again are the outcomes.

As well as these outcomes for people, it is important also to think of outcomes from the point of view of those who deliver care, as well as the wider system, in terms of operational efficiency and financial sustainability. This is because these underpin the ability of a care system to continue to deliver the best outcomes for local people.

There has already been a lot of work done on outcomes. The North West London CCGs, along with other stakeholders, have devised an outcomes framework based on what people have said they want from their care. This is shown opposite.

It is also based on an integration of existing frameworks from across health care, social care, and public health – an important basis for the integrated system we are seeking to create.

4. Focusing on outcomes that matter

The local care system will start with “what matters to you?” rather than “what’s the matter with you?”

An ‘I statement’ is a useful way of setting out people’s expectations of what receiving care will help them to do or feel.

Each of the domains on the previous page is built up from these statements, gathered from engagement with local people.

The statements below set out some of what local people have said they want from their care. These will be finalised through a co-design process with local stakeholders.

Outcome	Outcome domain
• I can achieve my personal goals	Quality of life
• I can look after my mental and physical health	
• I can maintain my mobility and independence	
• I can take care of myself, rather than relying on others	
• I can meet and talk to other people	
• I have the opportunity to enjoy life	
• I can live at home	
• I feel safe	Quality of care
• I feel in control and well-informed	
• I feel understood and accepted	
• I feel respected for my own experience and knowledge	
• I feel that people are there when and where I need them	
• I know who to contact when I am concerned	
• I am supported effectively	

Outcome	Outcome domain
• I am supported by people who work well together	Professional experience
• I am supported by people who enjoy their work	
Additional example care professional outcomes: • I feel that I get the support and resources I need to do my job well • I feel my views are taken into account in decisions • I feel that the outcomes that matter to me are taken account of in my work	
• I receive support that is financially sustainable	Financial sustainability
• I am supported by people who respect my time	Operational performance
• I am not admitted into secondary care unnecessarily	

4. Focusing on outcomes that matter

We are increasingly measuring outcomes so that we know what difference services are making to people

The 'I statements' frame the local ambitions for the care system. A set of accompanying metrics shows whether the system is achieving these ambitions.

The metrics to be used in the outcomes framework will be co-designed with a range of stakeholders, including providers and people who use local services.

Some potential metrics for the quality of life and quality of care domains are shown below. It might be necessary to devise new metrics that relate to specific local issues.

Over time, payments and financial arrangements will increasingly align to the delivery of outcomes.

	Metric	Data source
Quality of life	Health- and social care-related quality of life in people over 65 with long-term conditions	NHSOF (2) / ASCOF 1A
	Proportion of physically active people over age 55, 65, 75 years	PHOF (2.13) / Sport England: active people survey
	Self-reported wellbeing	PHOF (2.23)
	Permanent admissions to residential and care homes, per 100,000 population (both over 65 and 18-65)	ASCOF (2A)
	Zarit Burden Interview (ZBI) score (on the burden of care for carers)	ZBI 22 item survey
	Percentage of caregivers who agree they have the support and resources to continue caregiving for at least six more months	New data source?
	Unplanned hospitalisation for chronic ambulatory care sensitive conditions	HES, CCGOF (2.6), NHSOF (2.3i)

	Metric	Data source
Quality of care	Proportion of people with a care plan who were involved in putting it together	GP patient experience survey
	The difference between the number of people with a care plan and the number who say that they have a care plan	GP records; GP patient experience survey
	Proportion of people who use services who feel safe	ASCOF (4A)
	Delayed transfers of care from hospital	ASCOF (2C)
	Proportion of people and carers who report that the care they receive is delivered in a place that is convenient / accessible to them	New data source?
	Survey question: Have you or any members of your family had any experience where you have had to repeat your story to different health and care professionals?	New data source?

NHSOF – NHS Outcomes Framework • ASCOF – Adult Social Care Outcomes Framework
PHOF – Public Health Outcomes Framework • HES – Hospital Episode Statistics
CCGOF – CCG Outcomes Framework

4. Focusing on outcomes that matter

The CCG is working with partners across the city to achieve the improvements we need to see

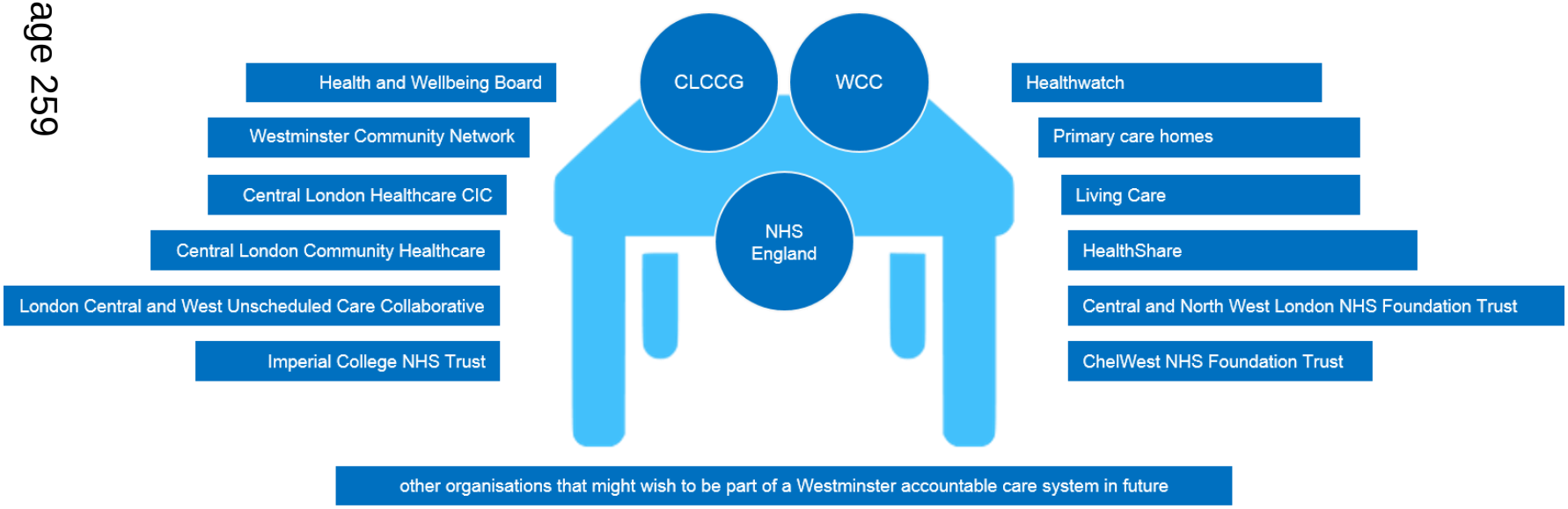
Achieving the right health and wellbeing outcomes for people in Westminster requires all care organisations – both commissioners and providers – to work together and with local people. Only in this way can we be sure that resources being spent in the city are maximising outcomes and delivering value for money.

Central London CCG and Westminster City Council will lead the process of bringing the right organisations together, along with representatives of local patients and service users. All parties can then drive progress on achieving the vision for care in Westminster.

This will be mainly through the **Westminster Partnership Board for Health and Care**.

Its main purpose is to co-design aspects of the commissioning approach with all relevant stakeholders, from across Westminster and beyond, and to drive rapid progress in both design and implementation.

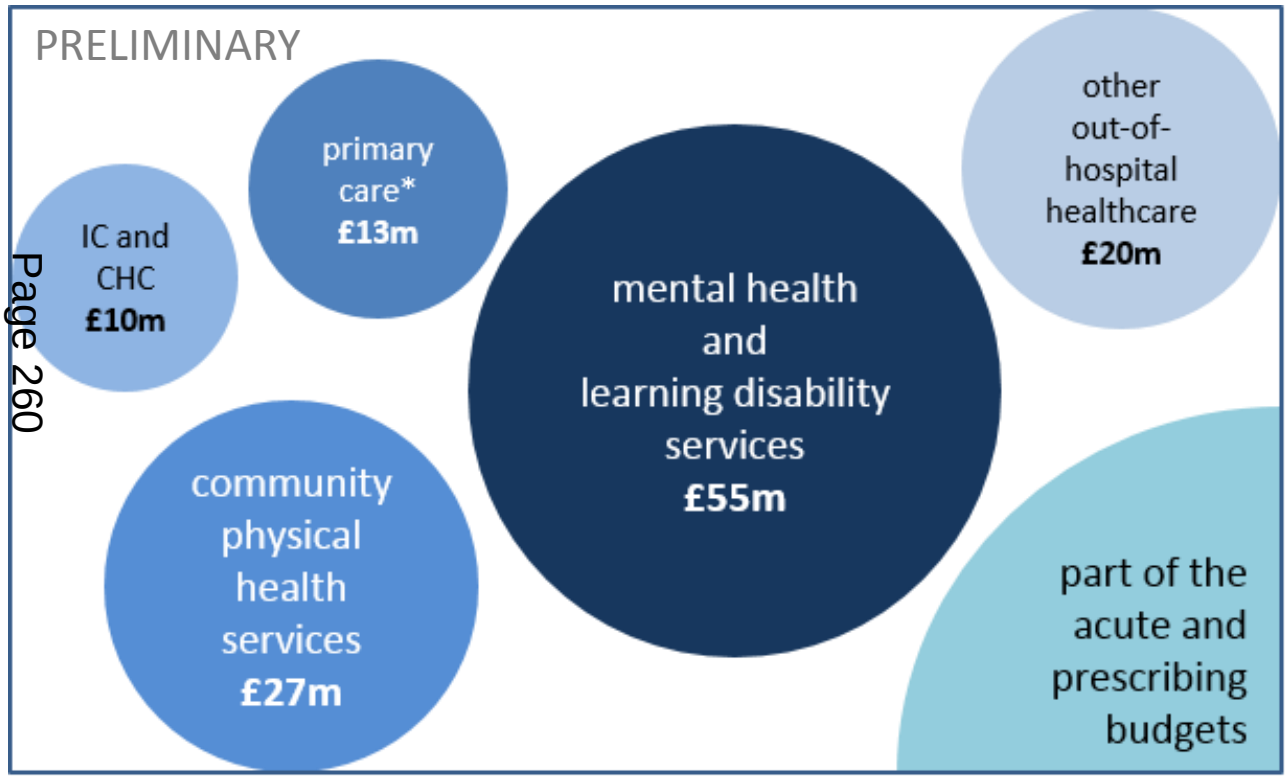
The range of organisations and stakeholders involved includes the following:



4. Focusing on outcomes that matter

Accountable care will bring together an ambitious scope of services and budgets

The initial scope for this programme of work is set out below. Its focus is on the services, contracts, and budgets that support people in the community.



* excluding contracts for core primary care services (GMS, PMS, APMS)

Source: Central London CCG 2017/2018 budget lines

Note: this preliminary financial analysis uses CLCCG budgets so does not include healthcare for the QPP non-coterminous area of Westminster

Section 5: The model of care we're looking to deliver

5. The model of care we're looking to deliver

How care is delivered in Westminster will reflect the needs of local people and communities

The future accountable care model will not involve commissioners specifying in great detail the services they wish to be provided. Instead, commissioners will work with residents to devise an outcomes framework and then fund the system to meet these outcomes. Providers will decide how best to organise and deliver services to meet the outcomes.

However, the commissioners are clear on the key **design principles** that they expect the local system to reflect. These are informed by what residents have told us they want and are listed on the left. Some more specific **core requirements** of the system are shown on the right.

These will be worked up in more detail in a co-design process with a range of local stakeholders.

- ✓ **Resident-focussed** – we expect all our residents to be supported by a single care team, using a single assessment and support process, supported by a single care plan if necessary
- ✓ **Community-focussed** – the care system will by default provide support in the community and make use of hospital or other bedded care only when necessary
- ✓ **Geographically relevant** – the approach to care must recognise the unique geography of Westminster and provide tailored solutions for people living in the north, centre, and south of the borough
- ✓ **Collaborative** – local approaches to care must be co-designed with local people and a wide range of local interest groups
- ✓ **Preventative** – the care model will focus on prevention and self-help, giving residents power over their own choices, health, and wellbeing

A **workforce** that is in the right place, with the right capacity and has the right skills

Access to **technology and data** that supports the delivery of joined up care

Time to focus on **prevention** as well as cure

Estates that are fit for purpose and support new ways of providing care in the community

Networks and structures that enable **collaborative working** centred around local people

Local structures that support **clinical leadership** of care networks

Digital **technology** that supports new ways of providing care

Processes that allow more of practitioners' **time** to be spent on caring

Freedom and support to **innovate** with how care is delivered

A **career path** for care professionals that mixes variety and specialisation, supported by appropriate professional development

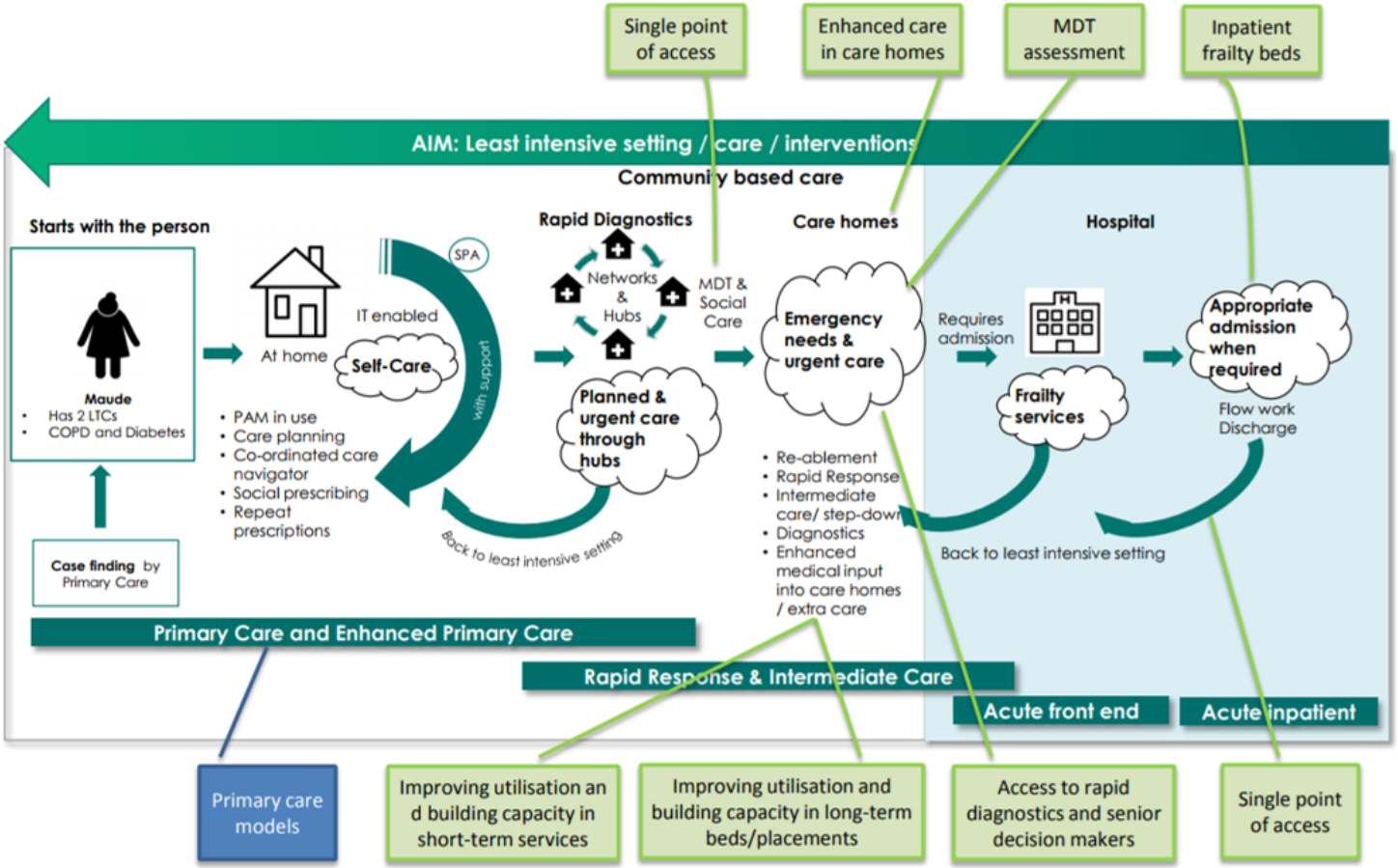
5. The model of care we're looking to deliver

Care must support a better quality of life and deliver better value for money

Our intention is to maximise people's quality of life by supporting them to stay well and delivering more of their care closer to home.

The diagram below shows how this will be achieved for an older person requiring the coordination of her care through a range of health and social care services.

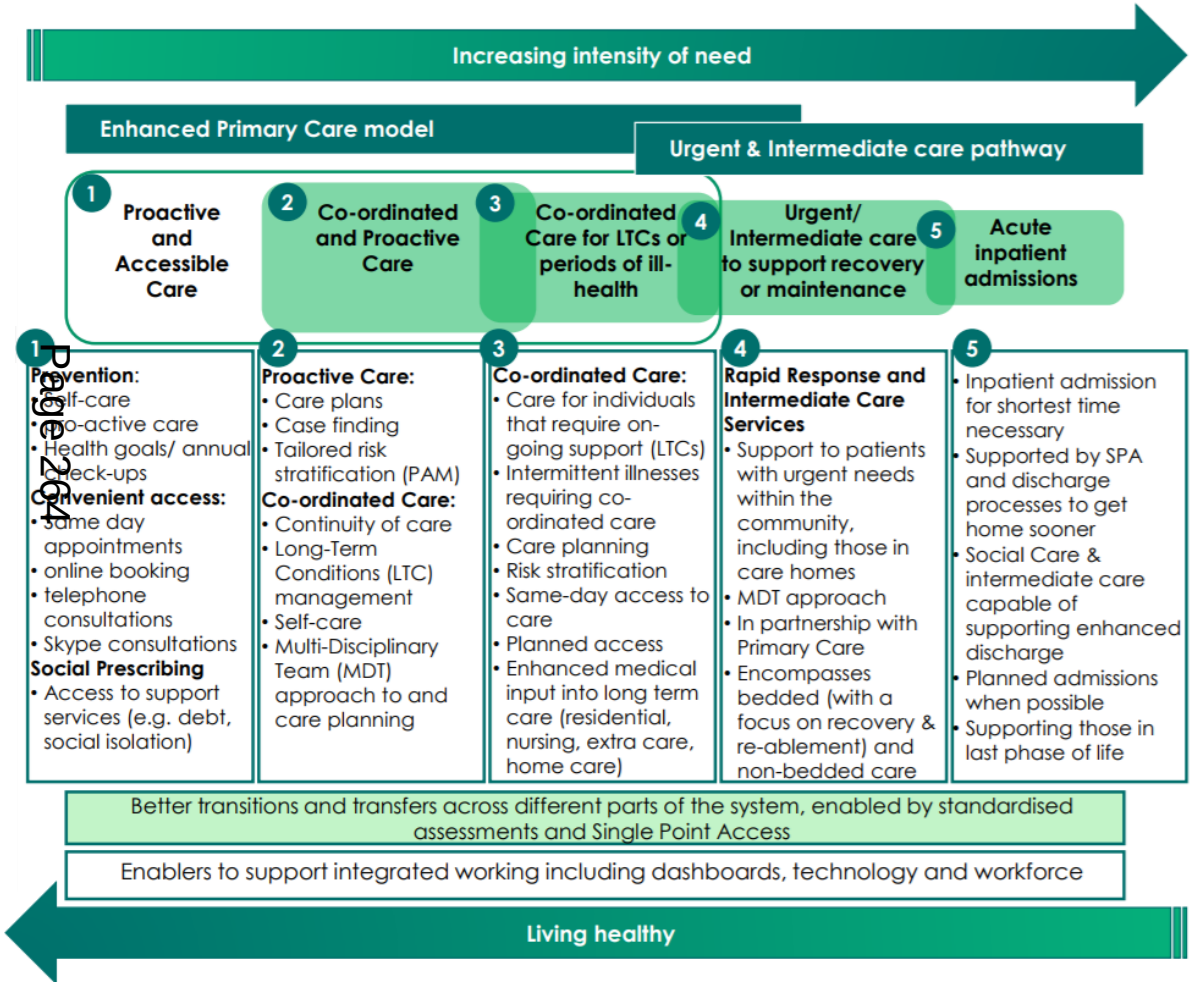
We also need to develop and integrate the support that **keeps all cohorts of people healthy and well** and therefore needing primary care less often. This includes housing, employment, and a variety of other forms of social support



Source: NWL Local Services strategy

5. The model of care we're looking to deliver

Achieving this ambition requires changes across the system



Source: NWL Local Services strategy

This is part of a broader social care model that integrates with primary and secondary care to support people in their communities:

NHS
Central London
Clinical Commissioning Group

Section 6: Implementing the change – from 2018/19

6. Implementing the change – from 2018/19

Enhancing services for people in the community – the Partnership in Practice contract

Beginning 1 April 2018:

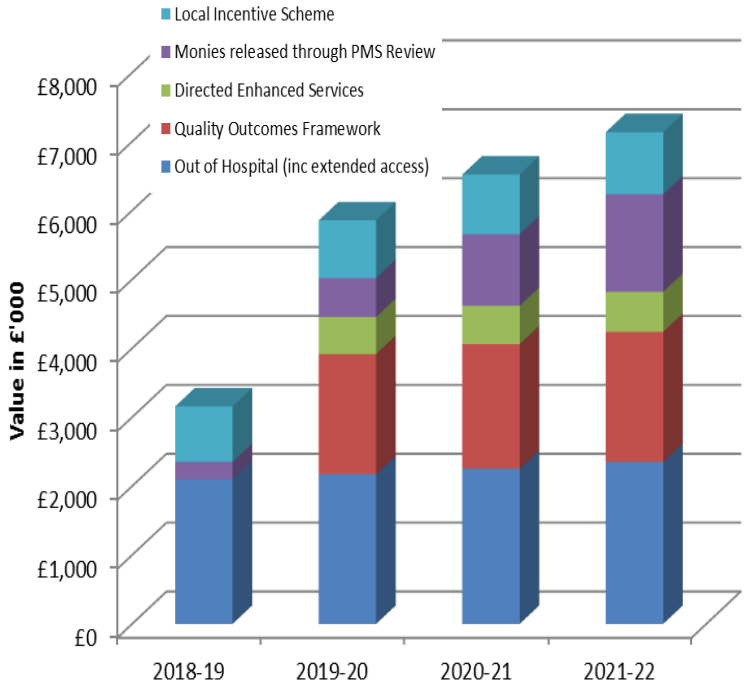
- The CCG's non-core primary care commissioning will be brought together into single contracts
- These contracts will begin with a specific scope but include opportunities to draw in other commissioning arrangements and funding streams
- To reduce variability in outcomes, the contract will be held by new at-scale providers of primary care services

This contract will support more of a system leadership role for primary care:

- Increasing collaboration across health and care teams, as well as collaboration in primary care
- Increasing the flexibility of primary care to direct funding across services in a way that best enhances care, rather than according to the requirements of multiple contract
- Encouraging new and innovative approaches within and across practices, alongside other community health and care teams
- Supporting the formation of primary care at-scale models, including primary care homes, as the basis for more of a system leadership role for primary care
- Reducing the level of administration of contracts required within primary care – and therefore boosting the money that can flow direct to care

Page 266

Funding for the new Partnership in Practice contract is expected to increase each year from 2018/19 to 2021/22, as shown in the chart below:



This contract will support the system to transition from the current model of commissioning to the future approach based on principles of accountable care.

6. **Implementing the change – from 2018/19**

The beginning of the shift of planned care pathways into primary care

What?

- The co-design of pathways around specific conditions with local people and clinicians so that they reflect national best practice and deliver care closer to people's homes, rather than in outpatient clinics within hospitals
- The CCG's hubs programme is a critical part of this shift of care as it will ensure that there is enough clinical space to deliver this care within the community. The South Westminster hub is in operation and there are plans for hubs in the central and north localities are under development

Why?

- To improve service quality and outcomes
- To prevent the need for people to attend hospital clinics for diagnosis and treatment of some simple conditions
- To improve the integration of the pathways into primary care and with the whole-systems approach
- To ensure integrated and seamless care for people receiving care along the pathway
- To pursue the objectives of accountable care in terms of providing more care closer to people's homes and removing current duplication between services and therefore improving efficiency

The pathways currently in development are:

Ophthalmology – a self-referral approach for people with minor eye conditions and cataracts to high-street optometrists

Gynaecology/Urology – consultant triage, with care planning and advice; the continence services will be maintained as a community service delivered as close to home as possible

Neurology – with a focus on pathways that should be delivered in a community setting, such as Parkinson's Disease

Gastroenterology – a more streamlined pathway

Cardiology – consultant triage, with care planning and advice; GP education to support keeping people in primary care wherever possible

Diabetes – education within primary care so that people can be cared for as close to home as possible; the development of a community-led diabetes service that will be rolled out in 2018/19

Cancer – support for primary care to increase participation in cancer screening at a local level

6. Implementing the change – from 2018/19

A new model to support frail elderly people in Westminster

What?

- The invitation to primary care homes to devise a new integrated model of care for frail elderly people on their practices' registered lists, focussed on bringing together all relevant care services to deliver seamless offer
- Commissioners are keen that this model involve the secondment of appropriate staff from a range of community-based teams into the primary care homes in order to reduce current organisational barriers to collaboration and assist joint assessment, support, and review. Other approaches should include more proactive care management of risk through up-scaled MDT working

Why?

- To improve quality of life and quality of care for one of Westminster's most vulnerable groups of people – especially the small but increasing number of people frail elderly people who are living alone
- Key outcomes should include more time spent at home, a reduction in avoidable admissions, a reduction in delayed transfers of care, and a better diagnosis rate against dementia prevalence
- To reduce unplanned admissions into hospital by frail elderly people, thereby bringing more of their care closer to home and achieving more efficient use of resources (a key priority of the NWL Sustainability and Transformation Plan)
- To demonstrate proof of concept of designing care around groups of people with similar care needs, which will be a core organising principle of how accountable care will be delivered across Westminster

The key principles of a Westminster frailty model should be:

- dignity, respect, and privacy
- a whole-system model where all parts of the system link from self-care, through primary care and social care, to services that should be provided in hospitals to enable people to return home to live healthy and independent lives
- improved communication and co-operation between health and social care in the community and the community and the hospital
- a focus on health inequalities, with everybody in the community receiving the best possible care and no one disadvantaged in access or experience due to their postcode
- consistent and rigorous assessment of need and an appropriate and prompt response in an appropriate location, in or near to the person's home wherever possible
- routine healthcare taking place as close to home as possible

6. Implementing the change

We are also now establishing the programme to deliver long-term change

The key information about this programme of work is summarised below.

Programme objective

- To launch accountable care working in 2019

Programme domains

- **Commissioning and contracting** – developing and implementing a joint CCG and WCC commissioning strategy and contractual approach
- **Primary care provider development** – establishing the primary care home model
- **System leadership** – supporting providers to respond to the challenge of accountable care
- **System enablers** – preparatory work on the improvement of estates, digital, and workforce infrastructure that will support accountable care

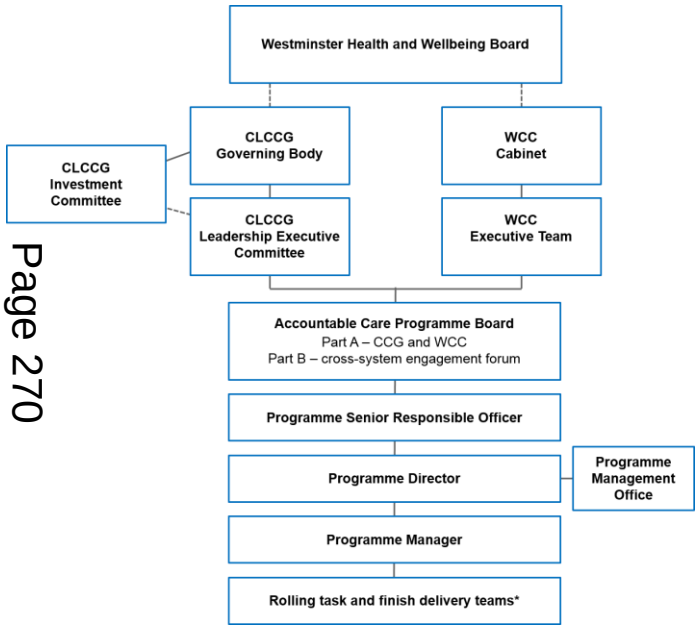
Success criteria

A system that supports the people of Westminster to achieve better health and wellbeing outcomes	An integrated health and care system with a "can do" and "it's my job" approach	Services designed around personalisation, prevention and population health improvement
A system that lives within its financial means	A demonstrable shift of investment and resources towards prevention	Greater workforce satisfaction and new, accessible career paths
A stronger role for primary care as the leader of the system	A reduction in transfers of accountability for patient care	Improved use of resources, particularly estates and digital technologies
A step-change in self-management and self-care	People using health and social care services are kept safe from harm	A system that does not waste patient or staff time

6. Implementing the change

We are also now establishing the programme to deliver long-term change (cont.)

➢ Programme structure



* For the delivery of specific tasks or products, such as the development of the capitated budget and finalisation of the outcomes framework

➢ Key constraints and assumptions

Constraints

- a current lack of alignment between commissioner projects and programmes where this is necessary for programme success;
- evolving guidance from NHS England on accountable care contract forms and procurement rules;
- the requirements of the Integrated Support and Assurance Process (ISAP);
- limited system resources for implementation and opportunity cost where existing resources are transferred;
- limited at-scale provider development within primary care to date;
- limited collaboration between potential accountable care partners to date; and
- challenging timelines in which to design the commissioning approach and for providers to construct a viable partnership capable of delivering accountable care.

Assumptions

- system-wide appetite to make accountable care work;
- the full business case developed by the commissioners will confirm the strategic, economic, commercial, management, and financial cases for accountable care;
- the system will make available sufficient resources for the design and implementation of accountable care;
- the programme will have access to all relevant legal and other technical advice required;
- local plans can be tailored in line with emerging NHS England guidance and more detailed technical guidance does not contradict or undermine local ambitions;
- national workarounds required for issues identified by earlier accountable care programmes will be devised by NHS England in time to inform this programme.

NHS
Central London
Clinical Commissioning Group

Section 7: Implementing the change – from 2019/20

7. Implementing the change – from 2019/20

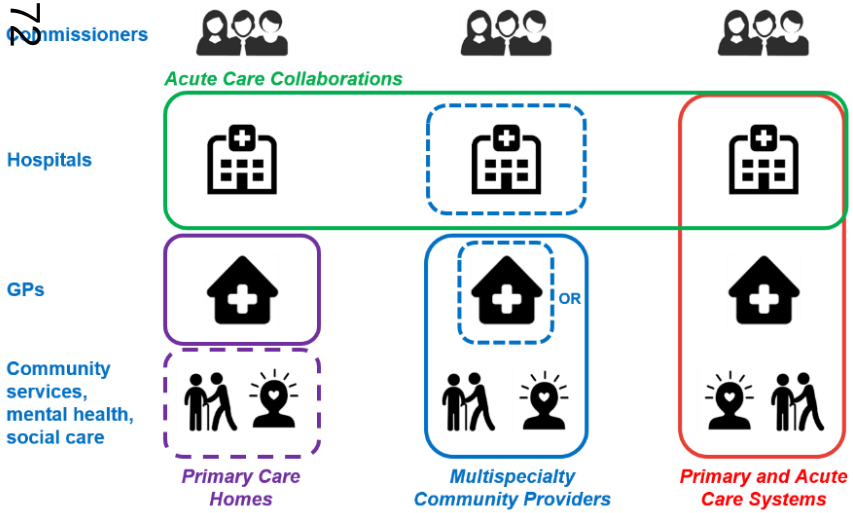
Accountable care in Westminster

The changes described above will help to improve local health and wellbeing by better joining up a range of primary care services.

On top of this, there needs to be a more formal and structured approach to ensuring that care is not hindered by boundaries between organisations or how money flows across the system.

This is the basis of the '**One** system, **One** budget, **Better** outcomes' – or accountable care – approach.

The NHS's *Five Year Forward View* describes a range of new care models, two of which in particular reflect the principles of accountable care. These are Primary and Acute Care Systems and Multispeciality Community Providers. The table opposite explains why a Multispeciality Community Provider, which is focussed on care delivered outside of hospital, is the form of accountable care most suited to Central London.



— *All services in scope (though in practice scope is determined by each care system)*

– – *Some services in scope*

Advantages of delivering accountable care through a Multispeciality Community Provider

- ✓ It focuses on the care delivered outside of hospitals, which is where:
  - care is most fragmented and the benefits of integration for local people are greatest;
  - many types of care can be wrapped around primary care and tailored to each community's specific needs;
  - holistic care can focus on the long-term support of people in their own surroundings; and
  - care services can best promote prevention, self-care, and the wider wellbeing agenda
- ✓ An MCP is built around GPs' registered lists and therefore reflects the role of primary care as the best integrator of the wide range of services that local people need
- ✓ The prominence of general practice in the model means that GPs are in the driving seat of leading local change
- ✓ Implementing an MCP reflects the principles of our approach to date, which has been to focus on the development of primary care at scale and its integration with other care services

7. Implementing the change – from 2019/20

Scope: The MCP will be built around general practice

The CCG has identified a **Multispecialty Community Provider** as the preferred local approach to accountable care.

This is partly because an MCP is built around GPs' registered lists and therefore reflects the role of primary care as the best integrator of the wide range of services that local people need.

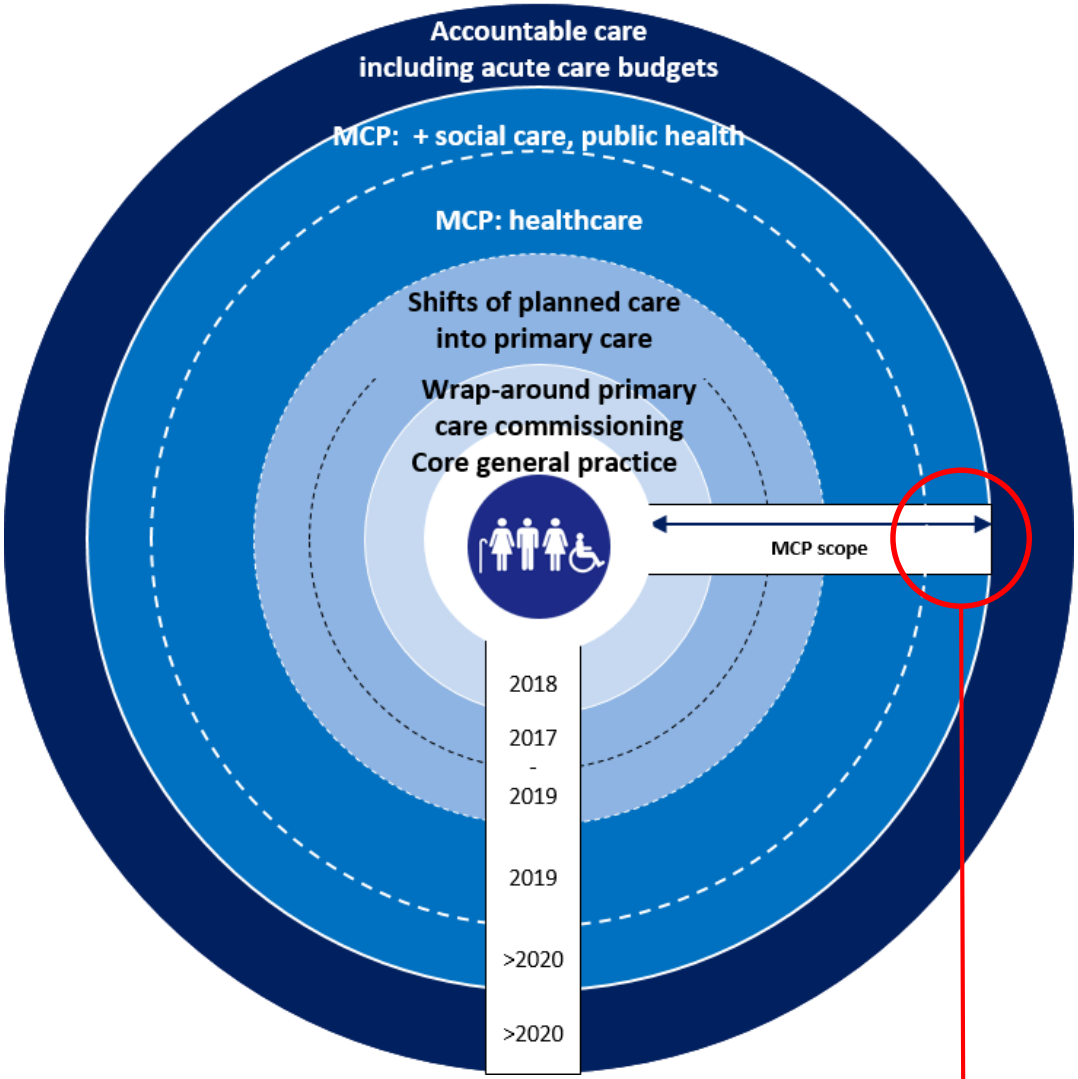
More specifically, many services will operate through the **primary care homes** now being developed.

These are groups of practices serving populations of around 30,000 to 50,000 people.

They will be the operational delivery units of the MCP.

Within general practice, they allow for the routine sharing of clinical skills and experience, specialisation that can drive up quality, and the provision of services at scale.

Beyond general practice, the primary care homes act as the cores around which other services organise themselves and deliver their services.



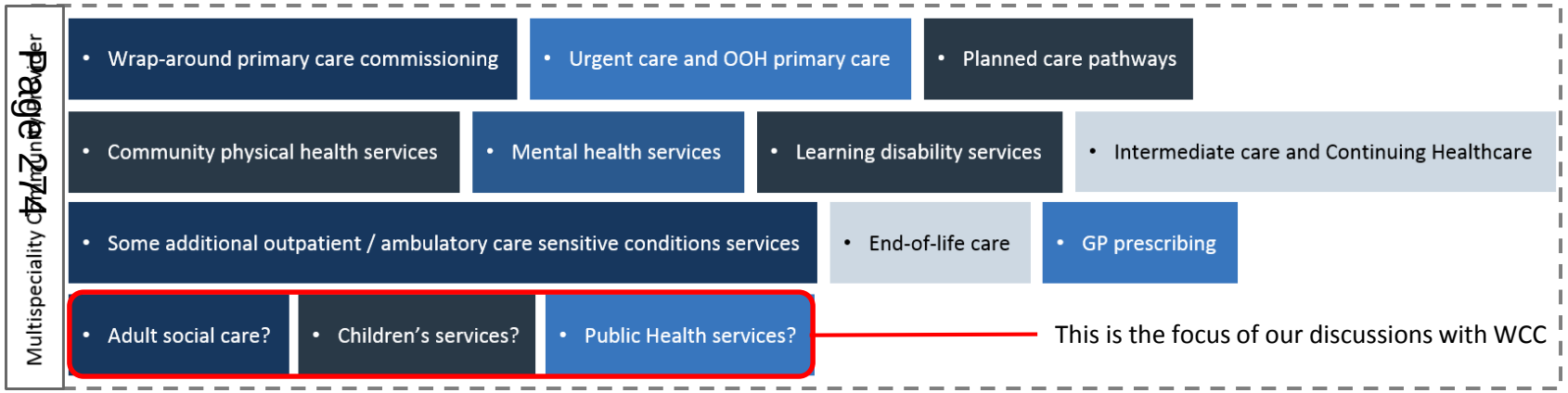
This is the focus of our discussions with WCC

7. Implementing the change – from 2019/20

Scope: The MCP needs to be broad enough to make a difference to people's care

The scope of an MCP needs to be large enough to improve local health and wellbeing outcomes by developing a truly integrated out-of-hospital service. A potential broad scope is shown in the diagram below.

This expands the detail on the previous page. It assumes that primary care core contracts are not included in the MCP (which makes it a partially integrated model rather than a fully integrated model, according to NHS England's definitions). The CCG will require the MCP to form integration agreements with the primary care homes, on behalf of their constituent practices, to ensure that the boundary between core general practice and the MCP does not impact negatively on how care is delivered.



An MCP will also assume various commissioner functions and funding necessary for it to achieve the health and wellbeing outcomes required. This could include service redesign, safeguarding, assessment, and medicines management.

Choice will remain as an important principle that the new accountable care approach will need to support. Our current thinking is that people who choose to be treated outside the local system should have their care paid for by the accountable care provider at the prevailing national tariff or, where there is no national tariff, at a locally agreed price.

7. Implementing the change – from 2019/20

Scope: The MCP will bring together multiple fragmented contracts and budgets

The high-level and preliminary healthcare budget for a local MCP, based on the scope set out above, is **c.£122m** per year.

Added to this will be portions of current spending on acute contracts, prescribing, and commissioning and programme costs.

These values are based on 2017/18 contract values.

This will form the basis for intensive work on the calculation of a capitated budget for the MCP, in addition to which there will be:

- incentive payments based on the achievement of defined health and wellbeing outcomes; and
- a risk-share / gain-share agreement.

The table below shows the values attached to the different categories of service:

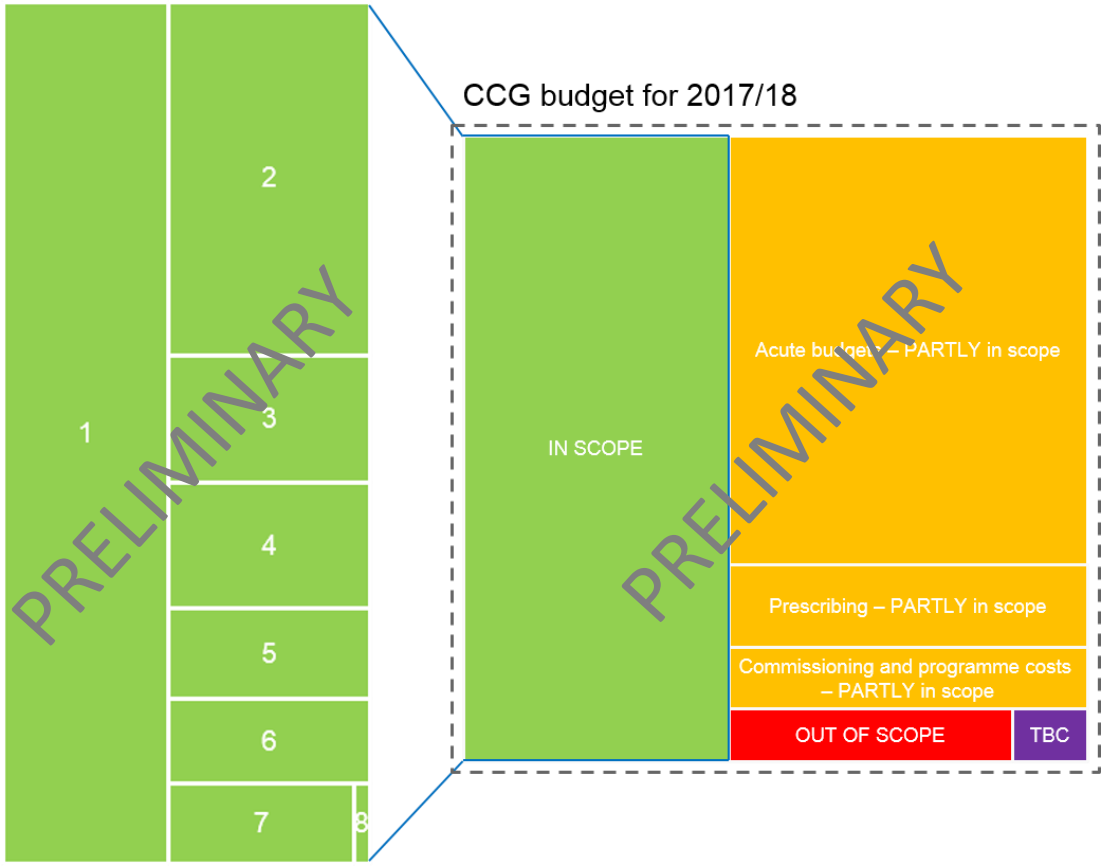
Commissioner	Category	Approximate value, £m*	
		In scope	**Partly in scope**
Central London CCG	Services in scope	122	
	Acute budgets – partly in scope		113
	Prescribing – partly in scope		22
	Commissioning and programme costs – partly in scope		16
	Totals	**£122m**	**£151m**

* based on 2017/18 contract values

7. Implementing the change – from 2019/20

Scope: The MCP will bring together health budgets currently managed separately

The diagram below shows how CCG spending potentially fully within the scope of the MCP is made up of a range of budgets.



#	Service	£m†
1	Mental health and learning disabilities	55.5
2	Community physical health services	27.4
3	Adults*	9.9
4	Intermediate care and Continuing Healthcare	9.8
5	Urgent care and OOH primary care	7.0
6	Multiple**	6.5
7	Additional primary care commissioning	5.8
8	Children's services*	0.5
	Total	**122**

† Approximate value, £m (based on 2017/18 budget values)
* This mainly reflects healthcare contributions to the Better Care Fund and local section 75
** Budgets and contracts covering multiple service categories

7. Implementing the change – from 2019/20

Integration: The MCP will provide the basis for integrating and transforming services over several years

NHS England guidance states that, if commissioners wish to avoid multiple formal procurements, the full scope of an MCP needs to be set out in the procurement process and accounted for in an MCP contract.

However, it is not feasible to expect the new MCP immediately to integrate and transform all services across its entire scope from the very start of the contract. The preferred approach is therefore to:

- mobilise the MCP in shadow form in April 2019 and then fully operationalise this in April 2020 for the healthcare services in scope, with a clear timetable of service integration and transformation based on local health and care needs; and
- subject to agreement with Westminster City Council, to bring social care services into the operational scope at a later date, as a scheduled variation advertised up front through the market engagement and procurement process.

The key advantages of this approach are:

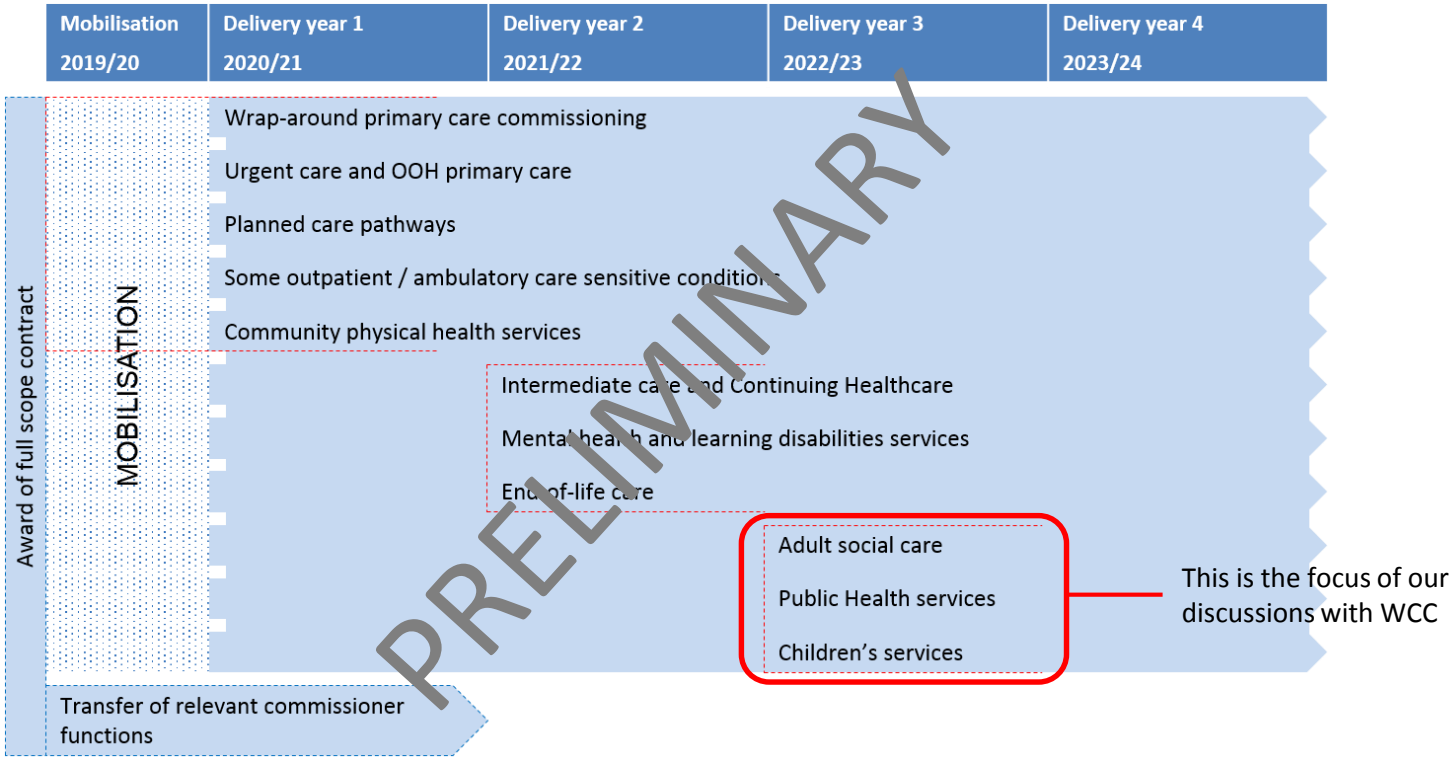
- ✓ the MCP has **near maximum reach to integrate and transform services** – and therefore to improve outcomes – from the earliest opportunity, beyond the alternative approach of incrementally folding contracts into the MCP's operational scope either as they expire or as pre-defined blocks of services relating to different population segments;
- ✓ **financial risks** associated with the mobilisation can be mitigated through the phased introduction of outcomes-based payments and the risk-share / gain-share model, as explained in this chapter;
- ✓ **operational risks** associated with the mobilisation can be mitigated through the extended shadow running period;
- ✓ it avoids the challenges of managing **rump contracts** outside of the MCP operational scope, in advance of their transfer to the MCP (although commissioners can require an integration agreement between the MCP and the providers of these services);
- ✓ it avoids an extended and complex **transfer of commissioning resources** to the MCP, in line with its growing operational scope;
- ✓ it avoids the potentially complex **unbundling of current contracts** required if services are folded into the MCP operational scope according to population segment; and
- ✓ finally, it makes a statement about the commissioners' intention to **move decisively**, rather than running a multi-year transition between system forms, providing that risks can be mitigated appropriately.

7. Implementing the change – from 2019/20

Integration: Care will be transformed in line with local needs

The chart below shows a preliminary view of a phased integration and transformation plan. Developing and verifying this requires:

- commissioner agreement on the vision for the end-state of the MCP and the local outcomes metrics it is designed to improve;
- detailed conversations with stakeholders on local transformational priorities;
- a clear understanding of operational interdependencies between services and their impact on phasing; and
- detailed contractual analysis covering expiry dates, notice options, and extension options.



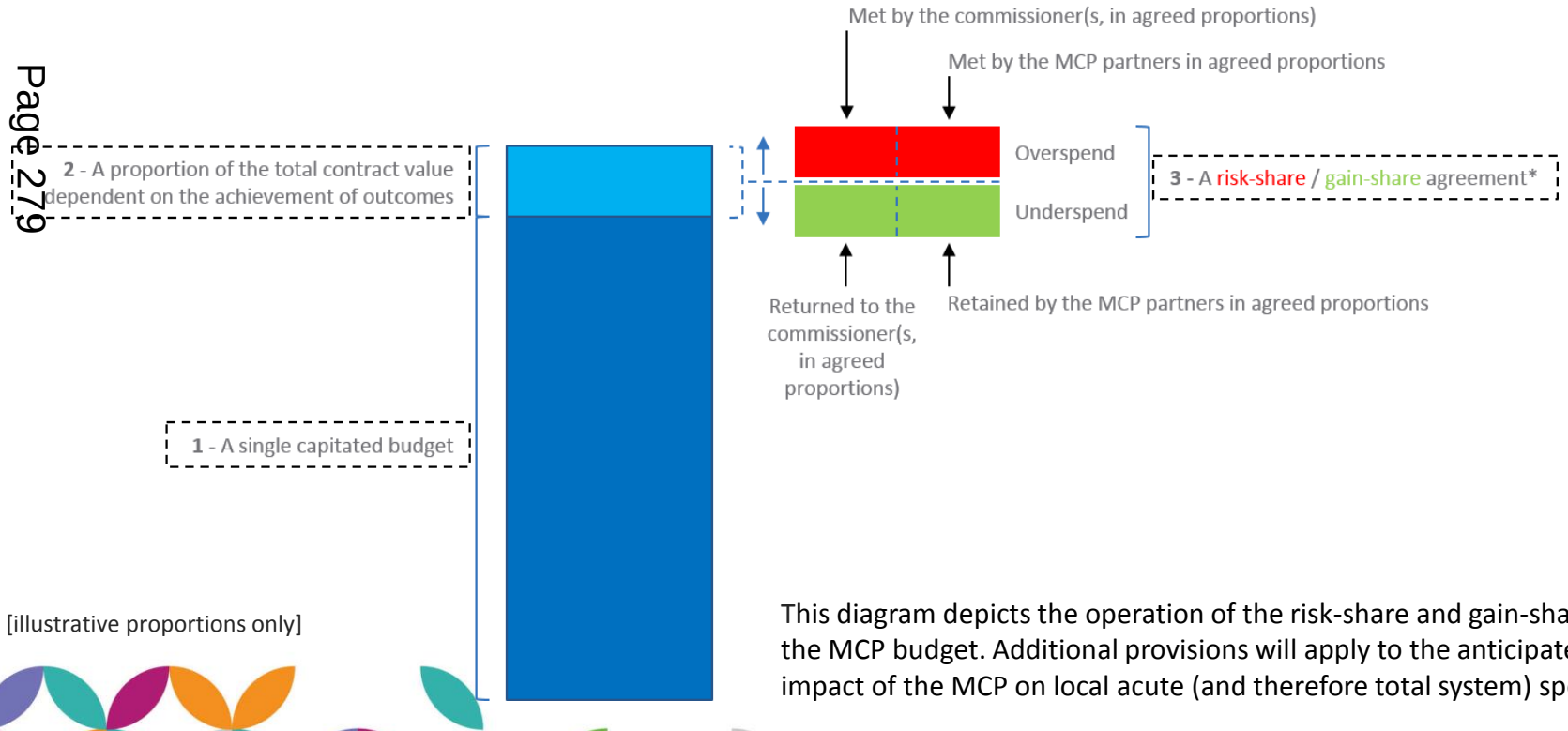
7. Implementing the change – from 2019/20

Financial strategy: The financial arrangements must work for all sides

The MCP financial strategy will:

- provide a fair, realistic, and affordable **whole-population capitated budget** for the delivery of better health and wellbeing outcomes;
- incentivise the achievement of the most important of these health and wellbeing **outcomes**; and
- apportion **risk and reward** across the system in a fair and sustainable way.

In order to do meet these objectives, the MCP budget will be formed in three main parts. These are shown in a simplified way in the diagram below. Each component is explained in more detail in this chapter.



This diagram depicts the operation of the risk-share and gain-share on the MCP budget. Additional provisions will apply to the anticipated impact of the MCP on local acute (and therefore total system) spending.

7. Implementing the change – from 2019/20

Financial strategy: A whole-population capitated budget will encourage accountability for all care

The MCP will receive a single capitated budget – a set amount of money based on the combined registered lists of local practices.

The capitated budget brings together a large number of individual budgets and has these advantages:

- **Accountability is for outcomes rather than activity:** The MCP will not be paid for undertaking any particular activity, which shifts the focus of payment arrangements from the delivery of services to whether outcomes are met.
- **Funds flow to where they are needed:** With one budget shared across the whole population and unconstrained by individual commissioner contracts, the MCP provider is able to direct money to where it can make the biggest contribution to improving outcomes, including for functions such as coordination, care plans, care navigators, shared management, and integrated information systems.

  It also allows for greater flexibility: The MCP will be able to personalise care according to what is best for an individual's outcomes, rather than having to follow service specifications used in the current payment model.

  There is a greater incentive to keep people well through more preventive care: The MCP is not penalised for reductions in activity caused by improved health and wellbeing and because people are able to look after themselves better at home. At the same time, the outcomes component of the capitated budget will reward the MCP for the achievement of population outcomes, so it has a reason to keep people well rather than just to provide care when it is needed.
- **The MCP can overcome current issues with shared investments:** A capitated budget across the MCP will allow it to invest in the direct costs of coordination, such as network management, information systems, and activities like care planning. These costs can be top sliced off the capitation with saving made in other areas. The current payment model, which fund providers separately for different services, means that agreeing these joint investments now is far more complicated.
- **The MCP is incentivised to manage overall costs:** The MCP is accountable for the end-to-end costs of care within its scope – ending the situation where individual providers can pass off activity and costs to other organisations.

7. Implementing the change – from 2019/20

Financial strategy: Capitated budgets are complex and need to stand the test of time

The initial value of the MCP accountable care budget will be calculated on the basis of current commissioner spend, using CCG current contract values, programme budgets, and running costs relevant to the services in scope.

From the initial analysis shown above, this preliminary value for healthcare services is **£122m** per year.

The capitated budget must be adjusted over the lifetime of the contract to take account of:

- pre-agreed growth rates in the size of the population;
- pre-agreed inflation rates and productivity improvement assumptions; and
- actual changes in the numbers of people assigned to particular population segments or risk-adjusted groups (if implemented – see below).

The early termination of the UnitingCare Partnership contract highlighted the importance of pre-agreeing these adjustments and then reviewing them at specified points during the contract.

Uncertainty

Commissioner budgets for the potential full length of the contract is not known. For the CCG, its allocation is predictable with any certainty only a few years in advance and the capitated budget will represent a large portion of the allocation. For this reason, the national accountable care contract is developing in a way that allows for flexibility. If either an adjustment to the capitated budget or the consequential contract variations cannot be agreed by both commissioners and the MCP, either party may terminate the contract.

Refinement

There are two ways in which the capitated budget can be refined to allow for greater insight into its composition:

→ development of accurate budgets for individual population segments, from providers' actual costs. In order to do this, providers will need to agree to the principle of open book accounting with their partners and commissioners; and

→ development of a risk-adjusted approach to capitation, where average price per person is adjusted for a series of risk factors to produce an individual or limited range of prices for each registered person. There are examples of this from elsewhere and previous work in North West London on Whole Systems Integrated Care provides a good starting point.

7. Implementing the change – from 2019/20

Financial strategy: The MCP will be incentivised to achieve certain outcomes

As chapter three described, the MCP outcomes framework will contain three categories of outcome:

1. Pay-for-performance outcomes – a small number of prioritised outcomes that the MCP will be paid for supporting people to achieve;
2. Local quality and assurance outcomes – applied contractually and able to support commissioners' assessment of overall MCP performance over a number of years; and
3. National operational standards and quality requirements – applied contractually, with relevant sanctions.

The financial strategy described here focuses on the pay-for-performance outcomes.

When developed in full it will be based on the following core principles:

The proportion of income dependent on outcomes will be sufficiently **material** to the MCP to act as an incentive to transform services.

At the same time, the outcomes and financial rewards will be **realistically attainable** and any value placed at considerable risk will not place the MCP in a rapidly deteriorating or unsustainable financial position. This can be done by, for example, using historic date to calibrate outcomes targets and rewards so that the MCP has a 95% likelihood of achieving ≥90% of the assigned reward by outcome, though with the maximum reward always reserved for a statistically significant improvement in an outcome.

✓ For **new outcomes**, where historical data is not available, the MCP will be incentivised to develop a sampling and data capture methodology and then form a baseline from which targets and rewards can be set.

✓ The outcomes and rewards set at the outcome will be **durable** – though they can be set annually where new performance data becomes available, in order to give the MCP sufficient operational and financial planning certainty as a rule they should not be reviewed annually but instead every three years. The reward proportions set for given outcomes should not change once set.

✓ There will be **clear business rules** associated with the management of outcomes measurement and payment.

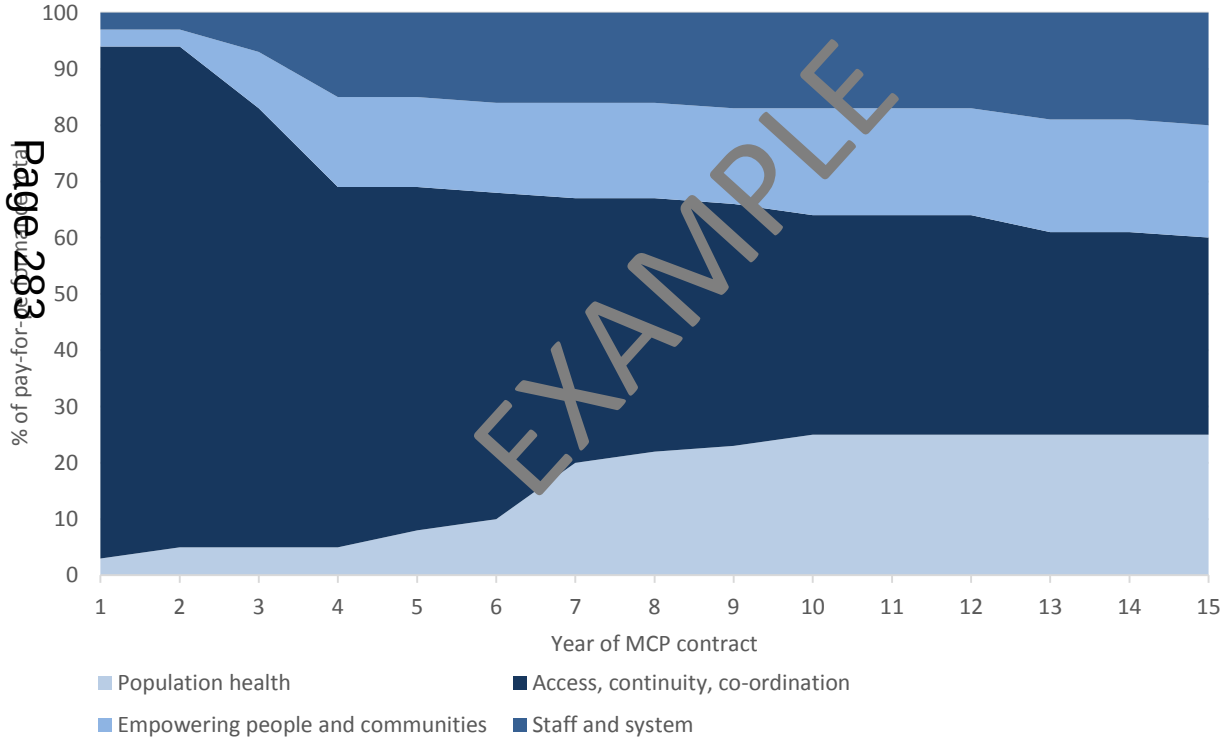
7. Implementing the change – from 2019/20

Financial strategy: How outcomes are incentivised will change over time

The balance of how different types of outcomes are incentivised will change over the lifetime of the MCP contract.

How this could work is shown in the diagram below. In Westminster, this will be determined primarily by:

- the prioritisation of particular local health and care needs with the local community;
- the MCP transformation programme and therefore its ability to impact on given outcomes; and
- the likely lag times between the MCP's interventions and the impact on an outcome measure.



For an example of a proposed MCP outcomes incentivisation model, open this link.

7. Implementing the change – from 2019/20

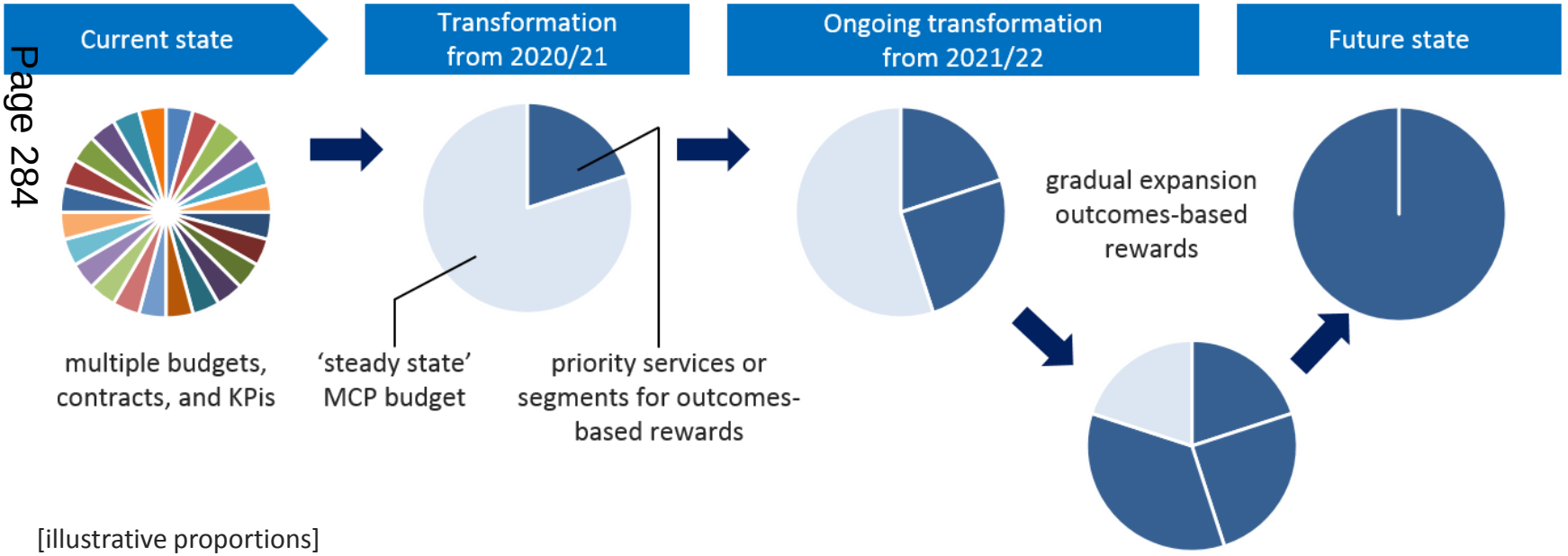
Financial strategy: The number of outcomes that are incentivised will grow over time

As a means of setting clear transformational priorities and mitigating the MCP mobilisation risk, the proportion of the MCP budget subject to outcomes incentive payments will grow over time.

So too will the proportion of the MCP budget subject to a risk-share / gain-share agreement, as explained below.

For outcomes, incentivisation will start with prioritised services or population segments and expand incrementally until the full scope of the MCP contract is measured by outcomes.

This means that the value of the 100% shown in the chart on the previous page will increase year by year.



[illustrative proportions]

7. Implementing the change – from 2019/20

Financial strategy: risk and reward will be distributed across the system

A key objective for the MCP financial strategy is to transfer to providers operational risks that they have better control over than commissioners, such as reducing hospital admissions or avoiding delayed discharges.

In order to do this, there must be strengthened incentives for providers to manage those risks more effectively.

This is achieved by sharing between commissioners and the MCP the risks and rewards of making improvements to services through a risk-share / gain-share mechanism, such that:

- any deficit will be met by commissioners and the MCP in agreed proportions; and
- financial benefits are shared as new ways of working generate efficiencies and better preventive care and supported self-management lead to reductions in demand for some types of care.

Deficits and benefits will be apparent in two ways – relative to the anticipated impact of the MCP on local acute spending and on the MCP budget itself.

The introduction of the risk-share/gain-share agreement will need to be carefully calibrated so as not to expose the MCP to excessive risk as it takes on new accountabilities and devises new ways of working.

This will likely mean that the mechanism is introduced incrementally, so that the MCP initially takes on upside risk (i.e. keeps a share of any savings generated) before taking on downside risk (i.e. also needs to fund a share of system overspend by generating additional savings).

The level of both upside and downside can increase over time (with the upside risk for the CCG probably capped at its surplus target, as surpluses cannot be carried over from year to year).

This reflects the incremental approach to introducing pay-for-performance outcomes discussed above.

7. Implementing the change – from 2019/20

Contracting: The extent of our ambition requires a contractual underpinning for the MCP

The MCP must be commissioned in a way that organises care professionals and money flows behind the achievement of better outcomes.

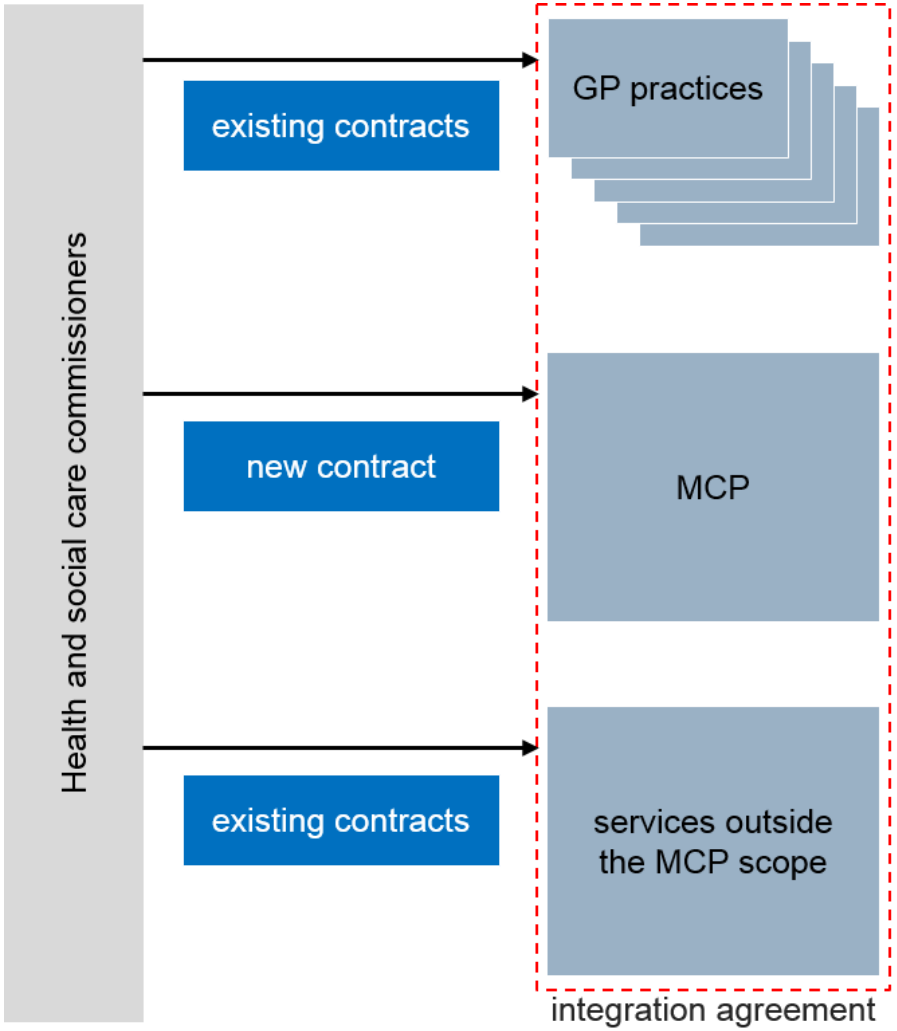
Commissioning an MCP is about enabling the integration of care services required to improve health and wellbeing, rather than a particular contracting form.

In fact, a 'virtual MCP' does not require a new contract. Rather, it involves a new alliance agreement between all relevant commissioners and providers. This overlies existing contracts and establishes a shared vision and commitment to managing resources, governance and gain/risk sharing arrangements, and agreements about operational delivery.

This approach is the least disruptive. However, the persistence of existing contracts means that it relies largely on goodwill. It also adds an extra layer to already complicated contractual arrangements. It is the weakest form of MCP in terms of its rights to create and manage integrated provision and to deploy resources flexibly across a care system. Organisational structures and money flows still hinder rather than help care professionals do the right thing.

The CCG therefore needs to commission an MCP through a contract that supports care professionals to do the right thing.

This will be through a **partially integrated MCP contract**, shown in the diagram opposite and explained on the next page.



7. Our approach to improving health and wellbeing – changes from 2019/20

Contracting: The partially integrated MCP contract works best for Westminster

There are two types of MCP contract: for a fully integrated model and for a partially integrated model.

The main difference is the treatment of GPs' existing GMS and PMS contracts: the fully integrated model includes them all and the partially integrated model does not.

The CCG's preference is for the partially integrated model, which does not require GPs to volunteer to suspend their current core contracts and effectively merge them into the single MCP contract. This is because:

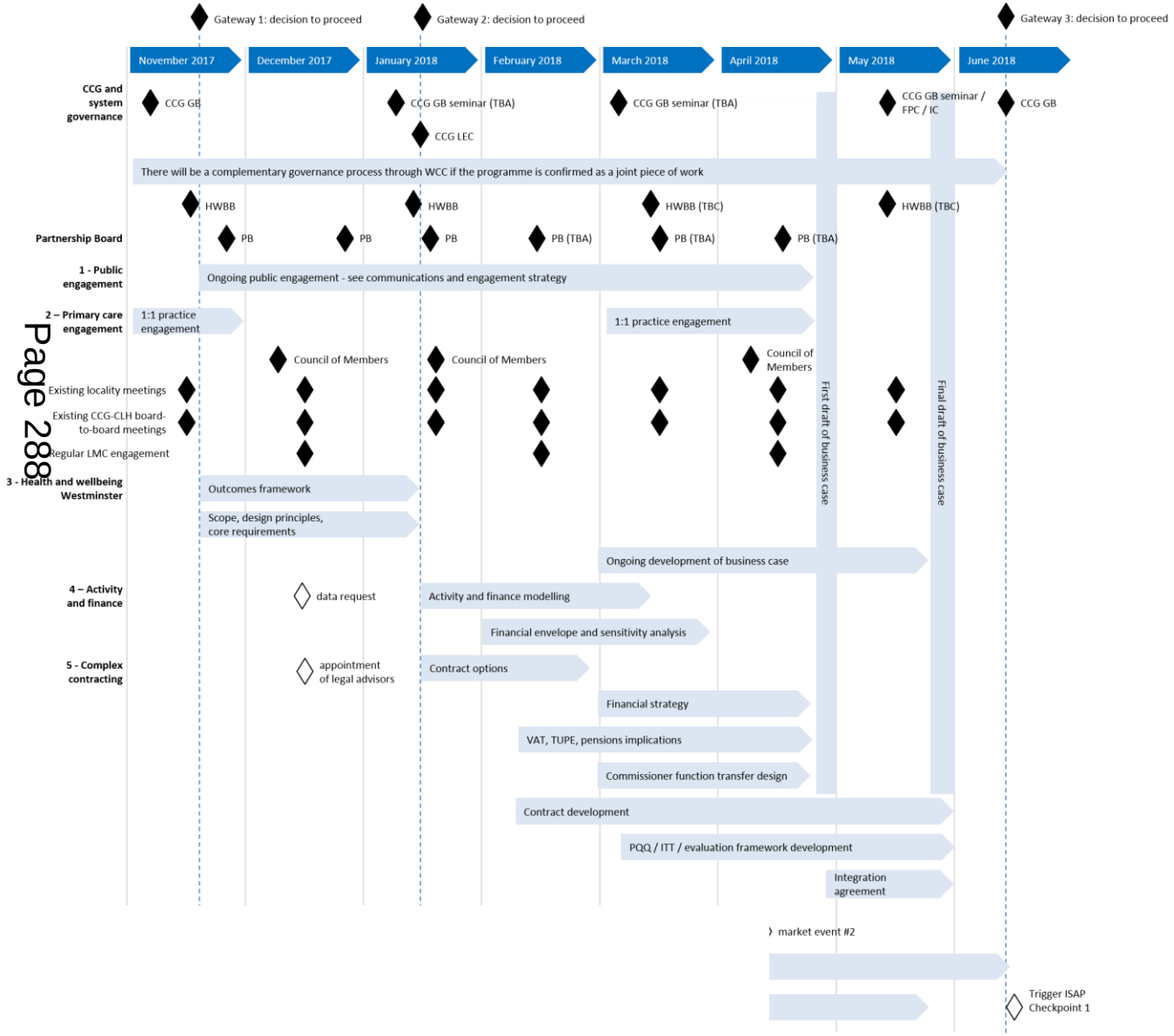
- the conditions around the temporary suspension and reactivation of core contracts set out in NHS England guidance are not yet sufficiently well understood or tested for local GPs to be likely to support a fully integrated model; and
- there are already very high expectations on general practice to lead the development of primary care homes and deliver the new wrap-around contract, which means that over the next twelve months energy is best dedicated to these tasks rather than a debate about core contracts.

Although narrower than a fully integrated model, a partially integrated MCP still brings significant local benefits:

✓ The healthcare scope remains very wide-ranging, across extended primary care, community services, mental health and learning disabilities, and some services currently delivered by acute trusts – which means a proportionately large remit to integrate services and allocate investment efficiently
✓ An integration agreement between general practice, the MCP provider, and other providers will support integration beyond the formal MCP scope – and commissioners will facilitate this to ensure that it allow is suitably ambitious for what the whole system working together can deliver for local people
✓ The procurement process will still quality for the Integrated Support and Assurance Process (ISAP) – meaning assistance from NHS England and NHS Improvement and a level of internal and external assurance commensurate with the risk of the contract
✓ GPs retain their current core contracts, which means that time and energy is not diverted from delivering the overall vision of the MCP into a debate about existing core contracts

7. Our approach to improving health and wellbeing – changes from 2019/20

Our programme plan for the next eight months



Disclaimer

This paper sets out a potential approach to commissioning a Multispeciality Community Provider (MCP) for consideration by the Central London CCG Governing Body. It represents the work done to date and is supported by a cover paper that sets out the further work required to bring about a formal decision of the Governing Body in 2018. Until the CCG has made the formal decision to proceed to commissioning a MCP, the CCG reserves the right to withdraw this draft commissioning plan. The CCG recognises this is a document in the public domain and that potential bidders may start to consider how to respond to this; however, the CCG accepts no liability for costs associated with this in the eventuality the Governing Body does not approve the commissioning plan and any subsequent procurement activity.

The CCG also reserves the right to continue to work on its commissioning plans in its entirety and individual sections of the plan remains draft and subject to change and/or removal. Any information provided by Central London CCG about the requirement and potential procurement process to be followed is indicative only, and subject to change/confirmation. No supplier selection or supplier preference is implied.

This page is intentionally left blank

Appendix 2
West London CCG
Integrated Care Strategy
2018-2020

Mobilising an Integrated Community Team through a Multispecialty Community Partnership (MCP)

Supporting Primary Care Working at Scale

Developing a road map towards accountable care

Version 20

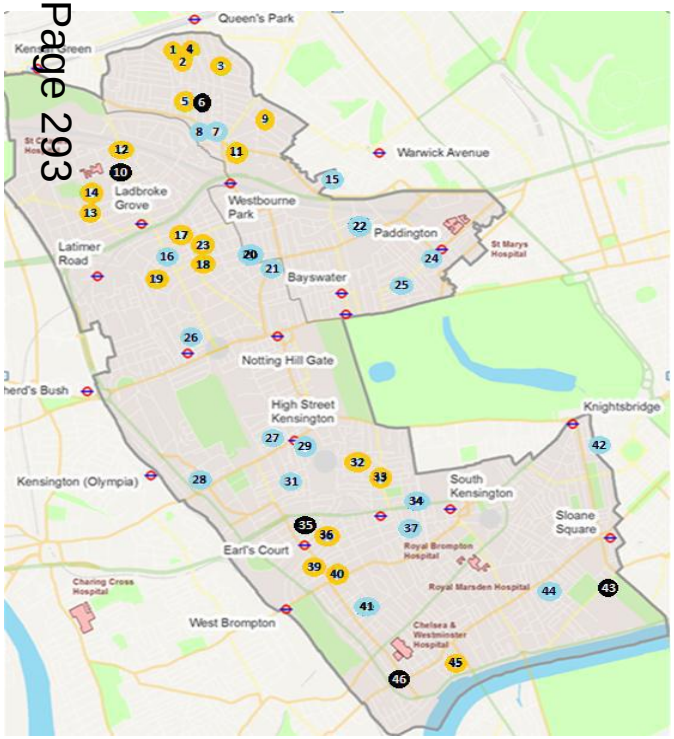
Contents

West London and NWL STP – who we are

West London CCG was established in April 2013 under the Health and Social Care Act 2012. It is made up of 45 GP member practices that in 2016/17 served an estimated registered patient population of 245,315 (QOF 2016/17) and is responsible for planning and buying (commissioning) health services for the people living in the Royal Borough of Kensington and Chelsea and the Queen's Park and Paddington area of Westminster.

Clinical Commissioning Groups do not provide any health services directly, but buy these services for our residents from providers such as NHS hospitals, GPs and the voluntary sector.

We are committed to improving the care provided to our residents, reducing health inequalities and raising the quality and standards of services within our allocated budget. Our vision is that everyone living, working and visiting West London should have the opportunity to be well and live well – to be able to enjoy being part of our capital city and the cultural and economic benefits it offers.

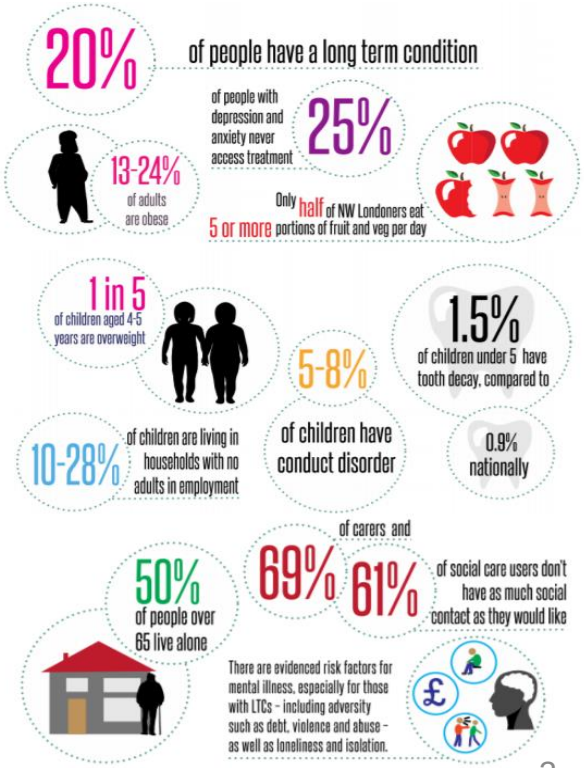


Sustainability and Transformation Plan

In 2016 West London CCG joined with Kensington & Chelsea Council, Westminster City Council and other local partners to look at what we wanted to do to make positive change happen, and feed this into the wider NW London Sustainability and Transformation Plan (STP). The STP which covers the eight boroughs in NW London takes its starting point from the national NHS Five Year Forward View strategy and translates it for our local situation

The STP is driven by a strong case for change across NW Lodon.

- Only half of our population is physically active Half of over-65s live alone and over 60 per cent of adult social care users want more social contact
- Many people are living in poverty
- People with serious long-term mental health needs live 20 years less than those without..



Our Journey

The Integrated Care Strategy is being co designed with our partners, including service users and carers, and builds on a number of programmes implemented in West London over the past 5 years. These programmes have focused on principles around integrated working, case management and care planning for those who need, and access to well-being and self care services, with GPs and their practices being central to how people are cared for.

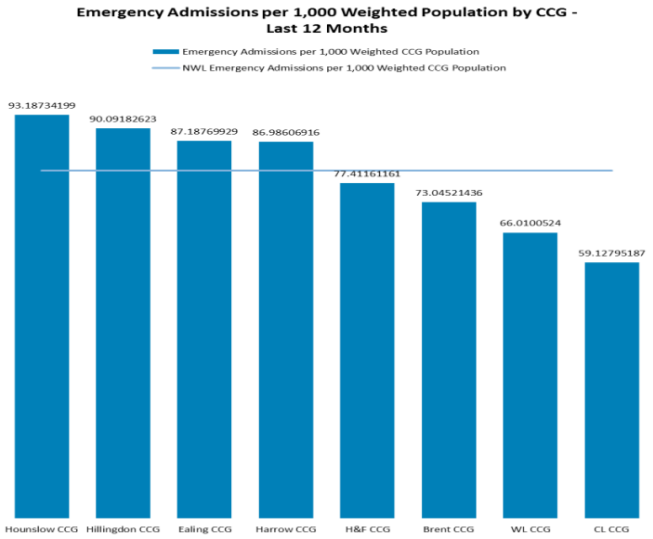
West London's **Better Care, Closer to Home Our strategy** (incorporating the Integrated Care Pilot) 2012-15 demonstrated a commitment to developing personalised, well coordinated and seamless pathways of care across health and social care, to shift care to community and primary care settings and reduce hospital admissions and improve early discharge.

The model of care described as part of this strategy was our strategy **Putting Patients First** which formalised the role of case managers and multi-disciplinary work through a Local Enhanced Scheme with all practices.

The CCG has two *Whole Systems Integrated Care* Pioneers covering two distinct but related population groups. The models of care have great synergy in terms of design and are both located in the two Hubs. In July 2015 the CCG agreed a 3 year business case to fund ***My Care My Way,*** targeting the over 65-focussed, providing case management and health and social care navigation rolled out in a phased manner, as well as a Hub model and a self care focus. In terms of long-term mental health needs across, the CCG funded a 3 year Business Case for ***Community Living Well*** in June 2016. Though far smaller in scale than MCMW, it is also predicated on Case Management, Navigators and Peer Support/Self Help, wrapped around the patient, and access to a range of health and well-being services in a single offer. It is planned to phase 'go live' in a phased approach by Q4 2017/18.

Key achievements include:

- A whole-hearted and on-going commitment to detailed co-production with service users and carers in both population groups over the last 3 years.
- Established Hubs in the North and South to co-locate service delivery.
- A 'Tried and tested' MDT approach, with skills mix and focus tailored to population needs. Motivated staff across both pioneer models, integrating delivery.
- MCMW: 24 practices with core MDT in operation, all 45 in place by 1/4/18.
- CLW: 16 existing clinicians now matched with 16 new 3rd Sector Well-Being Workers (a workforce doubled for £550K –showing the value of integration).
- CLW: demonstrable improved recovery outcomes, high uptake of navigator and Peer support services, c20 positive employment outcomes per month.
- MCMW: 2000 referrals into self care service, second lowest NEL across NWL, reduced GP appointments.



Strategy overview: Focusing on Function

"By far the most critical task in developing an MCP is to get going on model of care redesign"

NHS England 2016

This strategy develops West London's long term vision for integrated and accountable care. The aim over the next two years is to make a real difference to how care is delivered to our residents. We will focus on getting the function (the model of care) right whilst continuing at pace to work with our providers to develop our plan around the future form of the local system's accountable care approach.

We will develop our model of care with learning from the past two years of rolling out the **My Care My Way (MCMW)** service and more recently the **Community Living Well (CLW)** service. Our recent Rapid Learning and Evaluation Programme has set out the case for change by recommending:

- Closer integration with health and social care
- More efficient use of resources through single management structure and shared services where appropriate
- Integrating more care functions into MCMW (e.g. organic mental health; falls; rehab) to enhance the ability to meet patient need in the community

In order to deliver these improvements to our local model of care, our priority is to build on the current whole system models of care by integrating more care functions into these teams throughout 2018/19. This transformation will deliver a fully **Integrated Community Team** serving the whole population's health and care needs by April 2019.

Our **Integrated Community Team** will be responsible for the delivery of a single set of outcomes including:

- Proactive care to maintain good health
- Health is well managed
- Care tailored to personal need
- Reduced health inequalities
- Residents able to live independently but not isolated.
- Reduced need for secondary care/crisis intervention.
- Value for money from each intervention

Strategy overview: Developing Form

As a way of delivering our model of care locally, the case for change for **Primary Care Homes (PCHs)** is compelling. The Primary Care Home concept is a further development of an established principle in West London: clusters of practices working together to improve the health and care for their local populations. PCHs enable practices to use their resources more efficiently by providing economies of scale, which mean that they can provide more services for their patients by pooling resources to invest in technology, estates and workforce. PCHs will be the driver of delivery in their local area, managing resources to drive better outcomes for patients.

In our commissioning role as system facilitators we will support the mobilisation of **Primary Care Homes** with well funded PCH pilots launching at the start of 2018. We will work with practices to help them understand the needs of their local population in new ways, using population segmentation techniques, to tailor the configuration and skills mix of the **Integrated Community Team** for each PCH population. We are committed to supporting each individual practice to develop a practice resilience plan. The level of integration of each PCH will be determined by the appetite for change of each individual practice. However, the huge potential of closer working has been proven across the UK.

At the same time as working with local practices to develop their Primary Care Home, over the next few months the local system will begin detailed consultation on the development of a **Multi-Speciality Community Provider (MCP)** which is a type of accountable care system. Developing an MCP means:

- all partners across the CCG area will eventually share a single, capitated budget which provides funding for all of the health and care needs of the whole population (phasing begins in 19/20 with a pooled budget, with a capitated budget from 20/21).
- all partners will operate within a joined up model of care (coordinated by Primary Care Homes and delivered by GP practices, the Integrated Community Team and our north and south hubs)
- all partners will work together to deliver a single, shared set of outcomes

Primary Care Homes will be the local operational units of the MCP (*"Primary Care Homes are the practical, operational level of any model of accountable care provision"* NHS England), ensuring that the local population's needs are fully understood and resources are tailored accordingly, to provide what local people need. PCHs across the rest of the UK have had populations of between 30,000 to 50,000 so it's likely that four or more PCHs will be hosted within the West London MCP, which is likely to map over the CCG area.

To make this ambition a reality we need to focus on the next two years of rapid transformational change which will be driven through the Accountable Care Alliance Leadership Group, the CCG's Governing Body and through close-working with other CCG and partners across the NWL STP area.

Strategy overview: Key deliverables

An Integrated Community Team (ICT) with a single management structure delivered through an alliance arrangement ('virtual MCP') in 2018/19 and through a formal contract as one component of a partial MCP in 2019/20.

Building on the My Care My Way and Community Living Well models a framework for a single integrated community team will be developed which will ensure:

- A focus on co-design and delivery of a single set of shared outcomes
- A blended workforce model including social care and the third sector
- A focus on getting the care model right for older adults (65+) in 18/19 and for the whole population in 19/20
- High quality, accessible primary care with continuity with registered GP
- Continuity of care for patients and their carers through case management principles allocating resource around need, though risk stratification and tiering of patients
- Use of Hubs, embedding a multi disciplinary team approach and interface with other services as part of a wider team
- Proactive planned care and early escalation of risk when a patient becomes unstable
- Patient owned care plans and focus on the personalisation agenda with active self care supported through third sector organisations

Primary Care working at scale

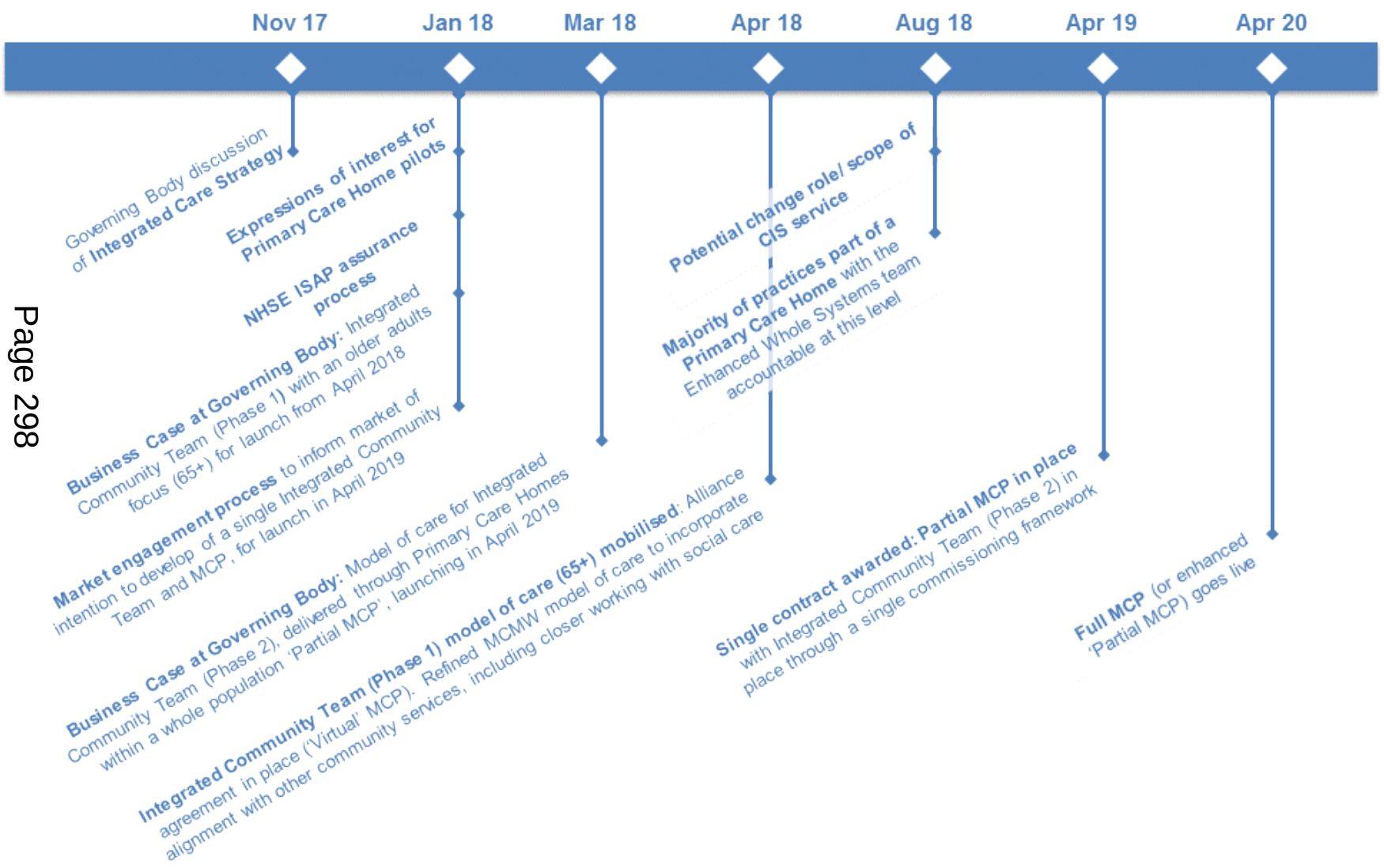
In order to build resilience we will support the development of primary care homes. This will include:

- Working with the GP federation to develop a Primary Care Home Development Plan
- Committing to providing resources at a PCH level to give practices time, capacity and capability to develop joint working
- Ensuring that the MCMW and CLW models are central to any local approach with the key principles embedded at PCH level
- PCHs developed within a North / South split in order to make best use of our Hubs
- Support practices to ensure they have long term resilience plan in place where necessary with a commitment to practices being part of informal PCH by August 2018 and formally aligned by March 2019

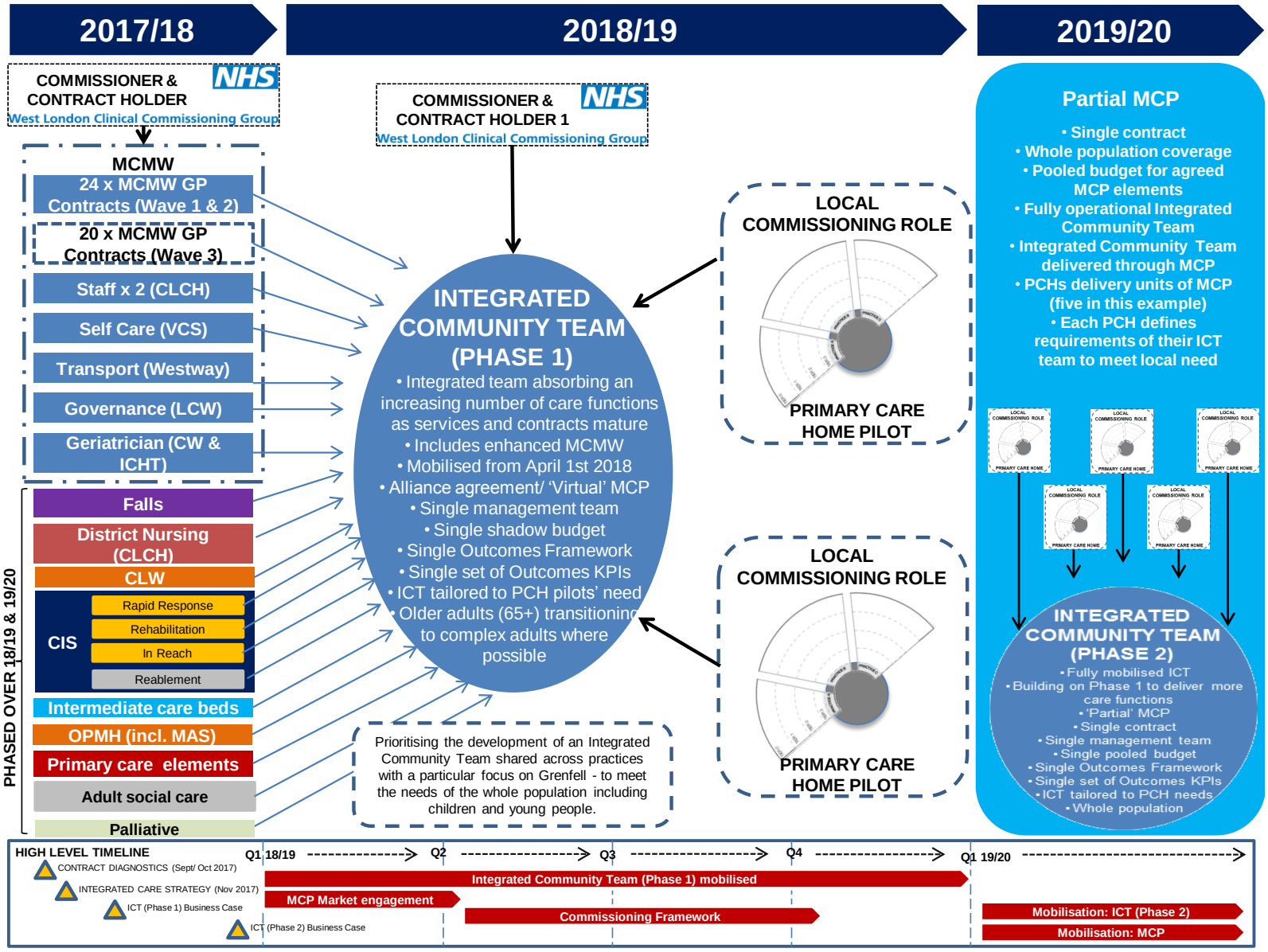
A Road map to Accountable Care

- A Single Integrated Community Team delivered at a PCH level will form part of a partial MCP by 2019/20. Our ambition is that beyond this we move to a more formal and fully accountable care system, incorporating other elements of spend potentially around our patients and primary care
- We have developed a detailed road map which will build capacity and capability to ensure that we have an outcome based approach to accountable care with a capitated, whole person budget from 2020/21

Strategy overview: Key Milestones



Strategy overview:
Developing our MCP components



Building a road map to accountable care

2017/18

- MCMW and CLW fully mobilised by the end of FY.
- 'Virtual MCP' in place for CLW. Formal Partnership Agreement signed November 2017, with shared outcomes and performance framework by Dec 2018.
- A number of individual community contracts in place across a number of organisations.
- Development of a single Outcomes Framework and single set of outcomes KPIs for our 18/19 contracts.
- Development and Improvement Programme to refine models of care and develop Business Cases for 18/19 and 19/20.
- Mobilisation of PCH pilots.
- Begin engagement with NHS ISAP Assurance process.

2018/19

- 'Virtual MCP' through Alliance agreement across all contracts/ between all local partners.
- Integrated Community Team (Phase 1) in place (65+) with additional functions as part of PCH/ Hub based model.
- Alignment of MCMW and CLW contracts with single Outcomes framework and set of outcomes-based KPIs across separate contracts.
- Commence commissioning framework for single Integrated Community Team via MCP.
- Consideration of what is in scope for 2019/20 including social care and acute.

2019/20

- 'Partial MCP' in place.
- MCP contract award: single contract, single outcomes framework and pooled budgets for agreed MCP elements.
- Integrated Community Team (ICT) mobilised and managed through MCP.
- Operational PCHs in place across the whole CCG patch, which ensure population coverage.
- Each PCH defines requirements of their ICT team to meet local need

2020/21

- Full MCP in place.
- Further care functions and services built in. In time to include : all Primary Care, Intermediate Care Beds, Outpatients, UCC, mental health, learning disabilities and acute pathways.
- Fully capitated budget covering the whole population.

Our progress against MCP 'Top 10' checklist - NHS England

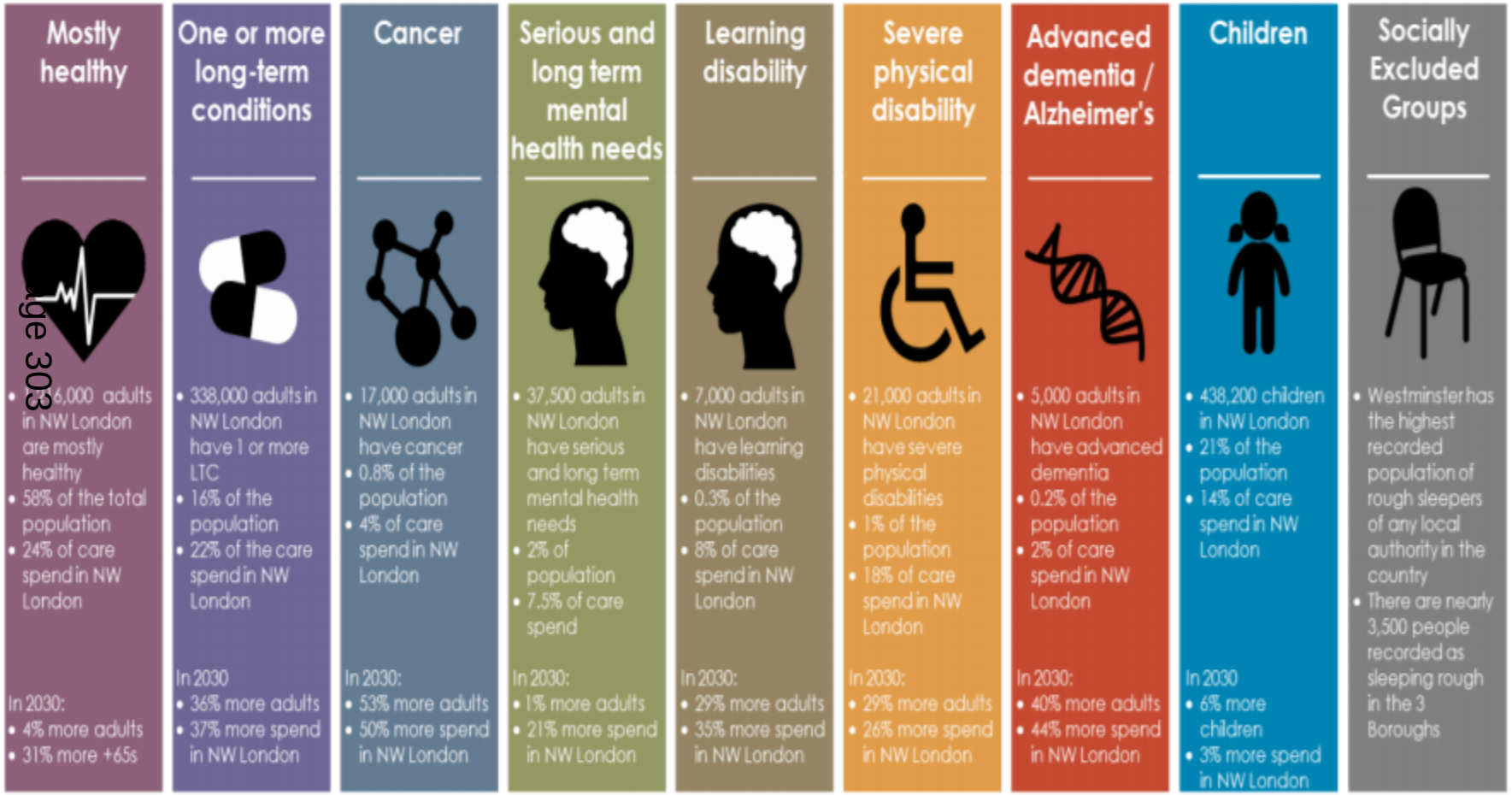
We have the right foundations in place….

MCP 'Top 10' checklist - NHS England	Gap	West London Integrated Care
Collaborative leadership		Already in place through HWBB, ALG and Change Academy
Dedicated 'engine room' that's more than a PMO		ALG and reference group in place
Transparent governance structure		Governance in place through ALG and CCG Transformation Board
Understands different needs of the diverse population and clear segmentation		Initiation population health analysis – segmentation, 'top-down', bottom-up and duplication analysis
Develop and maintain a clear LOGIC model		Emerging LOGIC model
Clear value proposition and commit to a clear return on investment		Emerging LOGIC model
Design and document each of the specific component parts of the care redesign		Business Case and updated SOPs will be developed
Systematically plan, schedule and manage the implementation		Resources need to be identified to support delivery
Learn and adapt quickly		Continued system development – e.g. learning labs, etc.
Commission and contract for the new model, so that organisational forms and financial flows are supporting your goals		Resources need to be identified to support delivery

Our Integrated Care Strategy

Our Case for Change

The NWL STP sets out the changing local demographics over the next 15 years that the local system must respond to and provides clarity on what will happen to demand if no action is taken.



MCMW Development and Improvement: Rapid Learning & evaluation findings

Key Area	Findings	Suggested Actions
Roles and Responsibilities	• Definition/ clarity for range of roles and responsibilities • Social service input/ integration • Duplication in tasks / roles undertaken by Case Managers and District nursing roles • Variation – My Care, My Way Health & Social Care Assistants focus on over 65s, whereas PCNs covered under 65s •	• Single management structure approach to support more joined up/ coordinated care delivery • Continuity and consistency of staff/ teams important for on-going knowledge of case mix and providing appropriate care • All agency participation at Practice MDT meetings • Increased trust between provider teams to remove barriers to integrated working • More flexibility within roles and expanded skills for staff
Responsiveness and Communications	• District Nursing response times can mean Community Independence Service can become a 'catch all' provider • GPs / Practice staff often approach most responsive team, even if it's not the most appropriate service as defined in specifications • Practices can receive mixed responses from District Nursing teams for management of stable housebound patients/ long term conditions • Cross border response/ access: ranging from response for patients to response for practice MDT meetings.	• More regular communication between nursing teams and practices • District and Community Nursing services improving links with care for housebound patients from community services and long term conditions (including diabetes; Cardio/ Respiratory)
Service Delivery	• Different operational hours for services can lead to gaps in provision • Weekend provision – often meaning that Rapid Response used for services such as taking bloods.	• Better access/ availability of twilight and night nursing services • Enhanced services for nursing home patients
Resources	• My Care My Way resources valued by practices - responsive care • Greater use of SystmOne – reduce paperwork • Hub space is limited – lack of free rooms for clinics •	• A&E links to My Care My Way: making use of Community Independence Service and SystmOne access in A&E • Greater use of SystmOne, and reduced paperwork, for more effective working • Making systems more intuitive for users – including new/ locum staff
Generic Case Management	• Focuses on wrap-around care • Builds a trusting relationship between the patient/carer and CM/HSCA • Built on regular (fortnightly/monthly) contacts and home visits • Supports patient and family in facing the reality of a deteriorating health trajectory • Enables patient and family to make realistic decisions about future health and social care needs • Requires dual health and social care skilled input	• Use extended GP appointments supported by MDT to make decision to refer for generic case management as patients health and functional ability is deteriorating • Develop teams of Case Managers with either a nursing or social work professional background to jointly manage an active caseload of about 120 patients. HSCA could be used for routine monitoring and home visits which could increase caseload to 180. • Use extended GP appointments supported by MDT to refer patients with anxiety, mental health and/or drug and alcohol problems to generic case management team comprising CM with a nursing (mental health) background and CM with social work background.

MCMW Development and Improvement: Rapid Learning & evaluation findings (2)

Key Area / Functions	Findings	Suggested Actions
Disease Case Management	• Currently provided by CIS/rapid response • Some input from District Nurses • Insufficient capacity to meet demand • Services are currently fragmented and not patient-centred • The current MCMW team is not consistently sufficiently clinically skilled to provide home-based disease management and integrate wider disease management support services. • Most GPs are willing to do more active home-based management of exacerbations of disease but need increased home-based clinical nursing support to do this. • Some GPs not convinced this is efficient use of health service resources.	• Use extended GP appointments to identify which patients would benefit from Disease-based Case Management. • Develop clinical case manager role drawing on District Nurse and current MCMW CM workforce • Develop relationship between patient/family and nurse case manager. • Facilitate relationship development between nurse case manager and GP to enable more proactive disease management.
Social Care	• Provided by Local Authority Adult Social Care • Joint provision between health and social care via Better Care Fund which supports CIS and re-ablement • CIS and re-ablement are universal services • Domiciliary care packages and care home provision is means tested • Social care focuses on optimising functional ability via re-ablement prior to assessment for care package • Health care focus on patient safety and risk reduction to prevent further crisis • Delays in referral and access to re-ablement exacerbates concerns about vulnerability creating additional high cost ameliorative care work • Social care is not able to provide an effective flexible response to fluctuating health needs	• Reduce delays in Social Work assessment and access to re-ablement services • Agree level of risk and vulnerability to be tolerated during assessment and re-ablement process at MDT to include family/carer in discussion • Develop care planning skills to facilitate care planning for deteriorating health and functional trajectories • Enable patients to access flexible, fluctuating domiciliary care packages integrated with Disease Case Management via CIS.
Care Planning	• Care planning focused on identifying unmet need • The language of care planning does not fit with the trajectory of health and functional deterioration which requires a process of patient and family adjustment and bereavement that takes time to unfold. • MCMW Case Managers do plan for deterioration but often can't articulate this in a care plan until the patient/family have accepted this trajectory.	• Care plans need to reflect segmented needs of the population • Care Planning needs to form part of all levels of disease management. • Care planning should incorporate disease management protocols and where appropriate advanced care plans. • Care planning should incorporate health and well-being goals.

Programme Team and development of strategy

- The key to success of this strategy is co-production with our local providers and the wider system, with all appropriate partners inputting into the detailed development and delivery of the programme.
- To assist with this, the CCG is currently participating in the NWL Change Academy (CA) Programme which is supporting the development of the Integrated Care Strategy.
  - The CA team is made up of stakeholders from across the local systems including CCG clinical leads, practice managers, the local GP Federation (LMA), CLCH, RB Kensington and Chelsea as well as two patient representatives.
- Another critical success factor for the Integrated Care Strategy is the coordination of a large amount of change activity which is taking place across the CCG. As a result, clinical and officer leads are in place to ensure representation from all of the CCG's key delivery teams.
- The CCG's programme team to deliver the Integrated Care Strategy is set out below.

Integrated Care Strategy (ICS) component	Clinical (or Subject Matter Expert) lead	CCG officer lead
Overall Integrated Care Strategy	Dr Richard Hooker & Dr Andrew Steeden	Jayne Liddle
Integrated Community Team	Dr Richard Hooker	Will Reynolds and AD Planned and Unplanned (CIS, DN, Falls)
Health and social care integration	Dylan Champion (RBKC)	Henry Leak
Grenfell	Dr Oisin Brannick	Mona Hayat
Primary care	Dr Naomi Katz	Simon Hope
Mental Health	Dr Will Squier	Glen Monks
Accountable Care Programme	Dr Andrew Steeden	Will Reynolds

Outcomes: Focusing on Quality

A joint team of clinicians and managers from both commissioners and providers have been attending the Change Academy to develop the local system's integrated care strategy. Focusing on building on the foundation of MCMW, with a focus on out of hospital and primary care-based care, the team agreed a high level Logic Model, which sets out a clear vision for the way the local system has to adapt to become more efficient and clinically effective.

INPUTS In order to deliver the purpose of the contract we invested the following:	ACTIVITIES In order to address the problem the contract requires the following activities:	OUTPUTS We expect that once accomplished, these activities will produce the following outputs:	OUTCOMES We expect that if accomplished, these activities will lead to these changes:
• Staff resource (CCG; provider; STP; ICHP/AHSN; other external expertise where required). • Clinical leadership • Infrastructure, hardware or software. • Financial Investment. • Best practice from national and international accountable care models with transferable insights.	• Comprehensive needs assessment using population health analytics and deep dive into case files of complex patients • Developing a workforce model based on care functions identified through needs analysis to make recommendations around staffing roles, responsibilities and skills mix • Refining the model of care (increased care functions; whole population; increased efficiency of effort and outcomes delivery) • Business case and commissioning framework development to deliver shorter (18/19) and longer (19/20 onwards) term efficiencies. Provider and patient engagement and co-production • Development and increased visibility of the Alliance Leadership Group – including review of membership • OD around Primary Care Home (driven by primary care) • Continuous monitoring and action learning to drive iterative improvement/ enhancement	• Single integrated community team • Single management structure • Single care record supported by integrated digital/ IT functionality • Single assessment of health and care • Single set of incentives (outcomes-based KPIs) and standards • 'Integrator' function set up to drive accountable care • Single capitated budget (virtual/ shadow in 18/19; 'live' in 19/20) • Primary Care Homes defining needs assessment of their local populations • Realistic financial plan with phased delivery of benefits • Workforce plan which provides a career trajectory for all staff, to improve staff retention and satisfaction.	**Population health** • Proactive care to maintain good health • Diseases well managed • Care tailored to local need **Patient experience** • Living independently at home but not isolated • Having one conversation • Reduced health inequalities **Financial benefits** • Reduced cost duplication by identifying and removing MCMW, CIS, DN, Practice nurse, home care duplication and identifying opportunities to use resources better. • Improved value by enhancing the cost effectiveness and quality of interventions **Staff experience** • Staff acting as one organisation with shared values (including voluntary sector, wider community assets including local businesses) • Information easily available to staff and readily shared when appropriate • Working as a single team with carers

ASSUMPTIONS

- Collaboration between commissioners and providers with strong clinical leadership.
- Staff recruited to populate workforce plan and meet skill mix requirements of the iteratively developing model of care.
- Building on the strong foundation of MCMW to develop the out of hospital care model functions, in order to drive shorter term financial benefits.

EXTERNAL FACTORS

- Engagement with acute providers to ensure vertical integration with the out of hospital pathways.
- NWL STP strategy will have an impact on elements of the local system's planning and close collaboration is required between NWL and other CCGs to ensure plans are aligned and planning resources are used efficiently.

The Alliance Operational Group have been working to develop a single Outcomes framework which will guide the collaborative development of a single set of outcome-based KPIs for all providers that jointly deliver an Integrated Community Team (Phase 1) in 2018/19.

Workforce: Emerging competency framework

As we move towards a single integrated health and social care team the need for a comprehensive competency framework, that covers all health and social care professional staff and which enables staff to fulfil their potential and provides a structure for career progression, becomes more apparent.

It is envisaged that all staff should be trained to provide as many core skills to patients to reduce duplication of effort where possible. Opportunities should be given to staff to add to existing professional skills with the right clinical and regulatory support. All staff should be encouraged to work to the top of their licence.

To do this we will need to:

- Scope, review and benchmark against all existing competency frameworks; working across partner organisations to pull together a whole community resource
- Reviewing existing complementary training modules and courses (Bucks University - Innovations in Health Programme)(Free modules to build CPPD)(Integrated learning – King's University)
- Co-design career pathways for staff and facilitate better staff retention
- Complete a workforce skills and task map and develop a systemised programme
- Share knowledge and training plans with other agencies / CCGs
- Establish a mandatory framework
- Establish a baseline to provide an overview of the current staff training situation for all staff and training required
- Develop inter-agency career opportunities and career pathways for new hybrid workers
- Identify shared baseline training and specialist training

Estates and Hubs

- West London CCG has the advantage of having in place two well established Integrated Care Centres (Hubs) from which CLW and MCMW services are run.

- Leaning from our evaluation and rapid learning show that co locating clinical teams has an impact on how care is integrated.

- An estates strategy (due March 2018) is being developed which will be in part driven by the Integrated Care Strategy to ensure that Estate is an enabler to how Hubs expand and support the emerging PCHs. The Estates Strategy will also focus on individual estates of GP practices.

- Hub Business Cases (VM Hub – Spring 2018) will align and will be based on the assumption that the hub will be central to the delivery of the strategy with clinical teams co located and with a single management team.

Capacity and capability to deliver

To support the scope and pace of transformational change resources will need to be considered:

- Link across STP area where possible to share learning and link with NWL Accountable Care Team
- Local Clinical Leadership
- Engagement and communications will be vital
- On the ground support for practices and emerging PCHs
- Focus on 'social' element of change and OD for this
- Identify (and potentially share) technical expertise required

Page 68 of 160

As part of our joint-process to develop the local model of care and improve the productivity of the local system, the programme team will investigate how the system can do more for less and deliver better outcomes to patients through digital technology. New ways of working have the potential to enhance the capacity and capability of our GP-led community teams and the local system is committed to exploring how digital innovation can help to deliver better value, including through:

- Mobile working
- Virtual team working/ meeting
- Improved risk stratification approaches
- Systematized continuous evaluation
- Better information collection and sharing

Our plan is to quickly and safely test options in order to establish which technologies may offer opportunities to improve ways of working and efficiency. This will be achieved by developing proposals to access funds to support closer integration-in-year (17/18) and over the next two years (e.g. via BCF funding)- as well as close working with the CW+ Digital team and Imperial College Health Partners to identify ways to improve the value the local system delivers to patients.

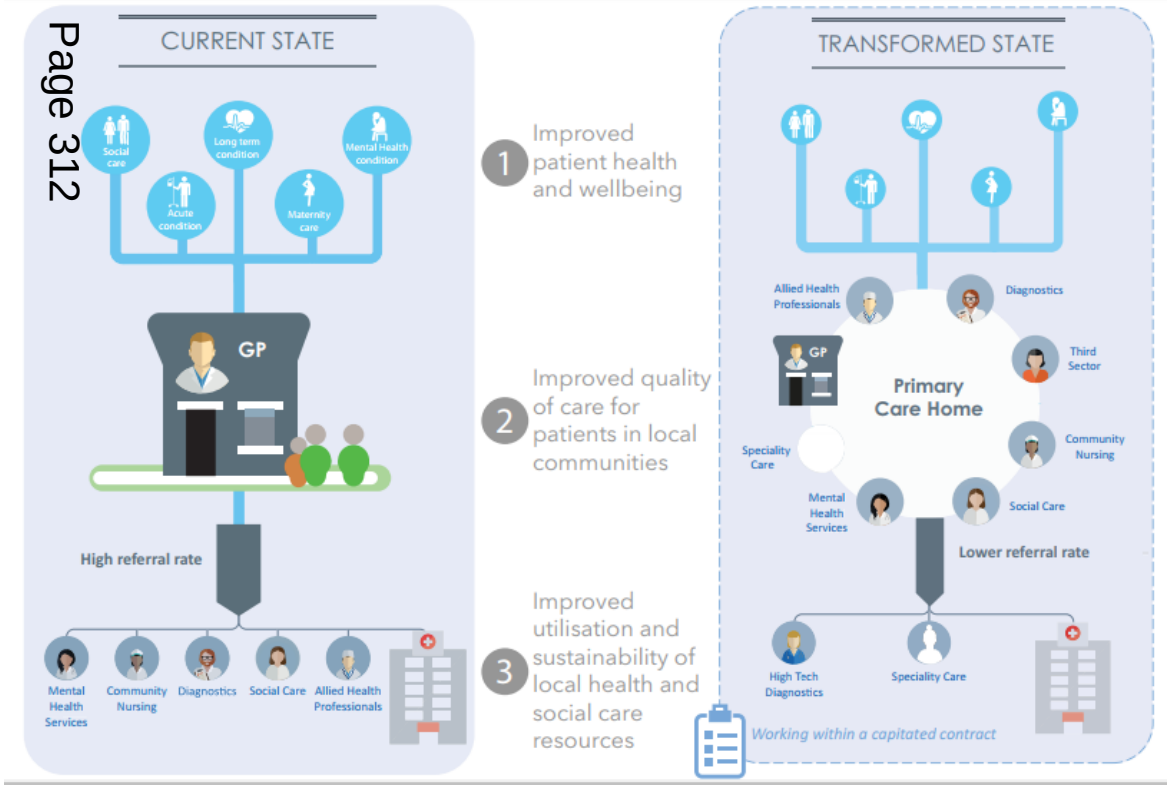
Integrated Community Team

The CCG is aiming to develop a truly integrated, primary care facing community team. This team will build on the current My Care My Way service to take on more care functions and expand to serve the whole population. The team will work to a single set of outcomes, with a single management structure and will be tailored to the population health needs of each Primary Care Home.

2017/18	Plans for a transitional change 18/19	Ambition for 19/20
- MCMW Rapid Learning recommendations rolled out across Waves 1 and 2. - MCMW rolled out across all 44 practices (including North Kensington). - Development of Integrated Community Team (Phase 1) for older adults (65+) Business Case (BC) with a range of additional care functions added to MCMW (for launch in April 2018). - Commencement of Integrated Community Team BC to cover all out of hospital care functions and whole population (due for launch in April 2019). - Working with providers to develop a single Outcomes Framework, outcomes-based KPIs and strengthened contracts.	- Launch of Integrated Community Team (Phase 1) for older adults (65+) model of care from April 1st 2018. - Service jointly managed by a single management team through with a single Outcomes Framework. - ICT providers working as a single service, with separate contracts, but an overarching Alliance Agreement. - Iterative addition of other care functions in-year where there is opportunity to do so (e.g. CLW). - Market engagement process to work with interested providers to refine the ICT Model of Care and BC. - ICT operating in PCH pilot sites, with PCHs determining needs and directing care. ICT tailored to local need, building on base model of care.	- Launch of Integrated Community Team in April 2019 as a component of a Partial MCP. - ICT covering the whole population. - Most if not all out of hospital health and care functions delivered by the ICT, including adult social care functions. - All ICT providers sitting within a single accountable care contract with a pooled budget from April 2019. - All care across the CCG directed by Primary Care Homes (PCHs), with PCHs tailoring and managing their ICT to deliver patient outcomes. - Single assessment and care plan supported by single IT system. - Optimised hub offer providing support to PCHs.

Primary Care Home: Background

The Next Steps of the FYFV is not prescriptive in terms of how accountable care should be achieved, but NHSE notes that one route is through the creation of locally integrated care for populations of 30-60k people based on GP registered populations. PCHs will allow us to start testing and developing our accountable care system – via a group of practices being supported by the Integrated Community Team (Phase 1) for older adults (65+) offer. We will be kicking-off with 'pilots sites' in January 2018.

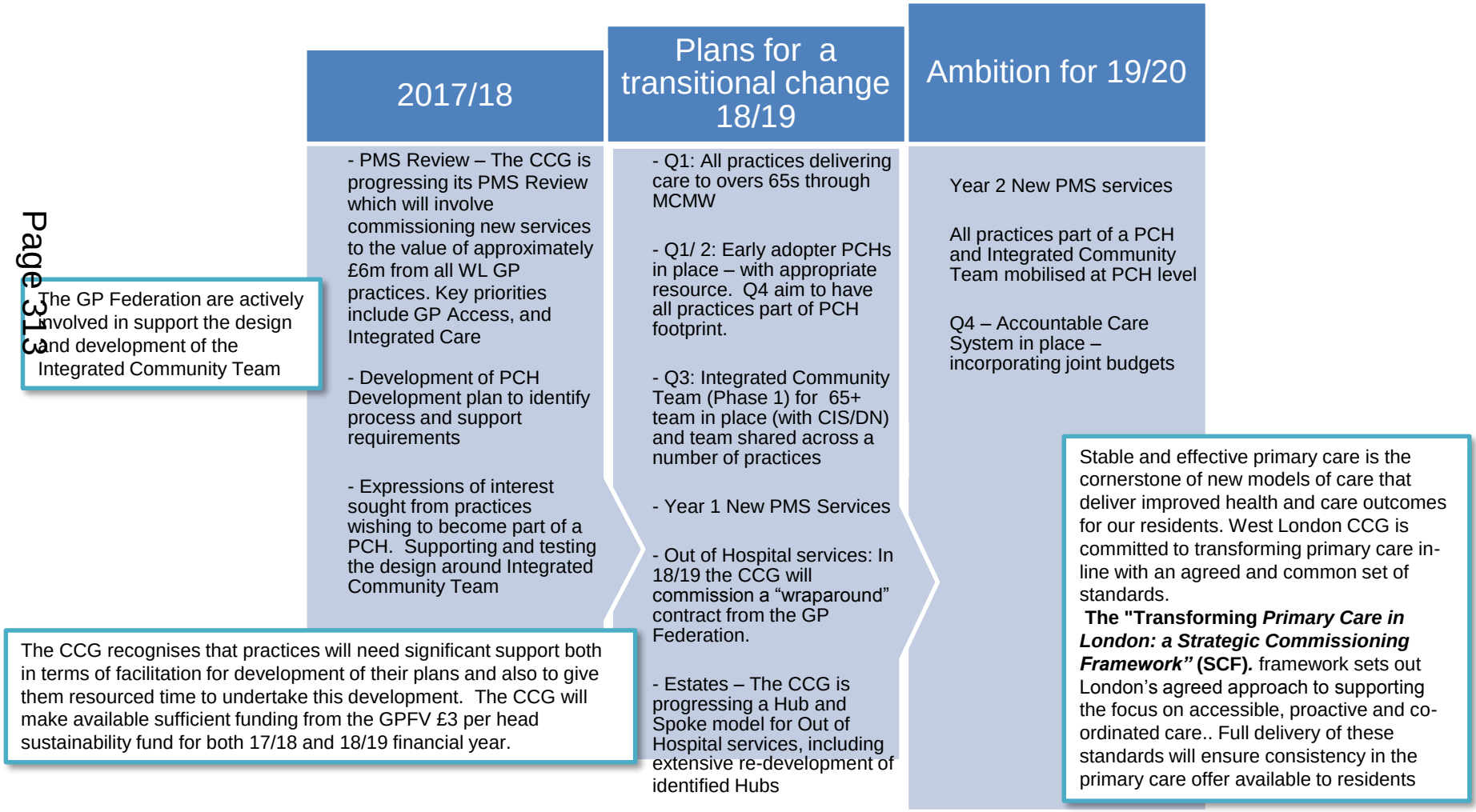


There are many variations of this, but **the four key features** are:

1. a combined focus on personalisation of care with improvements in population health outcomes
2. an integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care
3. aligned clinical and financial drivers through a unified, capitated budget with appropriate shared risks and rewards
4. provision of care to a defined, registered population of between 30,000 and 60,000.

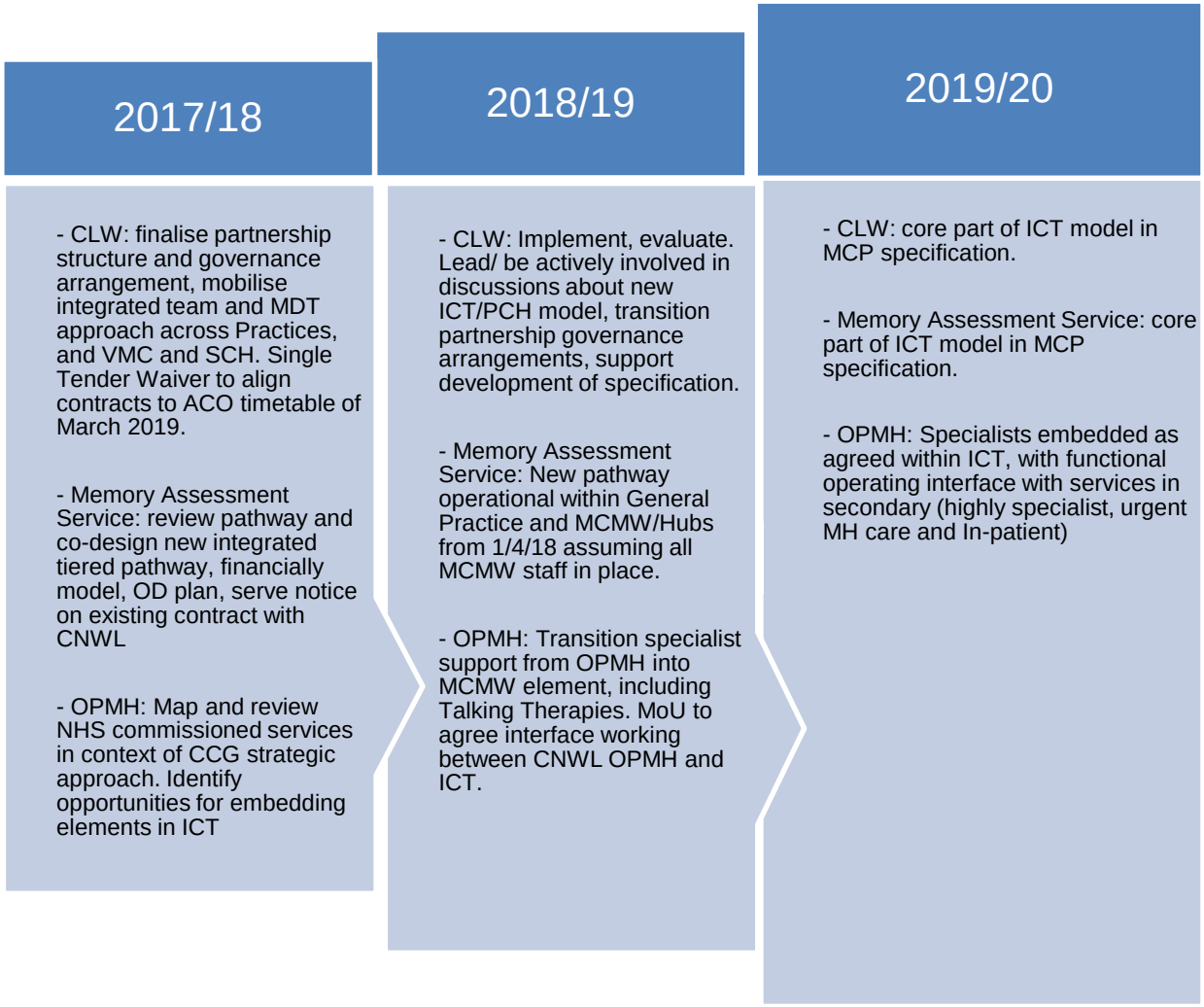
Primary Care

A key principle of the Integrated Care Strategy is keeping primary care and the GP central to how care is delivered, managed and coordinated. We will re invest PMS funds pack to practices to support delivery of the Integrated Care Strategy and we will ensure additional capacity and capability is developed at primary care level through PCHs.



Mental Health: Community Living Well, Dementia and Older Adults Mental Health

Three distinct client groups and services need to be a core part of the ICT offer.



Health and Social Care integration

Through the MCMW model a number of elements of integration are already in place. We will build on this and have ambitious plans to further integrate teams through a Single Integrated Community Team with a single budget and management structure.

We will share and agree our plans with RBKC and WCC HWBBs. We have representation on the Alliance Leadership Group and as part of the Programme Team developing the Int. Care Strategy

MCMW - current	Plans for a transitional change 18/19	Ambition for 19/20 as part of Single integrated Community Team
ASC Workers regularly attend Hub and Practice MDTs.	CIS (Rapid Response) part of Single Integrated Community Team. Q3.	Joint Integrated Community Team with associated single management structure, joint budget, KPIs and targets
Social Workers in MCMW offering advice and support.	Co-location of complex care teams at a PCH level. Q3.	Single 'assessor and case manager' able to access all resources for patients, with specialist input where required.
By Jan2018 all MCMW staff trained as 'trusted assessors' for equipment.	Developing competences and training to maximise single professional input opportunity across the 'community'.	Single IT system covering all community services.
Caseload visibility on both Health and Social Care IT systems	Aligning Health and Social Care Assessors and Independent Living Assessors roles as shared roles.	Alignment of domiciliary care at PCH level.
Tri B CIS service in place, service has access to all health records and ASC records.	Piloting 'trusted to assess' for services in other organisations, with access to both IT systems.	Partnership working with Extra Care, Care and Nursing facilities.
Hospital discharge services co-located to facilitate effective discharge and admission avoidance.	Shadow joint health and social care budget with MOU and governance arrangements in place.	Residents know how to access support through a single team, telling their story once.

NHS Services are free at the point of contact and one of the key principles around integrated care is to offer care proactively, while social care is means tested and only provided for people able to demonstrate a quantified level of need following assessment (except for reablement). Partners will need to work through the restrictions placed on the system by different statutory funding and payment models. This challenge should not be a deal breaker though, providing that partners can demonstrate that the model of care and the business case will deliver benefits for residents, the CCG and the Las.

North Kensington

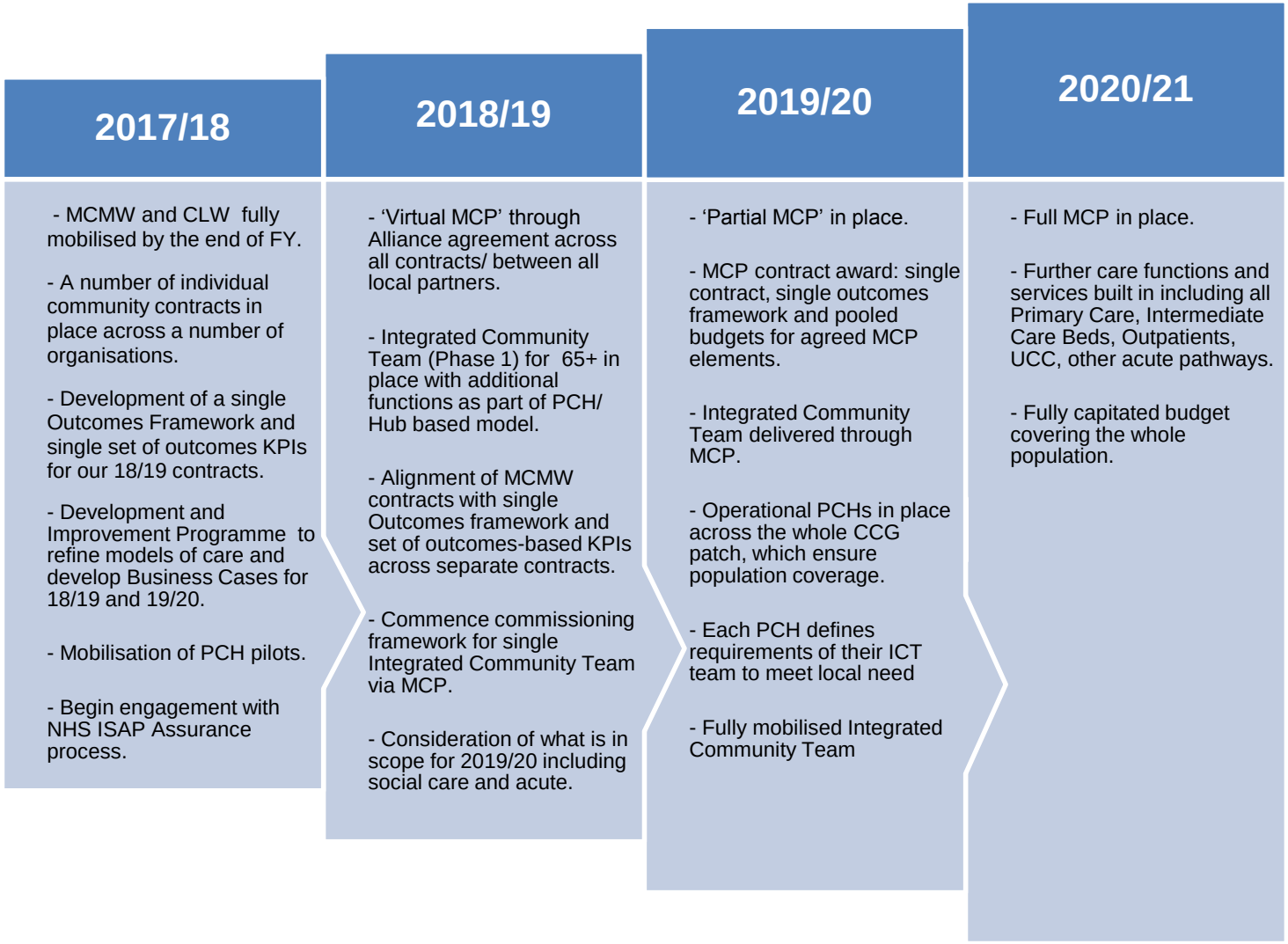
In responding to the Grenfell fire and to provide focused support to the wider North Kensington community in the future, the CCG is developing a proof of concept enhanced health and wellbeing model is being piloted following a series of engagement events with stakeholders. The team will build on the current My Care My Way and Community Living Well services to take on more care functions and expand to serve the whole population. This model will evolve over time.

2017/18	Plans for a transitional change 18/19	Ambition for 19/20
Proof of concept of a central coordination hub of the key agencies* working together.	Whole population approach including children and younger people.	Support the community to build their resilience.
Utilising and expanding existing services where relationship are already built up.	Focus on recovery, health, social care and improving long term outcomes.	A wider wrap around service to include primary care, mental health, voluntary sector.
Initial framework on which the community can then build a long term service.	Built on MCMW and CLW principles including case management , care planning, navigation and MDT working and family MDTs.	Ensure people with complex needs are supported to navigate their way through the different support available for them and their family.
Focus on an integrated offer to ensure we reduce the number of times people are referred between agencies.	Aligned to the RBKC Care for Grenfell model.	Potential for patient to join the MDT so they can contribute to the discussion on the care they will receive.
Ensuring the GP is central to how care is delivered for their residents.	Family based case manager where appropriate - Family MDTs	Integrated Community Team in place via a single communising framework.
Ensuring that when someone moves out of area there is some continuity for them once they move.	Central coordination function (Hub).	All ICT providers sitting within a single accountable care contractual framework (e.g. MCP or Alliance contract) from April 2019.
A model that is delivered in a place which is most suitable for the needs of the resident.	Effective use of the hubs - 'One stop shop' principle.	Single capitated budget for ICT, (with primary care, community and some acute service budgets) managed by the Accountable Care System.
	Proactively reaching out to high risk groups and patients.	

* For example:
- Outreach
- GP
- MCMW Case Manager
- CLW – PCLN
- Mental health team
- RBKC key worker
- Community support

Accountable Care System: The journey

"Establishing an MCP requires local leadership, strong relationships and trust."
NHS England



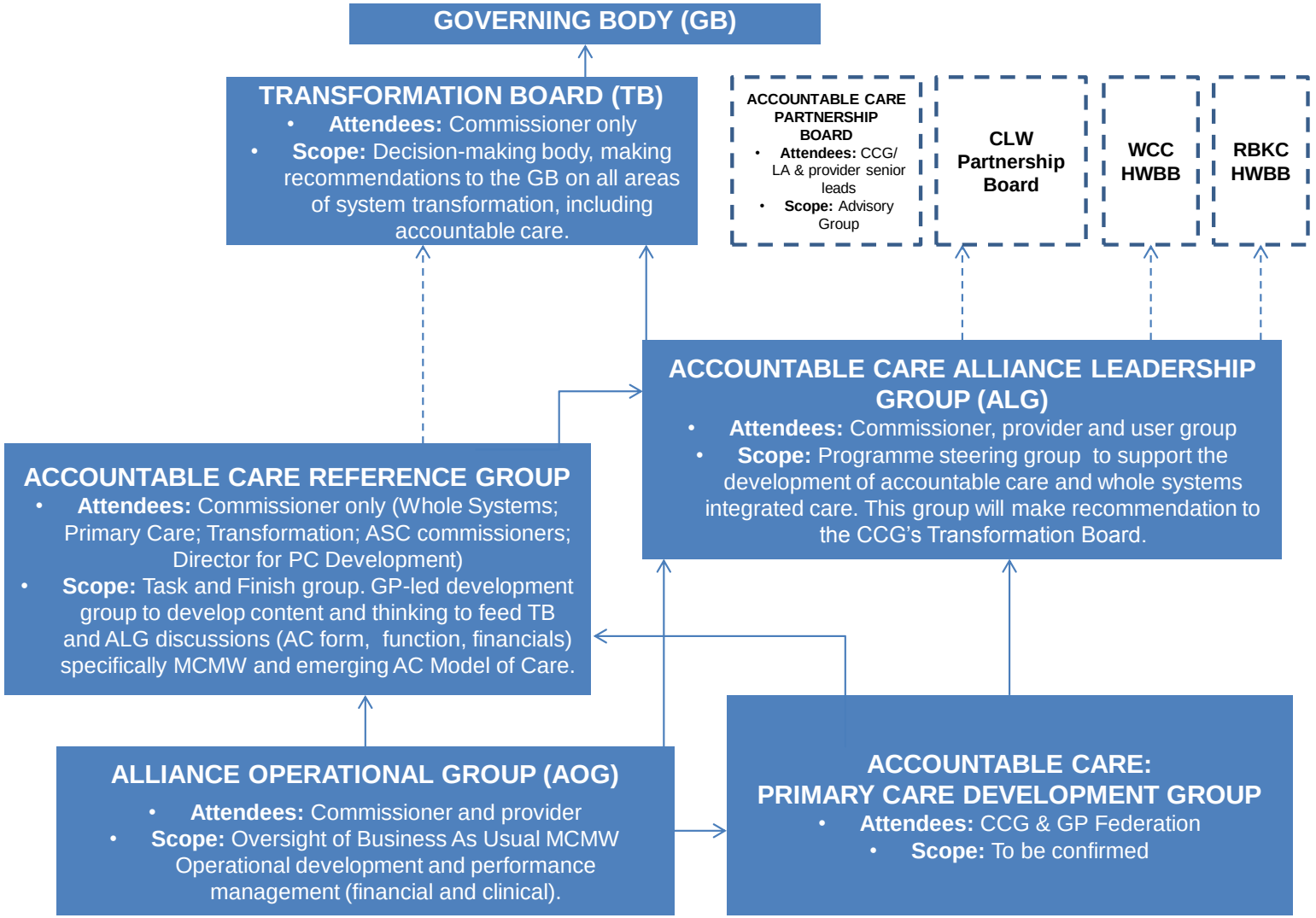
Accountable Care: Blending local and NWL STP approaches

- West London CCG agree that NWL CCG AC plans should share a set of common elements so that NWL has a coordinated approach to accountable care development across its STP footprint, whilst also recognising different starting points and capitalising on the firm foundations within West London.
- We acknowledge the common features or 'ingredients' of successful accountable care from NHS vanguard learning and will use these as a framework for both our local and NWL-wide work. **The below table sets out our delivery trajectory for these 17 'ingredients'.**

	Accountable Care 'Ingredient'	17/18	18/19	19/20
1.	Outcomes based contracts (& putting an end to activity based payments)		✓	✓
2.	Core outcome measures in key population or service segments – esp patient described outcome measures / targets		✓	
3.	Alignment on priority targets – eg 65+, frailty, children etc.		✓	✓
4.	Long-term contract (c.10years)			✓
5.	Pooled budgets			✓
6.	New payment mechanisms (based on outcomes, shared accountabilities)		✓	✓
7.	New risk / gain share arrangements			✓
8.	Capitation methodology			✓
9.	Requiring providers to increasingly focus on primary & secondary prevention	✓	✓	✓
10.	Shared Data / BI capability and information flows – building on and expanding the WSIC dashboard		✓	✓
11.	Single contracts covering multiple providers (ie all providers that are necessary to deliver target outcomes)		✓	✓
12.	Culture and system change – to prioritise new ways of thinking, working (ie a one system, one budget mindset) & staff development	✓	✓	✓
13.	Multi-partner provision – Primary Care, Community definitely need to be in 13a. MH, SC	✓	✓	
14.	One set of back-office functions across the AC partners		✓	✓
15.	Requiring providers in existing contracts or allied arrangements to commit to becoming part of wider accountable care arrangements as and when required		✓	✓
16.	Locking progress into contracts (contract updates, CVs etc)	✓	✓	✓
17.	Use of readiness matrix assessment / accreditation standards to support provider capacity and capability development toward AC working; driving principle to reduce unwarranted variation supports need for consistency	✓	✓	✓

KEY ✓ Delivered in year ✓ Partially delivered in year ✓ Highlighted element delivered in year

Managing the change: Governance



Provisional Governance structure

Managing the change: Engagement approach

The Integrated Care Strategy (ICS) is the next iteration of and a direct continuation of the Whole Systems Integrated Care approach which was subject to a public consultation and signed off by the WLCCG Governing Body in 2015. The ICS forms part of a longstanding strategic direction set by the local system three years ago which has been tested numerous times at GBs that are open to the general public.

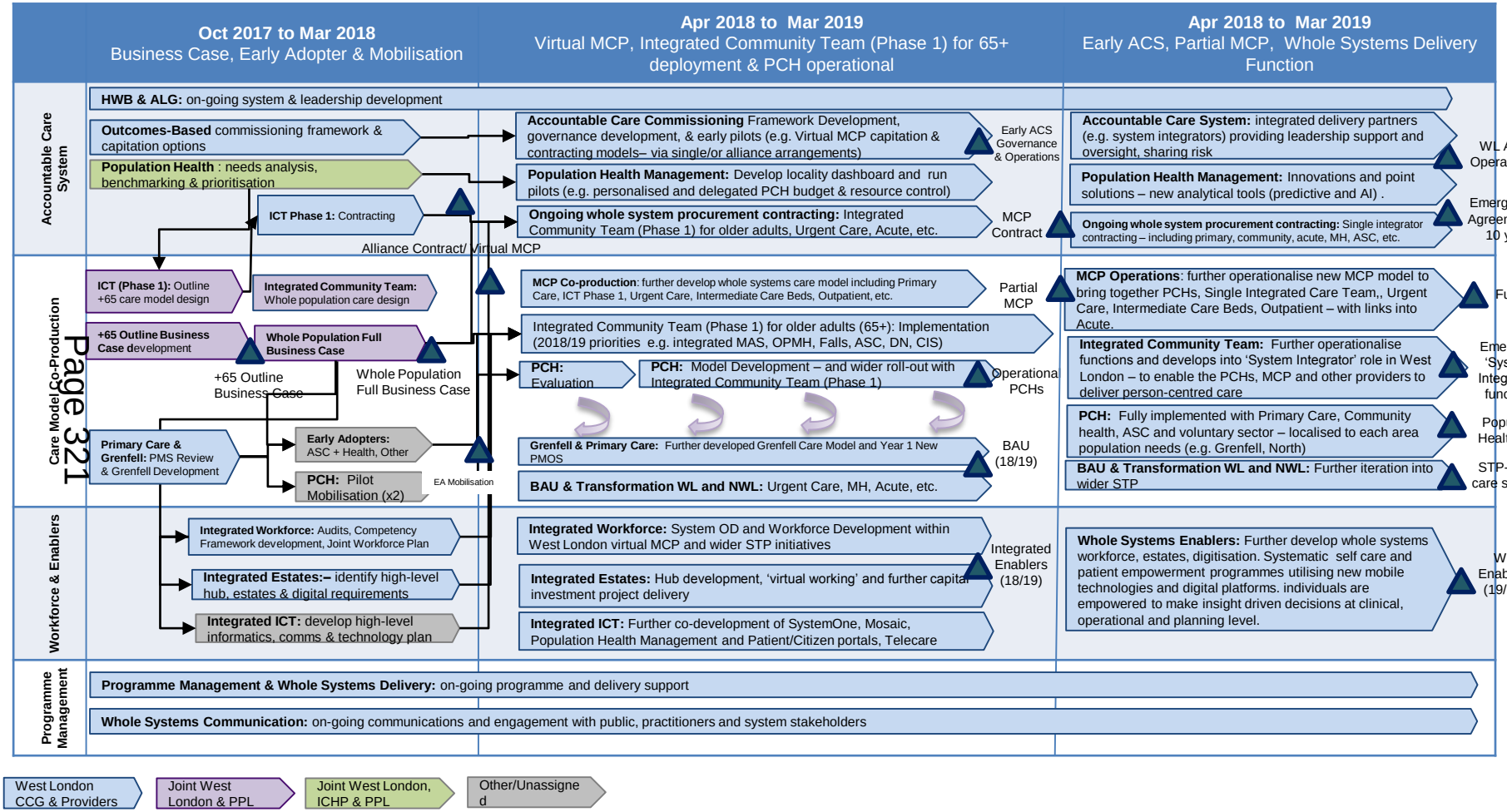
Wide ranging engagement has taken place with patients and the local system on this Integrated Care Strategy including:

- During the Change Academy where a mixed group of commissioners, patients and providers drew up the outline outcomes framework for the ICS **(September 2017)**
- CCG Transformation Board where the draft ICS was signed off by commissioners and patient reps **(September 2017)**
- Draft strategy was shared by Dr Richard Hooker – clinical Lead at West London 's GP Plenary**. (September 2017)**
- Governing Body Development Session where the next iteration of the ICS was signed off by commissioners and patient reps **(October 2017)**
- Violet Melchett Steering Group **(October 2017)**
- Accountable Care Alliance Leadership Group **(October 2017):** the system's key group for steering accountable care signed off the approach.
- Individual meetings with our providers' senior management **(October 2017)**
- Patient engagement including individual and group meetings with patient representatives **(ongoing)**.
- The Integrated Care Strategy is being submitted to the Patient Reference Group **(7th November 2017)**
- The strategy is also being submitted to the CCG's Quality and Safety Committee and Governing Body on **7th November 2017.**

In addition to all of the above engagement taking place to date, we are aware that this is just the start of the process. On approval, the ICS will be converted into a detailed Programme Plan, which will include an Engagement plan. As the transformation programme progresses, detailed consultation on the development of the associated models of care will be taking place with users of all of the services involved in the system transformation.

On approval of the ICS, a full Engagement Plan will be developed and tested with local stakeholders and patient groups to ensure that the live plan reaches all groups that have a stake in the delivery of the Strategy are consulted

Managing the change: 2018-20
Integrated Care Strategy on a page



Managing the change: Quality and Equalities and Inequalities Impact Assessments

- The intention of the strategy is to improve quality and reduce inequalities of service provision and outcomes.
- To this end, a Quality Impact Assessment tool has been submitted to the CCG's Quality and Performance Committee (QPC) on November 7th, 2017.
  - Following advice and steer from the QSC, further steps will be taken to ensure that all impacts on the local community are understood, mapped and managed to deliver better quality services for all of our local communities.

Furthermore, an Equalities and Inequalities Impact Assessment has also been completed and submitted for the Strategy to the CCG's Quality and Performance Committee (QPC) on November 7th, 2017.

- Following advice and steer from the QSC, further steps will be taken to ensure that all impacts on the local community are understood, mapped and managed to deliver increased equality and reduced inequality in our service provision to all local residents and communities.

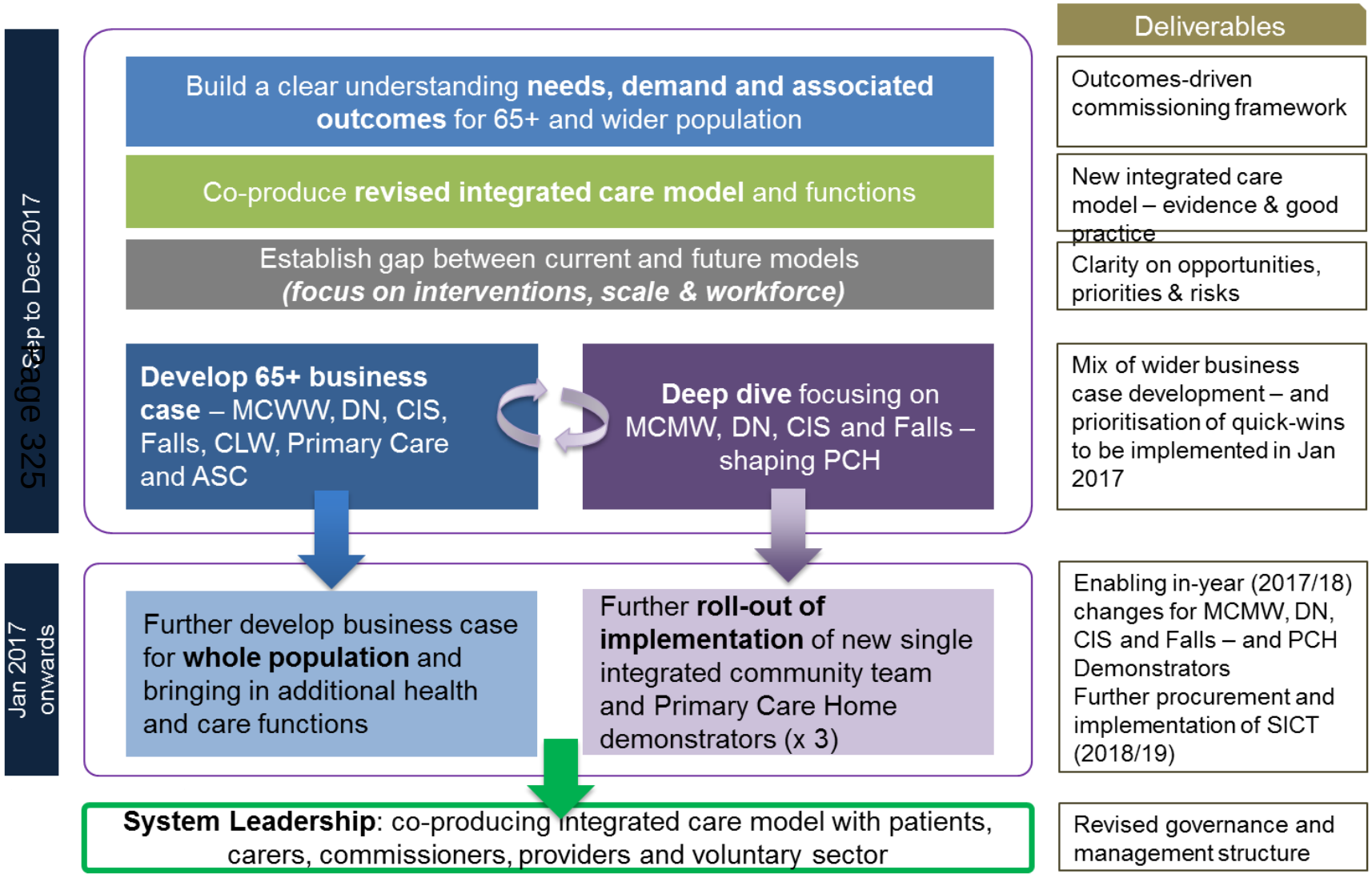
Integrated Care Strategy: Key risks

Risk/ Issue?		Likelihood	Consequence	Score	Mitigation
Risk	**Financial- Impact on Business as Usual** The transition to accountable care and scale and speed of the change is very disruptive, leading to a loss of focus on business as usual and delivery of short term efficiency savings, leading to an unsustainable financial position for the CCG and local providers.	2	5	10	The programme plan should be structured to ensure that delivery of savings (transactional and transformational, both QIPP and general cost control) is phased, with the change programme delivering, short, medium and longer term savings and enhanced cost-effectiveness to support the delivery of WCCG and the wider NWL STP area's financial sustainability.
Risk	**Financial- Failure to deliver anticipated benefits** The transition to accountable care does not deliver the planned financial savings, leading to an unsustainable financial situation for the local system and wider STP.	2	5	10	The change programme will involve a comprehensive, 'bottom up' business case development process which includes providers to ensure that accurate data and conservative, realistic assumptions are used when determining the financial impact of delivering the integrated care strategy and the move to accountable care.
Risk	**Provider workforce** The development of the Integrated Care Strategy and move towards a single, integrated community team destablises the workforce and staff decide to leave.	2	5	10	Co-production with our local providers and clear communication of desired system goals to the market will provide assurance to staff and follow a 'no surprises' ethos. Comms and engagement should also emphasise the key benefits to staff and local providers of the move towards a single integrated team and accountable care more widely. To this end a Comms and Engagement lead will be appointed to manage this part of the programme.
Risk	**Change Programme team capacity** The scale and speed of the change programme is substantial, putting too great a strain on limited CCG programme delivery resources, leading to delays in the programme and/or sub-optimal outcomes.	2	4	8	The CCG is taking steps to ensure that the programme team has sufficient capacity and capability to deliver the change programme. This means recruiting to vacant posts in the Whole Systems teams (Contracting and Commissioning support manager; Comms and Engagement lead) as well as drawing on the resources within other teams in the CCG (and potentially, local providers) to support the delivery of the integrated care strategy.
Risk	**Lack of engagement** Local system stakeholders are not sufficiently well engaged which leads to slow decision-making, difficulty in getting the right input and at the right time from local providers and this has an impact on both delivery timescales and the quality of the change programme's outputs and outcomes.	2	4	8	The governance structure for Whole Systems is already well established and has made great strides in delivering real change with the roll out of the MCMW service. This structure will be the driving force behind the CCG's accountable care change programme and this structure has been adjusted accordingly to ensure that the right people attend the right meetings, governance groups take place in a timely manner and decisions are expedited. To ensure visibility and attract stakeholders of appropriate seniority, the Alliance Leadership Group will be attended by Fiona Butler, the CCG's Chair of the Governing Body.

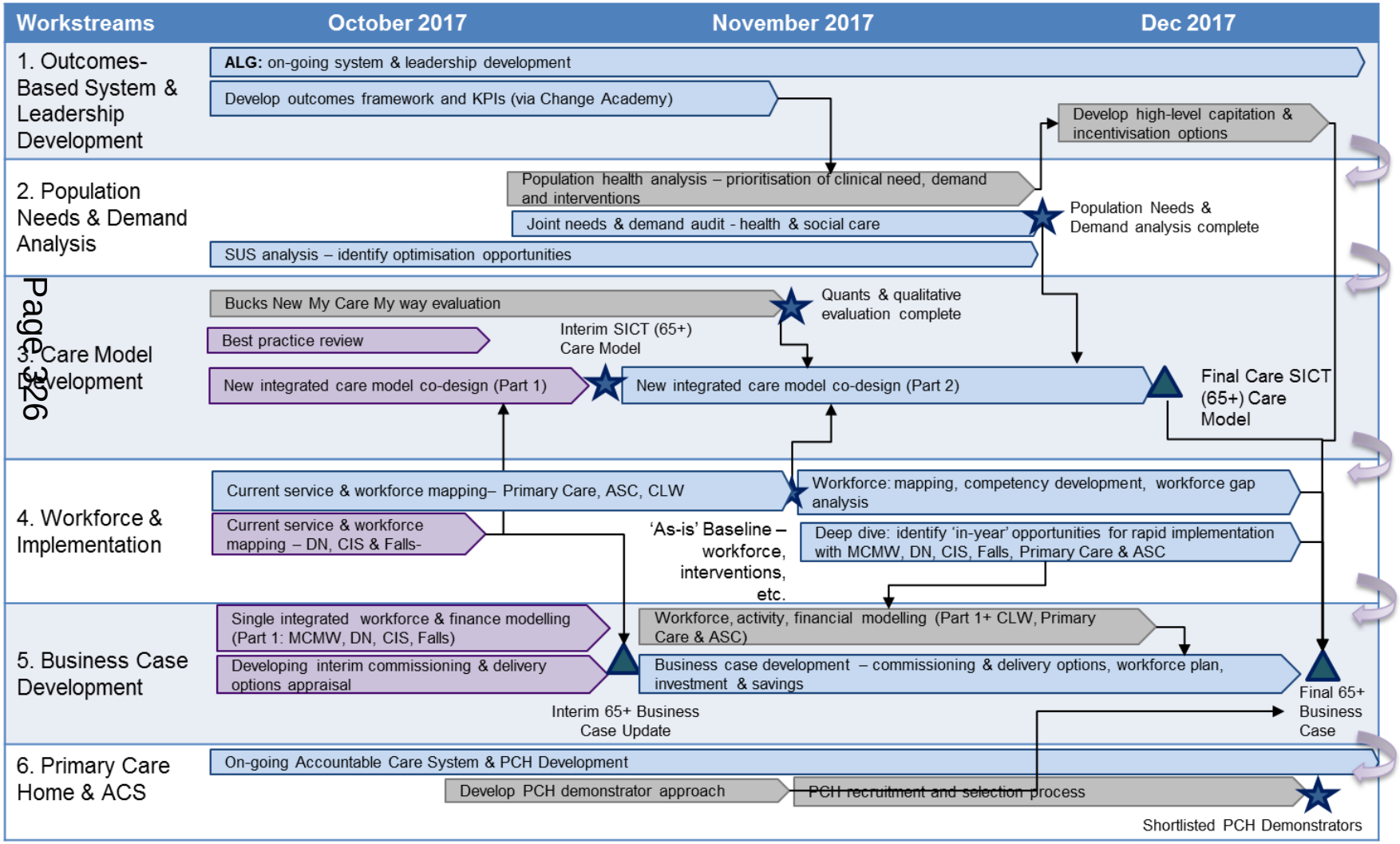
APPENDIX 1

Detailed plans for 17/18

Integrated Care Strategy: High-level approach for Q3 (Oct to Dec 2017)



Integrated Care Strategy: Detailed Plan Q3 (Oct to Dec 2017)



Integrated Care Strategy: Critical input, decisions and milestones (Q3)

#	Input/Decision/Milestone	Who/Where	When	Impact
1	**Integrated Care strategy 'buy-in'** – approach and mobilising wider system stakeholders (co-production)	• ALG • CCG GB (Public)	• 25 September 2017 • 7November 2017	Essential to get provider and wider system leadership 'buy-in' to support our approach – and **release operational capacity to support development** (e.g. Federation, LA, CLCH, voluntary sector)
2	Access to current baseline of **services and workforce and activity data**	• CCG & Providers	• Mid October 2017 • (Deep Dive) • Mid-November 2017 (Other)	Critical to work with commissioners and providers to establish 'as-is' and opportunities to **meet BC deadline in Dec 2017**
4	**Establish feasibility 'deep-dive'** and quick wins area (e.g. DN, CIS and Falls)	• CCG GB	• Late October 2017	Clarity on **savings and improvement opportunities** profiling in-year (2017/18) and 2018/19
3	**Interim 65+ Business Case** – strategic input and development	• AOG • CCG GB Development	• 16 November 2017 • 21 November 2017	Critical to engage with senior leadership across **CCG and system to shape final BC**
5	**Outcomes & population health needs** commissioning framework sign-off	• ALG • CCG GB?	• 7 December 2017 • TBC?	Input into 65+ business case – and, critical input to shift WL system **towards PCH, Accountable Care System and wider Accountable Care System**
6	**Final 65+ Business Case** – strategic input and development	• ALG • CCG GB • CCG GB	• 11 January 2018 • 16 January 2018 • 20 February 2018	Need to mobilise immediately with providers on in-year changes – and meet **re-procurement deadline for August 2018** (deep-dive)

Integrated Care Strategy: Critical input, decisions and milestones (Q4 onwards)

#	Input/Decision/Milestone	Who/Where	When	Impact
1	For completion			
2				
3				
3				
5				
6				